**"AGREED"**

**on behalf of the Central Bank of the Republic of Azerbaijan**

**/signature/**
**Director General**
**Ziya Aliyev**
***October 22, 2024***
**Stamp: available**

**"APPROVED"**

**based on the minutes of a meeting of the Management Board of the PASHA Life Insurance Open Joint-Stock Company, No. 089/24 dated on 21.06.2024**
**/signature/**
**Chairperson of the Management Board**
**Niyaz Ismayilov**
***June 24, 2024***
**Stamp: available**

# Rules of Insurance Against Incurable Diseases

**Baku 2024**

# Disclaimer

Please take into consideration that this document constitutes an unofficial translation from Azerbaijani. If there is any inconsistency between the Azerbaijani and English versions of the document, the Azerbaijani version shall prevail. In case of any questions or uncertainties regarding its content, we kindly recommend contacting the Insurer for verification.

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**Abbreviations used in the Rules of Insurance Against Incurable Diseases:**

**CT** — computed tomography;
**MRI** — magnetic resonance imaging;
**ECG** — electrocardiogram;
**MMSE scale** — Mini-Mental State Examination scale;
**AIDS** — Acquired Immunodeficiency Syndrome;
**HIV** — Human Immunodeficiency Virus;
**dB** — decibel;
**RAI** — Rai classification of chronic lymphocytic leukemia;
**TNM** — international classification of malignant tumors;
**CIN** (cancer in situ) — carcinoma in situ.

## 1. General Provisions

1.1. The Rules of Insurance Against Incurable Diseases *(hereinafter referred to as the "Rules")* of PASHA Life Insurance OJSC *(hereinafter referred to as the "Insurer")* have been developed in accordance with the Civil Code of the Republic of Azerbaijan, the Law of the Republic of Azerbaijan "On Insurance Activity," and other regulatory legal acts.
1.2. These Rules constitute an integral part of all insurance contracts against incurable diseases concluded by the Company *(hereinafter referred to as the "insurance contract")*.
1.3. The insurance application form, drawn up on the basis of these Rules and completed by the insured person, shall, upon signing, constitute an integral part of the insurance contract.
1.4. The application form referred to in clause 1.3 of these Rules shall be determined by the insurer.
1.5. Matters not provided for in the insurance contract and these Rules shall be governed by the legislation of the Republic of Azerbaijan.

## 2. Key Definitions

2.1. Unless otherwise provided by the content of these Rules, the terms and expressions used herein shall have the following meanings:

**Policyholder** — a natural or legal person who pays the insurance premium, has an insurable interest in the insurance of the insurance object, and is a party to the insurance contract;

**Insurer** — a local legal entity that is a party to the insurance contract, holds an appropriate license to carry out insurance activities in accordance with the Law of the Republic of Azerbaijan "On Insurance Activity", and assumes the obligation to make an insurance compensation in the manner prescribed by law or the insurance contract upon the occurrence of an insured event provided for in the insurance contract — PASHA Life Insurance Open Joint-Stock Company;

**Insured person** — a person whose property interests are insured under an insurance contract;

**Beneficiary** — a person to whom an insurance compensation must be made in accordance with the insurance contract;
**Actuary** — a specialist who, in accordance with the legislation, determines the basis for calculating insurance premiums by performing economic and mathematical calculations, and also calculates insurance reserves;

**Insurance contract** — an agreement setting forth the terms under which the insurer assumes the obligation, in exchange for payment of the relevant insurance premium by the policyholder, to compensate losses, reimburse damage, or pay an agreed monetary amount related to risks to which the insurance object may be exposed, upon the occurrence of a specified event;

**Insurance certificate** — a document issued by the insurer to the policyholder and/or the insured person confirming the fact of conclusion of the insurance contract;

**Insured event** — an event or circumstance that occurs during the term of the insurance contract and which, in accordance with the legislation or the insurance contract, constitutes grounds for payment of insurance compensation to the policyholder, the insured person, or other beneficiaries;

**Accident** — a sudden, unforeseen, and accidental event associated with an external physical impact that causes harm to the health of the insured person, accompanied by a sudden and acute impairment of health in the form of injury to organs or tissues, or resulting in death;

**Insured amount** — the maximum limit of the insurer's liability for the insured risks, expressed as the amount established by the insurance contract;

**Insurance premium** — the monetary amount that the policyholder is required to pay to the insurer, in the manner prescribed by the insurance contract, in consideration for the assumption or distribution of risks;

**Insurance compensation** — financial compensation paid by the insurer upon the occurrence of an insured event in accordance with the legislation and the insurance contract;

**Insurance rate** — the cost of a unit of insurance coverage, consisting of the net insurance tariff and the loading;

**Waiting period** — the period commencing from the date the insurance coverage enters into force, during which losses arising as a result of an insured event are not covered by the insurance coverage and the insurer bears no liability for events that occur;

**Survival period** — the period during which the insured person must survive from the date of occurrence of the insured event until the expiry of the period specified in the insurance contract. During this period, the insurer bears no liability in connection with the insured event;

**Disease** — a disruption of the normal functioning of the human body as a result of exposure to pathogenic factors;

**Incurable disease** — a group of diseases determined by a qualified physician that are life-threatening or have irreversible consequences;

**Physician** — a specialist with confirmed higher medical education who is in labor or civil-law relations with a medical institution;

**Qualified physician** — a certified specialist physician who has undergone appropriate certification, specializes in specific categories of diseases, types of patients, and treatment methods, and is capable of conducting examinations, treatment, and applying complex medical technologies for such diseases;

**Date of onset of the disease** — the first date officially confirmed by a medical document on which the insured person sought medical assistance from a physician or was diagnosed;

**Medical institution** — a legal entity that is registered and included in the state or non-state healthcare system, as well as a legal entity holding a relevant special permit to carry out medical activities in a foreign country. For the purposes of these Rules, "medical institution" also includes local and foreign natural persons engaged in private medical practice, provided that they hold the relevant license and have passed accreditation;

**Legal entities performing auxiliary activities in the insurance sector** — professional participants of the insurance market that provide services related to the assessment of insurance risks and losses, investigation of insured events, and settlement of losses.

2.2. Words and terms used in these Rules, unless otherwise expressly stipulated herein, shall be applied in the meaning assigned to them first under the legislation of the Republic of Azerbaijan, then under medical terminology, and subsequently under the explanatory dictionary of the Azerbaijani language.

## 3. Class of Insurance

3.1. Insurance against incurable diseases belongs to the class of life insurance which, by its insurance object, is classified as personal insurance and provides for the payment of an insurance compensation in the event that a medical institution determines that the insured person has a disease posing a threat to their life.

## 4. Subject Matter of Insurance

4.1. In accordance with these Rules, the subject matter of insurance is the natural person whose property interests are insured under the insurance contract.

## 5. Object of Insurance

5.1. In accordance with these Rules, the object of insurance is the property interests related to the life of the policyholder or the insured person.

## 6. Insurance Risks

6.1. In accordance with these Rules, under the concluded insurance contract the insurer provides insurance coverage for insured events that have occurred as a result of one or several *(or all)* of the following diseases, subject to the conditions set out in the sections of these Rules "Classification of Incurable Diseases — Limitations of Insurance Coverage" and "Exclusions":
6.1.1. Cancer;
6.1.2. Stroke;
6.1.3. Heart Attack;
6.1.4. Coronary Artery Bypass Surgery;
6.1.5. Kidney Failure;
6.1.6. Major Organ Transplant;
6.1.7. Paralysis;
6.1.8. Heart Valve Surgery;
6.1.9. Multiple Sclerosis;
6.1.10. Blindness;
6.1.11. Severe Burns;
6.1.12. Aorta Surgery;
6.1.13. Bacterial Meningitis;
6.1.14. Coma;
6.1.15. Encephalitis;
6.1.16. Loss of Hearing;
6.1.17. Loss of Speech;
6.1.18. Motor Neuron Disease;
6.1.19. Parkinson's disease;
6.1.20. Poliomyelitis;
6.1.21. Diabetes mellitus Type 1;
6.1.22. HIV through blood transfusion;
6.1.23. other incurable diseases specified in the insurance contract.

6.2. In respect of natural persons who have not attained the age of 18 (eighteen) years (hereinafter referred to as a "Child"), the Insurer, subject to the conditions set out in the sections of these Rules "Classification of Incurable Diseases — Limitations of Insurance Coverage" and "Exclusions", provides insurance coverage for insured events that have occurred as a result of one or several (or all) of the following diseases:
6.2.1. Aplastic Anemia;
6.2.2. Bacterial Meningitis;
6.2.3. Benign Brain Tumor;

6.2.4. Bone Marrow Transplantation;
6.2.5. Cancer;
6.2.6. Coma;
6.2.7. Diabetes Type 1 ;
6.2.8. Encephalitis;
6.2.9. Kidney Failure;
6.2.10. Loss of Hearing;
6.2.11. Organ Transplant;
6.2.12. Paralysis;
6.2.13. Severe Visual Impairment;
6.2.14. Stroke;
6.2.15. Third Degree Burns;
6.2.16. other incurable diseases specified in the insurance contract.

6.3. With regard to insurance against incurable female diseases, the insurer, subject to the conditions set out in the sections of these Rules "Classification of Incurable Diseases — Limitations of Insurance Coverage" and "Exclusions", provides insurance coverage for insured events that have occurred as a result of one or several *(or all)* of the following diseases:
6.3.1. breast cancer;
6.3.2. vulvar cancer;
6.3.3. vaginal cancer;
6.3.4. uterine cancer;
6.3.5. cervical cancer;
6.3.6. ovarian cancer;
6.3.7. placenta cancer;
6.3.8. ductal carcinoma in situ, provided that a mastectomy has been performed;
6.3.9. ductal carcinoma in situ or intraductal papilloma, provided that a lumpectomy or appropriate radiotherapy has been performed;
6.3.10. other incurable diseases specified in the insurance contract.

6.4. Insurance coverage may be provided cumulatively for the diseases listed in the sub-clauses of clauses 6.1, 6.2, and 6.3 of these Rules.
6.5. Subject to the preparation of an annex to these Rules and the approval of such annex by the Central Bank of the Republic of Azerbaijan in accordance with the legislation, insurance coverage may also be provided for diseases not specified in this section on the basis of such annexes.

## 7. Classification of Incurable Diseases — Limitations of Insurance Coverage

7.1. The classification of incurable diseases specified in article 6 of these Rules, as well as the limitations of insurance coverage for such diseases, shall be governed by this article.
7.2. The classification of incurable diseases specified in clause 6.1 of these Rules and the special conditions of insurance coverage for such diseases are as follows:

7.2.1. **Cancer** — a disease accompanied by the growth and spread of malignant cells together with the destruction of other tissues of various histological types.

7.2.1.1. **Coverage A** — the presence of a malignant tumour that is charaterised by progressive, uncontrolled growth, spread of malignant cells and invasion and destruction of normal and surrounding tissue. Cancer must be positively diagnosed with histopathological confirmation. Unless otherwise provided for in the insurance contract, under *"Coverage A"* provided in accordance with these Rules, the following neoplasms related to cancer are not included in insurance coverage and shall be deemed exclusions:
7.2.1.1.1. Hodgkin's disease and non-Hodgkin's lymphoma Stage I *(according to the Ann Arbor classification)*;
7.2.1.1.2. Leukaemia other than chronic lymphocytic leukaemia if there is no generalised dissemination of leukaemia cells in the blood-forming bone marrow;
7.2.1.1.3. Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant;
7.2.1.1.4. All skin cancers, unless there is evidence of metastases or the tumour is a malignant melanoma of greater than 1.5mm maximum thickness as determined by histological examination using the Breslow method;
7.2.1.1.5. Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1 (a) or T1(b), or are of another equivalent or lesser classification;
7.2.1.1.6. Papillary micro-carcinoma of the thyroid;
7.2.1.1.7. Non-invasive papillary cancer of the bladder histologically described as T1N0M0 or of a lesser classification ;
7.2.1.1.8. Chronic lymphocytic leukaemia less than RAI Stage I or Binet Stage A-I.

7.2.1.2. **Coverage B** — a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. . Unless otherwise provided for in the insurance contract, under *"Coverage B"* provided in accordance with these Rules, the following neoplasms related to cancer are not included in insurance coverage and shall be deemed exclusions:

7.2.1.2.1 All cancers in situ and all pre-malignant conditions;
7.2.1.2.2. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
7.2.1.2.3. All skin cancers, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin);
7.2.1.2.4. T1N0M0 (or less) papillary thyroid cancers.

7.2.1.3. The levels listed below are correlated with the general classification used by the American Joint Committee on Cancer *(applicable to all cancers except prostate cancer, leukemia, and lymphoma)*:
– Level A — Stage IV cancer;
– Level B — Stage III cancer;
– Level C — Stage II cancer;
– Level D — Stage I cancer.

7.2.1.4. The stages for which insurance coverage is provided for leukemia and lymphoma are as follows:

7.2.1.4.1. **Stage D**
The insurance compensation shall be made upon any of the following diagnoses:
– chronic lymphocytic leukaemia *(Stage 0 or I)*;
– hairy cell leukaemia;
– Hodgkins/Non Hodgkins lymphoma Stage 1 on Ann Arbor classification.
7.2.1.4.2. **Stage C**
The insurance compensation shall be made upon any of the following diagnoses:
– chronic lymphocytic leukemia *(Stage II on the Rai classification)*;
– acute lymphocytic leukemia *(children)*;
– chronic myeloid leukemia *(no bone marrow transplantation)*;
– Hodgkins / non-Hodgkins lymphoma *Stage II according on Ann Arbor classification system*;
– multiple myeloma *Stage I and II according on the Durie–Salmon staging system)*.
7.2.1.4.3. **Stage B**
The insurance compensation shall be made upon the following diagnosis:
– Hodgkins and non-Hodgkins lymphoma *Stage III on Ann Arbor classification)*.
7.2.1.4.4. **Stage A**
The insurance compensation shall be made upon any of the following diagnoses:
– acute myeloid leukaemia;
– chronic lymphocytic leukaemia *Stages III or IV on the Rai classification*;
– chronic myeloid leukaemia *(where red bone marrow transplantation is required)*;
– acute lymphocytic leukemia *(adults)*;
– Hodgkins/Non Hodgkins lymphoma *Stage IV on Ann Arbor classification*;
– multiple myeloma *Stage III according on the Durie–Salmon staging system*.

7.2.1.5. The stages for which insurance coverage is provided for prostate cancer are as follows:
**7.2.1.5.1. Stage II: T2, N0, M0, any G;**
**7.2.1.5.2. Stage III: T3, N0, M0, any G;**
**7.2.1.5.3. Stage IV: T4, N0, M0, any G;**
**7.2.1.5.4. In addition, the following are included in the insurance coverage in any case:**
– any T, N1–3, M0, any G;
– any T, any N, M1, any G, category D.
7.2.1.6. In prostate cancer, the stages listed below are not included in the insurance coverage and are considered exclusions:
- Stage I prostate cancer:
- classification T1a, N0, M0, G1;
- Stage II prostate cancer:
- T1a, N0, M0, G2–G4;
- classification T1b, T1c, N0, M0, any G.

7.2.1.7. Special notes relating to oncological diseases:
7.2.1.7.1. Histological confirmation is required;
7.2.1.7.2. For the submission of an insurance claim, it is sufficient that a diagnosis of an oncological disease be established for the insured person by a qualified physician; there is no requirement to undergo treatment;
7.2.1.7.3. Prophylactic mastectomy performed due to carcinoma in situ is not included in the insurance coverage and is considered an exclusion;

7.2.1.7.4. Unless otherwise provided for in the insurance contract, the procedure for payment of insurance compensation in case of oncological diseases shall be as follows:
**Under Coverage A:** for covered diseases — 100% of the insured amount;
**Under Coverage B:** for covered diseases *(excluding Stages I and II of oncological disease)* — 100% of the insured amount; for Stages I and II of oncological disease — 50% of the insured amount.

7.2.2. **Stroke** — a disease resulting from cerebrovascular disorders.
7.2.2.1. Neurological impairments arising in the insured person as a result of a stroke must be permanent and irreversible, and at the same time the insured person must exhibit one or several *(or all)* of the following signs:
7.2.2.1.1. inability to walk a distance of at least 200 meters on a flat surface without the use of assistive devices;
7.2.2.1.2. inability to feed himself once food has been prepared and made available;
7.2.2.1.3. inability to communicate with his environment by verbal speech without assistive devices;
7.2.2.1.4. the neurological deficit caused by stroke results in permanent and irreversible reduction of function of at least one whole limb where limb is defined as arm including hand or leg including foot. The reduction of function must be neurologically verifiable . A limb shall mean an arm *(including the hand)* or a leg *(including the foot)*.

7.2.2.2. For the assessment of the above conditions, at least 3 months must have elapsed from the date of the stroke.
7.2.2.3. The presence of one of the conditions listed below must be clearly proven by CT, MRI, or other similar imaging methods:
– infarction of brain tissue;
– intracranial or subarachnoid hemorrhage.

7.2.3. **Heart Attack** — Unequivocal diagnosis of the death of a portion of the heart muscle arising from inadequate blood supply to the relevant area.

7.2.3.1. All of the following criteria must be satisfied:
7.2.3.1.1. Typical central chest pain suggestive of heart attack — a symptom of myocardial infarction;
7.2.3.1.2. Diagnostic increase of specific cardiac markers typical for heart attack ;
7.2.3.1.3. new ECG changes characteristic of myocardial infarction ;

7.2.3.1.4. Proof of reduction in left ventricular function, such as reduced left ventricular ejection fraction or significant hypokinesia, akinesia, or wall motion abnormalities due to heart attack .

7.2.4. **Coronary artery bypass surgery** — the fact of performing surgery exclusively by thoracotomy for the purpose of correction or treatment of coronary artery disease of the heart.
7.2.4.1. The insurance compensation shall be paid only after the surgery has been performed;
7.2.4.2. angioplasty or other non-surgical techniques *(such as laser therapy)* are not considered coronary artery bypass grafting and therefore are not included in insurance coverage and constitute an exclusion from insurance compensation.

7.2.5. **Kidney failure** — end stage renal failure presenting chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated, or renal transplant is carried out.

7.2.5.1. The insurance compensation for kidney failure shall be paid after the commencement of dialysis procedures or after kidney transplantation has been performed;
7.2.5.2. The following cases are excluded from insurance coverage for kidney failure:
7.2.5.2.1. kidney failure at the compensated stage;
7.2.5.2.2. kidney failure without regular dialysis or transplantation.

7.2.6. **Major organs transplant**— Means the human to human organ transplant from a donor to the Life Insured of one or more of the following organs: kidney, liver, heart, lung, pancreas or the transplantation of bone marrow.
7.2.6.1. The insurance compensation for transplantation of major organs shall be paid after the transplantation surgery has been performed;
7.2.6.2. Transplantation of any other organs, parts of organs, tissues, or cells is excluded from insurance coverage.
7.2.7. **Paralysis** — Paralysis means the permanent and total loss of function of two or more limbs as a result of injury to, or disease of the spinal cord. Limb is defined as the complete arm or the complete leg.

7.2.8. **Surgical operation on the heart valves** — The undergoing of open-heart surgery via thoracotomy to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities.

7.2.9. **Multiple sclerosis** — Unequivocal diagnosis of multiple sclerosis that is a disease in which there are patches of demyelination throughout throughout the white matter of the central nervous system, sometimes extending into grey matter.

7.2.9.1. An insurance compensation for multiple sclerosis shall be made if it is accompanied by one or several *(or all)* of the following neurological impairments:

7.2.9.1.1. in the permanent and irreversible inability of the insured to walk 200 metres on a level surface without assistive devices;

7.2.9.1.2. in the permanent and irreversible inability of the insured to feed himself once food has

been prepared and made available ;
7.2.9.1.3. n a central scotoma that is neurologically proven .

7.2.10. **Blindness** — Clinically proven irreversible reduction of sight in both eyes as a result of sickness or accident.The corrected visual acuity must be less than 6/60 or 20/200 using e.g. Snellen test types, or visual field restriction to 20° or less in both eyes.

7.2.10.1. The possibility of full or partial restoration of vision through the use of medical devices or implants, as confirmed by a medical opinion, shall constitute grounds for refusal of an insurance compensation.

7.2.11. **Severe burns** — Means tissue injury caused by thermal, chemical or electrical agents causing third degree or full thickness burns to at least 20% of the body surface area as measured by The Rule of Nines or the Lund and Browder Body Surface Chart.

7.2.12. **Aorta surgery** — Means the actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta.

7.2.12.1. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches; an insurance compensation shall be made only if surgery is performed on the abdominal aorta or the thoracic aorta.

7.2.13. **Bacterial meningitis** — inflammation of the membranes of the brain or spinal cord caused by a bacterial infection. The disease must result in a permanent and irreversible neurological deficit in the insured person. The insured person must have one or several (or all) of the following impairments:
7.2.13.1.1. permanent and irreversible loss by the insured person of the ability to walk 200 meters on a flat surface without assistive devices;
7.2.13.1.2. permanent and irreversible loss by the insured person of the ability to independently consume prepared and accessible food;
7.2.13.1.3. permanent and irreversible loss by the insured person of the ability to independently engage in verbal communication;
7.2.13.1.4. a score of less than 16 *(sixteen)* points on the MMSE scale.

7.2.14. **Coma** — Means a state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously for at least 96 hours requiring the use of life support systems.

7.2.14.1. In the event of coma, the insurance compensation shall be paid based on the presence of one or several (or all) of the following neurological impairments:
7.2.14.1.1. permanent and irreversible loss by the insured person of the ability to walk at least 200 meters on a flat surface without assistive devices;
7.2.14.1.2. permanent and irreversible loss by the insured person of the ability to independently consume prepared and accessible food;
7.2.14.1.3. permanent and irreversible loss by the insured person of the ability to communicate verbally with the surrounding environment;
7.2.14.1.4. a score of less than 16 (sixteen) points on the MMSE scale.
7.2.14.2. In addition, the insurance compensation shall be paid if the coma lasts for 2 *(two)* months or longer.

7.2.15. **Encephalitis** — is an inflammation of the brain (cerebral hemisphere, brainstem or cerebellum). The disease must result in significant complications lasting at least 6 weeks, which include permanent neurological deficit. Permanent neurological deficit may include mental retardation, emotional lability, blindness, deafness, speech disorders, hemiplegia or paralysis*)*.
7.2.15.1. The insurance compensation shall be paid if the neurological impairment caused by the disease is accompanied by one or several (or all) of the following conditions:

7.2.15.1.1. permanent and irreversible loss by the insured person of the ability to walk at least 200 *(two hundred)* meters on a flat surface without assistive devices;
7.2.15.1.2. permanent and irreversible loss by the insured person of the ability to independently consume prepared and accessible food;
7.2.15.1.3. permanent and irreversible loss of the ability to communicate by verbal speech with the surrounding environment;
7.2.15.1.4. a score of less than 16 *(sixteen)* points on the MMSE scale.

7.2.16. **Loss of hearing** — complete and irreversible loss of hearing in both ears as a result of an accident or a disease, with a hearing loss level exceeding 90 *(ninety)* dB.
7.2.16.1. Partial or complete restoration of hearing acoustic stimuli by means of any treatment, implant, device, or any other assistive aid shall constitute grounds for refusal of the insurance compensation.

7.2.17. **Loss of speech** — complete and irreversible loss of the ability to speak as a result of an accident or a disease. Unless otherwise provided for in the insurance contract, loss of speech must persist continuously for a period of 12 *(twelve)* months.
7.2.17.1. Partial or complete restoration of the ability to speak by means of any treatment, implant, device, or any other assistive aid shall constitute grounds for refusal of the insurance compensation.

7.2.18. **Motor neuron diseases** — Motor neurone disease is characterised by progressive degeneration of corticospinal tracts of anterior horn cells or bulbar efferent neurones. Motor neurone disease includes spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis.
7.2.18.1. Insurance compensation for motor neuron diseases is made if the neurological impairments caused by the disease are expressed by one or several (or all) of the following:
7.2.18.1.1. permanent and irreversible loss by the insured person of the ability to walk at least 200 *(two hundred)* meters on a flat surface without assistive devices;
7.2.18.1.2. permanent and irreversible loss by the insured person of the ability to independently consume prepared and accessible food.

7.2.19. **Parkinson's disease** —is a slowly progressive degenerative disease of the central nervous system with degeneration of neurones a region of the brain that causes a reduction of dopamine levels in parts of the brain.
7.2.19.1. The disease must be unequivocally diagnosed and the following conditions must be fulfilled :
7.2.19.1.1. the disease cannot be controlled with medication;
7.2.19.1.2. The disease shows signs of progressive impairment;
7.2.19.1.3. the neurological impairments caused by Parkinson's disease are manifested by one or several of the following:
7.2.19.1.3.1. a permanent and irreversible walking impairment that is characteristic for Parkinson's disease that can be neurologically verified ;
7.2.19.1.3.2. a score of less than 16 *(sixteen)* points on the MMSE scale.

7.2.20. **Poliomyelitis** — unequivocal diagnosis of infection with the poliovirus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. In respect of this contract, claims shall only be admitted if poliomyelitis causes neurological deficit resulting in paralysis in limbs that is permanent.

7.2.21. **Diabetes mellitus Type 1** — a disease accompanied by total insulin deficiency and requiring replacement therapy in the form of regular daily multiple insulin injections.
7.2.21.1. An insurance compensation is made when the diagnosis of type 1 diabetes mellitus is unequivocally established and all of the following conditions are met:
7.2.21.1.1. At least 6 months must have elapsed since the diagnosis of type 1 diabetes mellitus was established;
7.2.21.1.2. The disease must be confirmed by medical records, laboratory test results, and relevant medical reports;
7.2.21.1.3. The following cases related to type 1 diabetes mellitus are considered exclusions from insurance coverage, and no insurance compensation is made in such cases:
7.2.21.2. disease resulting from the consumption of alcohol, narcotic substances, or medications not prescribed by a specialist physician;
7.2.21.3. diabetes insipidus;
7.2.21.4. type 2 diabetes mellitus.

7.2.22. **HIV through blood transfusion -** In the event that the insured contracts the human immunodeficiency virus, an insurance compensation is made provided that the following conditions are met:
7.2.22.1. the infection occurred as a result of a blood transfusion administered to the insured person after the commencement date of insurance coverage;
7.2.22.2. The institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability;
7.2.22.3. the insured person infected with the virus is not a hemophilia patient.

Note:
Medical treatment carried out for the treatment of the consequences of AIDS (Acquired Immunodeficiency Syndrome) and/or HIV (Human Immunodeficiency Virus), or for the purpose of preventing the development of AIDS, is considered an exclusion from insurance coverage.
Cases of infection by any other means, including infection as a result of sexual intercourse or intravenous use of narcotic substances, are also considered exclusions from insurance coverage.
The insurer shall have the right to examine all blood samples and to conduct independent testing of blood samples.

7.3. Unless otherwise stipulated in the insurance contract, under group insurance contracts, incurable diseases for which insurance coverage is provided shall not be considered an insured event, and the insurer may refuse to make an insurance compensation if, within 1 *(one)* year from the date of conclusion of the insurance contract, they arise as a result of the diseases and/or conditions specified in clauses 7.3.1–7.3.5 of these Rules, and if the insured person was aware of them in advance:

7.3.1. **With respect to oncological diseases** — a history of cancer or precancerous conditions, papilloma of the urinary bladder, polyposis of colon, Crohn's disease, ulcerative colitis, hematuria, blood in stool, hemoptysis, lymphadenopathy, splenomegaly, cachexia.

7.3.2. **With respect to myocardial infarction, coronary artery bypass graft, and surgical operation on the heart valves**— angina pectoris, arteriosclerosis and diseases of the coronary arteries, chest pain during physical exertion, cardiac rhythm disorders, abnormal changes on ECG, hyperlipidemia.

7.3.3. **With respect to stroke** — heart valve diseases, transient ischemic attack, hemophilia, pulmonary artery embolism, embolism of any major vessels, diabetes mellitus, aneurysms of intracranial blood vessels, arteriosclerosis, arteriovenous malformations, atrial fibrillation.

7.3.4. **7.3.4. With respect to transplantation of major organs:**

- *Lungs:* pulmonary insufficiency, cystic fibrosis;
- *Heart and heart/lung:* coronary artery disease, heart failure, cardiomyopathy, hypertension;
- *Liver: hepatitis B and C, terminal stage of chronic hepatitis, primary biliary cirrhosis of the liver, alcoholic liver disease, autoimmune hepatitis, hepatic vein thrombosis, metabolic disorders, neoplasms (tumors), cholangitis;*
- *Pancreas: diabetes mellitus, pancreatitis, cystic fibrosis;*
- *Kidneys: chronic glomerulonephritis, congenital diseases, polycystic kidney disease, nephropathy caused by analgesics or reflux nephropathy, hypertension, diabetes mellitus, lupus erythematosus;*
- *Bone marrow: any malignant conditions, anemias, leukopenia and/or thrombocytopenia.*

7.3.5. **With respect to kidney failure** — chronic glomerulonephritis, congenital diseases, polycystic kidney disease, analgesic or reflux nephropathy, hypertension, diabetes mellitus, lupus erythematosus.

7.4. Myocardial infarction, coronary artery bypass graft, surgery on heart valves, heart transplantation, and stroke are considered *"diseases of the cerebral and cardiovascular system"* and therefore are regarded as a single condition. Thus, for example, if the insured person suffered a stroke prior to the commencement of insurance coverage, no insurance compensation shall be made for a subsequent stroke, myocardial infarction, coronary artery bypass graft, or heart transplantation. The same rule shall apply to myocardial infarction, coronary artery bypass graft, heart valve surgery, and heart transplantation.

7.5. Unless otherwise stipulated in the insurance contract, under group insurance contracts, if the period of validity of coverage for incurable diseases exceeds 1 *(one)* year *(as a result of renewal, extension of the insurance contract, etc.)*, the exclusions specified in clauses 7.3.1–7.3.5 shall not apply.

7.6. The classification of incurable diseases specified in clause 6.2 of these Rules and the special conditions of coverage for such diseases are as follows:

7.6.1. **Aplastic anemia:**

7.6.1.1. Aplastic anemia — a chronic and persistent impairment of red bone marrow function accompanied by anemia, neutropenia, and thrombocytopenia. For an insurance compensation to be made:

7.6.1.1.1. the diagnosis must be confirmed by red bone marrow puncture or biopsy;

7.6.1.1.2. at least two of the following criteria must be reflected in the complete blood count:

– absolute neutrophil count < $0.5 \times 10^9$/L;

– reticulocytes constitute < 1% of erythrocytes;

– platelet count < 20 × $10^9$/L.

7.6.2. **Bacterial meningitis** — inflammation of the membranes of the brain or spinal cord caused by a bacterial infection.

7.6.2.1. As a result of the disease, the insured person must exhibit permanent and irreversible neurological impairment leading to the inability to perform age-related exercises specified in the table established in clause 7.7.

7.6.2.2. The diagnosis must be confirmed by a certified neurologist.

7.6.3. **Benign brain tumor** — a non-malignant but life-threatening neoplasm of the brain.

7.6.3.1. For an insurance compensation to be made, all of the following criteria must be met:

7.6.3.1.1. the presence of the tumor must be evidenced by MRI, CT, or similar appropriate imaging techniques;

7.6.3.1.2. severe consequences of the tumor, such as intracranial pressure, onset of first epileptic seizures, motor or sensory impairment are objectively verifiable;

7.6.3.1.3. at least one of the following must apply to the tumor:

7.6.3.1.3.1. the tumor was completely removed by surgical intervention or the maximum possible portion thereof was resected;

7.6.3.1.3.2. the tumor is treated in the form of either chemotherapy or radiotherapy;

7.6.3.1.3.3. due to the stage of disease progression, only palliative treatment is possible;

7.6.3.1.3.4. cysts, calcifications, granulomas, malformations in or of the cerebral arteries or veins of the brain, as well as hematomas, are excluded;

7.6.3.1.3.5. if the first symptoms of the disease, the initial onset of the condition, or the date of the initial diagnosis of the tumor fall within 90 *(ninety)* days from the commencement date of the insurance period, this shall constitute grounds for refusal of the insurance compensation.

7.6.4. **Red bone marrow transplantation** — means the receipt of a transplant of human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation .

7.6.4.1. Transplantation of other stem cells is excluded from insurance coverage.

7.6.5. **Cancer** — a disease accompanied by the uncontrolled growth and spread of malignant cells and destruction of tissues of different histological types. The diagnosis of cancer must be confirmed by histological examination, or, in cases of systemic cancer, by cytological evidence.

7.6.5.1. The following cases are not included in insurance coverage:

7.6.5.1.1. cancer in situ;

7.6.5.1.2. all types of malignant skin diseases, except for malignant melanoma invading skin layers beyond the epidermis;

7.6.5.1.3. any papillary carcinoma of the thyroid gland *(except for cases that have progressed to at least stage T2N0M0)*.

7.6.5.2. Any of the diseases or conditions listed below is not considered cancer under the above definition and is not included in insurance coverage:

7.6.5.2.1. pre-malignant;

7.6.5.2.2. non-invasive;

7.6.5.2.3. conditions with low malignant potential or borderline malignancy;

7.6.5.2.4. cervical dysplasia CIN 1, CIN 2, and CIN 3;

7.6.5.2.5. No benefits will be payable if symptoms first appear or the condition first occurs or is first diagnosed within 90 days after the risk commencement date or the date of any reinstatement.

7.6.6. **Coma** — a state of unconsciousness, with no reaction to external stimuli or internal needs, persisting continuously for at least 96 hours and requiring use of life support systems.
7.6.6.1. There must be medical indications for the induction of an artificial coma.
7.6.6.2. A benefit will also be paid if the coma without life support systems has lasted for at least 2 (two) months .
7.6.7. **Diabetes Type 1** — a chronic disorder of carbohydrate, fat, and protein metabolism resulting from a complete and irreversible insulin deficiency. The diagnosis must be established by a certified pediatrician, with evidence of dependence on exogenous insulin for a minimum period of three months.
7.6.8. **Encephalitis** — a disease resulting from inflammation of brain associated with a bacterial or viral infection. The diagnosis must be confirmed by a certified neurologist.
7.6.8.1. As a result of the disease, the insured person must exhibit permanent and irreversible neurological impairment leading to the inability to perform age-related movements specified in the table established in clause 7.7.
7.6.9. **Kidney failure** — a chronic irreversible failure of the function of both kidneys, as a result of which regular dialysis has been initiated or a kidney transplant has been performed. The diagnosis must be established by a certified nephrologist.
7.6.10. **Loss of hearing** — the complete and irreversible loss of the ability to hear all acoustic stimuli below 90 *(ninety)* dB across all frequesnies as a result of an accident or disease. The diagnosis must be confirmed by a certified otologist.
7.6.10.1. No benefits will be payable if in general medical opinion a device, implant, treatment or any other aid can improve the hearing ability such that acoustic stimuli below 90 decibels can be perceived.
7.6.11. **Organ transplant** — means the undergoing of human to human transplantation of the kidney, heart, lung, pancreas or of at least one entire lobe of the liver from a donor to the insured.
7.6.11.1. Autologous transplantation and the transplantation of other organs, parts of organs *(with the exception of the lobe of the liver)*, tissues, or cells constitutes an exclusion from insurance coverage.
7.6.12. **Paralysis** — the permanent, irreversible and total loss of muscle function of two or more entire limbs *(a limb meaning one complete arm or leg)* as a result of an accident or disease.
7.6.13. **Severe visual impairment** — a clinically confirmed and irreversible reduction of vision in both eyes as a result of disease or accident. A case is considered an insured event if visual acuity of the better eye with correction is less than 6/60 or 20/200 according to the Snellen chart, or if, due to visual field constriction, the maximum visual field of both eyes is less than (<) 20°.
7.6.13.1. The diagnosis must be established by a qualified ophthalmologist.
7.6.13.2. Partial or complete restoration of vision by means of any treatment, implant, device, or any other assistive aid constitutes grounds for refusal of the insurance compensation.
7.6.14. **Stroke** — a disease resulting in necrosis of brain tissue due to intracranial hemorrhage or inadequate blood supply within the scull. As a result of stroke, the insured person develops permanent and irreversible neurological disorders.
7.6.14.1. For an insurance compensation to be made, the condition must meet all of the following criteria:
7.6.14.1.1. Findings on magnetic resonance imaging (MRI), computerised tomography (CT) or similar appropriate imaging techniques consistent with the diagnosis of a new stroke ;

7.6.14.1.2. The stroke has caused persistent demonstrable deficits which occur in a field that is controlled by the affected area of the brain ;
7.6.14.1.3. assessment of the above conditions shall be carried out provided that at least 3 months have elapsed since the date of the stroke.
7.6.14.2. The following conditions are not included in insurance coverage:
7.6.14.2.1. transient ischemic attack;
7.6.14.2.2. traumatic injury to brain tissue or blood vessels.

7.6.15. **Third-degree burns** — burns of the third degree or full-thickness burns resulting from thermal, electrical, or chemical exposure. An insurance compensation shall be made if any of the following conditions occurs:
– burns covering at least 20% of the body surface area *(measured by the Rule of Nines or the Lund and Browder* Body Surface *chart)*;
– burns covering at least 25% of the head or face.

7.7. The relationship between the child's age and movements, depending on the permanent and irreversible neurological impairment caused by the disease in the child, shall be determined in accordance with the following table:

| **Age** | **The child must be unable to perform one or several of the following actions:** |
|---|---|
| 1 year old | - to crawl;<br>- grab any item; |
| 2 years old | - to stand up;<br>- - use a pen to scribble; |
| 3-4 years old | - to walk 20 (*twenty*) meters;<br>- use a straw to drink;<br>- to communicate with the surrounding environment through verbal speech *(all psychiatric related conditions are excluded);* |
| 4-9 years old | - to walk 100 (*one hundred*) meters on a level surface without assistive aids or devices;<br>- - feed themselves once food has been prepared and made available;<br>- to communicate with the surrounding environment through verbal speech *(all psychiatry-related conditions are excluded);* |
| 10 years old and older | - to walk 200 (*two hundred*) meters on a level surface without assistive aids or devices;<br>- - feed themselves once food has been prepared and made available;<br>- to communicate with the surrounding environment through verbal speech *(all psychiatric related conditions are excluded);*<br>- to have a score exceeding 15 (*fifteen*) points according to the MMSE scale. |

7.8. Under the coverage for women's diseases specified in clause 6.3 of these Rules, the diseases or conditions listed below shall not be considered oncological diseases:
7.7.1. cancer in-situ
7.7.2. premalignant condition;

7.7.3. non-invasive cancer;
7.7.4. cervical dysplasia CIN-1, CIN-2, or CIN-3.

## 8. Exclusions

8.1. Unless otherwise stipulated in the insurance contract, events covered under insurance contracts concluded in accordance with these Rules shall not be deemed insured events if they occurred directly or indirectly as a result of the following:
8.1.1. an attempted suicide by the insured person during the first 2 *(two)* years of the validity of the insurance contract;
8.1.2. the insured person's active or passive participation in war or occupation, acts of a foreign enemy, declared or undeclared hostilities, civil war, civil unrest, mutiny, uprising, revolution, seizure of power by military or usurpatory means, as well as participation in military operations, civil disturbances, terrorist acts, military coups, mass riots, forcible seizure of power, and also the insured person's performance of military service, participation in military assemblies, drills, officially declared or undeclared wars, and other similar circumstances;
8.1.3. exposure of the insured person to ionizing radiation, radioactive irradiation, or poisoning;
8.1.4. consumption by the insured person of alcoholic beverages, any toxic substances, or narcotic drugs (except in cases prescribed by a physician);
8.1.5. mental illness of the insured person;
8.1.6. engagement by the insured person, on a professional or amateur basis, in hazardous sports, participation in competitions, rallies, or hazardous activities *(for example, auto- and motorsports, mountaineering, diving, parachute jumping, hand-to-hand combat, shooting, etc.)*, *provided that such activities were not declared in the application form and the corresponding insurance premium was not charged*;
8.1.7. intentional self-inflicted injury or deliberate harm to one's own health, except in cases committed for the purpose of saving human life;
8.1.8. undergoing medical examinations, receiving treatment, or taking medications prescribed by persons who do not have the right to engage in medical practice;
8.1.9. acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or other similar diseases, as well as all conditions arising in connection with such diseases, except for cases provided for in the insurance certificate;
8.1.10. treatment of congenital defects of the brain, spinal cord, skull, or vertebral column.
8.2. The insurance compensation shall be made, if agreed in the insurance contract, provided that the insured person survives until the survival period specified in the insurance contract.
8.3. A waiting period may be established by mutual agreement of the parties. Events or conditions occurring during the waiting period specified in the insurance contract shall not be considered insured events, and the insurer shall have no obligation to make insurance compensation in respect thereof.
8.4. The exclusions provided for in this article or the limitations specified in the "Classification of Incurable Diseases" may be included in the insurance coverage by agreement of the parties in the insurance contract.
8.5. By mutual agreement of the parties, other exclusions not provided for in these Rules may be included in the insurance contract, depending on the health status of the insured person, professional activity, and other underwriting risks.

## 9. Insurance Contract

9.1. Under an insurance contract against incurable diseases concluded based on these Rules, the insurer undertakes, in exchange for the insurance premiums paid and in accordance with the terms of the contract, to pay the insured or another person specified as the beneficiary in the contract the insured amount in the event of an insured event occurring under the risks specified in the contract, either as a lump-sum insurance compensation or in partial payments.
9.2. An insurance contract is concluded: if the policyholder is a natural person, based on his/her insurance application; if the policyholder is a legal entity, based on the list of insured persons and questionnaire determined by the insurer. By mutual agreement of the parties, the contract may be concluded on the basis of a verbal request. The following must be specified in the application:
9.2.1. details of the document proving the identity of the insured person *(beneficiary)*;
9.2.2. date of birth (year, month, day) of the insured person;
9.2.3. term of the insurance coverage;
9.2.4. insured amount.
9.3. An insurance contract is concluded in writing in one of the following forms:
9.3.1. by drawing up and mutually signing by the parties a document called “insurance contract” based on these Rules;
9.3.2. by providing the policyholder with an insurance certificate by the insurer, provided that the policyholder confirms acquaintance with these Rules and agreement with their terms.
9.4. In the case specified in clause 9.3.2 of these Rules, the insurance certificate must specifically list the risks under which the insured object is covered. When concluding transactions, the use of a facsimile reproduction of a signature by means of mechanical or other copying devices, an electronic signature, or another analogue of a handwritten signature is permitted in the cases and in the manner stipulated by the agreement of the parties. The procedure for using electronic signatures is determined by legislation. When concluding an insurance contract, the insurer must provide the policyholder with a memorandum written in a clear and understandable form, reflecting:
9.4.1. how to act when an event that may be considered an insured event occurs;
9.4.2. the legal grounds for the insurer’s refusal to make an insurance compensation.
9.5. When concluding the contract, the insurer may require the insured person to undergo a medical examination at the insurer’s expense or at the policyholder's *(insured person’s)* expense to assess the current state of health depending on the terms of the insurance contract.
9.6. The insurer must issue to the policyholder a document confirming the conclusion of the insurance contract – the insurance certificate. This requirement also applies if the contract is concluded in the manner specified in clause 9.3.1 of these Rules.
9.7. The contract may provide for participation of several persons in paying the insurance premium. In this case, such persons act as a joint policyholder.
9.8. Age requirements for the insured person are determined as follows:
9.8.1. unless otherwise provided by the contract, at the moment the insurance coverage expires, the age of the insured person may not exceed 65 years.
9.9. During the term of the contract, additions and amendments may be made to the insurance contract in accordance with the legislation and the terms of these Rules. Such additions and amendments form an integral part of the insurance contract.

## 10. Early Termination of the Insurance Contract

10.1. The insurance contract may be terminated early in the following cases:
10.1.1. with the exception of the following cases, where the policyholder being a natural person dies or the activities of the policyholder being a legal entity are terminated or it is liquidated:
10.1.1.1. if the policyholder concluded a life insurance contract in favor of another person and dies, the rights and obligations under the contract are transferred to the beneficiary with the written consent of the deceased;
10.1.1.2. if the policyholder being a legal entity is reorganized during the term of the contract, its rights and obligations under the contract are transferred to the legal successor;
10.1.2. if a non-policyholder insured person dies and the insurer objects to the replacement of the insured person by another person;
10.1.3. if the insurer has fully performed its obligations to the policyholder;
10.1.4. if the insurance interest no longer exists;
10.1.5. if the policyholder fails to pay the insurance premium in accordance with the contract;
10.1.6. if the policyholder or the insurer requests early termination of the contract;
10.1.7. in other cases provided for in Article 919 of the Civil Code of the Republic of Azerbaijan.
10.2. If, during the term of the insurance contract, the policyholder is declared legally incapacitated by a court decision or their legal capacity is restricted by a court decision, the rights and obligations of the policyholder shall be exercised by their guardian or custodian.

## 11. Notice of Early Termination of the Insurance Contract

11.1. If circumstances arise that constitute grounds for termination of the insurance contract in the cases specified in clause 10.1 of these rules, taking into account clause 11.2 of these Rules, the party interested in terminating the contract shall immediately notify the other party thereof.
11.2. When the insurance contract is terminated early at the request of the policyholder or the insurer in accordance with clause 10.1.6 of these Rules, one party must send the other party a written notice justifying the request at least 30 *(thirty)* days in advance *(if the contract is concluded for more than 5 years – at least 60 (sixty) days, if the contract is concluded for less than 3 months – at least 5 (five) business days)*.

## 12. Consequences of Early Termination of the Insurance Contract

12.1. In the event of early termination of the insurance contract at the request of the policyholder, the insurer shall return to them the portion of the insurance premium for the remaining term, minus the portion of administrative costs proportional to the remaining term of the contract. If the policyholder's request for early termination is due to the insurer's failure to perform its obligations under the contract, the insurer shall return the full amount of the insurance premiums to the policyholder.
12.2. If the insurance contract is terminated early at the request of the insurer, the insurer shall return the full amount of the insurance premiums to the policyholder. If this request is due to the policyholder's failure to fulfill their obligations under the insurance contract, the insurer shall return the insurance premiums corresponding to the remaining term of the contract. In this case, the insurer may deduct from the returned portion of the insurance premium the portion of administrative costs proportional to the remaining term of the contract.

12.3. In the event of early termination of the insurance contract, if by the termination date the insurance compensation made by the insurer to the policyholder is equal to or exceeds the premiums paid, and partial payments are planned for future periods, the insurance premiums are not returned to the policyholder.
12.4. In the event of early termination of the insurance contract, if by the termination date the insurance compensation made is less than the premiums paid, the difference between the paid premium and the insurance compensation shall be returned to the policyholder in accordance with the procedure specified in clauses 12.1 and 12.2 of these Rules.

## 13. Insurance Period and Territorial Scope

13.1. The term of insurance coverage is determined by the insurance contract.
13.2. Unless otherwise provided in the insurance contract, in the event of partial or full payment of the first premium, the insurance coverage period shall begin at twenty-four o'clock on the day the insurance contract is concluded and shall end at twenty-four o'clock on the last day of the contract's validity in accordance with its terms.
13.3. Unless otherwise specified in the insurance contract, no territorial restrictions apply to the area where the insurance contract is valid.

## 14. Rights and Obligations of the Parties

**14.1. Rights of the policyholder and the insured person:**
14.1.1. when concluding the insurance contract, to review the insurer's annual financial results and annual balance sheet certified by an independent auditor;
14.1.2. to obtain a duplicate of the insurance certificate in case it is lost or destroyed;
14.1.3. to receive explanations from the insurer regarding the terms of the insurance contract and these Rules;
14.1.4. to submit proposals for amending the terms of the insurance contract;
14.1.5. in the event of the death of the policyholder being a natural person, or the liquidation of the policyholder being a legal entity, the insured person shall, in accordance with applicable legislation and the agreement between the policyholder and the insurer, perform the obligations of the policyholder as provided for in the contract and these Rules.
14.1.6. to receive the insurance compensation from the insurer for the policyholder, the insured person, or the beneficiary;
14.1.7. to exercise other rights provided for by the Civil Code of the Republic of Azerbaijan and these Rules.

**14.2. Obligations of the policyholder and the insured person:**
14.2.1. to provide correct answers to the questions in the insurance application and to complete the application fully, accurately, and honestly;
14.2.2. when concluding the insurance contract, to provide the insurer with information on all circumstances known to them, as well as those requested by the insurer in writing, which may affect the decision to enter into the contract, to refuse it, or to conclude it with amended terms;
14.2.3. to notify the insurer or the insurance intermediary acting on behalf of the insurer of all changes that occur after the conclusion of the insurance contract regarding the circumstances reported in accordance with clause 14.2.2 of these Rules;

14.2.4. to provide the insurer with accurate information regarding the beneficiary;
14.2.5. to enable the insurer or its representative to freely obtain information related to the insured event;
14.2.6. to pay the insurance premium in the amount and within the period specified in the insurance contract;
14.2.7. the policyholder or the insured person, as well as the beneficiary, shall immediately after becoming aware of the occurrence of an insured event, or within the shortest possible time, notify the insurer or its representative, as well as the relevant competent state authorities that are required to be informed of such event, by any available means;
14.2.8. to perform other duties provided for by the Civil Code of the Republic of Azerbaijan and these Rules.

**14.3. Rights of the insurer:**
14.3.1. to verify the accuracy of the information provided by the policyholder and the insured person;
14.3.2. in accordance with the requirements of legislation on combating the legalization of property obtained through criminal means and the financing of terrorism, to take measures to identify the policyholder, the insured person, the beneficiary, the beneficial owner, and the authorized representative, as well as to verify the identification data obtained in respect of them; where doubts arise as to the source of the insurance premium, to require additional supporting documents in order to determine the origin of such funds; to refuse to carry out transactions of policyholders who refuse to provide the required documents, or to terminate the insurance contract unilaterally.
14.3.3. to require the insured person to undergo a medical examination at the insurer’s expense or at the policyholder's expense to assess the current state of health depending on the terms of the insurance contract;
14.3.4. to require the insured person to undergo necessary medical examinations in medical institutions designated by the insurer for the purpose of settling the insurance event;
14.3.5. if it is discovered after the insurance contract has entered into force that the policyholder intentionally provided false answers in the insurance application, and if less than five years have passed since the contract’s effective date, the insurer may demand early termination of the contract;
14.3.6. when making an insurance compensation or refunding an amount subject to refund, to deduct from the payment amount any insurance premium that is due or overdue and any other outstanding debts payable by the policyholder or the beneficiary.
14.3.7. to refuse to conclude an insurance contract after assessing the insurance risks;
14.3.8. to exercise other rights provided by the Civil Code of the Republic of Azerbaijan and these Rules.

**14.4. Obligations of the insurer:**
14.4.1. to ensure that the policyholder is familiarized with these Rules or their electronic version when concluding the insurance contract;
14.4.2. to provide the policyholder with a memorandum prepared in a clear and understandable language when concluding the insurance contract;
14.4.3. to provide the policyholder with an insurance certificate incorporating these Rules;
14.4.4. in case of an insured event, within 7 *(seven)* business days from the date of receipt of documents specified in clause 17.2 of these Rules, to make the insurance compensation or provide

a written, reasoned refusal to make the insurance compensation to the policyholder, insured person, or beneficiary;
14.4.5. if refusing to conclude the insurance contract, to notify the policyholder of the refusal upon their request;
14.4.6. if the policyholder, insured person or beneficiary has informed the insurer of an insured event but the competent state authorities have not been notified, to immediately inform these authorities of the event;
14.4.7. to ensure the confidentiality of information constituting insurance secrets in accordance with the Law of the Republic of Azerbaijan "On Insurance Activity";
14.4.8. to send written requests to competent state authorities to get a document confirming the fact and/*or* cause, and consequences of insured events that require investigation or registration;
14.4.9. to perform other obligations provided by the Civil Code of the Republic of Azerbaijan and these Rules.

## 15. Disclosure of Information

15.1. Upon conclusion of the insurance contract, the policyholder or the insured person shall disclose to the insurer all circumstances known to them at that time, as well as all circumstances requested by the insurer in writing, which may affect the decision to refuse to conclude the contract or to conclude it on amended terms.
15.2. The policyholder (the insured person) shall provide the insurer with accurate information regarding the beneficiary.
15.3. The policyholder or the insured person, as well as the beneficiary, shall immediately after becoming aware of the occurrence of an insured event, or within the shortest possible time, notify the insurer or its representative, as well as the relevant competent state authorities that are required to be informed of such event, by any available means.
15.4. The policyholder (the insured person) shall ensure that the insurer or its representative has free access to information related to the insured event.

## 16. Insurance Premium and Insured Amount

16.1. The amount of the insurance premium shall be agreed upon in the insurance contract.
16.2. The insurance contract may provide for payment of the insurance premium in a lump sum or by installments.
16.3. If the insurance premium or any part thereof is not paid within the period specified in the contract, the insurer may, taking into account the requirements of clause 16.4 of these Rules, set an additional period of up to 15 *(fifteen)* days for payment by written notice.
16.4. In all cases, the insurance premium or its agreed first installment shall be paid no later than 1 *(one)* month from the date of conclusion of the insurance contract.
16.5. Payment of the insurance premium under an insurance contract executed in electronic document form confirms the policyholder's acknowledgment of and consent to these Rules and the terms of the insurance contract, as well as the fact of conclusion of the insurance contract.
16.6. The insured amount shall be determined by the insurance contract. The insured amount may be established as an aggregate amount or separately for each insurance risk *(coverage)*.

16.7. In cases provided for by the insurance contract, following the insurance compensation, the insured amount shall be reduced by the amount paid. The reduction of the insured amount shall apply from the date the insurance compensation is made.
16.8. By agreement of the parties, the policyholder may restore the initial insured amount for an additional insurance premium, subject to the insurer's assessment and consent.
16.9. The amount of the insurance compensation payable in respect of the occurred event, as well as the procedure for insurance compensation thereof, shall be determined by the insurance contract. The insurance contract may provide, as the procedure for insurance compensation, for full or partial reimbursement of expenses incurred in connection with services related to the treatment of incurable diseases.
16.10. If the date of conclusion of the insurance contract differs from the commencement date of the insurance coverage period and an event or circumstance that may be recognized as an insured event occurs prior to the commencement date of the insurance period, provided that the insurance premium has been paid in advance, the paid sum shall be refunded to the policyholder or to their heirs appointed in accordance with the legislation of the Republic of Azerbaijan.

## 17. Procedure for Making Insurance Compensation

17.1. The insurer shall make an insurance compensation for insured events that have occurred under the insurance risks covered by the insurance contract, in accordance with the provisions of the "Classification of Incurable Diseases" and "Exclusions" sections of these Rules.
Payment of the insured amount agreed upon at the time of contract conclusion is made by the insurer to the beneficiary only if the insurance premium has been paid in the amount and manner specified in the contract.
17.2. The documents required for the insurance compensation are as follows:
17.2.1. An insurance claim submitted by the insured or the beneficiary;
17.2.2. A copy of the identity document of the person submitting the insurance claim;
17.2.3. Medical documents certified by the signature of a qualified physician; all medical documents must be prepared on the official letterhead of the medical institution, signed by the physician, and stamped with the institution's seal. In particular:

- In documents reflecting the results of ECG, X-ray, CT, and other examinations, the insured person's full name and date of birth must be entered automatically in a way that cannot be altered;
- In other documents — medical certificates, extracts, opinions, and the documents mentioned above — the insured person's full name and date of birth must be entered without the possibility of correction.

17.2.4. If an event that can be considered an insured event must be reported to any state authority, the relevant document provided by that authority regarding the event;
17.2.5. In the event the insured person dies before submitting an insurance claim or after submitting it but before receiving the insurance compensation, the insurance compensation shall be made to the heirs of the person who submitted the claim or to the person*(s)* entitled to receive the payment, based on a certificate of inheritance or a notarized copy;
17.2.6. A copy of the document confirming the insured person's death;
17.2.7. If family members act as beneficiaries, a corresponding supporting document must be provided.

17.3. If necessary, copies of documents from the medical institution where the insured person underwent examination and the diagnosis of an incurable disease was confirmed. The insurer may not require all the documents listed in clause 17.2 of these Rules when reviewing the insured event.
17.4. If the beneficiary dies without receiving the insurance compensation due to them, the insurance compensation shall be made to their heirs.
17.5. The payment may be made to the representative of the beneficiary based on a notarized power of attorney certified in accordance with the law.
17.6. If the beneficiary is under 18 years of age, the insurance compensation due to them shall be deposited into a bank account opened in the name of the beneficiary at the designated bank with the written consent of their legal representative.

## 18. Grounds for Refusal of Compensation

18.1. The insurer shall refuse to pay insurance compensation in the following cases:
18.1.1. If, due to non-compliance with the requirements of Article 923.1 of the Civil Code, the insurer is deprived of the opportunity to determine whether an insured event occurred;
18.1.2. The actions or inactions of the policyholder, the beneficiary, or the insured person, except in cases provided for by the Civil Code of the Republic of Azerbaijan, the Code of Administrative Offenses of the Republic of Azerbaijan, and the Criminal Code of the Republic of Azerbaijan that exempt from liability, as well as, where applicable, the actions or inactions of the injured party directed at causing the relevant event, and the intentional commission of a crime directly linked to the occurrence of the event.
18.1.3. Unless otherwise provided by the contract, if the occurred event, case, condition, or disease is not included in the insurance coverage or is not recognized as an insured event in accordance with the "Classification of Incurable Diseases — Limitations of Insurance Coverage" section of these Rules;
18.1.4. If the date of the insurance contract differs from the start date of the insurance coverage and/or if a condition or an event that could be considered an insured event occurred before the start date of the insurance period;
18.1.5. Unless otherwise provided by the contract, if the occurred event, case, condition, or disease is a direct or indirect result of circumstances excluded from coverage under the "Exclusions" section of these Rules;
18.1.6. The insurer's ability to assess the insurance risk, as well as to determine the causes of the insured event and/*or* the amount of the insurance compensation, is wholly or partially deprived as a result of the policyholder intentionally providing the insurer with false information regarding the subject of insurance, the insured person, and/*or* the insured event *(in this case, if the falsity of the information was known to the insurer at the time of concluding the insurance contract, or the policyholder was not at fault in providing false information, as well as if the insurance contract was concluded despite the policyholder's failure to provide the required information, the insurer may not rely on the fact of providing false information or failing to provide the required information as a basis to refuse the insurance compensation)*.
18.1.7. Non-payment or late payment of the relevant portion of the insurance premium: if the payment term for any subsequent portion of the insurance premium specified in the contract has expired 15 *(fifteen)* days ago, or, in the case provided for in clause 16.3 of these Rules, 3 *(three)* days after the expiration of the period set by the insurer, and an insured event occurs while the relevant portion of the insurance premium has not been paid;

18.1.8. If the occurred event is not recognized as an insured event under the legislation, these Rules, or the terms of the insurance contract.

## 19. Liability of the Parties

19.1. The parties shall be liable for non-performance or improper performance of the contract terms in accordance with the procedure established by law.

## 20. Dispute Resolution Procedure

20.1. The validity, interpretation, and execution of the insurance contract are governed by the legislation of the Republic of Azerbaijan.
20.2. Disputes arising from the execution of the insurance contract shall be resolved by mutual agreement of the parties.
20.3. If mutual agreement cannot be reached in the disputes arising from the execution of the insurance contract, the parties shall use the pre-court dispute resolution methods provided by the legislation of the Republic of Azerbaijan.
20.4. If disputes cannot be resolved by the methods referred to in clause 20.3, the matters shall be considered in the courts of the Republic of Azerbaijan.
20.5. The policyholder, the insured person, or the beneficiary, as well as their relatives, who believe that their rights under the insurance contract have been violated by the insurer, may submit a complaint to the Central Bank of the Republic of Azerbaijan.

## 21. Force Majeure Events

21.1. The parties shall be released from liability for full or partial non-performance of their obligations if such non-performance occurs due to force majeure circumstances arising after the conclusion of the insurance contract, which are beyond the parties' control, could not have been foreseen in advance, and could not have been prevented. Such circumstances include floods, earthquakes, fires, explosions, and other natural disasters and emergencies; declared or undeclared epidemics or pandemics; declared or undeclared wars and military operations, civil conflicts, riots, uprisings, terrorist acts; any armed attack, prolonged failure of telecommunications and information systems, lockouts, strikes, boycotts, and other similar events; changes in legislation directly affecting the parties' relations, actions or acts of competent authorities making the performance of the insurance contract impossible; as well as other force majeure events not listed here but beyond the parties' control and preventing the performance of obligations.
21.2. If performance of the insurance contract becomes impossible due to the reasons specified in clause 21.1 of these Rules, the obligations shall be extended for the duration of the force majeure.
21.3. In the event of force majeure circumstances, the party unable to perform its obligations must, within 5 *(five)* business days, notify the other party in writing, explain how the force majeure affects the impossibility of fulfilling the obligations, and confirm the situation with the relevant documents. If the event does not lead to full non-performance, the parties must fulfill their obligations under the insurance contract.
21.4. Deterioration of the parties' financial situation or economic indicators shall not be considered a force majeure.

21.5. Failure by a party to notify the other party within the specified period deprives that party of the right to invoke any event referred to in clause 21.1.

## 22. Terms

22.1. In accordance with Clause 900.1.14 of the Civil Code, other conditions of the insurance contract may be included based on the mutual agreement of the parties.

## 23. Final Provisions

23.1. Unless otherwise provided in the insurance contract, a 3 (three) year statute of limitations applies to insurance contracts concluded under these Rules.
23.2. All financial settlements between the parties shall be carried out in a non-cash manner in accordance with the legislation of the Republic of Azerbaijan.
23.3. All notifications and information of the parties regarding the execution or termination of the contract shall be sent to the addresses and/or contact details specified in the insurance contract (postal address, and in cases provided for in the contract — electronic address or other means of communication). In case of a change of address or contact details, the party must notify the other party in advance. If a party fails to notify the other party of changes in addresses or contact details, notifications and information sent to the old addresses or contact details shall be considered delivered.
23.4. Regulation of relations with legal entities performing auxiliary activities (evaluation of insurance risks, investigation of the insured event, insurance compensation, etc.) shall be determined by the insurance contract.
23.5. In the event of a conflict between the provisions of these Rules and the legislation of the Republic of Azerbaijan, the provisions of the legislation of the Republic of Azerbaijan shall apply.
23.6. If, as a result of amendments to the legislation of the Republic of Azerbaijan, any provision of these Rules conflicts with the legislation, such provision shall be deemed null and void.
23.7. The invalidity or unenforceability of any provision of these Rules shall not entail the invalidity or unenforceability of other provisions or the Rules as a whole.
23.8. The parties must act in good faith during insurance operations, avoid actions that may harm the interests of the other party, and comply with the principle of “bona fides” (good faith) and the general principles of civil law.
23.9. Words numbered with natural numbers, highlighted in bold and underlined in these Rules indicate only the titles of the relevant provisions of the Rules, are added for convenience, and shall not be used for interpretation of any provision of the Rules.
23.10. Numbered sections of these Rules are referred to as “Articles,” subsections of these articles are referred to as “Clauses,” and all subsections of these clauses are referred to as “Sub-clauses.”

**Appendix No.1 to the Justification of Tariff Rates for the Insurance Against Incurable Diseases of PASHA Life Insurance OJSC**

The net insurance premium for one or several of the above-listed incurable diseases is calculated as follows:

Based on internal or external statistical data on morbidity, the number of individuals diagnosed with each disease and the total population is determined by gender, age group, and year. If there is a statistic on the diagnosis of more than one disease in the same person, these numbers are subtracted from the total. If such data is unavailable, it is assumed that such cases do not occur (or occur in such a negligible number that they can be disregarded).

Then, for each year, gender, and age group, the number of people affected by at least one of the diseases included in the coverage is divided by the total population belonging to that gender and age group in that year:

$$q_{y,g,x} = \frac{m_{y,g,x}}{n_{y,g,x}},$$

Here, $m_{y,g,x}$ is the number of individuals who contracted an incurable disease in calendar year $y$ among persons of gender $g$ and age group $x$, and $n_{y,g,x}$ is the total population of the same category at the beginning of the year.

For each age group and gender, the obtained ratios represent the frequency of occurrence of an insured event for the population within that age and gender group. A t statistical test is conducted for neighboring age groups: if, for any age groups, the hypothesis that the expected values of the probability of an insured event are equal is accepted with a specified confidence level (usually 99.5%), these groups are combined, and the respective indicators for these groups are aggregated. Next, if the number of years for which data were collected is less than 30, the Student's distribution is applied; if more than 30, the normal distribution is used. Using the corresponding coefficients and with the specified confidence level (usually 99.5%), the upper bound of the confidence interval for the probabilities calculated for each age range and gender is determined.

$$q_{g,x} = \frac{\Sigma_{i=1}^{k} q_{i,g,x}}{k} + t_{\alpha,k} * \frac{\sigma}{\sqrt{k}},$$

Here,

$k$ — the number of observed years,

$t_{\alpha,k}$ — the coefficient corresponding to the confidence level $\alpha$ and $k$ degrees of freedom,

$\sigma$ — the variance of the quantities $q_{i,g,x}$.

The obtained results represent the probabilities of contracting an incurable disease for each age group and gender. Based on these probabilities, the insurance premium is determined using the following formula:

$$r_{g,x} = a \cdot q_{g,x} + b, (a > 0, b > 0)$$

Here,

$q_{g,x}$ — the probability that an insured person of gender $g$ and age group $x$ will contract one of the covered diseases during the next year;

$\alpha$ — a quantity depending on the costs of paying insurance premiums, claims settlement expenses, the profit margin under the contract, and the increase/decrease factors applied to the insured person / insurance portfolio, as well as the insured person's probability of death;

$b$ — a quantity depending on the expenses incurred when concluding the insurance contract, the costs of paying insurance premiums, and the profit margin under the contract. In the evaluation,

not only the calculated rates but also the rates confirmed under reinsurance agreements can be used.

If the contract provides for a commission of $c\%$, the final rate will be:

$$\frac{r_{g,x}}{1 - c\%}$$

Each year, considering new statistical data, calculations can be redone based on this method, and insurance rates can be updated if necessary.

Insurance rates may be differentiated by age and gender, and based on statistical indicators of the insurance portfolio, loss distribution, and other various data, actuarial methods can be applied to determine weighted average single rates for the portfolio.

***Note:*** *Depending on the insured person's health, professional activity, and other underwriting risks, increasing coefficients may be applied to the insurance rate, and depending on the insurance portfolio and the number of covered diseases, decreasing coefficients may be applied.*

Stamp: available

Signature: available