PREMIUM INSURANCE COMPANY

PREMIUM Insurance Company Limited, a branch of an insurance company from another member state

General Insurance Terms and Conditions for Directors & Officers Liability Insurance

(Directors & Officers Liability Insurance)

Article 1 Introductory Provisions

1. PREMIUM Insurance Company Limited, an insurance company with its registered office at 68 George Borg Olivier Street, STJ 1081, St. Julian's, Malta, acting in the territory of Slovak Republic through its organizational unit PREMIUM Insurance Company Limited, a branch of an insurance company from other member state, with its registered office at Námestie Mateja Korvína 1, 811 07 Bratislava – district Staré Mesto, Slovak Republic, Company Reg. No.: 50 659 669, registered in the Companies Register at Bratislava I District Court, Section: Po, Entry No.: 3737/B (hereinafter the "Insurer") undertakes to provide compensation for damages in the form of benefits under the terms and conditions set out in the insurance policy which includes these General Insurance Terms and Conditions for Directors & Officers Liability Insurance (hereinafter the "PREMIUM DO") and the Questionnaire filled in by a representative of the insured person.

Article 2 Subject and Scope of the Insurance

1. The Insured Person is entitled to the Insurer making a payment to the Injured Person on their behalf based on the concluded insurance policy in the agreed scope of compensation for damages incurred by the third party (hereinafter the "Injured Person"), who claimed compensation for damages against the Insured Person for which the Insured Person is liable and this damage is covered by this Directors & Officers Liability Insurance (hereinafter the "Insurance").
2. An insured event under these insurance terms and conditions is a claim against the Insured Person covered by these PREMIUM DO General Terms and Conditions and the special contractual arrangements of the concluded insurance policy. A condition for entitlement to benefits is that the claim has been made and reported to the Insurer for the first time or circumstances that led to the claim have been reported to the Insurer for the first time (hereinafter the "Notification of Circumstances") during the insurance period or extended period, when claiming is possible and at the same time the claim related to a breach of obligations by the Insured Person(s) before the end of the insurance period stated in the insurance policy, however at the earliest after the insurance commencement date or retroactive date, if arranged on the insurance policy.
3. The Insurer will pay:

   a) benefits for damage caused by the Insured Person(s) to the Injured Person due to breach of obligations provided that the claim is covered by the insurance except for cases when the company has already compensated the Injured Person on behalf of the Insured Person(s);
   (Insurance for directors and officers of the company);

   b) benefits for damage caused by the Insured Person(s) to the company due to breach of obligations provided that the claim is covered by this insurance within the extent to which the company legitimately compensated the Injured Person(s), however, up to the amount the company actually compensated for;
   (Insurance of compensation for the company);

   c) defence costs (up to remuneration tariff of the attorney) of any insured person in the case of claims asserted under letters (a) and (b) of par. 3 of this article of the PREMIUM DO General Terms and Conditions in court proceedings or out-of-court proceedings initiated against the Insured Person until the full satisfaction of the claim, however only up to the liability limit stated in the insurance policy,
   (Defence costs insurance).

   Any attorney, lawyer, barrister etc. who will legally represent the insured person must be approved by the insurer in advance. The defence costs for such an attorney, lawyer, barrister etc. will be paid by the Insurer only if approved in advance. Instead of compensation for defence costs, the Insurer is entitled to provide the Insured Person with an attorney for a reasonable time who will represent the Insured Person in proceedings for compensation for damages and who will be paid by the Insurer. The Insurer reserves the right to investigate, examine and settle out-of-court any claim at their own discretion.
4. This insurance covers claims for compensation for damages made against the Insured Persons arising all round the world, except for the USA and Canada.
5. The scope of the compensation for damages by the Insurer is limited to the insured sum and other sub-limits arranged in the insurance policy and these PREMIUM DO General Terms and Conditions.

Article 3 Exclusions from the Insurance

1. The insurance does not cover the below mentioned insurance risks, which, however, may be additionally covered if agreed upon with the Insurer. Therefore, unless otherwise provided in the insurance policy, the insurance does not cover:
   a) public relation costs and cost of maintaining a good reputation;
   b) compensation for loss due to participation in court proceedings;
   c) costs of extradition proceedings - costs of extradition of the insured person;
   d) costs of defence in proceedings against personal liberty or property;
   e) costs of personal needs with regards to confiscation of property of the Insured Person;
   f) costs of financial guarantees in the court proceedings;
   g) defence costs related to damage to property or personal injury;
   h) costs of psychological support;
   i) costs related to regulatory interventions;
   j) costs in urgent cases.
2. According to these PREMIUM DO General Terms and Conditions, the insurance does not cover damage resulting from a claim against the Insured Person(s) resulting from:
   a) intentional breach of obligations, intentional crime, fraud, intentional misuse of powers or any other offence or breach of obligations done with the knowledge of the Insured Person that they were breaching their obligations or legal commitment; while such an exemption relates only to the breach of the Insured Person and not to other Insured Persons and may be asserted only based on confession of the Insured Person, valid decision of the court or other valid decision;
   b) facts or breaches of obligations that were or could have been known to the Insured Person before the insurance period as circumstances leading to a claim;
   c) claims that existed before the insurance period or;
   d) claims or facts that were notified before the insurance period;
   e) directly or indirectly from an accident, illness, damage to health, death or any mental disorder caused no matter how, from damage or destruction of material property including a loss of possibility to use the property, while the exception with regards to the liability for breaching employees' rights does not include any mental disorder;
   f) directly or indirectly
      i. from actual, alleged or imminent discharges, leakages or dispersions of pollutants into or into the soil, atmosphere or any water source, body of water, whether such discharges, leakages or dispersions were intentional or accidental;

ii. a requirement or instruction to test, monitor, clean, remove, retain, process, detoxify or neutralize pollutants;

while this exception does not apply to defence costs and any claim asserted by any shareholder of the company if the incident(s) giving rise to the claim was outside the jurisdiction of the United States of America or Canada, their territories and areas and the action regarding these claims was outside the jurisdiction of Canada or the United States of America, their territories and areas;

g) the conclusion, breach of obligation to conclude, failure to conclude any type of insurance policy, either mandatory, compulsory contractual or any other, as well as from the inability or impossibility for the company or the Insured Person(s) to obtain any benefits from any insurance of the company or the insured person(s) due to the insolvency of the insurance company where the insurance was concluded to pay benefits or any part thereof;

h) actual or intended trade or offer for sale or purchase or placement of any securities including a private company or joint-stock company, including, but not limited to, the first issue of securities, secondary issue of securities or private placement of securities;

i) or with regards to provision or failure to provide any advisory, consulting, intermediary, expert, telecommunication, investment, accounting, auditing, IT or any other services paid by the company or by the Insured Person for the benefit of third parties,

j) liability for damage caused by a faulty product, defect of services provided or due to withdrawal of products from the market including all costs related to withdrawal of products from the market;

k) the obligation of the Insured Person or the company to pay taxes, contributions, public insurance premiums or other legally imposed monetary obligations and the administration thereof;

l) the obligation of the Insured Person to pay:

i. fines or penalties imposed with regards to an intentional, fraudulent act or crime,

ii. fines or penalties that cannot be insured under generally binding legal regulations,

iii. fines or penalties imposed due to breach of generally binding legal regulations governing taxes, contributions, public insurance premiums or other legally imposed monetary obligations and their management.

3. Other special exceptions may be arranged in the insurance policy.

Article 4 Commencement and Termination of the Insurance

1. The insurance is arranged for an indefinite period or a definite period however, unless otherwise stipulated in the insurance policy, the insurance policy is concluded for an indefinite period with an insurance period of one year. The insurance commences on the first day after the conclusion of the insurance policy or unless parties agreed that the insurance commences upon conclusion of the insurance policy or a later insurance commencement date has been set.
2. The scope of the insurance arranged in the insurance policy may be amended only by the agreement of both parties, however, this does not apply if, during the insurance period a co-insured subject ceases to exist (for any reason whatsoever), in which case the associated liability insurance also terminates. The same rules apply for the conclusion of an agreement on amendments to the insurance policy as for conclusion of the insurance policy. The effective date of an amendment to the insurance policy is stated in the agreement on its amendment.
3. An amendment to the insurance policy does not cause a change in commencement and end dates of the insurance period agreed in the insurance policy, unless otherwise agreed.
4. If there is a transaction during the insurance period, the Policy Holder is obliged to immediately inform the policy holder, within 30 days after the transaction at the latest and the insurance will cover only breaches of obligations after the transaction date.
5. The insurance terminates:
   a) upon the elapse of the agreed period stated in the insurance policy;
   b) by written notice from one party at the end of the insurance period, while the notice has to be delivered to the other party six weeks before the end of the insurance period at the latest;
   c) by written notice from one party within two months from conclusion of the insurance policy, whereby the notice period is eight days;
   d) if the insurance premium for the first insurance period or one-time insurance premium has not been paid within three months from the due date, the insurance ceases to exists upon the elapse of this period,
   e) if the insurance premium for the subsequent insurance period has not been paid within one month from the delivery of the Insurer's call for payment, unless the insurance premium has been paid before the delivery of this call. The Insurer's call must contain a notification that the insurance will be terminated if not paid, while the same applies to partial payments;
   f) notice from either party within one month from provision of benefits or its refusal, while the notice period is eight days and upon its end the insurance terminates,
   g) cancellation of the business license, termination of the Insured Person,
   h) on the basis of a written agreement between the parties;
6. The Insurer may withdraw from the insurance policy in the event of an intentional breach of the Policy Holder's obligation or the Insured Person's obligation "to answer truthfully and completely all the Insurer's written questions concerning the insurance arrangement", where the Insurer would not have concluded the insurance policy if the questions had been answered truthfully and completely. The Insurer may exercise this right within three months from learning this fact, otherwise the right expires.
7. If the Insurer learns after the insured event that it was caused by a fact they could not have learned when arranging the insurance due to knowingly false and incomplete answers and was crucial for conclusion of the insurance policy they are entitled to refuse provide benefit from the insurance policy; the insurance terminates upon the refusal of benefits.

Article 5 Insurance premium

1. Insurance premium is a contractually agreed price for the insurance cover provided by the insurer to the extent stipulated by the insurance policy. The amount of the insurance premium shall be determined by the insurer. The insurance premium shall be paid by the policyholder in the amount and due dates agreed in the insurance policy. The amount of insurance premium, the due date of the insurance premium and the amount of insurance premium instalment provided that the insurance premium is to be paid in instalments shall be included in the insurance policy.
2. The part of the insurance term for which the insurance premium shall be paid is called the insurance period. Unless otherwise indicated the insurance policy, an insurance:
   (a) for an indefinite period the insurance period is one year (1 insurance year, i.e. 365 consecutive calendar days or 366 days for leap years, respectively.)
   (b) for a definite period, for a period of less than one year the insurance period and insurance term are identical.
3. If, during the course of the insurance period there is a change in the facts pursuant to which the amount of the insurance premium has been established, the insurer shall be entitled to adjust the amount of the insurance premium even retrospectively as to the date of such change.
4. The insurer shall be entitled to an insurance premium for the time period defined by the commencement and termination of the insurance. If the insurance expires before the end of the insurance period for which the insurance premium has been paid, the insurer shall return the outstanding amount of the paid insurance premium. In cases where the insured event occurred and thus the cause of further insurance has been lapsed (e.g. theft, destruction of the insured asset), the insurer shall be entitled for the insurance premium until the end of the insurance period during the course of which the insured event occurred.

5. The insurance premium shall be deemed to have been paid in time if it is credited to the bank account of the insurer in the correct amount no later than on the day of its maturity with a correctly indicated variable symbol assigned by the insurer.
6. The payment of the insurance premium for the insurance period may be stipulated by the insurance policy in half-yearly or quarterly instalments. In case where the insurance premium under the insurance policy is to be paid in instalments it follows that any non-payment of the instalment of the insurance premium the amount of the insurance premium corresponding to the end of the insurance period shall become due in full amount on the day following the due date of instalment of the insurance premium provided the insurer exercises this right to the due date of the next insurance premium instalment.

Article 6 Benefits

1. The Insurer will compensate for damages as a consequence of one or more cases of damage caused during one insurance period up to the amount of the insured sum or limit or sub-limit of benefits agreed in the insurance policy.
2. The Insured Person participates in paying the benefits from each case of damage with the amount agreed in the insurance policy as the insurance excess used by the Insurer to decrease the compensation for damages paid to the Injured Person.
3. If it is found that the Injured Person was not entitled to the benefits or the Insured Person and/or co-insured persons did not meet the requirements/conditions for benefits provided, the Injured Person or the Insured Person and/or co-insured persons are obliged to return the full benefits to the Insurer and the Insured Person is obliged to pay the Insurer's costs related to provision of benefits.
4. If the Insured Person causes an increase in costs to the Insurer because any decisive facts have to be re-ascertained, or because of delayed notification of the insured event, the Insured Person causes the Insurer not to be able to provide compensation for damages in time and the Insurer is entitled to apply a penalty of the sum of such costs.
5. If, due to late notification of a loss event, the insurer is not be able to objectively determine the cause of the damage and/or its scope, the insurer is entitled to refuse benefits or decrease the amount of benefits by the part of damage that could not be documented.

Article 7 Rights and Obligations of the Parties

1. In addition to the obligations imposed by generally binding legal regulations, the Insured Person and/or the Policy Holder are obliged to:
   a) answer completely and truthfully all written questions of the insurer including e-mail communication and the completion of the questionnaires related to arrangement of the insurance,
   b) immediately, in writing, notify the Insurer of any change in facts that were a part of the documentation (questionnaires written and e-mail communication including attachments) during the conclusion of the insurance policy and each change of facts that the Insured Person stated to the insurer when arranging the insurance, if they could cause an increase in the risk resulting from insured subject of activity,
   c) allow the Insurer to view all accounting and other documents all at all times, if it is necessary to ensure or verify values as decisive for setting the insurance premium amount,
   d) notify the Insurer of the conclusion of another insurance policy of the same scope and state its business name, the insured sum and the limits of its benefits,
   e) pay the insurance premium agreed in the insurance policy while the Policy Holder and/or the Insured Person are not entitled to settle the payment of insurance premium against the benefits without the consent of the Insurer,
   f) proceed in accordance with instructions of the insurer and act so that a loss event does not occur and at the same time not to breach obligations to avert or mitigate the risk of a loss event to which they are bound the insurance policy and generally applicable legal regulations, neither may they allow third parties to breach these obligations,
   g) read these PREMIUM DO General Terms and Conditions, contractual arrangements and insurance policy immediately after the conclusion of the insurance policy,
   h) without the consent of the Insurer, the Insured Person may not admit any liability for any damage, conclude a court settlement or voluntarily provide any compensation for "damages",
   i) let the Insurer decide on a lawyer and the initiation of court proceedings in all cases where the costs are paid by the Insurer,
   j) immediately notify the Insurer of an event that is or could be associated with liability of the Insured Person and that could establish an obligation on the part of the Insurer to provide benefits.
2. If there is the loss event that could give rise to the right to benefits, the company and the insured person are obliged to:
   a) take all purposeful measures to mitigate consequences of possible damage and prevent the spread of the damage,
   b) immediately notify the Insurer of the place, date, cause and scope of this event and submit a notification within 5 days in writing, while the Insured Person is obliged to provide documents requested by the Insurer and allow the insurer to inspect the reported facts,
3. If a claim is made against the Insured Person in court proceedings or out-of-court proceedings for compensation for damages, the Insured Person is obliged to:
   a) immediately notify the Insurer;
   b) use all available legal means to defend the claim made. The company and/or the Insured Person shall cooperate with the Insurer, collaborate and provide them with all information reasonably requested by the Insurer, which is a prerequisite for the Insurer to compensate for the damages;
   c) appeal against the decision of the relevant authorities on compensation for damages that is in any way to their detriment, unless otherwise agreed by the Insurer;
   d) if the claim for compensation for damage is not covered by this insurance, then all defence costs paid by the Insurer up to that point have to be returned to the Insurer, while the defence costs have to be returned to the Insurer even if the counterparty is obliged to pay them according to a valid judgement.
4. In addition to the obligations imposed by generally binding legal regulations, the Insurer is obliged to:
   a) notify the policy holder of insurance terms and conditions related to the arranged insurance,
   b) return, to the Policy Holder or the Insured Person, original documents they have asked to be returned unless they are a compulsory part of the insured event's file,
   c) on the agreed day, allow the Policy Holder or the Insured Person to view the file of their loss event. Based on a written request, provide a copy of documents from the insured event's file, while the costs thereof are borne by the Policy Holder,
   d) keep confidential all facts that they learned when arranging the insurance, managing the insurance and investigating of insured events. This information may be provided to third parties only with the consent of the Policy Holder or the Insured Person, if it is necessary for the management of the insurance or the investigation needed to determine the scope of the Insurer's obligation to provide the benefits and the amount of the benefits,
   e) pay a reasonable advance for defence costs if they are covered by the insurance, if required by the Insured Person.
5. The Policy Holder and/or the Insured Person is obliged to pay the insurance premium as agreed in the insurance policy. Unless otherwise agreed in the insurance policy, the insurance premium is payable on the first day of the insurance period. If the Policy Holder or the Insured Person is in arrears with the payment of the insurance premium, the Insurer is entitled to:
   a) require interest on arrears from the insurance premium for each day of arrears under the generally binding legal regulations,

b) compensation for damages arising in relation to delivery of documents related to payment of the insurance premium due,
c) deduct from the benefits an amount corresponding to the insurance premium due including interest on arrears if there is the insured event when the Policy Holder or the Insured Person is in arrears with payment of the insurance premium.

Article 8 Definitions

1. *Securities* are the following instruments:
   a) shares, temporary certificates, unit certificates, bonds, certificates of deposit, treasury bills, deposit books, coupons, bills of exchange, checks, traveller's checks, bills of lading, warehouse slips, any stock slips, goods slips, cooperative share slips, investment certificates or other securities under the generally binding legal regulations or
   b) other confirmations related to securities stated in letter (a) of this point.
2. A *subsidiary* is any legal person where the Policy Holder at the beginning of the insurance period owns more than 50% of the shares with voting rights or participation of more than 50% either directly or indirectly through one of more subsidiaries and/or where the Policy Holder during the insurance period through one or more transactions is the owner of more than 50% of the shares with voting rights or acquires participation of more than 50% either directly or indirectly through one of more subsidiaries.

   A company is considered a subsidiary only during the time it meets the above criteria. A subsidiary that has publicly traded shares or has securities listed on a stock market or stock exchange or is a financial institution is not automatically covered by this insurance and may be included into the insurance only with the consent of the Insurer, preceded by a risk assessment based on additional information requested by the Insurer and the payment of an extra insurance premium.

   Unless otherwise agreed, the insurance policy covers only the breach of obligations during the time, when the Policy Holder has more than 50% of shares with voting rights or participation of more than 50% either directly or indirectly through one of more subsidiaries.
3. An *insurance period* is a period when the insurance protection is provided starting on the insurance commencement day stated in the insurance policy. If insurance is terminated due to generally binding legal regulations before the end of the insurance period agreed in the insurance policy, the insurance period is the period from the insurance commencement date to the insurance termination date.
4. A *financial institution* means a bank, fund, insurance company, leasing company, asset or investment fund manager, investment company, investment services intermediary, securities or commodities trader, alternative investment companies (private equity, hedge funds, real estate, etc.) or other companies whose activities are similar to the activities of the companies mentioned in this point.
5. The *liability limit* is the amount stated in the insurance policy. It is a cumulative limit of benefits from the Insurer for one and all insured events under Article 2 of these PREMIUM DO General Terms and Conditions arising out of all claims claimed by the Insured Person during the insurance period or extended period, when making a claim is possible. Any sub-limit of liability stated in the insurance policy is also a sub-limit for one and all insured events during the insurance period or extended period, when making a claim is possible within the total liability limit and does no increase it.
6. *Public relation costs and the cost of maintaining good reputation* are any necessary, reasonable and needed fees and expenditures incurred by the Insured Person and paid with the prior written consent of the insurer in order to limit or eliminate any negative publicity and harm to good reputation of the insured person with regards the claim covered by this insurance.
7. *Defence costs* include:
   a) defence costs incurred by the insured person in pre-trial proceedings and before the court in criminal proceedings initiated against them if initiated in relation to the claim for compensation for damages;
   b) costs of civil court proceedings for compensation for damages before the competent authority, if these proceedings were necessary to determine the liability for the Insured Person's damages or the amount of the benefits paid by the Insurer, if the Insured Person is obliged to pay (bear) them;
   c) costs of legal representation of the Insured Person in proceedings for compensation for damages, as well as the costs of out-of-court settlement of the Injured Person's claims incurred by the Injured Person;
   d) costs of external consultants and other costs incurred by the Insured Person mitigating damage or in resolving an established claim relating to an alleged breach of duty;
   e) investigation costs.

   The payment of any defence costs must be agreed by the Insurer in advance. The defence costs do not include any wage costs, benefits, bonuses etc. paid by the Insured Person, Policy Holder or company.

   The defence costs shall be paid within the total liability limit stated in the insurance policy unless otherwise agreed in the insurance policy.
8. *Investigation costs* are reasonable defence costs incurred by the insured person and other reasonable costs incurred by the insured person or for their benefit with the prior written consent of the Insurer, which may not be unreasonably withheld related to investigation. Investigation costs do not include wages, salaries or other remuneration of the Insured Persons or employees of the company.

   Investigation means an official investigation, inquiry or inspection of the company's affairs carried out by a person or institution legally authorized to perform such acts (a public authority) and
   a) the Insured Persons are obliged to participate, or
   b) includes acts of the Insured Persons in the company.
9. *Compensation for loss for participation in court proceedings* is compensation for loss of a part of the earnings of the Insured Person due to participation in court proceedings or an investigation provided that the participation of the Insured Person is required by the public authority and the loss of earnings was not compensated for or acknowledged by the public authority.
10. *Costs of extradition proceedings - costs of extraditing the Insured Person* means reasonable defence costs and other reasonable costs paid by the insured person or for their benefit with the prior written consent of the Insurer which may not be unreasonably withheld related to their extradition or transfer or other measure related to this extradition or transfer according to the relevant legal regulations including the European or international arrest warrant or similar measures including appeals or other investigation procedures under the applicable legal regulations.
11. *Costs of defence in proceedings against personal liberty or property* means reasonable defence costs paid by the Insured Person or for their benefit and other needed expenditures paid by the Insured Person with a prior written consent of the Insurer which may not be unreasonably withheld related to their defence in proceedings against personal liberty or property.

    Proceedings against personal liberty or property means any proceeding which may lead to:
    a) the restriction or deprivation of rights to the property of the Insured Person;
    b) the temporary or permanent suspension of the Insured Person;
    c) the restriction or deprivation of liberty of the insured person.
12. *Costs of personal needs with regards to the confiscation of property of the Insured Person* mean the following personal and family costs of the Insured Person for tuition fees; housing; energy; telephone, internet; private insurance for the Insured Person, which is paid exclusively by the Insured Person, if the Insured Person is prohibited by a court decision to dispose of personal movable or immovable property. These costs will be paid provided that the Insured Person concluded a contract with the service provider before the court decision was issued and at the same time the Insured Person has exhausted financial means not affected by the decision. These costs will be paid directly to the service provider from the 30th day of notification of the above decision, however, for up to 24 months or until the limit set in the insurance policy is exhausted, whichever occurs first.
13. *Costs of a financial guarantee* in the court proceedings are reasonable costs paid by the Insured Person or paid for their benefit related to a financial guarantee or other similar financial instrument of the amount set by the

court used to secure obligations related to the court decision with regards to the claim. The financial guarantee itself or other similar financial institution is not paid by the insurance.

14. *Defence costs related to damage to property or personal injury* mean reasonable costs for the defence of the Insured Person related to the claim for compensation for damages upon personal injury, death or damage to moveable property.
15. *Costs of psychological support* mean reasonable costs paid by the insured person with the prior written consent of the Insurer which may not be unreasonably withheld for psychological support of a psychologist, psychotherapist or other professional in the field of managing the stress induced by the Insured Person as a result of the claim or investigation. These costs will be paid only above the scope of other insurance (public or private) covering similar costs.
16. *Costs related to regulatory interventions* mean reasonable defence costs and other needed expenditures of the Insured Person or paid for their benefit to represent the Insured Person by lawyers or to prepare a report or prediction of the public authority with regards to the regulatory interventions.

    Regulatory intervention means:
    a) the delivery of any written formal notification of the public authority to the Insured Person during the insurance period if this notification legally obliges the Insured Person to prepare or submit documents to the public authority, reply to questions of the public authority or to participate in hearing, proceedings with the authority;
    b) inspection, visit or check by the public authority at the company's premises during the period of insurance which included submission, revision, copying or seizure of documents or questioning of the Insured Person;
    c) public notice related to facts stated in the previous point.
17. *Costs in urgent cases* mean defence costs or costs related to regulatory interventions paid by the Insured Person or for their benefit when the prior written consent of the insurer could not have been requested due to objective reasons. The Insurer will grant their consent provided that the consent is requested within 14 days after the payment of the first of the above costs.
18. A *claim* is:
    a) any written request against the Insured Person from any natural or legal person related to any breach of obligations or
    b) any criminal or civil proceedings or arbitration proceedings against the Insured Person initiated by a natural or legal person related to any breach of obligations, or
    c) any administrative proceedings or administrative procedures or investigation against the Insured Person related to any breach of obligations, or
    d) any administrative proceedings or official procedures or investigations against the company related to any breach of obligations by the Insured Person.

    One claim means any number of claims against the Insured Person resulting from or related to one breach of obligations or a series of the same, similar or a continual breach of obligations resulting from of the same situation and that are temporally, economically or legally interconnected. The claim date will be the date of the first claim and all the claims will be related to the insurance period of the first claim.
19. A *non-profit organization* is a legal person established under Act No. 213/1997 Coll. on Non-Profit Organizations providing generally beneficial services as amended, providing generally beneficial services under conditions set in advance and same for all users, the profit of which may not be used for the benefit of founders, member of boards or employees, but must be used entirely to provide generally beneficial services.
20. A *notification of circumstances* is a written notification of the insured person or the company about circumstances that could give rise to a claim. The notification must be issued without undue delay, within 30 days of the day when the Insured Person or the company learned about it and must contain at least the following:
    a) reasons for the anticipated claim;
    b) description of breach of obligations;
    c) information on the Insured Persons that should have breached their obligations.

    Related notifications of similar nature or notifications resulting from the same cause are considered one notification. The date of the first notification is the notification date.
21. An *Insured Person* is a natural person - a former, current or future:
    a) member of the board, member of the supervisory board, managing director, member of an inspection committee, proxy of the company or equivalent position within the meaning of the law of countries other than the Slovak Republic;
    b) an employee of the company who, under their employment contract has a managerial or control position, provided that the claim against the employee arises out of breach of obligations resulting from the type of work arranged in the employment contract or the job description of the employee;
    c) any of the above stated in (a) and (b) who at the same time have the same above mentioned position in a related company or non-profit organization where in this position they represent the company and were appointed by the company, up to the limit stated in the insurance policy (sub-limit).
    d) a spouse of a member of the board or an employee where a claim is legitimately asserted against them due to joint ownership or possession of property. The insurance does not cover a breach of an obligation caused by a spouse of the Insured Person;
    e) a legal representative, heir or successor of the above persons if the event of their death, deprivation of legal capacity, insolvency or bankruptcy;
    f) any employee of the company who is named in a claim asserted against any of the above.
22. A *Policy Holder* is a legal person stated in the insurance policy who concluded the insurance policy.
23. A *breach of obligation* is any negligence, misrepresentation, deception, erroneous description, incorrect declaration, misleading information, error, misuse of powers, omission, breach of employees' rights or any other act committed by the insured person(s) in the performance of their duties in the company. Interrelated, continual or repeated breach of obligations means one breach of obligations regardless of whether it is caused by one Insured Person individually or jointly by multiple Insured Persons and regardless of whether the Injured Person is one or more persons.
24. A *breach of employees' rights* means any claim regarding a breach of the legal rights of an employee or a job applicant under the Labour Code and other generally binding legal regulations.
25. *Retroactive date.* It may be arranged in the insurance policy that this insurance covers damages resulting from claims during the insurance period but are related to breach of obligations before the commencement of the insurance period. This period is limited by the so-called retroactive date. The retroactive date is arranged in the insurance policy and means an earliest date in the past when obligations could be breached where this breach can be considered a reason for the claim covered by this insurance. Claims resulting from a breach of obligations before this retroactive date are not covered by this insurance.
26. The *extended period, when claiming is possible* is an additional period following the end of the insurance period when the Policy Holder and/or Insured Person may notify the Insurer of a claim or an event that could lead to a claim.
27. An *excess* is the amount of that the company and/or the Insured Person pay for benefits for each insured event, depending who has the obligation in each particular case. The excess applies to all damages resulting from all claims from one or more breaches of obligations or related thereto.
28. The *company* is the legal entity stated in the insurance policy. If arranged in the insurance policy, the company includes subsidiaries stated in the insurance policy.
29. A *related company* is any organization, association or legal entity where the company owns not more than 50% of shares with voting rights or participation of less than 50% either directly or indirectly through one of

more subsidiaries at the beginning of the insurance period or before it. A related company is not:

a) any organization, association or other legal person with its registered office, its shares are listed or traded on the stock exchange in the United States of America or Canada, or
b) any financial institution.

The insurance covers members of the bodies of these companies only when these companies are expressly listed in the insurance policy.

30. *Damage* means any payment the Insured Person is obliged to pay under the generally applicable legal regulations based on a valid judgement or other valid decision or payment paid based on a written claim for compensation for damages within the scope the Insured Person is liable under the generally applicable legal regulations. Damage includes fines, penalties and any other sanctions imposed under generally applicable legal regulations directly against the insured person resulting from fines, penalties or other sanctions imposed under generally binding legal regulations against the company or a third person due to a breach of the obligations of the Insured Person.
31. A *transaction* means:
    a) a merger or amalgamation of the company with another legal person, or
    b) the sale of 50% or more of the company's assets to another natural or legal person, or
    c) the fact that another legal person or natural person acquires more than 50% of the shares of the company with voting rights or a majority share in the voting rights in the company, or
    d) any legal or natural person or legal or natural persons acting in cooperation acquire control of the appointment of a majority of the members of the board of directors or managing directors of the company, or
    e) the company's entry into liquidation, the introduction of compulsory administration, declaration of bankruptcy for the company's assets or the company's insolvency.
32. An *employee* is any natural person in an employment relationship with the company or based on an agreement on work beyond employment relationship.
33. *Pollutants* means any solid, liquid, gaseous or thermal irritants or contaminants, including smoke, vapour, ash, fumes, acids, alkalis, toxic chemicals, liquids, gases and waste, petroleum, oil, petroleum products, medical waste, asbestos or products containing asbestos, fungi, moulds, lead or products containing lead and wastes from lead, other chemical substances or pollutants in the soil, atmosphere or any running liquids or water in artificial containers. Waste materials include, but are not limited to, recycled, reworked or refined materials.

Article 9 Handling Complaints

1. A complaint can be filed in any operation of the insurer during opening hours personally or in writing to: Premium Insurance Company Limited, a subsidiary insurance company from another Member State, Námestie Mateja Korvína 1, 811 07 Bratislava – district Staré Mesto, Slovak Republic. The complaint can also be filed electronically at e - mail: staznosti@premium-ic.sk
   More detailed information about the place, the method of submitting a complaint and the further procedure for its processing is available on the insurer's website www.premium-ic.sk
2. The complaint shall be handled promptly, no later than 30 days after its receipt. If this is not possible due to the circumstances of the case, the complainant will be informed of the reasons for extending the time limit for handling the complaint, stating the expected date for handling the complaint.

Article 10 Final Provisions

1. The insurance terms and conditions form an integral part of the insurance policy and may be derogated from in the insurance policy. If the provision of these insurance terms and conditions varies from the provisions of the insurance policy, the provision of the insurance policy shall prevail. If the provisions of the insurance terms and conditions differ from the provisions of the insurance policy in the same matter, provisions of both shall apply.
2. The insurance policy with its annex PREMIUM DO General Terms and Conditions shall be governed by the law of the Slovak Republic in terms of its effectiveness, interpretation and implementation. The courts of the Slovak Republic shall have exclusive jurisdiction over legal disputes arising from this insurance policy. The above also covers damages occurring abroad.
3. The provisions of these PREMIUM DO General Terms and Conditions related to the Insured Person apply to the Policy Holder (if the Policy Holder is not the Insured Person) and/or another authorized person.
4. Any documents shall be delivered to the Insurer, Policy Holder and Insured Person to the last known address or correspondence address of the Policy Holder or Insured Person if different from the address of the registered office and the Insurer has been notified about it. The Policy Holder and the Insured Person shall notify the Insurer of a change of address without undue delay.
5. The Insurer sends documents to the last known address of the Policy Holder or Insured Person. A document from the Insurer addressed to the Policy Holder or Insured Person (hereinafter the "Recipient") shall be deemed to have been delivered on the date of delivery to the recipient. If the document is kept at the post office because the recipient was not reached and the recipient does not collect it within the applicable collection period, the document is considered delivered on the day it begins to be kept at the post office, even if the recipient did not learn it was there. The same applies if the document has been returned to the Insurer as undelivered because of a change of address about which the Policy Holder or the Insured Person had not notified the Insurer. If the recipient refuses delivery of the document, the document shall be deemed to have been delivered on the day on which it was refused.
6. It is possible to report a change of address, business name or other data if practicable by telephone or e-mail. The Insurer is entitled to request completion of the notification in writing.
7. You may communicate a loss event even by telephone at the Insurer's telephone number or by e-mail to the Insurer's e-mail, which are set up for this purpose. However, this does not relieve the Insured Person from their obligation also to report the loss event in writing on the Insurer's prescribed form.
8. These PREMIUM DO General Terms and Conditions shall enter into force as of 1st September 2020.