OPTIMUM – Standard Conditions of Travel Insurance Policy for Citizens of Foreign Countries No. TRI-001

## Article 1. Travel Insurance Program OPTIMUM

| Program Type | A | |
|---|---|---|
| Service/ Coverage | Limit | Our share |
| 24-hour phone consultation | unlimited | |
| Urgent Medical Service provided by the ambulance crew | unlimited | |
| Personal doctor's service | unlimited | |
| Urgent hospital service due to personal accident | GEL 5,000 | 60% |
| Urgent outpatient service | GEL 300 | 50% |

## Article 2. Subject Matter of the Agreement

2.1. This Agreement governs relations arising among us, you and insured persons/policy holders when insuring people subject to insuring in compliance with the conditions set forth under this Agreement;

2.2. We, upon payment of the one-time-only insurance contribution (premium) by you, shall have to reimburse the cost of the insured's medical service in compliance with the determined procedure and stated conditions in the case of an insurance event.

## Article 3. General definition of the terms

The terms given below shall have the following meanings in all parts of this document:

3.1. **Insured (You)** – a person concluding this agreement with the Insurer;

3.2. **Insurer (We)** – JSC Insurance Company Imedi L;

3.3. **Policy Holder**– a person eligible to insuring under this agreement;

3.4. **People Subject to Insuring** – only the citizens of foreign countries, shall be subject to insuring on the conditions of this agreement;

3.5. **Insurance Agreement (hereinafter "the Agreement")** – unity of the insurance policy and these travel insurance conditions;

3.6. **Standard Conditions of** travel **Insurance Policy for the Citizens of Foreign Countries** – these conditions of travel insurance for the citizens of foreign countries, which, together with the travel insurance for insuring travel of the citizens of foreign countries, create the agreement on insuring the travel of a citizen of a foreign country;

3.7. **Insurance Policy (hereinafter "the Policy")** – a document confirming the fact of conclusion of an agreement on insuring the travel of a citizen of a foreign country in favor of the insured person/policy holder determined under the Insurance Policy;

3.8. **Medical Institution** – the institution functioning on the territory of Georgia, which, in compliance with the requirements of the legislation effective in Georgia, has the right of carrying out medical activities;

3.9. **Beneficiary** – the policy holder or a person, which, in compliance with the legislation effective in Georgia, has the right to be provided with the Insurance Reimbursement;

3.10. **Insured Risk** – the event containing possibility of its occurrence and features of eventuality because of which the Insurance Agreement is concluded;

3.11. **Insurance Coverage** – medical service/insurance risk subject to insurance reimbursement in compliance with the conditions of the Insurance Agreement;

3.12. **Insured Event** - occurrence of the Insured Risk envisaged under the Insurance Agreement, arising the Insurer's obligation pay the Insurance Reimbursement in compliance with the conditions of the Insurance Agreement;

3.13. **Accident** – an unforeseen, unexpected event, caused by visible external power resulting in bodily injury or incapacity of the policy holder;

3.14. **Insurance Period** – the time interval, during which the insurance conditions set forth under the Insurance Agreement of the Insurer remain effective; counting of the Insurance Period determined in the Insurance Policy shall commence at 00:00 of the date indicated in the box of the Insurance Police earmarked for commencement of the insurance period and shall finish at 00:00 of the date indicated in the box of the Insurance Agreement earmarked for completion of the insurance period;

3.15. **Insurance Limit (Limit)** – the amount indicated in the Agreement representing the maximum of total Insurance Reimbursement in the course of the Insurance Period for the certain Insurance Coverage;

3.16. **Insurance Conditions –** the conditions of this travel Agreement determining the content of the Insurance Coverage and procedures of its implementation;

3.17. **Territorial Limits (Insurance Coverage Range)** – the geographical range of effectiveness of the Insurance Coverage. The following is the range determined by the conditions of this Insurance Agreement: the territory of Georgia (except the occupied territories of Georgia);

**3.18. Insurance Contribution (Premium)** – the amount to be paid by You, the volume and payment procedure of which is given under this Agreement and which is the cost of the service to be provided by Us;

**3.19. Age Limits** – the age limit determining maximal possible age of the policy holder. Only the people, whose age in the moment of insuring is not less than the one and not more than 69, shall be subject to insuring under these conditions.

**3.20. Provider** – a concrete medical institution, including, a doctor (a doctor-specialist or personal physician), which, based on a corresponding agreement concluded with Us, provides the policy holder with a medical service under the Agreement in compliance with medical indication if the policy holder Event occurs. Besides, We can also define the providers, which can ensure just certain services (Certain Provider). The policy holder, prior to getting any service, through Our 24-hour Call Centre, shall obtain confirmation that the certain medical institution and/or doctor is really our Provider on the given date, including the Certain Provider to provide certain service;

**3.21. Hospital Care** – stationary treatment duration of which exceed 24 hours according to medical indications;

**3.22. Outpatient Service** – medical service, which, according to medical indications, does not need staying in the medical institution more than 24 hours;

**3.23. Waiting Period** – the period counted from the date of commencement of the Insurance Period and in the course of which the expenses incurred by the policy holder shall not be reimbursed;

**3.24. Earned Premium** – the earned premium of corresponding Agreement, taken for a certain date within the Insurance Period, represents the part of the total premium of the Insurance Period, which represents the number of days elapsed up to the above mentioned certain date against the duration measured during the days within the entire Insurance Period;

**3.25. Unearned Premium** - the unearned premium of corresponding Agreement, taken for a certain date within the Insurance Period, represents the difference between the total premium corresponding to the entire Insurance Period and Earned Premium;

**3.26. Medical Indication** – the state of health, which, based on the practice acknowledged in Georgia and/or world, relevant guidelines and protocols, under indications of a doctor (subject of independent medical business) having the right of working in the certain medical sphere/sub-sphere (profile), needs medical intervention (treatment or investigation) and is confirmed by submitted documentation (for instance, outpatient's card, stationary card and/or form No. 100, etc.) and, also, all medical documents coincide with each other and diagnosis;

**3.27. ID Document** – the following documents are necessary for identification of the policy holder/Insured:

**a) in the case of a person being a citizen of a foreign country:** international passport of a foreigner or a residence permit issued by the state of Georgia;

**b) in the case of a foreigner under 18 (under-age):** a birth certificate and passport or a passport of one of the parents;

**3.27. Hired Doctor** – a subject/doctor of independent medical service, the cost of the stationary medical service provided or to be provided to the policy holder in a corresponding medical institution exceeds the minimal tariff/price of the same/analogous stationary medical service determined in the same medical institution;

**3.28. Nonstandard Ward** – a ward in the medical institution the cost of accommodation in it exceeds the minimal tariff/price of a single-place ward earmarked for the analogous/similar medical service in the same medical institution;

**3.29. Claim** – the claim, submitted by you or the policy holder in the form of the corresponding annex to the Insurance Agreement, on dissatisfaction in the framework of the Insurance Agreement.

Article 4. Definitions of terms related to Insurance Cover

- **24 hour telephone service** - provides for 24-hour phone consultation rendered by **us**, providing the insurance related information and organization of medical service.
- **Urgent Medical care provided by ambulance crew -** provides for compensation of the cost for the service rendered by any licensed ambulance crew on the territory of Georgia, including medical transportation within the territory of Georgia;
- **Private/Personal Doctor Service -** means payment of expenses for service of personal physician. The service of personal physician includes: consultation (only in provider clinics indicated by the Insurer), in case of need - house-call, monitoring of health status of the policy holder and opening of medical card, coordination and management of policy holder event, in case of medical evidence - issue of referral for additional consultations or examinations, writing a prescription (letter of guarantee), issue of medical recommendations for establishing a healthy lifestyle.
- **Urgent outpatient service -** means payment of expenses for consultations of specialists, laboratory and/or instrumental examinations, out-patient manipulations, in case if delay of such services is not recommended according to Medical evidence.
  - **The Urgent Out-Patient Care** covers only the following:

A) Trauma

B) Hypertonic crisis

C) Hyperthermia

D) Hypothermia

E) Thermal Injuries

F) Bleeding

G) Kidney, abdominal and gallbladder colic

H) Bronchial and Cardiac Asthma

I) Intoxication (except for narcotic)

J) Allergic Reactions (anaphylaxis, hay fever, Kvinkes edema)

K) Dehydration

L) Abscess (Surgical treatment)

M) Croup syndrome

N) Emergency vaccination (antitetanus, antirabies, antibotulinum and anti-viper) (complete course)

O) Paroxysmal tachycardia

**Herewith, other cases, which are not listed above, shall not be covered**

- **Urgent Hospital Service due to personal accident –** provides for reimbursement of costs for hospital services during worsening of health condition due to personal accident. In-patient/days, medical manipulations, diagnostic instrumental and laboratory examinations, medications shall be reimbursed.

## Article 5.Terms of Receiving Insurance Services and Insurance Reimbursement

**5.1** In order to obtain any medical service at Our providers, The policy holder must present the Identification card along with the policy. Without these documents the policy holder is not authorized to receive covered medical service from provider.

**5.2** In case of violation by the policy holder of the procedure of receiving insurance services and insurance reimbursement defined by the article #5 of current conditions, We are authorized not to reimburse the costs of medical services, except for violations due to objective reasons, which must be confirmed by corresponding evidences.

**5.3** In case of the Insurance Event (need of receiving medical service) Insured/ policy holder or an authorized person shall notify Our 24-hour Call Centre regarding the Insurance Event (need of receiving medical service) on the following phone number: (995 32) 2 922 222;

**5.4 In the case of Calling Ambulance crew –** the policy holder (or his/her representative) shall contact Our 24-hour Call Centre. If the ambulance is needed, transportation of the policy holder (in Tbilisi, also, from regions to the nearest Medical Institution of relevant profile) shall be organized by Our 24-hour Call Centre, which also ensures compensation of the expenses incurred by the Medical Institution. In such case, the policy holder shall submit his/her Card and ID and he/she shall not have to pay the cost of the service;

**5.5 In the case of Urgent out-Patient Care,** the policy holder (or his/her representative), prior to obtaining the service or upon it, must contact 24-hour Call Centre. The notification shall involve the following information: name and surname of the policy holder, Card number, name of Medical Institution, time of appealing. The policy holder pays only his/her share from the amount of Co-Payment (if considered by the corresponding Card) and is absolutely free from paying the remaining part of the cost of service. If due to any reason the policy holder pays the cost of the service himself/herself, he/she shall refer to Us for compensation.

**5.6 In the case of Urgent In-Patient Care due to personal accident, the** policy holder (or his/her representative), must notify 24-hour Call Centre during 24 hours. The notification shall involve the following information: name and surname of the policy holder, Card number,

name of Medical Institution, time of appealing. In case the notifying prior the service is not possible due to objective reasons, these must be confirmed by corresponding evidences. Upon submission of full documentation by the policy holder's authorized representative the Insurer shall issue the Guarantee Letter. On the basis of the above letter the policy holder shall receive medical service at the corresponding hospital. In such case the policy holder pays only his/her share from the Co-Payment (if such is considered under the corresponding Card) and is free from paying the remaining part of the cost of medical service.

**5.7** If the policy holder receives medical services at Our provider medical institution, he/she pays only his/her share from the Co-Payment and compensation of the remaining expenses shall be carried out by Us directly to Medical Institution;

If the policy holder has to pay the cost of medical service himself, to get the compensation, it shall be mandatory to submit the Insurer the following:

1. The policy
2. ID
3. Medical documentation of the obtained service (Form #100, prescription, results of the conducted examinations, etc.);
4. Payment order of the person having received the amount and the original of the cash register receipt or printout of the POS-terminal confirming payment.

Herewith, the deadline for submission of the abovementioned documentation and the demand for reimbursement from the Insurer is the period of 15 (fifteen) days upon the payment of such sums by the policy holder (representative authorized person). The policy holder shall not be authorized to demand from Us the payment of the insurance reimbursement after the expiration of the aforementioned period of time;

**5.8** To be provided with Urgent Hospital Care due to personal accident, to take the Guarantee Letter from the Insurer, the policy holder or his/her representative, along with the policy holder's Card and ID, shall submit the Insurer the following:

5.8.1 form # IV-100/A;

5.8.2 detailed calculation of the cost of the medical service;

5.8.3 invoice

**5.9** In case of Urgent Hospital Care due to personal accident the Insurer shall issue the Guarantee Letter only for Provider Medical Institutions. At non-provider Medical Institution the policy holder shall pay full cost of the service himself/herself and submit to the Insurer Form # IV-100/A, detailed calculation of the cost of the medical service, invoice. We, in compliance with the conditions of the Insurance Agreement, shall decide whether to reimburse or not the cost of the medical service.

The deadline for submission of the abovementioned documentation and the demand for reimbursement from the Insurer is the period of 15 (fifteen) days upon the payment of such sums by the policy holder (representative authorized person). The policy holder shall not be authorized to demand from Us the payment of the insurance reimbursement after the expiration of the aforementioned period of time;

**5.10** We shall pay the insurance reimbursement via non-cash payment.

## Article 6. Exclusions

**6.1 The insurance does not cover the events which resulted directly or indirectly by the following events:**

6.1.1 Those insurance events which have occurred prior to this Agreement came into force.
6.1.2 Cost of personal accident cases occured prior to Insurance period.
6.1.3 Costs for treatment conducted without notifying 24-hour call center, except the urgent cases, when notification is not possible.
6.1.4 Costs for purchase of (eye)glasses, contact lenses and hearing aids;
6.1.5 Insurance events occured due to any kind of psychiatric (mental) illnesses as well as any neurological disorder or depressive condition;
6.1.6 Costs for treatment by means of alternative medicine, acupuncture, homeopathy, manual therapy, laser therapy, cryotherapy, plasmapheresis, balneo- and physiotherapy, therapeutic massage, therapeutic exercise, speech therapist (logopedist), rehabilitation and sanatorium-and-spa treatment;
6.1.7 Costs for treatment abroad, which is expanded beyond the boundaries of the established policy territory;
6.1.8 Costs for consultation and treatment at the medical institutions which do not comply with the requirements of the existing legislation of Georgia and/or do not have appropriate license; costs for consultation and treatment carried out by natural persons unauthorized to practice medicine, as well as costs for self-treatment (autotherapy);
6.1.9 Costs for treatment of the physical injuries suffered during committment of an illegal act provided for by the Criminal Code/Administrative Offences Code or costs for treatment of the physical injuries suffered by self-injury; except the cases when such actions are performed in order to save a human's life or for necessary self defence;
6.1.10 Costs for treatment of aggravation of condition as a result of alcohol and/or drug abuse and events occurred as a result of the effect of such substances;
6.1.11 Costs for treatment of injuries suffered from the exposure to radiation;
6.1.12 Reimbursement of costs for prosthesis, transplantation and implants;
6.1.13 The reimbursement is not provided for the costs which are related to the enjoyment of exclusive and additional services during the in-patient treatment (hired medical personnel, non-standard ward, conditioning agents, etc.).
6.1.14 Costs for treatment of diseases not disclosed by the Life Insured/policy holder in the individual insurance application (if such application was filled in by Life Insured/policy holder).

## Article 7. Rights and Obligations of the Parties

**7.1. We are to:**

7.1.1. pay full Insurance Reimbursement in timely manner in compliance with the conditions of the Agreement;

7.1.2. if You or the policy holder submit a claim, give a written respond within 30 (thirty) calendar days from the claim receipt in relation to the indicated problem. The insurer shall review only the claims submitted observing the procedure determined under the Insurance Agreement

**7.2. We shall have the right to:**

7.2.1. require due and sufficient execution of the obligations assumed under the Agreement;
7.2.2. require payment of the Premium in compliance with the procedure and terms set forth under the Agreement;
7.2.3. require submission of the information necessary for conclusion of the Agreement in the form determined by Us and through completion of an application;
7.2.4. not to reimburse the cost of the medical service, which is not envisaged under the conditions of the Agreement and/or is in the list of the exceptions;
7.2.5. refuse to pay the Insurance Reimbursement if You fail to fulfil the obligations assumed under this Agreement or if You carry out them insufficiently;
7.2.6. investigate the policy holder with the help of a doctor-expert authorize by Us and get acquainted with her/his medical record if We think it reasonable; besides, our representative shall have the right to check the volume and cost of the medical service provided to the policy holder in the medical institution;
7.2.7. if the Provider does not meet the service criteria and standards determined by Us, remove it from the list of Providers and replace by some other one, which will be notified to You in writing;
7.2.8. do not pay the Insurance Reimbursement in the case of falsification of the documents necessary for confirmation of occurrence of the policy holder Event for the policy holder (or with his/her participation), also, if there is revealed the fact of submission of the false information and terminate the insurance effectiveness unilaterally;
7.2.9. after reimbursement of the cost of the medical service for the policy holder, We shall retain the right to require compensation of corresponding expenses from the parties, responsible for the damage caused to the health of the policy holder;
7.2.10. refuse to pay the Insurance Reimbursement if the medical service is provided after expiration of the individual insurance period despite of the fact whether the policy holder Event/provision of the medical service is completed or not when expiration of the individual Insurance Period;
7.2.11. refuse to finance the medical service/ policy holder Event if by the date of commencement of the service provision the Insurance Period envisaged under the Insurance Agreement is expired; We shall also refuse to issue a referral/ guarantee letter the term of effectiveness of which exceeds the Insurance Period.
7.2.12.In order to ensure timely and effective provision of **medical services** to the **health insured persons** at **medical institutions**, to transfer the information related to **health insured persons** (including personal informations) to the **medical institutions**. The **insured** confirms that

respective written consent letters has already been signed by the **health insured persons** and in case of demand from the side of **insurer,** respective documents shall be presented immediately;

**7.3. You are to:**

7.3.1. pay the Premium in compliance with the procedure and terms determined under this Agreement;
7.3.2. ensure submission of true information in the form determined by Us for conclusion of the Agreement;
7.3.3. ensure handing over of the Policy provided by Us to the policy holder and informing him/her on the conditions and obligations envisaged under this Agreement (if the policy holder is some other person);
7.3.4. ensure handing over/ provision of the policy holder (s) with cards and any information/ documentation earmarked for the policy holder, including the documents necessary for due submission of claims.

**7.4. You shall have the right to:**

7.4.1. submit a claim observing requirements of this Agreement;
7.4.2. appeal Our decision, which You think to be unfair, observing the procedures set forth under the effective legislation;
7.4.3. get the Insurance Reimbursement from us in compliance with the conditions of this Agreement.

**Article 8. Settlement (Insurance Premium and payment conditions)**

8.1. The amount of the total (annual) Insurance Premium to be paid by You to Us for insuring under this Agreement is indicated in the Policy. The Insurance Premium shall be paid one-time-only upon signing of the Policy by the both parties;
8.3. Prior to payment of the first and one-time-only Insurance Premium We are free from the obligations assumed under this Agreement.

**Article 9. Validity of the insurance**

9.1. The insurance set forth under this Agreement shall become valid at 00:00 hrs of the date indicated in a corresponding box of the Insurance Policy (at the same time, the Insurance Period shall not be less or more than 1 calendar year);
9.2. The following shall become the basis of early termination of the insurance:
a) full execution of the obligations assumed by Us, i.e. full expiration of the corresponding responsibilities/ reimbursement limit(s) (if any);

b) failure to execute its obligations by the other party;
c) preliminary written agreement between the parties;
d) other cases considered under the legislation and/or the Insurance Agreement.
9.3. For early termination of the insurance envisaged under this Agreement it is necessary to send a written notification to the other party;
9.4. If You refuse/terminate the Insurance Agreement by any reason prior to its expiration, the Earned Insurance Premium shall not be subject to refunding by Us.

## Article 10. Dispute; Damage reimbursement

10.1. Any dispute arisen between the parties shall be resolved based on mutual consent. If the agreement is impossible to reach it will be resolved in the Tbilisi City court with the procedure set forth under the legislation effective in Georgia;
10.2. The parties, in order to settle misunderstanding, shall have the right to appeal the Georgian Insurance Association Insurance Mediation at it Hot Line phone number +995(32)2-555-155 or email address: mediacia@insurance.org.ge;
10.3. Each party shall unconditionally and fully reimburse the other party the damage (including the loss, lost income and moral damage) caused by its action, incompliance with the obligations, incomplete/insufficient, unfair or/and delayed execution of its obligations in compliance with the Georgian legislation.

## Article 11. Your applications and guarantees

11.1. Signing the Insurance Policy You confirm and guarantee that:
- this Agreement is concluded by You upon reasonable judgment;
- You have received from Us all the information and explanation in connection with this Agreement;
- this Agreement does not contain conditions obscure for You or strange obligation and/or notes;
- You have full authorization for conclusion and execution of this Agreement;
- You represent a totally capable person;
- if this Agreement is concluded in favour of the third parties (insured people/policy holders), You have obtained all necessary consents from such third party (ies): (a) on conclusion of this Agreement and implementation of insurance in his/her/their favour and (b) that we can fully and without any restriction use the authority granted under sub-paragraph 7.2.6;
- if this Agreement is concluded in favour of the third parties (insured people/policy holder), You shall explain him/her/them in details all the conditions envisaged under this Agreement and, also, all the obligations and responsibilities which may be imposed on them as a result of the above mentioned conditions;
- You understand that based on this Agreement only the people subject to insuring can be policy holder;

- You provide the policy holder with full and comprehensive information in relation to the form of this Agreement and presentation;
- You have notified the policy holder that due to procurement of the Insurance Policy envisaged under the conditions of this Agreement they cannot make use of the state healthcare programs effective in Georgia and neither You nor none of Your Insured(s) shall have any claim against the Policy Holder in future.

11.2. You confirm that You understand that We are concluding this Agreement with You based on Your above applications and guarantees;

11.3. Signing the Insurance Policy You confirm that in the case of failure to comply or comply insufficiently with the obligations assumed by the policy holder/You in the framework of this Agreement, Your responsibility is solidary to the policy holder's responsibility.

## Article 12. Final provisions

12.1. Any amendment or addendum introduced to this Agreement shall be valid only if it is made in writing and signed by the parties; upon the above they shall represent integral parts of the entire Agreement;

12.2. Cancellation of any of the articles or paragraphs of this Agreement shall not cancellation of the entire Agreement if it would have been concluded even without such void article/paragraph;

12.3. All the notifications necessary for execution of this Agreement shall be submitted to the parties in writing and to the correspondence address. If the changes introduced to the correspondence addresses are not timely submitted to Us, any notification sent by Us to You shall be considered as received at the address given in this Agreement. Besides, We shall have the right to provide You with any information related to this Agreement in the form of SMS and/or through email;

12.4. In cases which are not envisaged under this Agreement, the parties shall be guided by the legislation effective in Georgia;

12.5. The parties shall be released from the obligation to execute their liabilities if they were not executed or were executed insufficiently as a result of the Force Majeure Event (natural calamities, war, military exercises, diversion, effective acts of the Government and managing bodies of Georgia, other events that, independently from the parties' will, have delayed or/and made impossible execution of the assumed obligations). Effectiveness of this Agreement shall be suspended until completion of the Force Majeure Event. A competent body shall confirm occurrence and completion of the Force Majeure Event. If the Force Majeure Event does not cease more than three months, each party shall have the right to request termination of the Agreement;

12.6. All annexes of this Agreement, the application completed by You represent the integral parts of this Agreement and they are reviewed as the whole;

12.7. Each party undertakes to observe confidentiality of the conditions of this Agreement. The mentioned restriction does not apply to the following: (i) the information which is or shall become publicly available independently from the parties; (ii) information disclosure of which is agreed between the parties; (iii) information which will be disclosed by any of the parties resulting from the requirement of the legislation and/or corresponding regulations (including, in the case of the Policy Holder, according to and observing the requirements of the stock exchange, where are traded the stocks of its beneficiary owner). Despite of the above, signing the Insurance

Agreement You provide Us with the unconditional right to give all the credit and related information about You available for Us to the organization keeping the base of bad payers if You fail the obligation of settlement envisaged under the Insurance Agreement.

**Travel Insurance Agreement for Citizens of Foreign Countries (Standard Conditions No. TRI-001) and the form of a claim represent the analogue of the conditions verified in compliance with the fact verification act. (which, together with the corresponding act is uploaded to the Insurer's web-page: https://www.imedil.ge/en/travel-insurance . Besides, any type/character changes in the standard conditions and/or a claim form is permissible only through verification of the fact of the change; correspondingly, all the conditions different from these conditions, which have not been changed under the established procedure, do not create any other kind of rights-obligations or responsibilities for the parties. When changing the standard conditions each of them will be put in compliance with new conditions through verification of the fact and the corresponding act, together with the changed condition, shall be uploaded to the indicated web page. The web page shall contain all the acts (indicating the corresponding date), with the help of which the changes have been introduced to the Travel Insurance Agreement for citizens of foreign countries (standard conditions No. TRI-001) and/or claim form and, as to the standard conditions and/or claim form (implies the conditions without the fact verification act, which represents an analogue of the verified conditions each time), they will be upgraded on the web page each time; besides, the standard conditions if each agreement are valid up to the date indicated in a new fact verification act, etc. up to verification of each new standard condition.**