Assuria VERZEKERINGEN

POLICY CONDITIONS & COMPENSATION AZPAS BASIC

JANUARY 2023

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Assuria VERZEKERINGEN

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ARTICLE 1 | DEFINITIONS

1.1. Company/insurer
Assuria *Medische Verzekering N.V.* [Medical Insurance N.V.]

1.2 Policyholder
The person who has entered into the insurance contract with the insurer.

1.3 Insured
Anyone listed as such on the policy schedule, the policy appendix or insurance card and on grounds thereof is entitled to the provisions according to the policy conditions.

1.4 Insurance
The AZPAS Basic insurance policy taken out by policyholder with the Company.

1.5 Policy year
A period of twelve months from the premium due date and each consecutive period of equal duration. If the period from the inception date of the insurance to the premium due date or from the premium due date to the expiry date is less than twelve months, the payments to which you are legally entitled according to these policy conditions will be determined pro rata. This also applies to a period of validity of less than twelve months.

1.6 Ambulance
A means of transport intended for the professional transport of the sick and/or victims.

1.7 Physician
The person who under Surinamese law is competent to practice medicine and:
- is registered as such with the competent authority and if applicable, has a permanent residence permit or letter of consent;
- practices the general medical practice as is customary;
- has entered into a service provider agreement with the Company.

1.8 AZPAS-card
(Digital) Proof of entitlement to medical care according to the policy conditions, provided by the insurer to the insured.

1.9 Additional costs
Medical expenses that are directly related to specialist treatment and/or examination, such as costs for X-rays, blood transfusions, laboratory examinations, medicines, radiotherapy, anaesthesia, dressing material and the use of the operating room. The additional costs shall be claimed by the hospital or other agency where such costs were made.

1.10 Congenital anomalies (Birth defects)

Any defect or disease present at birth, irrespective of the cause thereof, whether or not manifested or diagnosed at birth.

1.11 List of Service Providers

List of health care providers / service providers with whom the Company has an agreement to provide services to AZPAS insured persons.

1.12 Pharmaceutical care

Pharmaceutical care includes the delivery of the medicines and dressing materials described in article 11.7.

1.13 Medical advisor

The physician who advises the insurer on medical matters.

1.14 Medical necessity

The necessity for the purchase, treatment, examination, or nursing of the insured person in accordance with generally recognised and medically scientific considerations.

1.15 Health care provider / service provider

The natural person or legal person domiciled in Suriname who is legally authorized to provide medical care. Health care providers also include suppliers of medicines and medical devices. A list of the care providers / service providers who have an agreement with the insurer (service provider list) may be obtained from the insurer on request.

1.16 Medical Consumables Index (*MVK- Dutch abbreviation*)

List of medical consumables as compiled by the Ministry of Public Health of Suriname.

1.17 Accident

A sudden impact of violence on the body of the insured person, external in origin, causing medically demonstrable physical injuries.

1.18 Hospitalization

Admission to a hospital if and as long as nursing, examination and treatment have to be provided in a hospital on medical grounds. This is meant to refer to:

- *Day nursing*
  Bed nursing in a hospital shorter than 24 hours, necessary to undergo examination or treatment on that same day by a specialist.
- *Hospital nursing*
  Hospitalisation longer than 24 hours in a hospital, if and as long as on medical grounds nursing, examination and treatment can solely be offered in a hospital, while continuous treatment by a specialist is medically necessary.

1.19 Optical care

Care with regard to the vision or eyesight.

1.20 Supplementary cover

Care offered optionally by the insurer and which the prospective policyholder / insured person may opt for.

1.21 AZPAS-Medicines Index

List of medicines especially compiled by the insurer for AZPAS insured persons, which is more extensive than the National Medicines Index. This list is revised once a year and is available for the insured persons.

1.22 Premium

The amount that the policyholder must pay to the insurer in order to be entitled to the medical care to be compensated by the insurer.

1.23 Preventive care

Services provided by a health institution or a health care professional to the insured person, aimed at maintaining the normal health of the insured person or the timely identification of a deterioration thereof.

1.24 Rehabilitation

Examination, advice, guidance and treatment of a specialist, paramedical, behavioural scientific and rehabilitation-specific nature. This aid is provided by a multi-disciplinary team of experts under the leadership of a specialist.

1.25 Reckless behaviour

To behave or to act in such manner, without taking into account the consequence of the behaviour or the action, or the danger that may ensue for oneself and others.

1.26 SEH

Accident and Emergency Department of a hospital in Suriname.

1.27 Home care

Nursing or care in the home situation on request of the practitioner, policyholder or the insured person with permission of the insurer.

1.28 Hospital

An institution domiciled in Suriname to nurse, examine or treat the sick, which institution is registered as such in Suriname. A list of the hospitals that have an agreement with the insurer (services providers list) is available from the insurer on request.

1.29 Nursing home
An institution located in Suriname where patients can be nursed, who no longer need to be admitted to a hospital for medical treatment.

1.30 Hospice
A place where people with a terminal illness, whose life expectancy is less than three months, have a home with the specialised care they need.

1.31 Specialist
The person who is competent under the Surinamese law to practice medicine and:
- is registered as such with the competent authority and if applicable, has a permanent residence permit or letter of consent;
- practises the specialist medical practice as is customary;
- has entered into a service provider agreement with the insurer.

1.32 Policy territory
The insurance is solely effective within the natural borders of Suriname.

ARTICLE 2 | BASIS OF THE INSURANCE

2.1 The insurance agreement is based on the application form with the written statements either or not personally written by the policyholder or the insured person and any written information that has been provided separately by the policyholder or the insured person.

2.2. The insurer provides a policy and a(n) (digital) insurance card as proof of the insurance to the policyholder or the insured person.

2.3. The insured person is only entitled to compensation of the costs of care insofar as on reasonable grounds he has a claim thereto in terms of content and scope.

ARTICLE 3 | REGISTRATION

3.1 The policyholder and the insured person undertake to fill out the application form completely and truthfully and to provide it with a date and signature.

3.2. If it turns out during the application procedure that by or on behalf of policyholder/insured person, matters were concealed, which are important for the decision-making by the insurer, or questions were answered incorrectly or incompletely, the application will not be taken into consideration anymore.

3.3. If it turns out after the approval of the application that by or on behalf of policyholder/insured person, matters were concealed which are important for the decision-making by the insurer, or questions were answered incorrectly or incompletely, then in pursuance of article 320 of the Commercial Code, the acceptance of the insurance will be deemed to be null and void up to the inception date, on penalty of forfeiture of the premium paid. Expenses arisen during the acceptance period and resulting from wrongly using this insurance, will be recovered from the policyholder/the insured person.

3.4 The Company has the right to collect medical information about the insured person and to share it with the doctors by whom the insured person is or will be treated. The insured person is obliged to authorize his healthcare providers to provide all necessary information to the Company and its medical adviser. The service provider is requested to provide the Company all information, reports and data to the Company as well as to provide all cooperation necessary for the implementation and/or the supervision of the care provided.

3.5 Necessary and relevant medical information shall be communicated with the medical adviser(s) of Assuria. Other relevant information shall be communicated with the Assuria employee(s) who is/are charged with the monitoring of the coverage and the invoices of the healthcare providers.

3.6 Newborns of an insured mother are co-insured free of charge in the first 2 weeks after birth, if insurance is subsequently taken out for the child for the rest of the mother's policy year.

ARTICLE 4 | INCEPTION DATE, TERM AND EXPIRY OF THE INSURANCE

4.1. Inception date and term of the insurance

4.1.1 The insurance becomes effective on the date referred to as the inception date on the policy schedule, provided that the premium due has been paid as at such date.

4.1.2 The insurance is entered into for a term of 1 year.

4.1.3 The insurance is each time renewed with a period of 1 year unless it has been cancelled no later than 14 days prior to the expiry of the validity term by registered letter, subject to the case described in article 8.3.

4.1.4 Upon entering into the insurance the insured person gets a(n) (digital) Azpas card.

4.2 Expiry / Cancellation of the insurance

The insurance expires or is cancelled in the following cases:

- by means of a notification in writing as to not agreeing with the adjustments of the policy conditions and this within 30 days following receipt of such conditions;
- In case the insured person takes up permanent residence abroad; this shall be communicated in writing by the policyholder at least 30 days prior to departure;
- In case of art. 3.3;
- In case of fraud or abuse of circumstances and if the policyholder does not properly comply with one of the obligations arising from the insurance;
- In case of arrears of payment of the premium in accordance with article 8.3.1;
- In case of death of the insured;
- Upon termination of employment in case of a collective Insurance.

ARTICLE 5 | OBLIGATIONS OF THE INSURED

5.1 Policyholder/insured person undertakes to provide (or cause to be provided) the Company all the information so desired.

5.2 If through the actions of a third-party policyholder/insured person incurs costs, which costs have been compensated by the Company, policyholder/insured person is obliged to entirely cooperate to recover such costs from the third party in question.

Without the permission in writing of the Company, it is not permitted to effect a settlement, (cause to effect a settlement) with said third party or with his insurance Company.

5.3 In case the interests of the Company are impaired as a result of the fact that policyholder/insured person does not comply with the obligations referred to under article 5.1 and 5.2, the Company is not obliged to compensate the costs.

5.4 Policyholder undertakes to notify the Company in writing of any event that may be of importance for the correct implementation of the insurance, yet no later than 30 days after the occurrence of such event. If such notification reaches the Company after 30 days, the date of receipt of the notification will be used as the inception date of the necessary change as a result of the relevant event.

5.5 Events that may be important for the correct implementation of the insurance include birth, divorce, death, moving house, changing telephone number, or joining another health insurance.

5.6 Notifications to the policyholder, addressed to the last known (email) address are deemed to have reached the policyholder.

ARTICLE 6 | COMPENSATION PROCEDURES

6.1. Payment of the compensation

6.1.1 In principal the Company pays the costs directly to the health care providers.

6.1.2 If, due to special circumstances, the policyholder/insured person pays the costs himself, the Company will, in principle, compensate the costs on the basis of the applicable agreed rate with the care provider, as soon as the entitlement has been established (also refer to article 6.2.2)

6.2 Compensation conditions

6.2.1 The Company solely compensates costs made during the validity of this insurance.

6.2.2. In applying the provisions set out in article 6.1.2, the right to compensation will only be established after submission of original and clearly itemised invoices. The invoices shall be provided by the care provider with a signature, stamp and treatment date. If applicable, the invoice shall be submitted, accompanied by a valid referral letter from the doctor, as well as clear information about diagnosis and treatment.

6.2.3 The Company pays only invoices of healthcare costs incurred if these invoices are denominated in Surinamese dollars.

6.2.4 Costs as referred to in article 6.1.2 shall only be compensated if the relevant invoices are submitted to the Company no later than 2 weeks following the date of treatment. A requirement in this respect is that the treatment was done by means of a referral as referred to in article 9.4 and 9.5.

6.2.5 Medical costs are compensated on the basis of the tariff and the conditions agreed between the health care provider and the Company in effect at the time of taking such care.

6.2.6 The costs for medically necessary treatments will be compensated.

6.3 Concurrence of insurances

Pursuant to art. 5.2 and in the event, costs have arisen as a result of illnesses or accidents which the insured person may claim under a statutory insurance, a government regulation, a subsidy scheme or - had this insurance contract not been entered into - under any other agreement for the costs arising therefrom, these costs shall not be compensated and/or recovered.

The insurance shall only apply as supplement to the cover that has been or would be granted under another insurance, government arrangement and/or subsidy scheme, if this insurance did not exist.

ARTICLE 7 | EXCLUSIONS

7.1 Costs related to the treatment of primary and secondary fertility disorders are not compensated.

7.2 Costs that are directly or indirectly the result of nucleus reactions and radiation – unless applied by a medical treatment – acts of God and acts of war are not compensated. 'Act of war' is meant to refer to any cause of nursing and/or treatment, which ensues from violence inflicted by human-beings, not by nature, such as unrest, riots or political conflicts, war, terrorism or of the enforcement of measures taken by any military, paramilitary, or civil government or by any power that may appoint itself as such. If at the time and on the site of the creation of the cause for nursing and/or treatment the risk of an act of war existed, the company may have the payment depend on proof to be established by the policyholder/insured person, that the cause for nursing and/or treatment was not caused by an act of war.

7.3 Costs related to unrecognized medicine are not compensated by the company.

7.4 Costs of medication related to venereal diseases, HIV and AIDS are not compensated by the company.

7.5 Costs of inspections and medical certificates are not compensated by the company.

7.6 Costs that are related to negligent or reckless behaviour and/or caused by or as a result of excessive use of alcohol and/or the use of drugs as well as costs resulting from intoxications and suicide (attempts) are not compensated.

7.7 Costs during detention are not compensated.

7.8 Costs that are related to assistance provided by a specialist in an area that does not belong to his speciality are not compensated.

7.9 Costs related to specialities, which are not mentioned in the policy conditions, are not compensated.

7.10 Costs of additional examination that do not fall under the cover specified in these policy conditions are not compensated.

7.11 Costs of dental treatment are not compensated unless these costs are co-insured.

7.12 Costs of vaccinations and all preventive measures when travelling both domestically and abroad are not compensated.

7.13 Unless otherwise agreed, costs of medicines that do not occur in the AZPAS Medicines Index are not compensated.

7.14 Costs relating to all forms of transplantation are not compensated.

ARTICLE 8 | PREMIUM

8.1 Amount of the premium

8.1.1 The policy schedule / payment statement states the amount of the premium for the insurance, the administrative costs and card fee.

8.1.2 The company determines the level of the premium for the insurance, depending on the age and the optional additional cover.

8.2 Payment of the premium

8.2.1 The policyholder is obliged to pay in advance the premium (incl. administrative costs and card fee).

8.2.2 The premium paid, will always first be deducted from the longest outstanding claim.

8.2.3 It is not permitted to setoff the premium with payments yet to be received from the Company.

8.2.4 The premium is payable via the bank by giro transfer or at the office of the Company. The fact that the Company does not offer a notification does not discharge the policyholder from the obligation to pay the premium.

8.3 Late payment of instalments

8.3.1 Non-payment of the premium
In case the premium is not paid within 14 days following the premium due date, the Company shall be entitled to terminate the insurance and to charge administrative costs.

8.3.2 Costs attached to the collection of overdue premium

The Company has the right, in addition to the overdue premium, to claim or cause to be claimed the administrative costs and the legal interest. In case collection measures are taken, both the judicial and the extra-judicial costs shall be at the expense of the policyholder. These costs shall minimally amount to 15% of the premium amount due.

8.3.3 Recurring overdue premium

In case of recurring overdue premium, the Company has the right to claim or cause to be claimed on call and in full, the premium over the remaining part of the period over which the insurance was entered into or was thereafter continued.

8.4 Premium refund

8.4.1 In the following cases the premium will be refunded up to the day of returning the (digital) Azpas card.

- In case the insured person takes up permanent residence abroad, by submitting a certificate of deregistration from the Central Civil Registry;
- In case of termination of an employment with a collective Azpas Insurance other than the case referred to in article 8.4.2.

In case of premium refund, administrative costs will be charged. There is no refund of the premium as long as the (digital) AZPAS card has not been surrendered.

8.4.2 No refund of premium applies if the insurance is terminated due to the death of the insured person.

ARTICLE 9 | CHOICE OF PHYSICIAN AND OTHER HEALTH CARE PROVIDERS

9.1 Upon inception of the insurance, the insured person makes a choice, preferably from the list of general practitioners with whom the Company has a service contract, provided that there is no limit for the chosen general practitioner in terms of the number of Assuria insured persons. If the insured person wants a general practitioner who is not affiliated with the Company and there is no objection in this respect pursuant to the norms and standards used by the Company, the Company will try to reach an agreement with the general practitioner concerned.

9.2 Only in case of renewal of the insurance may the insured change physician. If the occasion arises, the Company may conduct an investigation into the reason for such a request for change.

To make a new (digital) AZPAS card, the policyholder will be charged administrative costs.

9.3 Without prejudice to the provisions set out in the previous paragraphs, change of physician may be done free of charge if the Company has been informed of this in writing at the latest 30 days prior to the renewal of the insurance, in the event of death of the physician or if the agreement between the Company and the physician is terminated.

9.4 After referral by the physician, the insured person is free to make use of the services of any health care provider affiliated with the Company. This information may also be found on the website of ***Assuria Verzekeringen***.

9.5 Only after obtaining written permission from the Company may use be made of the services of a health care provider not affiliated with the Company at the expense of the Company.

ARTICLE 10 | AMENDMENTS TO PREMIUMS AND CONDITIONS

10.1 With due observance of the law, the Company has the right to revise the premium and/or conditions and to adjust this insurance in the interim to the new premium and/or conditions. In the event of an amendment to conditions, the conditions that applied before such amendment will cease to exist. Any adjustment to premiums and/or policy conditions is made available to the policyholder by the Company through various channels, including the Assuria website, www.assuria.sr.

10.2 The policyholder who does not agree with the amendment to the conditions of the insurance may terminate the insurance unless the revision directly results from an amendment to any statutory provision. Such termination shall be notified in writing to the Company within 30 days of the day on which the policyholder is notified of the adjustment of the conditions of the insurance. The insurance is then terminated on the effective date of the adjustment.

10.3 The policyholder who does not agree with an adjustment to the premium may terminate the insurance. The termination shall be notified in writing to the Company in the period between the date on which the policyholder was notified of the adjustment and the date of adjustment, yet not later than 30 days after the day on which the policyholder was notified of such adjustment.

10.4 If the Company has not received a written notification from the policyholder within the response times specified in paragraphs 2 and 3, the insurance will be continued under the new premium and/or conditions.

10.5 The adjustments as mentioned, will automatically apply to the policyholder if:
- He / she has not yet been insured with the Company for 12 months;
- The premium is increased by the insured person(s) exceeding the limit of an age group.

ARTICLE 11 | COMPENSATION

The company shall compensate necessary medical costs incurred in Suriname and related to activities obtained by means of presenting a valid (digital) Azpas card and a letter of guarantee in accordance with the conditions set out in the policy. The required letter of guarantee does not apply to the general practitioner, the SEH, the optician or the pharmacist.
Agreements have been made with the pharmacies associated with the Company as to the medicines and dressing materials available in Suriname according to the MVK and the Assuria Medicines Index.

Medical costs are meant to include:

11.1 General Practitioners
This includes:
Doctor's visits; Medical operations according to the agreement with the general practitioner.

11.2 Electrograms
Electrocardiogram (ECG), Electro encephalogram (EEG), Electromyogram (EMG) at the request of the general practitioner or medical specialist.

11.3 Laboratory exam
Laboratory exam performed at the request of the general practitioner or medical specialist.
This includes tests:
- Occurring on the AZPAS laboratory operations list;
- Immuno-histochemical tests, if medically necessary.

For all other additional exams that do not appear on the AZPAS laboratory operations list and for which the medical diagnostic need becomes evident, prior permission shall be granted by the Company.

11.4 Pregnancy, delivery, and infants
- Prenatal monitoring by the general practitioner, midwife, or gynaecologist, including the twelve and twenty-week ultrasound;
- A delivery in hospital, at home or in a maternity care facility by a recognised service provider in accordance with the agreed rates.
- Compensation of consultations at a health centre with the exception of vaccinations, which as part of the National Immunisation Programme fall under the regulation of public health care and belong to the permanent preventive population programmes

11.5 Congenital anomalies*

11.6 Emergency care (SEH - Dutch abbreviation)
Costs related to the acute care at the Accident and Emergency Department.

11.7 Pharmaceutical help prescribed by the general practitioner or specialist, namely:
- Registered medicines listed in the AZPAS Medicines Index that are dispensed on prescription through a pharmacy;
- Anticancer drugs are subject to a cumulative maximum amount of **SRD 45,000**, - per policy year*;
- Blood products, maximum 10 flasks per admission;
- Dressing materials listed in the Medical Consumables Index (MVK – Dutch abbreviation);
- Hormone preparations up to a cumulative maximum amount of **SRD 5,000,** -per policy year.

11.8 Paramedical care*
Compensation for a maximum amount of **SRD 5,000, -** per policy year cumulated for the various disciplines and if medically necessary on referral from the general practitioner.

11.9 Optical care
- Eye measurements by the optometrist or optician;
- One-off compensation of optical care up to a maximum amount of **SRD 1,000**, - per 24 months on prescription by ophthalmologist, optician, or optometrist*;
- Waiting period of 12 months after the effective date of the Insurance.

11.10 Preventive care*

11.11 Specialist care
The following specialities available in Suriname or (as the case may be) specialized treatments are eligible for compensation. Costs of medical specialist treatment by foreign missions are only compensated after the Company has granted permission in advance.

Anaesthesiology

General Surgery

Cardiology and cardiac surgery*
- Pacemaker, 50% of the purchase costs with an accumulated maximum of **SRD 35,000**, - per policy year, a maximum of once per policy year;

- Costs related to cardiac catheterization as a diagnostic examination, a maximum of once per policy year;
- Costs related to interventional cardiac therapy, including percutaneous angioplasty and / or placement of stents and vascular surgery (including bypass and valve surgery, insertion and possibly repositioning of a pacemaker), accumulated maximum of **SRD 35,000**, - per policy year.

Dermatology
Dermatology costs will be compensated if medically necessary. Costs related to treatments arising from personal need, circumstance, or necessity such as cosmetic treatments are not compensated.

Gynaecology
Costs related to examination of primary and secondary fertility disorders; this includes the costs for:

- Laboratory tests;
- Medical imaging;
    - Hysterosalpingogram or HSG, once a lifetime;
    - Laparoscopic tuba test (or blue test), once a lifetime;
    - Ultrasound monitoring of the follicle growth: once a lifetime;
- Post-coitus test: once a lifetime.

Sterilization*
Compensation for sterilization, **if medically necessary**. Per insured person, sterilization is compensated once per lifetime and in the following way: the full cost of sterilization, provided that in case of male sterilization, maximally the costs of an outpatient treatment are compensated.

Internal Medicine

As regards haemodialysis:

- Costs are compensated up to an accumulated maximum of **SRD 100,000**, - per policy year. The costs are inclusive of medicines and the costs related to placing a shunt*;
- Compensation for the acquisition of a dialysis catheter in connection with haemodialysis up to a maximum of 50% of such costs up to an accumulated maximum of SRD **5,000**. - per policy year. *

Dental surgery*
The costs of oral surgery will be compensated if medically necessary. Costs related to treatments arising from personal need, circumstance, or necessity such as cosmetic or preventive dental treatments are not compensated.

ENT [Ear, Nose and Throat] science
Hearing aid, maximum amount of **SRD 3,500, -** per ear once every 2 policy years, if the strength has changed.

Paediatrics

Neurosurgery*
Costs for neurosurgery: an accumulated maximum of **SRD 20,000, -** per policy year.

Neurology

Orthopaedics

Artificial means and aids*
- Compensation of up to 75% of the purchase costs for all means and aids on medical prescription up to an accumulated maximum of **SRD 50,000, -** per policy year;
- Compensation of up to 50% for the costs of hip loc, plates and screws up to a maximum amount of **SRD 50,000, -**.
- The hiring of orthopaedic devices, namely splints, orthopaedic crutches, and orthopaedic collar, exclusively on medical prescription.

Ophthalmology
An accumulated maximum compensation of **SRD 7,500, -** per policy year applies to eye surgery. *

Parasitology

Plastic surgery*
The costs of plastic surgery are compensated up to an accumulated maximum of **SRD 7,500, -** per policy year, if medically necessary, in case of mutilation as a result of an accident or illness and a congenital anomaly. Costs associated with treatments arising from personal need, circumstance or necessity are not compensated.

Psychiatry*
- As an outpatient, maximally 10 visits and/or treatments per policy year;
- Clinical, maximally 6 weeks per policy year, either or not consecutively.

Pulmonology

Radiology
Performed at the request of the general practitioner or medical specialist. This includes:
- Ultrasound;
- X-rays;
- Scopies (exploratory exam);

- CT scan and / or MRI scan*; a maximum of 3 per policy year, with the first scan and the second scan being fully compensated and 50% of the costs compensated for a third scan.

Rehabilitation medicine

Urology*
With regard to Extracorporeal shock wave lithotripsy (ESWL) a maximum of 3 times per policy year. Multiple treatments, if necessary, only after approval of Assuria.

11.12 Medical home care*
To prevent or shorten hospitalization. Maximum and cumulative compensation of 90 days per policy year, whether consecutive or not. Only after written permission from Assuria.

11.13 Hospital*

11.13.1 The cost of medically necessary stay in a hospital, i.e., any hospital facility including Lung Pavilion and Psychiatric Centre Suriname. The cost of medically necessary stay in a hospital, is on the basis of third class for the purpose of specialist treatment, examination, and nursing care. This includes admission in connection with neonatal care, admission to intensive care and admission to a nursing home.

11.13.2 For costs when admitted to a higher class, the costs will be compensated according to the rate of the insured class (unless a higher class is co-insured).

11.14 Nursing home*
Admission to a nursing home is made on the indication of the attending medical specialist and only if it follows discharge from a hospital.

11.15 Hospice*
Coverage for up to 3 months. This is compensated for terminal patients only.

11.16 Ambulance transport
Ambulance transport: max. **SRD 1,000, -** with an own contribution of SRD 125, -. per policy year. The costs of ambulance transport by land from and / or to a health institution on indication of the general practitioner or attending medical specialist, if subsequently there is an admission, or after being discharged.

ARTICLE 12 | DISPUTES

12.1. This agreement is governed by the laws of Suriname.

12.2. In case of a dispute between the parties concerning the amount of compensation for damages to which the Company is obliged under the policy conditions, such dispute shall be submitted to an advisory committee consisting of three members. The decision of the committee shall be accepted by the parties as binding.

12.3. The members of the advisory committee shall be chosen from persons who may be deemed to be experts in the subject matter of dispute. Each of the parties shall appoint one member; the members appointed by the parties shall appoint the third member by mutual agreement. If the parties cannot reach agreement on the appointment of this third member, the third member shall be appointed by the competent court in Suriname, at the request of both parties or by any of the parties, which shall notify the other party of the submission of such application. The appointment of the members of the advisory committee shall be evidenced by an instrument signed by the parties and the members, which shall include a description of the subject of the dispute.

12.4 The members of the advisory committee shall give their advice in reasonableness and fairness. Each party shall bear the costs of its designated member. The costs of the third member shall be borne half by each party. The third member shall be authorized to require the parties to furnish such sum as he shall determine as security before hearing the case. The parties shall then be obliged to provide such deposit.

ARTICLE 13 | LOSS OF THE AZPAS CARD

Administrative costs will be charged to create a new AZPAS card.