INSURANCE POLICY FOR MEDICAL INSURANCE

This Insurance Policy testifies that in return of payment to the Company YPERA INSURANCE CO. LTD (herein after referred to "The Company") of the premium as defined in the Policy, the Company will provide the benefits described in the Schedule of Benefits attached, subject to terms, exceptions, provisions and conditions contained herein or endorsed, the Company will indemnify the Insured up to the limits detailed on the Insured Person's policy of insurance during the policy period.

Understood and expressly agreed that the Insurance Proposal, statements of the Policy Holder and/or insured contained in the Insurance Proposal, additional endorsements, medical reports, statements of the policy holder and / or the Insured made to the Company's physician and any other signed document, and anything else related to the Policy and the terms and conditions of this agreement is the complete Insurance Policy and read and understood as one document.

Signed for and on behalf of the Company

Managing Director

1. Definitions

Words in the masculine gender shall be deemed to include the feminine and vice versa, as well as words in singular shall be deemed to include the plural. Any word explained in the Definitions section herein will have the same meaning throughout this document.

1.1 Recognized Expenses

Medical expenses for which coverage is provided based on the terms and limits of the Policy.

1.2 Rehabilitation

Medical treatment or other care, in an approved rehabilitation center, where the aim is to restore the natural sensory and mental abilities of a patient, who lost these abilities, due to an injury or illness during the period of insurance, so as to regain maximum possible self-preservation and function.

1.3 Illness

Any change in health status of the Insured Person that needs treatment that manifests for the first time thirty (30) days after the date of inception or the date of reinstatement.

1.4 Insured Person

Any person and/or the Policyholder and/or the dependents, named on the Policy Schedule, as insured person.

1.5 Insurance Policy

The contract of Insurance, that specifies the terms and conditions of the coverage.

1.6 Premium

The payable amount by the Policyholder to the Company, on specified dates, in consideration of the coverage provided by the Policy.

1.7 Accident

An unexpected, unforeseen and involuntary external event resulting in bodily injury whilst the policy is in force. The cause and symptoms should be objectively and medically identified, diagnosed and in need of medical treatment.

1.8 Geographical Area

Cyprus, EU, Israel and Worldwide as based on the Schedule of Benefits.

1.9 Diagnostic Tests

Diagnostic tests prescribed by the treating doctor that are directly related to the main cause of the medical condition.

1.10 Special Terms-Endorsements

Any attached special terms/endorsements, that amend or negate any terms and conditions of the Policy, constitute an integral part of the Policy.

1.11 Alternative Medicine

Chiropractic, osteopathy, homeopathy and acupuncture provided by a qualified professional who is licensed under the laws of the country where treatment is provided.

1.12 Endoscopy
The visual examination of a closed interior cavity of the body using an endoscope (colonoscopy, laparoscopy, arthroscopy, bronchoscopy and thoracoscopy are all performed using endoscopes).

1.13 Dependents
The insured's spouse/partner and the unmarried children over the age of fourteen (14) days and less than eighteen (18) years of age or are serving their military obligation in the National Guard in Cyprus or studying in higher educational institutions in Cyprus and not exceeding the age of twenty-five (25).

1.14 In-Patient
Insured Person admitted to hospital for at least one (1) night.

1.15 Company/Insurer
YPERA INSURANCE CO. LTD

1.16 Third Party Administrator (TPA)
The Company preserves the right to cooperate with an independent Third-Party Claims Administration Company, for the processing of claims, which in this case it replaces the Company in the management/control of claims and receipt of the necessary information and personal data. The Company, in such event, will give details to the independent administrator (TPA).

1.17 Age
The age of the Insured person on his last birthday.

1.18 Accommodation (Room and Board)
Charges for room and board in case of in-patient hospitalization.

1.19 Enrollment Date
The date the insured member is enrolled on the Policy.

1.20 Treatment/Medical Care
Medical Care including examinations required for the treatment of illness or injury.

1.21 Medical Necessity
The provided medical services certified by the Company and its medical advisors as medically appropriate to:

- Meet basic medical needs of insured.
- Be provided in the proper and medically appropriate manner, taking into account both the quality and cost of service.
- Be consistent with the diagnosis of disease.
- Be necessary for the diagnosis and not serve other needs.
- Demonstrate through local or recognized international protocols and scientific literature, that it is safe and effective for the treatment of specific ailments.

The medical necessity as interpreted in this Insurance Policy is referred to the coverage of recognized expenses and is not identical with the interpretation that would be given by a treating physician.

1.22 Medically Appropriate
Based on prevailing standards of medical practice for the specific medical condition.

1.23 Medical Practitioner
A person who is licensed to practice medicine, according to the Law of the country he is registered and works, within the limits which are determined by his license.

1.24 Reasonable and Customary Charges
Charges for medical care consistent with usual local charges and are at similar levels to the charges made by other suppliers for similar cases as those for which the claim is submitted. The provided hospital services, medical fees and materials cannot exceed in value the usual local average market prices and are comparable with the corresponding charges of other entities, public or private.

1.25 Hospitalization
The justified days (overnight stays) of an insured person stay in a hospital as an inpatient solely to receive treatment for conditions not included in the exclusions and cannot be treated unless hospitalized (e.g., at home, on an out-patient basis, with short or medium stay in the emergency department, etc.) The admission must be well documented (with medical records, diagnostic test results, doctor's reports, monitoring charts for vital signs and medication, discharge and surgical report). Two (2) or more hospitalizations for the same condition or its complications are considered as one provided, they do not exceed ninety (90) days in between.

1.26 Home Nursing
The necessary nursing care recommended by the treating doctor and is provided by a registered and licensed nurse after hospital discharge.

1.27 Hospital Expenses
Accommodation charges, medicines and consumables, operating theatre and ICU charges, surgeon's and anesthesiologist's fees and the necessary diagnostic tests done during hospitalization.

1.28 Hospital
Any public or private hospital or clinic which operates legally and assumes the in-hospital care and treatment of ill or injured patients has the technical and scientific equipment for diagnoses, surgical procedures and provides 24-hour services by permanent qualified staff of doctors and nurses. Out-patient clinics, sanatoriums, rehabilitation and physiotherapy centers, convalescent and nursing homes or similar establishment, establishments for the recovery of alcoholics and drug addicts are not deemed to be hospitals.

1.29 Outpatient Care
The medical care provided to an insured person without the need of overnight stay in hospital.

1.30 Waiting Period
The period during which the Insured Person is not entitled to compensation.

1.31 Insurance Period
The Policy Period specified in the policy schedule and the renewals.

1.32 Grace Period
The time limit given to the insured to pay the premium.

1.33 Insurance Schedule
The Schedule attached to the policy and includes, inter alia, the insured persons, the coverage,

premiums and the mode of payment.

1.34 Schedule of Benefits
Summary of the coverage provided by the Policy.

1.35 Deductible Amount
The amount mentioned on the Insurance Schedule for which the insured person is liable for each claim.

1.36 Network Providers
Providers that have contractual agreements with the Company, to offer services.

1.37 Pre-existing Conditions
Any medical condition for which the insured sought medical attention or/and received treatment, experienced symptoms, were foreseeable or medically pre-existing, or is a consequence of genetic abnormality, injury, or illness, before the insured's enrollment date.

1.38 Policyholder
The person or legal entity that signs a contractual agreement with the Company and is responsible for the payment of premiums, as defined in the Policy Schedule.

1.39 Birth
The birth of live or stillborn baby after the twenty-fourth (24^{th}) week of pregnancy.

1.40 Medicines
Compounds and substances which are clinically proven to be effective and the administration is necessary for the treatment and stabilization of a disease or injury.

1.41 Student
A person who attends a higher educational institution in Cyprus or abroad from the age of eighteen (18) up to the age of twenty-five (25).

1.42 Physiotherapy
Treatment recommended by a doctor, provided by a registered and licensed physiotherapist and aims to restore bodily health to the maximum possible, after an accident or illness that occurred during the policy period.

1.43 Physiotherapist
A person who is registered, in a recognized professional body by the Republic of Cyprus, as a physiotherapist and licensed to practice.

1.44 Surgery that doesn't need hospitalization
Surgery that does not require overnight stay.

1.45 Country of Residence
Republic of Cyprus

INSURANCE COVERAGE

The Insurance Policy covers, according to the Schedule of Benefits, medical expenses incurred during the policy term as a result of an illness or accident subject to all the terms and exclusions of this Policy.

In case of medical care outside the Geographical area, the Company will reimburse the Reasonable and Customary expenses that would have been paid to similar Service Network Providers in Cyprus.

2. Insurance Coverage

The Company will pay the reasonable, necessary and recognized expenses incurred in case of hospitalization as an in-patient directly to the Network Hospitals. In case of hospitalization in a Non-Network Hospital the company will cover up to 100% of the maximum amount paid to a Network Hospital.

2.1 Maximum Annual Limit

The maximum amount payable in a period of 365 days, i.e., underwriting year as mentioned on the Insurance Schedule.

2.2 Inpatient Care

Hospitalization

Hospitalization at least for one night for necessary medical or surgical reasons that require systematic monitoring provided that these are not included in the exclusions and cannot be dealt in another environment (i.e., at home, on an out-patient basis or in the emergency department).

The medical necessity/hospitalization must be adequately documented with medical records, nursing charts, doctor's reports and referrals, diagnostic test results, DVD/CD, discharge reports, biopsy results.

Day Care Patients

The necessary hospital treatment that does not require overnight stay. The medical necessity for day care treatment must be adequately documented as above. Day case admissions in the emergency department or for diagnostic purposes are not covered.

2.2.1 Hospital Charges and Theatre Fees

The Company will cover the reasonable and customary expenses for room and board (up to single room, according to the Schedule of Benefits), and Intensive Care Unit for a maximum period of one hundred and eighty days (180) annually.

Covered Expenses: surgery, medications and supplies, physiotherapy (up to 12 sessions), diagnostic tests directly related to the cause of hospitalization and are not for general control or secondary diagnoses, blood transfusion and oxygen. Any non-medical expenses not covered.

2.2.2 Surgeon's/Assistant surgeon/Physicians/Anesthetists Fees

The Company will cover the usual and customary expenses for surgeons and anesthesiologist's fees in surgical cases, and a physicians/specialist fees in case of conservative treatment.

In case of multiple procedures during the same session and incision the secondary procedures will be paid at a maximum of 30% of the reasonable and customary charges of the secondary

procedures.

In case of multiple procedures with different incisions during the same session, the Company will pay the fees of the most expensive surgery plus 50% of the charge of any additional surgery. If an assistant surgeon (doctor) is medically necessary for a surgery the Company will cover the

reasonable and customary expenses up to a maximum of 15% of the surgeon's fees.

In case of Laser surgery an additional 15% on surgeon's fees only will be paid.

A treating physician is the doctor whose specialty is directly related to the patient's condition. The treating doctor's specialty must be directly related to the patient's problem. Fee for only one treating doctor will be accepted. If other doctor is medically necessary to be called for a consultation the Company will pay for one such consultation.

If doctors' other specialties are medically necessary to attend to, then only one visit a day will be paid. If treatment and monitoring is done jointly with another specialty doctor, the fee will be equally distributed, equally meaning fee for treatment and observation plus one doctor's visit divided by two (2).

2.2.3 Chemotherapy and Radiotherapy Treatment

The Company will cover the reasonable and customary expenses for chemotherapy and radiation therapy either as an inpatient or day care patient. In addition, all the diagnostic tests that are directly related to the treatment that are carried out within a thirty-day (30) period of pre-and post-therapy sessions are covered. Chemotherapy drugs are paid if they have the approval of the Cyprus Ministry of Health.

2.2.4 Outpatient Surgical Procedure

Any surgical procedure performed on an outpatient basis where overnight hospitalization for recovery and/or observation is not required.

2.2.5 Outpatient Treatment of an Accident

The Company will cover the reasonable and customary expenses required and incurred during the first visit immediately after an accident and are related to bone fracture, suturing and first care of burns. The benefit covers only the first visit and treatment, i.e., consultation fee, x-ray). It does not cover follow up treatment.

2.2.6 Organ Transplantation

The Company will cover the reasonable and customary expenses of the recipient, required for the Medically needed transplantation of human organs such heart, lung, liver, pancreas, kidney and bone marrow, to a maximum amount specified in the Schedule of Benefits. Any collection and transportation expenses related to the donor of organs are not covered. The prior approval of the Company is necessary.

2.2.7 Reconstructive Surgery

Reconstructive surgery will be covered if it is necessary after an accident or mastectomy due to cancer that was covered by this Policy as an inpatient, the prior approval of the Company is necessary.

2.3 Pre and Post Operative Expenses

2.3.1 Pre-operative diagnostic tests and consultation

The Company will cover one consultation and the diagnostic tests that are directly related to the covered surgical procedure as an in-patient, which incurred within sixty (60) days prior to

the surgical procedure.

2.3.2 Post-Operative Expenses

a) Diagnostic tests and medication

The Company will cover the medical diagnostic tests and prescribed medication directly related to the covered surgical procedure as an in-patient, which incurred within three weeks after Hospital discharge.

b) Physiotherapy

The Company will cover the prescribed physiotherapy sessions incurred within three months after the discharge date and are limited to twelve (12) sessions or up to the maximum amount specified in the Schedule of Benefits.

2.4 Allowances and Other Benefits

Allowances will be reimbursed after the confirmation of the fact.

2.4.1 Childbirth Allowance

Reimbursement, with the maximum amount specified on the Schedule of Benefits provided that the mother was insured under this policy for at least twelve (12) consecutive months before the delivery day and Birth Certificate must be submitted. No other expense related to complications of pregnancy or child birth is covered. An automatic cover will be granted to these newborn subject to 100% good health and enrollment within 30 days of birth with the payment of the appropriate premium. ***No excess or deductible is applicable.***

2.4.2 New Born Allowance

Reimbursement, with the maximum amount specified on the Schedule of Benefits provided that the mother was insured under this policy for at least twelve (12) consecutive months before the delivery date. Pediatrician's medical report needed. ***No excess or deductible is applicable.***

2.4.3 Diagnostic Endoscopies

Reimbursement with the maximum annual amount specified in the Schedule of Benefits.

2.4.4 Air Ambulance

The Company will pay up to the annual maximum amount specified in the Schedule of Benefits for emergency transportation after a sudden medical emergency, when the insured’s health is in serious danger and when every second counts to prevent deterioration of health.

2.4.5 Ambulance

The Company will pay up to the annual maximum amount specified in the Schedule of Benefits for ambulance in case of emergency or if based on a doctor's advice and there was no other way of transportation suitable for the patient's condition. The Company will not cover any other transfers during hospitalization except for transfer to another hospital for continuing patients in hospital treatment.

2.4.6 Repatriation of Mortal Remains in Cyprus

Reimbursement up to the annual maximum amount specified in the Schedule of Benefits in case of sudden death abroad for the transporting the corps to Cyprus. Relevant receipts should be submitted.

2.4.7 Dilatation and Curettage (D&C)

The Company will pay up to the annual maximum amount specified in the Schedule of Benefits for a Diagnostic or Therapeutic Dilatation and Curettage provided there is histological evidence

and there is no pregnancy involved.

2.4.8 Home Nursing

The Company will pay the annual maximum amount specified in the Schedule of Benefits for nursing received following treatment as an in-patient provided such services are confirmed as being necessary by the attending physician, in writing. This service must be provided by a qualified nurse who is registered with the Republic of Cyprus Ministry of Health.

2.4.9 Diagnostic Coronary Catheterization *I* Coronary Angiography

The Company will pay the annual maximum amount specified in the Schedule of Benefits for the above invasive Diagnostic Coronary Catheterization/Angiography procedures which are carried out at least three (3) months after the inception date of the policy provided results are submitted and the condition was not a pre-existing one. ***No excess or deductible is applicable.***

2.4.10 Rehabilitation Centers

The Company will pay the annual maximum amount specified in the Schedule of Benefits provided the insured needs further treatment (i.e., physiotherapy, speech therapy, occupational therapy) after an accident or illness that was covered under the current Policy and the insured is in a state where this treatment cannot be provided on an outpatient basis. Submission of analyzed services, itemized invoices and receipts is a prerequisite.

2.4.11 Daily Allowance for Free Treatment

The Company will pay the daily maximum amount specified in the Schedule of Benefits and up to thirty (30) days per hospitalization, in case of in-hospital treatment at a public hospital, provided that the Insured Person is a beneficiary for free treatment and the incident would have been covered. ***No excess or deductible is applicable.***

2.4.12 Hospitalization without treatment

The Company will only pay for one day accommodation in case the Insured Person is hospitalized without a diagnosis being confirmed by diagnostic tests and/or without any medical treatment (medication) and/or this medication could have been administered on an out-patient basis without risking the patients' health.

2.4.13 Accommodation Costs of a Parent

The Company will pay for the accommodation of one parent staying in the same room, provided the child is insured and under the age of twelve (12).

2.4.14 Dental Care after an Accident

Expenses up to the maximum amount specified in the Schedule of Benefits for treatment to sound, natural teeth damaged due to an accident that occurred during the insurance period and that the Insured was covered for treatment as an in-patient. Pre-requisite for coverage is: supporting documents with panoramic x-rays done prior and post treatment.

2.4.15 Coverage outside the Geographic Area

Geographic Area: Worldwide excluding USA & Canada.

The Company will reimburse the reasonable and customary expenses for inpatient hospitalization due to an accident or illness outside the Geographical Area, provided these do not exceed the respective costs in a Network Hospital in Cyprus, Europe or Israel. In case of illness there is a waiting period of six (6) months after commencement date or reinstatement of

the policy. In such a case the insured is required to validate the hospital documents and original receipts at the nearest consulate of Cyprus and these documents should be officially translated to Greek or English.

2.4.16 Check-up

The policy covers the Policy Holder and spouse/partner, if insured, for a check-up as specified in the Schedule of Benefits. The company has the right to amend this benefit. These blood tests can only be performed in a Network Laboratory Center presenting the Insured's ID card and Insurance Policy or Medical Card. The Company will pay directly the Network laboratory upon submission of invoices and test results. If the Insured Person chooses to have these tests in a non-Net-Work center, the Company will reimburse the insured up to the amount specified in the Schedule of Benefits after receiving the test results. Prerequisite for this benefit is that the policy is in force, paid for one year's premium and the first monthly payment of the following year without interruption. Each subsequent check-up must be twelve (12) months apart from the previous one.

2.4.17 Critical Illnesses

The allowance for the below critical illnesses is paid off once and only for one critical illness during the term of the policy with the amount specified in the Schedule of Benefits. The benefit is paid provided that the critical illness has occurred at least six (6) months after the insured's enrollment date. This Benefit ceases to be valid and cannot be reinstated upon renewal of the policy. The Company has the right, at its discretion, to determine the onset of the critical illness with the Company's consultants. If the insured refuses to give any information requested, the Company will not be liable to any payment. ***No excess or deductible is applicable.***

Cancer of Specified Severity

A malignant tumor characterized by uncontrolled growth and spread of malignant cell with the invasion and destruction of normal tissues. The diagnosis must be supported by histological evidence of malignancy and confirmed by an oncologist. Cancer also includes leukemia and malignant diseases of the lymphatic system such as Hodgkin's disease.

Excluded are:

- Any form of non-invasive cancer which is histologically described as pre-malignant or non-invasive including but not limited to carcinoma in situ of the breast, cervical dysplasia (CIN-1, CIN-2, CIN-3).
- Any skin cancer other than invasive malignant melanoma.
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2NOMO.
- Chronic lymphocytic leukemia less than RAI stage 3.
- Micro carcinoma of the bladder.
- Basal cell carcinoma and squamous cell carcinoma.
- Any malignant tumor in the presence of any human immunodeficiency virus.

Coronary Artery {By-pass) surgery

The actual undergoing of open chest surgery for the correction of one or more coronary arteries which are narrowed or blocked, by coronary artery by-pass graft (CABG). The diagnosis must be supported by coronary angiography and confirmation of the surgery must be by a specialist medical practitioner.

Excluded are:

- Angioplasty
- Any other intra-arterial procedures
- Key-hole surgery or laser surgery

Major Organ transplantation

The actual undergoing of transplantation of one of the following human organs, heart, lungs, liver, pancreas, kidney that resulted from irreversible end-stage failure of the relevant organ. The undergoing of a transplant must be confirmed by a specialist medical practitioner.

Permanent Paralysis of the limbs

Total and irreversible loss of use of two or more limbs due to accident or illness of the brain or spinal cord. A specialist medical Practitioner (physician/neurologist/neurosurgeon) must medically document that paralysis will be permanent with no hope of recovery and must be present for at least ninety (90) days. Excluded is paralysis due to Guillain-Barre syndrome.

Stroke resulting in Permanent Symptoms

Any cardiovascular incident producing permanent neurological sequelae. This includes infraction of brain tissue or hemorrhage or embolization from an extra cranial source. The diagnosis has to be confirmed by a specialist medical practitioner and evidenced by a typical clinical symptom as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least ninety (90) days must be produced.

Excluded are:

- Transient Ischemic Attack (TIA)
- Traumatic injury to the brain
- Neurological symptoms due to migraine
- Vascular diseases affecting only the eye or optic nerve or vestibular function

Multiple Sclerosis

Unequivocal diagnosis of Multiple Sclerosis by a specialist medical practitioner evidenced by typical clinical symptoms of demyelination and impairment of motor and sensory functions as well as typical MRI and CSF findings. The diagnosis must be confirmed by a specialist medical practitioner and evidenced by all of the following:

- Typical clinical symptoms (neurological abnormalities) of demyelination manifested as an impairment of motor and sensory functions.
- The diagnosis must be established that the insured person has exhibited these clinical symptoms (neurological abnormalities) that have existed for a continuous period of at least 6 calendar months or at least 2 clinically documented episodes at least 30 days apart. Excluded are all other causes of neurological damage such as systemic lupus erythematosus (SLE).

2.5 Out-Patient Cover

The Company recognizes and covers the necessary, reasonable and customary expenses incurred for out-patient medical care up to the maximum amount indicated in the Schedule of Benefits.

2.5.1 Consultation Fees

The Company provides the insured and any dependents (if covered by the policy) the costs incurred for medical visits after illness or accident up to the maximum amount specified in the Schedule of Benefits.

2.5.2 Medication

The Company provides the Insured Person and any dependents (if covered by the policy) the costs incurred for the purchase of necessary drugs at the doctor's orders (prescription, dosage, quantity, time) and are directly related to the mentioned diagnosis after an illness or an accident.

2.5.3 Diagnostic Tests

The Company provides the Insured Person and any dependents (if covered by the policy) the costs incurred for the necessary diagnostic tests with the amount specified in the Schedule of Benefits. These tests must be prescribed by a medical doctor and must be necessary and appropriate to diagnose the specified medical condition

2.5.4 Physiotherapy

The Company provides the Insured Person and any dependents (if covered by the policy) the necessary costs incurred in the event that requires physiotherapy following a medical condition that was not a pre-existing condition. A prerequisite is a referral from a specialist, indicating in detail the number and type of physiotherapy sessions required.

2.5.5 Paramedical Services

Services administered by a registered chiropractor, osteopath, homeopath, podiatrist and acupuncturists. A referral from a physician is required except podiatrist or if above professionals are medical doctors.

2.5.6 Unrelated Diagnostic Tests

The Company will pay the diagnostic tests prescribed by the Insured's doctor that are directly related to the diagnosis mentioned on the claim form. In case additional unrelated tests are performed the Company will cover up to the maximum out-patient overall limit mentioned on the Schedule of Benefits and will be deducted from the Outpatient annual amount of cover.

2.6 Waiting Period

Illness that occurred within thirty (30) days of the effective date of the policy is not covered. Coverage for the following diseases, illness or injury will be payable in twelve (12) months of continuous coverage after the inception date provided, they were not pre-existing conditions. Benign prostatic hypertrophy, gynecological problems, any kind of hernia including prolapse of intervertebral disk, hydrocele, varicocele, fistula/fissure in anus, hemorrhoids, pilonidal sinus, Tonsils, adenoids and ear diseases/conditions. Skin and all internal tumors/cysts/nodules/ polyps/nevi unless malignant. Gastric and duodenal ulcers, Gastroesophageal reflux. Any musculoskeletal disorders, (except fractures due to an accident) meniscus, ligaments and tendons, joint replacement, all forms of calculus, thyroid gland.

3 Exclusions

This policy does not cover expenses caused or contributed directly or indirectly by:

3.1 Any sickness, disease, injury as well as their complications or recurrences which appeared before commencement of this policy (pre-existing conditions), for which the insured sought medical advice, have received treatment, experienced symptoms. Any illness/condition that was foreseeable or medically pre- existed prior to the effective date whether or not was known to the insured person.

The term foreseeable means that the insured knew or reasonably should have known the existence of the medical condition, even if he had not sought medical advice. All pre-existing conditions stated on the proposal are excluded, unless the Company decides otherwise and informs the policy holder in writing.

3.2 Defects/Deformities at birth, congenital or genetic diseases/disorders. Treatment arising from or related to any abnormality, deformity, illness or injury or been diagnosed or not regardless of onset of symptoms.

3.3 Pregnancy, childbirth, complications, miscarriage, termination of pregnancy and/or any charges relating to, unless childbirth took place twelve (12) months after the effective date or reinstatement of the Policy in accordance with the Schedule of Benefits.

3.4 Treatment of symptoms that are not due to any underlying disease, illness or injury, their complications or consequences. Included but not limited:

a) Symptoms commonly associated with any physical changes resulting from physical and physiological causes such as aging (e.g., osteoporosis, age related macular degeneration, macula) menopause or puberty (acne).

b) Symptoms associated with the menstrual cycle (e.g., dysmenorrheal, endometriosis) or other hormonal condition or disorder (polycystic ovaries). Treatment of endometriosis and polycystic ovaries is covered after five (5) years of continuous coverage.

c) Treatment of hormone replacement therapy or bone density testing.

3.5 Treatment of spinal disorders, scoliosis, kyphosis, lordosis, osteoporosis. Examinations and treatment associated with arthritis, rheumatism, osteoarthritis, back pain sciatica, myalgia, neuralgia and cervical syndrome will be covered after two (2) years of continuous coverage.

3.6 Nasal scoliosis/deviation of nasal bone/septum, turbinates, (cauterization, ablation). The correction of fracture and deviation are covered if needed after an accident that was covered as an in-patient.

3.7 Allergies including but not limited to allergic conditions such as allergic asthma, rhinitis, eczema, urticaria, conjunctivitis and hay fever. Circumcision, phimosis, frenum, Nevus unless malignant, varicose veins and phlebitis, cataract and hallux valgus. Circumcision, phimosis, frenum and hallux valgus are covered after five (5) years of continuous coverage.

3.8 Venereal diseases or any other sexually transmitted disease including but not limited to HPV. The Human Immunosufficiency Virus (HIV) Acquired Immune Deficiency syndrome (AIDS), syndromes associated with AIDS (ARCS), all diseases caused by and/or associated with, or complications arising from these diseases.

3.9 Expenses for the provision, maintenance and fitting of any external prosthetic device,

artificial limbs, corrective or assistive device, visual or hearing aids, medical supplies, consumables, aids including but not limited to crutches, wheelchairs, bandages, elastic stockings, inner shoe soles etc.

Non-medical expenses, including but not limited to admission fees, medical reports, and the purchase of renting or depreciation of medical equipment.

3.10 Plastic, Aesthetic, Reconstructive surgery, removal of fat or surplus tissue from any part of the body, whether is for psychological purposes or not. Reconstructive surgery will be covered if it is necessary after an accident or mastectomy due to cancer that was covered by this Policy as an inpatient, the prior approval of the Company is necessary.

Treatment or surgery associated directly or indirectly with sexuality or gender reassignment, obesity and weight loss remedies, treatment of alopecia and baldness and photodynamic therapy.

3.11 Charges incurred primarily for routine medical examinations, diagnostic tests that are not directly related to the diagnosis and treatment of a disease, illness or injury. Experimental, preventative or non-medically proven treatment. Vaccination and immunization.

3.12 Psychiatric, psycho-geriatric, nervous or mental illness or disorder of any kind, neurodevelopmental and neurovegetative disorders, bulimia, anorexia nervosa, neuroses, seizures, sleep disorders like sleep apnea, snoring or any respiratory problems associated with sleep. Parkinson and Alzheimer disease, general debility or exhaustion or hormonal disorders. Treatment associated with developmental problems, learning difficulties or delayed speech disorders, e g. dyslexia, ADHD (attention deficit hyperactivity disorder) hyperactivity, autism etc.

3.13 Vitamins, tonics, supplements, body care solutions, skin products, soaps, shampoos, contraceptives, cosmetic creams or products even if they are recognized to have therapeutic properties, weight control drugs and any medication/product that can be purchased without prescription.

Products classified as vitamins or minerals are not accepted as medicines unless prescribed for treatment for clinically diagnosed vitamin deficiency syndrome. Drugs that are not directly related to treatment of an illness or accident or which are not recognized as drugs by the Cyprus Ministry of Health.

3.14 Treatment arising from, is related to or is a result of dialysis for chronic renal failure. Renal dialysis is covered for a period of six months for the preparation of kidney transplant.

3.15 Any dental treatment related to teeth, roots, jaw and their surroundings, dental prosthesis such as bridges, crowns implants and orthodontic treatment.

3.16 Infertility, impotence, treatment that affects fertility and conception, infertility, any form of assisted reproduction, birth control drugs, supplies or services and their complications, sterilization, vasectomy and reversal.

3.17 Treatment for alcoholism, drug or substance abuse or any addictive condition or any injury or illness arising directly or indirectly from such abuse or addiction.

3.18 Suicide attempt, voluntary or involuntary self-inflicted injury sustained as a result of felony regardless of the mental condition of the insured.

3.19 Violation of the Law by the Insured, including but not limited in participation of illegal activities.

3.20 Treatment directly or indirectly arising from or required as a consequence of: War, invasion, revolution, insurrection, usurpation of power, rebellion, riot, strike, military intervention and stage of siege, coup and any act of terrorism. Chemical contamination or contamination by radioactivity from any nuclear material whatsoever, or from the combustion of nuclear fuel, asbestosis or any related conditions.

3.21 Treatment received in health hydros, nature cure clinics, spas or similar establishments/clinics/hospitals.

3.22 Treatments arising from or required directly or indirectly from, but not limited to any dangerous activities, professional athletic or sports activities, sport groups that are imbedded in federations, races, rallies or speed competitions by motorized vehicle or device, bungee jumping, parasailing and skiing, ballooning, parachuting, skydiving, paragliding, scuba diving, rock climbing or mountaineering, sports and pastimes on ice and snow.

3.23 Expenses arising from unrecognized medical practice in Cyprus, or/and expenses incurred at the initiative of the insured, or expenses that exceed the reasonable and customary charges or the treatment is medically unnecessary and/or inappropriate. Experimental or unproven treatment and/or medical device/equipment or pharmaceutical regimen.

3.24 Consultation and treatments, investigations, surgery and laser surgery associated with ocular refraction, including refractive keratectomy (RK) and photo-refractive keratectomy (PRK), routine visual examination, and any treatment, investigation or surgery for auditory acuity.

3.25 Deafness arising as a result of any congenital abnormality or ageing. Treatment for deafness is covered as a result of an acute medical condition.

3.26 Preventive treatment, diagnostic tests check-up) or consultations including but not limited to vaccinations, Pap test, blood analysis or other tests done for preventive or informational purposes unless otherwise specified in the Schedule of Benefits.

3.27 Treatment arising from deliberate neglect of health by refusing to seek or follow medical advice or treatment.

3.28 Treatment relating to epidemics recognized by the World Health Organization (WHO) and/or public authorities.

4 Claims Procedure

In case of a scheduled admission to hospital the policy holder or insured person must notify the Company or the third-party administrator of the impending hospitalization at least 48 hours prior.

In case of emergency requiring hospitalization the policy holder or insured person must notify the Company or the TPA immediately after admission and no later than the discharge day.

The policy holder or the insured must submit properly completed the claim form immediately and not later than thirty (30) days from discharge date, together with medical reports, diagnostic test results, and any other forms and documents requested by the Company or TPA, with detailed original invoices and/or original receipts.

Any amount payable will be paid to the policy holder or insured person unless otherwise agreed.

The Company reserves the right not to compensate a claim if this is not submitted within thirty (30) days from discharge date.

In case of outpatient expenses due to an illness or accident, the insured person must within 30 days of the incident date, submit to the Company or the TPA written notice (claim form) accompanied by all original documentations required (e.g., doctor's reports, diagnostic test results etc.) otherwise the Company reserves the right not to accept or reimburse any amount.

The Company reserves the right to examine, at its own expense, any insured person when submitting a claim. If the insured refuses to undergo such examination the Company is not obliged to accept and pay any amount.

The Company and/or the TPA during the investigation of a claim reserve the right to ask for medical information from the hospital, treating doctors, and diagnostic centers as often as required and if necessary, visit the insured person while in hospital.

Any actions of the Company or the TPA during the investigation and evaluation of the claim will not in any way be considered as guarantee of payment.

The claim of the insured person will be considered as abandoned and all the benefit will be deducted if the insured does not file a court action within three (3) months from the date his/her claim was rejected by the insurance company.

5 General Conditions

5.1 Agreement

This insurance policy is designed to cover losses arising from sudden and unforeseen circumstances/situations. Coverage is subject to certain limitations and exceptions including but not limited to pre-existing conditions, exclusions, provisions, terms and conditions as specified in this contract.

The insurance policy will be issued only when the insured has completed a proposal form that has been accepted by the insurer provided the required premium has been paid.

In consideration of the payment of premium, the insurer agrees to reimburse up to the annual limit specified on the insured person's Schedule of Insurance for the costs incurred during the policy period, subject to all of the terms, exceptions, limitations and conditions or endorsements of this policy.

5.2 Geographical Area

Geographical Area means coverage in Cyprus, Member States of the European Union, Israel and Worldwide, as specified on the Schedule of Insurance. It is noted that the cover is provided only to the areas controlled by the Republic of Cyprus.

5.3 Eligibility

For the purpose of this policy, persons who shall be considered eligible for coverage are those who:

a) Are age sixty-five (65) years or less

b) Are permanent residents and reside in Cyprus for at least 183 days in a year.

c) Have completed and signed the proposal form in acceptance of the policy terms and conditions and have been accepted by the insurer.

The Company reserves the right to request evidence or documentation providing proof of residence.

5.4 Acceptance

The Company reserves the right to:

a) Refuse to accept an application from any person without giving any reason

b) Request proof of age and status of health

c) Apply additional options, requirement and exclusions or increase premium to reflect any circumstances.

5.5 Effective Date / Inception Date

The date on which the coverage under this policy first begins, as specified on the Schedule of Insurance.

5.6 Obligations of the Policy Holder and /or Insured at the Application Date

All applicants stated on the proposal form are obliged to describe truthfully their health status, their profession and hobbies and all facts necessary to evaluate the insurance risk. If the policy holder and/or insured make false or misleading statements that if they were known to the Company, the decision might have been different pertaining the terms and conditions or declaim the acceptance of the proposed insured persons, then the insurance policy is considered void from inception.

5.7 Obligations of the Policy Holder and /or Insured during the Insurance Period

The policy holder and/or insured person is obliged to notify the Company in writing pertainingany change in his profession and hobbies and any other material fact affecting the insurability of an insured person. They must also disclose if they take up any other insurance policy with similar benefits.

5.8 Policy Nullity

The policy would be considered null and void on grounds of misrepresentation, fraud, and non-disclosure by any Insured Person. If any claim under this insurance shall be in any respect fraudulent, misleading, and exaggerated or have used fraudulent means, the Company also will not pay any amount for such a claim.

5.9 Premiums

Premiums must be paid to Company's headquarters or to the local branches. Premiums can also be paid through bank transfer, standing order, direct debits or deposited to the Company's Bank Account. The deposit date will be considered payment date. Payment of premiums is only proven with official receipt of the Company or the Bank.

For every subsequent payment, after the first installment, as agreed, there is a thirty (30) days grace period from the due date, with no extra charge, and during this period the Policy is in force.

If hospitalization/compensation occurs during the thirty (30) days grace period the premium must be paid immediately otherwise the policy will be terminated and claims that occur after the due date will not be paid.

The premium is paid in advance as specified in the insurance schedule, another way of payment can be determined upon the Insured's written request and the Insurer's acceptance. An endorsement will be issued.

The Insurer is not obliged to notify the Insured for the payment of his premiums. If such Notification is sent, it is agreed, that in no way this is interpreted as a waiver of this condition by the company.

5.10 Compensation from Another Source

In case of a claim submitted to the Company for which any amount was received from another source, the Company will pay the difference that may exist. The amount payable to the insured cannot exceed the amount specified on the Schedule of Benefits. Furthermore, the total amount received by the insured cannot exceed the total amount actually paid for the claim.

In case the insured receives compensation from another source, he is obliged to reimburse the Insurer with the part of the equivalent amount related to the benefits paid by the Company.

5.11 Subrogation

In case any amount is paid for an incident covered by the policy for which a third party is responsible the Company will automatically replace the policy holder or insured person against that party up to the amount paid by the Company. The policy holder and/or insured is obliged to sign any necessary document to enable the Company for recovery.

5.12 Residential Address

The insured must notify the insurer in writing in case of any change of address or residence. The Company will notify the insured person in writing at the address mentioned on the Schedule of Insurance or to the last known address, if the Company has been notified in writing by the policy holder.

5.13 Alterations
The Company is bound only by documents signed by authorized officers.

5.14 Waiver of Right
Any claim arising from this policy ceases to exist, if the insured does not notify the Company within thirty (30) days of the event.

5.15 Applicable Law and Currency
The policy is governed by the Laws of the Republic of Cyprus. All payments to or by the Company, according to the terms and condition of this Policy, will be transacted in the official currency of the Republic of Cyprus.

5.16 Jurisdiction
Any dispute arising between the policy holder and/or insured person and the Company, in connection with this policy, is subject to the jurisdiction of the Courts of the Republic of Cyprus.

5.17 Acceptance of the Policy
The Company invites the insured to read the policy and be satisfied that the coverage offered is consistent with the one requested and agreed. Otherwise, he has the right to request cancellation of the policy within fifteen (15) days of receiving the policy, by returning it to the Company. In this case, the policy will be cancelled and the premiums will be refunded, minus the cost of the administration expenses, period of cover and other costs.

5.18 Complaints (complaints@ypera.com.cy)
The Company wishes to acknowledge and examine any complaints by an insured person concerning this policy. The Company will consider and respond to all complaints within reasonable time but not later than three (3) months, provided these are submitted in writing to the Company's main offices indicating all personal details of the Insured, the policy number and the facts concerning the complaint. The content of this paragraph will not affect in any way the right of the Insured member or the Company to take legal action.

5.19 Renewal of the Policy
Upon payment of premium the policy will be renewed for a period of another twelve (12) consecutive months.

5.20 Policy Termination/Cancellation
The policy holder has the right to cancel, for any reason at any time, his policy with written notification to the Company’s main offices. Cancellation date will be considered the date that the notification letter was received or the dispatch date of the registered letter.

The Company has the right to cancel, for any reason at any time, the policy by giving fourteen (14) days written notification at the insured's last known address. Cancellation date will be the fifteenth (15th) day after the dispatched date by registered letter. In both cases the appropriate premium will be refunded.

Also, the policy will automatically be terminated without any notice:

- With the death of the Policy Holder or by dissolving the legal entity. In such a case, the dependents have the right to conclude a new policy with the same terms and conditions but without waiting periods. The new policy will be a continuation of the previous one.
- If the premium is not paid on time.

5.21 Dependents Coverage

The policy holder has the right to apply to include in the policy his dependents. Dependents as defined in the Definitions of this contract.

5.22 Amendments and Termination of Health Insurance

The Company reserves the right to change the terms and conditions (including Benefits etc.) of the Policy, by notifying in writing the Policy Holder at his last known address. The amendment will have immediate effect.

The Insured Person has the right to cancel his policy within fifteen (15) days from the renewal date provided there was no claim during that period. There will be a premium refund.

If, for any reason the Company terminated or suspends operation in Health Insurance the Policy will be cancelled at its next renewal.

5.23 Policy Expiration

The Policy expires automatically:

- With the death of the Insured Person
- On the anniversary of the policy following the seventy-four (74) anniversaries of the Insured's birth. The Policy may be extended on written request by the insured provided they meet the Company's prerequisites of insurability.
- For the people under the age of forty (40) and the policy remains valid without interruption up to the age 65 the Company will offer coverage for life provided the insured pays the premium determined by the Company.
- For the spouse/partner, the dissolution of her marriage.
- For the children upon marriage or with the completion of their obligation to the National Guard in Cyprus or after the next anniversary of the Policy following the eighteenth (18th) birthday or the twenty-fifty (25th) if studying In Higher Educational Institutions in Cyprus.
- If the Insured's permanent residence ceases to be Republic of Cyprus.

5.24 Liability

Any liability of the Company will cease to exist after the expiry of the policy for any reason, including without limitation, the non-renewal or non-payment of premium.

Greek to English translation

This Insurance Policy has been translated at the nearest form in English. In case of different interpretation of the Greek text by the English, then the interpretation of the Greek text is applicable

SCHEDULE OF BENEFITS

	MED4YOUNG	SILVER	GOLD	PLATINUM	WORLDWIDE	STUDENT
	€	€	€	€	€	€
INSURANCE COVERAGE	WORLDWIDE EXCLUDING USAS CANADA				WORLDWIDE	WORLDWIDE EXCLUDING USA & CANADA
2.1 MAXIMUM ANNUAL LIMIT	**300,000**	**150,000**	**1,000,000**	**1,500,000**	**2,000,000**	**1,000,000**
2.2 INPATIENT CARE						
2.2.1 Hospital Charges and Theatre Fees	100%	100%	100%	100%	100%	100%
2.2.2 Surgeon's/Assistant Surgeon/Physicians /Anesthetists Fees	Based on Attached List (CD)					
2.2.3 Chemotherapy & Radiotherapy Treatment	—	100%	100%	100%	100%	100%
2.2.4 Outpatient Surgical Procedures	1,000 €	1,000 €	100%	100%	100%	100%
2.2.5 Outpatient Treatment of an Accident	100%	100%	100%	100%	100%	100%
2.2.6 Organ Transplantation, up to	—	150,000	250,000	300,000	400,000	100,00
2.2.7 Reconstructive Surgery						
a.Reconstructive surgery will be covered if it is necessary after an accident	100%	100%	100%	100%	100%	100%
b. Mastectomy due to cancer that was covered as an inpatient	—	100%	100%	100%	100%	100%
2.3 PRE AND POST OPERATIVE EXPENSES						
2.3.1 Pre-Operative diagnostic tests and consultation	300	400	650	800	5,000	200
2.3.2 Post Operative Expenses	}					
a. Diagnostics tests and medication						
b. Physiotherapy (Amount included in 2.3)	150	200	300	400	1,000	200
2.4 ALLOWANCES AND OTHER BENEFITS						
2.4.1 Childbirth Allowance	—	1,500	2,000	2,500	3,000	—
2.4.2 New Bom Allowance	—	100	150	200	300	—
2.4.3 Diagnostics Endoscopies	—	300	450	600	1,000	300
2.4.4 Air Ambulance up to	—	—	1,000	2,000	3000	—
2.4.5 Ambulance up to	—	250	400	500	1,000	250
2.4.6 Repatriation of Mortal Remains in Cyprus, up to	—	1,000	3,000	4,000	5,000	—
2.4.7 Dilatation and Curettage (D+C)	—	350	400	500	1,000	350
2.4.8 Home Nursing, up to 20 days annually	—	50 per day	80 per day	100 per day	125 per day	—
2.4.9 Diagnostics Coronary Catheterization /Coronary Angiography	—	1,000	1,200	1,700	2,000	1,000
2.4.10 Rehabiliation Center	—	30 days 80 per day	30 days 150 per day	45 days 200 per day	60 days 250 per day	30 days 75 per day
2.4.11 Daily Allowance for free treatment, up to 30 days per treatment	—	80 per day	100 per day	150 per day	200 per day	—
2.4.12 Hospitalization without treatment	One day accommodation & food					
2.4.13 Accommodation costs of a Parent	100%	100%	100%	100%	100%	—
2.4.14 Dental Care after an Accident	—	800	1,500	2,000	2,500	800
2.4.15 Coverage outside the Geographical Area	YES	YES	YES	YES	W/W	YES
2.4.16 Check-up, up to	—	—	75	125	300	—
2.4.17 Critical illnesses, paid only once	—	—	8,000	10,0000	15,0000	—
2.5 OUTPATIENT COVER						
ANNUAL TOTAL COVERAGE	—	**600**	**1,000**	**1,500**	**2,000**	**1,000**
2.5.1 Consultation Fees	—	100% up to €50	100% up to €100	100% up to €150	100% up to € 200	100% up to € 100
2.5.2 Medication	—	100%	100%	100%	100%	100%
2.5.3 Diagnostic Tests	—	100%	100%	100%	100%	100%
2.5.4 Physiotherapy	—	100%	100%	100%	100%	100%
2.5.5 Paramedical Services	—	100%	100%	100%	100%	100%
2.5.6 Unrelated Diagnostic Test	—	50	100	150	200	50

Where "100% Total Compensation" is to be understood as compensation based on the Reasonable and Customary charges. Charges beyond R
Customary will not be compensated. The Schedule of Benefits is to be read and interpreted always in conjunction with the definitions, coverag
of the Policy.

Methodology of Personal Data Processing (GDPR)

The Company takes all necessary measures to protect the personal data of customers, claimants and other business associates.

1. The Company

Ypera Insurance Co. Ltd

2.The Subject of Processing may be

- Anyone who applied to the company for insurance contract coverage, receiving an insurance offer and / or anyone who provided information for the aforementioned purpose.
- Insured and / or Contractors and anyone named as recipient of insurance coverage.
- Anyone who can benefit or is directly involved in a claim (e.g., claimant, witness).

3. How we Use Personal Data

- Provision of offer and insurance contract, provision of services related to insurance services to the insured for the correct compliance with the terms of the insurance policy.
- Establishment and defense of legal rights and provision of services regarding the claims of third parties.
- Legal and supervisory compliance including prevention and avoidance of financial crimes.
- For the better management of the company and the products offered by the Company.
- Sending information for the promotion of products and services after obtaining the necessary consent.

4. Automated Processing, including profiling

Data processing may involve automated decision-making, including profiling, on risk assessment and contract management.

Any object is subject to automated processing has the right to object by contacting the Company's Data Processing Officer (DPO) either via phone or by e-mail.

5. The types of personal data that may be collected

Personal data collected may include: identification and contact information, payment card number and bank account number, vehicle number, sensitive medical or health information and other personal data provided by you, depending on the type of service you request as a subject and these are absolutely necessary for the company to decide whether or not to provide the required insurance service.

6. Personal Data

It’s the information that identifies or relates to the subject or other persons (i.e., its dependents). Personal data is collected and used - as described below - with the consent of the subject.

- The provision of personal information of another person is done only by persons who are authorized to provide it for the use described below.

- There is no obligation to promote personal data, however it may not be possible for the Company to provide insurance services and products without the aforementioned information.

The subject of the processing has the right to know the personal data that the Company keeps. It may also revoke the processing consent at any time by sending a written request to the Company's Data Processing Officer (DPO). The Company, upon written request and after verifying the identity of the applicant and evaluating the effects that this transaction may have, may take the appropriate actions in the circumstances.

7. Exchange of Personal Data

For the above purposes, personal data may be passed on to agents, associates, intermediaries and other distributors of insurance products/services, insurance and reinsurance companies, credit or banking institutions, doctors and medical staff, lawyers, loss assessors and other service providers with whom our company cooperates. Personal data will be provided to other third parties (including government authorities) if required by law. Personal data (including injury details) may be recorded in claim registers and shared with other insurance companies.

These records may be searched to detect and prevent fraud or to establish the claim history of the subject or another person or property that may be involved in the insurance policy or claim.

Personal data may be shared with buyers and potential buyers and transferred through the sale of the Company or the transfer of the Company's business assets.

8. International Transport

Due to the nature of the Company, personal data may be transferred to locations located in other countries, including the US and other countries that have different legal frameworks for data protection.

9. Security and retention of personal data

Appropriate legal and security measures are taken to protect personal data. The Company ensures that all service providers themselves take appropriate protective measures and process the information in compliance with the regulation by signing a relevant certificate of commitment to the Company. Personal data will be retained only for the period required to fulfill the purposes described above or required by law or government authorities.

In addition, all service providers must, as well as themselves, take appropriate safeguards and process the data in accordance with the regulation.

10. The Rights of the Subject

Any personal data processed by the Company may in writing:

- Request to terminate any form of processing.
- Receives a copy of his personal information held by the Company.
- Ask for them to be upgraded and / or corrected so as to ensure their accuracy.
- Request deleted items that are no longer needed.

Request that processing be prohibited for a specific group of information.

- File a complaint if he / she considers that his / her personal data is being abused.
- Revokes editing consent.

11. Data Protection Officer – Ypera Insurance Co. Ltd

In case where the subject of data wished to exercised his/her rights, as they derived from the regulation, he/she can send a written request to the Data Protection Officer (DPO) via fax: 24 82 82 90 or email at DPO@ypera.com.cy or to Ypera House, 2 Medousis Street, 6059 Larnaca by registered mail.

More details about the use and processing of personal data can be found in the Privacy Policy at http://www.ypera.com.cy/gdpr.html or by requesting a copy using the above contact details.