Critical Illness Insurance

Policy Terms L-10

This document is an AI translation of the official Icelandic text. In the event of any discrepancy between the translation and the original Icelandic version, the Icelandic version shall take precedence.

The insurance is governed by the insurance certificate together with its endorsements and special terms, these policy terms, the company's general terms no. AS-1, and the provisions of the Insurance Contracts Act no. 30/2004, hereinafter referred to as ICA. Provisions in these terms take precedence over provisions in the general terms where there is any conflict.

The basis of the insurance contract is these policy terms, the information on the insurance application, the current risk assessment procedures applicable at any given time for personal insurance, and other documents related to the contract both at the time of its original conclusion and subsequently.

Definitions

Main due date: The main due date of the insurance is once a year and is the first day of the month in which the insurance originally came into effect, unless otherwise agreed.

Age-linked premium: The premium of the insurance is gender-neutral and is calculated on the basis of the sum insured, increasing each year in accordance with the age of the insured.

Trauma: An event that causes severe stress reactions in an individual and leads to the person suffering from psychological difficulties in its aftermath.

The company: The party who, by contract, undertakes to provide insurance — here Vörður líftryggingar hf.

ICD: The International Classification of Diseases and Related Health Problems. The definitions of illnesses set out in these terms are from the World Health Organization (WHO), which maintains dedicated websites on ICD-10 and its regular updates. Updates in Iceland are guided by WHO directives on their entry into force.

Beneficiary: The insured is the beneficiary under this insurance, cf. Art. 3.

Accident: A sudden, external event that causes bodily injury to the insured and occurs against their will.

Policyholder: The person who enters into an individual contract with the company.

Insured: The individual to whom the insurance applies.

Insured event: An occurrence which, pursuant to the insurance contract, may give rise to payment of benefits.

Insurance certificate: The company's confirmation that an insurance contract has been concluded.

Chapter 1. Scope of Benefits

The scope of the insurance covers five specifically defined benefit categories pursuant to Art. 1, with several illnesses falling under each of them. The illnesses covered by this insurance are classified into five benefit categories according to their nature and type, and payment is made only once from each category even if the insured is diagnosed with two illnesses in the same category.

Art. 1. What does the insurance cover?

a. The company pays benefits if the insured is diagnosed with any of the illnesses listed below, undergoes any of the procedures listed below, suffers loss of a limb, paralysis, deafness, blindness, a serious head injury, loss of speech, or sustains serious burns, as further defined below.
    I. Cardiovascular diseases
    II. Stroke, paralysis, and loss of speech
    III. Cancer
    IV. Neurological and degenerative diseases
    V. Other serious illnesses

Art. 2. What does the insurance not cover?

The company does not pay benefits:

a. in the event of death, and it is a condition of payment that the insured survives for at least thirty days from the date of diagnosis, the date on which the procedure was carried out, or the date on which another insured event occurred pursuant to these terms. The same applies to benefits under the children's critical illness insurance. Events other than the insured events or benefit categories listed as compensable under Art. 1 are not covered under this insurance.
b. for cancer diagnosed within the first three months after the insurance came into effect.
c. from more than one benefit category per insured event.

Benefits are paid to the insured only once from each benefit category (I–V) as referred to in Art. 1.

If a loss arises from a benefit category other than one already paid out, no entitlement to benefits exists if the illness or event can be traced to the same occurrence and/or event, consequences of treatment and/or procedures attributable to the illness for which payment has already been made or with which the insured has already been diagnosed.

Benefits under the children's critical illness insurance are paid only once per child. The maximum benefit under the children's critical illness insurance is ISK 10,000,000. Benefits can never exceed this amount, even if more than one critical illness insurance policy is in force with the company and thus more than one insured person is covered. If more than one policy is in force, benefits are paid to the insured proportionally according to the sum insured of each policy's critical illness insurance.

Art. 3. Children's critical illness insurance

a. If a child of the insured, aged from 3 months to 18 years, experiences an insured event as defined in Art. 1 during the insurance period, the company pays 50% of the critical illness insurance sum insured, up to a maximum of ISK 10,000,000, as further detailed in Art. 2.
b. Benefits are not paid for insured events that can demonstrably be traced, directly or indirectly, to the child's condition prior to the insurance being taken out. For adopted children, the company is not liable if the cause of the insured event can be traced to a medical condition the child had before being adopted.
c. Furthermore, benefits are not paid for procedures carried out between the ages of 3 months and 18 years if the diagnosis that led to the procedure was made before the child reached 3 months of age.

d. Payment of benefits under the children's critical illness insurance does not affect the insured's own critical illness insurance. Benefits are paid in respect of the insured's biological children. Benefits are also paid in respect of foster children and stepchildren, provided they share a registered domicile with the insured. The reservations of point (b) also apply in such cases.

I. Cardiovascular Diseases

Art. 4. Acute Myocardial Infarction (Heart Attack)

Death of part of the heart muscle due to ischaemia. All of the following must be present simultaneously for a diagnosis of acute myocardial infarction:

a. chest pain (anginal pain)
b. new changes on an electrocardiogram (ECG) with ST elevation
c. elevation of cardiac-specific enzymes released during a heart attack, such as CK-MB or Troponin

Payment of benefits is conditional on the acute myocardial infarction meeting all three of the above criteria upon diagnosis. Excluded under this definition are:

a. myocardial infarction without ST elevation (NSTEMI), with elevation of Troponin I or T
b. other acute coronary syndromes

The diagnosis shall be confirmed by a recognised specialist in cardiology.

Art. 5. Coronary Artery Bypass Surgery

Open heart surgery to correct narrowing or blockage in one or more coronary arteries by means of a bypass procedure. Excluded under this definition are other procedures that are not open surgery, such as percutaneous coronary intervention (PCI) and laser procedures.

Art. 6. Heart Valve Surgery – Replacement or Repair

Open heart surgery to replace or repair one or more heart valves.

Art. 7. Aorta Graft Surgery

Open surgery carried out on the advice of a specialist to remove and repair, using a graft, a narrowing, rupture, or aneurysm of the main artery (aorta) in the chest or abdominal cavity. Excluded under this definition are procedures carried out on branches of the aorta outside the chest or abdominal cavity.

II. Stroke, Paralysis, and Loss of Speech

Art. 8. Stroke

Any circulatory disturbance in the brain that causes symptoms from the central nervous system lasting more than 24 hours and involves infarction of brain tissue or haemorrhage. A condition of payment of benefits is that there are symptoms of permanent damage to the central nervous system (neurological sequelae) and that investigations (CT/MRI) support the diagnosis. Excluded under this definition are:

a. transient ischaemic attack (TIA)
b. neurological symptoms attributable to migraine

The diagnosis shall be confirmed by a recognised specialist in neurology.

Art. 9. Paraplegia

Covers paralysis of the spinal cord (paraplegia) caused by illness or accident. The paralysis must extend to both legs and/or both arms, or at least one leg and one arm. The paralysis must be permanent and the diagnosis must be made by a specialist in neurology.

Art. 10. Loss of Speech (Aphasia)

Total and permanent loss of the ability to speak (aphasia) over a continuous period of at least 12 months. The diagnosis must be confirmed by a specialist in neurology. Excluded is loss of speech attributable to psychological disorders.

III. Cancer

Art. 11. Cancer – Malignant and Invasive

A malignant tumour characterised by uncontrolled growth and spread of malignant cells along with invasive growth into tissue. This applies to leukaemia (other than chronic lymphocytic leukaemia, CLL), malignant lymphomas, and Hodgkin's disease at stage II–IV. Excluded are:

a. pre-malignant tumours
b. tumours that are localised and non-invasive (in situ)
c. all stages of CIN (cervical intraepithelial neoplasia)
d. Hodgkin's disease at stage I
e. chronic lymphocytic leukaemia
f. prostate tumours at stage T1 and Gleason grade 6 or lower
g. all types of tumours where AIDS (HIV) is present
h. Kaposi's sarcoma
i. all skin cancers other than malignant, invasive melanoma
j. cancer diagnosed within the first three months after the insurance came into effect, cf. Art. 2(b)

IV. Neurological and Degenerative Diseases

Art. 12. Multiple Sclerosis (MS)

An unambiguous diagnosis of multiple sclerosis (MS), confirmed by a specialist in neurology. The diagnosis must be based on at least two typical episodes with well-defined symptoms from the nervous system, or alternatively a progressively worsening disease course consistent with MS. The diagnosis must be confirmed by an MRI scan of the brain showing typical changes in brain tissue.

Art. 13. Motor Neurone Disease (MND) before the age of 60

An unambiguous diagnosis of MND before the age of 60. The diagnosis must be confirmed by a specialist in neurology.

Art. 14. Alzheimer's Disease before the age of 60

An unambiguous diagnosis of Alzheimer's disease before the insured reaches the age of 60. The diagnosis shall be confirmed by a recognised specialist in neurology or geriatrics, using appropriate investigations and assessments confirming characteristic deterioration of brain function. The condition must be deemed irreversible and must have reached a stage requiring continuous supervision and assistance.

Art. 15. Parkinson's Disease before the age of 60

An unambiguous diagnosis of idiopathic Parkinson's disease before the insured reaches the age of 60. The diagnosis shall be confirmed by a specialist in neurology. The condition must be deemed irreversible and must have reached a stage requiring continuous supervision and assistance. Excluded under this definition is Parkinson's disease resulting from alcohol or substance abuse.

V. Other Serious Illnesses

Art. 16. Benign Brain Tumour

A tumour in the brain that is not malignant but causes permanent damage to the central nervous system. Excluded are:

a. cysts
b. granulomas
c. meningiomas
d. chordomas
e. vascular malformations of arteries or veins
f. cerebral contusions and tumours of the pituitary gland or spinal cord

Art. 17. Major Organ Transplantation

The insured undergoes surgery as the recipient of a heart, lung, liver, pancreas, kidney, or bone marrow transplant.

Art. 18. Kidney Failure

End-stage renal disease, characterised by chronic irreversible failure of both kidneys, resulting in the insured requiring either regular peritoneal dialysis or haemodialysis, or a kidney transplant.

Art. 19. Third Degree Burns

Third degree burns covering at least 20% of the surface area of the insured's body, confirmed by a specialist.

Art. 20. Loss of Limbs

Permanent loss of two or more limbs above the wrist or ankle joint.

Art. 21. Blindness

Permanent and irremediable loss of vision so severe that even when tested with visual aids, vision measures 3/60 or less in the better eye using a Snellen eye chart.

Art. 22. HIV Infection through Blood Transfusion, Physical Assault, or in the Performance of Certain Duties

The insured contracts HIV or is diagnosed with AIDS (HIV) and the cause can be traced to one of the following:

a. a blood transfusion received as part of medical treatment
b. a physical assault suffered by the insured
c. an incident occurring in the course of the insured's duties as an employee in health services or as a firefighter, paramedic, or police officer

The event causing the infection must have occurred during the insurance period and must satisfy the following conditions:

a. the event must have been reported to the relevant authorities and investigated using recognised methods
b. where HIV infection occurs as a result of a physical assault or an incident arising in the course of ordinary professional duties, a negative HIV antibody test result must be submitted, carried out within 5 days of the event
c. a further HIV antibody test must also be carried out within 12 months, confirming that the HIV virus has emerged or that HIV antibodies are present
d. the event causing the infection must have taken place in Iceland

The insurance does not cover HIV infection arising from any other causes.

Art. 23. Deafness

Permanent and irreversible hearing loss to the extent that hearing loss exceeds 85 decibels across all frequencies in the ear with better hearing, using an audiogram from a pure-tone hearing test. The relevant specialist (ENT specialist) must provide medical documentation that must include an audiogram and threshold measurement. The hearing loss must not be treatable by medical means.

Art. 24. Bacterial Meningitis

Bacterial infection and inflammation of the meninges or spinal cord, confirmed by a specialist in neurology using blood and cerebrospinal fluid tests, computed tomography (CT), or magnetic resonance imaging (MRI) of the head.

The illness must have resulted in a permanent inability to independently perform three or more activities of daily living (ADL) — bathing, dressing and undressing, using the toilet, transferring from bed to chair or vice versa, controlling bowel and bladder function, eating, drinking, and taking medication — or must have resulted in permanent confinement to bed and inability to get up without external assistance. This condition must have persisted for at least three months according to medical confirmation.

Art. 25. Serious Head Injury

A serious injury to the head that causes disruption of brain function. The diagnosis must be confirmed by a specialist and the results of neurological imaging, such as CT or MRI. The injury must have resulted in a permanent inability to independently perform three or more activities of daily living (ADL) — bathing, dressing and undressing, using the toilet, transferring from bed to chair or vice versa, controlling bowel and bladder function, eating, drinking, and taking medication — or must have resulted in permanent confinement to bed and inability to get up without external assistance. It must be medically confirmed that this condition has persisted for at least three months.

Chapter 2. Maternity and Parental Protection

Critical illness insurance also covers certain medical events that may arise during pregnancy or childbirth. In addition, the insured is given access to psychological support in the form of counselling sessions when the insured experiences trauma during the pregnancy or birth period.

Art. 26. Pregnancy- or Childbirth-Related Events

What does the insurance cover?

The insurance pays a lump sum equal to the sum insured if any of the following occurs during pregnancy or childbirth. Benefits are paid only once per pregnancy to the pregnant person even if more than one compensable event occurs. The sum insured is stated on the insured's certificate.

Benefits are paid if one of the following events or diagnoses occurs during pregnancy or childbirth:

a. **Pre-eclampsia.** Benefits are paid if pre-eclampsia develops in the pregnant person (ICD O14 or O15).
b. **Ectopic pregnancy requiring intervention.** If the foetus implants outside the uterus and must be removed by surgery or drug treatment (ICD O00).
c. **Pregnancy loss after 14+0 weeks.** Benefits are paid when pregnancy loss occurs after 14+0 weeks of pregnancy (ICD O02–O03) or pregnancy termination attributable to a confirmed diagnosis of a serious foetal abnormality (ICD O28).
d. **Severe morning sickness.** This refers to pathological nausea and vomiting requiring hospitalisation or intravenous fluid administration, defined as severe hyperemesis gravidarum (ICD O21.1).
e. **Severe postpartum haemorrhage.** Benefits are paid if medical records from the maternity ward confirm blood loss of ≥1,500 ml in connection with delivery (ICD O72).
f. **Severe perineal tear.** A severe tear means a 3rd or 4th degree perineal tear, which can be confirmed by medical records from the maternity ward (ICD O70.2 or O70.3).
g. **Placenta accreta.** When the placenta grows abnormally deep into the uterine wall and does not separate normally after delivery (ICD O43.2).
h. **Placental abruption.** If the placenta separates before delivery of the child, benefits are paid (ICD O45).
i. **DIC (disseminated intravascular coagulation).** If a serious disturbance of blood coagulation occurs in connection with delivery, benefits are paid (ICD O72.3, D65).

What does the insurance not cover?

The company does not pay benefits for:

a. illnesses or conditions that existed before the insurance came into effect, including diagnoses or symptoms traceable to a condition that began prior to pregnancy. The coverage also does not extend to conditions that recur or worsen during the pregnancy or birth period due to a prior condition.
b. pregnancy termination for reasons other than those listed above.
c. events or illnesses other than those specifically listed above.
d. illnesses, physical defects, or other conditions attributable in any part to the consumption of alcohol, drugs, or narcotics.
e. illnesses or conditions rooted in cosmetic or reconstructive procedures during pregnancy.

General provisions

a. Benefits for pregnancy- and childbirth-related events are paid once per pregnancy, regardless of how many insurance certificates the insured may hold in force.
b. Once benefits have been paid for a specific event, benefits are not paid again on the insured's next pregnancy for the same event.

c. It is a condition of entitlement to benefits under this coverage that confirmation of the pregnancy- or childbirth-related event from a physician, midwife, or specialist is available.
d. The coverage is valid only while the insured's critical illness insurance is in force. No benefits are paid for events occurring before the insurance comes into effect or after it lapses.
e. The company is entitled to obtain information about the insured's prior health if such information is necessary to assess the insured's entitlement to benefits. The company pays the cost of necessary medical certificates in connection with an insured event when obtained at the company's request.

Art. 27. Congenital Health Condition of a Child

What does the insurance cover?

The insurance pays a lump sum equal to the sum insured to the policyholder if the insured's child is diagnosed with one of the following, provided the diagnosis is confirmed within 12 months of the child's birth. The sum insured is stated on the insured's certificate.

Entitlement to benefits does not arise until at least 30 days after the diagnosis has been confirmed by a specialist physician.

Benefits are paid for:

a. **Cerebral palsy.** A diagnosis of cerebral palsy confirming permanent motor impairment caused by damage to the central nervous system (ICD G80).
b. **Hydrocephalus.** Congenital hydrocephalus requiring medical treatment, such as surgery or ongoing monitoring (ICD Q03).
c. **Spina bifida.** A diagnosis of spina bifida involving neurological consequences and/or the need for surgery (ICD Q05).
d. **Congenital heart defects.** Heart defects requiring surgery within the first 6 months of the child's life (ICD Q20–Q26).
e. **Cleft palate and cleft lip.** A diagnosis of cleft lip and/or palate requiring surgery and/or specialised treatment (ICD Q35–Q37).
f. **Serious congenital structural abnormalities of the abdominal wall or diaphragm.** A diagnosis of congenital defects requiring immediate surgery after birth (ICD Q79.2, Q79.3).
g. **Chromosomal abnormalities.** Congenital disability or chromosomal abnormalities, confirmed by genetic analysis, requiring long-term care (ICD Q00–Q99).
h. **Club foot or serious limb abnormality.** A diagnosis of club foot requiring casting or surgery (ICD Q66.0, Q66.1, Q66.4) or absence of a limb (ICD Q71–72).
i. **Serious hypoxia.** Serious oxygen deprivation at birth resulting in cooling treatment (ICD P21.0).

Rare diseases

Even if a congenital condition does not fall under the diagnoses listed above, the insurance nonetheless pays benefits for rare, life-threatening, and hereditary diseases of the insured's child, or for a serious accident occurring to the child in the womb or at birth.

For benefits to be paid for a rare disease or accident, two of the following conditions must be met:

1. Confirmed medical diagnosis.

2. The disease/accident must involve reduced life expectancy and long-term care needs.
3. The disease/accident must involve physical or biological impairments causing serious reduction in quality of life and/or function.

What does the insurance not cover?

a. Health conditions of the child that existed before the insurance came into effect, including diagnoses or symptoms.
b. The sum insured is paid for only one of the diagnoses listed above, even if the child has multiple diagnoses and even if the insured holds more than one policy in force.
c. It is a condition of payment of benefits that the child survives for 30 days from the date of diagnosis, the date on which the procedure was carried out, or the date on which another insured event occurred.

Art. 28. Counselling Sessions

What does the insurance cover?

The insurance provides the insured with up to five hours of counselling sessions per pregnancy with a recognised service provider designated by the company from time to time. The sessions may be individual sessions, therapeutic consultations, or comparable services aimed at supporting the insured in processing trauma, difficulties, or serious life experiences related to pregnancy or childbirth.

Entitlement to counselling sessions arises if the insured experiences one or more of the following during pregnancy or childbirth:

a. a compensable event pursuant to Arts. 26 and 27 of the insurance
b. antenatal or postnatal depression (ICD F53.0)
c. pregnancy loss before 14+0 weeks of gestation (ICD O01–O03, O36.4)
d. a difficult or traumatic birth experience
e. emergency caesarean section (ICD O82.1)
f. domestic violence
g. consequences of cerebrospinal fluid leak following epidural anaesthesia (e.g. spinal headache) (ICD G97.0)
h. very premature birth, meaning the child is born before 32+0 weeks of gestation and required hospitalisation following birth due to premature development (ICD P07)
i. multiple pregnancy of more than two children (ICD O30.2, O30.3)
j. in the event of pregnancy loss, the insured may also request counselling sessions for the insured's children, taking into account their age and circumstances

What does the insurance not cover?

The company does not provide counselling sessions for:

a. traumas or illnesses that began before the insurance came into effect or coverage commenced
b. events or illnesses other than those specifically listed as compensable in these terms

General provisions

a. Other additional costs that may arise in connection with treatment or events, such as travel costs or comparable expenses, are not covered by the insurance.

b. It is necessary to notify the company of the event in order to obtain approval for the treatment.
c. The company bears no responsibility for the quality or outcome of the service, only for ensuring that the insured is allocated the designated hours with a contracted service provider within a reasonable time.

Chapter 3. General Provisions

Art. 29. Who is insured?

The insured is the beneficiary of benefits under the insurance. In the event of death, the provisions of Chapter XV of Act no. 30/2004 apply, cf. however Art. 2(a) of these terms.

Art. 30. Where does the insurance apply?

The insurance applies anywhere in the world.

The insurance is valid from the date of issue stated on the insurance certificate and until the time specified on the insurance certificate, but no longer than until the insured reaches the age of 70. The company does not insure individuals under the age of 18 under this critical illness insurance (cf. however Art. 3).

The policyholder has a 30-day period (cooling-off period) in which to cancel the insurance from the time they receive notification from the company that the contract has come into effect.

Art. 31. Risk assessment procedures

The company follows specific risk assessment procedures for personal insurance, both its own procedures and the detailed procedures of its reinsurer at any given time.

Art. 32. Policyholder's right to cancel the insurance

The insured may cancel the insurance at any time during the insurance period. Cancellation must be made in writing. The policyholder shall pay the premium for the period during which the company is liable under the insurance.

Art. 33. Right to increase the sum insured without a health declaration

The insured may request an increase in the sum insured without providing further information about their health. A written request for an increase and the necessary documentation must be received by the company within six months of any of the following events:

a. the insured has a child
b. the insured adopts a child
c. the insured purchases a residential property

The sum insured may increase by a maximum of 25% or a maximum of ISK 2,500,000, subject to the condition that the total sum insured does not exceed ISK 15,000,000. The said increase has the same term as the insurance being increased.

The sum insured may only be increased once in connection with a property purchase. The right to an increase lapses from the insured's 45th birthday. This right also lapses once a claim has been made under the critical illness insurance, premium waiver has been requested, or the insured has been diagnosed with any of the illnesses, has undergone or is awaiting any of the procedures, or has experienced any of the events considered compensable under these terms.

Art. 34. Right to reinstate critical illness insurance

If the insurance has lapsed due to non-payment, it may not be reinstated except upon submission of a new insurance application with a new risk assessment.

Art. 35. Benefit payments under the insurance contract

The company pays the sum insured in force on the date of loss in respect of an insured event experienced by the insured pursuant to the insurance certificate and these terms.

A claim for benefits or the sum insured falls due 14 days after sufficient proof of the company's liability has been received and the amount of benefits can be determined. The company reserves the right to obtain the necessary and sufficient documentation before benefits are determined and paid. Interest on benefit payments is governed by Art. 123 of the ICA, cf. Art. 50 of the same Act.

Upon payment of benefits in respect of an illness belonging to one of the benefit categories (I–V) listed in Art. 1, that benefit category lapses. Payment is therefore made only once from each category. The insurance continues in force but the benefit category already paid out is excluded. The right to premium waiver pursuant to Art. 33 lapses upon payment of benefits.

Art. 36. Premium waiver

The insured may request in writing that the insurance premium be waived if they lose at least half of their working capacity due to accident or illness during the insurance period. Premium waiver may last for a maximum of five years. Total loss of working capacity entitles the insured to full premium waiver, while a reduction of 50% or more entitles them to a proportional reduction in premium.

It is a condition that the reduced working capacity and/or incapacity for work is not compensable under Art. 1 of these terms. The insured must notify the company of the loss of working capacity and/or incapacity for work without undue delay, but at the latest within one year of the onset of incapacity, cf. Art. 124 of the ICA.

It is a condition that the loss of working capacity or incapacity for work is confirmed by the treating physician with a certificate. The company reserves the right to send the insured for a medical examination by the company's assessment physicians to confirm incapacity. Premium waiver is granted from the time the company's decision to grant it is made. Furthermore, overpaid premiums for a period covered by the premium waiver will be refunded, but for a maximum of six months back from the date the application for premium waiver is received by the company.

It is a condition for granting premium waiver that the insured has kept up with premium payments until the time the decision on premium waiver is made.

The insured does not acquire the right to premium waiver if the cause of the loss of working capacity is:

- war, military operations, civil unrest, rebellion, or comparable actions
- misuse of alcohol, narcotics, or toxic substances
- participation in criminal conduct
- conduct by the insured attributable to intent or gross negligence, cf. Arts. 89 and 90 of the ICA

The insured does not acquire the right to premium waiver for illnesses and their consequences that existed or had shown symptoms before the insurance came into effect, nor for the consequences of an accident that occurred before the insurance came into effect. The insured is not entitled to premium waiver if they have received payment from one or more of the benefit categories listed in Art. 1.

An application for premium waiver must be accompanied by the necessary documentation for assessing the loss of working capacity, such as a medical certificate. The insured bears all costs of obtaining the necessary documentation for assessment of premium waiver.

In assessing loss of working capacity, the company will base its assessment on the insured's ability to perform their own occupation and their prospects for other employment. Premium waiver is not granted for a period of more than one year prior to the date the application for premium waiver was received by the company.

Premium waiver commences 6 months (waiting period) after the loss of working capacity occurred and lasts for a maximum of five years, but never beyond the insured's 60th birthday or the end of the contract period, whichever is earlier. The company shall notify the insured in writing of its decision no later than 14 days after the necessary documentation is received by the company. While the insured is benefiting from premium waiver, they must provide the company with the necessary health information and other documentation and undergo medical examinations as often as required.

The insured is obliged to notify the company immediately upon regaining working capacity in whole or in part.

The provisions on breach of the duty of disclosure, fraud, and misrepresentation apply to premium waiver as applicable, pursuant to the company's general terms AS-1.

Art. 37. Sum insured, premium, and indexation

The first premium for this insurance is calculated in accordance with the company's current premium schedule, based on the sum insured and the age of the insured at the time the insurance comes into effect, unless otherwise stated in the policy terms.

The sums insured under this insurance follow the development of the price level in the country and therefore change in accordance with the consumer price index at each renewal. A decrease in the index does not result in a reduction of the sum insured or the annual premium. The premium of the insurance is gender-neutral, is calculated on the basis of the sum insured, and changes each year in accordance with the age of the insured.

Up to the age of 55, the premium increases on the main due date in accordance with the age of the insured. From the age of 56, the premium is adjusted annually in line with index changes and the sum insured decreases in proportion to the increasing age of the insured.

The company reserves the right to determine the renewal premium in accordance with a new premium schedule, taking into account general changes in risk and other factors that cause a disruption to the basis for benefits, if these factors do not result in changes to the sum insured of the insured.

Art. 38. Time limit for notifying an insured event

The insured forfeits the right to benefits if they do not notify the company of their claim within two years of becoming aware of the event on which it is based.

Art. 39. Time limit for legal action

If the company rejects a claim for benefits in whole or in part, the person who considers themselves entitled to benefits loses that right if they have not commenced proceedings or requested that the matter be referred to an adjudication committee within one year of receiving written notification of the rejection from the company, cf. Art. 124(2) of the ICA.