Child Insurance 1

Policy Terms L-16

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.

Child Insurance 1 protects a child against future loss of income due to accidents and illnesses that may have permanent consequences for their health. In addition, it provides support to parents who may suffer loss of income or incur expenses due to a child's illness.

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.

Table of Contents:

Daily allowances for home care, daily allowances for hospital stays, and psychological services are not paid after the age of 18.

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.

Trauma: A specific event that causes severe stress reactions in a child and leads to the child 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.

Illness: A deterioration of health that does not qualify as an accident as defined below. The illness demonstrably results in a reduction of the insured's physical or mental capacity. The onset of an illness is determined by the date of diagnosis.

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

Permanent medical disability: An illness or accident has resulted in a permanent reduction in the physical capacity of the insured as a consequence of the insured event.

Policyholder: The person who enters into an individual contract with the company for the insurance. The policyholder may only be a guardian of the child. Upon the insured reaching

the age of 18, the legal status of the parties changes such that the insured also becomes the policyholder with the associated rights and obligations, while the custodial parent loses their status as policyholder.

Insured: The individual aged from 1 month to 26 years to whom the insurance applies.

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

Insurance contract: The contract in force between the company and the policyholder for the child insurance.

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

Chapter 1. Disability Benefits for Permanent Medical Disability

Art. 1. Assessment of permanent medical disability

Permanent medical disability is assessed at the earliest one year after the insured event.

Disability shall be assessed as a percentage in accordance with the Disability Assessment Committee's impairment tables in force at the time the assessment is carried out. If an injury or condition is not listed in the Disability Assessment Committee's impairment tables, Swedish impairment and disability tables published by the association of Swedish insurance companies, or other standards considered recognised for such assessments, shall be used.

Art. 2. Benefits

Benefits paid out correspond to the same percentage of the base disability sum insured as the assessed medical disability level pursuant to Art. 1. The total disability level for the same illness or accident is capped at 100%, and medically related illnesses are treated as one and the same illness.

The benefit amount is adjusted by a multiplier according to the following table based on the disability level of the illness or accident:

Disability level	Multiplier
0% – 10%	0
11% – 50%	1
51% – 75%	2
76% – 100%	3

If the disability level is 10% or lower, no benefits are paid for permanent medical disability.

Upon reaching the age of 18, the disability level table changes as follows:

Disability level	Multiplier

0% – 15%	0
16% – 50%	1
51% – 75%	2
76% – 100%	3

After the age of 18, no benefits are paid for permanent disability if the disability level is 15% or lower.

Entitlement to benefits for permanent medical disability arises when an illness or accident has caused a permanent reduction in the insured's physical capacity and their condition has stabilised. In cases of permanent medical disability, the right to payment of disability benefits arises at the earliest 12 months after the illness was diagnosed or the accident occurred, and a disability assessment confirming permanent consequences must be available.

The disability assessment may be deferred for as long as necessary according to medical experience or due to existing rehabilitation prospects, but for no longer than 10 years from the loss event. At the time of payment, the consumer price index for the month preceding the date of loss is used as the basis, and the benefit amount is updated in line with changes to the index up to the month preceding the settlement date.

If the insured dies before the right to benefits for permanent medical disability has arisen, no disability benefits are paid. If the right to disability benefits has arisen, the amount corresponding to the confirmed permanent medical disability considered to have existed at the time of death is paid out.

Upon payment of benefits for permanent medical disability, the insurance lapses.

Benefits for permanent medical disability will be paid into a dedicated account held with a recognised financial institution in Iceland in the name of the insured, and will be available for withdrawal when the insured reaches the age of 18. After the insured turns 18, benefits for permanent medical disability are paid directly to the insured.

Chapter 2. Daily Allowances for Hospital Stays

Art. 3. What does the insurance cover?

The insurance pays the policyholder daily allowances of 0.04% of the base sum insured, cf. Art. 20, if the insured is admitted to hospital for at least 6 consecutive days. After 6 consecutive days of hospitalisation, daily allowances are paid from the first day and for a maximum of 365 days if the insured is in hospital due to the same illness or accident or its consequences, and while the insurance was in force.

Art. 4. What does the insurance not cover?

Daily allowances for hospital stays are not paid after the age of 18.

Chapter 3. Daily Allowances for Home Care

Art. 5. What does the insurance cover?

The insurance pays benefits to the policyholder if they, or another guardian of the insured, are entitled to care benefits from the social security system due to illness or accident of the insured. A condition of payment of daily allowances for home care is that the insured has been hospitalised due to the illness or accident.

Art. 6. Entitlement to benefits

Entitlement to benefits continues for as long as the conditions for payment are met, but no longer than until the insured reaches the age of 18 or for a maximum of 10 years.

If the insured dies, the right to monthly benefits lapses at the end of the month of death.

The annual benefit amount is calculated as follows:

- If social security care benefits are 81–100%, 10% of the base sum insured is paid.
- If social security care benefits are 61–80%, 7.5% of the base sum insured is paid.
- If social security care benefits are 41–60%, 5% of the base sum insured is paid.
- If social security care benefits are 20–40%, 2.5% of the base sum insured is paid.

Benefits are paid monthly in arrears as soon as entitlement arises, at which point 1/12 of the annual benefit is paid to the policyholder.

Chapter 4. Critical Illness Benefits

Art. 7. What does the insurance cover?

Critical illness benefits are paid as a lump sum if the insured receives any of the following diagnoses:

a. **Multiple Sclerosis (MS).** MS diagnosed at a paediatric department of a recognised hospital or by a specialist in neurology. The insured must have had neurological symptoms for at least six months or have had at least two clinically confirmed episodes of symptoms. In support of this, symptoms of demyelination and disturbance of movement and sensation must be typical and diagnosed by MRI and/or examination of cerebrospinal fluid.

b. **Cancer.** 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) and malignant lymphomas, and Hodgkin's disease at stage II–IV.

c. **Benign Brain Tumour.** A tumour in the brain that is not malignant but causes permanent damage to the central nervous system.

d. **Diabetes Mellitus Type 1.** Diabetes diagnosed by a specialist in paediatrics or internal medicine. Fasting blood glucose must have measured above 8 mmol/l in repeated samples and the insured must have received insulin treatment for more than three months.

e. **Third Degree Burns.** Serious burns are defined here as third degree burns covering at least 20% of the surface area of the insured's body, confirmed by a specialist.

f. **Cystic Fibrosis.** Cystic fibrosis diagnosed by a specialist in paediatric diseases. The insured must have had chronic lung disease and/or a deficiency in pancreatic enzyme production. In addition, a sweat test must show a chloride concentration exceeding 60 mmol/l for those aged 16 and under, and exceeding 80 mmol/l for those over 16.

g. **Juvenile Rheumatoid Arthritis.** Juvenile or chronic arthritis diagnosed at a recognised hospital or by a specialist in rheumatology. In this context, arthritis

refers to joint inflammation accompanied by at least two of the following symptoms: reduced range of motion, raised temperature, and pain.

Arthritis in those under 16 years of age:
Arthritis in more than one joint for more than three months. Investigations must have been carried out that rule out the symptoms arising from joint inflammation related to infection, infectious arthropathy, orthopaedic disease, injury, abnormal tissue formation, immune rejection, and vasculitis.

Arthritis in those aged 16 and over:
At least four of the following seven symptoms must be present:

1. morning stiffness
2. arthritis in three or more of the following joints simultaneously: wrist, proximal interphalangeal joints of the fingers, metacarpophalangeal joints, elbow, knee, ankle, and metatarsophalangeal joints
3. arthritis in the following joints of the hand: wrist, proximal interphalangeal joints of the fingers, or metacarpophalangeal joints
4. symmetrical arthritis (arthritis in the same joints on the right and left sides of the body at the same time)
5. rheumatoid nodules
6. positive rheumatoid factor
7. typical X-ray changes in images of the hands and wrists

Symptoms 1–4 must have been present for at least 6 weeks. Symptoms 2–5 must have been found by the same physician who diagnosed the illness.

h. **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. The diagnosis must have been made by an ophthalmologist or specialist in eye diseases.

i. **HIV infection / AIDS.** HIV infection as a result of a needlestick accident suffered by the insured from a needle left on a playground, outdoor area, or other open space; or infection as a result of a blood transfusion received as part of medical treatment. The notification of infection must be accompanied by an incident report and confirmation of a negative HIV antibody test taken immediately after the incident. Conversion to a positive test must have occurred within 6 months of the incident.

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

- the event must have been reported to the relevant authorities and investigated using recognised methods
- a further HIV antibody test must also be carried out within 12 months, confirming that HIV has emerged or that HIV antibodies are present
- the event causing the infection must have taken place in Iceland

Art. 8. What does the insurance not cover?

The insurance does not pay benefits for:

a. **Cancer**
   - Any type of skin cancer.
   - All tumours described histologically as pre-malignant or showing only early malignant changes.

- Localised cancer, non-invasive.

b. **Benign Brain Tumour**
   - Cysts
   - Granulomas
   - Meningiomas
   - Chordomas
   - Vascular malformations
   - Cerebral contusions and tumours of the pituitary gland or spinal cord

No benefits are paid for the above illnesses if diagnosed within the first three months of the insurance period.

Art. 9. Entitlement to benefits

Entitlement to benefits is conditional on the insured being alive 30 days after the diagnosis has been received. The diagnosis of the illness must be confirmed by a specialist.

The benefit amount is 15% of the base disability sum insured, paid as a lump sum to the policyholder.

Benefits are paid once for each of the illnesses listed in Art. 7 above and the insurance continues in force for other types of illness listed therein. This means, for example, that benefits for cancer are paid only once.

If critical illness benefits are paid, daily allowances for home care under Chapter 3 are not paid for the same medical condition.

Chapter 5. Psychological Services

Art. 10. What does the insurance cover?

The insurance pays for psychological services if the insured experiences trauma due to:

a. the death of a parent or guardian
b. physical assault or violence, including sexual violence
c. diagnosis of an event that is compensable under the insurance
d. bullying

The insurance covers a maximum of 5 hours with a psychologist and no higher amount than the maximum benefit stated on the insurance certificate. Benefits are paid upon submission of payment receipts from a psychologist. It is a condition that the diagnosis is confirmed by a psychologist with a certificate. The insured bears any resulting costs themselves.

It is a condition that the treatment is provided in Iceland and commences within one year of the compensable event and is completed within 3 years of the compensable event.

Art. 11. What does the insurance not cover?

The insurance does not cover:

a. losses attributable to illnesses, accidents, or traumas that occurred after the insurance lapsed or before it came into effect
b. treatment if the child carried out or participated in an event considered criminal under Icelandic law

Art. 12. Entitlement to benefits

Benefits are paid only once under the psychological services component and this component of the insurance lapses after benefits have been paid for one course of treatment for the insured, up to a maximum of 5 sessions.

Chapter 6. Death Benefit

Art. 13. What does the insurance cover?

The insurance pays benefits to the policyholder if the insured dies while it is in force. The benefit amount is stated on the insurance certificate.

After the age of 18, the beneficiary of the death benefit is governed by the provisions of Chapter XV of the ICA. Upon payment of the death benefit under this article, the insurance lapses.

Chapter 7. Premium Waiver

Art. 14. What does the insurance cover?

If the policyholder, who must be under 65 years of age, dies during the insurance period, the company pays the insurance premium for the remainder of the contract period. This is however subject to the condition that the insurance has been in force for 24 months at the time of death.

Chapter 8. General Provisions

Art. 15. Commencement and term of insurance

The insurance is valid from the date of issue stated on the insurance certificate and renews annually until the time specified on the insurance certificate, up to a maximum of the insured's 26th birthday. The company does not insure children under 1 month of age.

The insurance pays benefits for illness, accident, injury, or trauma of the insured that is diagnosed during the insurance period. The insurance therefore does not cover losses attributable to illnesses, accidents, injuries, or traumas of the insured that occurred before the insurance came into effect or after it lapsed.

Art. 16. Where does the insurance apply?

The insurance applies in the Nordic countries. However, the insurance applies for up to one year if the insured moves away from the Nordic countries. Any change in the insured's place of residence must be notified in writing.

Art. 17. Limitations on entitlement to benefits

The insurance does not cover the following illnesses, syndromes, or conditions regardless of when the first symptoms appear:

- Haemophilia ICD10 D66 and D67
- Developmental disorders ICD10 F70–F99 (e.g. ADHD, autism, developmental delay, Asperger syndrome, Tourette syndrome)
- Epilepsy ICD10 G40
- Diseases of the central nervous system and muscular system ICD10 G11, G12, G60, G71, and G80 (e.g. cerebral palsy, muscular dystrophy)
- Conductive and sensorineural hearing loss ICD10 H90

- Congenital disability or chromosomal abnormalities ICD10 Q00–Q99 (e.g. Down syndrome and malformed internal organs)
- Mental health disorders ICD10 F00–F69

The limitation on insurance coverage during stays abroad is set out in Art. 16. If the insured fails to notify a change of residence, this may affect the company's liability, cf. Art. 88 of the ICA.

Art. 18. Age-related limitations for those aged 16 and over

From the age of 16, the insurance does not cover accidents occurring in any type of motor sport, combat sport, mountaineering, rock climbing, abseiling, scuba diving, hang-gliding, gliding, parachuting, and/or comparable and related sports.

Art. 19. Intent or gross negligence

If a loss is attributable to the intent of the insured, the company's liability lapses, cf. however Art. 89 of the ICA.

If the insured causes a loss through gross negligence, this may result in a limitation or removal of the company's liability, cf. Art. 90 of the ICA. In assessing the company's liability, regard shall be had to the fault of the insured, the circumstances of the insured event, whether the insured was under the influence of alcohol or narcotics, and other circumstances.

Art. 20. Sum insured

The base disability sum insured is chosen on the insurance application and is stated on the insurance certificate. The sum insured is used to determine disability benefits, daily allowances for hospital stays, home care, and critical illness benefits, as further defined in these terms. The death benefit and the maximum amount for psychological services are stated on the insurance certificate.

A claim for benefits falls due 14 days after sufficient documentation of the company's liability has been received and the benefit amount can be determined. The company reserves the right to obtain the necessary and sufficient documentation before benefits are determined and paid.

Art. 21. Indexation of the sum insured and premium

The sum insured stated on the insurance certificate changes on the main due date each year in accordance with changes to the consumer price index from the base index. The base index is the consumer price index published in the month preceding the month of issue/main due date.

The premium changes in line with the change in the sum insured.

If the index decreases, this does not result in a reduction of the sum insured or the premium.

Art. 22. 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 pursuant to Art. 141 of the ICA within one year of receiving written notification of the rejection from the company.