Life and Critical Illness Insurance for Young People

Policy Terms L-19

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.

This insurance consists of a life insurance component and a critical illness insurance component for young people. It is available to individuals aged 18–39.

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 company's 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.

Children of the insured: The insured's biological children, foster children, and stepchildren, provided foster children or stepchildren share a registered domicile with the insured.

The company: 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 person designated by the policyholder in the insurance contract as the beneficiary of the life insurance, who is entitled to receive the sum insured after an insured event has occurred. Where a spouse is designated as beneficiary, this refers to the person the insured is married to. It does not refer to a cohabiting partner.

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

Chapter 1. Life Insurance for Young People

This insurance is a life insurance.

Art. 1. What does the insurance cover?

The company covers:

a. **Death benefit.** The company pays the beneficiary benefits if the insured dies during the term of the insurance.
b. **Child death benefit.** If a live-born child of the insured dies during the insurance period, the company pays a death benefit of ISK 750,000. Payment of benefits applies to children aged 18 and under and does not affect the insured's life insurance.
c. **Terminal illness.** The insured may, during the term of the insurance, request payment equivalent to the life insurance benefit if they are diagnosed with a terminal illness before the age of 39. Benefits are paid to the insured if they are diagnosed with an illness considered to be terminal before the end of the insurance period. It is assumed that the life expectancy of the individual in question is then considered to be less than six months. In determining whether the relevant conditions are met, the opinion of the insured's specialist physician, the opinion of the company's specialist physician, and comparable cases regarding the life expectancy of those diagnosed with a similar stage of the same illness are taken into account. The benefit under this item is the sum insured stated on the insurance certificate and is always equal to the life insurance sum. Upon payment, the life insurance lapses.

Art. 2. What does the insurance not cover?

The insurance does not cover:

a. death where the insured takes their own life within one year of the insurance coming into effect
b. death attributable to the consequences of an illness or condition that has manifested (i.e. symptoms or diagnosis) before the insurance came into effect and that the insured knew or ought to have known about upon signing the insurance contract, or after the insurance lapsed

Chapter 2. Critical Illness Insurance for Young People

This insurance is a critical illness insurance.

The scope of the insurance covers five specifically defined benefit categories, 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. Events other than the insured events or benefit categories listed in Art. 3 of these terms are not covered under this insurance.

Art. 3. 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.
    I. Cardiovascular diseases
    II. Stroke, paralysis, and loss of speech
    III. Cancer
    IV. Neurological and degenerative diseases

V. Other serious illnesses

It is a condition of entitlement to benefits under the critical illness insurance that the insured survives for at least 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 pursuant to these terms.

b. The company pays benefits if a child of the insured is diagnosed with the same illnesses as listed in point (a). If a child of the insured, aged from 3 months to 18 years, experiences an insured event as defined in point (a) during the insurance period, the company pays 50% of the critical illness insurance sum insured, up to a maximum of ISK 2,000,000, as further detailed in Art. 5. Payment of benefits under the children's critical illness insurance does not affect the insured's own critical illness insurance.

Art. 4. What does the insurance not cover?

The company does not pay benefits:

a. for cancer diagnosed within the first three months after the insurance came into effect
b. for consequences of an illness or condition that has manifested (i.e. symptoms or diagnosis) before the insurance came into effect and that the insured knew or ought to have known about upon signing the insurance contract, or after the insurance lapsed. The same applies to the children's critical illness insurance.
c. for illnesses or events attributable to the consequences of treatments and/or procedures for which benefits have previously been paid under the insurance
d. if the cause of the insured event can be traced to a medical condition that an adopted child had before being adopted. 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.

Benefits are paid from only one benefit category per insured event. Payment is made only once from each benefit category and the insurance lapses in its entirety once payment has been made from three benefit categories.

Art. 5. Determination of benefits

Benefits are paid to the insured only once from each benefit category (I–V) as listed in Art. 3.

Benefits under the children's critical illness insurance are also paid only once per child even if more than one critical illness insurance policy based on these terms is in force with the company and thus more than one insured person is covered. Benefits can never exceed 50% of the sum insured stated on the insured's certificate. 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.

I. Cardiovascular Diseases

Art. 6. 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
d. payment of benefits is conditional on the acute myocardial infarction meeting all three of the above criteria upon diagnosis. Excluded under this definition are:
    - myocardial infarction without ST elevation (NSTEMI), with elevation of Troponin I or T
    - other acute coronary syndromes

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

Art. 7. 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. 8. Heart Valve Surgery – Replacement or Repair

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

Art. 9. 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. 10. 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. 11. 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. 12. 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. 13. 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. 4(a)

IV. Neurological and Degenerative Diseases

Art. 14. 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. 15. Motor Neurone Disease (MND)

An unambiguous diagnosis of MND. The diagnosis must be confirmed by a specialist in neurology.

Art. 16. Alzheimer's Disease

An unambiguous diagnosis of Alzheimer's disease. 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. 17. Parkinson's Disease

An unambiguous diagnosis of idiopathic Parkinson's disease. 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. 18. 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. 19. Major Organ Transplantation

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

Art. 20. 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. 21. Third Degree Burns

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

Art. 22. Loss of Limbs

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

Art. 23. 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. 24. HIV Infection through Blood Transfusion, Physical Assault, or in the Performance of Certain Duties

The insured contracts HIV or is diagnosed with AIDS 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 HIV infection 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. 25. 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. 26. 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. 27. 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 3. Maternity and Parental Protection

The 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. 28. 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.** 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 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. 29. 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. 30. 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. 28 and 29 of the insurance
b. antenatal or postnatal depression (F53.0)
c. pregnancy loss before 14+0 weeks of gestation (O01–O03, O36.4) or pregnancy termination following a diagnosis of a serious foetal abnormality (ICD O28)
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 4. General Provisions

Art. 31. When does the insurance come into effect?

The company's liability commences on the date of issue, when it has received and approved the signed application with the necessary supporting documents pursuant to the company's procedures, unless otherwise agreed.

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 39. The company does not insure individuals under the age of 18, cf. however Art. 3(b).

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. 32. Where does the insurance apply?

The insurance applies anywhere in the world.

Art. 33. Beneficiary of the sum insured

The insured is the beneficiary of benefits under the critical illness component of the insurance.

If the policyholder has not designated a beneficiary in the life insurance component of the insurance, the provisions of Chapter XV of the ICA apply. The general rule is that benefits are paid to the spouse. If the insured does not leave a spouse, the sum insured passes to the insured's heirs pursuant to a will or the Inheritance Act no. 8/1962. In the event of death, the provisions of Chapter XV of the ICA apply.

Art. 34. 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. 35. Cancellation

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. 36. Duty to notify

In the event of a loss, the insured must notify the company without undue delay and attend an examination with the physician nominated by the company if the company deems this necessary. The beneficiary forfeits entitlement to benefits under this insurance if a claim is not made to the company within one year in the case of life insurance, or within two years in the case of critical illness insurance, from the date on which the beneficiary obtained knowledge of the circumstances on which the claim is based, cf. Art. 124 of the ICA.

Art. 37. Fraud and misrepresentation

If the policyholder or the insured has fraudulently or in a manner that cannot be considered immaterial failed to fulfil their duty of disclosure with regard to circumstances that are relevant to the company's risk assessment, this may result in the company's liability lapsing in whole or in part, cancellation of the contract, or an increase in the premium, cf. Chapter XIII of the ICA.

Art. 38. Right to reinstate life 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. In the case of life insurance, the insured may request reinstatement if the insurance has been in force for at least one year and the outstanding premium has been paid within three months of the expiry of the 14-day payment grace period following a reminder.

Art. 39. 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. Up to the age of 39, the premium increases on the main due date in accordance with the age of the insured.

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.

The company reserves the right to determine the renewal premium in accordance with a new premium schedule, taking into account general changes in risk.

Art. 40. Sum insured and right to increase the sum insured

The sum insured is a fixed amount chosen at the outset on the insurance application. 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 1,000,000 per benefit component of the insurance. The said increase has the same term as the insurance being increased. The sum insured may only be increased twice during the insurance period in connection with any of the above events, subject to the condition that the total sum insured does not exceed ISK 9,000,000.

The right to an increase lapses once a claim has been made under the critical illness insurance, or if 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, and the company reserves the right to request documentation to confirm this.

Art. 41. Benefit payments under the insurance contract

Upon the death of the insured, the company pays the beneficiary the sum insured in force on the date of death 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. 3, 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.

Art. 42. Obtaining documentation and paying costs

The company pays all reasonable costs of obtaining medical certificates that, in the company's assessment, are necessary for processing a claim for benefits under the insurance and that are obtained at the company's request.

Art. 43. 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.

The limitation period for benefit claims is governed by the provisions of Art. 125 of the ICA. Other claims related to the insurance contract, such as claims for premium, are time-barred in accordance with the general rules of Act no. 150/2007 on the limitation of claims.

Art. 44. 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.

Art. 45. Handling of disputes

Disputes regarding the insurance contract and the company's liability may be referred to the Insurance Complaints Committee. The policyholder can obtain further information about the Insurance Complaints Committee on the website of the Financial Supervisory Authority (fme.is) and the committee's website (www.nefndir.is).

Notwithstanding the remedy under the first paragraph, the parties are entitled to bring the dispute before the courts. Such cases shall be brought before the District Court of Reykjavík.

Art. 46. Domicile and jurisdiction

The company's domicile and place of jurisdiction is Reykjavík. Cases that may arise against the company in connection with this insurance shall be brought before the District Court of Reykjavík.

These terms are valid from 01.10.2022
Terms last updated 15.10.2025