Critical Illness Insurance S7

The Insurance Contract

This insurance is subject to the terms and conditions stipulated in the following documents:

- the Insurance Policy
- the Insurance Terms, i.e.:
  - any Special Terms that might be stated in the Insurance Policy
  - these Present Terms
- the Act on Insurance Contracts No. 30 of 2004.

The Insurance Policy contains further details of the Insurance Contract, which are not referred to in these Present Terms. The provisions of the Insurance Policy shall supersede any permissive legal clauses. The Insurance Policy Special Terms shall expand, restrict or modify the scope of this Insurance Contract beyond what is directly stated in these Present Terms. Above and beyond what may be stated in the Insurance Policy Special Terms, the provisions of these Present Terms shall apply to the Insurance Contract.

If there is any inconsistency between different provisions concerning the same subject matter, the provisions of the Insurance Policy shall supersede the Insurance Terms, and the Special Terms shall supersede any general provisions, provided, however, that specific rules shall at all times supersede general rules.

Definitions of concepts and terms

The insurer: Sjóvá Almennar líftryggingar hf.

Policyholder: The one entering into an agreement with the insurer.

The insured: The one whose health is insured.

Right of regret: The insured has 30 days to terminate the insurance after it enters into force. If the insurance is terminated within this period, the insured is obligated to pay a premium for the time that he was insured.

Beneficiary: Anyone having a claim for the payment of compensation.

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The Insurance Contract 1

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Article 1 Basis of the agreement

This agreement is based on information in the insurance application forms and other information related to the agreement, both at its original preparation and later.

Article 14 of these terms makes stipulations regarding the effect of violations of the duty to inform, fraud and the provision of wrong information about risk when taking out the insurance and when claiming for benefit payements.

Article 2 Entry into force

The insurer's liability begins when it has accepted a completed and signed application and other necessary information and certificates so that it is possible to issue a policy in accordance with the insurer's rules on risk assessment and reinsurance. A written agreement can be made about another effective date. The period of the insurance agreement is recorded on the insurance policy.

Article 3 Insurance coverage and benefit payments

The insurer pays out the benefit if a confirmed insurance event occurs in accordance with Article 4 of the terms. Critical Illness Insurance is a lump-sum payment insurance policy, and upon payment of benefit, it becomes invalid, although not upon payment in accordance with Article 5 of the terms.

Benefit is not paid to the insured unless an insurance event is confirmed during the validity period of the insurance.

If a disease is diagnosed after the insurance expires, no duty of compensation exists even though it could be argued that the disease existed while the insurance was still in force.

Benefit is not paid until a relevant medical specialist in Iceland as confirmed the diagnosis of the disease. The insurer pays the cost of obtaining medical certificates that it deems necessary to process the case, and which are obtained at its request. The insurer, without its prior approval, does not pay the costs of legal assistance or other costs incurred because of an insurance event.

Benefit is paid out within 14 days of when the insurer receives satisfactory information confirming its liability, and the benefit amount of compensation is based on the sum insured in force when the insurance event occurred, in accordance with Article 4 of the terms.

Interest on amounts of compensation is governed by Article 123 of Act No. 30/2004.

Article 4 Insurance event and definitions

An insurance event is only deemed to occur if the insured is diagnosed with one of the following diseases, and undergoes any of the procedures or suffers one of the events listed and defined below:

Heart Attack (Myocardial infarction)

The death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

1. a history of typical chest pain
2. new characteristic electrocardiogram changes
3. elevation of infarction specific enzymes, Troponins or other biochemical markers

Excluded are: Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T; other acute Coronary Syndromes.

Coronary Artery (Bypass) 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 bypass graft (CABG). The surgery must have been proven to be necessary by means of coronary angiography.

Excluded are: angioplasty and/or any other intra-arterial procedures; key-hole surgery.

Heart Valve Surgery

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Open heart valvuloplasty, valvulotomy or replacement of one or more heart valves. This includes surgery to the aortic, mitral, pulmonary or tricuspid valves for stenosis or incompetence or a combination of these factors.

Surgery of the Aorta

The actual undergoing of surgery for a chronic disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Stroke

Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of neurological deficit for at least 3 months has to be produced.

Excluded are: Transient ischemic attacks (TIA); neurological symptoms due to migraine.

Cancer

A disease manifested by the presence of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells, and the invasion of tissue. The diagnosis must be evidenced by definite histology. The term cancer also includes leukaemia and malignant disease of the lymphatic system such as Hodgkin's Disease.

Excluded are: any CIN stage (cervical intraepithelial neoplasia); any pre-malignant tumour; any non-invasive cancer (cancer in situ); prostate cancer stage 1 (1a, 1b, 1c); all skin cancers plus malignant melanoma stage IA (T1a N0 M0); any malignant tumour in the presence of any Human Immunodeficiency Virus.

Benign brain tumour

Removal of a non-cancerous growth of tissue in the brain under general anaesthesia leading to a permanent neurological deficit. Specifically excluded are all cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine.

Multiple sclerosis

Unequivocal diagnosis of Multiple Sclerosis by a consultant neurologist holding such an appointment at an approved hospital. The Insured must exhibit neurological abnormalities that have existed for a continuous period of at least 6 months or must have had at least two clinically documented episodes (each lasting at least 24 hours and occurring at least one month apart in different areas of the central nervous system). This must be evidenced by the typical symptoms of demyelination and impairment of motor and sensory functions as well as by typical MRI findings.

Motor neuron disease

Confirmation of definite diagnosis of Motor Neurone Disease (e.g. amyotrophic lateral sclerosis, primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, pseudo bulbar palsy) by a consultant neurologist holding such an appointment at an approved hospital. The disease must result in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or must result in a permanent bedridden situation and inability to get up without outside assistance. These conditions have to be medically documented for at least 3 months.

Major organ transplants

The actual undergoing of a transplantation as the recipient of a heart, lung, liver, pancreas, kidney, or bone marrow.

Kidney failure

End stage renal disease presented as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out.

Alzheimer's disease before the age of 60

Clinically established diagnosis of Alzheimer's Disease (presenile dementia) before age 60 resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to

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and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and the permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

Parkinson's disease before the age of 60

Unequivocal diagnosis of idiopathic or primary Parkinson's Disease (all other forms of Parkinsonism are excluded) before age 60 by a consultant neurologist holding such an appointment at an approved hospital. The disease must result in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or must result in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

Serious burns

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

Loss of limbs

Total and irrecoverable severance of two or more limbs from above the elbow/wrist or knee/ankle joint as the result of an accident or of a medically required amputation

Blindness

Total, permanent and irreversible loss of all sight in both eyes as a result of sickness or accident. The diagnosis has to be confirmed by an ophthalmologist.

Article 5 Children's health insurance

The insurer pays compensation for an insurance event befalling the children of the insured during the validity period of the insurance, in accordance with the age limits specified below. In accordance with the same definition, the insurer is also liable for the insured's foster children and stepchildren who have the same domicile and residence as the insured.

An insurance event is only deemed to occur if the insured is diagnosed with one of the following diseases, and undergoes any of the procedures or suffers one of the events listed and defined in Article 4:

The following age limits apply to children's critical illness insurance:

a. children between the ages of 3 months and 17 years are insured for the following insurance events under Article 4 of the terms: cancer – benign brain tumours – serious burns

b. children aged 2 to 17 are insured for insurance events under Article 4 of the terms.

Children's Critical Illness insurance benefit is 50% of the insurance amount of the insured up to a maximum of ISK 6,800,000 for each child. The benefit for the same child can never be higher even though more than one insurance policy is in effect with the insurer that the child could induce a right to benefit payment from, and benefit is then paid in proportion to the insurance amounts.

The payment of benefits from the insurance for children, foster children and stepchildren of the insured does not affect the insurance amount or validity of the insurance. Benefit for each child is paid only once.

Benefit is not paid for children, foster children or stepchildren of the insured unless an insurance event occursduring the validity period of the insurance. If a disease is diagnosed after the insurance expires, no liability exists even though it could be argued that the disease probably existed while the insurance was force.

Benefit is not paid for diseases or procedures that can be provably traced, directly or indirectly, to a child's condition before the above-specified age limits or before the insurance was taken out or reinstated.

Benefit is not paid for adopted children if the cause of the disease or procedure can be attributed to the child's condition before it was adopted. The same applies to stepchildren and foster children.

It is a condition of liability for compensation that children, foster children or stepchildren live for at least thirty days from the date of diagnosis of a disease or a medical procedure, leading to liability for benefit payment.

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Reference is made to Articles 3, 4, 6 and 7, as relevant, for more details concerning the payment and scope of compensation and limitations.

Article 6 The insured causes an insurance event

Intention

If the insured has intentionally caused an insurance event to occur, the insurer has no liability, cf. Article 89 of Act No. 30/2004.

Article 7 Limitations on the duty of payment

Other diseases, procedures and instances than those listed as insurance events in Article 4 are not payable under this insurance. Benefit is not paid if the party involved undergoes a coronary artery procedure or is diagnosed with cancer, multiple sclerosis or myocardial infarction in the first three months after taking out the insurance or upon reinstatement of the insurance. Benefit from this insurance because of the insured is paid to him only once. Benefit from children's critical illness insurance, cf. Article 5, is paid to the insured only once for each child.

A condition for payment of benefit is that the insured lives for at least thirty days from the date of diagnosis or medical procedure falling under the definition of insurance events.

Article 8 Waiver of premium

If the insured losses at least half of his ability to work during the validity period of the insurance because of an accident or disease, he acquires the right to a proportional decrease in premiums while this condition lasts. A waiver of premium can be applied for six months after the loss of ability to work started and may continue in force to age 65. Complete loss of ability to work conveys the right to complete waiver of the premium, while a decrease in working ability by 50% or more conveys the right to a proportional decrease of the premium.

A request for a waiver of premium shall be received by the insurer in writing on the appropriate form along with necessary information for the assessment of disability, at no cost to the insurer. The insurer will base the evaluation of disability on the insured's ability to do his work and the possibility of doing other jobs.

A waiver of premium is never granted for a period longer than one year prior to when a request regarding it was received by the insurer. While the insured enjoys a waiver of premium, he is obligated to provide the insurer with necessary information on his health in addition to other information and undergo necessary medical examinations at the insurer's expense. The insured is obligated to notify the insurer as soon as he has regained his ability to work in whole or in part.

The insured does not acquire a right to waiver of premium if his ability to work is diminished, directly or indirectly, because of:

a. War, riot, turmoil, strike procedures or other comparable events. The same applies to any kind of damage caused by nuclear energy, ionized radiation and radioactive substances.

b. Terrorist acts because of any kind of biological or chemical effects and/or poisoning, including from bacteria and viruses.

c. Disease that existed or had exhibited symptoms before entry into force of the insurance or because of the consequences of an accident occurring before entry into force of the insurance.

If the cause of the loss of work energy can be attributed to behaviour that is evaluated as the life-insured's gross negligence or design, such as the misuse of alcohol, addictive drugs or toxic substances or participation in a criminal act, the insured does not acquire a right to waiver of premium. If purposeful behaviour is involved, the insurer has no liability, cf. Article 89 of Act No. 30/2004. If gross negligence is involved, the insurer's liability may be decreased or cancelled, cf. paragraph 1 of Article 90 of Act No. 30/2004.

The provisions of Article 14 on the violation of the duty to inform, fraud and wrong information also apply, as relevant, to waiver of premium.

The insurer will notify the policyholder in writing of its decision on waiver of premium.

In other respects, the general provisions of the terms of the insurance apply to waiver of premium, as applicable.

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Article 9 Right to increase insurance amount without health declaration

If a premium for critical illness insurance is determined without a premium surplus, the insured can apply in writing for an increase in the insurance amount during the validity period of the insurance without further information about his health within three months of when either of the following events occurs:

a. The insured has a child or

b. the insured adopts a child younger than 18.

The maximum increase in the insurance amount is 25% of the amount, but up to a maximum of ISK 2 million, although so that the total amount of the insured's health insurance does not exceed ISK 12,000,000.This right of increase is cancelled at age 45 on the insured's birthday.

Upon increase of the insurance amount, the insured's premium increases in accordance with the insurer's premium tariff. This right cannot be utilized if a claim for benefit payment has been made under Article 4, or if the insured has been diagnosed with one of the diseases, undergone or is awaiting a procedure, has suffered one of the events defined in Article 4, or if the insured has a serious accident during the agreement period.

Article 10 Premium payment date – arrears – settlement upon dissolution of the agreement during the insurance period

Premium

The policyholder shall pay a premium to the insurer. A premium is determined by the insurer's current premium tariff. The first premium's payment date is the date that the insurance enters into force. Later premium payments are due on the first day of each renewal period. The grace period shall be at least one month from the day that the insurer sent a notice of payment to the policyholder.

A demand for payment of premium will be sent to the policyholder at the address he has notified the insurer of. Sending a notice or a payment slip is the equivalent of a demand for payment.

The insurer shall be notified immediately of changes of address.

Arrears

If a premium is not paid at the end of the grace period, the insurer can send a new notice demanding payment within 14 days. If the premium is not paid within 14 days from the date of the notice, the insurance is immediately cancelled, cf. Article 96 of Act No. 30/2004.

If the insured wishes to reinstate the insurance, he must fill out a new application that the insurer evaluates each time.

Settlement if agreement is dissolved during the insurance period

If an insurance agreement that shall be valid for one year or longer is terminated during the insurance period, the insurer has a right to a proportional premium, based on the time that the insurance was in force. This does not apply when an insurance event has occurred during the insurance period that conveys a right to payment of the insurance amount. Nevertheless, premium for the first three months after issue of the insurance are non-refundable.

Article 11 Indexation clause

Within each insurance year the insurance amount changes quarterly accordance with changes in the consumer price index for indexation. Calculation is based on the monthly index before the insurance or an increase of the insurance amount enters into force.

If the index decreases, this does not decrease the insurance amount. The premium is dependent on age, sex, and smoking or non-smoking, and is subject to change upon renewal of the contract. If premium is paid more than once a year, later payments increase in proportion to the insurance amount.

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Article 12 Changes in the premium and changes based on the insurance

The first premium for the insurance is calculated according to the insurer's current premium tariff, based on the insurance amount and age of the insured when the insurance enters into force.

For critical illness insurance with an age-related premium, the premium increases on the main payment date each year until the insured reaches age 55, in accordance with the insurer's premium tariff. At the age of 56, the insurance amount decreases on the main payment date each year, and the decrease is based on the premium remaining unchanged in real terms.

The insurer reserves the right to change the premium tariff if there is a general increase in risk, or the general assumptions of the insurance prove to be other than those estimated in the actuarial model for the insurance. All such changes would be submitted to the Financial Supervisory Authority, Iceland, before entering into force.

Article 13 Right to terminate during the insurance period

The insurer can terminate the insurance if any of the following events apply:

1. If wrong or inadequate information about the risk has been provided, with a 14-day notice, cf. Articles 84 and 76 of Act No. 30/2004;
2. If a policyholder has acted fraudulently in providing information to the insurer about risk, without notice, cf. Articles 84 and 76 of Act No. 30/2004;

The policyholder can terminate the agreement at any time in accordance with paragraph 1 of Article 75 of Act No. 30/2004. The cancellation shall be done in writing.

Article 14 Violation of the duty to inform – fraud and wrong information

Information about risk

If the policyholder or the insured fraudulently neglects the duty to inform of an event that could be significant for the insurer's evaluation of risk, and an insurance event has occurred, the insurer has no liability, cf. paragraph 1 of Article 83 of Act No. 30/2004.

If the policyholder or the insured have otherwise neglected the duty to inform to an extent deemed not immaterial, the insurer's liability is cancelled in whole or in part, cf. paragraph 2 of Article 83 of Act No. 30/2004.

Information upon settlement of benefits

One who purposely provides wrong or inadequate information when settling insurance benefits loses all rights vis-a-via the insurer under this and other insurance agreements because of the specified insurance event, cf. paragraph 2 of Article 120 of Act No. 30/2004. In such instances, the insurer can terminate all of its insurance agreements with the party involved with one week's notice.

Article 15 Beneficiaries

The insured is a beneficiary unless otherwise specified in the insurance policy or premium payment receipt.

Article 16 Period for notification of an insurance event

The insured loses his right to compensation if:

1. He does not notify the insurer of his claims within a year from when he knew of the incident on which the claim is based.
2. He has not filed a suit or demanded that the case be addressed by the Insurance Complaints Committee within a year from when he obtained written notification that his claim was rejected, cf. Article 124 of Act No. 30/2004.

Article 17 Expiration of claims

Claims under this insurance for damages expire under the rules of Article 125 of Act No. 30/2004.

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Article 18 Dispute

If a dispute arises regarding the insurance, an Icelandic court shall rule on it under Icelandic law, unless an international agreement obligating Iceland requires otherwise.

A dispute about the insurer's liability to pay compensation, including the culpability and division of culpability of liable parties, can be submitted to the Insurance Companies' Complaints Committee. The parties incur no cost for the committee's handling of the case. By paying an appeals fee, a dispute over liability to pay compensation, culpability and division of culpability, in addition to a dispute over aspects of the provisions of Act No. 30/2004 on insurance agreements, can be submitted to the Insurance Complaints Committee, which is housed at the Financial Supervisory Authority, Iceland. An appeals application form for the Complaints Committee can be obtained from the insurer, in addition to information about the purview and procedures of the committees.

Handling of the case before these committees does not diminish an appellant's right to submit the case to general courts.

Article 19 Venue

The insurer's venue is in Reykjavík. Cases arising against the insurer because of this insurance shall be conducted before the District Court of Reykjavík.

Article 20 Duty of confidentiality – protection of personal information

Information about the insurance is treated confidentially.

Under the Act on the Data Protection Authority and handling of personal information, no. 77/2000, the one whose information is recorded has the right to obtain information from the insurer on the processing of his personal information. In addition, he has the right to have the insurer correct wrong, misleading or defective information.

The insurer uses the personal information gathered because of this insurance only in assessing the application for the insurance, for the purpose of evaluating the need for insurance protection and advising the policyholder on selection of the insurance, processing demands for benefits, providing information to the policyholder and for other normal business activities.

The insurer heavily emphasizes the security and confidentiality of the handling of personal information. Information about the insurer's clients is not delivered to a third party unless in accordance with a clear power of attorney, the law or a court judgement.

This document is an English translation of the original Icelandic insurance terms. In case of any discrepancy between this translation and the Icelandic terms, the Icelandic terms shall apply. These conditions enter into effect as of 1st March 2007.

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