Forenede Gruppeliv

# Cover on certain critical illnesses

## The terms of insurance are valid as from 1 January 2017 and replace the previous terms of 1 January 2016

*The following is a translation of an original Danish document. The original Danish document is the governing document for all purposes, and in case of any discrepancy, the Danish wording will be applicable.*

**Clause 1.** The below terms and conditions are applicable for the insurance together with FG's group life agreements and terms of insurance.

The insurance covers the illnesses/diagnoses described in clause 7 A-X.

When a diagnosis has been made as required under the terms of insurance, the insurance sum may be paid out.

The terms of insurance and the insurance sum applicable at the date of the diagnosis will be applied and paid out.

**Clause 2.** For the insurance to cover a critical illness, it is a condition that the insured person is diagnosed during the policy period. Please note that it is the date of the diagnosis being made and not the date at which the insured person has been made aware of the diagnosis that is the decisive factor. The policy period is stipulated in the group life agreement.

**The insurance does not cover the critical illnesses mentioned in clause 7 which the insured person has been diagnosed with or treated for before the inception date of the insurance, cf. however cancer in clause 7 A.**

**Clause 3.** It is stated in the group life agreement whether the cover on a critical illness will cease upon payment of an insurance sum on a critical illness, see below under a), or whether the critical illness will still be covered by the insurance, see below under b):

a) If payment has been made in accordance with clause 7, the insured person's right to further payment in case of critical illness will be terminated.

b) If payment has been made in accordance with clause 7, the insurance no longer covers the diagnosis or diagnoses which caused an insurance sum on critical illness to be paid out, cf. however cancer in clause 7 A.

It is a condition for the payment of more than one insurance sum that at least six months have elapsed between the date when the latest covered diagnosis was made and the time when the new diagnosis was made. If payment of compensation was made based upon acceptance to the waiting list for surgery, the six months' period of time will be counted only as of the date of surgery.

**Clause 4.** If the insured person dies during the set-off period established in the group life agreement, the sum paid on critical illness will be set off against the cover on death.

**Clause 5.** The right to receive the agreed insurance sum in connection with critical illness will be terminated upon the death of the insured person unless the insured person has made a written request for compensation to FG.

**Clause 6.** If the insured person has retired from the group life agreement, or if the group life agreement has been terminated as a consequence of notice or otherwise, a written request for payment is to be presented to FG within six months upon the expiry of the policy period. Upon expiry of this time limit, the right of payment of an insurance sum for an unreported critical illness will lapse.

**Clause 7.** Critical illness comprises any of the following:

### A. Cancer

A malignant tumour which is microscopically characterised by the uncontrolled growth and spread of malignant cells, and the invasion of normal surrounding tissue, and clinically by a tendency of local recurrence and spreading to regional lymph nodes or other organs (metastases).

Moreover, the following diseases in the blood, lymphs or the haematopoietic cells of the bone marrow are covered:

- Acute leukaemia
- Chronic myeloid leukaemia
- Multiple myeloma
- Lymphoma (cancer of the lymph nodes)
- Hodgkin's disease stages II-IV
- High-risk myelodysplastic syndrome (MDS)
- Chronic myelomonocytic leukaemia (CMML)

and

- Chronic lymphatic leukaemia stages III and IV (high risk/stage B and C) requiring treatment
- Essential thrombocytosis
- Polycytaemia vera
- Myelofibrosis

"Requiring treatment" means illnesses requiring cytocidal treatment (incl. chemotherapy and radiation therapy) for the illness. Treatment with acetyl-salicylic acid or blood-letting are not considered citocidal treatment.

Moreover, malignant melanoma (birthmark cancer) is covered.

The diagnosis is considered to have been made when a histological or cytological examination has been performed by a specialist in pathological anatomy. For cancer types where it is required that the illness requires treatment, diagnosis is considered to have been made at the date in the medical records from a department of onchology or heamatology that there are therapeutic indications for the illness.

The cover does not comprise:

- Initial stages of cancer (dysplasia and carcinoma in situ), for instance in the cervix, breast or testes
- Borderline changes
- All types of skin cancer
- Kaposi's sarcoma
- Benign papilloma of the urinary bladder
- Initial stages of cancer in the blood, lymphs or the haematopoietic organs

If the insured person has been diagnosed as suffering from cancer before the inception date of the insurance, and a minimum of 10 years have elapsed without the insured person being diagnosed with cancer, the insured person may claim compensation on the diagnosis of another cancer disease.

Payment can be made for up to two cancer diagnoses where the diagnoses are made in the policy period and that meet the requirements of clause 7 A. For the insurance to cover the second cancer diagnosis, it is a condition that at least 10 years have past since the first cancer diagnosis in the policy period was made.

It is also a condition for the second payment that no relapse has been identified (recurrence) in connection with the cancer diagnosis in the 10-year period.

## B. Coronary thrombosis (coronary infarction)

An acutely arisen necrosis of the cardiac muscle as a result of insufficient supply of blood to the regional part of the heart.

The diagnosis must be provable and based on:

- Significant increase and decrease in blood levels (troponins and CK-MB)

Together with at least one of the following criteria:

- Anamnesis with typical continuous chest pain, or
- Simultaneously arisen electrocardiographic changes compatible with the diagnosis acute myocardial infarction

The diagnosis is considered to have been made when the above conditions have been met and a specialist in cardiology has made the diagnosis coronary thrombosis (coronary infarction).

If the insured person has previously been diagnosed, cf. clause 7 C (bypass surgery or balloon angioplasty) and/or cf. clause 7 W (implantation of ICD unit) and/or cf. clause 7 W (chronic heart failure), the insured person is not entitled to payment under clause 7 B.

## C. Bypass surgery or balloon angioplasty of coronary thrombosis (arteriosclerosis)

Performed heart surgery of arteriosclerosis (revasculisation), including one or more coronary arteries with application of vein and/or artery grafts or performed balloon angioplasty of one or more coronary arteries.

On bypass surgery, the insured person may claim compensation if the insured person has been accepted on the waiting list.

On balloon angioplasty, the surgery must have been performed.

The diagnosis is considered to have been made at the date of surgery. On planned bypass surgery, the diagnosis is considered to have been made at the date that the insured person was accepted on the waiting list.

If the insured person has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or cf. clause 7 W (implantation of ICD unit) and/or cf. clause 7 W (chronic heart failure), the insured person is not entitled to payment under clause 7 C.

## D. Heart valve surgery

Planned or performed heart surgical treatment of heart valve diseases with implantation of artificial, mechanical or biological heart valve prostheses and homograft or plastic surgery of the heart valve.

In connection with planned surgery, the insured person must have been accepted on the waiting list.

The diagnosis is considered to have been made at the date of surgery. In connection with planned surgery, diagnosis is considered to have been made at the date when the insured person is accepted on the waiting list.

## E. Cerebral haemorrhage/thrombosis (stroke)

Acute lesion of the brain or the brain stem causing simultaneously occurring objective neurological symptoms of malfunction of a duration of more than 24 hours as a consequence of an infarction caused by an embolism or a thrombosis, by a haemorrhage or by an intra-cerebral haematoma. Results of a brain scan (CT or MR) with findings compatible with the above diagnosis must be available.

If a thrombosis has not been verified by a brain scan (CT/MR), the diagnosis will be covered if all the classical signs of a thrombosis are present with permanent objective neurological symptoms of malfunction in the form of paralysis, speech disorder, visual disturbance or intellectual reduction.

The objective neurological symptoms of malfunction may be assessed after three months at the earliest.

The diagnosis is considered to have been made when the above conditions have been met and a specialist in neurology has confirmed objective neurological symptoms of malfunction and diagnosed the insured person with apoplexy.

The cover does not comprise:

- Transient cerebral ischemia (TCI)/Transient ischemic attack (TIA)
- Brain infarctions detected by chance at a brain scan (CT/MR), for instance when diagnosing another illness
- Thromboses or haemorrhages in the peripheral part of the nervous tissue, i.e. outside the brain, for instance in the eyes and ears

## F. Sacculate aneurysm of the brain arteries (intracranial sacculus aneurysm) or intracranial arteriovenous vascular malformation (AV malformation) and cavernous angioma in the brain

Planned or received surgery for sacculate aneurysm of the brain arteries, intracranial arteriovenous vascular malformation or cavernous angioma which must have been detected by means of X-ray examination of the brain arteries (angiography) or CT/MR scan.

Cover also includes instances where there are indications for surgery but where surgery cannot be performed due to technical reasons.

The diagnosis is considered to have been made at the date of surgery. In connection with planned surgery, diagnosis is considered to have been made at the date when the insured person is accepted on the waiting list. If surgery is not technically feasible, diagnosis is considered to have been made at the date in the medical records from a department of neurology or thoracic surgery showing that there are indications for surgery but that surgery is not technically feasible.

## G. Certain benign tumours in the brain and the spinal cord

Benign tumours in the brain, brain stem, the spinal cord or the membranes of these organs (central nervous system) which are either

- (radically) inoperable or
- which after radical surgery leave sequels in the nervous system resulting in a degree of impairment of at least 15% in accordance with Arbejdsskadestyrelsen's (the Danish National Board of Industrial Injuries) impairment table. The degree of impairment may be assessed three months after the surgery at the earliest or
- where there are indications for surgery but where surgery cannot be performed for technical reasons.

The diagnosis is considered to have been made at the date of surgery. If surgery is not technically feasible, diagnosis is considered to have been made at the date in the medical records from a department of thoracic surgery showing that there are indications for surgery but that surgery is not technically feasible.

The cover does not comprise:

- Cysts or granulomas
- Schwannomas/neurinomas, including acousti neuromas
- Adenomas of the pituitary gland

## H. Multiple sclerosis

A chronic disease which is clinically characterised by continuous attacks of neurological symptoms of malfunction from various parts of the central nervous system.

The diagnosis must be provable by one or more well-defined attacks of symptoms compatible with a diagnosis of multiple sclerosis. Moreover, primary progressive sclerosis is covered. The diagnoses must be confirmed by at least one of the following three examinations:

- Increased IgG index or oligoclonal bands in the cerebrospinal fluid
- Extended latency on VEP (not sufficient if clinically there is only affection of the optic nerve)
- Typical changes at MR scan of the central nervous system with multiple affections of the white matter.

The diagnosis is considered to have been made when the above conditions have been met and a specialist in neurology has diagnosed the insured person with multiple sclerosis.

## I. Motor Neurone Disease (MND)

Motor Neurone Disease (MND) of one of the following types:

- Amyotrophic Lateral Sclerosis (ALS)
- Progressive Bulbar Palsy (PBP)
- Progressive muscular atrophy (PMA)
- Primary Lateral Sclerosis (PLS)

The diagnosis is considered to have been made when a specialist in neurology has diagnosed the insured person with one of the covered diagnoses.

## J. Certain muscular diseases and nervous disorders

Progressive muscular dystrophy of one of the types:

- Facio-scapulohumeral Dystrophy
- Limb-Girdle Muscular Dystrophy
- Myaestenia Gravis
- Hereditary Motor Sensory Neuropathy (previously known as Charcot-Marie-Tooth Disease) or
- Inclusion Body Myositis.

The diagnosis is considered to have been made when a specialist in neurology has diagnosed the insured person with one of the covered diagnoses.

## K. HIV infection as a result of a blood transfusion or infection caused by occupational transmission

HIV infection as a result of a blood transfusion performed after the inception date of the insurance.

Only individuals who have been found to be entitled to compensation for transfusion-transmitted HIV infection by Sundhedsstyrelsen (the Danish National Board of Health) meet the requirements for payment of the insurance sum.

Moreover, individuals who develop an HIV infection when performing their professional occupation due to occupational lesions or mucous membrane exposure are included.

To prove transmission, the accident must have been reported as an industrial injury and presented together with a negative HIV test performed within the first week after exposure and followed by a positive HIV test performed within the next 12 months.

The diagnosis is considered to have been made when the above conditions have been met and a specialist in infectious diseases has diagnosed the insured person with HIV.

## L. AIDS

A disease in the immune system caused by an infection by human immunodeficiency virus (HIV).

The diagnosis must meet the Danish National Board of Health's criteria for notification in relation to AIDS.

The diagnosis is considered to have been made when the above condition has been met and a specialist in infectious diseases has diagnosed the insured person with AIDS.

If the insured person was diagnosed with HIV before the inception date of the insurance, the insured person cannot claim compensation pursuant to clause 7 L.

## M. Chronic renal failure

End stage renal failure with a chronic irreversible failure of both kidneys resulting in either permanent dialysis or a kidney transplant.

In connection with planned kidney transplant with cadaver kidney, the insured person must have been accepted on the active waiting list.

The diagnosis is considered to have been made when permanent dialysis has been commenced.

In connection with kidney transplant from a living donor, diagnosis is considered to have been made at the date of the transplant, and in connection with kidney transplant with cadaver kidney, the diagnosis is considered to have been made at the date of acceptance on the active waiting list.

## N. Major organ transplants

Planned or performed organ transplant, including heart, lung, liver or stem cells/bone marrow where the insured person is the organ recipient.

In connection with planned organ transplant, the insured person must have been accepted on the active waiting list.

The diagnosis is considered to have been made at the date of the transplant. In connection with planned organ transplant, diagnosis is considered to have been made at the date when the insured person is accepted on the active waiting list. In connection with organ transplant with autologous stem cells/bone marrow, diagnosis is considered to have been made at the date of the transplant.

## P. Parkinson's disease (paralysis agitans)

Primary Parkinson's disease with the principal symptoms of muscle rigidity, tremor or poverty of movement. Symptoms of Parkinson's disease secondary to treatment with psychopharmacological drugs are not covered.

The diagnosis is considered to have been made when a specialist in neurology has diagnosed the insured person with Parkinson's disease (paralysis agitans).

The diagnosis is covered as from 1 January 2002.

## Q. Blindness

Total and irreversible loss of vision in both eyes, the visual power of the better eye being 1/60 or less.

The diagnosis is considered to have been made when a specialist in eye diseases has assessed and confirmed the loss of vision in the medical records.

The diagnosis is covered as from 1 January 2002.

## R. Deafness

Total and irreversible hearing loss in both ears with a hearing threshold of 100 db or more on all frequencies.
The diagnosis is considered to have been made when a specialist in audiology has assessed and confirmed the loss of hearing in the medical records.

The diagnosis is covered as from 1 January 2002.

## S. Diseases of the aorta (diseases of the great artery)

Local dilation of the aorta (aorta aneurism) of more than 5 cm in diameter, aorta rupture or aortic dissection with a rupture in the inner layers of the aorta and bleeding in the aortic wall or total aortic occlusion.

The term aorta includes both the thoracic and abdominal aorta but not its branches.

The diagnoses aorta aneurism and aortic dissection are considered to have been made when provable by either:

- ultrasound
- echocardiography
- CT/MR scan or
- aortography.

In connection with total aortic occlusion, the diagnosis is considered to have been made when provable by clinical findings and aortography or MR angiography.

The diagnosis is covered as from 01 January 2005.

## T. Sequels to encephalitis or meningitis

Persistent neurological sequels to infection of the brain, nerve roots of the brain or meninges caused by bacteria, viruses or fungi. The persistent neurological sequels must have entailed a degree of impairment of at least 8% in accordance with Arbejdsskadestyrelsen's (the Danish National Board on Industrial Injuries) impairment table.

Diagnosis must be made based on:

- detection of microorganisms in spinal fluid or
- examination of the spinal fluid with detection of apparent inflammatory reaction (pleocytosis), including an increased number of leucocytes and protein and supplemented by CT/MR scan, if relevant

The degree of impairment cannot be assessed until at least three months after the examination of the spinal fluid showing encephalitis or meningitis. The degree of impairment must have been assessed and confirmed by a specialist in neurology or infectious diseases.

When the above conditions have been met, the diagnosis is considered to have been made three months after the date of the examination of the spinal fluid showing encephalitis or meningitis.

The diagnosis is covered as from 01 January 2005.

## U. Sequels to Borrelia infection or Tick-Borne Encephalitis (TBE)

Prolonged or chronic neuroborreliosis following a tick bite that has lead to persistent neurological sequels. The persistent neurological sequels must have entailed a degree of impairment of at least 8% in accordance with Arbejdsskadestyrelsen's (the Danish National Board on Industrial Injuries) impairment table.

Diagnosis must have be made based on examinations of the spinal fluid with borrelia-/TBE-specific antibody assays.

The degree of impairment cannot be assessed until at least three months after the examination of the spinal fluid showing Borrelia infection or Tick Borne Encephalitis (TBE).

The degree of impairment must have been assessed and confirmed by a specialist in neurology or infectious diseases.

When the above conditions have been met, the diagnosis is considered to have been made three months after the date of the examination of the spinal fluid showing Borrelia infection or Tick Borne Encephalitis (TBE).

The diagnosis is covered as from 01 January 2005.

## V. Severe burns, frostbites or corrosive burns

Third-degree burn injuries, frostbites or corrosive burns covering at least 20% of the insured person's body.

The diagnosis is considered to have been made when the above conditions have been met and the medical records include an assessment and confirmation from a burn unit.

The diagnosis is covered as from 01 January 2007.

## W. Implantation of ICD unit (heart starter) as secondary prophylaxis

Performed implantation of implantable cardioverter defibrillator (ICD) due to documented previously life-threatening arrhythmia (secondary prophylaxis).

The diagnosis is considered to have been made at the date of surgery.

Implantation of an ordinary pacemaker is not covered.

If the insured person has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or cf. clause 7 C (bypass surgery or balloon angioplasty) and/or cf. clause 7 X (chronic heart failure), the insured person is not entitled to payment under clause 7 W.

The diagnosis is covered as from 01 January 2014.

## X. Chronic heart failure with implantation of ICD/CRT unit or durable mechanical heart device, e.g. Heartmate

Chronic heart failure with reduced ejection fraction (EF) in the left ventricle of 35% or lower despite optimised medical treatment. Implantation of an advanced pacemaker system (cardioverter defibrillator (ICD unit) or biventricular pacemaker (CRT unit)) or a durable mechanical heart device, e.g. Heartmate, must have been performed.

The diagnosis is considered to have been made at the date of surgery, when the above conditions have been met.

Implantation of an ordinary pacemaker is not covered.

If the insured person has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or cf. clause 7 C (bypass surgery or balloon angioplasty) and/or cf. clause 7 W (implantation of ICD unit), the insured person is not entitled to payment under clause 7 X.

The diagnosis is covered as from 1 January 2016; however, implantation of a durable mechanical heart device, e.g. Heartmate, is covered as from 1 January 2017.