Forenede Gruppeliv

Children's cover for certain critical illnesses

These insurance conditions are effective from 1 January 2023 and replace the previous conditions of 1 January 2020

The following is a translation of an original Danish document. The original Danish language version is the governing text for all purposes, and in case of any discrepancy, the Danish language version will prevail.

1. This insurance is subject to the following conditions in connection with FG's group life contracts and insurance conditions.

The insurance covers the illnesses, planned, or performed surgeries and after-effects of any illness listed in clause 6 A-N. Illnesses, surgeries and after-effects of illnesses are hereafter referred to as diagnoses.

Moreover, the insurance may include:

- Cover in the event of death, cf. clause 7, and/or
- Cover in the event of type 1 diabetes, cf. clause 8.

The group life contract states whether the insurance has been extended to cover death and/or type 1 diabetes.

When a diagnosis has been made according to clause 6 or 8, as required by the insurance conditions, the insurance sum may be paid out.

The insurance sum will be paid to the person insured under the group life contract ("the insured").

The insurance conditions to be applied and the amount to be paid out are the conditions and insurance sum applicable on the date when the diagnosis was made or on the date of death, as the case may be.

2. Unless otherwise provided in the group life contract, entitlement to payment commences if the child, after its date of birth and until its 18th birthday, is diagnosed with one of the listed illnesses or dies during the policy period. To be eligible for cover, the child must be born alive. The policy period is stipulated in the group life contract.

The insurance does not cover the diagnoses listed in clauses 6 and 8 if the child received, or received treatment for, any such diagnosis before the commencement of the policy period. Diagnoses covered under the provisions of clauses 6 A-N and 8 are considered as one diagnosis. "Extended cover for diagnoses listed in 6 A" applies to cancer.

The date of diagnosis is the determining date, and not the time when the insured or the child is informed about the diagnosis.

3. When a payment has been made under clause 6 or 8, the insurance will no longer cover the diagnosis or diagnoses that led to payment of the insurance sum for critical illness. Payment may only be claimed once for each of the provisions of clauses 6 A-N and 8. "Extended cover for diagnoses listed in 6 A" applies to cancer.

To be able to claim for more than one of the illnesses and diagnoses covered under clause 6 or 8, it is a condition that at least six (6) months have elapsed between the date of the last eligible diagnosis and the date of the new diagnosis. If the insurance has paid out on acceptance onto a waiting list, the six-month period will be calculated from the date of surgery.

4. The entitlement to payment of the insurance sum for critical illness and diabetes, respectively, ceases if no written request for payment has been presented to FG within six (6) months of the death of the child.

5. If the insured has withdrawn from the group life contract, or if the group life contract has ceased due to cancellation or for other reasons, a written request for payment must be presented to FG within six (6) months of the expiry of the policy period. At the expiry of this deadline, the entitlement to payment of the insurance sum for a critical illness that has not been reported will cease.

6. Critical illness means any one of the following conditions:

A. Cancer

1) Cancer with the exception of less aggressive forms

A malignant tumour which is characterised microscopically by abnormal cells and uncontrollable, infiltrative growth into surrounding tissue, and clinically by a tendency to local relapse and spread to regional lymph nodes or more distant organs (metastases).

The cover does **not** include:

- Pre-cancerous stages (dysplasia and carcinoma in situ)
- Borderline changes
- Cancer localised exclusively to the skin, with the exception of malignant melanoma
- Kaposi's sarcoma
- Benign papilloma of the urinary bladder
- Grade 1 neuroendocrine (carcinoid) tumours, with no sign of invasive growth or metastasis.

The diagnosis is considered definite when a specialist in examination of tissue samples (pathological anatomy) has made a diagnosis based on a microscopic examination of a tissue sample (biopsy), or optionally of a cell sample (cytology).

2) Cancer of the blood, lymphoid system or haematopoietic cells of the bone marrow

A malignant disease of the blood, lymphoid system or haematopoietic cells of the bone marrow, characterised by an atypical blood cell count with uncontrolled growth of blood cells and progression and with relapse tendency.

The cover comprises:

- Acute leukaemia
- Chronic myeloid leukaemia
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Hodgkin's lymphoma, stages II to IV
- High-risk myelodysplastic syndrome (MDS)
- Chronic myelomonocytic leukaemia (CMML)

The diagnosis of cancer is considered definite when a specialist in examination of tissue samples (pathological anatomy) has made one of the above diagnoses based on a microscopic and/or flow cytometric analysis of blood, bone marrow or other tissue.

If requiring treatment, the following conditions are also covered:

- Chronic lymphatic leukaemia (CLL)/small-cell lymphocytic lymphoma (SLL)
- Essential thrombocytosis
- Polycythaemia vera
- Myelofibrosis.

"Requiring treatment" means a disease requiring cytotoxic treatment (including chemotherapy, radiation therapy and biological treatment) of the disease. Treatment with acetylsalicylic acid, adrenocortical hormone and phlebotomy are not considered cytotoxic treatments.

In the case of cancer types for which it is mandatory that the disease requires treatment, the diagnosis is considered definite on the date on which a department of paediatric oncology or department of haematology has stated in the medical records that there is treatment indication for the disease.

The cover does **not** comprise:

- Pre-cancerous stages of cancer of the blood, lymphoid system or haematopoietic organs
- Lymphoma solely localised to the skin.

Extended cover for diagnoses listed in 6 A
If the child was diagnosed with cancer before the commencement of the policy period, and the child has been cancer-free for at least ten (10) years, the child will be entitled to payment if cancer is re-diagnosed during the policy period and meets the conditions of clause 6 A.

Payment may be claimed for up to two (2) cancer diagnoses made during the policy period, provided that such diagnoses meet the conditions of clause 6 A. However, to be able to claim for the second cancer diagnosis, it is a condition that at least ten (10) years have elapsed since the first cancer diagnosis was made within the policy period. A further condition for claiming a second payment is that no recurrence of the cancer was detected or no other cancer was diagnosed during the 10-year period.

B. Heart disease requiring surgery

Treatment for a heart disease by surgery or intervention via a blood vessel.

The heart disease must have been diagnosed at a department of cardiology or thoracic surgery.

Surgery or intervention via a blood vessel must have been performed subsequent to the child's birth and during the policy period.

The diagnosis is considered definite on the date of surgery.

C. Cerebral haemorrhage/thrombosis (stroke)

An acute lesion of the brain or brain stem combined with the onset of objective neurological deficit symptoms lasting more than 24 hours and resulting from an infarction caused by an embolism or a thrombosis, by a cerebral haemorrhage or by an intra-cerebral haematoma. Results of a brain scan (CT or MRI) with findings compatible with the above conditions must be available.

If a stroke is not verified by a brain scan (CT or MRI), the condition will be covered if the classic clinical signs of cerebral thrombosis are present and there are lasting objective neurological deficits in the form of paralysis or speech or vision impairment.

The objective neurological deficits can be assessed no sooner than three (3) months after the stroke.

When the above conditions are met and a specialist in neurology has confirmed objective neurological deficits and diagnosed a stroke, the diagnosis is considered definite on the date of hospitalisation at a neurological unit or on the date of initial consultation with a specialist in neurology in connection with the stroke.

The cover does **not** comprise:

- Transient cerebral ischaemia (TCI)/Transient ischaemic attack (TIA)
- Brain infarctions detected randomly by a brain scan (CT or MRI), for instance while examining for and diagnosing another illness
- Blood clots or haemorrhages in the peripheral part of the nervous tissue, i.e. outside the brain, for instance in eyes and ears.

D. Saccular aneurysm of the cerebral arteries (aneurysm) or intracranial arteriovenous vascular malformation (AV malformation) and cavernous angioma of the brain

Performed surgery for saccular aneurysm of the cerebral arteries, intracranial arteriovenous vascular malformation or cavernous angioma, which must be detected by x-ray examination of the cerebral arteries (angiography) or by a CT or MRI scan.

The cover also applies in cases where surgery is indicated, but where surgery cannot be performed for technical reasons.

Surgery must have been performed subsequent to the child's birth and during the policy period.

The diagnosis is considered definite on the date of surgery. If surgery is not technically feasible, diagnosis is considered definite on the date on which a neurological or neurosurgical department in medical records has stated that there is indication for surgery, but that surgery cannot be performed for technical reasons.

E. Certain benign tumours of the brain and spinal cord

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

- which are surgically removed, or
- where surgery is indicated, but where surgery cannot be performed for technical reasons.

Surgery must have been performed subsequent to the child's birth and during the policy period.

The diagnosis is considered definite on the date of surgery. If surgery is not technically feasible, diagnosis is considered definite on the date on which a neurolosurgical department in medical records has stated that there is indication for surgery, but that surgery cannot be performed for technical reasons.

The cover does **not** comprise:

- Cysts or granulomas
- Schwannomas/neuromas, including acoustic neuromas
- Adenomas of the pituitary gland.

F. Multiple sclerosis

A chronic disease clinically characterised by recurrent attacks, showing neurological deficits in various parts of the central nervous system.

The diagnosis must be documented by one or more well-defined episodes (attacks) of symptoms compatible with multiple sclerosis. Primary progressive sclerosis is also covered.

The diagnoses must be confirmed by at least one of the following three (3) examinations:

- Elevated IgG index or oligoclonal bands in the cerebrospinal fluid
- Prolonged VEP latency (not sufficient if there is clinical affection of the optic nerve only)
- Typical changes detected by an MRI scan of the central nervous system, showing multiple lesions in the white matter.

The diagnosis is considered definite when the above conditions are met and a specialist in neurology or a paediatric neurologist has diagnosed multiple sclerosis.

G. Chronic renal failure

Chronic irreversible failure of both kidneys, resulting in either permanent dialysis or a kidney transplant.

In the case of a planned cadaveric kidney transplant, the child must have been accepted onto an active waiting list.

The diagnosis is considered definite when permanent dialysis has been initiated.

In the case of a kidney transplant from a living donor, diagnosis is considered definite on the date of the transplant, and in the case of a planned cadaveric kidney transplant, the diagnosis is considered definite on the date of acceptance onto an active waiting list.

H. Major organ transplants

Planned or performed organ transplants, including heart, lung, liver, pancreas or stem cells/bone marrow, where the child is the recipient.

In the case of a planned organ transplant, the child must have been accepted onto an active waiting list.

The diagnosis is considered definite on the date of the transplant.

In the case of a planned organ transplant, it is the date of acceptance onto an active waiting list. In the case of a transplant with autologous stem cells/bone marrow, the diagnosis is considered definite on the date of the transplant.

I. After-effects of encephalitis or meningitis

Permanent neurological sequelae following an infection of the brain, cerebral nerve roots or meninges caused by bacteria, viruses or fungi.

The diagnosis must be based on:

- Detection of microbes in the spinal fluid, or
- A spinal fluid examination showing distinct inflammatory reaction (pleocytosis), including an increased number of white blood cells and protein and, if relevant, supplemented by a CT or MRI scan.

The permanent objective neurological deficits can be assessed no sooner than three (3) months after the onset of the first symptoms.

It is a condition that a specialist in neurology or a paediatrician has assessed and confirmed that the infection has caused permanent objective neurological deficit symptoms in the form of hearing loss, vision loss, paralysis or hydrocephalus.

When the above conditions are met, the diagnosis is considered definite at three (3) months following the onset of the first symptoms.

J. After-effects of borrelia infection or Tick-Borne Encephalitis (TBE)

Long-term or chronic neuroborreliosis following a tick bite which has caused permanent neurological sequelae in the form of hearing loss, vision loss, paralysis or hydrocephalus.

The diagnosis must be based on spinal fluid examinations with detection of borrelia/TBE-specific antibodies.

The neurological sequelae can be assessed three (3) months after the onset of the first symptoms at the earliest.

It is a condition that a specialist in neurology or paediatrician has assessed and confirmed permanent neurological sequelae.

When the above conditions are met, the diagnosis is considered definite at three (3) months following the onset of the first symptoms.

K. Severe burns, frostbite or corrosive burns

Second- and third-degree burns, frostbite or corrosive burns covering at least 10% of the child's body surface area.

The diagnosis is not considered definite until the above conditions have been met and the medical records include an assessment and confirmation from a burns unit.

L. Histiocytosis and fibromatosis

Histiocytosis and fibromatosis treated with chemo- or immunotherapy and/or radiation therapy.

The diagnosis is considered definite when a specialist in paediatric oncology has diagnosed one of the conditions covered, and chemo- or immunotherapy and/or radiation therapy has been initiated.

The diagnosis is covered from 1 January 2014.

M. Cerebral palsy

Permanent motor disorders due to cerebral circulation impairments which have caused brain injury (cerebral palsy), with characteristic symptoms in the form of spasticity, movement disorders, weakness of the muscles, ataxia and rigidity.

The insurance covers cerebral palsy at motor function level

III-V according to the Gross Motor Function Classification System (GMFCS).

The diagnosis is considered definite when a specialist in paediatrics or a paediatric neurologist has diagnosed cerebral palsy at GMFCS level III-V.

The diagnosis is covered from 1 January 2023.

N. Certain severe epilepsy syndromes

Severe epilepsy syndromes of one of the following types:

- Lennox-Gastaut syndrome (LGS)
- West syndrome (infantile spasms)
- Ohtahara syndrome
- Dravet syndrome
- Progressive myoclonic atonic epilepsy.

Diagnoses must be documented by electroencephalography (EEG) outside epileptic seizures, supplemented, where appropriate, by EEG during an epileptic seizure.

The diagnosis is considered definite when a specialist in paediatrics or a paediatric neurologist has diagnosed one of the conditions covered.

The diagnosis is covered from 1 January 2023.

The insurance may be extended to include the following cover(s):

7. Cover in the event of death

If the child dies during the policy period, the policy will pay out an amount equal to the insurance sum for critical illness of children agreed in the group life contract.

If the insurance sum for critical illness has been paid out, payment of the death benefit will be subject to the condition that at least six (6) months have elapsed between the date of diagnosis of the critical illness that most recently led to payment and the date of death.

If a claim for critical illness cover is made after the death of the child and less than six (6) months have elapsed between the date of the critical illness diagnosis and the date of death, only the death benefit will be paid out and not the critical illness benefit.

The insurance sum will be paid to the insured.

No amount paid to the insured is subject to estate tax.

No special beneficiary may be designated.
Cover is effective from 1 January 2017.

8. Type 1 diabetes

Insulin-dependent diabetes mellitus, type 1 (IDDM).

The diagnosis is considered definite when a specialist in paediatrics or endocrinology has diagnosed insulin-dependent diabetes mellitus, type 1.

The diagnosis is covered from 1 January 2017.