Forenede Gruppeliv

Cover in the event of certain critical illnesses

These terms of insurance are effective from 1 January 2020 and replace the previous terms of 1 January 2017

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.

1. The terms and conditions outlined below apply to the insurance policy, in continuation of FGs group life agreements and insurance terms.

This insurance policy covers the illnesses/diagnoses listed in clause 7 A-X.

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

The insurance terms and the sum insured applicable on the date of diagnosis will be applied and paid out, respectively.

2. For the insurance to cover a critical illness, it is a condition that the disease is diagnosed during the policy period. The deciding factor is the date of diagnosis and not the date on which the insured was informed of the diagnosis. The policy period is stipulated in the group life agreement.

The insurance policy does not cover the critical illnesses stated in clause 7 if the insured was diagnosed with, or treated for, such illnesses before commencement of the term of the policy. However, the provisions in clause 7 A apply in the case of cancer.

3. It is stated in the group life agreement whether cover in the event of critical illness will cease if a sum insured is paid out for 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 a payment is made according to clause 7, the insured's right to further payments in the event of critical illness ceases.

b) If a payment is made according to clause 7, the policy ceases to cover the diagnosis or diagnoses that caused payment of the sum insured for critical illness. However, the provisions in clause 7 A apply in the case of cancer.

In order to receive payment for more than one claim, it is a condition that at least six (6) months elapse between the date of diagnosis of the most recent illness covered by the policy and the date of the new diagnosis. If the sum insured was paid out on addition to a waiting list, this six-month period commences on the date of surgery.

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

5. The right to payout of the sum insured for a critical illness ceases on the death of the insured, unless the insured has submitted a written request for payment to FG.

6. If the insured has withdrawn from the group life agreement, or if the group life agreement has terminated due to cancellation or for other reasons, a written request for payment must be presented to FG within six (6) months of expiry of the term of the policy. On expiry of this deadline, the right to payment of the sum insured for a critical illness that has not been reported will lapse.

7. Critical illness comprises any of the following:

A. Cancer

1) Cancer with the exception of its 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 recurrence and spread to regional lymph nodes or more distant organs (metastases).

Cover does **not** include:

- Initial stages of cancer (dysplasia and carcinoma in situ), for instance in the cervix, breast or testes
- Borderline changes
- Purely cutaneous cancers, 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 confirmed once a specialist in pathological anatomy has made a diagnosis based on a histological (biopsy) or cytological examination.

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 count with uncontrolled growth of blood cells and a tendency to progression and recurrence.

Cover includes:

- 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 is considered confirmed once a specialist in 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.

The following conditions requiring treatment are also covered:

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

"Requiring treatment" refers to diseases requiring cytotoxic treatment (incl. chemotherapy, radiation therapy and biological treatment) of the disease. Treatment with acetyl-salicylic acid, adrenocortical hormone and phlebotomy are not considered cytotoxic treatment.

In the case of cancer types for which it is a requirement that the disease requires treatment, diagnosis is considered confirmed on the date on which it is stated in the medical records of a department of oncology or haematology that treatment of the disease is indicated.

Cover does **not** include:

- Initial stages of cancer of the blood, lymphoid system or haematopoietic organs
- Purely cutaneous lymphoma

General provisions applying to 7 A
If the insured was diagnosed with cancer before commencement of the term of the policy, and the insured has been cancer-free for a minimum of ten (10) years, the insured will be entitled to payment if cancer is again diagnosed during the term of the policy and meets the conditions of clause 7 A.

Payment may be made for up to two (2) cancer diagnoses during the term of the policy, provided that such diagnoses meet the conditions in 7 A. However, in order for the second cancer diagnosis to be covered, it is a condition that at least ten (10) years have elapsed since the first cancer diagnosis was made in the policy period. A further condition for the second payment is that no recurrence of the cancer is diagnosed during the ten-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:

- Typical rise and fall in blood counts (troponins and CK-MB)

Together with at least one of the following criteria:

- Anamnesis with sudden, typically persistent chest pain, or
- Simultaneous appearance of electrocardiographic changes compatible with a diagnosis of acute myocardial infarction

The diagnosis is considered confirmed when the above conditions are met and a specialist in cardiology has made a diagnosis of coronary thrombosis (coronary infarction).

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

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

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

In the case of bypass surgery, the insured may claim compensation if the insured has been added to a waiting list.

In the case of balloon angioplasty, the surgery must have been performed.

The diagnosis is considered confirmed on the date of surgery. In the case of planned bypass surgery, it is the date of addition to a waiting list.

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

D. Cardiac valve surgery

Planned or performed treatment of cardiac valve disorders with implantation of artificial, mechanical or biological cardiac valve prostheses and homograft or plastic surgery on the cardiac valve.

In the case of planned surgery, the insured must be added to a waiting list.

The diagnosis is considered confirmed on the date of surgery. In the case of planned surgery, it is the date of addition to a waiting list.

E. Cerebral haemorrhage/thrombosis (stroke)

Acute lesion of the brain or brain stem with simultaneous evidence of objective neurological loss, lasting more than 24 hours, resulting from an infarction caused by an embolism or thrombosis, by a haemorrhage or intra-cerebral haematoma. Results of a brain scan (CT or MRI) with findings compatible with the above diagnosis must be available.

If a stroke is not verified by a brain scan (CT or MRI), the diagnosis will be covered if all of the classic signs of stroke are present as well as lasting objective neurological loss in the form of paralysis or disturbances of speech or vision or intellectual impairment.

The objective neurological loss cannot be assessed until three (3) months after the event, at the earliest.

The diagnosis is considered confirmed when the above conditions have been met and a specialist in neurology has confirmed objective neurological loss and diagnosed a stroke.

Cover does **not** include:

- Transient cerebral ischemia (TCI)/Transient ischemic attack (TIA)
- Brain infarctions detected by chance during a brain scan (CT or MRI), for instance when diagnosing another illness
- Strokes 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 (aneurysm) or intracranial arteriovenous vascular malformation (AV malformation) and cavernous angioma of the brain

Surgery planned or performed for sacculate aneurysm of the brain arteries, intracranial arteriovenous vascular malformation or cavernous angioma which must be demonstrated by X-ray examination of the brain arteries (angiography) or a CT og MRI scan.

Cover also includes instances where there is indication for surgery but where surgery cannot be performed for technical reasons.

The diagnosis is considered confirmed on the date of surgery. In the case of planned surgery, it is the date of addition to a waiting list. If surgery is not technically feasible, diagnosis is considered confirmed on the date on which the medical records of a department of neurology or neurosurgery state that there is indication for surgery but that surgery is not technically feasible.

G. Certain benign tumours in the brain and spinal cord

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

- which are (radically) inoperable, or
- which after radical surgery leave sequels in the nervous system resulting in a degree of impairment of at least 15% according to Arbejdsmarkedets Erhvervssikring (Danish National Board of Industrial Injuries) impairment table. The degree of impairment may not be assessed until three (3) months after the surgery at the earliest. or
- where there is indication for surgery but where surgery cannot be performed for technical reasons

The diagnosis is considered confirmed on the date of surgery.

If surgery is not technically feasible, diagnosis is considered confirmed on the date on which the medical records of a department of neurosurgery state that there is indication for surgery but that surgery is not technically feasible.

Cover does **not** include:

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

H. Multiple sclerosis

A chronic disease which is characterised clinically by repeated attacks, showing neurological loss 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:

- Increased 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 in MRI scans of the central nervous system, showing multiple affections of the white matter

The diagnosis is considered confirmed when the above conditions are met and a specialist in neurology has diagnosed 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 confirmed when a specialist in neurology has diagnosed one of the covered conditions.

J. Certain muscular diseases and nervous disorders

Progressive muscular dystrophy of one of the types:

- Facioscapulohumeral 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 confirmed when a specialist in neurology has diagnosed one of the covered conditions.

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 commencement date of the insurance policy.

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

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 be reported as an industrial injury and presented together with a negative HIV test performed within the first week after exposure, followed by a positive HIV test performed within the next 12 months.

The diagnosis is considered confirmed when the above conditions are met and a specialist in infectious diseases has diagnosed HIV.

L. AIDS

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

The diagnosis must meet Sundhedsstyrelsen's (Danish Health Authority) criteria for notifiable AIDS.

The diagnosis is considered confirmed when the above conditions are met and a specialist in infectious diseases has diagnosed AIDS.

If the insured was diagnosed HIV-positive prior to the policy period, the insured has no claim for compensation pursuant to clause 7 L.

M. Chronic renal failure

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

In the case of a planned cadaver kidney transplant, the insured must be on an active waiting list.

The diagnosis is considered confirmed on commencement of permanent dialysis.

In the case of a kidney transplant from a living donor, diagnosis is considered confirmed on the date of the transplant, and in the case of a planned cadaver kidney transplant, the diagnosis is considered confirmed on the date of addition to an active waiting list.

N. Major organ transplants

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

The diagnosis is considered confirmed on the date of the trans-plant. In the case of a planned organ transplant, it is the date of addition to an active waiting list. In connection with an organ transplant with autologous stem cells/bone marrow, diagnosis is considered confirmed on the date of the trans-plant.

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 induced by psychopharmacological drugs are not covered.

The diagnosis is considered confirmed when a specialist in neurology has diagnosed Parkinson's disease (paralysis agitans).

The diagnosis is covered 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 confirmed when a specialist in eye diseases has assessed and confirmed the loss of vision in the medical records.

The diagnosis is covered 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 confirmed when a specialist in audiology has assessed and confirmed the hearing loss in the medical records.

The diagnosis is covered from 1 January 2002.

S. Diseases of the aorta

Diseases of the aorta include:

- Local dilation of the aorta (aortic aneurysm) to more than 5 cm in diameter
- Local dilation of the aorta (aortic aneurysm) which has been surgically corrected
- Aortic rupture
- Rupture of the inner layer of the aorta and bleeding into the aortic wall (aortic dissection), or
- Total aortic occlusion

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

The diagnoses must be proven by:

- Ultrasound scan
- Echocardiography
- CT/MRI scans

In the case of aortic aneurysm, the diagnosis is considered confirmed on the date of surgery or when dilation of the aorta exceeds 5 cm in diameter.

In the case of aortic rupture, aortic dissection and total aortic occlusion, the diagnosis is considered confirmed when documentation is available in the form of clinical findings and ultrasound, echocardiography or CT/MRI scans.

The diagnosis is covered from 1 January 2005.

T. Sequels to encephalitis or meningitis

Permanent neurological sequels to infections of the brain, nerve roots of the brain or meninges caused by bacteria, viruses or fungi. The permanent neurological sequels must have resulted in a degree of impairment of at least 8% according to Arbejdsmarkedets Erhvervssikring (the Danish National Board of Industrial Injuries) impairment table.

Diagnosis must be made based on:

- Detection of microorganisms in the spinal fluid, or
- Spinal fluid examination, showing distinct inflammatory reaction (pleocytosis), including an increased number of leucocytes and protein, if relevant supplemented by a CT or MRI scan

The degree of impairment cannot be assessed until at least three (3) 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 confirmed three (3) months to the day after examination of the spinal fluid showing encephalitis or meningitis.

The diagnosis is covered from 1 January 2005.

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

Prolonged or chronic neuroborreliosis following a tick bite, leading to permanent neurological sequels. The permanent neurological sequels must have resulted in a degree of impairment of at least 8% according to Arbejdsmarkedets Erhvervssikring (the Danish National Board of Industrial Injuries) impairment table.

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

The degree of impairment cannot be assessed until at least three (3) months after 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 confirmed three (3) months to the day after examination of the spinal fluid showing borrelia infection or Tick-Borne Encephalitis (TBE).

The diagnosis is covered from 1 January 2005.

V. Severe burns, frostbite or corrosive burns

Third-degree burns, frostbite or corrosive burns, covering at least 20% of the insured's body surface.

The diagnosis is considered confirmed when the above conditions have been met and the medical records include an assessment and confirmation by a burns unit.

The diagnosis is covered from 1 January 2007.

W. Implantation of ICD unit (defibrillator) as second-conddary prophylaxis

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

The diagnosis is considered confirmed on the date of surgery.

Implantation of an ordinary pacemaker is not covered.

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

The diagnosis is covered from 1 January 2014.

Q. 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 confirmed on the date of surgery, if the above conditions are met.

Implantation of an ordinary pacemaker is not covered.

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

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