Critical Illness Terms

Terms L-8

The insurance contract consists of these insurance terms, information in the application form and other documents linked to the contract, both in its original and subsequent forms. The insurance policy and its contents, as well as the provisions of Act No. 30/2004, also form a part of the insurance contract.

For the purposes of these Terms the following definitions shall apply:

The "Company" means Vörður líftryggingar hf. (Vörður Life Insurance hf.), see Article 62(a) of Act No. 30/2004.

The "Policyholder" is the person contracting with the Company on critical illness insurance, see Article 62(b) of Act No. 30/2004.

The "Insured" is the critical illness insured person, as specified in the application, see Article 62(c) of Act No. 30/2004.

An "Insurance Event" has occurred if the Insured is diagnosed with any of the medical conditions, undergone any treatment or suffers any of the circumstances defined in the Insurance.

The "Contract" is the agreement in effect between the Company and the Insured on the insurance.

The "Contract Term" is the time from the date of issue of the policy to the end date therein defined.

"Insurance Amount" means the amount to be paid in the event of the occurrence of an Insurance Event in the form of a lump sum.

"Age-Related Premium": The premium for the insurance is independent of gender, calculated based on the Insurance amount and adjusted each year based on the Insured's age.

"Permanent" means a lifelong condition of the individual covered by the insurance, regardless of when the Contract Term expires and when the individual retires due to old age.

"Index" is the consumer price index used for price indexation.

"The Financial Supervisory Authority" is a government regulator responsible for supervision of the activities of insurance undertakings in Iceland pursuant to Act No. 56/2010 on insurance activities.

"Risk assessment procedures" are rules of procedure observed by the Company in risk assessment for personal insurance, both its own rules and the detailed rules of reinsurers at any time. Information is available on the Company's website.

Article 1 Beginning and end of the Company's liability

The liability of the Company begins at the time when the Company has received and approved a signed application for critical illness insurance together with other necessary information and certification, as provided in the first paragraph of Article 74 of Act No. 30/2004, but not until the date specified in the application. The Contract Term is entered in the insurance policy.

The Insured has 30 days (grace period) to cancel the insurance from the time that the Insured received a notice from the Company confirming the entry into force of the Contract.

After that time the Insured can cancel the insurance at any time during the Contract Term. The insurance shall be cancelled in writing.

Article 2 Payment of premiums and default
The first premium shall be paid when the insurance takes effect and subsequent premiums shall be paid on specified due dates. The Insured is granted a 30-day grace period for payment from the date that the Company sends a call for payment of the premium. If the premium then remains unpaid when the grace period has ended, the Company will send a notice with a reminder of the default and a 14-day payment deadline. The call for payment will be sent to the address of the payer according to the National Register unless the payer has specified another address. The Insurance Contract will lapse if premiums are not paid by the appointed deadline.

Article 3 Right to reinstate critical illness insurance
If the insurance has lapsed as a result of default it will not be renewed except by virtue of a new insurance application with a new risk assessment.

Article 4 Settlement of accounts if the Contract is terminated during the Contract Term
If an Insurance Contract which is intended to remain in effect for one year or longer is cancelled during the Contract Term the Company shall reimburse the premium for the insurance *pro rata*.

Article 5 Cancellation
The Company may terminate the Insurance if false or inadequate information has been provided when the Insurance is taken or if the policyholder or Insured has fraudulently neglected his or her disclosure obligation.

Article 6 Fraud and false information
If the Policyholder or Insured has fraudulently neglected the obligation to inform the Company of events that could influence the Company's risk assessment, the Company's liability for insurance or compensation will end in full or in part pursuant to Article 83 of Act No. 30/2004. False and incomplete information also entitles the Company to terminate the insurance under the provisions of Article 84 of Act No. 30/2004 and any other insurance contract it may have with the policyholder or Insured without notice.

If a person claiming compensation from the Company provides false information that he or she knows, or should know, will lead to his or her receiving compensation to which he or she is not entitled, the entitlement to compensation will lapse and the Company may then terminate all its insurance contracts with the person, as provided in Article 120 of Act No. 30/2004.

Article 7 Where does the policy apply?
The Insurance is valid anywhere in the world.

Article 8 Change in risk
If the Insured gives up smoking a written confirmation to such effect may be submitted to the Company for a reduction in premium amounts. The Insured must have abstained from smoking for 12 consecutive months for the reduction to take effect, in which case the premium will be adjusted as of the next renewal after that period.

Article 9 Coverage
The Company will pay non-pecuniary compensation in a lump sum in accordance with the Insurance Amount in respect of a covered Insurance Event pursuant to Article 11 of these Terms.

Article 10 Payment of compensation and interest
On the payment of insurance compensation the insurance will lapse except in cases where compensation is being paid in respect of the Insured's child. Payments of compensation in respect of the Insured's child will affect neither the Insurance Amount nor the validity of the insurance. Compensation will not be paid unless the Insurance Event is confirmed during the Contract Term. After the insurance has lapsed no

liability will exist even if it may be regarded as probable that a medical condition existed while the insurance was in effect.

Compensation will not be paid until a specialist in the area of specialisation in question has confirmed the medical diagnosis.

Compensation may be claimed 14 days after satisfactory proof of the liability of the Company is received. Interest on compensation amounts is subject to Article 123 of Act No. 30/2004.

The Company will not pay the cost of legal assistance nor any other expense that accrues in respect of an Insurance Event without the approval of the Company.

Article 11 Insurance event and definitions
An Insurance Event is regarded has having taken place only if the Insured suffers harm by being diagnosed with of any of the following medical conditions, by undergoing any of the procedures listed, by losing a limb, being afflicted with paralysis, blindness or aphasia, or by suffering a serious physical trauma or burns as further defined below.

Compensation categories, insurance event and definitions
The medical conditions covered by this insurance are divided into five categories by their nature and type, and only one payment is made out of each category even if the Insured is diagnosed with two medical conditions in the same category.

Category I CARDIOVASCULAR DISEASE

Heart attack/coronary occlusion (myocardial infarction)
Necrosis of a part of the heart muscle as a consequence of inadequate blood supply. All three items below must be diagnosable and confirmed by a cardiologist:

a) Typical angina pectoris (chest pains)
b) New changes in electrocardiogram
c) Elevation of cardiac enzymes, troponins or other biomarkers

Excepted are:

- Heart attack without ST elevation but with troponin I or T elevation
- Other acute coronary syndromes
- Asymptomatic heart attack

Coronary bypass surgery
The Insured undergoes open heart surgery at the recommendation of a cardiologist where a coronary artery bypass graft (CABG) is inserted to bypass stenosis in one or more coronary arteries. This does not include other procedures, such as angioplasty or balloon angioplasty and laser or key-hole surgery.

Heart valve replacement
A cardiac procedure where one or more heart valves are replaced with an artificial valve. This includes procedures involving the aortic valve, mitral valve, pulmonary valve and tricuspid valve in the presence of stenosis, leaking or both. Excepted are: heart valve repair, valvuloplasty or valvulotomy.

Aorta surgery
The Insured undergoes surgery for chronic aortic disease at the recommendation of a cardiologist, where a part of the aorta is resected and replaced with a graft. This includes the thoracic and abdominal aorta, but not its branches.

Category II STROKE, PARALYSIS AND APHASIA

Cerebral event/stroke
Any cerebral blood flow disorder which causes symptoms from the central nervous system (CNS) and involves necrosis of cerebral tissue, bleeding or thrombosis/embolism of extracranial origin. Symptoms of permanent CNS damage are a prerequisite. Symptoms lasting less than 24 hours are excepted. Diagnosis must be confirmed by a neurologist. It must be possible to establish that impaired reflexes persisted for at least three months. Transient ischemic attacks (TIA), neurological symptoms associated with migraine, cerebral injury resulting from trauma and a stroke without impaired neurological function are excepted.

Paraplegia
Includes spinal cord paralysis due to disease or accident. The paralysis must include both legs and/or both arms or at least one leg and one arm. The paralysis must be permanent and diagnosed by a neurologist.

Aphasia
Complete and permanent loss of the ability to speak during a continuous period of at least 12 months. Diagnosis must be confirmed by a neurologist. Aphasia resulting from psychological disorders is excepted.

Category III CANCER

Cancer (malignant tumour)
A malignant tumour characterised by the uncontrolled growth and dissemination of malignant cells and invasion of tissue. Diagnosis of cancer must by confirmed by means of a biopsy. This definition also includes leukaemia (other than chronic lymphocytic leukaemia, CLL) and malignancies in the lymphatic system, such as Hodgkin's disease. Excepted are:

a) any stage of cervical intraepithelial neoplasia (CIN);
b) any pre-stage of a malignant tumour
c) any cancer without invasion (cancer in situ)
d) stage 1 prostate cancer (T1a, 1b and 1c)
e) all stage 1A skin cancers (T1a, NO and MO), including melanoma
f) any malignant tumour associated with the HIV virus
g) epithelial skin cancers (basal cell carcinoma and squamous cell carcinoma).

Category IV NEUROLOGICAL AND DEGENERATIVE DISORDERS

Multiple sclerosis (MS) – with ongoing symptoms
Permanent diagnosis of multiple sclerosis (MS), which has been diagnosed by a neurologist. Ongoing impairment of mobility or sensation resulting from multiple sclerosis must be evident.

Motor neuron disease (MND) – leading to permanent symptoms
Permanent diagnosis of Motor Neuron Disease (MND), which has been diagnosed by a neurologist. The liability coverage includes all kinds of motor neuron disease, including progressive spinal muscular atrophy (SMA). Mobility must be permanently impaired.

Alzheimer's disease before the age of 65 – leading to permanent symptoms.
The Insured must be permanently diagnosed with Alzheimer's disease or early-onset dementia (before the age of 65), as diagnosed by a neurologist, psychiatrist or geriatrician.
The individual in question must have lost the ability to perform all of the following functions:

- to remember
- to reason
- to perceive, understand, express and react to ideas.

Parkinson's disease before the age of 65 – leading to permanent symptoms
Permanent diagnosis of Parkinson's disease or another specified severe Parkinson-related syndrome which is diagnosed by a neurologist. The Parkinson-related syndromes covered by the insurance are corticobasal degeneration and Lewy disease (diffuse Lewy body disease).

Permanent impairment of mobility must be diagnosed with the associated tremor, muscle stiffness and postural instability.

The following items are not included in the above definition: Other Parkinson-related syndromes.

Category V OTHER SERIOUS DISORDERS AND ACCIDENTS

Benign brain tumour
Resection of an intracranial brain tumour which is not malignant. The surgery or the tumour leads to ongoing neurological dysfunction. Diagnosis must be confirmed by a specialist and by results from CT scanning or electroencephalography. Ongoing neurological dysfunction means that the duration of the condition must have been at least three months (confirmed by a physician).

Excepted are:

a) Cysts
b) Granulomas
c) Tumours of the pituitary body or spinal cord
d) Vessel defects in or on arteries or veins
e) Cerebral contusion.

Major Organ Transplantation
The Insured undergoes organ transplantation, as a recipient of a heart, lung, liver, pancreas, small intestine, kidney or bone marrow.

Kidney failure
End-stage renal failure which is characterised by chronic and permanent dysfunction of both kidneys and leads either to regular haemodialysis, peritoneal dialysis or the performance of renal transplantation.

Severe burns (third degree burns)
Third degree burns covering at least 20% of the body surface of the Insured, confirmed by a specialist with extensive experience in the treatment of burns. The Lund-Browder Chart or a similar assessment system should be used for diagnosis.

Loss of limbs
Permanent loss of two or more limbs above the wrist or ankle due to accident or disease.

Blindness
Permanent and irretrievable loss of sight of both eyes due to disease or accident leading to a test with visual aids rendering a measurement result of 3/60 or less for the better eye using a Snellen Eye Chart.

Deafness
Complete, permanent and irretrievable loss of hearing of both ears due to disease or accident, confirmed by a otolaryngologist (throat, nose and ear specialist) and by results from audiometry.

HIV resulting from a blood transfusion or physical assault
The Insured is infected with HIV or diagnosed with AIDS as a consequence of one of the below factors:

- The infection results from a blood transfusion which was necessary for medical reasons and must have taken place after the insurance policy took effect. The criteria are that the health care institute where the blood transfusion was performed must accept its responsibility and that the Insured is not a bleeder.
- Physical assault which the Insured suffers.

Occupationally transmitted AIDS (HIV)
Transmission of HIV resulting from an accident suffered by the Insured in the course of his/her work according to his/her routine job description. Any accidents potentially leading to a liability claim must be notified to the Company within seven days from the accident. An accident report must be attached to the notification together with confirmation of a negative result from an HIV-antibody test taken immediately prior to the accident. Seroconversion must have happened within six months from the accident.

Bacterial meningitis.

Bacterial infection and inflammation of the membranes covering the brain and spinal cord, which has been confirmed by a neurologist based on blood and cerebrospinal fluid tests, CT-scanning or an MRI of the head.

The disease must have led to permanent inability to individually perform three or more activities of daily living (ADL), i.e. bathing, dressing, undressing, getting to and using the toilet, getting out of a bed into a chair or out of a chair into a bed, controlling bowel movements and the passing of urine, eating, drinking, taking medications, or must have led to confinement to bed and inability to get up without external help. It must be medically confirmed that the duration of this condition has been at least three months.

Serious head wounds
A serious head wound causing cerebral dysfunction. Diagnosis must be confirmed by a specialist and by results of diagnostic imaging of the nervous system, e.g. CT or MRI. The wound must have led to permanent inability to individually perform three or more activities of daily living (ADL), i.e. bathing, dressing, undressing, getting to and using the toilet, getting out of a bed into a chair or out of a chair into a bed, controlling bowel movements and the passing of urine, eating, drinking, taking medications, or must have led to confinement to bed and inability to get up without external help. It must be medically confirmed that the duration of this condition has been at least three months.

Article 12 Limitation of the Company's liability
Medical conditions, procedures and incidents other than those listed here as covered are not covered under this insurance.

Compensation will not be paid in respect of cancer or multiple sclerosis which is diagnosed in the first three months following the entry into effect of the insurance, nor on its reinstatement.

Compensation will be paid to the Insured only once out of this insurance for the Insured himself/herself and compensation from the Child critical illness insurance will be paid only once in respect of each child.

A condition for payment of compensation is that the Insured must live for a minimum of thirty days from the time of confirmation of the Insurance Event.

Article 13 Child critical illness insurance
Compensation in respect of children will be paid to the Insured if their children are, within the age limits set out below, afflicted by any of the medical conditions covered by these Terms. The definition of children covers the children and adopted children of the Insured, and also foster children and stepchildren of the Insured who have their domicile and residence in the same place as the Insured.

The following age limits apply to the child insurance:

Children who have reached the age of three months and are younger than 18 years of age are insured against Insurance Events pursuant to the Terms.

Compensation amounts to 50% of the insurance amount or ISK 10,000,000, whichever is lower.

Compensation in respect of the same child can never be higher, even if more than one critical illness insurance policies are in effect with the Company. Payment of compensation from child critical illness insurance will not affect the critical illness insurance of the Insured.

The following are not covered by these Terms:

- any condition arising before a child is thirty days old
- any surgical operation undergone in respect of a condition arising before a child is thirty days old (even if such operation takes place after that age)
- any condition arising after a child's eighteenth birthday
- any surgical procedure which takes place after a child's eighteenth birthday (even if such procedure is in respect of a condition which arose before that birthday).

Compensation is not paid in respect of adopted children if the cause of the medical condition or surgical procedure can be traced to the condition of the child before its adoption. The same applies to stepchildren and foster children.

Compensation is not paid in respect of medical conditions or surgical procedures which can be traced directly or indirectly to the condition of a child prior to the above age limits or prior to the obtaining or reinstating of the insurance.

As regards further information on the payment of compensation, coverage and limitations on liability reference is made to Articles 9, 10, 11 and 12, as applicable.

Article 14 Beneficiary
The Insured is the beneficiary if another party is not designated as such in the insurance policy or premium payment receipt.

Article 15 Insurance amount and indexation
The insurance amount is indicated on the insurance policy or renewal slip. On the renewal of a policy the insurance amount and annual premium will be increased in line with changes in the consumer price index from the base index of the Contract, which is noted in the Policy, to the index for the month preceding the renewal. A decrease in the index will affect neither the insurance amount nor the annual premium.

If the Insurance Amount is adjusted by age, this is noted in the policy and the Insurance Amount will then decrease annually from that time on the first day of each insurance year.

Article 16 Time limit for reporting an Insurance Event
The Insured will forfeit the right to compensation if

1. the Insured does not file a claim with the Company within one year from the time of knowledge of the event on which the claim is based;
2. the Insured has not initiated proceedings or applied for due process before the Insurance Complaints Committee within a year of receiving a written notice that his claim was rejected, see Article 124 of Act No. 30/2004.

Article 17 Limitation period
Claims for compensation under this insurance are limited in time pursuant to the rules of Article 125 of Act No. 30/2004.

Article 18 Cash surrender value and loans
This critical illness insurance has no cash surrender value and does not confer rights of borrowing from the Company.

Article 19 Premium waiver benefit (optional)
If noted in the insurance policy the Insured is entitled to a proportional reduction in premiums if his or her capacity for work is reduced by 50% or more. An application may be submitted for a waiver of premiums six months after the start of the loss of capacity. The maximum period for a premium waiver is five years.

An application for a premium waiver shall be submitted in writing to the Company in a form supplied by the Company together with any documents necessary for the assessment of the reduction in work capacity

at no cost to the Company. The Company will base its assessment of the loss of capacity on the ability of the Insured to pursue his or her normal work and possibility of undertaking other employment.

The Insured is required to notify the Company as soon as he or she recovers his or her capacity for work in part or in full.

While the Insured enjoys a premium waiver the Company may require critical illness information from the Insured or medical examination at its own cost.

The Insured is not entitled to a premium waiver:

- for a longer time than 1 year retroactively from the time that an application for a premium waiver was received by the Company;
- if the reduced capacity for work is the result of a covered Insurance Event pursuant to Article 11 of these Terms.
- for medical conditions that the Insured suffered or showed symptoms of prior to the entry into effect of the insurance, nor for the consequences of an accident that occurred prior to the entry into effect of the insurance;
- if the loss of capacity for work is caused by war, armed conflict, riots, insurrections or other similar events;
- if the loss of capacity for work is caused by the abuse of alcohol, drugs or toxic substances or participation in a criminal act;
- if the loss of capacity for work is caused by intent or gross negligence.

Provisions on violations of disclosure obligations, fraud and false information also apply, as applicable.

The premium waiver is in other respects subject to the provisions of the terms of the Insurance, as applicable.

Article 20 Right to increase the Insurance Amount without disclosure of health information
If critical illness insurance has been approved without surcharge and on ordinary terms the Insured may request an increase in the Insurance Amount without providing further health information. An application together with necessary documents must be received by the Company within three months from the occurrence of the following events:

- the Insured has a child
- the Insured adopts a child under the age of 18.

The Insurance Amount can be increased by a maximum of 25% or ISK 3,500,000, whichever is lower. The increase in the Insurance Amount shall have the same term of effect as the insurance being increased.

This right may be exercised twice. The right to increase will lapse as of the 45th birthday of the Insured, when a claim has been made for compensation out of the critical illness insurance or if the Insured has been diagnosed with any of the covered medical conditions, has undergone or is awaiting any such procedures or has suffered any of the events that are covered under these Terms.

Article 21 Adjustment of the actuarial risk table
The Company reserves the right to adjust the actuarial risk table in the event of a general increase in risk or if the general conditions on which the insurance is based prove different from those initially assumed, as provided in Article 65 of Act No. 56/2010 on insurance activities.

Article 22 Confidentiality and personal privacy
The Company and its staff will treat information on the critical illness insurance as confidential information and is bound by the rules of Act No. 77/2000 on data protection and the processing of personal data.

The Company will use personal information collected in respect of the insurance only for the purpose of assessing requests for insurance, to assess the need for insurance coverage and to provide policyholders

with guidance on the selection of insurance, in processing claims for compensation, disclosure of information to the policyholder and in other normal course of business of the Company. The Company places great emphasis on security and confidentiality in its handling of personal data. No information on customers is disclosed to third parties except by express consent, by law or by virtue of court orders.

Article 23 Settlement of disputes
With the completion of a formal appeal and payment of an appeal fee a dispute regarding liability, blame and division of blame, in addition to disputes on matters relating to the provisions of Act No. 30/2004, may be referred to the Insurance Complaints Committee, which works under the auspices of the Financial Supervisory Authority

Services provided by, or appeals to, these parties do not curtail the right of the party in question to refer a dispute to the public courts in Iceland.

Article 24 Renewal of insurance coverage
If this insurance lapses following payment of compensation in respect of a medical condition in one or more categories pursuant to Article 11 of these Terms the Insured is entitled, within three months from the time that the insurance lapses, to purchase new insurance without a new declaration of health. However, the categories in respect of which payments have been made previously will be excluded.

Article 25 Jurisdiction
Any disputes arising from this insurance policy shall be brought before the District Court of Reykjavík.

Article 26 Act on insurance contracts
In other respects reference is made to the terms of the Contract or other documents on which the Contract is based, the Insurance Policy and the Act on insurance contracts No. 30/2004.

If there is any discrepancy between the terms in English and the Icelandic version, then the Icelandic version has precedence.

These Terms are effective as of 1 July 2015.