storebrand

# Policy conditions for personnel insurances with Storebrand

**Contents:**



These policy conditions, any supplementary policy conditions and the insurance contract entered into between the enterprise and Storebrand Livsforsikring AS apply to this insurance. The Act no. 69 of 16 June 1989 relating to insurance contracts and other legislation also apply, however such that the policy conditions take precedence over these when the policy conditions are different from non-mandatory legal provisions.

The insurance covers that have been agreed on will be stated in the insurance contract and the insurance certificate.

Replaces the conditions dated 1 January 2012.

**Notice of disclaimer**

Translated from Norwegian. Only the terms and conditions of the insurance contract in Norwegian are to apply. This document shall not be recognised as legally binding material and has been prepared for the sole purpose of understanding the contractual contents of the Norwegian legal document in force.

Valid as from 1 October 2014

# 1. Definitions

### 1.1 The Company
The Company is Storebrand Livsforsikring AS.

### 1.2 The Policyholder
The Policyholder is the party that enters into the insurance contract with the Company.

### 1.3 The Insured
The Insured is the party to whose life or health the insurance is linked.

### 1.4 Spouse/registered civil partner
The Insured's spouse is the person who has entered into marriage with the Insured. A party who has entered into a registered civil partnership with the Insured is treated as a spouse.

A person is not counted as an insured spouse or registered civil partner after the date when a court order or administrative order regarding a separation or divorce has been granted, even if it is not legally enforceable or final.

### 1.5 Cohabitant
A cohabitant is:
- a person with whom the Insured lives in a marriage- or civil-partnership-like relationship provided the National Population Register states that these two have shared the same home for the past two years, or
- a person with whom the Insured has children and shares a home.

However, a person is not counted as a cohabitant if, at the time when the insurance event occurred, circumstances existed that prevented a lawful marriage or civil partnership from being entered into.

A person is not counted as a cohabitant beyond the date when the parties cease living together or beyond the date when the abovementioned definition of a cohabitant is for some reason no longer met.

### 1.6 Children
Children are the Insured's own children and step-children. Other children who, according to a public authority, are supported by the Insured and have been included in the Insured's family are also covered.

### 1.7 Family provider
A family provider is an employee who has a spouse/registered civil partner (see clause 1.4) or cohabitant (see clause 1.5) or who is single and has children (see clause 1.6) under the age of 21 years.

### 1.8 Ability to work
A full ability to work means that the employee is fully able to work in a full-time job.

### 1.9 The insurance contract
The insurance contract is entered into between the Policyholder and Company and contains details of the agreed scope of the cover, the sums insured, administration, etc.

### 1.10 Insurance certificate
A written certificate given to members containing information on the agreed benefits and the policy conditions that apply.

### 1.11 The National Insurance basic amount - G
G is the National Insurance Scheme's basic amount.

### 1.12 The term of the insurance
The term of the insurance is the period during which the insurance contract is in force. For the individual member, the term of the insurance means the period when the person concerned belongs to the group covered by the insurance contract.

### 1.13 Insurance year
The insurance year is the 12-month period starting on the insurance's annual renewal date.

### 1.14 Offshore
An employee is covered by the insurance contract's offshore provisions while staying on installations used for petroleum activities on the continental shelf as well as during journeys between the home and such installations.

### 1.15 Occupational injury/occupational disease
Occupational injuries and occupational diseases are bodily injuries or diseases covered by Act no. 65 of 16 June 1989 relating to occupational injury insurance (Occupational Injury Insurance Act).

### 1.16. Travel between the home and workplace
Travel between the home and workplace means the route that the insured employee regularly takes from his/her home to the workplace and vice versa.
Any deviation from this route is not counted as travel between the home and workplace, and no compensation is payable for accidents which occur during such deviations.
If the insured employee takes short detours from the route (max. two hours), the insurance comes into force once again when the Insured returns to the normal route.
If an employee is to carry out work at a place other than his/her permanent workplace, compensation is payable for accidents that occur on the journey between the home and the temporary workplace.

### 1.17 Leisure-time injury

A leisure-time injury is an accidental injury that:

**a)** is not covered by clause 1.15, or

**b)** has not taken place during work for another employer or during work that the Insured carries out as a self- employed person.

Accidental injuries that occur during work in the home are also considered to be leisure-time accidents.

### 1.18 Accidental injury

An accidental injury is understood to be a bodily injury caused by a sudden and unforeseen external event - the accident. Injury to the mind, such as shock, is not counted as an accidental injury unless a bodily injury that involves permanent medical disability which provides a right to compensation has occurred at the same time.

### 1.19 Medical disability

Medical disability is understood to be the physical and/or mental impairment of functions that a specific injury or disease usually causes. The degree of disability is to be determined on an objective basis, without taking into consideration the Insured's occupation, impaired ability to carry out paid work (degree of incapacity for work), outdoor interests, etc. The degree of medical disability is to be determined on the basis of the Ministry of Social Affairs' disability table, see clause 7.3.1 of the policy conditions. The loss of or injury to most bodily parts and organs is assigned a specific degree of medical disability in the table. For consequential injuries that are not included in the table, the degree of disability is to be determined following a discretionary comparison with the consequential injuries in the table.

### 1.20 Incapacity for work

Incapacity for work means the full or partial loss of the ability to carry out paid work. The degree of incapacity for work is determined according to the Insured's ability to carry out paid work (ability to earn income). When assessing whether and to what extent the ability to earn income has been permanently reduced, the possible incomes from any work that the person concerned can now carry out are to be compared to the possible incomes that the person concerned had before the disease, injury or medical condition arose.

### 1.21 Group life insurance – non-occupational disease

Group life insurance is a death-risk insurance that an enterprise may take out for selected groups of employees and possibly their spouses, registered civil partners or cohabitants. A group life insurance may also include disability cover. Disability cover means that the Insured will be paid a lump sum if he/she meets the incapacity for work requirements stated in the policy conditions.

### 1.22 Critical illness

A critical illness is one of a number of selected illnesses, see clause 6.1.

## 2. When the personnel insurance enters into force

### 2.1.The entry into force of the insurance

The insurance enters into force on the date stipulated in the insurance contract.

The conditions for the individual employee being admitted to the insurance are stated in clauses 2.1.1 to 2.3.

**2.1.1 - if, pursuant to the Company's rules, an actively at work (full ability to work) declaration is to be provided:**

For employees, co-insured spouses/registered civil partners or cohabitants who are not fully able to work on the admission date, the insurance enters into force on the date when the person concerned is fully able to work again.

However, the Company's liability for employees pursuant to the policy conditions' provisions regarding occupational injury insurance and leisure-time accident insurance comes into force on the same date as the insurance contract comes into force, irrespective of the employee's ability to work.

**2.1.2- if, pursuant to the Company's rules, health information is also to be provided:**

If the employee or a co-insured spouse/registered partner or cohabitant is to provide information on his/her health, the Company is liable for insurance events that take place after the insurance contract has come into force. However, this does not apply if the Company would under any circumstances have refused to provide the insurance cover after assessing the person's health. Nor is the Company liable for the consequences of circumstances that existed on the application date if these circumstances would have been revealed by the Company's investigations and would have led to cover being refused, see section 12-2 subsection 3 of the Insurance Contracts Act.

No actively at work declaration or declaration regarding health is required for a co-insured spouse/registered civil partner or cohabitant who is to be covered by the group life insurances in schemes involving obligatory membership. If the spouse/registered civil partner or cohabitant dies within two years of becoming a co-insured, the Company's duty to provide compensation is reduced, see clause 5.7.4. The same applies in the case of an increase in the insurance applicable to spouses/registered civil partners or cohabitants.

No health declaration is required in a group life insurance with voluntary membership if the number of employees entitled to the insurance is at least 750 and at least 80% of these have joined the insurance, or the number of employees entitled to the insurance is at least 250 and at least 90% of these have joined the insurance.

A spouse/registered civil partner or cohabitant may not be a co-insured in critical illness insurances.

**2.1.3 – Employees and co-insureds who do not meet the conditions**

For employees and co-insured spouses/registered civil partners or cohabitants who, due to the employee's state of health, cannot be covered by the insurance, the insurance enters into force, unless otherwise agreed, on the date when the conditions stated in clause 2.1.2 are met.

### 2.2 Subsequent admissions

**2.2.1 - if, pursuant to the Company's rules, an actively at work declaration is to be provided**

For employees, co-insured spouses/registered civil partners or cohabitants who are not fully able to work on the admission date, the insurance comes into force as from the date when the person concerned is fully able to work again. However, the Company's liability for employees pursuant to the provisions regarding occupational injury insurance and leisure-time accident insurance, see clause 2.1.1, comes into force as from the date when the employee starts to work for the Company, irrespective of the employee's ability to work.

Employees who meet the conditions for admission to an insurance with voluntary membership and do not join this insurance within one month must provide approved health information in order to be admitted to the insurance later on. The health information is to be provided at no cost to the Company on a form issued by the Company.

### 2.3 Amendments to the contract

In the case of an amendment to the contract that leads to new groups of employees being admitted to the Insurance or an increase in the sums insured or in the case of an expansion of the insurance's scope after the date when the insurance has entered into force, clauses 2.1.1 and 2.1.2 apply correspondingly.

In the case of an increase in the sum insured that is within the group insurance's or critical illness insurance's framework, only an actively at work declaration from the employer is required.

If the sum insured under the contract is to be increased in accordance with the National Insurance basic amount (G), no health or actively at work declaration is required.

# 3. Occupational injury insurance

## PART A: COVER PURSUANT TO THE ACT NO. 65 OF 16 JUNE 1989 RELATING TO OCCUPATIONAL INJURY

### 3.1 What the insurance covers

The insurance pursuant to part A of this chapter covers occupational injury and occupational disease pursuant to the Norwegian Occupational Injury Insurance Act and regulations issued pursuant to it provided this has been agreed upon.

The agreed benefits are stated in the insurance contract and insurance certificate.

Occupational injuries and occupational diseases refer to bodily injuries and diseases covered by sections 10 and 11 of the Act no. 65 of 16 June 1989 relating to occupational injury insurance, i.e. injury and disease incurred by employees while at work at the workplace during working hours when:

**a)** It is an injury or disease caused by an accident at work (occupational injury),

**b)** It is an injury or disease equated with an occupational injury pursuant to section 13-4 of the National Insurance Act,

**c)** It is a non-occupational injury or disease if this is due to the effect of harmful substances or work processes. Repetitive strain injuries are not counted as an occupational injury/disease.

Injuries and diseases like those mentioned in the first paragraph letter b) above are to be regarded as being caused during the work at the workplace during working hours unless the enterprise can prove that this is obviously not the case. When considering whether an injury or disease provides the right to cover, the employee's particular susceptibility to the injury or disease is to be disregarded unless this particular susceptibility must be regarded as the completely overwhelming cause.

An occupational injury/disease must be ascertained during the term of the insurance, see nonetheless section 6 of the Occupational Injury Insurance Act.

An occupational injury or disease is regarded as having been ascertained at the earliest when the injured party either

**a)** died of the injury or disease without having sought medical aid

**b)** first sought medical aid for the injury or disease, or

**c)** first notified the Company of his claim on the grounds of the injury or disease.

### 3.2 Special settlement rules, a reduction in compensation or compensation being no longer payable due to contributory negligence, etc

**3.2.1 The date when the compensation is payable**

Settlement shall take place as soon as the Company has had reasonable time to clarify its liability and calculate the com-

pensation due. If it is clear at an earlier date that the Company must at least pay some of the amount claimed, a corresponding advance payment is to be made, see section 8-2 of the Insurance Contracts Act.

#### 3.2.2 Subsequent settlement

If the compensation for future expenses, the loss of future income or permanent injury has been determined and the injured party's degree of incapacity for work or medical disability as a result of the accident changes significantly, the injured party may submit a claim for a subsequent settlement. A claim for a subsequent settlement must be submitted within five years of the settlement being finalised.

#### 3.2.3 Contributory negligence

The compensation may be reduced or no longer be payable if the employee has intentionally or with gross negligence contributed to the injury. However, this shall not reduce the surviving next-of-kin's rights to compensation. Section 5-1 of the Act no. 25 of 13 June 1969 relating to compensation in certain circumstances applies correspondingly in so far as applicable.

#### 3.2.4 Time-barring

The employee's claim against the Company is time-barred after three years. The limitation period starts at the end of the calendar year when the employee obtained, or ought to have obtained, the necessary knowledge of the factors on which the claim is based. The limitation periods stipulated in the Insurance Contracts Act and in section 9 of the Act no. 18 of 18 May 1979 relating to the limitation period for claims do not apply. Otherwise, the rules stipulated in the Act relating to the limitation period for claims apply in so far as they are applicable. Claims notified to the Company prior to the expiry of the limitation period are time-barred at the earliest six months after the person entitled to compensation has received separate written notification that time-barring will be invoked. Section 20-3 of the Insurance Contracts Act regarding the use of electronic communication applies correspondingly. The notification must state how the limitation period may be interrupted. The limitation period is not extended by this provision if more than 10 years have elapsed since the claim was notified to the Company.

### 3.3 Interest on compensation

Regarding the Company's duty to pay interest on compensation, the rules stipulated in the Occupational Injury Insurance Act and regulations issued pursuant to it apply.

### 3.4 The Company's liability if the insurance contract is cancelled

If the insurance contract regarding occupational injury insurance pursuant to part A is cancelled, the Company is still liable until a corresponding insurance contract comes into force. However, the Company's liability under the insurance contract is terminated at the latest four months after the contract has been cancelled, see section 6 subsection 1 of the Occupational Injury Insurance Act.

## PART B: HIGHER SUM INSURED

### 3.5 The provisions which apply when a higher sum insured has been agreed upon

If a higher sum insured for occupational injuries/diseases than that stated in part A has been agreed on and is not covered by the group life insurance pursuant to chapter 5, the provisions in part A apply correspondingly to the supplementary cover, with the following exceptions:

#### 3.5.1 Limitations compared to the rules stated in part A:

**a.** Section 5, last subsection (referring to former employees) of the Occupational Injury Insurance Act does not apply.

**b.** ) Clause 3.4 (regarding the Company's liability if the insurance contract is cancelled) does not apply, but is replaced by chapter 10.

**c.** ) Chapter 4, clause 4.5.1 (causing the insurance event to occur), clause 4.5.3 (flights, aviation and aviation sports), and clause 4.5.4 (war, etc – nuclear reactions) apply correspondingly.

#### 3.5.2 Right to compensation in the case of an occupational injury or occupational disease

**a)** In the case of an occupational injury, the provisions in clause 4.3.a) apply correspondingly, but such that compensation pursuant to the supplementary cover is payable at the same time as the compensation pursuant to clause 3.2.1 In order to be entitled to compensation, the occupational injury must occur during the term of the insurance. In the case of any claim for compensation, the Company is not liable unless the claimant informs the Company of the insurance event that has occurred within one year of the party concerned finding out about the factors on which the claim is based.

**b)** The right to compensation in the case of occupational disease arises if the Insured dies as a result of an occupational disease, or if the occupational disease leads to permanent medical disability that is covered by the insurance while the insurance is in force.

#### 3.5.3 Duty to pay interest

For this part of the insurance, the Company undertakes to pay interest in accordance with clause 7.4.3 of the policy conditions.

#### 3.5.4 Time-barring

For covers pursuant to part B, claims for compensation are time-barred after three years. The limitation period starts at the end of the calendar year when the person entitled to make the claim obtained the necessary knowledge about the

circumstances on which the claim is based. The claim is time-barred at the latest 10 years after the expiry of the calendar year when the insurance event occurred. Otherwise, section 18-6 of the Insurance Contracts Act and the rules stipulated in the Act relating to the limitation period for claims apply.
Claims notified to the Company prior to the expiry of the limitation period are time-barred at the earliest six months after the party entitled to make the claim has received separate written notification that time-barring will be invoked. The notification must state how the limitation period can be interrupted.
The limitation period is not extended pursuant to this provision if more than 10 years have elapsed since the claim was sent to the Company.

#### 3.5.5 Statutory regulations

For cover pursuant to part B, the rules stated in part B of the Insurance Contracts Act apply unless the policy conditions state another agreed way in which the Act may be departed from.

## PART C: EXTENDED OCCUPATIONAL INJURY INSURANCE

### 3.6 Travel between the home and workplace

The occupational injury insurance is extended to also apply to accidents that occur on travel between the home and workplace, see clause 1.16. If the insurance also covers leisure-time accidents, see chapter 4, the total compensation payable under the extended occupational injury insurance shall be deducted from the compensation payable under the leisure-time accident insurance.

# 4. Leisure-time accident insurance

### 4.1 What the insurance covers

The insurance covers leisure-time injuries provided such an insurance has been agreed upon.

The agreed benefits are stated in the insurance contract and insurance certificate.

### 4.2 The benefits that may be included in the insurance

Leisure-time accident compensation may be agreed on for:
**a)** Permanent medical disability, see clause 1.19
**b)** Incapacity for work, see clause 1.20
**c)** Death
**d)** Existing and future treatment expenses, see clause 4.6.

The benefits agreed on are stated on the insurance certificate. If the contract includes co-insureds, the co- insureds' cover is also stated on the insurance certificate.

### 4.3 The insurance event

**a)** Permanent medical disability, death and treatment expenses

The insurance event is regarded as having occurred on the date of the accident even if the consequences of the injury (permanent medical disability or death) are not clear on this date.

**b)** Incapacity for work

The insurance event in the case of incapacity for work occurs when the Insured has been incapacitated for work:

- as a result of a leisure-time injury for the continuous period stated in the insurance contract, and
- has the degree of incapacity for work that the insurance contract stipulates is required for compensation to be payable, and
- the incapacity for work is deemed permanent, if this is a requirement under the insurance contract.

If such incapacity for work has been continuous for five years, it is deemed permanent unless special circumstances indicate otherwise.

**c)** The insurance event pursuant to a) and b) must take place while the insurance is in force for the person concerned.

### 4.4 The date when the compensation is payable

Claims for compensation in the case of permanent medical disability, permanent incapacity for work and death fall due for payment as soon as the insurance event has occurred and the Company has had reasonable time to clarify its liability and calculate the final compensation due. However, compensation for permanent medical disability as a result of a leisure-time accident falls due for payment at the earliest one year after the insurance event took place. If it is clear at an earlier date that the Company must at least pay part of the amount claimed, a corresponding advance amount shall be paid, see section 18-2 of the Insurance Contracts Act.

### 4.5 The limitations that apply

#### 4.5.1 The bringing about of the insurance event

**a) Intent**

If the Insured has intentionally caused the insurance event, the Company is not liable. However, the Company is liable if the Insured could not understand the scope of his/her acts due to his/her age or state of mind. In this context, the scope of the acts means the immediate consequences of the act, namely the bodily injury. The Company is not liable for a suicide or attempted suicide. However, the insurance does cover suicide if the Insured can prove, on the balance of probabilities, that this was due to an acute mental derangement with an external cause – and not a mental disorder. The claimant bears the burden of proving that the suicide or attempted suicide was due to the Insured being incapable of understanding the scope of his/her acts due to his/her age or state of mind, see paragraph one.

**b) Gross negligence**
If the Insured has, due to gross negligence, caused the insurance event or increased the extent of the damage, the Company's liability may be reduced or eliminated completely. In deciding this, emphasis shall be placed on the degree of guilt, the course of events, whether the Insured was subject to self-induced intoxication, the effect that the reduction or termination of the Company's liability will have on the party who is entitled to the insurance or on other people who are financially dependent on the Insured and on the other circumstances. In cases other than those mentioned in paragraph one, the Company may not plead that the Insured has negligently caused the insurance event. The Company may not invoke the rules stated in paragraph one if the Insured could not understand the scope of his/her acts due to his/her age or state of mind.

**4.5.2 Special activities – sports**

**a)** The insurance does not apply to accidental injury due to boxing, wrestling, judo, karate and other similar martial arts.

**b)** Unless specially agreed to, the insurance does not apply to accidental injury that is due to:
- diving using breathing gas or skin diving at depths of more than 10 metres
- mountain climbing, bungee jumping, Super G skiing, downhill skiing, off-piste skiing and suchlike, as well as all activities that are considered to be extreme sports
- speed races involving motor vehicles or motor vessels, or training for such races
- voyages of discovery, expeditions and similar journeys

**4.5.3 Flights, aviation and aviation sports**

**a)** Without a separate agreement, the insurance does not cover accidental injury due to hang gliding, paragliding, flying using micro-light or ultra-light aircraft, parachuting and base jumping, hot-air ballooning and similar aviation-sport activities.

**b)** Regarding flights using other aircraft and helicopters, the Company's total liability to pay compensation for accidental injury that occurs during flying, irrespective of whether one or more accident insurances have been taken out, is limited to:
- For each passenger, NOK 5 million on death and NOK 5 million in the case of 100% permanent medical disability.
- For private pilots, NOK 2.5 million on death and NOK 2.5 million in the case of 100% permanent medical disability.

The limitations apply to accident insurance pursuant to this chapter and group/individual accident insurances taken out with Storebrand Livsforsikring AS, but not to special aircraft-accident insurances.

**4.5.4 War, etc – nuclear reactions**

Without a separate agreement, the Company is not liable for accidental injury or the worsening of any such injury that is directly or indirectly caused by or related to nuclear reactions, wars or warlike acts, irrespective of whether or not war has been declared, riots or similar serious disturbances of the peace, see, however, clause 4.5.5.

**4.5.5 Holiday trips abroad**

The provision in clause 4.5.4 regarding war or warlike acts does not apply to holiday trips abroad. However, the provision does apply to the areas for which the Ministry of Foreign Affairs has issued travel advice. Information on such areas may be obtained from the Ministry of Foreign Affairs' official travel advice webpages. The Company's liability is limited to injuries that occur within 30 days after the Ministry of Foreign Affairs has issued official travel advice for the area in question and is conditional on the Insured being in the affected area when the war clause is invoked.

**4.5.6 Earthquakes and volcanic eruptions**

The insurance does not cover accidental injury due to earthquakes or volcanic eruptions in Norway. The Norwegian Continental Shelf and Svalbard are also regarded as being in Norway.

**4.5.7 Injury due to medical treatment or the use of medication.**

The insurance does not apply to accidental injury caused by medical treatment, examinations or suchlike, or by taking medicines. This does not apply if the Insured has been treated for an accidental injury for which the Company is liable. The insurance shall under no circumstances cover accidental injury caused directly or indirectly by taking sleeping pills, painkillers, sedatives or narcotic substances.

**4.5.8 Limitations in the case of illness and other special conditions**

The insurance does not apply to

**a)** accidental injury caused by a stroke, fainting or other medical condition

**b)** the following illnesses or medical conditions, even if an accidental injury can be proven to be the cause: strokes, myocardial infarction and cancer. Back pains, unless the pains have arisen as a result of a break in the spinal column that can be seen on X-rays and is due to a leisure-time accident. Infectious diseases, unless the infection has entered the body through damaged tissue resulting from a leisure-time accident and other means of infection, such as insect bites, can be ruled out.

**c)** injury to the mind, such as shock, unless a bodily injury that results in permanent medical disability for which compensation is payable has occurred at the same time.

**d)** in other cases, the compensation will be reduced if it can be assumed that a medical condition or susceptibility has, together with the accidental injury, contributed to the Insured's death, medical disability or incapacity for work.

The compensation is reduced in proportion to the importance that the medical condition or susceptibility has had for the death, disability or incapacity for work.

#### 4.5.9 Fights and criminal acts

The insurance does not apply to accidental injuries caused by the Insured voluntarily taking part in fights or criminal acts.

#### 4.5.10 Poisoning, etc.

The insurance does not apply to accidental injuries due to the poisoning of food, drink or stimulants.

### 4.6 Incurred and future expenses

Incurred expenses are covered in accordance with the rules stated in the Occupational Injury Insurance Act, although limited to a maximum of 75 per cent of G (Nat. Ins. Scheme's basic amount).

Expenses under 2 per cent of G on the loss date are not covered.

Future non-recurring expenses and future annual expenses are covered in accordance with the rules stipulated in the Occupational Injury Insurance Act but limited to a total of 3G on the settlement date.

### 4.7 Incurred loss of income

The Company covers the loss of income incurred up to the settlement date, see section 3-1 of the Act relating to compensation in certain circumstances.
The following limitations apply:

**a)** For employees of the Policyholder, only the incurred loss of income from the Policyholder is covered

**b)** When the insurance is taken out by a person who is self-employed, his/her incurred loss of income from the business is covered instead of his/her loss of salary. The compensation is limited to 0.15G on the loss date per month.

### 4.8 Special settlement rules

#### 4.8.1 Deadline for giving notice of the insurance event

If compensation is claimed, the Company is not liable unless the party making the claim informs the Company of the insurance event that has occurred within one year of this party becoming aware of the circumstances on which the claim is based.

#### 4.8.2 Time-barring

Claims for compensation are time-barred after three years. The limitation period starts at the end of the calendar year when the person entitled to compensation gained the necessary knowledge of the circumstances on which the claim is based. The claim is time-barred at the latest 10 years after the expiry of the calendar year when the insurance event took place. Otherwise, section 18-6 of the Insurance Contracts Act and the rules stipulated in the Act relating to the limitation period for claims apply.

Claims which are notified to the Company prior to the expiry of the limitation period are time-barred at the earliest six months after the person entitled to compensation has received separate written notification that time-barring will be invoked. The notification must state how the limitation period can be interrupted. The limitation period is not extended pursuant to this provision if more than 10 years have elapsed since the claim was sent to the Company.

### 4.9 Subsequent settlement

If the compensation for future expenses, loss of future income or permanent injury has been determined and the injured party's level of incapacity for work or medical disability resulting from the accident changes significantly, the injured party may demand a subsequent settlement. A claim for a subsequent settlement must be submitted within five years of the settlement being concluded. It is a prerequisite for a subsequent settlement that the injured party is still an employee of the Policyholder and that the insurance is in force with the Company.

## 5. Group life insurance (insurance that covers non-occupational diseases)

### 5.1 What the insurance covers

The insurance covers non-occupational diseases if this has been agreed upon.

The assessment of whether or not a "non-occupational disease" exists must be based on a disease concept that is scientifically based and generally recognised in medical practice.

The agreed benefits are stated in the insurance contract and insurance certificate.
If the contract includes co-insureds, the co-insureds' covers are also stated in the insurance contract and insurance certificate.

### 5.2 The benefits that the insurance may include

Pursuant to this chapter, compensation may be agreed upon for:

**a)** Permanent medical disability, see clause 1.19

**b)** Incapacity for work, see clause 1.20.

**c)** Death.

## 5.3 Relationship to the other covers in the personnel insurance, lapse of the limitations on liability

### 5.3.1 The relationship to the cover pursuant to the Occupational Injury Insurance Act (chapter 3 part A)

#### 1. Incapacity for work

Regarding the sum insured for incapacity for work that is agreed upon pursuant to chapter 5, the Company cannot invoke limitations in clause 5.7 other than those stated in clause 5.7.3 in the case of occupational injury or occupational disease (injury caused with intent).

#### 2. Death

Regarding the sum insured in the case of death that is agreed upon pursuant to chapter 5, the Company may not invoke the limitations stated in clause 5.7.4 in the case of an occupational injury or occupational disease.

### 5.3.2 The relationship to other covers (chapters 3 part B and 4)

The risk exceptions and limitations stated in clause 5.7 apply to the sum insured that is agreed on pursuant to chapter 5 if the sum insured is higher for an occupational injury/disease and leisure-time accident. The Company may not invoke the risk exceptions that otherwise apply according to clauses 3.5.1.c) and 4.5.

## 5.4 Right to compensation

### 5.4.1 In the case of a sum insured pursuant to the Occupational Injury Insurance Act

In the case of an occupational injury or occupational disease pursuant to chapter 3 part A, the right to compensation arises pursuant to the provisions in section 5 of the Occupational Injury Insurance Act.

### 5.4.2 In the case of a sum insured in excess of that stated in the Occupational Injury Insurance Act

**a)** Medical disability

In the case of permanent medical disability, the insurance event occurs when:

- the Insured has been medically disabled as a result of a non-occupational disease for a continuous period of two years, and
- the level of medical disability is at least 50 per cent, and
- the medical disability is deemed permanent.

If such medical disability has lasted for a continuous period of five years, it is to be regarded as permanent unless special circumstances indicate otherwise.

**b)** Incapacity for work

In the case of incapacity for work, the insurance event occurs when:

- the Insured has been incapacitated for work as a result of a non-occupational disease continuously for the period agreed upon in the insurance contract, and
- has the degree of incapacity for work stipulated by the insurance contract for compensation to be payable, and
- the incapacity for work is deemed permanent if this is a requirement under the insurance contract. If such incapacity for work has lasted for a continuous period of five years, it is to be deemed permanent unless special circumstances indicate otherwise.

The incapacity for work must have occurred during the term of the insurance.

If a claim for the sum insured in the case of incapacity for work is made later than on the date when the insurance event occurred, the sum insured that is to be paid is calculated on the basis of the sum insured and degree of disability that prevailed on the date when the insurance event occurred.

The Insured is entitled to part-payment of 20% of the compensation for incapacity for work as a result of his/her incapacity for work, irrespective of the cause, when: the disease has led to a degree of incapacity for work of at least 50% and the Norwegian Labour and Welfare Administration (NAV) has granted the Insured at least 50% of the work assessment allowance in one or more decisions that in total have a continuous duration of at least four years.

The insurance event for the part-payment occurs on the date when NAV makes the decision that means the period is a continuous period of at least four years.

The 20% part-payment is calculated according to the same rules as those applicable to permanent incapacity for work irrespective of the cause.

Where a part-payment has been made, the compensation if permanent incapacity for work is agreed to later on will be 80% of the compensation for incapacity for work calculated according to the same rules as for incapacity for work irrespective of the cause.

Exceptions:

The insurance does not provide any right to a part-payment if the Insured:

- Is participating in or waiting for work-oriented measures or active treatment
- Is participating in or waiting for work-testing
- Is applying for jobs

The right to a part-payment only applies to persons who are members of the Norwegian National Insurance Scheme and such persons are only entitled to one part-payment.

**c)** Death

In the case of death, the insurance event occurs upon the Insured's death.

If the group life insurance includes a spouse/registered civil partner/cohabitant insurance and both the employee and

spouse/registered civil partner or cohabitant die during a 30-day period, the sum insured under the spouse/registered civil partner/cohabitant insurance is also payable even if the spouse/registered civil partner/cohabitant dies last.

**d)** The insurance event pursuant to a), b) and c) must occur while the insurance is in force for the person concerned.

## 5.5. Deadline for giving notice of the insurance event in the case of medical disability

In the case of a claim for compensation for medical disability, the Company is not liable if the claimant fails to notify the Company of the insurance event that has taken place within one year of the person concerned finding out about the factors on which the claim is based.

## 5.6 The due date for payment of the compensation

A claim for compensation pursuant to this chapter falls due for payment as soon as the Company has had reasonable time to clarify its liability and calculate the final compensation to be paid, see section 18-2 subsection 1 of the Insurance Contracts Act.
If it is clear at an earlier point in time that the Company must at least pay some of the amount claimed, a corresponding advance payment is to be made, see section 18-2 subsection 2 of the Insurance Contracts Act.

## 5.7 The limitations that apply

### 5.7.1 When no health information is obtained – compensation for incapacity for work

The Company is not liable to pay compensation for incapacity for work when this is caused by a disease or medical condition from which the Insured suffered when he/she was admitted to the insurance – and which it must be assumed the person concerned knew about – and which within two years of this results in the Insured's capacity for work decreasing by at least 50%. If the sum insured is increased due to an amendment to the contract, the limitation period starts on the date when the sum insured was increased.

### 5.7.2 Compensation for medical disability

The Company is not liable to pay compensation for medical disability resulting from a disease or disorder that was diagnosed or showed signs or symptoms less than three months after notice of admission to the insurance was sent to the Company or the person concerned was automatically admitted to the insurance.

### 5.7.3 Compensation for incapacity for work

Intentional causation of the insurance event
If the Insured has intentionally caused the insurance event, the Company is not liable unless the Insured could not understand the scope of his/her actions due to his/her age or state of mind.

### 5.7.4 Death

Co-insurance of spouse or cohabitant – spouse insurance
When a spouse/registered civil partner/cohabitant is admitted to the insurance and no health declaration is provided, the Company is not liable if the spouse/registered civil partner/cohabitant dies within two years of admission as a result of a disease or medical condition from which the person concerned suffered on the admission date and which it must be assumed that the person concerned knew about. If the sums insured under the spouse/registered civil partner/cohabitant insurance are increased as a result of an amendment to the contract, the limitation period starts on the date when the sum insured is increased.

### 5.7.5 War, riots and suchlike

Unless there is a special agreement, the Company is not liable for insurance events that are directly or indirectly caused by, or linked to, war or warlike acts, whether or not war has been declared, revolts, riots or similar serious disturbances of the peace.

## 5.8 Fully paid life insurance in the case of incapacity for work

It may be agreed that an Insured who meets the conditions stated in clause 5.4.2 b) is to be entitled to a fully paid life insurance with the same termination age as for the group life insurance. This insurance is payable upon the Insured's death.

## 5.9. Time-barring

Claims for compensation pursuant to this chapter are time-barred after 10 years. The limitation period starts at the end of the calendar year when the person entitled to compensation gained the necessary knowledge of the factors on which the claim is based. The claim is, however, time-barred at the latest 20 years after the end of the calendar year when the insurance event occurred. Otherwise, section 18-6 of the Insurance Contracts Act applies. Claims which are notified to the Company before the limitation period expires are time-barred at the earliest six months after the person entitled has received separate written notification that time-barring will be invoked. This notification must state how the limitation period may be interrupted. The limitation period is not extended pursuant to this provision if more than 10 years have elapsed since the claim was sent to the Company.

## 5.10. Subsequent settlement

If the compensation for loss of future income or permanent injury has been determined and the injured party's degree of incapacity for work or medical disability resulting from the disease changes significantly, the injured party may demand a subsequent settlement. A claim for a subsequent settlement must be submitted within five years of the settlement being concluded. It is a prerequisite for a subsequent settlement that the injured party must still be employed by the Policyholder and that the insurance is in force with the Company.

# 6. Critical Illness

## Selected diseases

The agreed benefits are stated in the insurance contract and insurance certificate.

## 6.1 Term of the insurance

The term of the insurance is the period during which the insurance contract is in force. For the individual member, the term of the insurance means the period when the person concerned belongs to the group covered by the insurance contract.

## 6.2 The diseases, etc, covered by the insurance

In order to provide a precise definition of the diseases and limitations, we use some medical expressions. These medical expressions are explained at the end of the policy wording.

### Myocardial infarction

The death of some of the heart muscles as a result of a decrease in the blood supply to this area. The diagnosis must be made on the basis of fresh changes that are typical of myocardial infarction shown by an ECG and a significant increase in heart enzymes. The occurrence of typical chest pains may be used as an additional criterion.

### Cerebral infarction (stroke)

The rapid development (within 72 hours) of clinical signs of a localised disturbance in the brain function, with signs of permanent injury confirmed by a physician at the earliest six weeks after the event. The reason must be a cerebral haemorrhage or ischaemia that must be confirmed by a CT or MR. In cases of doubt, the diagnosis must be confirmed by a neurologist.

### The insurance does not cover:

- A brain injury due to a general reduction in the supply of blood/oxygen to the brain, even if the requirements in the definition of a cerebral infarction (stroke) have been met.
- A brain injury due to an infectious disease, arteritis of any kind, tumours apart from that defined in the policy conditions under cancers and brain tumours, injuries/accidents or a migraine, even if the definitions of a cerebral infarction (stroke) have been met.
- Dementia caused by disturbances to the blood circulation in the brain.
- Vascular diseases that affect the sight nerve or eye, the hearing/balance nerve or associated sensory bodies (the labyrinth containing the hearing organ and equilibrium organ) and any isolated injury to the rest of the equilibrium system (central or peripheral vestibular disorder)

### Cancer

The presence of a malignant tumour (a tumour that is not encapsuled and can invade nearby tissues and create metastases (secondary cancer)). The cancer diagnosis also includes leukaemia and malignant lymphomas. The diagnosis must be supported by a histological description of the malignity.

The insurance does not cover:

- Any skin cancer (including lip cancer). Malignant melanomas with a thickness of more than 0.5mm are nonetheless covered.
- Any tumours that are histologically described as pre-malignant or just show early malignant changes such as in cancer in situ.

This means that the following conditions are not covered:

- In the urinary bladder and colon/rectum, tumours that do not grow into the muscularis (T1 N0 M0 or less in the TNM classification system) are not covered
- In the prostate, tumours that are not palpable or cannot be discovered using medical imaging diagnosis (T1 N0 M0 or less in the TNM classification system) are not covered
- In the cervix (cervix uteri), cancer in situ is not covered (Tis or less in the TNM classification system). However, intraductal cancer mamma is covered.

### Brain tumour

Comprises tumours that develop from tissue in the brain or brain membrane. Brain tumours provide a right to compensation even when they only spread locally and not through metastases. The diagnosis must be made by a neurology specialist/neurosurgery and a special examination (CT/MR) must have shown an intracranial tumour that must be operated on.

The insurance does not cover:
Abscesses, cysts, granulomata, haematoma and deformations in veins/arteries.

### Multiple sclerosis

Undisputably diagnosed multiple sclerosis.
The diagnosis must be made by a neurology specialist. The Insured must have neurological attacks that have lasted for more than six months, or must at least have had one recurrence of such an attack. The diagnosis must be verified by typical symptoms of demyelination and the weakening of movements and feelings and by an MR examination.

### A heart operation

A heart operation carried out to correct a narrowing or blockage of the heart's coronary arteries when there are objective findings (a work ECG or scintigraphy) of coronary heart disease and where adequate medicinal treatment has not been sufficiently effective. Open heart surgery to replace cardiac valves is also covered by the insurance.

**An angioplasty**
An angioplasty carried out to correct a narrowing or blockage of the heart's coronary arteries when adequate medicinal treatment has not been sufficiently effective.

**Any claim for indemnification must be documented with the following:**

1. A report from the specialist in cardiac diseases who is providing treatment regarding the previous treatment and medication.

2. A copy of an ECG showing significant changes (ie, a ST-sedimentation rate of 2mm or more) after a graded physical strain (a work ECG) or equivalent heart scintigraphy changes.

3. A copy of a description of a coronary angiography in which at least 70 per cent of the area has narrowed in two or more of the heart's coronary arteries, or the left coronary artery's main branch, or the top third of the left descendens coronary artery.

**Organ transplants**
A patient who has had a transplant or is on the waiting list for a heart, liver, lung, kidney or bone-marrow transplant in Norway. All autotransplantation is excluded.

**New diagnoses as from 1.6.02**
For contracts established before 1.6.02, the diagnoses below only apply if the Insured has been diagnosed and shown symptoms or signs after 1.6.02.

**Motor neurone disease**
Motor neurone disease with an unknown cause. Includes the diagnoses amyotrophic lateral sclerosis, primary lateral sclerosis, progressive spinal muscular atrophy and progressive bulbous paralysis.

**Paralysis**
Covers paralysis in the spinal cord due to disease or an accident. The complete paralysis of both legs and/or both arms, or at least one arm and one leg, is required. The paralysis must be permanent and the diagnosis must be made by a neurology specialist.

**Kidney failure**
The reduction or complete termination of the kidney function in both kidneys, which require permanent dialysis or a transplant. The diagnosis must be made by a specialist in kidney diseases.

**Blindness**
The total permanent and irreversible loss of sight in both eyes as a result of an acute illness or accident. The total loss of sight equals a sight strength of 1/50 or worse in the best eye with the best correction. The blindness must be confirmed by a specialist in eye diseases.

**Deafness**
The total and permanent loss of hearing in both ears using the best hearing aid, due to an acute disease or accident. The diagnosis must be confirmed by a specialist in ear, nose and throat diseases and the results of audiometric and sound threshold tests must be presented.

**Loss of speech**
The total and permanent loss of the ability to speak (aphasia) for a continuous period of at least 12 months. The diagnosis must be confirmed by a neurology specialist. A psychogenic loss of speech is excluded.

**Severe burn injuries**
Third-degree burns (thermal or chemical) on more than 20 per cent of the body surface measured by the "rule of nine" or a corresponding method. The diagnosis must be confirmed by a specialist in plastic surgery.

**Loss of legs or arms**
The total loss of a part of at least two limbs above the ankle or wrist, when reconstructive surgery is impossible. The diagnosis must be confirmed by a specialist in surgery or orthopaedics.

## 6.3. When Storebrand's liability starts. Limitations on Storebrand's liability.

### 6.3.1 Requirement of health information

Unless otherwise agreed, the employer is to provide a written declaration stating that the employees whom the insurance is to cover are fully able to work, see clause 2.1.1.
In addition, unless otherwise agreed, the individual employee is to provide health information on a form provided by the Company, see clause 2.1.2.

Employees who do not meet the requirement of full ability to work or regarding the state of health on the admission date will, unless otherwise agreed, be admitted to the insurance on the date when these requirements are met.

### 6.3.2 When Storebrand's liability starts

Storebrand is liable for insurance events that occur after the Company has received notification that the person has been admitted to the insurance scheme, unless otherwise agreed. However, this does not apply if Storebrand would in any case have rejected the application due to the health assessment. Nor is Storebrand liable for the consequences of circumstances that existed on the admission date if these circumstances would have been revealed in Storebrand's investigations and led to rejection, see section 12-2 subsection 3 of the Insurance Contracts Act.

**6.3.3 Later admissions**
When new employees are admitted to the insurance after the insurance contract enters into force or the insurance is extended, clauses 2.2.1 and 2.2.2 apply correspondingly.

**6.3.4 The Insured is withdrawn from the insurance**

**a)** at the end of the insurance year when the Insured reaches the age of 67 years or on an earlier agreed date,

**b)** when a sum insured is paid out,

**c)** in the case of a symptom during the symptom period, see clause 6.4.2.1, or

**d)** when the Insured no longer belongs to the group of employees covered by the insurance pursuant to the insurance contract, however see section 19-6 of the Insurance Contracts Act. Employees who leave the group as a result of incapacity for work may nonetheless remain covered by the insurance until it is clear whether the incapacity for work is due to a disease that is covered by the insurance. The prerequisite for this is that premium is paid for the person concerned in the same way as for the other insureds.

NB! The Critical Illness insurance does not provide any right to a portable insurance when the Insured is withdrawn from the insurance.

## 6.4. What the insurance covers

**6.4.1 The Critical Illness insurance**
The Critical Illness insurance is a health insurance where the sum insured is paid out either

**a)** If the Insured is finally diagnosed with a myocardial infarction, cerebral infarction (stroke), brain tumour, multiple sclerosis, cancer, motor neurone disease, paralysis, kidney failure, blindness, deafness, loss of speech, major burns and the loss of legs and arms, or

**b)** if the Insured has, during the term of the insurance, had an operation, including an angioplasty to correct a narrowing or blockage in the coronary arteries or an open heart operation to insert a new cardiac valve, or

**c)** if the Insured is, during the term of the insurance, put on a transplant waiting list in Norway or has had a heart, lung, kidney, liver or bone marrow transplant. For a further definition of these illnesses, refer to clause 6.2 and the limitations stated in clause 6.5

## 6.5. The limitations that apply

**6.5.1** It is a prerequisite for the payment of the sum insured that the Insured is alive 30 days after the diagnosis is finally made, the operation is carried out or the Insured is put on a waiting list.

**6.5.2 Storebrand is not liable for:**

**1.** Critical illness that is a result of a disease/disorder that has been diagnosed or has shown signs and/or symptoms within three months after notice of admission to the Critical Illness insurance was sent to the Company, or the person concerned was automatically admitted to the insurance.

**2.** A critical illness, see clause 6.2, that is a result of a disease/disorder that the Insured has, due to gross negligence, caused or worsened, see section 13-9 of the Insurance Contracts Act.

**3.** Critical illness, see clause 6.2, that Storebrand has excluded in the insurance certificate.

**4.** The insurance event must have occurred during the term of the insurance, see clause 6.1

## 6.6. Claims settlement

**6.6.1** The date when the sum insured falls due for payment
The sum insured in the Critical Illness insurance falls due for payment as soon as Storebrand has had reasonable time to clarify the distribution of liability and calculate its final liability.

The agreed sum insured is stated on the insurance certificate.

**6.6.2 Deadline for giving notice of an insurance event**
Storebrand is not liable if the claimant has not reported the claim to the Company within one year of the claimant finding out about the factors on which the claim is based, see section 18-5 of the Insurance Contracts Act.

**6.6.3 Interest on the sum insured**
Storebrand is to pay interest on the sum insured once two months have elapsed after the insurance event was reported to Storebrand, see section 18-4 of the Insurance Contracts Act.

**6.6.4 Declarations from experts**
The Insured undertakes to submit the declarations from experts stated in clause 6.2.

The insurance payment may depend on the claimant giving the Company the necessary authorisations to obtain information in order to be able to decide on the claim for indemnification. The Company may demand an examination by a specific physician. Both parties are entitled to obtain declarations by specialists.

If the Insured is outside Norway on the compensation date, the Company may stipulate, as a condition for paying the compensation, that the Insured is to be examined by a physician in Norway for an assessment of whether the conditions for payment exist. The physician's fee is to be paid by the Company, while any other expenses (travel, etc) are to be paid by the Insured.

### 6.6.5 The Insured's duty of disclosure and consequences of a breach of the duty of disclosure

When submitting a claim for the payment of the sum insured, the Insured must give the Company the information and documents that are available to him or her and which the Company needs in order to decide on the claim and pay the sum insured.

According to section 18-1 of the Insurance Contracts Act, anyone who provides incorrect or incomplete information may lose any claim for compensation against the Company and the Company may terminate this person's other insurances. Clause 6.2 of the policy conditions states the documentation required for various diagnoses.

If the policyholder or insured has breached his/her duty of disclosure when the insurance for the person concerned enters into force, the provisions in sections 13-2 to 13-4 of the Insurance Contracts Act apply.

### 6.6.6 Time-barring

If a claim for indemnification under the Critical Illness insurance has not already lapsed according to clause 6.5.2 and clause 14, the claim is time-barred after three years in accordance with section 18-6 of the Insurance Contracts Act.

Claims reported to the Company before the expiry of the limitation period are normally time-barred at the earliest six months after the person entitled has received a separate written notice stating that time-barring will be invoked, see section 18-6 subsection 3 of the Insurance Contracts Act.

## 6.7 Changes to policy conditions and prices

The Company may change its policy conditions, risk prices and charges each year on the insurance's annual renewal date in compliance with the prevailing rules stipulated by the authorities.

**The Critical Illness policy conditions contain some medical expressions.**
**Below, we provide a simplified explanation of some of them. If you are in doubt, contact Storebrand or your doctor.**

| | |
|---|---|
| abscess | a cavity with pus (infected fluid) |
| aphasia | loss of speech |
| amyotrophic lateral sclerosis | motor neurone disease, see this |
| angiography | an X-ray to examine blood vessels |
| angioplasty | a balloon widening (used, among other things, to widen narrowed arteries or veins) |
| artery | blood vessels that carry blood away from the heart |
| audiometry | hearing test |
| autotransplantation | a part of the body that is transplanted from one part of the body to another in the same person |
| cancer in situ | an early stage of cancer, really before the cancer cells have managed to grow into the surrounding tissue |
| cerebrovascular | relating to the blood vessels in the brain |
| CT | computer tomography (an advanced X-ray examination) |
| cyst | a fluid-filled cavity |
| demyelination | the disappearance of the myelin sheath (a kind of sheath that surrounds nerve fibres) |
| descendens | descending |
| dialysis | blood cleansing if the kidney has ceased to function or is functioning very poorly |
| ECG | electrocardiogram |
| focal | limited |
| granuloma | a group of inflamed cells |
| haematoma | a collection of blood |
| histological | a description of the tissue as it appears under the microscope |
| cardiac markers | substances from the heart, can be shown by a blood test |
| left main coronary artery | the main coronary artery (the largest part of an artery |
| in situ | “at the place” (ie, local) |
| intraductal cancer mamma | an early stage of breast cancer |
| intracranial | inside the skull |
| ischaemia | reduced blood supply |
| coronary artery | an artery that supplies the heart muscles with blood |
| coronary angiography | an X-ray examination of coronary arteries after a contrast fluid has been inserted |
| coronary heart disease | illness in one or more coronary arteries in the heart |
| leukaemia | cancer of the blood |
| sound threshold test | a method for determining hearing loss |
| malformation | a deformity |
| malignant | very virulent or infectious |
| malignant lymphomas | a very virulent or infectious tumour in lymphatic tissue |
| malignant melanomas | a very virulent mole tumour |
| metastasis | the spread of a tumour to a different site |
| motor neurone disease | an illness that attacks nerve paths and nerve roots in the brain and spinal cord |
| MR | magnetic resonance (an X-ray-like examination which in many cases provides a better picture than a normal X-ray or CT) |
| palpable | a tumour that can be felt by the physician during an examination |
| pre-malignant | an early stage in the development of a tumour (before it has developed into cancer) |
| primary lateral sclerosis | motor neurone disease, see this |
| progressive bulbous paralysis | motor neurone disease, see this |
| psychogenic | that is related to mental factors |
| “rule of nine” | a method for determining body surface. For example, the entire back equals 18% of the body’s surface. |
| sequel | a subsequent condition |
| scintigraphy | a recorded image of radiation from a radioactive substance in the body |
| spinal muscular atrophy | motor neurone disease, see this |
| ST | a part of the curve produced by an ECG |
| thermal | related to high temperature |
| third-degree burns | deep burns to the skin, subcutaneous layer and underlying tissue |
| TNM | a classification system that says something about how serious a cancer is |
| vascular | related to blood vessels |
| vestibular | related to the balance organ in the inner ear |

# 7. Settlement rules, etc.

The provisions in this chapter apply generally, with the exception of special rules stated in Chapters 3, 4, 5 and 6.

## 7.1 Notification of the insurance event, documentation, etc

**a)** Notification of the insurance event
If the insurance event has occurred, persons who believe they have a claim against the Company must notify the Company of this without undue delay.

**b)** Reports from expert witnesses
The Insured and Company are entitled to obtain reports from physicians and specialists that are important for determining the basis of the compensation calculations. If the Company finds it necessary to obtain a medical report from a new expert witness, reasons for this shall be stated in writing.

**c)** Death
The party submitting a claim under the insurance must obtain a death certificate together with documentation showing the person or persons entitled to receive compensation.

**d)** Documentation of losses and expenses
Losses and expenses for which the Company is liable shall be documented by original vouchers or other authorised statements.

## 7.2. The Insured's right to use the compensation or sum insured, etc.

### 7.2.1 Medical disability and incapacity for work

Compensation for medical disability and incapacity for work is payable directly to the Insured. If the Insured dies after becoming entitled to disability compensation and/or incapacity for work compensation but before this compensation has been paid, the payment shall be made to the Insured's estate.

### 7.2.2 Assignment and creation of a charge

As long as the Insured's claim against the Company has not fallen due, the person concerned cannot assign or create a charge on his/her right to claim against the Company.

### 7.2.3 Surrender value and paid-up policy value

The insurance has no surrender or paid-up policy value.

## 7.3 Settlement rules

### 7.3.1 Determination of the permanent degree of medical disability

**7.3.1.1** Basis for determining the degree of medical disability.
The degree of medical disability is determined according to the disability table – published by the Ministry of Health and Social Affairs in regulations regarding compensation for permanent injury due to an occupational injury – that applies on the date when the insurance event occurs. The determination of the degree of medical disability is to be based on the principles stated below. Regarding consequential injuries that are not included in the table, the degree of disability is to be determined following a discretionary comparison with the consequential injuries stated in the table.

**7.3.1.2 Principles applied when determining the permanent degree of medical disability:**

**a)** Occupational injury/occupational disease
If the Insured suffers from several consequential injuries following the same occupational injury/occupational disease or after several occupational injuries, including occupational injuries covered by the National Insurance Act, the degree of disability is to be determined on the basis of an overall assessment.

**b)** Leisure-time accidents
The permanent degree of medical disability is to be determined for each individual insurance event and for the individual organ or part of the body. If it has been agreed that no compensation is payable for disability below a certain level, this also applies for each insurance event. The loss of or damage to a limb or organ that was completely useless prior to the insurance event does not provide any right to compensation. If a limb or organ was previously partially lost or useless, a corresponding deduction is to be made when determining the degree of disability. The distribution rules stated in subsection three also apply.

- maximum degree of medical disability
  The degree of disability applicable to the same insurance event cannot exceed 100% even if several limbs or organs are injured.
- distribution rule in the case of an interaction between causes
  If it can be assumed that a medical condition or susceptibility has, together with the insurance event, contributed to the Insured's medical disability, the compensation is to be reduced by the percentage by which the medical condition or susceptibility has contributed.

**c)** Non-occupational diseases
When determining the permanent degree of medical disability for insurance covering a non-occupational disease, clause b above applies correspondingly.

### 7.3.2 Compensation for incapacity for work

**7.3.2.1 The basis for calculating compensation**

**a)** In the case of an occupational injury/occupational disease (chapter 3)
The basis for calculating the future loss of income due to an occupational injury/disease is the pensionable salary for the year before the injury or disease was ascertained. The limitations mentioned in section 3-13 subsection 4 of the National Insurance Act do not apply. Should the injured party's estimated pensionable salary, if he/she had not been injured or suffering from the disease, for

the year when the injury or disease was ascertained result in a higher basis, then this is to be used as the basis. The same applies if the injured party has, in a later income year, achieved a pensionable salary that results in a higher basis. If there are particular grounds for assuming that the basis for the calculations pursuant to subsections one and two deviates significantly from that which would have been the injured party's normal level of income if he/she did not suffer from the injury or disease, the basis for the calculations is to be set at this level.

**b)** In the case of an insurance other than an occupational injury/occupational disease insurance (chapters 4 and 5)

- If the basis for calculating compensation for incapacity for work under an insurance other than an occupational injury/disease insurance is the Insured's pensionable salary, the pensionable salary that the Insured had during the year prior to the start of the incapacity for work period is to be used. If there are particular grounds for assuming that the basis for the calculations pursuant to the first paragraph deviates significantly from that which would have been the injured party's normal level of income if he/she did not suffer from the injury or disease, the basis for the calculations is to be set at this level.
- If the basis for calculating compensation for incapacity for work due to a non-occupational disease is the sum insured upon death stipulated for the Insured in the contract, the sum insured upon death shall include any allowances payable for children or a spouse/registered civil partner or any family provider's (dependants') allowance.
- If the sum insured is reduced, through an amendment to the contract, after the incapacity for work has occurred, the sum insured shall nonetheless be determined in accordance with the contract that applied when the incapacity for work started.

**c)** The salary base

The determination of the salary base as a multiple of G takes place on the basis of the G (National Insurance Scheme's basic amount) on 1 January of the income year when the salary was earned.

#### 7.3.2.2 Determination of the degree of incapacity for work

The degree of incapacity for work is determined according to the Insured's ability to carry out paid work (ability to earn income). When assessing whether and to what extent the ability to earn income has been permanently reduced, the possible incomes from any work that the person concerned can now carry out are to be compared to the possible incomes that the person concerned had before the disease, injury or medical condition arose.

## 7.4 Calculation rules. Duty to pay interest

#### 7.4.1 The National Insurance Scheme's basic amount - G

The compensation in the case of a settlement pursuant to chapter 3 part A (occupational injury insurance) is calculated according to the value of G on the settlement date. The compensation is otherwise calculated according to the value of G when the insurance event occurs.

#### 7.4.2 Age

When compensation depends upon age, the age on the date when the insurance event occurs is applied. When determining the compensation pursuant to chapter 3 part A, however, the following are applied:

- for compensation for permanent injury, the employee's age on the ascertainment date.
- for compensation for incapacity for work, the employee's age on the settlement date.
- for compensation for death, the employee's age at death.

#### 7.4.3 The Company's duty to pay interest

**a)** Interest on compensation

The Company shall pay interest on the compensation or sum insured when two months have elapsed since the notification of an insurance event was sent to the Company – refer, however, to clause 3.3 regarding statutory occupational injury insurance.

**b)** Interest on payment of outlays

The Company shall pay interest on the Insured's outlays when two months have elapsed since the claim for payment of outlays was sent to the Company – refer, however, to clause 3.3 regarding statutory occupational injury insurance.

**c)** The duty to pay interest lapses

If the Insured fails to provide the information or hand over the documents stated in clause 7.1, the Insured cannot claim interest for the period lost due to this. The same applies if the person entitled to the amount wrongfully rejects a full or partial settlement.

**d)** Statutory rules regarding the duty to pay interest

Provisions regarding the duty to pay interest are stated in section 18-4 of the Insurance Contracts Act, the Act no. 100 of 17 December 1976 relating to interest on overdue payments, et seq, and the Occupational Injury Insurance Act and regulations issued pursuant to it.

## 7.5 Coordination

**a)** National Insurance benefits

When paying compensation for incurred expenses and when calculating compensation for future additional expenses, loss of income and compensation to persons other than a spouse/cohabitant or children, all the National Insurance benefits that the Insured is entitled to as a result of the injury or illness are to be deducted. If the Insured is not a member of the Norwegian National Insurance Scheme, the National Insurance benefits that the Insured would have been entitled to are to be deducted.

**b)** Automobile Liability Act/law of damages

Compensation claimed under the Automobile Liability Act or other damages legislation will be deducted in full in the insurance settlement.

Coordination rules stated in items a) and b) do not apply to benefits payable under chapter 5 of the group life insurance or chapter 6 of the critical illness insurance.

# 8. The policyholder's duties regarding notifications to the Company and the Insureds

## 8.1 Notifications to the Company

### 8.1.1 Duty of disclosure

Provided the Company has not agreed to accept the insurance, the Company may request information that may be of importance to the assessment of the risk. The Policyholder shall provide correct and complete answers to the Company's questions and on its own initiative provide information on particular circumstances that it must understand are of considerable importance to the Company's assessment of the risk. This applies correspondingly to the renewal or expansion of the insurance. The Policyholder also undertakes to notify the Company of any changes to or expansion of its operations.

### 8.1.2 Actively at work declaration – health declaration

The Policyholder shall provide a written declaration stating that the employees whom the insurance is to cover are fully able to work, see clause 2.1.1. If the insurance covers incapacity for work and death in accordance with chapter 5, the Company is entitled to require employees to provide health information when the contract covers fewer than a certain number of insureds. When health declarations are to be provided, the employer shall send these to the Company in a sealed envelope. If the contract allows employees to refuse to become members of the insurance, refusal declarations shall be sent to the Company.

### 8.1.3 Notification of an insurance event

The Policyholder undertakes to inform the Company in writing and without undue delay when a member has been exposed to an event that must be assumed to entitle him/her to compensation.

## 8.2 Notifications to the employees

### 8.2.1 Information on the insurance

The Policyholder shall inform the Insureds of the insurance scheme, of any right they have to refuse to be members of the insurance and of the consequences of such refusal. Upon admission and any later amendments to the covers, the Policyholder undertakes to give the Insureds an insurance certificate. During the term of the insurance, the Policyholder shall impart the information on the insurance scheme that the Company makes available.

### 8.2.2 Information when the employee leaves the Company and when the contract is terminated

At the latest on the date when the employee withdraws from the insurance or at the latest one month before the contract is terminated, the Policyholder undertakes to notify the employees of the termination of the Company's liability in a separate letter prepared by the Company. Correspondingly, the employees shall be informed when the insurance contract is amended in their disfavour by the sums insured being reduced, by the policy conditions being altered or by the termination of covers and suchlike. Co-insured spouses/cohabitants are to be notified via the employee.

## 8.3 Liability for damages – right of recourse

**a.** If the Policyholder has caused the Company to incur financial loss due to a failure to comply with the provisions of the insurance contract and policy conditions, the Company will require its loss to be indemnified by the Policyholder.

**b.** If the Policyholder or employee is entitled to require a third party to indemnify a loss covered by the insurance in accordance with the normal rules governing damages, the Company assumes their rights regarding this third party, see section 3-7, no. 3 of the Act relating to compensation in certain circumstances and section 8 of the Occupational Injury Insurance Act.

**c.** The Company may seek to recover an amount from a Policyholder that has intentionally caused the employee's injury or disease. This opportunity also applies to amounts reimbursed to the National Insurance Scheme, see section 8 subsection 2 of the Occupational Injury Insurance Act.

# 9. The employee's duty of disclosure in the case of an insurance other than an insurance pursuant to the Occupational Injury Insurance Act

## 9.1 Duty to provide information on the risk

Provided the Company has not agreed to cover the insurance, the Company may request information that may be of importance to the assessment of the risk. The employee shall provide correct, full answers to the Company's questions. The employee shall also, on his/her own initiative, provide information on special factors that the person concerned must understand are of considerable importance to the Company's assessment of the risk.

## 9.2 The consequences of failing to comply with the duty of disclosure

### 9.2.1 Reduction in or waiving of the Company's liability

**a)** If the employee has fraudulently failed to comply with his/her duty of disclosure pursuant to clause 8.1 and an insu-

rance event has occurred, the Company is not liable, see section 13-2 subsection 1 of the Insurance Contracts Act.

**b)** If the employee has otherwise failed to comply with his/her duty of disclosure and the employee is not only slightly to blame for this, the Company's liability may be reduced or eliminated completely, see section 13-2 subsection 2 of the Insurance Contracts Act. In the case of life insurance, the Company may only claim, unless fraud is proven, that the duty of disclosure has not been complied with if the insurance event has occurred or the Company has given notice pursuant to section 13-13 of the Insurance Contracts Act within two years of the Company's liability starting, see section 13-4 subsection 2 of the Insurance Contracts Act.

#### 9.2.2 The Company's right to cancel the insurance

**a)** If the employee has acted fraudulently, the Company may cancel this and other insurance contracts it has with the employee concerned with immediate effect, see section 13-3 subsection 1 of the Insurance Contracts Act.

**b)** If the Company becomes aware during the term of the insurance that the duty of disclosure has not been complied with and the Insured is not only slightly to blame for this, the Company may cancel the insurance by giving 14 days' notice, see section 13-3 subsection 1 of the Insurance Contracts Act.

#### 9.2.3 The Company's right to cancel other insurance contracts

In cases such as those mentioned in clause 9.2.1.a), the Company may cancel any insurance contract it has with the person concerned by giving one week's notice of this, see section 18-1 subsection 5 of the Insurance Contracts Act.

### 9.3 Duty to provide information in the case of a claim for compensation

A party wishing to submit a claim against the Company shall provide the Company with the information and documents that are available to the person concerned and which the Company needs to be able to decide on the claim and pay the compensation amount, see section 18-1 subsection 1 of the Insurance Contracts Act. When the Company brings a claim for recourse against a person responsible for causing a loss in order to recover compensation or a sum insured that the Company has paid, the Insured shall give the Company the information that is available to the Insured and which is of importance for enforcing the Company's claim against a third party.

### 9.4 The consequences of providing incorrect information

#### 9.4.1 Reduction or waiving of the Company's liability

**a)** If a party submitting a claim against the Company provides incorrect or incomplete information that the party knows or ought to understand may lead to compensation being paid to which he or she is not entitled, the person concerned loses any claim for compensation against the Company pursuant to this and other insurance contracts for the same event, see section 18-1 subsection 4 of the Insurance Contracts Act.

**b)** If the circumstances are only slightly blameworthy, only relate to a small part of the claim or if there are other special grounds, the claimant may still receive partial compensation, see section 18-1 subsection 4 of the Insurance Contracts Act.

#### 9.4.2 The Company's right to cancel the insurance and other insurance contracts in the case of an insurance other than life insurance

In cases such as those mentioned in clause 9.4.1, the Company may cancel any insurance contract it has with the party concerned by giving one week's notice of this, see section 18-1 subsection 5 of the Insurance Contracts Act.

## 10. Withdrawal from the insurance

### 10.1 The Insured's withdrawal from the insurance

#### 10.1.1 The employee withdraws from the insurance

**a)** on the date when the employee relationship is terminated, but at the latest on the date stipulated in the insurance contract. In the case of insurances that cover a death risk in accordance with chapter 5, it may be agreed that leaving the Company with a disability pension or early retirement pension is not to be regarded as a reason for withdrawal from the insurance. The cover for disability pensioners and any early retirement pensioners must in such case be stated in the insurance contract.

**b)** on the date when the employee leaves the group covered by the insurance.

**c)** in the case of a leave of absence to work for another employer, unless otherwise agreed.

**d)** irrespective of the items above, the Insured is withdrawn from the group life insurance on the date when the right to a fully paid-up death-risk insurance arises. A co-insured spouse/registered civil partner or cohabitant is withdrawn from the group life insurance on the same date. A spouse/registered civil partner or cohabitant is in such case entitled to a fully paid-up death-risk insurance with the same term of insurance as the group life insurance and with the sum insured that applied on the withdrawal date.

#### 10.1.2 Unless otherwise agreed, the insurance is in force

**a)** during parental leave

**b)** during other leave of up to six months, apart from leave to work for another employer

**c)** while taking part in mandatory military or civilian service
**d)** while taking part in a lawful strike or lock-out.

**10.1.3 A co-insured spouse/registered civil partner/ cohabitant is withdrawn from the insurance**
**a)** on the date when the criteria for being counted as a co-insured spouse/registered civil partner/cohabitant stated in clauses 1.4 and 1.5 are no longer fulfilled, or
**b)** on the date when the employee is withdrawn from the insurance scheme.

**10.1.4** A group life insurance has no surrender value or paid-up policy value.

### 10.2 The date when the Company's liability is terminated

When an employee or co-insured is withdrawn from the insurance pursuant to clause 10.1, the Company's liability is terminated at the earliest 14 days after a written reminder of the termination is sent to the employee, who also receives the reminder on behalf of any co-insureds. If no reminder has been sent, the Company's liability is terminated two months after the employee or co-insured is withdrawn from the insurance. If the Company is liable for insurance events pursuant to the above paragraph, the compensation is to be reduced to the extent that the person concerned has in the meantime been admitted to a corresponding insurance and receives compensation under this.

### 10.3 Right to an individual portable insurance

When the employee is withdrawn from the insurance for reasons other than reaching the age limit, the employee concerned is entitled to continue the insurance relationship according to further rules, with individual calculation of the premium and without the employee having to provide new information on his/her health, see section 19-7 of the Insurance Contracts Act. The right to a portable insurance applies to a life insurance that covers incapacity for work and death. A co-insured spouse/registered civil partner/cohabitant has the same right to take out such an individual portable insurance when the person concerned is withdrawn from the insurance.
The Company must have received written notification that the person wishes to exercise this right within six months of the Company's liability being terminated according to clause 10.2 and/or chapter 11. The right to take out a portable insurance does not apply when the insurance is cancelled in order to be transferred to another company.

### 10.4. Restrictions on the right to take out an individual life insurance

An insured who has become entitled to a fully paid-up life insurance in accordance with clause 5.8 is not entitled to take out an individual life insurance as mentioned in clause 10.3.

**10.4.1 Insurance that does not provide a right to an individual insurance:**
Benefits pursuant to an occupational injury insurance, chapter 3,
Benefits pursuant to a leisure-time accident insurance, chapter 4,
Benefits pursuant to a critical illness insurance, chapter 6.

## 11. Renewal and cancellation of the insurance contract

### 11.1 Renewal of the insurance contract

If the Policyholder or Company does not exercise its right to cancel, the contract is automatically renewed for one year at a time.

### 11.2 The Policyholder's right to cancel the insurance contract

If the Policyholder does not want the insurance to be renewed automatically on its annual renewal date, notification of this must be sent to the Company by the end of the insurance year. The same applies if the Policyholder wishes to amend the insurance contract and this amendment leads to a reduction of the rights of some of the Insureds. The Policyholder may cancel a current insurance policy during the insurance year if there is no longer a need for insurance or for other special reasons, or in order to transfer the insurance to another company.
The Policyholder is to notify the Company in writing, giving at least one month's notice. If the insurance is transferred to another company, the Company is to be notified of the name of the company to which the insurance is being transferred and the date of the transfer.

If the insurance is cancelled, the Policyholder is to inform the Insureds of this as quickly as possible and at the latest one month before the insurance's termination date. If the insurance is transferred to another company, the Insureds are to be informed about this in a corresponding manner.

### 11.3 The Company's right to cancel the insurance contract

If, at the end of an insurance year, the insurance does not comply with the Company's requirements regarding the minimum number of Insureds, the Company is entitled to cancel the contract regarding the cover in accordance with chapter 5 of the policy conditions. However, the cover is terminated at the earliest at the end of the subsequent insurance year provided the conditions are still not complied with on that date. Nevertheless, the cover may be extended for another one year if the Policyholder proves that the conditions will probably be complied with at the end of that insurance year.

**The Company may otherwise cancel the insurance:**
**a)** If the Policyholder has acted fraudulently, the Company may cancel this and other insurance contracts it has with

the Policyholder with immediate effect, see section 13-3 subsection 1 of the Insurance Contracts Act.

**b)** If the Company becomes aware, during the term of the insurance, that the duty of disclosure has not been complied with and the Policyholder is not only slightly to blame for this, the Company may cancel the insurance by giving 14 days' notice of this, see section 13-3 subsection 1 of the Insurance Contracts Act.

**The Company's right to cancel other insurance contracts:**
In cases where the Policyholder has fraudulently failed to comply with the duty of disclosure such that the Company is no longer liable to pay compensation, the Company may cancel any insurance contract it has with the Policyholder by giving one week's notice of this, see section 18-1 subsection 5 of the Insurance Contracts Act.

### 11.4 When liability for the Insureds is terminated following the cancellation of the insurance contract

If the Policyholder or Company cancels or fails to renew the insurance contract, or the Company's liability is terminated due to the Policyholder's failure to make premium payments, the insurance ceases to apply to the Insured one month after either written notification of this is given to the Insured or the Insured becomes aware in some other manner that the insurance contract is no longer in force. In the case of insurance events for which the Company is liable, the compensation will be reduced to the extent that the Insured has in the meantime been covered by a corresponding insurance and receives compensation under this.

If the insurance is cancelled, the insurance cover is maintained without premium payments for Insureds who are incapacitated for work to an extent that entitles them to disability compensation as a result of a leisure-time accident and/or non-occupational disease.

If the incapacity for work ceases or the degree of incapacity of work is reduced without the Insured having become entitled to the aforementioned benefits, the insurance is also cancelled. In such case, the Insured is entitled to take out an individual portable insurance, see clause 10.3. Upon the termination of the Company's liability pursuant to this clause, clause 10.3 regarding the employee's and any co-insured's rights to take out individual portable insurances applies. If the insurance contract covered occupational injury insurance, clause 3.4 applies.

However, the right to take out a portable insurance does not apply when the insurance is cancelled in order to be transferred to another insurance company.

## 12. Reservation of the right to make future changes to the policy conditions and premium schedules

The Company is entitled to change premium schedules and conditions as from the first annual renewal date.
The Company is to give the Policyholder and the Insureds information on the change. This particularly applies if the conditions are changed to the detriment of the Insured.

## 13. Disputes, Complaints Board and legal venue

**Disputes and Complaints Board**
Complaints that refer to the insurance contract are to be made directly to the Company:
Storebrand Livsforsikring AS
Postboks 500
NO-1327 Lysaker
Tel 08880

Complaints that relate to the insurance contract and settlements pursuant to this may also be made to:

The Norwegian Financial Services Complaints Board (Finansklagenemnda)
Postboks 53, Skøyen,
NO-0212 Oslo.
Tel (+47) 23 13 19 60

**Legal venue**
Disputes regarding the policy conditions are to be determined by a Norwegian court provided this does not contravene the rules regarding legal venues for insurance disputes stipulated in Act no. 21/1993.

## 14. Deadline for taking legal steps

In relation to accident and health insurances, the Company is not liable if the claimant has not brought legal proceedings or asked the Complaints Board to deal with an issue within six months. This limitation period starts on the date when the Company has notified the person concerned in writing that it does not regard itself as liable and at the same time reminded him or her of the limitation period, its length and the consequences of it being exceeded – see section 18-5 of the Insurance Contracts Act.

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