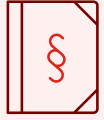


Group life insurance for businesses



Effective January 1, 2026

Replaces conditions of 1 January 2024

For the insurance, these terms and conditions, the insurance agreement, and insurance certificates entered into between the company and Storebrand Livsforsikring AS apply. Applicable legislation also applies; however, the terms and conditions shall prevail where they differ from statutory provisions that may be deviated from.

The insurance coverage and sums insured that have been agreed will be stated in the insurance contract and the insurance certificate.

What is a group life insurance?

A group life insurance policy is a collective life insurance agreement that an employer can establish for its employees or groups of employees, and possibly their spouse, registered partners or cohabitants.

A group life insurance policy may include the risk of death and/or disability risk with permanent or temporary disability.

Notice of disclaimer

Translated from Norwegian. The Norwegian terms and conditions apply. This document shall not be recognized as legally binding and has been prepared for the sole purpose of understanding the Norwegian legal document in force.

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1. Definitions

1.1 The company

The enterprise means Storebrand Livsforsikring AS.

1.2 Policyholder

The policyholder means the person who enters into the insurance contract with the company.

1.3 Insured

The insured means the person whose life or health the insurance is linked to.

1.4 The insurance contract

The insurance contract means the agreement entered into between the policyholder and the undertaking, and contains details of the mutual rights and obligations of the established insurance contract, the agreed scope of coverage, sums insured, administration, etc.

1.5 Insurance certificate

A written certificate to the insured that must contain information about agreed benefits, limitations and which insurance terms apply.

1.6 Insurance period

The insurance period means the period for which the insurance contract is valid. For the individual insured, the period of insurance means the period during which the insurance is valid for him/her.

1.7 Year of insurance

Insurance year means the 12-month period from the main maturity of the insurance.

1.8 When the insurance incident occurs

An insurance event occurs when the conditions for payment of compensation are met. When an insurance event occurs, this is described in more detail under each insurance cover in the personal insurance.

1.9 Spouse/registered partner

The insured's spouse means the person who has entered into marriage with the insured. A person who has entered into a registered partnership with the insured is treated as equal to a spouse.

A person shall no longer be regarded as an insured spouse or registered partner from the time a decree or official authorization for separation or divorce has been issued, even if the decision is not final or legally binding.

1.10 Cohabitant

Cohabitants are considered to be cohabitants:

- person with whom the insured person lives in a marriage or partnership-like relationship, if the National Population Register shows that the two have had the same home for the past two years, or
- person who has children together and a shared home with the insured.

However, a person is not considered to be a cohabitant if, at the time the insurance event occurs, there were circumstances that prevented legal marriage from being entered into, cf. Sections 1 to 5a and Sections 8 and 9 of the Marriage Act.

A person is not considered to be a cohabitant for longer than the time when there is an actual breakdown of cohabitation or until the time when the above-mentioned definition of cohabitant is no longer fulfilled for any other reason.

1.11 Children

By children is meant the insured's own children and stepchildren. Furthermore, other children are included as follows. public authority is supported by the insured and is busy in his/her family.

1.12 Provider

By provider is meant an employee who has a spouse/registered partner (see section 1.9) or cohabitant (see section 1.10) or is single with children (see section 1.11) under the age of 21.

1.13 Single provider

By single provider is meant a person who has sole responsibility for the child/children, because the other parent is dead or unknown.

1.14 Co-insured

By co-insured is meant the insured's spouse, registered partner or cohabitant, cf. sections 1.9 and 1.10.

1.15 National Insurance basic amount – G

By G is meant the basic amount in the National Insurance Scheme. The basic amount is determined annually by the Storting, cf. Section 1-4 of the National Insurance Act.

1.16 Capacity for work

By full capacity for work means that the person in question is fully fit for work, corresponding to a full-time position.

1.17 Incapacity for work (loss in future acquisition)

By Incapacity for work is meant full or partial loss of the ability to provide income-generating work.

The degree of disability is determined according to the insured's ability to perform income-generating work (earning capacity). When assessing whether and to what extent the person's earning capacity is to be considered permanently impaired, the income opportunities in any work that the person in question is now able to perform must be compared with the income opportunities that the person in question had before the illness, injury or defect occurred.

1.18 Determination of the date of disability

The date of disability is understood to be the first day of the last continuous period of sick leave leading up to an insurance event.

2. Group life insurance (insurance that covers illness other than occupational disease)

A collective life insurance policy that an employer can establish for its employees. This insurance can provide one-off compensation to the employees' survivors in the event of the employee's death, and/or employees who become permanently or temporarily incapacitated for work of at least 40 percent.

It will be stated in the insurance agreement and the insurance certificate whether group life insurance has been established.

2.1 Who the insurance applies to

The group life insurance applies to permanent employees of the policyholder mentioned in the insurance contract and the insurance certificate who have not reached the termination age of the insurance. The insurance contract and the insurance certificate state the age of termination that applies.

For insured persons who are not members of the Norwegian National Insurance Scheme, the following limitation applies:

- The degree of permanent incapacity for work shall be determined by a doctor in Norway in accordance with current regulations in Norway.
- Expenses in connection with the determination of the permanent degree of disability are not reimbursed.

2.2 Where the insurance applies

Group life insurance is valid throughout the world, however, see the exemption provisions in war/unrest and terrorist acts.

2.3 When the insurance applies

The insurance is valid from the time specified in the insurance contract and the insurance certificate.

The prerequisites for the individual employee's enrolment in the insurance are set out in sections 2.3.1 to 2.3.4

2.3.1 Requirements for full employability

The insurance only applies to employees, co-insured spouses or cohabitants who were fully fit for work at the time of enrolment. For an employee, co-insured spouse or cohabitant who is not fully fit for work at the time of enrolment, the insurance begins to run from the day he or she is fully fit for work again.

2.3.2 Requirements for self-declaration around the neck

Group life insurance with compulsory membership:

- a) When the number of insured is less than 5 people:

The employee must submit a self-declaration of health. The company is responsible for insurance cases that occur after the insurance contract has entered into force. However, this does not apply if the enterprise would have refused the insurance coverage under any circumstances through the health assessment. Nor is the

undertaking liable for the consequences of circumstances that existed at the time of the application if these circumstances would have been uncovered during the undertaking's investigations and led to a rejection, cf. Section 12-2, second paragraph, of the Insurance Contracts Act.

If the company does not find the health information satisfactory, the person in question cannot be included in the insurance or have a reservation for the illness/disorder in question.

For employees who, due to their state of health, cannot be included in the insurance, the insurance comes into force on the day the requirements for a health assessment are again met.

For co-insured spouses or cohabitants who are to be included in the group life insurance, no declaration of fitness for work or state of health is required in schemes with compulsory membership. If the spouse or cohabitant dies within 2 years of becoming co-insured, the company's liability for compensation is limited, cf. section 5.10.12. The same applies in the event of an increase in the insurance of a spouse or cohabitant.

b) When the number of insured is 5 people or more

The employee must not submit a self-declaration of health when the number of insured persons is 5 persons or more.

Group life insurance with voluntary membership:

When the member can join the group life insurance on a voluntary basis, a self-declaration of health is always required from the employee and, if applicable, co-insured spouse and cohabitant.

For group life insurance with voluntary membership, no self-declaration of health is required if the number of employees entitled to insurance is at least 750 and the coverage of the insurance is at least 80%, or the number of employees entitled to insurance is at least 250 and the acceptance of the insurance is at least 90%.

2.3.3 Later enrollments

The insurance is valid from the time specified in the insurance contract and the insurance certificate. There is a requirement for full work ability, but there is no requirement for a self-declaration of health.

When there is no requirement for a self-declaration of health, the provisions of section 2.3.1 also apply correspondingly to subsequent reports.

For employees who are not fully fit for work, the insurance begins to run from the day they are fully fit for work again.

If an employee who meets the conditions for inclusion in an insurance with compulsory membership reserves membership or does not join it within 1 month, approved health information is required to later join the insurance. The health information is provided at no cost to the enterprise on a form stipulated by the enterprise.

2.3.4 Amendment of the agreement

In the event of a change in the agreement that entails the enrolment of new groups of employees in the insurance, an increase in the sum insured that takes place after the entry into force of the insurance, the following applies:

a) In the event of an increase in insurance sums that are within the scope of the insurance, such as from one wage group to another, from the group of married to the group of unmarried, only full employability is required.

- b) In the event of an increase in the sum insured that is outside the scope of the insurance, such as an increase in the sum insured for one or more insured, the requirement for full fitness for work and a self-declaration of health applies as at the time of the establishment of the insurance, cf. sections 2.3.1 and 2.3.2.
- c) If, in accordance with the insurance contract, the sum insured is to be increased in accordance with the National Insurance basic amount (G), no fitness for work or self-declaration of health is required.

Unless otherwise agreed, the increase or extension takes effect on the day the new insurance contract is entered into.

2.4 What the insurance can cover

The insurance may cover permanent incapacity for work, temporary incapacity for work and/or death if this has been agreed.

When determining whether a disease exists, a concept of illness that is scientifically based and generally recognised in medical practice must be used.

The agreed benefits are stated in the insurance contract and the insurance certificate. If the agreement covers the co-insured, the co-insured's coverage is also stated in the insurance contract and the insurance certificate.

2.5 What benefits the insurance can cover

Pursuant to this chapter, compensation may be agreed in the event of:

- Permanent incapacity for work of at least 40 per cent,
 - Incapacity for work (illness other than occupational disease), cf. section 3
- Temporary incapacity for work of at least 40 per cent,
 - Payment after the agreed time (up to 4 independent dates), cf. section 4
 - Payment after the agreed time for the age group 67+, cf. section 5
- Traditional disability capital with or without fully paid death, cf. section 6
 - Disability related to death coverage
- Deaths, item 7

3. Permanent incapacity for work of at least 40 per cent

Collective life insurance that can provide one-off compensation in the event of permanent disability from at least 40 per cent. The coverages and sums insured are stated in the insurance contract and the insurance certificate and may include:

3.1.1 Permanent incapacity for work (loss in future acquisition) at least 40 per cent

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, basic compensation in the event of 100 per cent permanent incapacity for work is determined as follows in relation to the employee's income basis:

Pensionable income in the year before the disability period began.	Basic compensation
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Income up to and including 7G	22G
Revenue between 7G and 8G	24G
Revenue between 8G and 9G	26G
Income between 9G and 10G	28G
Income above 10G	30G

If the insured's permanent incapacity for work is less than 100 per cent, the compensation is reduced accordingly.

The basis for calculating permanent incapacity for work is the pensionable income in the year before the disability period began.

3.1.1.1 The basis for the compensation

The basis for calculating compensation in the event of disability is the insured's pensionable income the insured had in the year before the disability period began. If there is particular evidence to assume that the basis for the calculation pursuant to the first paragraph deviates significantly from what would have been the injured party's ordinary income level without the injury or illness, the basis for the calculation shall be set to this level.

If, in the event of a change in the agreement, the sum insured is reduced after the incapacity for work has occurred, the sum insured shall nevertheless be determined in accordance with the agreement that was in force at the beginning of the incapacity for work.

The income basis

The determination of the income basis in relation to G is made on the basis of G on 1 January of the income year in which the income was earned.

3.1.1.2 Determination of permanent degree of disability

The degree of disability is determined according to the insured's ability to perform income-generating work (earning capacity). When assessing whether and to what extent the person's earning capacity is permanently impaired, the income opportunities in any work that the person in question is now able to perform must be compared with the income opportunities that the person in question had before the illness, injury or disability. It is assumed that appropriate treatment and measures to improve earning capacity have been implemented.

3.1.1.3 Adjustment according to the insured's age when the insurance event occurs

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, the basic compensation is regulated as follows:

- If the insured is 45 or 46 years old, the compensation corresponds to the basic compensation.
- For each year the insured is over 46 years of age, a deduction of 5 per cent of the basic compensation is made, but the compensation must still amount to at least 10 per cent of the basic compensation.
- If the insured is between 35 and 44 years of age, the compensation is increased for each year the insured is younger than 45 years of age by 3.5 per cent of the basic compensation.
- If the insured is 34 years of age or younger, the compensation is increased for each year the insured is younger than 35 years of age by 2.5 per cent of the basic compensation. In addition, the compensation will be increased by 35 per cent of the basic compensation.

3.1.2 The insurance event - permanent incapacity for work

The insurance event in the event of permanent disability occurs when:

- The insured has been unable to work for a continuous period of at least 2 years, and
- The degree of permanent disability is at least 40 per cent, and
- The permanent degree of disability is judged to be permanent.

If NAV has applied for disability benefit, the enterprise can await the outcome of this application.

If such incapacity for work has lasted continuously for 5 years, it is considered to be permanent unless special circumstances indicate otherwise.

The incapacity for work is considered to have occurred on the first day of the last continuous period of sick leave leading up to an insurance event, cf. the first bullet point above.

It is a prerequisite that the incapacity for work occurs during the insurance period and before the end of the year in which the insured turns 65.

If permanent incapacity for work has been assessed at least 40 per cent during the insurance period, the insured is entitled to payment of the sum insured when the insurance event occurs as mentioned in the first paragraph, regardless of whether the person in question is still covered by the insurance.

Any deterioration of the permanent degree of incapacity for work after the person in question has been withdrawn from the insurance is not covered.

It is assumed that the incapacity for work occurred during the insurance period.

If a claim for the sum insured in the event of incapacity for work is made later than at the time of the insurance event occurred, the sum insured to be paid is calculated on the basis of the sum insured and the degree of disability that was applicable at the time the insurance event occurred.

3.1.3 Later increase in degree of disability

If an insured person is covered in accordance with the provisions of the terms and conditions, and has had the sum insured reduced because the permanent degree of disability has been set at a degree of disability lower than 100 per cent, a subsequent increase in the degree of disability during the insurance period will entitle the insured to an insured sum determined at the increase in the permanent degree of disability in employment. A later increase in the degree of disability during the insurance period is calculated as a new insurance event unless the insured has been continuously incapacitated for work, with a higher degree of disability than previously determined, in the period until the new degree of disability has been determined as permanent.

4. Temporary incapacity for work of at least 40 per cent

4.1.1 Payment after the agreed time – up to 4 independent times

Collective life insurance that can provide one-off compensation in the event of temporary incapacity for work from at least 40 per cent. The coverages and sums insured are stated in the insurance contract and the insurance certificate and may include:

Up to 4 independent insurance coverages can be agreed.

Continuous incapacity for work of at least 40 per cent during the agreed period(s):

- 18 months
- 24 months
- 36 months
- 48 months

If the injured party has only lost part of their ability to work, the compensation is reduced accordingly.

4.1.1.1 The basis for the compensation

The basis for calculating compensation in the event of payment after the agreed time is the sum insured that appears in the insurance contract and the insurance certificate for the date or dates chosen.

If, in the event of a change in the agreement, the sum insured is reduced after the incapacity for work has occurred, the sum insured shall nevertheless be determined in accordance with the agreement that was in force at the beginning of the incapacity for work.

4.1.1.2 Determination of temporary degree of disability

The degree of disability is determined according to the insured's ability to perform income-generating work (earning capacity). When assessing whether and to what extent the person's earning capacity is temporarily reduced, the income opportunities in any work that the person in question is now able to perform must be compared with the income opportunities that the person in question had before the illness, injury or disability. It is assumed that appropriate treatment and measures to improve earning capacity have been implemented.

4.1.1.3 Adjustment in relation to the insured's age

The sum insured for payment after the agreed time is not adjusted in relation to the insured's age.

4.1.2 The insurance event – payment after the agreed time

The insurance event in the event of disability occurs when the insured has been:

- At least 40% incapacitated,
- Continuously for the period of time agreed.

The incapacity for work is considered to have occurred on the first day of the last continuous period of sick leave leading up to an insurance event.

It is a condition that the incapacity for work occurs before the end of the year in which the insured person turns 65.

The insurance event must occur during the insurance period.

If temporary incapacity for work has been assessed at least 40 per cent during the insurance period, the insured is entitled to payment of the sum insured when the insurance event occurs as mentioned in the first paragraph, regardless of whether the person in question is still covered by the insurance.

Any deterioration of the temporary degree of disability after the person in question has been withdrawn from the insurance is not covered.

4.1.3 Later increase in degree of disability

A compensation payment is only made during the insurance period. No compensation will be paid for any subsequent increase in the degree of disability during the insurance period.

5. Temporary incapacity for work of at least 40 per cent for employees over the age of 67+

5.1.1 Paid out after the agreed time for the age group 67+

Collective life insurance that can provide one-off compensation in the event of permanent disability from at least 40 per cent. The coverages and sums insured are stated in the insurance contract and the insurance certificate and may include:

An optional additional cover when disability insurance has been established pursuant to section 4.

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, basic compensation in the event of 100 per cent incapacity for work (sick leave) is determined continuously for 12 months as follows in relation to the employee's income basis:

Pensionable income in the year before the disability period began.	Basic compensation
Income up to and including 7G	2.2G
Revenue between 7G and 8G	2.4G
Revenue between 8G and 9G	2.6G
Income between 9G and 10G	2.8G
Income above 10G	3.0G

The sum insured is paid no earlier than 12 months from the first consecutive day of sick leave.

If the injured party has only lost part of their ability to work, the compensation is reduced accordingly.

5.1.1.1 The basis for the compensation

The basis for calculating compensation in the event of payment after the agreed time for the age group 67+ is the insured's pensionable income the insured had in the year before the disability period began.

If, in the event of a change in the agreement, the sum insured is reduced after the incapacity for work has occurred, the sum insured shall nevertheless be determined in accordance with the agreement that was in force at the beginning of the incapacity for work.

The income basis

The determination of the income basis in relation to G is made on the basis of G on 1 January of the income year in which the income was earned.

5.1.1.2 Determination of temporary degree of disability (sick leave)

It is a requirement that the disability (sickness absence) is documented with continuous sick leave for at least 12 months from a doctor. It is assumed that appropriate treatment and measures to improve earning capacity have been implemented.

5.1.1.3 Adjustment in relation to the insured's age

The sum insured for payment after the agreed time is not adjusted in relation to the insured's age.

5.1.2 The insurance case – Payout after the agreed time for the age group 67+

The insurance event occurs when the insured has been:

- At least 40 % incapacitated for work (on sick leave),
- Continuous for at least 12 months.
- The insurance event occurs at the earliest on the day the employee turns 67.

It is a prerequisite that the incapacity for work/sick leave occurs during the insurance period and before the end of the insurance year in which the employee reaches the termination age of the agreement.

For compensation for payment after the agreed time for the age group 67+, the illness is to be considered to have occurred on the date of the first day of the continuous sick leave period leading up to an insurance event.

5.1.3 Later increase in degree of disability

A compensation payment is only made during the insurance period. No compensation will be paid for any subsequent increase in the degree of disability during the insurance period.

6. Traditional disability capital – Disability insurance linked to death insurance

6.1.1 Traditional disability capital linked to death coverage

Collective life insurance that can provide lump-sum compensation in the event of permanent incapacity for work from at least 40 per cent, and which is linked to a death insurance policy as described in section 2.10 Death.

The sums insured are stated in the insurance contract and the insurance certificate.

If the injured party has only lost part of his or her ability to work, the compensation will not be reduced accordingly.

6.1.1.1 The basis for the compensation

The basis for the compensation in the event of incapacity for work is calculated in relation to the sum insured in the event of death that is determined for the insured in accordance with the agreement at the time the sum insured in the event of incapacity for work falls due.

The sum insured in the event of death includes any child and spouse/registered partner/cohabitant supplement or provider supplement.

However, the sum insured for disability may not amount to more than 30G.

6.1.1.2 Determination of permanent degree of disability

The degree of disability is determined according to the insured's ability to perform income-generating work (earning capacity). When assessing whether and to what extent the person's earning capacity is permanently impaired, the income opportunities in any work that the person in question is now able to perform must be compared with the income opportunities that the person in question had before the illness, injury or disability. It is assumed that appropriate treatment and measures to improve earning capacity have been implemented.

6.1.1.3 Adjustment according to the insured's age when the insurance event occurs

If the sum insured in the event of incapacity for work is paid in the calendar year in which the employee reaches the age of 25 or earlier, the sum insured in the event of incapacity for work is 80 per cent of the sum insured in the event of death.

If the sum insured is paid in the event of incapacity for work when the employee is older than 25 years of age, 80 per cent of the sum insured determined for the employee is paid in the event of death. The sum insured is then reduced by 2 percentage points for each year the employee is older than 25 years.

Table for traditional disability capital:

Age at which the disability capital falls due for payment (i.e. the age at which the conditions for disability capital are met)	Disability capital as a percentage of sum insured
15-25 years	80 %
26 years	78 %
27 years	76 %
28 years	74 %
29 years	72 %
30 years	70 %
31 years	68 %
32 years	66 %
33 years	64 %
34 years	62 %
35 years	60 %
36 years	58 %
37 years	56 %
38 years	54 %
39 years	52 %
40 years	50 %
41 years	48 %
42 years	46 %
43 years	44 %
44 years	42 %
45 years	40 %
46 years	38 %
47 years	36 %
48 years	34 %

49 years	32 %
50 years	30 %
51 years	28 %
52 years	26 %
53 years	24 %
54 years	22 %
55 years	20 %
56 years	18 %
57 years	16 %
58 years	14 %
59 years	12 %
60 years	10 %
61 years	8 %
62 years	6 %
63 years	4 %
64 years	2 %
65 years of age or older	0 %

Example: For a person who meets the conditions for disability capital at the age of 40, 50 per cent of the sum insured is paid.

6.1.2 The insurance event – traditional disability capital

The insurance event in the event of permanent disability occurs when:

- The insured has been unable to work for a continuous period of at least 2 years, and
- The degree of permanent disability is at least 40 per cent, and
- The permanent degree of disability is judged to be permanent.

If NAV has applied for disability benefit, the enterprise can await the outcome of this application.

The incapacity for work is considered to have occurred on the first day of the last continuous period of sick leave leading up to an insurance event, cf. the first bullet point above.

It is a prerequisite that the incapacity for work occurs during the insurance period and before the end of the year in which the insured turns 60.

If a claim for the sum insured in the event of incapacity for work is submitted later than at the time the insurance event occurred, the sum insured to be paid is calculated on the basis of the sum insured that was in force at the time the insurance event occurred.

6.1.3 Later increase in degree of disability

Only a compensation payment is made during the insurance period, regardless of the degree of disability between 40 per cent and 100 per cent.

6.1.4 Fully paid death insurance

It may be agreed that an insured who fulfils the condition in section 2.9.1 will be entitled to a fully paid death insurance policy with the same termination age as in the group life insurance. This insurance is paid out upon the death of the insured.

It will be stated in the insurance contract and the insurance certificate whether fully paid death insurance is optional.

When an employee has been at least 40 per cent incapacitated for work continuously for 2 years and the incapacity for work has been judged to be permanent, he or she is entitled to a fully paid death insurance with a termination age chosen for the death cover.

The sum insured in the fully paid death insurance is determined as follows:

The fully paid sum insured is calculated in relation to the sum insured in the event of death that has been determined for the insured at the time the fully paid death insurance comes into force. The sum insured includes spouse/registered partner/cohabitant supplement, provider supplement and child supplement if this has been agreed.

The fully paid sum insured amounts to 20 per cent of the sum insured in the event of death if the insured dies in the calendar year in which he or she reaches the age of 25 or earlier. If the insured dies after the year in which he or she reaches the age of 25, the fully paid sum insured is increased by 2 per cent points of the sum insured in the event of death for each year the insured is older than 25 years. However, the highest amount is 100 per cent of the sum insured in the event of death.

If the incapacity for work occurs after the end of the year in which the insured person reaches the age of 60, the fully paid sum insured amounts to 100 per cent of the sum insured in the event of death.

Employees who receive fully paid death insurance in accordance with these rules must be withdrawn from the entire group life insurance.

Table of traditional disability capital with fully paid death insurance

Age at which the disability capital falls due for payment (i.e. the age at which the conditions for disability capital are met)	Death insurance as a percentage of sum insured
15-25 years	20 %
26 years	22 %
27 years	24 %
28 years	26 %
29 years	28 %
30 years	30 %
31 years	32 %
32 years	34 %
33 years	36 %
34 years	38 %
35 years	40 %
36 years	42 %
37 years	44 %

38 years	46 %
39 years	48 %
40 years	50 %
41 years	52 %
42 years	54 %
43 years	56 %
44 years	58 %
45 years	60 %
46 years	62 %
47 years	64 %
48 years	66 %
49 years	68 %
50 years	70 %
51 years	72 %
52 years	74 %
53 years	76 %
54 years	78 %
55 years	80 %
56 years	82 %
57 years	84 %
58 years	86 %
59 years	88 %
60 years	90 %
61 years	92 %
62 years	94 %
63 years	96 %
64 years	98 %
65 years of age or older	100 %

Example. If a person dies at the age of 55, an additional 80 percent of the sum insured is paid.

7. Deaths

7.1.1 Coverages that can be selected for the death insurance

Collective life insurance that can provide lump-sum compensation in the event of death. The coverages and sums insured are stated in the insurance contract and the insurance certificate and may include:

7.1.1.1 Main insured

The main insured is an insurance policy that is paid out in the event of the insured employee's death during the insurance period.

The amount insured is stipulated in the insurance contract and the insurance certificate.

If the sum insured is to be adjusted according to the insured's age, this is stated in the insurance contract and the insurance certificate. If the sum insured is adjusted according to age, the age of the insured employee at the time the insurance event occurs is taken into account.

The highest sum insured for the main insured is 80G

7.1.1.2 Spouse/cohabitant supplement

It will be stated in the insurance contract and the insurance certificate whether the insurance includes spouse/cohabitant supplement.

Spouse/cohabitant supplement is a supplement to the main insured and is paid upon the death of the main insured during the insurance period if the main insured leaves behind a spouse or cohabitant at this time.

The sum insured is stipulated in the insurance contract and the insurance certificate.

If the sum insured is to be adjusted according to the insured's age, this is stated in the insurance contract and the insurance certificate. If the sum insured is adjusted according to age, the age of the insured employee at the time the insurance event occurs is taken into account.

Either a spouse/cohabitant supplement or a provider supplement must be chosen.

The highest sum insured for spouse/cohabitant supplement is 25 times the sum insured for the main insured, and a total of no more than 80G.

7.1.1.3 Dependency supplement

It will be stated in the insurance contract and the insurance certificate whether the insurance includes a dependant supplement.

The sum insured is stipulated in the insurance contract and the insurance certificate.

If the sum insured is to be adjusted according to the insured's age, this is stated in the insurance contract and the insurance certificate. If the sum insured is adjusted according to age, the age of the insured employee at the time the insurance event occurs is taken into account.

Either a spouse/cohabitant supplement or a provider supplement must be chosen.

The maximum sum insured for dependency supplement is 25 times the sum insured for the main insured, and a total of no more than 80G.

7.1.1.4 Child supplement

It will be stated in the insurance contract and the insurance certificate whether the insurance includes child supplement.

Child supplement is a supplement to the main insured and is paid upon the death of the main insured during the insurance period if the main insured at that time had children under the age of 21. The child supplement is paid for each child the main insured had at the time of death.

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, the sum insured for the child supplement is determined as follows:

The age of the child at the time of the employee's death	Sum insured	The age of the child at the time of the employee's death	Sum insured
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Under 1 year	6,5G	11 years	3,0G
1 year	6,0G	12 years	2,5G
2 years	6,0G	13 years	2,5G
3 years	5,5G	14 years	2,0G
4 years	5,0G	15 years	2,0G
5 years	5,0G	16 years	1,5G
6 years	4,5G	17 years	1,5G
7 years	4,0G	18 years	1,0G
8 years	4,0G	19 years	1,0G
9 years	3,5G	20 years	1,0G
10 years	3,5G	21 years	0,0G

If the employee was the sole provider at the time of death, double child supplement is paid.

If another sum insured has been chosen for child supplement, compensation is calculated proportionately according to the same principle as the above table, unless otherwise stated in the insurance contract and the insurance certificate.

If the sum insured is not to be adjusted according to the child's age, this is stated in the insurance contract and the insurance certificate.

The highest sum insured for child supplement is 10G, and for the main insured and any spouse/provider supplement a maximum of 80G.

7.1.1.5 Spouse/cohabitant insurance

It will be stated in the insurance contract and the insurance certificate whether the insurance includes spouse/cohabitant insurance.

Spouse/cohabitant insurance is an insurance policy that is established on the employee's spouse or cohabitant's life.

Spouse/cohabitant insurance is paid out in the event of the death of the main insured person's spouse or cohabitant during the insurance period.

If spouse/cohabitant insurance is chosen, this coverage must be mandatory for the group that has such coverage.

The sum insured is stipulated in the insurance contract and the insurance certificate.

If the sum insured is to be adjusted according to the insured's age, this is stated in the insurance contract and the insurance certificate. If the sum insured is adjusted according to age, the age of the insured's spouse/cohabitant at the time the insurance event occurs is taken as a basis.

The sum insured for spouse/cohabitant insurance may not exceed the sum insured for the main insured, and yet no more than 30G.

7.1.2 The basis for the compensation

The basis for calculating compensation in the event of death is the sum insured and age provisions that appear in the insurance contract and the insurance certificate.

7.1.3 Insurance event – death

The insurance event in the event of death occurs upon the death of the insured. If the group life insurance includes spouse/registered partner/cohabitant insurance, and both the employee and the spouse/registered partner or cohabitant die within a 30-day period, the sum insured for the spouse/registered partner and the cohabitant insurance is also paid, even if the spouse/registered partner or cohabitant dies last.

It is assumed that the insurance event occurred during the insurance period.

7.2 Limitations

7.2.1 Reservations

The enterprise's liability does not extend to illnesses or defects that it has opted out of in the insurance certificate.

7.2.2 Symptom clause when obtaining health information

The enterprise is not liable for compensation in the event of incapacity for work as a result of illness or illness that has been detected or has shown signs or symptoms within three months after the enrolment in the insurance was sent to the enterprise.

For the following diseases/disorders, the symptom period has been extended from 3 to 12 months:

- Mental disorders
- Drug addiction
- Fatigue states
- Muscle/skjelettlidelser

7.2.3 When health information is not requested

7.2.3.1 Incapacity for work

When no health information is requested from the employee or co-insured spouse/cohabitant, the right to payment in the event of incapacity for work lapses if the incapacity for work occurs within two years of enrolment in the insurance when the incapacity for work is due to an illness or defect the person in question had at the time of enrolment and of which it must be assumed that the person in question was aware, cf. Section 19-10 of the Insurance Contracts Act. In the event of an increase in the sum insured as a result of a change in the agreement, the deadline is calculated from the day the sum insured was increased.

7.2.3.2 Death – Co-insured spouse or cohabitant – Spousal insurance

When a spouse/cohabitant is included in the insurance and a health certificate has not been submitted, the enterprise is exempt from liability if the spouse/cohabitant dies within two years of being included in the insurance as a result of illness or defect that the person in question had at the time of admission and which they must be

assumed to have been aware of. In the event of an increase in the sum insured for spouse/cohabitant insurance, the deadline is calculated from the day the sum insured was increased, cf. Section 19-10 of the Insurance Contracts Act.

7.2.4 Participation

The compensation may be reduced or cancelled if the employee has intentionally contributed to the injury.

7.2.5 Coordination of benefits

1. Social security benefits

If the insured person is not a member of the National Insurance Scheme, a deduction is made for the social security benefits to which he or she would have been entitled.

2. The Motor Liability Act/Tort Law

Compensation claimed under the Motor Liability Act or other tort law will be deducted krone for krone in the insurance settlement

7.2.6 Subrogation

- a) If the policyholder has caused the company financial loss by failing to comply with the provisions of the insurance contract and terms and conditions, the company may claim compensation from the policyholder.
- b) The company may claim recourse from the responsible tortfeasor for payment of compensation pursuant to the provisions of Section 3-7 no. 3 of the Compensation of Injuries Act and Section 8 of the Occupational Injury Insurance Act.

7.2.7 Deadline for notification of the insurance event

The insurance incident must be reported to Storebrand Livsforsikring AS as soon as possible.

7.2.8 Medical treatment

If the insured without reasonable cause opposes surgery or other treatment, the final degree of disability may take into account the probable improvement that such treatment could have brought about

7.2.9 War/unrest and terrorist acts

War and civil unrest

Without a special agreement, the company does not cover accidental injury, or any increase in such injury, that is directly or indirectly caused by or connected with nuclear reactions, war or war-like actions (whether war is declared or not), riots, or other similar serious disturbances of public order. See, however, section 3.6.11.

Information about such areas can be found on the Ministry of Foreign Affairs' information pages – Countries with travel advisories.

Acts of terrorism

Storebrand's aggregate liability for all compensable loss events that are directly or indirectly caused by, or connected with, an act of terrorism is limited to a maximum of NOK 1 billion for any one event, and limited to NOK 1 billion per calendar year in total for all events.

These limits apply to the liability under all insurance contracts within the Storebrand Group combined.

"Act of terrorism" means any harmful act that appears to have been intended to cause serious bodily injury, property damage, or other substantial loss in order to influence political, religious, or other ideological bodies, or to create fear within the population.

"Any one event" means all loss events affecting Storebrand that occur within a period of 48 hours from the first loss event and that are directly or indirectly caused by, or connected with, an act of terrorism.

If the aggregate limit per event is exceeded, all eligible claimants must accept a proportional reduction of the compensation amount.

The insurance does not cover terrorism involving radioactive, chemical, or biological weapons.

7.2.10 Travelling abroad

The provision in section 7.2.9 on war or warlike acts applies correspondingly to travel abroad. If the insured is already staying ashore when the provisions of section 7.2.9 are applied, the Investment Firm's liability is limited to cover damage or increase in such damage for 30 days from the date on which the travel advice is issued.

7.2.11 Triggering the insurance event

Intent

If the insured has intentionally caused the insurance event, the undertaking is not liable. However, the company is liable if the insured could not understand the scope of his or her action due to age or state of mind. In this context, "reach" is to be understood as the immediate consequence of the act, namely the bodily injury, cf. Section 13-8 of the Insurance Contracts Act.

The company is not responsible for suicide or attempted suicide. However, the insurance covers suicide if the insured can substantiate that this is due to an acute mental confusion with an external cause – and not a mental disorder. The claimant has the burden of proving that the suicide or attempted suicide is due to the fact that the insured person was unable to understand the scope of his or her action due to age or state of mind, cf. section 1.

7.3 Settlement rules

7.3.1 Notification of insurance incident, documentation

a) Notification of the insurance event

If the insurance event has occurred, the person who believes that he or she has a claim against the company without undue delay must notify the company as soon as possible.

b) Expert reports

The insured and the undertaking have the right to obtain medical and specialist certificates that are of significance for the determination of the basis for the calculation of compensation. If the undertaking finds it necessary to obtain a medical certificate from a new expert, the reasons for this shall be given in writing.

c) Deaths

The person who submits a claim under the insurance must provide a death certificate together with documentation showing who is entitled to receive compensation.

7.3.2 The due date of the compensation

Claims for compensation pursuant to this chapter fall due for payment as soon as the company has had a reasonable time to clarify the liability and calculate its final liability, cf. Section 18-2, paragraph 1 of the Insurance Contracts Act.

If a police investigation/investigation has been initiated by the Labour Inspection Authority in connection with an injury case, the enterprise has the right to postpone settlement until the investigation has been concluded.

7.3.3 Statute of limitations

Claims for compensation pursuant to this chapter are time-barred after 10 years. The time limit begins to run at the end of the calendar year in which the entitled person acquired the necessary knowledge of the circumstance that justifies the claim. However, the claim is time-barred no later than 20 years after the end of the calendar year in which the insurance event occurred.

Section 18-6 of the Insurance Contracts Act also applies. Claims that have been notified to the enterprise before the limitation period has expired are time-barred no earlier than 6 months after the entitled party has received special written notice that the limitation period will be invoked. The message must specify how the statute of limitations is interrupted. The limitation period is not extended under this provision if more than 10 years have passed since the claim was sent to the enterprise.

7.3.4 The enterprise's liability in the event of termination of the insurance contract

If the insurance contract for group life insurance is terminated, the company's liability ceases in accordance with the rules in Section 19-6 of the Insurance Contracts Act.

7.3.5 Legal rules

For group life insurance, the rules in the Insurance Contracts Act apply, unless another agreement has been made in the terms and conditions from which the Act may be derogated.

7.3.6 Which insurance term is used as a basis

In the event of a claim for payment of the sum insured in the event of permanent or temporary incapacity for work, it is the terms and conditions that applied on the first day of the last continuous period of sick leave that lead up to the insurance event that are used. In the event of a claim for payment of the sum insured in the event of death, the terms and conditions that applied when the insurance event occurred are used.

7.4 Calculation rules

7.4.1 National Insurance basic amount – G

The compensation calculation is based on the value of G when the insurance event occurs.

7.4.2 The company's interest obligation

a) Interest on compensation

The enterprise shall pay interest on compensation or the sum insured when 2 months have passed since notification of the insurance incident was sent to the enterprise.

b) Interest on coverage of expenses

The enterprise pays interest on the insured's disbursements when 2 months have passed since the claim for coverage of disbursements was sent to the enterprise.

c) Loss of interest obligation

If the insured neglects to provide information or disclose documents as mentioned in section 7.3.1, he or she may not claim interest for the time lost as a result. The same applies if the entitled party wrongfully rejects full or partial settlement.

d) Statutory rules on interest liability

Provisions on interest liability are set out in Section 18-4 of the Insurance Contracts Act, the Act on Interest on Late Payment, etc. of 17 December No. 100.

7.5 The insured's disposal of the compensation or sum insured, etc.

7.5.1 Incapacity for work

Compensation in the event of incapacity for work is paid directly to the insured. If the insured dies after the right to compensation in the event of incapacity for work has arisen, but before compensation has been paid, the payment will be made to the insured's estate.

7.5.2 Deaths

Compensation in the event of the death of the insured is paid in accordance with the provisions of the insurance contract and the insurance certificate

7.5.3 Transfer and pledge

As long as the insured's claim against the enterprise has not fallen due, he or she may not assign or pledge his or her right against the enterprise.

7.5.4 Repurchase and paid-up policy value

The insurance has neither repurchase nor paid-up policy value.

8. The policyholder's obligations when notifying the undertaking and the insured

8.1 Notification to the enterprise

8.1.1 Duty of disclosure

As long as the company has not undertaken to cover the insurance, the company may request information that may be of importance for the assessment of the risk. The policyholder must provide correct and complete answers to the undertaking's questions and, on its own initiative, provide information on special circumstances that must be understood to be of significant importance for the undertaking's assessment of the risk. For renewal and extension of

the insurance, this applies correspondingly. The policyholder is also obliged to notify the undertaking of any change or expansion of the business.

8.1.2 Reservation against participation in the insurance

If, according to the agreement, it is possible to opt out of membership of the insurance, reservation declarations must be submitted to the enterprise.

8.1.3 Notification of insurance incident

The policyholder is obliged to notify the undertaking in writing without undue delay when a member is exposed to an event that can be assumed to give rise to a right to compensation.

8.2 Notices to employees

8.2.1 Information about the insurance

The policyholder must inform the insured about the insurance scheme, about any right to opt out of membership of the insurance and the consequences of a reservation. Upon enrolment, and any subsequent change of coverage, the policyholder is obliged to hand over insurance certificates to the insured. During the insurance period, the policyholder must communicate the information about the insurance scheme that the undertaking makes available.

8.2.2 Information on resignation and termination of the agreement

No later than the day on which the employee withdraws from the insurance or no later than 1 month before the agreement ends, the policyholder is obliged to notify the employee of the loss of the enterprise's liability by means of a separate letter prepared by the enterprise. Correspondingly, employees must be informed when the insurance contract is changed to their disadvantage by reducing the sum insured, by changing the terms of the insurance or by the loss of coverage, etc. The co-insured spouse/cohabitant is notified via the employee.

9. The employee's duty to provide information

9.1 Duty to provide information about the risk

As long as the company has not undertaken to cover the insurance, the company may request information that may be of importance for the assessment of the risk. The employee must provide correct and complete answers to the enterprise's questions. The employee must also, on his or her own initiative, provide information about special circumstances that he or she must understand to be of significant importance for the undertaking's assessment of the risk, cf. Section 13-1a of the Insurance Contracts Act.

9.2 Consequences of neglected duty of disclosure

9.2.1 Reduction or elimination of the enterprise's liability

- a) If the employee has fraudulently neglected the duty to provide information pursuant to section 9.1, and an insurance incident has occurred, the enterprise is not liable, cf. Section 13-2, paragraph 1 of the Insurance Contracts Act.

- b) If the employee has otherwise neglected his or her duty to provide information, and there is not only little to blame him/her, the enterprise's liability may be reduced or eliminated, cf. Section 13-2, paragraph 2 of the Insurance Contracts Act. In the case of life insurance, unless fraud has been demonstrated, the enterprise may invoke that the duty of disclosure has been neglected only if the insurance event has occurred or the enterprise has given notice pursuant to Section 13-13 of the Insurance Contracts Act within 2 years after the enterprise's liability began to run, cf. Section 13-4, paragraph 2 of the Insurance Contracts Act. The same applies to disability coverage if gross negligence has been shown.

9.2.2 The enterprise's right to terminate other insurance contracts

- a) If the employee has acted fraudulently, the undertaking may terminate this and other insurance contracts it has with the person in question with immediate effect, cf. Section 13-3, paragraph 1 of the Insurance Contracts Act.
- b) If, during the insurance period, the undertaking becomes aware that the duty of disclosure has been neglected, and there is not only little to blame the insured, the undertaking may terminate the insurance with 14 days' notice, cf. Section 13-3, paragraph 1 of the Insurance Contracts Act.
- c) In cases as mentioned in section 8.2.1, the undertaking may terminate any insurance contract the undertaking has with the person in question with 1 week's notice, cf. Section 18-1, paragraph 5 of the Insurance Contracts Act.

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

A person who wishes to make a claim against the undertaking must provide the undertaking with the information and documents that are available to him or her, and which the undertaking needs in order to be able to decide on the claim and pay the compensation amount, cf. Section 18-1, paragraph 1 of the Insurance Contracts Act. When the undertaking asserts a claim for recourse against the responsible tortfeasor for compensation paid or the sum insured, the insured shall provide the undertaking with the information available to the person concerned and which is of importance for the implementation of the undertaking's claim against a third party.

9.4 Consequences of providing incorrect information

9.4.1 Reduction or elimination of the enterprise's liability

- a) If the person making a claim against the undertaking provides incorrect or incomplete information that he or she knows or must understand may lead to compensation being paid to which he or she is not entitled, he or she loses any claim for compensation against the undertaking under this and other insurance contracts in connection with the same incident, cf. Section 18-1, paragraph 2 of the Insurance Contracts Act.
- b) If the matter is only slightly reprehensible, only concerns a small part of the claim, or if there are other special reasons, the claimant may still receive partial compensation, cf. Section 18-1, paragraph 2 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) The date on which the employment relationship ends, however, no later than the date stipulated in the insurance contract. In the case of insurance that covers the risk of death, it may be agreed that resignation with disability or early retirement shall not be considered a reason for withdrawal from the insurance. Coverage for disability and, if applicable, disability pensioners must then be stated in the insurance contract.
- b) The day on which the employee resigns from the group covered by the insurance.
- c) In the event of leave of absence for service with another employer, unless otherwise agreed.
- d) Notwithstanding the points above, the insured withdraws from the group life insurance on the day on which the right to fully paid death risk insurance arises. At the same time, the co-insured spouse/registered partner or cohabitant also withdraws from the group life insurance. In such a case, the spouse/registered partner or cohabitant is entitled to a fully paid death risk insurance with the same insurance period as in the group life insurance and with the sum insured that applied at the time of withdrawal.

10.1.2 Unless otherwise agreed, the insurance is valid

- a) During maternity leave.
- b) During other leave for up to 6 months, except leave for service with another employer.
- c) During participation in compulsory military or civilian service.
- d) During participation in a legal strike or during a lockout.

10.1.3 Co-insured spouse/registered partner/cohabitant withdraws from the insurance

- a) The date on which the criteria for being considered to be with an insured spouse/registered partner/cohabitant in sections 1.9 and 1.10 are no longer met, or
- b) The day the employee withdraws from the insurance scheme.

10.2 Time of the company`s liability

When an employee or co-insured withdraws from the insurance pursuant to section 10.1, the company's liability ceases no earlier than 14 days after a written reminder of termination has been sent to the employee, who also receives the reminder on behalf of any co-insured.

If a reminder has not been sent, the company's liability ceases 2 months after the employee or co-insured withdrew from the insurance.

If the undertaking is liable for insurance cases pursuant to the above subsection, a deduction will be made from the compensation to the extent that the person in question has in the meantime been covered by a similar insurance policy and receives compensation under it.

10.3 Entitlement to individual continuation insurance

When the insured withdraws from the insurance for reasons other than reaching the age limit, he or she has the right to continue the insurance relationship in accordance with further rules, with individual premium calculation and without providing new health information, cf. Section 19-7 of the Insurance Contracts Act. The right to continuation insurance applies to life insurance in the event of incapacity for work and death. The co-insured spouse/registered partner/cohabitant has the same right to take out such individual continuation insurance when he or she withdraws from the insurance. Written notification that you wish to exercise this right must be received by the company within 6 months of the company's liability falling. The right to take out continuation insurance does not apply when the insurance ceases to be transferred to another company.

For employees who have reported injury/illness during the insurance period or are on sick leave at the time of resignation, insurance coverage in the event of incapacity for work is maintained without premium payment for the injury/illness that has been reported or for which the person in question is on sick leave until the report of recovery or until full or partial settlement has taken place.

Continuation insurance must be established to cover new injuries/illnesses or worsening of the injury/illness after withdrawal.

10.4 Termination of the insurance. Right to fully paid insurance

If the insured is at least 40% incapacitated, he or she cannot be withdrawn from the group life insurance until the question of entitlement to the sum insured in the event of disability and/or any fully paid death insurance has been decided.

Notwithstanding the provisions of section 2.12.3, the insured person withdraws from the group life insurance on the day on which the right to fully paid death insurance arises. At the same time, the co-insured spouse/registered partner/cohabitant also withdraws from the group life insurance. In that case, the spouse/registered partner/cohabitant is entitled to a fully paid death insurance with the same insurance period as in the group life insurance and with the sum insured that applied at the time of withdrawal.

10.5 Restrictions on the right to take out individual life insurance

Insured persons who have been entitled to a fully paid death insurance in accordance with section 2.9.4 are not entitled to take out individual life insurance as mentioned in section 10.3.

11. Renewal and termination of the insurance contract

11.1 Renewal of the insurance contract

If the policyholder or company does not exercise its right to termination, the agreement is automatically renewed for 1 year at a time.

11.2 The policyholder's right to terminate the insurance contract

If the policyholder does not want the insurance to be renewed automatically at the main due date, notification must be sent to the company before the end of the insurance year. The same applies if the policyholder wishes to change the insurance contract and the change leads to a reduction of rights for some of the insured.

The policyholder may terminate a current insurance policy during the insurance year if the need for insurance ceases or there are other special reasons, or for the transfer of the insurance to another enterprise. The policyholder must notify the undertaking in writing with a deadline of at least one month.

When the insurance is transferred to another company, information must be provided about which company the insurance is being transferred to and about the time of the move.

Upon termination of the policy, the policyholder must inform the insured of this as soon as possible, and no later than one month before the date of termination of the policy. In the event of a transfer of the insurance to another undertaking, the insured shall be informed of this in the same manner.

11.3 The company's right to terminate the insurance contract

If, at the end of an insurance year, the insurance does not satisfy the company's requirement for a minimum number of insured, the company has the right to terminate the agreement. However, the coverage lapses at the earliest at the end of the following insurance year, provided that the conditions are not met at that time either. However, coverage can be extended for a further 1 year if the policyholder demonstrates that the conditions are likely to be met by the end of that policy year.

The company may also terminate the insurance:

- a) If the policyholder has acted fraudulently, the undertaking may terminate this and other insurance contracts it has with the person in question with immediate effect, cf. Section 13-3, paragraph 1 of the Insurance Contracts Act.
- b) If, during the insurance period, the undertaking becomes aware that the duty of disclosure has been neglected, and there is not only little to blame the policyholder, the undertaking may terminate the insurance with 14 days' notice, cf. Section 13-3, paragraph 1 of the Insurance Contracts Act.

The company's right to terminate other insurance contracts:

In cases where the policyholder has fraudulently neglected the duty of disclosure so that the undertaking's liability for damages lapses, the undertaking may terminate any insurance contract the undertaking has with the person in question with 1 week's notice, cf. Section 18-1, paragraph 3 of the Insurance Contracts Act.

11.4 When the liability of the insured ceases after the termination of the insurance contract

If the policyholder or the undertaking terminates or fails to renew the insurance contract, or the undertaking's liability ceases to run due to the policyholder's failure to pay premiums, the insurance ceases to apply to the insured 1 month after written notice of this has been given to the person in question or the insured has otherwise become aware that the insurance contract is no longer valid. In the case of insurance cases for which the enterprise is responsible, a deduction will be made from the compensation to the extent that the person in question has in the meantime been covered by a similar insurance policy and receives compensation under it.

Upon termination of the insurance, the insurance coverage is maintained without payment of premiums for insured persons who are incapacitated for work to an extent that entitles them to disability compensation as a result of a leisure accident and/or illness other than an occupational disease.

If the disability ceases or the degree of disability is reduced without the insured being entitled to the aforementioned benefits, the insurance also ceases. In that case, the insured has the right to take out individual continuation insurance, cf. section 10.3. In the event of termination of the enterprise's liability pursuant to this section, section 10.3 applies to the employee's and, if applicable, the co-insured's right to take out individual continuation insurance. However, the right to take out continuation insurance does not apply when the insurance is terminated in order to be transferred to another insurance company.

12. Reservation of the right to future changes to insurance terms and premium tariffs

The Investment Firm has the right to change premium tariffs and terms from the first main due date. The company must provide the policyholder and the insured with information about the change. This is especially true if the terms change to the detriment of the insured.

13. Disputes, Appeals Board and Jurisdiction

Disputes and Appeals Committee

Complaints concerning the insurance contract should be directed directly to the company: Storebrand Livsforsikring AS P.O. Box 500, 1327 Lysaker, Telephone 915 08 880

Complaints concerning the insurance contract and settlements under it can also be directed to:

The Norwegian Financial Services Complaints Board, P.O. Box 53, Skøyen, 0212 Oslo. Phone 23 13 19 60

Cross-linking

Disputes under the terms and conditions of insurance are settled by a Norwegian court, unless this is not in conflict with the rules on jurisdiction in insurance cases laid down in Act No. 21/1993