

# Insurance terms and conditions for Personnel insurance in Storebrand



Effective January 1, 2026

Replaces conditions of 1 January 2024

For the insurance, these insurance terms and conditions, the insurance agreement, and the insurance certificates entered into between the policyholder and Storebrand Livsforsikring AS apply. In addition, the Insurance Contracts Act of 16 June 1989 No. 69 and other applicable legislation apply, nevertheless so that the terms take precedence where these differ from statutory provisions that can be derogated from.

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

## What is personal insurance?

A personal insurance policy is a collective term for several personal insurance policies that an employer can establish for its employees. Personal insurance provides one-time compensation in the event of specific incidents.

The personal insurance must therefore be put together based on the policyholders needs and wishes.

Personal insurance policies that can be included in personal insurance are:

- Occupational injury insurance
- Leisure accident insurance
- Medical disability due to illness other than occupational disease
- Group life insurance
- Critical illness insurance
- Psychological First Aid

These personal insurance policies are described in more detail on the following pages of the terms and conditions for Personal insurance.

## 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 Company is 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 Company, 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 Insurance year

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

## 1.8 When the insurance event 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 a marriage with the insured. A registered partner of the insured shall be considered equivalent 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

### A Cohabitant are:

- 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 who, according to the public authority, are supported by the insured and are included in the person's 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 sole provider is meant a person who alone has the responsibility for supporting the child/children, because the other parent is deceased 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 is fully able to work corresponding to a full-time position.

## 1.17 Offshore

An employee is covered under the offshore provisions of the insurance agreement during stays on facilities engaged in petroleum activities on the Norwegian continental shelf, as well as during travel between home and such facilities.

## **1.18 Accidental injury**

By accidental injury is meant bodily harm caused by a sudden and unforeseen external event – the accident. Injury to the mind, e.g. shock, is not regarded as an accidental injury unless it occurs simultaneously with a bodily injury that results in permanent and compensable medical disability.

## **1.19 Medical disability**

By medical disability, we understand the physical and/or mental impairment that experience has shown to cause a specific injury or illness. The degree of disability is determined on an objective basis without regard to the insured's occupation, reduced ability to provide income-generating work (degree of disability), outdoor interests and the like. The degree of medical disability is determined on the basis of Regulations 21.04.1997 no. 3 on injury compensation in the event of occupational injury and regulation 01.03.2021 no. 622 on injury compensation in the event of patient injuries. The degree of disability may also be determined on the basis of other relevant tables if Norwegian tables are not adequate, such as the Swedish or Danish disability tables. Loss/damage to most body parts and organs is given a specific degree of medical disability in the table. For injury consequences that are not included in the table, the degree of disability is determined after a discretionary comparison with the injury consequences in the table.

## **1.20 Incapacity for work (loss in future earnings)**

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.

## **1.21 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.

## **1.22 Travel between home and work**

By travel between home and place of work is meant the direct travel route that the insured employee regularly uses from home to work and vice versa. Deviations from this travel route are not considered to be travel between home and workplace, and accidents that occur during such a deviation are not compensated. If the insured employee makes short deviations from the travel route (max. 2 hours), the insurance comes into force again at the time the insured returns to the normal travel route. If an employee is to carry out work at a place other than his or her permanent place of work, accidents that occur on the direct route between home and the temporary place of work are compensated.

## **1.23 Occupational injury/illness**

By Occupational injury and illness is meant bodily injury and illness covered by the Act on Occupational Injury Insurance of 16 June 1989 No. 65

## **1.24 Leisure accident**

By leisure accident is meant an accident injury that:

- a) does not fall under section 1.23, or
- b) has not occurred during work for another employer or during work performed by the insured person as a self-employed person.

## **1.25 Group life insurance – illness other than occupational disease**

By group life insurance is meant a collective life insurance. Group life insurance is a death risk insurance that a company can take out for agreed groups of its employees and possibly their spouses or cohabitants. A group life insurance policy may also include disability coverage. Disability coverage means that the insured person will be paid a lump sum in the event of fulfilment of the conditions for disability.

## **1.26 Critical illness**

By critical illness is meant selected diseases, cf. section 6.5.

## **1.27 Psychological First Aid**

By psychological first aid is meant a sudden and unforeseen traumatic event that causes an immediate psychological reaction, for example in the event of accidents, death, serious illness, assault or burglary, cf. section 7.

## 2. Occupational injury insurance

Occupational injury insurance is a statutory insurance that employers must establish for all their employees. This insurance can provide one-off compensation to employees who are exposed to an occupational injury or illness pursuant to the Occupational Injury Insurance Act of 16 June 1989 No. 65.

It will be stated in the insurance contract and the insurance certificate whether occupational injury insurance has been established.

### 2.1 Who the insurance covers

The occupational injury insurance applies to employees for whom the policyholder has an obligation to insure and who are employed by the policyholder at the time the injury or illness is ascertained, cf. the Occupational Injury Insurance Act of 16 June 1989 No. 65.

The insurance also applies to former employees of the policyholder who have not been employed since the termination of the employment relationship with the policyholder. It is a prerequisite that the former employee was employed when the Occupational Injury Insurance Act entered into force on 1 January 1990.

If this is agreed and stated in the insurance contract and the insurance certificate, the occupational injury insurance also applies to self-employed persons with the limitations set out in section 2.6.2 of the terms and conditions.

### 2.2 Where the insurance applies

Occupational injury insurance applies to the individual employee at work, at the workplace during working hours, cf. Section 10 of the Occupational Injury Insurance Act.

### 2.3 When the insurance applies

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

For the individual employee, the insurance comes into force from the same time as the insurance contract enters into force.

#### 2.3.1 Later enrollments

The insurance is valid from the time specified in the insurance contract and the insurance certificate. If the employee is employed after the insurance contract entered into force, the insurance applies from the time of employment.

#### 2.3.2 Amendment of the agreement

In the event of an amendment to the agreement that results in inclusion of new groups of employees in the insurance, or an increase in insurance sums occurring after the insurance entered into force, the insurance shall apply from the time specified in the insurance contract and the insurance certificate.

## 2.4 What the insurance can cover

The insurance covers occupational injury and illness pursuant to the Occupational Injury Insurance Act with regulations if this has been agreed.

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

Occupational injury and illness means bodily injury and illness covered by Sections 10 and 11 of the Occupational Injury Insurance Act of 16 June 1989 No. 65, i.e. injury and illness suffered by employees at work at the workplace during working hours when:

- a) Injury and illness caused by an accident at work (occupational injury),
- b) Injury and illness which, pursuant to Section 13-4 of the National Insurance Act, is equated with an occupational injury,
- c) Other injury and illness, if this is due to the influence of harmful substances or work processes.

Musculoskeletal disorders are not considered occupational injuries/diseases. The same applies to disorders that have developed over time as a result of mental stress or strain, cf. Section 13-3 of the National Insurance Act.

Injury and illness as mentioned in the first paragraph (b) above, shall be deemed to have been caused in the course of work at the workplace during working hours, unless the company can prove that this is clearly not the case.

When assessing whether an injury or illness entitles the employee to coverage, the employee's particular susceptibility to the injury or illness must be disregarded, unless the special susceptibility must be regarded as the predominant cause.

### 2.4.1 The insurance event/date of confirmation

Occupational injury/illness must have been established during the insurance period, cf. nevertheless Section 5 of the Occupational Injury Insurance Act.

An occupational injury or illness is considered to have been established at the first time when the injured party either

- a) Died from the injury or illness without seeking medical attention
- b) The first time sought medical attention for the injury or illness, or
- c) The first time a claim was filed with the company because of the injury or illness.

## 2.5 Benefits under occupational injury insurance

### 2.5.1 Incurred additional expenses

Reasonable and necessary additional expenses that are caused by the occupational injury or illness are compensated individually from the time of settlement, cf. Section 3-1 of the Compensation for Injuries Act.

The company can cover documented additional expenses incurred by the insured due to the occupational injury or illness.

### 2.5.2 Future additional expenses

Future additional expenses are compensated individually, cf. Section 3-1 of the Compensation for Injuries Act.

The insurance can cover future annual additional expenses as a result of the occupational injury or illness. The compensation is paid as a lump sum and is determined as follows:

| <b>The injured party's age at the time of settlement</b> | <b>Compensation</b>      |
|--|--------------------------|
| Under 35 years of age                                    | 21 times annual expenses |
| Between 35 and 49 years                                  | 19 times annual expenses |
| Between 50 and 59 years                                  | 16 times annual expenses |
| Between 60 and 69 years                                  | 14 times annual expenses |
| Over 70 years  | 8 times annual expenses  |

When calculating compensation, the insured's age at the time of settlement is used.

Future additional expenses are expenses that accrue after the settlement date.

### **2.5.3 Lost income**

Lost income in the period up to the time of settlement is compensated individually, cf. Section 3-1 of the Compensation for Injuries Act

### **2.5.4 Permanent incapacity for work (loss in future earnings)**

Basic compensation in the event of 100 per cent permanent disability is determined as follows in relation to the employee's income basis:

| <b>Pensionable income in the year prior to the date of determination</b> | <b>Basic compensation</b> |
|--|---------------------------|
| 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 person's permanent incapacity for work is less than 100 per cent, the compensation is reduced accordingly.

#### **2.5.4.1 The basis for the compensation**

The basis for calculating permanent incapacity for work is the pensionable income in the year before the injury or illness was established.

If the insured's presumed pensionable income, excluding the injury or illness, in the year in which the injury or illness was ascertained, provides a higher basis, this is taken into account. The same applies if the insured in a later income year has achieved a pensionable income that provides a higher basis.

If there is particular evidence to assume that the basis for the calculation pursuant to the first and second paragraphs differs significantly from what would have been the insured's ordinary income level without the injury or illness, the basis for the calculation shall be set at this level.

The same applies if the insured in a later income year has achieved a pensionable income that provides a higher basis. If there is special evidence to assume that the basis for the calculation differs significantly from what would have been the insured's ordinary income level without the injury or illness, the basis shall be set at this level.

The calculation basis is determined in relation to the National Insurance basic amount (G) on 1 January in the income year in which the income was earned.

#### **2.5.4.2 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.

#### **2.5.4.3 Adjustment according to the insured's age at the time of settlement**

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.

#### **2.5.4.4 Previously disabled**

If, regardless of the injury or illness in question, the insured was 50 per cent incapacitated or more, the insured may claim compensation assessed pursuant to Section 3-1 of the Compensation for Injuries Act, if this leads to higher compensation than the assessment under these rules.

#### **2.5.5 Permanent medical disability (injury compensation)**

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, compensation for injury is paid in the event of permanent medical disability of 15 per cent or more.

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

| Degree of medical disability | Basic compensation for sum insured 4.5G |
|------------------------------|---|
| 15 – 24 per cent             | 0.75G                                   |
| 25 – 34 per cent             | 1.00G                                   |
| 35 – 44 per cent             | 1.50G                                   |
| 45 – 54 per cent             | 2.00G                                   |
| 55 – 64 per cent             | 2.50G                                   |
| 65 – 74 per cent             | 3.00G                                   |
| 75 – 84 per cent             | 3.75G                                   |
| 85 – 100 per cent            | 4.5G                                    |

The same proportionate compensation applies if other sums insured have been agreed.

An injury that is significantly greater than an injury that gives rise to a permanent medical disability degree of 100 per cent will result in compensation of 5.5G. This does not apply when higher sums insured have been agreed and stated in the insurance contract and the insurance certificate.

#### **2.5.5.1 The basis for determining the degree of medical disability**

The degree of medical disability is determined on the basis of Regulations 21.04.1997 no. 3 on injury compensation in the event of occupational injury and Regulations 01.03.2021 no. 622 on injury compensation in the event of patient injuries. The degree of disability may also be determined on the basis of other relevant tables if Norwegian tables are not adequate, such as the Swedish or Danish disability tables. Loss/damage to most body parts and organs is given a specific degree of medical disability in the table. For injury consequences that are not included in the table, the degree of disability is determined after a discretionary comparison with the injury consequences in the table.

#### **2.5.5.2 Principles for determining the degree of permanent medical disability**

If the insured has suffered several injuries following the same occupational injury/illness or after several occupational injuries, including occupational injuries covered under the National Insurance Act, the degree of disability is determined on the basis of an overall assessment.

#### **2.5.5.3 Regulation according to the insured's age at the time of determination**

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 older than 46 years, a deduction of 2 per cent of the basic compensation is made. However, the compensation must amount to at least 50% of the basic compensation.
- For each year the insured is younger than 45 years of age, the compensation is increased by 2 per cent of the basic compensation.

It must be stated in the insurance contract and the insurance certificate whether the sum insured is to be calculated with or without adjustment according to the insured's age.

## 2.5.6 Compensation in the event of death

### 2.5.6.1 Compensation for the insured's spouse or cohabitant

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, the basic compensation is 15G. The compensation is paid to the insured's spouse or cohabitant jr. sections 1.9 and 1.10.

### 2.5.6.2 Regulation according to the insured's age at the time of death:

For each year the insured is older than 46 years, the compensation is reduced by 5 per cent. The compensation must nevertheless amount to at least 20 per cent of the basic compensation.

The same proportional reduction applies if other sums insured have been agreed.

It must be stated in the insurance contract and the insurance certificate whether the sum insured is to be calculated with or without adjustment according to the insured's age.

### 2.5.6.3 Compensation for children under the age of 20

The compensation is calculated separately for each child under the age of 20 who was the deceased's dependent. Children mean the insured's only children (biological) and adopted children under the age of 20.

### 2.5.6.4 Adjustment in relation to the child's age in the event of the death of the provider.

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

| The child's age at the time of the insured person's death | Compensation | The child's age at the time of the insured person's death | Compensation |
|---|--------------|---|--------------|
| Under 1 year  | 6.5G         | 10 years  | 3.5G         |
| 1 year  | 6.0G         | 11 years  | 3.0G         |
| 2 years   | 6.0G         | 12 years  | 2.5G         |
| 3 years   | 5.5G         | 13 years  | 2.5G         |
| 4 years   | 5.0G         | 14 years  | 2.0G         |
| 5 years   | 5.0G         | 15 years  | 2.0G         |
| 6 years   | 4,5G         | 16 years  | 1,5G         |
| 7 years   | 4,0G         | 17 years  | 1,5G         |
| 8 years   | 4.0G         | 18 years  | 1.0G         |
| 9 years   | 3.5G         | 19 years  | 1.0G         |

If the deceased was a single parent, cf. section 1.10, the child will receive double compensation.

### 2.5.6.5 Expenses in connection with the death

Expenses associated with the death (funeral supplement) are compensated with 0.5G. This applies even if the deceased does not leave behind persons who are entitled to compensation for loss of breadwinner.

## **2.5.7 Travel between home and work**

Occupational injury insurance has been extended to also cover accidents that occur on the direct route between home and workplace, cf. section 1.22. If the insurance also covers leisure time accidents, cf. Chapter 3, the compensation from the extended occupational injury insurance shall be deducted krone for krone from the compensation from the leisure accident insurance.

## **2.6 Limitations**

### **2.6.1 Relationship to the National Insurance Scheme and other public reimbursement schemes**

Occupational injury insurance is subsidiary to social security and public law coverage.

If no application has been made for social security benefits and the like, the enterprise will be able to deduct from the compensation for what the injured party would have been entitled to. This does not apply if an application for coverage from the National Insurance Scheme would obviously not have been successful. In the event of doubt about the extent of the social security benefit, the probable coverage is taken as a basis.

### **2.6.2 Self-employed**

If it has been agreed and it is stated in the insurance contract and the insurance certificate that occupational injury insurance has been established for self-employed persons, the following applies:

In order for the self-employed person (ENK/ANS/DA) to be able to establish occupational injury insurance for owner(s), it is a requirement that the self-employed person has also established voluntary occupational injury insurance with the National Insurance Scheme. If this requirement is not met, the right to compensation from the occupational injury insurance also lapses.

### **2.6.3 Participation**

The compensation may be reduced or cancelled if the employee has intentionally or grossly negligently contributed to the injury. However, this shall not restrict the bereaved person's right to compensation. Section 5-1 of the Act on Compensation for Damages of 13 June 1969 No. 25 applies correspondingly to the extent that it is appropriate.

### **2.6.4 Coordination of benefits**

1. Social security benefits

When paying compensation for expenses incurred and when calculating compensation for future additional expenses, lost income and compensation to others than a spouse/cohabitant or children, a deduction is made krone-for-krone for the social security benefits to which the insured person is entitled as a result of the injury or illness. 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

3. Occupational injury/illness or Leisure accident - disability coverage

When injury or illness entitles you to occupational disability compensation from occupational injury insurance or leisure accident insurance and occupational disability other illness, compensation from occupational disability other illness will be deducted krone for krone from the occupational disability compensation in occupational injury insurance/leisure accident insurance.

### **2.6.5 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 enterprise may claim recourse from the responsible tortfeasor for compensation payment pursuant to the provisions of Section 3-7(3) of the Compensation of Injuries Act and Section 8 of the Occupational Injury Insurance Act.

### **2.6.6 Deadline for reporting the insurance event**

In the event of a claim for compensation, the undertaking is free from liability unless the party making the claim notifies the undertaking of the occurrence of an insurance event within one year after the person in question became aware of the circumstances that justify the claim.

### **2.6.7 Medical treatment**

If the insured without reasonable grounds opposes surgery or other treatment, the final degree of disability/incapacity for work may be taken into account when determining the degree of disability/incapacity for work.

## **2.7 Settlement rules**

### **2.7.1 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) The person who wishes to make a claim against the enterprise must provide the enterprise with the information and documents that are available to the person in question and that the enterprise needs in order to be able to decide on the claim and pay the sum insured. A person who provides incorrect information may lose any claim for compensation against the undertaking, cf. Section 8-1 of the Insurance Contracts Act, and the undertaking may terminate the person's other insurance policies.
- c) 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.
- d) Losses and expenses that are claimed to be covered by the enterprise must be documented with original vouchers or other legitimised statements.
- e) 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.

## **2.7.2 The due date of the compensation**

Settlement shall take place as soon as the company has had a reasonable time to clarify the liability and calculate the compensation. If it is clear at an earlier stage that the company is to pay at least part of the amount claimed, a corresponding advance must be paid, cf. Section 18-2 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.

## **2.7.3 Post-settlement**

If the compensation has been determined for future expenses, loss of future income or compensation for permanent injury, and the injured party's degree of disability or medical disability as a result of the accident changes significantly, the injured party may claim settlement in arrears. A claim for settlement in arrears must be submitted within 5 years after the settlement was concluded.

## **2.7.4 Statute of limitations**

The employee's claim against the enterprise is time-barred after 3 years. The time limit begins to run at the end of the calendar year in which the employee acquired or should have acquired the necessary knowledge of the circumstances that justify the claim. The limitation periods in the Insurance Contracts Act and Section 9 of the Act on the Limitation of Claims of 18 May 1979 No. 18 do not apply. Otherwise, the rules in the Limitation Act apply as far as they are appropriate. 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. Section 1-6 of the Insurance Contracts Act (communication) applies correspondingly. 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 reported to the enterprise.

## **2.7.5 The company's liability in the event of termination of the insurance contract**

If the insurance contract for occupational injury insurance is terminated, the undertaking will nevertheless respond until the corresponding insurance contract enters into force. However, the company's liability under the insurance contract lapses no later than four months after the termination of the agreement, cf. Section 6, paragraph 1, of the Occupational Injury Insurance Act.

## **2.7.6 Provisions that apply when an increased sum insured has been agreed**

If an increased sum insured has been agreed in the event of an occupational injury/illness, the provisions apply correspondingly to an increased sum insured, but with the following exceptions:

- Section 5 last paragraph of the Occupational Injury Insurance Act (on former employees) does not apply.
- Section 2.7.5 (on the undertaking's liability in the event of termination of the insurance contract) does not apply, but is replaced by Chapter 10.
- Sections 3.6.7 (induction of the insurance event), 3.6.9 (Aviation, aviation and air sports), 3.6.10 (War etc. – nuclear reactions) and 3.6.11 (travel abroad) apply correspondingly to increased insurance sums.
- For this part of the insurance, the company is obliged to pay interest in accordance with section 3.8.2 of the terms and conditions.

### **2.7.6.1 Entitlement to compensation in the event of occupational injury and illness in the event of an increased sum insured**

- a) In the case of an occupational injury, the provisions of section 3.4.1 a) (insurance case of leisure accident) apply correspondingly, however, so that the compensation after the additional coverage falls due for payment at the same time as compensation pursuant to section 2.7.2 (the due date of the compensation). It is a condition for entitlement to compensation that the occupational injury occurs during the insurance period. In the event of a claim for compensation, the undertaking is free from liability unless the party making the claim notifies the undertaking of the occurrence of an insurance event within one year after the person in question became aware of the circumstances that justify the claim.
- b) The right to compensation in the event of occupational illness arises if the insured dies as a result of an occupational disease, or if the occupational illness results in permanent medical disability in terms of coverage, while the insurance is in force.

### **2.7.6.2 Limitation period in the event of an increased sum insured**

For coverage with an increased sum insured, claims for compensation are time-barred after 3 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. The claim is time-barred no later than 10 years after the end of the calendar year in which the insurance event occurred. In addition, the Insurance Contracts Act 18-6 and the rules in the Limitation Act apply. 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.

### **2.7.6.3 Legal rules in the event of an increased sum insured**

For coverage with an increased sum insured, the rules in Part B of the Insurance Contracts Act apply, unless another agreement has been made in the terms and conditions from which the Act may be derogated.

### **2.7.7 Which insurance term is used as a basis**

In the event of a claim for payment of the sum insured in the event of an occupational injury and illness, the terms and conditions that applied to the occurrence of the occupational injury or illness occurred/were ascertained are used.

## **2.8 Calculation rules**

### **2.8.1 National Insurance basic amount - G**

The compensation calculation is based on the value of G at the time of settlement.

### **2.8.2 The company's interest obligation**

The company's obligation to pay interest on compensation is governed by the rules laid down in the Occupational Injury Insurance Act and regulations.

Provisions that apply when an increased sum insured has been agreed - for the increase: (new)

- a) The company must pay interest on compensation or the sum insured when 2 months have passed after notification of the insurance case was sent to the enterprise.
- b) Interest on coverage of expenses  
The company pays interest on the insured's disbursements when 2 months have passed after the claim for coverage of disbursements was made sent to the enterprise.
- c) Loss of interest obligation  
If the insured neglects to provide information or disclose documents as mentioned in section 2.7.1, the person in question shall not claim interest for the time lost as a result. The same applies if the beneficiary 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 Interest Act In the event of late payment, etc., of 17 December no. 100 and the Occupational Injury Insurance Act with regulations.

## **2.9 The insured's disposal of the compensation or sum insured, etc.**

### **2.9.1 Medical disability, incapacity for work and death**

#### **Medical disability and incapacity for work**

Compensation for incurred and future additional expenses, medical disability and incapacity for work is paid directly to the insured.

If the insured dies after the right to disability compensation and/or earned income compensation has arisen, but before compensation has been paid, the payment will be made to the insured's estate.

If the insured dies before the right to disability compensation/occupational compensation has arisen, only death compensation will be paid.

#### **Death**

Compensation in the event of death is paid to the spouse/cohabitant and compensation for loss of provider is paid to the child, cf. sections 2.5.6.1 and 2.5.6.2.

In the event of the insured's death, a notification must be sent to the enterprise without undue delay with a death certificate and a certificate of probate of confession.

If compensation is to be paid to a surviving cohabitant in accordance with the agreement, a transcript from the National Population Register must be attached.

### **2.9.2 Transfer and pledge**

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

### **2.9.3 Repurchase and paid-up policy value**

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

## 3. Leisure accident insurance

An accident insurance that the employer can establish for its employees. This insurance can provide one-time compensation to employees who are exposed to an accident in their spare time.

It will be stated in the insurance contract and the insurance certificate whether leisure accident insurance has been established.

### 3.1 Who the insurance applies to

The leisure accident insurance applies to permanently employed 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 medical disability and the permanent degree of incapacity for work shall be determined by a doctor in Norway in accordance with the applicable regulations in Norway.
- Expenses in connection with the determination of the degree of permanent medical disability or the degree of permanent incapacity for work are not reimbursed.
- Expenses pursuant to the provisions of the terms and conditions regarding incurred and future additional expenses will not be reimbursed.
- Deductions are made for the benefits that the person in question would have been entitled to from the National Insurance Scheme.

If this is agreed and stated in the insurance contract and the insurance certificate, the insurance may also apply to other specified persons or specified groups.

### 3.2 Where the insurance applies

Leisure accident insurance is valid worldwide, however, see the exemption provisions in war/unrest and terrorist acts.

### 3.3 When the insurance applies

The leisure accident insurance is valid from the time specified in the insurance contract and the insurance certificate. For the individual employee, the insurance comes into force from the same time as the insurance contract enters into force.

#### 3.3.1 Later enrollments

The insurance is valid from the time specified in the insurance contract and the insurance certificate. If the employee is employed after the insurance contract entered into force, the insurance applies from the time of employment.

### 3.3.2 Amendment of the agreement change

In the event of an amendment to the agreement that results in inclusion of new groups of employees in the insurance, or an increase in insurance sums occurring after the insurance entered into force, the insurance shall apply from the time specified in the insurance contract and the insurance certificate.

## 3.4 What the insurance can cover

The insurance covers accident damage that occurs during the insurance period.

In the event of a leisure accident, compensation can be agreed in the event of:

- Permanent medical disability, cf. section 1.19.
  - When medical disability has been chosen, incurred and future expenses are also covered, cf. sections 3.5.1 and 3.5.2.
- Permanent incapacity for work, cf. section 1.20.
  - When incapacity for work has been chosen, lost income is also covered, cf. section 3.5.3.
- Deaths.

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

### 3.4.1 The insurance event

a) Permanent medical disability, death and treatment expenses:

The insurance event is considered to have occurred on the day of the accident, even if the consequences of the injury at that time have not been clarified.

b) Permanent incapacity for work:

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

- Incapacitated for a continuous period of at least 2 years, and
- The incapacity for work is assessed as permanent. If such disability has lasted continuously for 5 years, it is considered permanent, unless special circumstances indicate otherwise.

It can be agreed that the incapacity for work must be at least 40 per cent.

c) The insurance event pursuant to a) and b) must occur during the insurance period.

## 3.5 Benefits under the leisure accident insurance

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

### 3.5.1 Incurred additional expenses

If medical disability is not chosen to be covered, compensation for additional expenses incurred is not covered.

If medical disability has been chosen to be covered, reasonable and necessary additional expenses that are caused by a leisure accident are also covered. Such expenses are compensated individually up to the time of settlement, cf. Section 3-1 of the Compensation for Injuries Act.

The enterprise covers documented additional expenses incurred by the insured due to a leisure time accident.

Incurred expenses are covered in accordance with the rules of the Occupational Injury Insurance Act, nevertheless limited upwards to 75 per cent of G.

Expenses below 2 per cent of G on the date of injury are not covered.

### 3.5.2 Future additional expenses

If medical disability is not chosen to be covered, compensation for future additional expenses will not be covered.

If medical disability is chosen to be covered, reasonable and necessary future additional expenses will also be covered. Such expenses are reimbursed individually, cf. Section 3-1 of the Compensation for Injuries Act.

Future additional expenses are expenses that accrue after the settlement date.

Future one-off expenses and future annual expenses are covered in accordance with the rules in the Occupational Injury Insurance Act, but limited upwards to a total of 3G at the time of settlement.

The compensation is paid as a lump sum and is determined as follows:

| The injured party's age at the time of settlement | Compensation             |
|---|--------------------------|
| Under 35 years of age                             | 21 times annual expenses |
| Between 35 and 49 years                           | 19 times annual expenses |
| Between 50 and 59 years                           | 16 times annual expenses |
| Between 60 and 69 years                           | 14 times annual expenses |
| Over 70 years                                     | 8 times annual expenses  |

When calculating compensation, the insured's age at the time of settlement is used.

### 3.5.3 Lost income

If coverage for disability is not chosen to be covered, compensation for lost income is not covered either.

If coverage for disability is chosen to be covered, lost income (actual/incurred loss of income) is also covered, which is compensated in the time up to the time of settlement. The amount of compensation is determined individually, cf. Section 3-1 of the Compensation for Injuries Act

The following limitation applies:

- Incurred loss of income is covered for up to 5 years from the date of the injury, see section 3.4.1 b).
- Incurred loss of income is not covered after compensation has been paid for disability/future loss of income.
- It is a prerequisite for coverage of incurred loss of income that the insurance is valid for the person in question.
- For employees of the policyholder, only the loss of income incurred by the policyholder is compensated
- When the insurance has been taken out by a self-employed person, the loss of income incurred in the industry is compensated and no loss of salary income is incurred. The compensation is limited to 0.15G on the injury case per month.

- If the termination age of the insurance is higher than 67 years, employees over the age of 67 will only be compensated for any loss of income during the period of sick leave that entitles them to sickness benefit from NAV.

### 3.5.4 Permanent incapacity for work (loss in future earnings)

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

| Pensionable income in the year prior to the date of determination | Basic compensation |
|---|--------------------|
| 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 occupational disability is less than 100 per cent, the compensation is reduced accordingly.

It can be agreed that permanent disability applies from at least 40 per cent. If this has been agreed, this must be stated in the insurance contract and the insurance certificate.

#### 3.5.4.1 The basis for the compensation

The basis for calculating the future loss of income is the pensionable income (earning capacity) in the year before the insurance event occurred. 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 injury occurred.

If the insured's presumed pensionable income, excluding the injury, in the year in which the insurance event occurred, provides a higher basis, this is taken into account. The same applies if the insured in a later income year has achieved a pensionable income that provides a higher basis.

If there is particular evidence to assume that the basis for the calculation pursuant to the first and second paragraphs differs significantly from what would have been the insured's ordinary income level without the injury, the basis for the calculation shall be set at this level.

The calculation basis is determined in relation to the National Insurance basic amount (G) on 1 January in the income year in which the income was earned.

#### 3.5.4.2 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.

### 3.5.4.3 Adjustment according to the insured's age at the time of settlement

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.

### 3.5.5 Permanent medical disability (injury compensation)

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, compensation for injury is paid in the event of permanent medical disability of 15 per cent or more.

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

| Degree of medical disability | Basic compensation for sum insured 4.5G |
|------------------------------|---|
| 15 – 24 per cent             | 0.75G                                   |
| 25 – 34 per cent             | 1.00G                                   |
| 35 – 44 per cent             | 1.50G                                   |
| 45 – 54 per cent             | 2.00G                                   |
| 55 – 64 per cent             | 2.50G                                   |
| 65 – 74 per cent             | 3.00G                                   |
| 75 – 84 per cent             | 3.75G                                   |
| 85 – 100 per cent            | 4.5G                                    |

The same proportionate compensation applies if other sums insured have been agreed.

An injury that is significantly greater than an injury that gives rise to a permanent medical disability degree of 100 per cent will result in compensation of 5.5G. This does not apply when higher sums insured have been agreed and stated in the insurance contract and the insurance certificate.

#### 3.5.5.1 The basis for compensation the degree of medical disability

The degree of medical disability is determined on the basis of Regulations 21.04.1997 no. 3 on injury compensation in the event of occupational injury and Regulations 01.03.2021 no. 622 on injury compensation in the event of patient injuries. The degree of disability may also be determined on the basis of other relevant tables if Norwegian tables are not adequate, such as the Swedish or Danish disability tables. Loss/damage to most body parts and

organs is given a specific degree of medical disability in the table. For injury consequences that are not included in the table, the degree of disability is determined after a discretionary comparison with the injury consequences in the table.

### **3.5.5.2 Principles for determining the degree of permanent medical disability**

If the insured has suffered several injuries after the same leisure accident or after several leisure accidents, the degree of disability is determined on the basis of an overall assessment, in the same way as for occupational injuries (called the reduction method).

### **3.5.5.3 Regulation according to the insured's age on the day 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 older than 46 years, a deduction of 2 per cent of the basic compensation is made. However, the compensation must amount to at least 50% of the basic compensation.
- For each year the insured is younger than 45 years of age, the compensation is increased by 2 per cent of the basic compensation.

When calculating compensation, G and age at the time the insurance event occurs are used.

## **3.5.6 Compensation in the event of death**

### **3.5.6.1 Compensation for the insured's spouse or cohabitant**

If the insurance includes coverage for death as a result of a leisure accident and is not otherwise agreed and stated in the insurance agreement and the insurance certificate, the compensation is paid to the insured's spouse or cohabitant jr. clauses 1.9 and 1.10.

### **3.5.6.2 Regulation according to the insured's age on the day the insurance event occurs**

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

- For each year the insured is older than 46 years, the compensation is reduced by 5 per cent. The compensation must nevertheless amount to at least 20 per cent of the basic compensation.
- The same proportional reduction applies if other sums insured have been agreed.

When calculating compensation, G and age at the time the insurance event occurs are used.

### **3.5.6.3 Compensation for children under the age of 20**

The compensation is calculated separately for each child under the age of 20 who was the deceased's dependent. Children mean the insured's only children (biological) and adopted children under the age of 20. The amount of compensation depends on the age of the child at the time of the loss of the provider.

### **3.5.6.4 Adjustment in relation to the child's age in the event of the death of the provider.**

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

| The child's age at the time of the insured person's death | Compensation | The child's age at the time of the insured person's death | Compensation |
|---|--------------|---|--------------|
| Under 1 year  | 6.5G         | 10 years  | 3.5G         |
| 1 year  | 6.0G         | 11 years  | 3.0G         |
| 2 years   | 6.0G         | 12 years  | 2.5G         |
| 3 years   | 5.5G         | 13 years  | 2.5G         |
| 4 years   | 5.0G         | 14 years  | 2.0G         |
| 5 years   | 5.0G         | 15 years  | 2.0G         |
| 6 years   | 4,5G         | 16 years  | 1,5G         |
| 7 years   | 4,0G         | 17 years  | 1,5G         |
| 8 years   | 4.0G         | 18 years  | 1.0G         |
| 9 years   | 3.5G         | 19 years  | 1.0G         |

If the deceased was a single parent, cf. section 1.10, the child will receive double compensation.

### 3.5.6.5 Compensation to someone other than spouse/cohabitant or children

In the event of death due to a leisure accident, compensation is paid to someone other than a spouse/cohabitant or children when they were wholly or partly supported by the deceased.

### 3.5.6.6 Expenses in connection with the death

Expenses associated with the death (funeral supplement) are compensated with 0.5G. This applies even if the deceased does not leave behind persons who are entitled to compensation for loss of breadwinner.

### 3.5.6.7 Determination of compensation in the event of death

If the leisure time accident results in death within 2 years of the date of injury, death compensation is paid. Any Disability compensation that may have been paid in advance for the same injury will be deductible. If the insured dies for any other reason within 2 years of the date of injury, neither death nor disability compensation is paid. If the insured dies later than 2 years after the date of the injury, death compensation is not paid, but disability compensation according to the degree of disability the injury would have caused.

## 3.6 Limitations

### 3.6.1 Relationship to the National Insurance Scheme and other public reimbursement schemes

Leisure time accidents are subsidiary in relation to social security and public law coverage.

If no application has been made for social security benefits and the like, the enterprise will be able to deduct from the compensation for what the injured party would have been entitled to. This does not apply if an application for coverage from the National Insurance Scheme would obviously not have been successful. In the event of doubt about the extent of the social security benefit, the probable coverage is taken as a basis.

### **3.6.2 Participation**

The compensation may be reduced or cancelled if the employee has intentionally or grossly negligently contributed to the injury. However, this shall not restrict the bereaved person's right to compensation.

### **3.6.3 Coordination of benefits**

1. Social security benefits

When paying compensation for expenses incurred and when calculating compensation for future additional expenses, lost income and compensation to others than a spouse/cohabitant or children, a deduction is made krone-for-krone for the social security benefits to which the insured person is entitled as a result of the injury or illness. 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.

3. Leisure accident

When an injury entitles you to occupational disability compensation from both leisure accident insurance and insurance coverage for occupational disability other illness, compensation from occupational disability other illness will be deducted krone for krone from the occupational disability compensation in the leisure accident insurance.

### **3.6.4 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 compensation payment pursuant to the provisions of Section 3-7 no. 3 of the Compensation for Damages Act.

### **3.6.5 Deadline for reporting the insurance event**

In the event of a claim for compensation, the undertaking is free from liability unless the party making the claim notifies the undertaking of the occurrence of an insurance event within one year after the person in question became aware of the circumstances that justify the claim.

### **3.6.6 Medical treatment**

The insurance does not cover accidental injuries caused by medical examination, treatment and the like, or by taking medication. This does not apply if the insured has been treated due to an accident injury for which the company is liable. In no case does the insurance cover accidental damage caused directly or indirectly by the consumption of sleeping, painkillers, sedatives or narcotics.

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

### **3.6.7 Triggering of the insurance event**

- a) 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.

b) Gross negligence

If the insured has grossly negligently caused the insurance event or increased the extent of the damage, the enterprise's liability may be reduced or eliminated. In making the decision, emphasis shall be placed on the degree of fault, the course of the injury, whether the insured was in self-inflicted intoxication, the effect that the reduction or loss of the enterprise's liability will have for the person entitled to the insurance or for other persons who are financially dependent on the insured and other circumstances in general. In cases other than those mentioned in the first subsection, the undertaking may not claim that the insured has negligently caused the insurance event. The undertaking may not invoke the rules in the first paragraph if, due to age or state of mind, the insured could not understand the scope of his or her action, cf. Section 13-9 of the Insurance Contracts Act.

### **3.6.8 Special activities – Sports**

a) The insurance does not cover accidental injuries caused by boxing, wrestling, judo, karate and other similar martial arts.

b) Without a special agreement, the insurance does not cover accident damage caused by:

- diving with breathing gas deeper than 20 meters and freediving deeper than 10 meters
- mountaineering that requires belay equipment, bungee jumps, Super G, downhill and the like, as well as all activities that are considered extreme sports
- speed races with motor vehicles and motor craft or training for such races
- explorations, expeditions and similar journeys.

The list is not exhaustive.

### **3.6.9 Aviation, air travel and air sports**

Without a separate agreement, the insurance does not cover accident damage caused by hang gliding, paragliding, flying with microlight and ultralight aircraft, parachuting and base jumping, ballooning and similar air sports activities.

### **3.6.10 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.

### **3.6.11 Travelling abroad**

The provision in section 3.6.10 on war or warlike acts applies correspondingly to travel. If the insured is already staying ashore when the provisions of section 3.6.10 are applied, the company's liability is limited to cover damage or increase in such damage for 30 days from the date on which travel advice is issued. The same also applies when you are on a business trip during the time of day when you are not performing work for the employer.

### **3.6.12 Earthquakes and volcanic eruptions**

The insurance does not cover accidental damage caused by earthquakes or volcanic eruptions in Norway. The Norwegian continental shelf and Svalbard are also considered to be Norway.

### **3.6.13 Harm from medical treatment or the use of drugs**

The insurance does not cover accidental injuries caused by medical treatment, examinations and the like, or by taking medication. This does not apply if the insured has been treated due to an accident injury for which the company is liable. In no case does the insurance cover accidental damage caused directly or indirectly by the consumption of sleeping, painkillers, sedatives or narcotics.

### **3.6.14 Limitation in case of illness and other special conditions**

The insurance does not apply to:

- a) In the event of an accident injury due to stroke, fainting or other morbid condition.  
For the following diseases or morbid conditions, even if an accidental injury can be detected as the cause: stroke, heart attack and cancer. Pain conditions in the back, unless the pain has arisen as a result of an X-ray detectable fracture of the spine, and the fracture is due to a leisure accident. Infectious diseases, unless the infection has come through tissue damage as a result of a leisure accident, and other modes of infection, such as insect stings, can be ruled out.
- b) Damage to the mind, e.g. shock, unless bodily injury has occurred at the same time that results in compensatory and permanent medical disability.
- c) In other cases, compensation is reduced if it can be assumed that a morbid condition or facility together with the accident injury has contributed to the insured's death, medical disability or incapacity for work.

The compensation is reduced in proportion to the significance of the morbid condition or the morbid condition for the death, disability or incapacity for work.

### **3.6.15 Assults and Crime**

The insurance does not cover accidental damage caused by the insured voluntarily participating in a fight or crime.

### **3.6.16 Poisoning, etc.**

The insurance does not cover accidental damage caused by poisoning of food, drink or stimulants.

## **3.7 Settlement rules**

### **3.7.1 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.
- d) Documentation of losses and expenses.  
Losses and expenses for which the enterprise is responsible must be documented with original vouchers or other legitimised statements.

### **3.7.2 The due date of the compensation**

Settlement shall take place as soon as the enterprise has had a reasonable time to clarify the liability and calculate the compensation. If it is clear at an earlier stage that the undertaking is to pay at least part of the amount claimed, a corresponding advance must be paid, cf. Section 18-2 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.

### **3.7.3 Post-settlement**

If the compensation has been determined for future expenses, loss of future income or compensation for permanent injury, and the injured party's degree of disability or medical disability as a result of the accident changes significantly, the injured party may claim settlement in arrears. A claim for settlement in arrears must be submitted within 5 years after the settlement was concluded. It is a prerequisite for settlement in arrears that the injured party is still employed by the policyholder and that the insurance is valid in the enterprise.

### **3.7.4 Statute of limitations**

Claims for compensation are time-barred after 3 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. The claim is time-barred no later than 10 years after the end of the calendar year in which the insurance event occurred. In

addition, Section 18-6 of the Insurance Contracts Act and the rules of the Limitation Act apply. 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.

### **3.7.5 The company`s liability in the event of termination of the insurance contract**

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

### **3.7.6 Provisions that apply when an increased sum insured has been agreed**

If an increased sum insured has been agreed in the event of a leisure accident, the provisions apply correspondingly to the increase.

### **3.7.7 Legal rules**

For leisure accident insurance, the rules in Part B of the Insurance Contracts Act apply, unless another agreement has been made in the terms and conditions from which the Act may be derogated.

### **3.7.8 Which insurance term is used as a basis**

In the event of a claim for payment of the sum insured in the event of a leisure accident, the terms and conditions that applied at the time of the injury are used.

## **3.8 Calculation rules**

### **3.8.1 National Insurance basic amount - G**

The compensation calculation is based on the value of G at the time the insurance event occurred.

### **3.8.2 The company`s interest obligation**

- a) Interest on compensation  
The enterprise shall pay interest on the compensation or sum insured when 2 months have passed after notification of the insurance incident was sent to the enterprise, cf. Section 18-4 of the Insurance Contracts Act.
- 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 fails to provide information or disclose documents as mentioned in section 3.7.1, 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, and the Act on Interest on Late Payment, etc. of 17 December No. 100.

## **3.9 The insured's disposal of the compensation or sum insured, etc.**

### **3.9.1 Medical disability, incapacity for work and death**

#### **Medical disability and incapacity for work**

Compensation for incurred and future additional expenses, medical disability and incapacity for work is paid directly to the insured.

If the insured dies after the right to disability compensation and/or earned income compensation has arisen, but before compensation has been paid, the payment will be made to the insured's estate.

If the insured dies before the right to disability compensation/occupational compensation has arisen, only death compensation will be paid.

#### **Death**

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, compensation in the event of death is paid to the spouse/cohabitant and compensation for loss of provider is paid to children, cf. sections 3.5.6.1 and 3.5.6.3.

In the event of the insured's death, a notification must be sent to the enterprise without undue delay with a death certificate and a certificate of probate of confession.

If compensation is to be paid to a surviving cohabitant in accordance with the agreement, a transcript from the National Population Register must be attached.

### **3.9.2 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.

### **3.9.3 Repurchase and paid-up policy value**

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

## 4. Medical disability due to illness other than occupational disease

A sickness insurance that the employer can establish for its employees. This insurance can provide one-off compensation to employees who become permanently medically disabled of at least 40 per cent as a result of an illness other than an occupational disease. The permanent medical disability of at least 40 per cent must be due to one and the same disease.

It will be stated in the insurance contract and the insurance certificate that medical disability as a result of illness other than occupational disease has been established.

### 4.1 Who the insurance applies to

The insurance applies to permanently employed 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 medical disability shall be determined by a doctor in Norway in accordance with current regulations in Norway.
- Expenses in connection with the determination of the degree of permanent medical disability are not reimbursed.

If this is agreed and stated in the insurance contract and the insurance certificate, the insurance may also apply to other specified persons or specified groups.

### 4.2 Where the insurance applies

The insurance is valid worldwide, however, see the exemption provisions in war/unrest and terrorist acts.

### 4.3 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 4.3.1 to 4.3.4.

#### 4.3.1 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.

#### 4.3.2 Requirements for self-declaration of health

- 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.

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.

### **4.3.3 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.

### **4.3.4 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 persons, the requirement for full fitness for work, a self-declaration of health and a symptom clause applies as at the time of the establishment of the insurance, cf. sections 4.3.1, 4.3.2, 4.3.3 and 4.3.4.
- 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, self-declaration of health or symptom clause is required.

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

## **4.4 What the insurance can cover**

The insurance covers permanent medical disability as a result of an illness other than an occupational disease if such insurance has been agreed.

The insurance covers permanent medical disability that occurs during the insurance period.

In the event of medical disability as a result of a non-occupational illness, compensation may be agreed in the event of:

- Permanent medical disability of at least 40 per cent for one specific disease.

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

#### 4.4.1 The insurance event

The insurance event in the event of permanent medical disability as a result of an illness other than an occupational disease occurs when:

- The insured has been medically disabled as a result of an illness other than an occupational disease continuously for at least 2 years, and
- The degree of medical disability is at least 40 per cent for one and the same disease. In the case of several diseases, each individual disease must give a VMI of at least 40 percent, and
- The medical disability is judged to be permanent.

In total, the degree of permanent medical disability may not exceed 100 per cent.

The insurance event must occur during the insurance period.

If permanent medical disability of at least 40 per cent has been assessed 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 degree of permanent medical disability after the person in question has been withdrawn from the insurance is not covered.

### 4.5 Benefits under the insurance

#### 4.5.1 Permanent medical disability (injury compensation)

Unless otherwise agreed and stated in the insurance contract and the insurance certificate, compensation for injury is paid in the event of permanent medical disability as a result of an illness that is not an occupational disease of 40 per cent or more.

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

| Degree of medical disability | Basic compensation for sum insured 4.5G |
|------------------------------|---|
| 40 – 49 per cent             | 1.80G                                   |
| 50 – 54 per cent             | 2.00G                                   |
| 55 – 64 per cent             | 2.50G                                   |
| 65 – 74 per cent             | 3.00G                                   |
| 75 – 84 per cent             | 3.75G                                   |
| 85 – 100 per cent            | 4.5G                                    |

#### **4.5.1.1 The basis for determining the degree of medical disability**

The degree of medical disability is determined on the basis of Regulations 21.04.1997 no. 3 on injury compensation in the event of occupational injury and Regulations 01.03.2021 no. 622 on injury compensation in the event of patient injuries. The degree of disability may also be determined on the basis of other relevant tables if Norwegian tables are not adequate, such as the Swedish or Danish disability tables. Loss/damage to most body parts and organs is given in the table one specific degree of medical disability. For injury consequences that are not included in the table, the degree of disability is determined after a discretionary comparison with the injury consequences in the table.

#### **4.5.1.2 Principles for determining the degree of permanent medical disability**

In the case of several diseases, each individual illness must result in a permanent degree of medical disability of at least 40 per cent, and the total disability may not exceed 100 per cent.

#### **4.5.1.3 Regulation 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 older than 46 years, a deduction of 2 per cent of the basic compensation is made. However, the compensation must amount to at least 50% of the basic compensation.
- For each year the insured is younger than 45 years of age, the compensation is increased by 2 per cent of the basic compensation.

It must be stated in the insurance contract and the insurance certificate whether the sum insured is to be calculated with or without adjustment according to the insured's age.

When calculating compensation, G and age at the time the insurance event occurs are used.

## **4.6 Limitations**

### **4.6.1 Reservations**

The enterprise's liability does not extend to illnesses for which it has made a reservation in the insurance certificate.

### **4.6.2 Illnesses not covered by the insurance**

The enterprise's liability does not include the following diseases:

- Mental retardation F70-79 in ICD-10 or equivalent coding system
- Pervasive developmental disorders F84 in ICD-10 or equivalent coding system (includes autism and Asperger's syndrome)
- Chronic fatigue conditions, including CFS/ME, postviral fatigue syndrome, neurasthenia, chronic fatigue and equivalent conditions: G93.3, F48.0, Z73.0, R53 (ICD-10) and A04 (ICPC-2) or equivalent coding system
- Substance abuse with associated conditions/diseases: F10-19 in ICD-10 or equivalent coding system

### **4.6.3 Symptom clause**

The enterprise is not responsible for compensation in the event of medical disability as a result of illness or illness that has been diagnosed or has shown signs or symptoms within three months of enrolment in the insurance or the person in question was automatically included in the insurance, cf. Section 13-5, second paragraph, of the Insurance Contracts Act.

### **4.6.4 Participation**

The compensation may be reduced or cancelled if the employee has intentionally or grossly negligently contributed to the injury. However, this shall not restrict the bereaved person's right to compensation.

### **4.6.5 Coordination of benefits**

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

### **4.6.6 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.

### **4.6.7 Deadline for notification the insurance event**

In the event of a claim for compensation in the event of medical disability, the company is free from liability unless the claimant notifies the company of the occurrence of an insurance event within one year after the person in question became aware of the circumstances that justify the claim.

### **4.6.8 Medical treatment**

If the insured without reasonable cause opposes surgery or other treatment, the final degree of disability/earning shall take into account the probable improvement that such treatment could have caused.

### **4.6.9 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.

### 4.6.10 Travelling abroad

The provision in section 4.6.9 on war or warlike acts applies correspondingly to travel abroad. If the insured is already staying ashore when the provisions of section 4.6.9 are applied, the Investment Firm's liability is limited to damage or increase in such damage for 30 days from the date on which the travel advice is issued.

### 4.6.11 Triggering the insurance event

#### a) 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.

#### b) Gross negligence

If the insured has grossly negligently caused the insurance event or increased the extent of the damage, the enterprise's liability may be reduced or eliminated. In making the decision, emphasis shall be placed on the degree of fault, the course of the injury, whether the insured was in self-inflicted intoxication, the effect that the reduction or loss of the enterprise's liability will have for the person entitled to the insurance or for other persons who are financially dependent on the insured and other circumstances in general. In cases other than those mentioned in the first subsection, the undertaking may not claim that the insured has negligently caused the insurance event. The undertaking may not invoke the rules in the first paragraph if, due to age or state of mind, the insured could not understand the scope of his or her action, cf. Section 13-9 of the Insurance Contracts Act.

## 4.7 Settlement rules

### 4.7.1 Notification of insurance incident, documentation, etc.

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.

#### **4.7.2 The due date of the compensation**

Settlement shall take place as soon as the enterprise has had a reasonable time to clarify the liability and calculate the compensation. If it is clear at an earlier stage that the undertaking is to pay at least part of the amount claimed, a corresponding advance must be paid, cf. Section 18-2 of the Insurance Contracts Act.

#### **4.7.3 Post-settlement**

In the event of a significant increase of at least 20 per cent of the degree of medical disability, after compensation for injury has been paid, the insured is entitled to additional compensation. Such a settlement in arrears presupposes that the insured is still employed by the policyholder and the insurance is still in force in the enterprise.

A new insurance event occurs at the time when the increase in the degree of medical disability is deemed to be permanent.

The compensation falls due for payment when the new insurance event has occurred, the company has received the claim with the necessary documentation, and has had a reasonable time to map its liability.

When calculating compensation, G and age at the time the insurance event occurred are used.

Settlement in arrears requires that the change is significant, corresponding to at least an addition of permanent medical disability of 20 percentage points over and above the original degree of disability.

#### **4.7.4 Statute of limitations**

Claims for compensation are time-barred after 3 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. The claim is time-barred no later than 10 years after the end of the calendar year in which the insurance event occurred. In addition, Section 18-6 of the Insurance Contracts Act and the rules of the Limitation Act apply. 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.

#### **4.7.5 The company`s liability in the event of termination of the insurance contract**

If the insurance contract for medical disability is terminated as a result of illness other than an occupational disease, the company's liability ceases in accordance with the rules in Section 19-6 of the Insurance Contracts Act.

#### **4.7.6 Provisions that apply when an increased sum insured has been agreed**

If an increased sum insured has been agreed, the provisions apply correspondingly to the increases.

### **4.7.7 Legal rules**

The rules in Part B of the Insurance Contracts Act apply to the insurance, unless another agreement has been entered into in the terms and conditions from which the Act may be derogated.

### **4.7.8 Which insurance term is used as a basis**

In the event of a claim for payment of the sum insured in the event of medical disability as a result of an illness other than an occupational disease, 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.

If there is no period of sick leave, the insurance terms and conditions that applied at the time the degree of permanent medical disability exceeded 40 per cent are used.

## **4.8 Calculation rules**

### **4.8.1 National Insurance basic amount - G**

For medical disability as a result of an illness that is not an occupational disease, G is used at the time the insurance event occurs.

### **4.8.2 Age**

When the compensation depends on age, age is taken into account on the day the insurance event occurs.

### **4.8.3 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 fails to provide information or disclose documents as mentioned in section 4.7.1, 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.

## **4.9 The insured's disposal of the compensation or sum insured, etc.**

### **4.9.1 Medical disability**

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

### **4.9.2 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.

### **4.9.3 Repurchase and paid-up policy value**

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

## 5. Group life insurance (insurance that also 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.

### 5.1 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 medical disability and the permanent degree of incapacity for work shall be determined by a doctor in Norway in accordance with the applicable regulations in Norway.
- Expenses in connection with the determination of the degree of permanent medical disability or the degree of permanent incapacity for work are not reimbursed.
- Expenses pursuant to the provisions of the terms and conditions regarding incurred and future additional expenses will not be reimbursed.
- A deduction is made for the benefits the person in question would have been entitled to from the National Insurance Scheme.

### 5.2 Where the insurance applies

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

### 5.3 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 5.3.1 to 5.3.4

#### 5.3.1 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.

### **5.3.2 Requirements for self-declaration of health**

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%.

### **5.3.3 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 5.3.1 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.

### **5.3.4 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 5.3.1 and 5.3.2.
- 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.

## 5.4 What the insurance can cover

The insurance may cover permanent incapacity for work, temporary incapacity for work and/or death as a result of illness other than occupational illness if this has been agreed.

When determining whether there is a «disease other than an occupational disease», 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.

## 5.5 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 5.6
- Temporary incapacity for work of at least 40 per cent,
  - Payment after the agreed time (up to 4 independent dates), cf. section 5.7
  - Payment after the agreed time for the age group 67+, cf. section 5.8
- Deaths, point 5.9

## 5.6 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:

### 5.6.1 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 |
|--|--------------------|
| 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.

#### **5.6.1.1 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.

#### **5.6.1.2 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.

#### **5.6.1.3 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.

## **5.6.2 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.

## **5.6.3 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.

## **5.7 Temporary incapacity for work of at least 40 per cent**

### **5.7.1 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.

#### **5.7.1.1 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.

#### **5.7.1.2 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.

#### **5.7.1.3 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.

### **5.7.2 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.

### 5.7.3 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.

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

### 5.8.1 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 5.6.

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.

#### 5.8.1.1 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.

### **5.8.1.2 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.

### **5.8.1.3 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.

## **5.8.2 Insurance event – 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.

### **5.8.3 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.

## **5.9 Deaths**

### **5.9.1 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:

#### **5.9.1.1 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

#### **5.9.1.2 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.

### **5.9.1.3 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.

### **5.9.1.4 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:

| <b>The age of the child at the time of the employee's death</b> | <b>Sum insured</b> | <b>The age of the child at the time of the employee's death</b> | <b>Sum insured</b> |
|---|--------------------|---|--------------------|
| 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.

#### **5.9.1.5 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.

#### **5.9.2 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.

### **5.9.3 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.

## **5.10 Limitations**

### **5.10.1 Reservations**

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

### **5.10.2 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

### **5.10.3 When health information is not requested**

#### **5.10.3.1 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.

#### **5.10.3.2 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.

### **5.10.4 Participation**

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

### **5.10.5 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

3. Occupational injury/illness or leisure accident

When injury or illness entitles you to occupational disability compensation from both occupational injury insurance/leisure accident insurance and occupational disability from group life insurance, compensation from occupational disability compensation from group life insurance will be deducted krone for krone from occupational injury insurance/leisure accident insurance.

### **5.10.6 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.

### **5.10.7 Deadline for notification of the insurance event**

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

### **5.10.8 Medical treatment**

If the insured without reasonable cause opposes surgery or other treatment, the final degree of disability may be taken into account when determining the final degree of disability.

### **5.10.9 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.

### **5.10.10 Travelling abroad**

The provision in section 5.10.9 on war or warlike acts applies correspondingly to travel abroad. If the insured is already staying ashore when the provisions of section 5.10.9 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.

### **5.10.11 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.

## **5.11 Settlement rules**

### **5.11.1 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.

### **5.11.2 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.

### **5.11.3 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.

### **5.11.4 The company'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.

### **5.11.5 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.

### **5.11.6 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.

## **5.12 Calculation rules**

### **5.12.1 National Insurance basic amount - G**

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

### **5.12.2 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 fails to provide information or disclose documents as mentioned in section 5.11.1, 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.

## **5.13 The insured's disposal of the compensation or sum insured, etc.**

### **5.13.1 Incapacity for work**

#### **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.

#### **Death**

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

### **5.13.2 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.

### **5.13.3 Repurchase and paid-up policy value**

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

## 6. Critical illness

Critical illness is a health insurance policy where the sum insured is paid out if the insured is diagnosed with one of the covered diseases/diagnoses listed in the points below during the insurance period.

It will be stated in the insurance contract and the insurance certificate whether critical illness insurance has been established.

### 6.1 Who the insurance applies to

The insurance applies to permanently employed 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.

If this is agreed and stated in the insurance contract and the insurance certificate, the insurance may also apply to other specified persons or specified groups.

### 6.2 Where the insurance applies

The insurance is valid worldwide, however, see the exemption provisions in war/unrest and terrorist acts.

### 6.3 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 6.3.1 to 6.3.4.

#### 6.3.1 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.

#### 6.3.2 Requirements for self-declaration of health

Critical illness insurance with mandatory 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 get a reservation against 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.

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.

Critical illness 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 Critical Illness 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%.

### **6.3.3 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 sections 6.3.1, 6.3.2 and 6.3.3 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.

### **6.3.4 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:

- d) 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.
- e) 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 6.3.1 and 6.3.2.
- f) 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.

## **6.4 What the insurance can cover**

The agreed sum insured is stated in the insurance contract and the insurance certificate.

### **6.4.1 The insurance event – Critical illness**

The insurance event in the event of critical illness occurs when the insured is alive 24 hours after the diagnosis has been finalised, surgery has been carried out or the insured is on the waiting list for transplantation in Norway.

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

## 6.5 Which diseases the insurance covers.

In order to provide a precise delimitation of the diseases and limitations, we use a number of medical terminology. Medical terminology is explained at the end of the terms and conditions text.

### 6.5.1 Myocardial infarction or severe angina pectoris

Death of part of the heart muscle as a result of a failure of blood supply to this area. The diagnosis should be made on the basis of recent changes typical of myocardial infarction on ECG and a pronounced increase in cardiac markers. The presence of typical chest pain can be used as an additional criterion. Severe angina pectoris entitles you to compensation if treatment with PCI or coronary artery bypass is deemed necessary by a specialist in cardiology or at the Department of Cardiology

### 6.5.2 Stroke

Acute cerebral haemorrhage or cerebral infarction (blood clot in the brain) that causes neurological deficits (paralysis, speech difficulties or the like) that are still present after 24 hours. Similarly, acute bleeding or infarction of the spinal cord is also covered. The diagnosis must be made by a specialist in neurology or at a hospital department that treats stroke, and must generally be confirmed with findings on CT or MRI scans.

#### The insurance does not cover:

- Cerebral haemorrhage or bleeding in the spinal cord caused by external injury.
- Transient symptoms and conditions with neurological deficits of less than 24 hours duration due to disturbances in the blood supply in the brain, regardless of whether or not infarction changes are detected by MRI, such as TIA (transient ischaemic attack) or "mini-stroke".

### 6.5.3 Cancer

Presence of malignant tumor (a tumor that is not encapsulated and has the property that it can infiltrate and metastasize). Also included in the cancer diagnosis are leukemia and malignant lymphomas. The diagnosis must be supported by a histological description of the malignancy.

#### The insurance does not cover:

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

#### In particular, this means that the following conditions are not covered:

- In the urinary bladder, tumours that do not grow into the muscularis (T1 N0 M0 or lower in the classification system TNM) are not covered
- In the prostate, tumours that are not palpable or
- Detectable by imaging (T1 N0 M0 or lower in
- The classification system TNM) Prostate cancer requiring treatment is nevertheless covered.
- In the cervix (cervix uteri), cancer in situ (Tis or lower in the classification system TNM) is not covered

Intraductal cancer mom is still covered.

#### **6.5.4 Benign tumor of the brain, meninges, and spinal cord**

Includes tumors that develop from tissues in the brain, meninges, or spinal cord. The diagnosis must be made by a specialist in neurology/neurosurgery, and a special examination (CT/MRI) must have detected a tumor requiring surgery.

##### **The insurance does not cover:**

- Microadenomas, abscesses, cysts, granulomas, hematomas and malformations of blood vessels.

#### **6.5.5 Multiple sclerosis (MS)**

Diagnosed multiple sclerosis. The diagnosis must be made by a specialist in neurology and examinations must have been carried out that rule out that the symptoms are due to other diseases. The diagnosis must be confirmed by typical symptoms of demyelination and impairment of movement and sensation, as well as characteristic findings on MRI.

#### **6.5.6 Coronary artery bypass or coronary angioplasty (PCI)**

Completed heart surgery to correct narrowing or blockage of the coronary arteries of the heart by coronary bypass surgery or angioplasty (PCI). Interventions for ablation treatment of cardiac arrhythmias and/or insertion of pacemakers/ICDs are not covered.

#### **6.5.7 Heart valve surgery**

Completed surgery for repair/replacement of the heart valve.

#### **6.5.8 Organtransplantasjon**

Performed a transplant or put on a waiting list for a transplant in Norway of the heart, liver, lung, kidney, pancreas or bone marrow. All autotransplantation is excluded.

#### **6.5.9 ALS and other motor neuron diseases**

Motor neuron disease of unknown cause. Includes the diagnoses of amyotrophic lateral sclerosis (ALS), primary lateral sclerosis, progressive spinal muscular atrophy and progressive bulbar palsy.

#### **6.5.10 Tverrsnittlammelser**

Includes cross-sectional paralysis of the spinal cord due to illness or accident. 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 specialist in neurology.

#### **6.5.11 Kidney failure**

Renal impairment or complete discontinuation of both kidneys requiring permanent dialysis or transplantation. The diagnosis should be made by a specialist in kidney diseases.

### **6.5.12 Blindness**

Total and permanent vision loss in both eyes as a result of illness or accident. Total vision loss corresponds to visual acuity of 3/60 (finger count of 3 meters) or worse in the best eye with the best correction. The blindness must be confirmed by a specialist in eye diseases.

### **6.5.13 Deafness**

Total and permanent loss of hearing in both ears with the best hearing aid that is due to acute illness or accident. The diagnosis must be confirmed by a specialist in ear, nose and throat diseases and the results of audiometry and a sound threshold test must be presented.

### **6.5.14 Loss of speech**

Total and permanent loss of speech (aphasia) for a continuous period of at least 12 months. The diagnosis must be confirmed by a specialist in neurology. The exception is psychogenic loss of the ability to speak.

### **6.5.15 Major burns**

Third-degree burns and/or deep second-degree burns (thermal or chemical) on more than 20% of the body surface measured by the rule of nine or equivalent method. The diagnosis must be confirmed by a specialist in plastic surgery.

### **6.5.16 Amputation**

Amputation of the foot at the ankle joint or larger part of the leg, or amputation of the hand at the wrist or larger parts of the arm.

### **6.5.17 Bacterial meningitis**

Infectious meningitis caused by bacteria. The diagnosis must be made by the neurological, neurosurgical or internal medicine hospital department. The diagnosis should be based on typical medical history, cerebrospinal fluid findings and other relevant examinations.

The insurance does not cover viral meningitis or myelitis.

### **6.5.18 Outpouching of the brain's blood vessels**

Outpouchings (aneurysms) on the brain's blood vessels that require surgery. The need for surgery must be assessed by a specialist in neurosurgery. Outpouching that is only monitored with controls is not covered.

### **6.5.19 Outpouching on the main artery (aortic aneurysm)**

Outpouching (aneurysm) on the main artery (aorta) that requires surgery. The need for surgery has been assessed by a vascular surgeon or equivalent. The branches of the main artery are not included. Outpouching that is only monitored with controls is not covered.

### **6.5.20 Parkinson's disease before the age of 60**

Primary Parkinson's disease diagnosed before the age of 60 by a specialist in neurology. The insurance does not cover other forms of parkinsonism (e.g. drug-induced or as a result of external brain damage, infection, etc.)

### **6.5.21 Alzheimer's disease before the age of 60**

Alzheimer's disease with progressive memory loss and loss of ability to think, language, problem solving and with the need for daily supervision. The diagnosis must be made before the age of 60 by a specialist in neurology or geriatrics based on combined neurological and cognitive testing, MRI findings (possibly PET) and relevant biomarkers of the brain.

The insurance does not cover dementia accompanied by other neurological diseases/disorders. Dementia as a result of calcification disease of the cerebral vessels (vascular dementia), trauma, infections, solvents or alcohol abuse is also not covered.

### **6.5.22 Severe epilepsy**

Repeated seizures with generalized convulsions and change in consciousness despite treatment for at least one year. The diagnosis must be made by a specialist in neurology and confirmed by EEG. There are exceptions for epilepsy caused by head injuries.

### **6.5.23 Displaced intestine**

Permanently displaced bowel. Permanent means a displaced bowel that is not made temporary/relieving in connection with the treatment of illness or injury.

### **6.5.24 Guillain-Barrés syndrome**

The diagnosis must be made by a specialist in neurology and must be confirmed by relevant examinations, including measurement of nerve conduction and findings in the cerebrospinal fluid with low white blood cell counts and increased protein content.

### **6.5.25 Creutzfeldt-Jakob disease**

The diagnosis must be made by a specialist in neurology and must be confirmed by relevant examinations, including blood and cerebrospinal fluid examination.

### **6.5.26 Extra Payout for Emotional Support**

An extra payment of NOK 10,000 if the insured is diagnosed with one of the diseases/diagnoses in sections 6.2.1 to 6.2.25. The payout is intended as additional financial support during a difficult time, which can be used to purchase psychological treatment or other emotional support. There is no requirement for documentation of actual expenses. The compensation is paid at the same time as the compensation has been granted related to one of the diseases/diagnoses in sections 6.2.1 to 6.2.25.

## **6.5.27 Long-term hospital stay**

Compensation of NOK 50,000 for continuous hospital stays of at least 60 days at a publicly approved hospital in the Nordic region in the event of illness or accident. The coverage can only be paid once during the insurance period, and cannot be paid if compensation has already been granted related to one of the diseases/diagnoses in sections 6.2.1 to 6.2.25.

## **6.6 Limitations**

It is a prerequisite for payment that the insurance is valid and that the insured is alive 24 hours after the diagnosis has been finalised, surgery has been carried out or the insured is on the waiting list for transplantation in Norway.

### **6.6.1 Reservations**

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

### **6.6.2 Symptom clause**

The enterprise is not liable for compensation 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, cf. Section 18-5, second paragraph, of the Insurance Contracts Act.

### **6.6.3 Participation**

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

### **6.6.4 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 compensation payment pursuant to the provisions of Section 3-7 no. 3 of the Compensation for Damages Act.

### **6.6.5 Deadline for notification of the insurance event**

In the event of a claim for compensation for critical illness, the company is exempt from liability unless the person making the claim notifies the company of the insurance event that has occurred within one year after the person in question became aware of the circumstances that justify the claim.

### **6.6.6 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.

### **6.6.7 Travelling abroad**

The provision in section 6.6.6 on war or warlike acts applies correspondingly to travel abroad. If the insured is already staying ashore when the provisions of section 6.6.6 are applied, the company's liability is limited to cover damage or increase in such damage for 30 days from the date on which travel advice is issued.

### **6.6.8 Triggering the insurance event**

a) 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.

b) Gross negligence

If the insured has grossly negligently caused the insurance event or increased the extent of the damage, the enterprise's liability may be reduced or eliminated. In making the decision, emphasis shall be placed on the degree of fault, the course of the injury, whether the insured was in self-inflicted intoxication, the effect that the reduction or loss of the enterprise's liability will have for the person entitled to the insurance or for other persons who are financially dependent on the insured and other circumstances in general. In cases other than those mentioned in the first subsection, the undertaking may not claim that the insured has negligently caused the insurance event. The undertaking may not invoke the rules in the first paragraph if, due to age or state of mind, the insured could not understand the scope of his or her action, cf. Section 13-9 of the Insurance Contracts Act.

### **6.6.9 Termination**

The Critical Illness insurance is discontinued:

- No later than the end of the insurance year in which the insured turns 67.
- When paying compensation for critical illness in the list of illnesses.
- The insurance does not cease if only compensation for long-term hospital stays is paid.

## **6.7 Settlement rules**

### **6.7.1 Notification of insurance incident, documentation, etc.**

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.

If the insured is located outside Norway at the time of the compensation, the company may, as a condition for payment of the compensation, require the insured to present himself or herself to a doctor in Norway for an assessment of whether the conditions for payment are met. The doctor's fee is paid by the enterprise, any other expenses (travel, etc.) are paid by the insured himself.

The insured is obliged to present the expert reports specified in section 6.5.

### **6.7.2 The due date of the compensation**

Claims for compensation in the event of critical illness fall due for payment as soon as the insurance event has arisen and the company has had a reasonable time to clarify the liability and calculate its final liability. If it is clear at an earlier stage that the undertaking is to pay at least part of the amount claimed, a corresponding advance must be paid, cf. Section 18-2 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.

### **6.7.3 Statute of limitations**

Claims for compensation are time-barred after 3 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. The claim is time-barred no later than 10 years after the end of the calendar year in which the insurance event occurred. In addition, Section 18-6 of the Insurance Contracts Act and the rules of the Limitation Act apply. 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.

### **6.7.4 The company's liability in the event of termination of the insurance contract**

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

## 6.7.5 Legal rules

For critical illness, 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.

## 6.7.6 Which insurance term is used as a basis

In the case of a claim for payment of the sum insured in the event of critical illness, these are the conditions that applied when the insured is alive 24 hours after the diagnosis has been finalised, surgery has been carried out or the insured person is placed on a waiting list for transplantation in Norway.

## 6.8 Calculation rules

### 6.8.1 National Insurance basic amount – G

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

### 6.8.2 Age

When the compensation depends on age, age is taken into account on the day the insurance event occurs.

### 6.8.3 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 fails to provide information or provide documents as mentioned in section 6.7.1, 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.

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

### 6.9.1 Critical illness

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

## 6.9.2 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.

## 6.9.3 Repurchase and paid-up policy value

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

## 6.10 Medical terms

|                               |  |
|-------------------------------|--|
| abscess                       | cavities with pus (infected fluid)   |
| Aphasia                       | tap av taleevnen   |
| Amyotrophic Lateral Sclerosis | motor neuron disease, see this   |
| angiographs                   | X-ray examination to examine blood vessels   |
| angioplastikk                 | balloon dilation (used, among other things, to dilate narrowings in a blood vessel)  |
| artery                        | artery   |
| Audiometers                   | Hearing test   |
| autotransplantasjon           | body part that is transplanted back again on the same individual   |
| cancer in situ                | cancer at an early stage, actually before the cancer cells have had time to grow into the tissue that surrounds them         |
| <br>                          |  |
| cerebrovaskulær               | concerning the blood vessels in the brain  |
| CT c                          | Computer tomography (an advanced X-ray examination)  |
| Cyst                          | Fluid-filled cavities  |
| Demyelination                 | the myelin sheath (a kind of sheath that surrounds nerve fibers) is lost   |
| descendens                    | Descending dialysis blood purification in cases of abated and severely impaired  |
| kidney function               |  |
| ECG                           | Electrocardiogram  |
| Focal                         | Circumscribed  |
| granuloma                     | accumulation of inflammatory cells   |
| Hematoma                      | accumulation of blood  |
| Histological                  | Description of the tissue as it appears under a microscope   |
| Heart markers                 | substances from the heart, can be detected in a blood sample   |
| Main tribe                    | main coronary artery (the largest part of an artery)   |
| In situ                       | "On-site" (i.e. local)   |
| Intraductal cancer mamma      | an early stage of breast cancer  |
| intracranial                  | Inside the skull   |
| Ischemic                      | Failing blood supply   |
| Coronary artery               | artery that supplies blood to the heart muscle   |
| coronary angiography          | X-ray examination of coronary arteries after insertion of contrast fluid   |
| coronary heart disease        | disease of one or more coronary arteries of the heart  |
| leukemia                      | blood cancer   |
| Sound threshold test          | Method of determining hearing loss   |
| Malformation                  | Deformity  |
| malignant                     | malignant  |
| malignant lymphomas           | malignant tumor of lymphatic tissue  |
| maligne melanomer             | malignant mole tumor   |
| metastase                     | Spread of a tumor to a new place   |
| motor neuron disease          | disease that attacks nerve pathways and nerve roots in the brain and spinal cord   |
| MR                            | magnetic resonance imaging (an X-ray-like examination that in many cases provides a better image than regular X-rays and CT) |



|                           |   |
|---------------------------|---|
| palpabel                  | a tumour that can be recognised by the doctor on examination  |
| pre-malign                | an early stage of development of a tumour (before it has developed into cancer)                             |
| Primary Lateral Sclerosis | motor neuron disease, see this  |
| progressive bulbous palsy | motor neuron disease, see this  |
| psychogenic               | that have to do with mental health conditions   |
| "rule of nine"            | method of determining body surface area. For example, the entire back makes up 18% of the body surface area |
| Sequele                   | Follow-up   |
| Scintigraphs              | Imaging of radiation from a radioactive substance in the body   |
| Spinal muscular atrophy   | motor neuron disease, see this  |
| ST                        | part of the curve produced by ECG   |
| Thermal                   | that have to do with high temperatures  |
| Third-degree burns        | Deep burns involving the skin, subcutaneous tissue and underlying tissues                                   |
| TNM                       | a classification system that says something about the severity of cancer                                    |
| Vascular                  | Has to do with the blood vessels  |
| Vestibular                | has to do with the balance organ in the inner ear   |

## 7. Psychological First Aid

Psychological first aid is a health insurance where the sum insured is paid out if the insured needs treatment by a psychologist after a sudden and unforeseen traumatic event during the insurance period.

It is stated in the insurance contract and the insurance certificate if psychological first aid has been chosen.

### 7.1 Who the insurance applies to

Psychological first aid includes the person or persons mentioned in the insurance contract and the insurance certificate.

### 7.2 Where the insurance applies

The insurance is valid worldwide, however, see the exemption provisions in war/unrest and terrorist acts.

### 7.3 When the insurance applies

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

### 7.4 What the insurance covers

Psychological first aid covers expenses for up to 10 treatment hours with a psychologist when the insured has suffered a sudden and unforeseen traumatic event that causes an immediate psychological reaction, such as an accident, death, serious illness, assault or burglary.

Treatment must be initiated in direct connection with the incident and without undue delay.

Psychological first aid is provided by Falck. After an incident as described above, the insured can contact Falck's 24-hour emergency hotline.

#### 7.4.1 The insurance event

The insurance event occurs at the time the insured has suffered a sudden and unforeseen traumatic event during the insurance period.

### 7.5 Limitations

#### 7.5.1 Ordinary psychological treatment

Psychological first aid does not include ordinary psychological treatment of disorders that have developed as a result of mental strain over time, and which do not require immediate psychological assistance.

#### 7.5.2 Pre-approval of the enterprise

The treatment does not require a referral from a doctor, but must be pre-approved by the enterprise.

### **7.5.3 Membership of the Norwegian National Insurance Scheme**

The insured must be a member of the Norwegian National Insurance Scheme.

### **7.5.4 Delimitation against other insurance coverages covered by the personal insurance**

The right to psychological first aid under this condition does not automatically entitle you to other insurance coverages covered by the staff insurance

### **7.5.5 Participation**

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

### **7.5.6 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 compensation payment pursuant to the provisions of Section 3-7 no. 3 of the Compensation for Damages Act.

### **7.5.7 Deadline for reporting an insurance event**

In the event of a claim for compensation for psychological first aid, the company is free from liability unless the party making the claim informs the company of the insurance event that has occurred within one year after the person in question became aware of the circumstances that justify the claim.

### **7.5.8 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.

### **7.5.9 Traveling abroad.**

The provision in section 7.5.8 on war or warlike acts applies correspondingly to travel abroad. If the insured is already staying ashore when the provisions of section 7.5.8 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.

### **7.5.10 Triggering the insurance event**

a) 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.

b) Gross negligence

If the insured has grossly negligently caused the insurance event or increased the extent of the damage, the enterprise's liability may be reduced or eliminated. In making the decision, emphasis shall be placed on the degree of fault, the course of the injury, whether the insured was in self-inflicted intoxication, the effect that the reduction or loss of the enterprise's liability will have for the person entitled to the insurance or for other persons who are financially dependent on the insured and other circumstances in general. In cases other than those mentioned in the first subsection, the undertaking may not claim that the insured has negligently caused the insurance event. The undertaking may not invoke the rules in the first paragraph if, due to age or state of mind, the insured could not understand the scope of his or her action, cf. Section 13-9 of the Insurance Contracts Act.

### **7.5.11 Termination**

In all cases, the employee withdraws from the insurance at the time the insurance contract is terminated for him/her.

For the employee's spouse/cohabitant, the insurance ceases at the time the insurance ceases for the employee.

For the employee's spouse/cohabitant, the insurance ceases at the time the insurance ceases for the employee, or at the time when the employee is no longer a spouse/cohabitant.

For children, the insurance expires in the insurance year in which the child turns 21, or when the child no longer has the same registered residential address as its parents, or when the insurance ceases for the employee.

## **7.6 Settlement rules**

### **7.6.1 Notification of insurance incident**

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.

### **7.6.2 The due date of the compensation**

Claims for compensation in connection with psychological first aid fall due for payment as soon as the insurance event has arisen and the undertaking has had a reasonable time to clarify the liability and calculate its final liability, cf. Section 18-2, first paragraph, of the Insurance Contracts Act.

### **7.6.3 Statute of limitations**

Claims for compensation are time-barred after 3 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. The claim is time-barred no later than 10 years after the end of the calendar year in which the insurance event occurred. In addition, Section 18-6 of the Insurance Contracts Act and the rules of the Limitation Act apply. 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.

### **7.6.4 The company's liability in the event of termination of the insurance contract**

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

### **7.6.5 Legal rules**

For psychological first aid, 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.

### **7.6.6 Which insurance terms are used as a basis**

In the case of a claim for compensation for psychological first aid during the insurance period, these are the conditions that applied when the need for treatment by a psychologist after a sudden and unforeseen traumatic event arose.

## **7.7 Calculation rules**

### **7.7.1 National Insurance basic amount - G**

The enterprise covers the costs of psychological first aid regardless of the National Insurance basic amount.

### **7.7.2 Interest obligation**

There is no interest obligation to cover the costs of Psychological First Aid.

## **7.8 The insured's disposal of the compensation or sum insured, etc.**

### **7.8.1 Psychological First Aid**

Cost coverage for psychological first aid is paid to Falck.

### **7.8.2 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.

### **7.8.3 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 Notifications to the company**

#### **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 for insurance policies other than statutory occupational injury 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 in the case of insurance other than under the Occupational Injury Insurance Act**

### **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 company'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 in accordance with Chapter 5, it may be agreed that resignation with disability or disability pension 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 The time of the company's liability

When an employee or co-insured withdraws from the insurance pursuant to section 9.1, 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 Insurance policies that do not entitle you to individual insurance

- Benefits under occupational injury insurance
- Benefits under leisure accident insurance
- Benefits after Critical Illness Insurance
- Benefits after psychological first aid

# 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 coverage agreement pursuant to Chapter 5 of the terms and conditions. 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

## **14. Deadline for taking legal action**

In the case of accident and health insurance, the enterprise is free from liability if the claimant has not brought a case or requested a board hearing within six months. This is calculated from the date on which the undertaking has notified the person concerned in writing that it does not consider itself responsible and at the same time reminded him or her of the deadline, its length and the consequences of it being missed, cf. the provision in Section 18-5 of the Insurance Contracts Act.