MANDATUM LIFE

Optimi and the Business Optimi Personal Insurance

Insurance terms and conditions, condition 133

Valid as from 1 January, 2016

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I General terms and conditions

1. Contents of the insurance

Vakuutus voi sisältää:

- a sum payable at death
- a lump-sum payment for permanent disability
- compensation for permanent handicap resulting froman accident
- a daily allowance for the period of disability
- a daily hospitalisation allowance for bed-days
- compensation for medical expenses
- lump sum in case of a critical illness.

The insurance always includes death cover in case of the death of the Primary Insured. The death benefit paid is always the minimum amount specified by the Insurance Company at any given time. Index adjustments, as specified in section 8 of the terms and conditions, are not made to this amount.

The contents of the Insurance are noted in the Contract Document.

2. Insurance cover

2.1. Definition of Insurance Cover

Insurance cover refers to the cover in case of death, disability, illness, and accident provided by the insurance policy. The insurance cover may cover either illnesses and accidents (extensive cover) or accidents only (accident cover). However, the Permanent Disability Insurance will always cover both illnesses and accidents, and the Permanent Handicap Insurance against Accident will only cover accidents. Cover for critical illnesses only covers the illnesses and procedures specified in the terms and conditions.

2.2. Definition of an Accident

An accident is a sudden and unexpected event that causes bodily injury and happens without the intent of the insured due to an external factor. Drowning, heat stroke, sunstroke, hypothermia, gas poisoning, sudden injury caused by significant change in air pressure and poisoning caused by a substance consumed by mistake, without the intent of the insured, are also considered accidents.

Illnesses, defects or injuries that are not caused by the accident, or the atrophy of the musculoskeletal system, are not compensated as accidents even if they had been asymptomatic prior to the accident. Injuries resulting from an illness or a sudden attack of illness are also not compensated as accidents.

3. Insurance contract

3.1. The Insurance Contract is an agreement made between the Policyholder and Mandatum Life Insurance Company Limited (hereinafter the Insurance company), the main contents of which are defined in the Contract Document, Insurance Terms and Conditions, the calculation formulae for the Insurance, and an Optimi or Business Optimi Statement sent to the Policyowner once a year.

In addition, the Finnish Insurance Contracts Act and other Finnish legislation apply to the Contract.

3.2. The Policyowner is a private or legal person who owns the Insurance and has the right to give instructions concerning the Insurance. In accordance
with the conditions below, the Policyowner has, for example, the right to choose the insurance cover, reduce the cover, and to apply for an increase in cover or a change of cover. In order to assign a right relating to the Insurance, written notice must have been given to the Insurance Company.

3.3. One of the insured persons covered by the Insurance is the Primary Insured. The Secondary Insured refers to a person who is insured in case of death by joint cover for two persons. The Insurance may also include other insured persons.

3.4. The Insurance Contract has an annual maturity date. The annual maturity date refers to the first day of the month on which the Insurance comes into force, unless otherwise stated by the Policyowner in the application. The annual maturity date starts the insurance period, which is of one year's duration. The length of the first and last insurance period may, however, deviate from this.

4. Specifying the beneficiary

4.1. The Policyowner must inform the Insurance Company in writing as to who is to be paid the sum payable at death or other compensation, or savings sum (= Beneficiary). The Clause may later be amended by written notification to the Insurance Company.

5. Supplying information to the insurance company

Before the Insurance is granted or revalidated, the Policyholder and the Insured must give correct and complete answers to the questions put by the Insurance Company for the purpose of estimating its own liability. Should this information not be correct and complete, the liability of the Insurance Company is determined under the Finnish Insurance Contracts Act and the calculation formulae for the Insurance.

6. Entry into force of the insurance

6.1. Unless a specific date has been agreed on, the Insurance enters into force when the Insurance Company or the Policyholder has submitted or sent a reply accepting the offer of the other party.

The Insurance Company is liable for an insured event occurring after the submission or sending of the written insurance application, even if the application has not yet been handled, if it is obvious that the Insurance Company would have approved the application.

6.2. If there is no account of what time the application or reply was submitted or sent, this is considered to have taken place at 12 midnight.

6.3. The agreed period of validity of the Insurance is noted in the Contract Document.

7. Paying the premium

7.1. The premiums required to keep the insurance cover valid must be paid by the maturity date. In the contracts of private persons, cover premiums are determined according to the age of the insured and the selected cover amount. The use of tobacco products by the insured also influences the premium for critical illness cover. In the contracts of corporate customers, the gender of the insured also affects the premium. The cover premiums will increase with the age of the insured.

The Insurance Company is entitled to restirict he maximum amount of premiums.

7.2. If the payment of the first premium is neglected, the Insurance Company is entitled to give notice of cancellation of the Insurance 14 days from the date of sending the notice of cancellation.

8. Index adjustments to insurance cover

8.1. The insurance cover and premium payments will be adjusted in equal proportions on the annual maturity date by the amount of the index adjustments based on the cost-of-living index (1951=100), using the September scores for the previous year and rounding the figures to the nearest full percentage. The index adjustment is not made to the minimum amount referred to in section 21.1 of the terms and conditions.

8.2. Deductibles, maximum limits of the expense items of the Insurance Company, and special fees may be increased accordingly.

9. Credits on insurance savings

9.1. An annual calculated interest is credited on insurance savings. The amount of the possible client credits granted on the insurance savings on the first day of the year – in addition to the calculated interest – is determined annually. The client credits may differ for different types of insurance. Client credits are not granted for a year at the end of which the Insurance has not been valid.

9.2. The final possible client credit will be granted on the day on which the savings sum falls due for payment.

10. Amounts debited

10.1. The premiums required for keeping the insurance cover valid and the expense items complying with the calculation formulae for the Insurance will be debited to the insurance savings.

10.2. Fees will be charged for any specific measures required by the Policyowner, including surrender, certificate for the revenue service, and an additional Optimi or Business Optimi Statement.

11. Expiry of the insurance

11.1. If savings have accumulated to the Insurance, it will be valid until all the savings have been used up for keeping the Insurance in force; otherwise, the Insurance will expire if no premium other than the first one has been paid by the maturity date.

11.2. The Insurance expires completely on the date agreed in the Insurance Contract. The Insurance will expire before this on the date of death of the Primary Insured, or on the date when a request for the withdrawal of the surrender value is received by the Insurance Company.

11.3. The expiry dates of the insurance covers are stated in the Contract Document. The various insurance covers may only be valid up to the maximum age limit specified in the Special Clauses for each cover.

11.4. The Insurance expires if the Insurance Company or the Policyowner gives notice on the Insurance (Clause 13).

11.5. When the Insurance expires before the agreed date for a reason other than surrender or the death of the Primary Insured, or the Insurance Company is otherwise released from liability, the surrender value will be remitted to the Policyowner.

12. Termination of insurance on the agreed date and surrender of insurance

12.1. On the agreed date

12.1.1 The insurance is terminated on the agreed date if the Primary Insured is alive at the time. The Insurance Company will notify the Policyowner of the savings sum falling due at the latest address given by the Policyowner.

12.1.2 The insurance savings amount will be paid within 14 days from the termination of the insurance and the receipt of the notification concerning the withdrawal of the savings at the insurance company.

12.2. Before the agreed date (surrender)

12.2.1 The Policyowner is entitled to withdraw the surrender value at any time, unless this is prevented by the Insurance having been pledged.

12.2.2 The Policyowner must give notification of withdrawal of the surrender value in writing.

12.2.3 The surrender value is calculated according to the calculation formulae for the Insurance. The surrender value will be paid within 30 days of receiving the notification.

13. Giving notice of the cancellation of the insurance

13.1. The Policyowner is entitled to give written notice of cancellation of the Insurance at any time. The Insurance expires on the date specified in the notice of cancellation, or, if this has not been stated, on the date the notice was submitted or sent to the Insurance Company.

13.2. The Insurance Company is entitled to give notice of cancellation of the Insurance if

- the first premium is not paid (Clause 7.2), or
- the Policyholder or Insured has neglected the obligation to supply information (Clause 5):

  – intentionally or inadvertently, where the inadvertence cannot be considered negligible, and if the Insurance Company would not have granted the Insurance at all had the correct and complete infor mation been supplied, or

  – fraudulently, and the Insurance is not directly invalid by law or

  – the Insured has intentionally caused the insured event or

  – the Insured has, after the insured event, fraudulently provided the Insurance Company with false or incomplete information that is relevant to the determination of the insurance company's liability.

The Insurance Company must terminate the insurance in writing without undue delay after having received notice of the basis entitling to termination. The basis for termination must be included in the notice of termination. In situations other than those concerning non-payment of the insurance contribution, the insurance shall end one month after the Insurance Company sent the notice of termination to the policyholder.

If the Insurance covers several insured persons, the above consequences will only concern the person who has neglected the obligation to supply information.

13.3. The Insurance Company also has the right to give notice of an accident or sickness insurance (not, however, the extensive death cover) to expire on the following annual maturity date. Notice must be given in writing no later than one month before the annual maturity date.

A deterioration in the state of health of the Insured subsequent to taking the Insurance, or the occurrence of an insured event will not be causes for giving notice on the Insurance..

14. Revalidation of the insurance

14.1. If the first premium has not been paid by the maturity date, the Insurance may be revalidated within two months of the maturity date by paying the premiums that have fallen due. If 2 to 12 months have elapsed from the maturity date, it will depend on the new health report submitted by the Insured whether the Insurance can be revalidated and on what Terms and Conditions.

14.2. If the Insurance has expired because of failure to pay other than the first premium, the Policyowner may revalidate it by paying the premiums that have fallen due within six months of the expiry. If 6 to 12 months have elapsed from the expiry, it will depend on the new health report submitted by the Insured whether the Insurance can be revalidated and on what Terms and Conditions.

14.3. The Insurance will be revalidated at 12 midnight on the day the premiums are paid, or, if a health report is required, the Insurance will be revalidated at 12 midnight on the day the acceptable health report has been received by the Insurance Company. Furthermore, if a health report is required, the premiums due must be paid within 30 days of the date on which the notice of acceptance of the revalidation and its Terms and Conditions are sent to the Policyowner.

15. Right of continuing the insurance cover

15.1. The Insured is entitled to continue the cover without a health report, completely or partly under a comparable Insurance granted by the Insurance Company at the time of continuation, where the Insurance has expired due to death of the Primary Insured.

15.2. Notice on exercising the right of continuation must be given in writing within two months of the expiry of the insurance cover. The notice is considered to have been given when it has been received by the Insurance Company in writing. Where the right of continuation has been exercised, the Policyowner is no longer entitled to revalidate the Insurance as far as the part of the cover transferred is concerned.

15.3. Where the Policyowner is a private person, an Insured who is of age is entitled to give notice on the insurance cover and transfer it to a comparable Insurance by giving notification of this in writing to the Insurance Company.

The Policyowner will not in this case be entitled to keep the Insurance valid as far as the part of the cover transferred is concerned.

15.4. In addition, the Policyowner is also entitled to continue the life insurance cover if the insurance has expired due to surrender. The Insurance Company will send a notice on the right of continuation in connection with the surrender. The continued insurance must be applied for within 6 months of the sending of the notice, but no later than within one year of the payment of the surrender value. The insured can be granted a life insurance cover continued insurance only if the Policyholder does not exercise this right.

16. Amending the insurance contract

16.1. The Insurance Company is entitled to amend the premiums or other contractual clauses of cover in case of death (extensive cover) and a savings life insurance if there are specific grounds for amendment due to

- general trends in the incidence of loss or
- change in the interest rate.

16.2 The Insurance Company is entitled to amend the premiums or other contractual clauses of other personal insurance (sickness insurance and accident insurance) where the grounds for the amendment arises from

- developments in claims expenditure,
- new or amended legislation or order by the authorities,
- change in circumstances, including an international crisis, major catastrophe or exceptional natural phenomenon,
- change in the mortality rate,
- fall in the general interest rate below the rate used in calculating the premium, or
- change in a cost level affecting the Insurance and exceeding the index used in connection with the Insurance, provided that the change is due to a factor beyond the control of the Insurance Company.

16.3. The premiums and other contractual clauses may only be amended in corresponding degree as the basis of the amendment.

16.4. The Insurance Company may, in addition, make minor changes in the Terms and Conditions and other contractual clauses that have no effect on the main content of the Insurance Contract.

16.5. The premium and insurance cover may also change due to a change in the index (Clause 8) affecting the Insurance.

16.6. If the Terms and Conditions or calculation formulae are amended, the amendment is observed from the following annual maturity date. The Insurance Company will notify any amendments no later than 30 days prior to the annual maturity date. If the Policyowner does not accept any changes that reduce the benefits of the Insurance, or a premium increase resulting from a change in the calculation formulae, the Policyowner must give written notice of this to the Insurance Company (Clause 13.1). On notification, the Insurance Contract expires either completely or only as regards the part of the insurance cover affected by the amendment. Unless otherwise indicated in the notification, the Insurance Contract expires only as regards the part of the insurance cover affected by the amendment.

16.7. The Insurance Company is also entitled to amend the premiums and other contractual clauses to correspond to the true circumstances if the Policyholder or Insured has neglected the obligation to supply information (Clause 5) intentionally or inadvertently, and this inadvertence cannot be considered negligible. The Insurance Company will send the Policyowner a notification of the amendment without undue delay, having been informed of the above matter.

17. Appeal

In order to appeal against the Insurance Company's decision in a matter relating to the Insurance, legal proceedings must be instituted at the Helsinki District Court, or the Finnish District Court of the district in which the Policyowner permanently resides.

Legal proceedings concerning a decision on compensation must be instigated within three years of the date on which the party in question received written notification of the decision and this time limit.

II Special terms and conditions

Life insurance

20. General provisions concerning life insurance

20.1. The death cover may be taken either as a fixed or as a decreasing sum. The Insurance may be taken either as cover for one person or as joint cover for two persons.

In the case of life insurance for a fixed amount, the benefit payable upon death stays otherwise unchanged for the entire validity of the insurance policy but is increased by index adjustments. Thus the insurance premiums increase with age. The alternative is life insurance for a decreasing amount, where the insurance amount decreases annually so that the insurance premium remains the same except for any index adjustments.

20.2. A health report is required from the Insured in order to increase the sum payable at death. The sum payable at death may only be increased up to the maximum limit determined by the Insurance Company.

20.3. The Insurance may be granted from birth. Life insurance granted to a child younger than fifteen years will expire at the latest when the Insured reaches the age of 20. Life insurance granted to a person who has reached the age of 15 will expire at the latest when the Insured reaches the age of 90. Insurance taken only against accident will expire at the latest when the Insured reaches the age of 70.

21. Right to the sum payable at death

21.1. If the Insured dies during the period of validity of the Insurance, the Insurance Company will pay the sum payable at death to the beneficiaries. The sum payable at the death of the Primary Insured also includes the insurance savings at the time of death. The amount paid in case of the death of the Primary Insured is at least the minimum amount specified by the Insurance Company at any given time. This minimum amount is not tied to the index.

21.2. If two people insured under a joint cover die simultaneously, and the sums payable at death are equal in amount, the sum will be divided in half between the beneficiaries of the two parties, unless otherwise stated.

If the sums differ, the smaller sum will be divided in half between the

beneficiaries of both parties. The beneficiaries of the larger sum will additionally receive the difference between the larger and smaller sums. The sum payable at death to the beneficiaries of the Primary Insured also includes the insurance savings at the time of death.

22. Exclusions relating to the payment of the sum payable at death

22.1. The sum payable at death is not paid where

- the Insured has committed suicide before one year has elapsed from the commencement of the liability of the Insurance Company, or the date on which the Insurance was revalidated, by presenting a health report; this exclusion is applied regardless of the Insured's age or state of mind,
- the death of the insured is caused by his/her involvement in war or an armed conflict outside Finland (the restriction does not apply to service in international peace-keeping operations or associated tasks), provided that, upon the death of the insured, at least one (1) year has passed from the start of the Insurance Company's liability and the validation of the policy through a health report) or
- the Insured has died due to the sudden effect of a weapon or device based on nuclear reaction, and causing mass destruction of human lives.

22.2. Finnish legislation has specific decrees concerning the liability of the Insurance Company in case Finland should become involved in a war or armed conflict.

22.3. Where the sum payable at death is not paid for the Primary Insured in accordance with Clause 22.1, the surrender value will, nevertheless, be paid.

23. Additional exclusions relating to a life insurance taken against accident (accident cover)

23.1. The sum payable at death is only paid where death was caused by an accident as specified under Clause 2.2, during the validity of the Insurance.

23.2. In addition to that which has been stated under Clause 22, the sum payable at death will not be paid where

- the Insured dies of an infectious disease or illness caused by the sting or bite of an insect, tick or some other animal,
- the death is caused by an attempted suicide; this restriction is applied regardless of the Insured's age or mental state,
- the death results from an operation, treatment or other medical procedure carried out to cure an illness or defect, unless this procedure was carried out to treat an injury covered by this Insurance,
- the Insured dies after three years have elapsed since the accident, or
- the Insured dies of poisoning caused by a therapeutic drug, alcohol or other intoxicant.

23.3. Where an illness or defect unrelated to the accident contributes substantially to the death, compensation will only be paid where the accident in question is considered to have been a decisive factor leading to the premature death.

Permanent disability insurance

30. Insured events

30.1. The lump-sum compensation for permanent disability is paid where the Insured is permanently disabled by an illness or injury while this Insurance has been valid. Disability can be judged permanent after it has continued for at least one year. In addition, the payment of compensation requires that the insured has applied for compensation during his/her lifetime. The index level of the compensation will be determined on the basis of the established commencement date of the permanent disability.

30.2. An Insured who has permanently lost his/her ability to perform any work and cannot be retrained for any work is considered to be permanently disabled.

30.3. The Insurance may be granted to a person who has reached the age of 15, and will expire at the latest when the Insured reaches the age of 65.

31. Exclusions relating to the payment of compensations

No lump-sum compensation is paid where the permanent disability

- arises from an illness or injury which, had it led to the death of the Insured, would not be compensated by the Insurance Company as stated under Clause 22.1 of the Terms and Conditions,
- is intentionally caused by the Insured, or
- arises from the abuse of alcohol, therapeutic or other drugs or other intoxicants.

Permanent handicap insurance against accident

40. Insured events

40.1. Full compensation is paid as a lump-sum compen-sation for permanent and total medical handicap arising from an accident defined under Clause 2.2 that has occurred to the Insured during the validity of the Insurance, and, in the case of a partial handicap, the part of the full compensation indicated by the degree of medical handicap is paid. The insurance must be valid at the time when the permanent handicap is established.

The degree of handicap is determined solely on the basis of the type of injury; any individual circumstances such as the occupation or hobbies of the insured do not have any effect. To determine the degree of handicap, the injuries are classified according to the degree of difficulty into the handicap classes 0–20 on the basis of a decision regarding degrees of disability issued by the Ministry of Social Affairs and Health by virtue of the Accident Insurance Act. Compensation will be paid if the handicap class of the permanent handicap caused by an accident is at least 2 (10%).
A requirement is that the handicap is observed within three years from the accident.

40.2. The compensation granted is according to the sum insured in force at the time of accident. If the degree of disability changes before three years have elapsed since the first payment of the handicap compensation, the amount of compensation will be adjusted accordingly.

Any compensation paid will not, however, be reclaimed. If the degree of handicap changes at a later stage, it does not entitle the policy holder to additional compensation. The compensation paid reduces the amount of compensation remaining. The maximun amount of compensation paid is the sum insured under the insurance.

40.3. The Insurance may be granted from birth. Insurance granted to a child younger than fifteen years will expire at the latest when the Insured reaches the age of 20. Insurance granted to a person who has reached the age of 15 will expire at the latest when the Insured reaches the age of 70.

41. Exclusions relating to the payment of compensations

41.1. No lump-sum compensation is paid where

- the injury which, had it led to the death of the Insured, would not be compensated by the Insurance Company as stated under Clause 22.1 of the Terms and Conditions,
- the injury is caused by an attempted suicide; this restriction is applied regardless of the Insured's age and mental state,
- the injury results from an operation, treatment, or other medical procedure carried out to cure an illness or defect, unless this procedure was carried out to treat an injury covered by this Insurance,
- the injury is intentionally caused by the Insured,
- the injury arises from the abuse of alcohol, therapeutic or other drugs or intoxicants, or
- a handicap becomes evident more than three years after the accident.

41.2. Where an illness or defect unrelated to the accident contributes substantially to the injury, compensation for permanent handicap is only paid for that part of the handicap that can be considered to have been caused by the accident.

41.3. Compensation for a permanent handicap may be reduced or refused where the Insured has been, at the time of occurrence, under the influence of alcohol or other intoxicant, and where this has contributed substantially to the occurrence or to the extent of injury.

Disability insurance

50. Insured events

50.1. If the Insured is disabled due to illness or injury during the validity of the insurance, a daily allowance is paid for as many days as the disability continues uninterrupted during the validity of the insurance after the qualifying period for benefit. The payment of compensation and calculating the waiting period start at the earliest at the commencement of medical care. The daily allowance is paid monthly in arrears.

50.2. The Insured is considered to be disabled on having lost the ability to carry out his/her normal work or otherwork that can be regarded as suitable and providing an adequate livelihood, considering the Insured's age and skills.

50.3. The Insurance may be granted to a person who has reached the age of 15, and it will expire at the latest when the Insured reaches the age of 60. Where the Insurance is taken only against accident, it will expire at the latest when the Insured reaches the age of 70. Daily allowance is paid at most for the period stated in the Optimi or Business Optimi Statement, after which the Insurance expires.

51. Exclusions relating to the payment of compensations

No daily allowance is paid where the disability

- arises from an illness or injury which, had it led to the death of the Insured, would not be compensated by the Insurance Company as stated under Clause 22.1 of the Terms and Conditions,
- arises exclusively from symptoms reported by the Insured when no evidence of illness is detected in medical examinations,
- is intentionally caused by the Insured,
- arises from the Insured being partly disabled,
- arises from disability determined in a medical certificate issued to the Insured for a retroactive period, other than hospitalisation,
- arises from the abuse of alcohol, therapeutic or other drugs or intoxicants, or
- arises from pregnancy, childbirth, or abortion.

52. Additional exclusions relating to a disability insurance taken against accident (accident cover)

52.1. Compensation is only paid in case of an accident as specified under Clause 2.2, and occurring during the validity of the Insurance. Where an illness or defect unrelated to the accident contributes substantially to the injury, compensation is paid only for that part of the injury that can be considered to have been caused by the accident.

52.2. In addition to what has been stated under Clause 51, no compensation is paid where the injury

- results from an operation, treatment or other medical procedure carried out to cure an illness or defect, unless this procedure was carried out to treat an injury coverable under this Insurance,
- results from an attempted suicide; this restriction is applied regardless of the Insured's age and mental state,
- results from a ski jumping or downhill racing event, or in a football, ice hockey, bandy, rink bandy, floorball, basketball, handball, American football or rugby match organised by a sports federation or club, or in practice for competitions in these sports organised by a sports federation or club or similar sports,
- results from racing or speed training in a motorised vehicle or similar activity,
- results from mountaineering, rock climbing, ice climbing or wall climbing or similar activity,
- results from sailplaning, hot-air ballooning, parachute jumping, hanggliding, paragliding, bungee jumping or similar activity,
- results from weightlifting, powerlifting, bodybuilding, boxing, wrestling, judo, karate, or similar sports,
- results from scuba diving, free diving or similar activity.

52.3. The Insurance does not cover consequences to mental health caused by an accident. Infectious diseases or illnesses caused by the sting or bite of an insect, tick or some other animal are not compensated as accidents.

52.4. Compensation may be reduced or refused where the Insured has been, at the time of occurrence, under the influence of alcohol or other intoxicant, and where this has contributed substantially to the occurrence or to the extent of injury.

Hospitalisation insurance

60. Insured events

60.1. Daily hospitalisation allowance is paid for the period during which the Insured has received treatment in a hospital for an illness or injury for at least five consecutive days during the validity of the Insurance.

60.2. Hospitals are regarded as the hospitals owned by the state, municipalities or federations of municipalities, municipal health care wards, and private institutions that operate as hospitals located in Finland. The term 'hospital' does not, however, include spas, naturopathy or rehabilitation institutions.

60.3. Hospitalisation Insurance may be granted to a person who has reached the age of 2, and against accident from birth. Hospitalisation insurance granted to a child younger than fifteen years will expire at the latest when the Insured reaches the age of 20. Hospitalisation insurance granted to a person who has reached the age of 15 will expire at the latest when the Insured reaches the age

of 65. Insurance taken only against accident will expire at the latest when the Insured reaches the age of 70.

Hospitalisation allowance is paid at most for the period stated in the Optimi or Business Optimi Statement, after which the Insurance expires.

61. Exclusions relating to the payment of compensations

61.1. No daily hospitalisation allowance is paid where the cause of hospitalisation

- arises from an illness or injury which, had it led to the death of the Insured, would not be compensated by the Insurance Company as stated under Clause 22.1 of the Terms and Conditions,
- arises from an intentional act of the Insured,
- arises from the abuse of alcohol, therapeutic or other drugs or intoxicants, or
- arises from pregnancy, childbirth, abortion, artificial insemination, or foetal monitoring.

61.2. Daily hospitalisation allowance will not be paid for the period the Insured, though registered as a patient of the institution in question, has been in home care or on leave from the institution.

62. Additional exclusions relating to a hospitalisation insurance taken against accident (accident cover)

62.1. Daily hospitalisation allowance is paid only in case of an accident as specified under Clause 2.2 of the Terms and Conditions during the validity of the Insurance. Where an illness or defect unrelated to the accident contributes substantially to the injury, daily allowance is paid only for such part of the injury as can be considered to have been caused by the accident. The insurance must be valid during hospital treatment.

62.2. In addition to that which has been stated under Clause 61, no daily hospitalisation allowance is paid where the injury

- results from an operation, treatment or other medical procedure carried out to cure an illness or defect, unless this procedure was carried out to treat an injury coverable under this Insurance,
- results from an attempted suicide; this restriction is applied regardless of the Insured's age and mental state,
- results from a ski jumping or downhill racing event, or in a football, ice hockey, bandy, rink bandy, floorball, basketball, handball, American football or rugby match organised by a sports federation or club, or in practice for competitions in these sports organised by a sports federation or club or similar sports,
- results from racing or speed training in a motorised vehicle or similar activity,
- results from mountaineering, rock climbing, ice climbing or wall climbing or similar activity,
- results from sailplaning, hot-air ballooning, parachute jumping, hanggliding, paragliding, bungee jumping or similar activity,
- results from weightlifting, powerlifting, bodybuilding, boxing, wrestling, judo, karate, or similar sports,
- results from scuba diving, free diving or similar activity.

62.3. The Insurance does not cover consequences to mental health caused by an accident. Infectious diseases caused by the sting or bite of an insect tick or some other animal are not compensated as accidents.

62.4. The daily allowance compensation may be reduced or refused where the Insured has, at the time of occurrence, been under the influence of alcohol or other intoxicant, and where this has contributed substantially to the occurrence or to the extent of injury.

Medical expenses insurance

70. Insured events

70.1. Insurance covers such expenses incurred for an illness or injury in Finland mentioned in section 70.2, that occurred in Finland during the validity of the insurance policy and apply to the period of validity of the insurance policy, provided that they are not indemnified by law. The insurance only covers treatment expenses that the insured would have to pay for the treatment him/herself and that have not been compensated under another insurance policy. The insurance does not cover costs included in the scope of the occupational healthcare services.

70.2. Medical expenses are compensated provided the examination or treatment is prescribed by a physician and generally recognised on the basis of medical experience as necessary for examining or treating an illness or injury.

Such medical expenses comprise:

- fees paid to physicians or health care personnel for medical procedures carried out by them,
- costs of medicines that are sold in a pharmacy based on a licence granted by an authority, have been defined as medicines, have been granted a marketing authorisation in Finland and have been prescribed by a doctor for the treatment of an illness or injury, with the exception of the preparations specified under 71.2,
- fees for hospital bed-days up to the maximum limit stated in the Optimi or Business Optimi Statement. Hospitals are regarded as the institutions listed in section 60.2 reasonable expenses for the first purchase/rental of a medical appliance required by an illness or injury and regarded as necessary by a specialist, and for its replacement due to breakage in connection with an accident,
- reasonable expenses for the treatment of a dental injury or damage to dentures caused by an accident that has taken place during the validity of the insurance policy. Compensation for the treatment of teeth damaged in an accident will be limited to the state prior to the accident at the most.

70.3. Medical expenses insurance may be granted to a child who has reached the age of two months, and against accident from birth. Medical expenses insurance granted to a child younger than fifteen years will expire at the latest when the Insured reaches the age of 20. Medical expenses insurance granted to a person who has reached the age of 15 will expire at the latest when the Insured reaches the age of 60. Insurance taken only against accident will expire at the latest when the Insured reaches the age of 70. The Insurance may expire earlier if compensation has been paid up to the maximum limit stated in the Optimi or Business Optimi Statement.

70.4. The Insurance may include a deductible, the amount and structure of which can be changed. The deductible is stated annually in the Optimi or Business Optimi calculation.

71. Exclusions relating to the payment of compensations

71.1. No compensation is paid, where

- the expenses are caused by an illness or injury which, had it led to the death of the Insured, would not be compensated by the Insurance Company as stated under Clause 22.1 of the Terms and Conditions,

- an illness or injury intentionally caused by the Insured contributes substantially to the medical expenses,
- the expenses result from the abuse of alcohol, therapeutic or other drugs or intoxicants,
- the expenses are caused by pregnancy, childbirth, abortion, investigation or treatment of infertility, artificial insemination or foetal monitoring, regardless of the reason for the operation,
- the expenses are caused by rehabilitation or the medical examinations completed to determine the need for rehabilitation,
- the expenses are caused by speech, psychological, nutrition, functional or neuropsychological therapy or other comparable therapy or treatment,
- the expenses result from an examination or analysis performed or commissioned elsewhere than in Finland;
- the expenses result from medicines, treatments or examinations that are considered experimental or non-necessary, or
- the injury or damage in question was caused to a tooth or dental prosthesis through biting, even where an external factor contributed to the damage.

71.2. Compensation is not paid for

- contraception or pharmaceutical preparations used for contraception even if they were prescribed for the treatment of an illness,
- prophylactic treatments, vaccinations or preparations,
- medicines that are intended for preventive treatment, for relieving the impacts of ageing or other physiological changes or for improving the quality of life. Hormone replacement therapy, medicines that increase sexual ability or desire, and medicines that are intended to prevent or decrease obesity, baldness or the detrimental effects of other physiological changes are regarded as such, for example,
- medicines intended for relieving the withdrawal symptoms of nicotine or that help one quit or reduce smoking,
- milk products and other nutritional supplements,
- vitamins, trace elements, calcium preparations, herbal remedies, health foods and homeopathic and anthroposophic preparations or examination used to define the need of these even if they were prescribed for the treatment of an illness,
- purchase of contact lenses or spectacles, or correction of a refractive error by an operation, hearing aid and other aids,
- physical examinations,
- treatment of the teeth or organs of mastication (even where the disease of the teeth or organs of mastication has caused symptoms other than in the teeth),
- physiotherapy or comparable treatment,
- cosmetic or plastic surgery treatments, procedures or operations or the expenses caused by their repercussions, except those performed to correct injuries caused by an accident within three years of the date of the accident,
- breast reduction, augmentation and reshaping surgery and related complications and repercussions,
- eyelid lifting operations regardless of the reason for the operation,
- liposuction, obesity surgeries or similar and associated complications
- treatment day charges in spas, naturopathy, and rehabilitation institutions or similar,
- home care or household care, day care and similar indirect costs, or
- travelling or accommodation expenses.

71.3. Should it become obvious that the expenses for which a claim is made will considerably exceed the normal level of expenses that is generally accepted and observed, the Insurance Company has the right to reduce the amount of compensation as far as these expenses are concerned, but not, however, below a reasonable level. No compensation will be paid for a home visit performed or care provided by a physician or another healthcare professional in the insured's home to the extent that the cost exceeds a reasonable cost level for similar care in a healthcare establishment.

72. Additional exclusions relating to a medical expenses insurance taken against accident (accident cover)

72.1. Compensation for medical expenses in accordance with Clause 70 is only paid in case of an accident as specified under Clause 2.2 of the Terms and Conditions during the validity of the Insurance. Where an illness or defect unrelated to the accident contributes substantially to the injury, a daily allowance is only paid for that part of the injury that can be considered to have been caused by the accident.

72.2. In addition to that which has been stated under Clause 71, no compensation for medical expenses is paid where the injury

- results from an operation, treatment or other medical procedure carried out to cure an illness or defect, unless this procedure was carried out to treat an injury coverable under this Insurance,
- results from an attempted suicide; this restriction is applied regardless of the Insured's age and mental state,
- results from a ski jumping or downhill racing event, or in a football, ice hockey, bandy, rink bandy, floorball, basketball, handball, American football or rugby match organised by a sports federation or club, or in practice for compe-titions in these sports organised by a sports federation or club or similar sports,
- results from racing or speed training in a motorised vehicle or similar activity,
- results from mountaineering, rock climbing, ice climbing or wall climbing or similar activity,
- results from sailplaning, hot-air ballooning, parachute jumping, hanggliding, paragliding, bungee jumping or similar activity,
- results from weightlifting, powerlifting, bodybuilding, boxing, wrestling, judo, karate, or similar sports,
- results from scuba diving, free diving or similar activity.

72.3. The Insurance does not cover consequences to mental health caused by an accident. Infectious diseases or illnesses caused by the sting or bite of an insect, tick or some other animal are not compensated as accidents.

72.4. Compensation from the Medical Expenses Insurance against Accident may be reduced or refused where the Insured has, at the time of occurrence, been under the influence of alcohol or other intoxicant, and where this has contributed substantially to the occurrence or to the extent of injury.

Cover for critical illnesses

75. Insurance covers

75.1. The agreed lump-sum compensation will be paid in case of critical illnesses specified in the terms and conditions. The cover can be granted to persons of 20–64 years of age. The cover for critical illnesses or the application to increase the cover amount enters into force in accordance with the agreement 90 days after the signing of the application, provided that the insurance company accepts the application made and grants the cover.

75.2. Unless otherwise stated by the insurance company, the cover will always be continued for the next 10

years after its 10-year validity, provided that the cover for critical illnesses is offered by the company at the time of continuation. The cover will continue without providing a health report on the terms and conditions of the cover at the moment of continuation. However, the cover will terminate at the latest on the insured's 65th birthday or when full compensation for the cover has been paid.

75.3. The compensation is paid to the insured or other beneficiary if the critical illness referred to in the terms and conditions is stated to appear for the first time for the insured (i.e., the diagnosis date) or a surgery or procedure referred to in the terms and conditions is performed for the first time while the cover is valid.

The index level of the compensation will be in accordance with the diagnosis date, the operation date or official date of referral to an organ transplant queue referred.

In addition, the payment of compensation requires that the insured has applied for compensation during his or her lifetime within 30 days of the diagnosis or procedure at the earliest.

75.4. Illnesses and procedures required by the illness entitling to compensation include:

75.4.1 Cancer

Cancer refers to malignant tumours that are characterised by uncontrollable growth and spreading of malignant cells over normal tissue and the destruction of normal tissue.

The malignancy of a tumour must be indicated histologically through an examination performed by an oncologist or a pathologist.

Malignant tumours also include leukemia, malignant lymphosarcoma, Hodgkin's disease, malignant bone marrow diseases and skin cancer that sends metastases.

However, the following diseases do not constitute illnesses to be compensated:

- pre-state of cancer or carcinoma in situ, pre-states of cervical cancer (dysplasia, carcinoma in situ, CIN 1, CIN 2 and CIN 3) and states preceding (pre-malign) cancer and cancer that does not spread in its environment,
- early prostate cancer: Class T1 of the TNM classification (including T1a and T1b) or a similar category of another classification,
- Skin melanoma which is in Class 1a according to the new AJCC 2002 classification: thickness (Breslow) a maximum of 1 mm, depth growth class (Clark) a maximum of III and no ulceration,
- Hyperkeratosis and the skin's basal cell and spinocellular cancer,
- Any tumours appearing in connection with an HIV infection.

75.4.2 Coronary artery bypass surgery

Open heart surgery where one or more constrictions or occlusions of the coronary artery are bypassed using an artery transplant is to be compensated.

A significant constriction or occlusion of the coronary artery must be indicated through coronary artery imaging and the bypass surgery must be medically necessary according to a cardiologist's examination.

However, the compensation will not be paid for angioplasty, other method based on a catheter inside the artery or a laser procedure.

75.4.3 Myocardial infarction

The first myocardial infarction of the insured will be compensated. A myocardial infarction refers to the necrosis of a part of the cardiac muscle caused by the sudden prevention of blood circulation.

The diagnosis must be based on typical chest pain, new EKG changes indicating a myocardial infarction and a significant increase in heart-based enzymes.

Compensation will not be paid for the following:

- Chest pain (angina pectoris) without the myocardial infarction as described above
- Microinfarction which includes a minor increase in the troponin T content but no EKG changes diagnostic for myocardial infarction or clinic symptoms or findings characteristic of a myocardial infarction.

75.4.4 Kidney failure

An end-stage chronic renal disease which appears as a difficult unrecoverable insufficiency of both kidneys must be compensated. Such renal failure must be indicated through regular long-term dialysis treatment or a kidney transplant.

75.4.5 Organ or bone marrow transplant

An organ transplant surgery or referral to an official organ transplant queue must be compensated if the situation concerns any of the organs listed below and the transplant is medically necessary and is based on objective evidence of organ insufficiency, provided that the situation concerns:

- heart, lung, liver, kidney or pancreas transplant or
- bone marrow transplant using stem cells and the transplant was required because of the destruction of the patient's bone marrow.

Cellular transplant other than that described above will not entitle to compensation.

The insurance will only compensate for the aforementioned organ, tissue or cell transplants.

75.4.6 MS disease (multiple sclerosis)

A definitely indicated MS disease that has been diagnosed by a neurologist after more than one deterioration stage that has been clearly indicated through neurological functional disorders must be compensated, when the functional disorders have occurred over a period of more than six (6) months and are caused by the demyelination of the brain or spinal cord. Neurological functional disorders refer to neurological deficiencies or combinations of deficiency symptoms that apply to the optic nerve, brain stem, spinal cord, coordination or sensory functions.

75.4.7 Cerebral palsy

Cerebral palsy that is caused by cerebral haemorrhage or a cerebral infarction caused by cerebral thrombosis and which causes permanent neurological damage must be compensated. Neurological damage refers to a neurological functional deficiency classified at least in deficiency class 6 in accordance with Decision 1012/1986 of the Ministry of Social Affairs and Health and which must be able to be stated after three (3) months of the cerebral palsy. The diagnosis must be based on new changes observed through CT or MRI.

The insurance will not compensate for:

- cerebral infarction, haemorrhage or cerebral palsy caused by an accident or external force
- transient ischaemic attacks (TIA disorders).

75.5. The impact of the use of tobacco products

The use of tobacco products will increase the cover premium. The insured is considered to use tobacco products if he/she uses or has used tobacco products during the twelve (12) months before the start of the cover. If the insured starts using tobacco products during the insurance period, the cover premium will be increased to the level following the use of tobacco products. After receiving written notification of the insured having started to use tobacco products,

the Insurance Company will send a notification of the changed premium and other agreement terms and a notification of the Policyholder´s right of cancellation.

The cover premium will increase after two (2) months of sending the notification.

If the insured stops the use of tobacco products during the insurance period, the cover premium will decrease to the level of a non-smoking person after twelve (12) months of the date on which a written notification regarding the termination of the use of tobacco is received by the Insurance Company.

The Insurance Company must be immediately notified of the start of use of tobacco products. The written notification of stopping the use of tobacco products can be made no sooner than twelve (12) months after stopping the use of tobacco products.

If the insured has started to use tobacco products during the validity of the cover and the Policyholder has, intentionally or through negligence which cannot be regarded as minor, neglected his/her obligation to notify the Insurance Company, the Insurance Company will reduce the compensation to be paid according to the Insurance Contracts Act.

III Claiming and payment of compensation

80. Claiming compensation

80.1. The recipients of the sum payable at death must provide the Insurance Company with a death certificate, an official certificate showing the dates of birth and death of the Insured (extract from population register), an official account of the beneficiaries (official certificate showing family relationships), and any other account required.

80.2. To obtain the lump-sum compensation for permanent disability, the claimant must at one's own cost provide the Insurance Company with a medical certificate, or a copy of it, on the permanence of the disability.

80.3. To obtain compensation for a handicap caused by an accident, the claimant must at one's own cost provide the Insurance Company with a medical certificate, or a copy of it, on the degree of the handicap and its cause and permanence.

80.4. To obtain daily disability allowance, the claimant must at one's own cost provide the Insurance Company with a medical certificate, or a copy of it, on the disability and its cause.

80.5. To obtain daily hospitalisation allowance, the claimant must at one's own cost provide the Insurance Company with a report on the cause and duration of the hospitalisation.

80.6. Prior to claiming compensation for treatment expenses expenses, the Insured must claim statutory compensation in accordance with the Finnish Act on Sickness Insurance from the local office of the Finnish Social Insurance Institution Kela. After this, the Insured must present the claim for compensation and the original voucher from Kela, with copies of receipts for expenses attached, to the Insurance Company. Any receipts on which Kela does not pay compensation must be presented to the Insurance Company in the original.

If the right to compensation under the Finnish Act on Sickness Insurance is lost, the Insurance Company will deduct that part which would have been payable under the Act on Sickness Insurance from the compensation for medical expenses.

80.7. If compensation is claimed for receiving the cover amount for a critical illness, the fully completed application must be submitted to the Insurance Company with medical certificates and other required information to state the critical illness referred to in the terms and conditions. The Insurance Company will not compensate the costs caused by obtaining the documents referred to in the above.

80.8. Compensation must be claimed from the Insurance Company within one year of the date on which the person entitled to compensation discovered the possibility of claiming compensation, and, in any event, within ten years of the occurrence of the eligibility to claim. If compensation has not been claimed within the timeframe specified above, the right to compensation shall be lost.

80.9. If the claimant has, after the insurance event, fraudulently provided the Insurance Company with false or incomplete information that is relevant to the determination of the insurance company's liability, his/her compensation can be reduced or it can be refused or recovered depending on what is reasonable considering the circumstances.

81. Paying compensation

81.1. The Insurance Company will pay the compensation within 30 days of receiving written notice of the insured event.

If the amount of compensation is disputed, the Insurance Company will pay the undisputed part of the compensation within the above period. The Insurance Company is not, however, liable to pay compensation before 14 days have elapsed from the date on which all documents necessary for the establishment of the Insurance Company's liability were received.

81.2. In case the payment is delayed, the Insurance Company will pay the penal interest prescribed in the Finnish Interests Act on the compensation.

81.3. If the Insurance Company advises the Insured to have their state of health examined by a physician named by the Insurance Company, the Insured is under obligation to follow this advice, and the insurance company will compensate the expenses caused by the required medical certificates and medical examinations.

81.4. The Insurance Company is entitled to deduct from the compensation payable any unpaid premiums that have fallen due. If the compensation is not sufficient for the payment of the unpaid premiums that have fallen due, the compensation is conditional on payment of the premiums.