Forenede Gruppeliv

Cover for certain critical illnesses

These insurance conditions are effective from 1 January 2023 and replace the previous conditions of 1 January 2020

The following is a translation of an original Danish document. The original Danish language version is the governing text for all purposes, and in case of any discrepancy, the Danish language version will prevail.

1. This insurance is subject to the following conditions in connection with FG's group life contracts and insurance conditions.

The insurance covers the illnesses, planned or performed surgeries and after-effects of any illness listed in clause 7 A-Y. Illnesses, surgeries and after-effects of an illness are hereafter referred to as diagnoses.

When a diagnosis has been made as required by the insurance conditions, the insurance sum may be paid out.

The insurance conditions to be applied and the amount to be paid out are the conditions and insurance sum applicable on the date when the diagnosis was made.

2. To be able to claim for a critical illness, it is a condition that the diagnosis is made during the policy period. The date of diagnosis is the determining date, and not the time when the insured is informed about the diagnosis. The policy period is stipulated in the group life contract.

The insurance does not cover the diagnoses listed in clause 7 if the insured received, or received treatment for, any such diagnosis before the commencement of the policy period. Diagnoses covered under the provisions of clause 7 A-Y are considered as one diagnosis. "Extended cover for 7 A diagnoses" applies to cancer.

3. The group life contract states whether critical illness cover will cease after payment of the insurance sum for critical illness, see a) below, or whether critical illness cover will be retained, see b) below:

a) When a payment has been made under clause 7, the insured's entitlement to further payment under critical illness cover will cease.

b) When a payment has been made under clause 7, the insurance will no longer cover the diagnosis or diagnoses that led to payment of the insurance sum for critical illness. Payment may only be claimed once for each of the provisions of clause 7 A-Y. "Extended cover for diagnoses listed in 7 A" applies to cancer.

To receive payment for more than one claim covered, it is a condition that at least six (6) months have elapsed between the date of the last eligible diagnosis and the date of the new diagnosis. If the insurance has been paid out on acceptance onto a waiting list, the six-month period will be calculated from the date of surgery.

4. If the insured dies during the set-off period set out in the group life contract, the lump sum paid for critical illness will be set off against the death benefit.

5. The entitlement to payment of the insurance sum for critical illness ceases on the death of the insured unless a prior written request for payment has been presented to FG.

6. If the insured has withdrawn from the group life contract, or if the group life contract has ceased due to cancellation or for other reasons, a written request for payment must be presented to FG within six (6) months of the expiry of the policy period. At the expiry of this deadline, the entitlement to payment of the insurance sum for a critical illness that has not been reported will cease.

7. Critical illness means any one of the following conditions:

A. Cancer

1) Cancer with the exception of its less aggressive forms
A malignant tumour which is characterised microscopically by abnormal cells and uncontrollable, infiltrative growth into surrounding tissue, and clinically by a tendency to local relapse and spread to regional lymph nodes or more distant organs (metastases).

The cover does **not** include:

- Pre-cancerous stages (dysplasia and carcinoma in situ), for instance in the cervix, breast or testes
- Borderline changes
- Cancer localised exclusively to the skin, with the exception of malignant melanoma
- Kaposi's sarcoma
- Benign papilloma of the urinary bladder
- Grade 1 neuroendocrine (carcinoid) tumours, with no sign of invasive growth or metastasis.

The diagnosis is considered definite when a specialist in examination of tissue samples (pathological anatomy) has made a diagnosis based on a microscopic examination of a tissue sample (biopsy), or optionally of a cell sample (cytology).

2) Cancer of the blood, lymphoid system or haematopoietic cells of the bone marrow
A malignant disease of the blood, lymphoid system or haematopoietic cells of the bone marrow, characterised by an atypical blood cell count with uncontrolled growth of blood cells and progression and with relapse tendency.

The cover comprises:

- Acute leukaemia
- Chronic myeloid leukaemia
- Multiple myeloma
- Non-Hodgkin's lymphoma
- Hodgkin's lymphoma, stages II to IV
- High-risk myelodysplastic syndrome (MDS)
- Chronic myelomonocytic leukaemia (CMML)

The diagnosis of cancer is considered definite when a specialist in examination of tissue samples (pathological anatomy) has made one of the above diagnoses based on a microscopic and/or flow cytometric analysis of blood, bone marrow or other tissue.

If requiring treatment, the following conditions are also covered:

- Chronic lymphatic leukaemia (CLL)/small-cell lymphocytic lymphoma (SLL)
- Essential thrombocytosis
- Polycythaemia vera
- Myelofibrosis.

"Requiring treatment" means a disease requiring cytotoxic treatment (including chemotherapy, radiation therapy and biological treatment) of the disease. Treatment with acetylsalicylic acid, adrenocortical hormone and phlebotomy is not considered cytotoxic treatment.

In the case of cancer types for which it is a mandatory that the disease requires treatment, the diagnosis is considered definite on the date on which an oncology department or department of haematology has stated in the medical records that there is treatment indication for the disease.

The cover does **not** include:

- Pre-cancerous stages of cancer of the blood, lymphoid system or haematopoietic organs
- Lymphoma solely localised to the skin.

Extended cover for diagnoses listed in 7 A
If the insured was diagnosed with cancer before the commencement of the policy period, and the insured has been cancer-free for at least ten (10) years, the insured will be entitled to payment if cancer is re-diagnosed during the policy period and meets the conditions of clause 7 A.

Payment may be claimed for up to two (2) cancer diagnoses made during the policy period, provided that such diagnoses meet the conditions of clause 7 A. However, to be able to claim for the second cancer diagnosis, it is a condition that at least ten (10) years have elapsed since the first cancer diagnosis was made within the policy period. A further condition for claiming a second payment is that no recurrence of the cancer was detected or no other cancer was diagnosed during the 10-year period.

B. Coronary thrombosis (myocardial infarction)
Acute degeneration of a portion of the cardiac muscle caused by insufficient blood supply to the regional part of the heart, which has resulted in loss of functional cardiac muscle tissue, corresponding to a LVEF of 50% or less.

The diagnosis must be supported by appropriate evidence and based on:

- Typical rise and fall in blood counts (troponins or CK-MB)

Combined with at least one of the following criteria:

- A history of sudden, typical persistent chest pain, or
- Simultaneous electrocardiographic changes compatible with a diagnosis of acute myocardial infarction.

The diagnosis is considered definite when the above conditions are met and a specialist in cardiology has diagnosed coronary thrombosis (myocardial infarction).

If the insured has previously been diagnosed, cf. clause 7 C (bypass surgery or balloon angioplasty) and/or clause 7 D (cardiac valve surgery) and/or clause 7 W (implantation of ICD unit) and/or clause 7 X (chronic heart failure), the insured is not entitled to claim under clause 7 B.

C. Bypass surgery or balloon angioplasty for coronary artery constriction (atherosclerosis)
Cardiac surgery treatment for atherosclerosis (revascularisation) involving one or more coronary arteries with the use of venous and/or arterial grafts or balloon angioplasty of one or more coronary arteries.

In the case of bypass surgery, the policy will pay out if the insured has been accepted onto a waiting list.

In the case of balloon angioplasty, surgery must have been performed.

The diagnosis is considered definite on the date of surgery. In the case of planned bypass surgery, it is the date of acceptance onto a waiting list.

If the insured has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or clause 7 D (cardiac valve surgery) and/or clause 7 W (implantation of ICD unit) and/or clause 7 X (chronic heart failure), the insured is not entitled to claim under clause 7 C.

D. Cardiac valve surgery
Planned or performed treatment of cardiac valve disorder with implantation of an artificial mechanical or biological heart valve prosthesis and homograft or valvular plastic surgery.

In the case of planned surgery, the insured must have been accepted onto a waiting list.

The diagnosis is considered definite on the date of surgery. In the case of planned surgery, it is the date of acceptance onto a waiting list.

If the insured has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or clause 7 C (bypass surgery or balloon angioplasty) and/or clause 7 W (implantation of ICD unit) and/or clause 7 X (chronic heart failure), the insured is not entitled to claim under clause 7 D.

E. Cerebral haemorrhage/thrombosis (stroke)
An acute lesion of the brain or brain stem combined with the onset of objective neurological deficit symptoms lasting more than 24 hours and resulting from an infarction caused by an embolism or a thrombosis, by a cerebral haemorrhage or by an intra-cerebral haematoma. Results of a brain scan (CT or MRI) with findings compatible with the above conditions must be available.

If a stroke is not verified by a brain scan (CT or MRI), the condition will be covered if the classical clinical signs of cerebral thrombosis are present and there are lasting objective neurological deficits in the form of paralysis or impairment of speech, vision or cognitive functions.

The objective neurological deficits can be assessed no sooner than three (3) months after the stroke.

When the above conditions are met and a specialist in neurology has confirmed objective neurological deficit symptoms and diagnosed a stroke, the diagnosis is considered definite on the date of hospitalisation at a neurological unit or on the date of initial consultation with a specialist in neurology in connection with the stroke.

The cover does **not** include:

- Transient cerebral ischaemia (TCI)/Transient ischaemic attack (TIA)
- Brain infarctions detected randomly by a brain scan (CT or MRI), for instance while examining for and diagnosing another illness
- Blood clots or haemorrhages in the peripheral part of the nervous tissue, i.e. outside the brain, for instance in eyes and ears.

F. Saccular aneurysm of the cerebral arteries (aneurysm) or intracranial arteriovenous vascular malformation (AV malformation) and cavernous angioma of the brain

Planned or performed surgery for saccular aneurysm of the cerebral arteries, intracranial arteriovenous vascular malformation or cavernous angioma, which must be detected by x-ray examination of the cerebral arteries (angiography) or a CT or MRI scan.

The cover also applies in cases where surgery is indicated, but where surgery cannot be performed for technical reasons.

The diagnosis is considered definite on the date of surgery. In the case of planned surgery, it is the date of acceptance onto a waiting list. If surgery is not technically feasible, diagnosis is considered definite on the date on which a neurological or neurosurgical department in medical records has stated that there is indication for surgery, but that surgery cannot be performed for technical reasons.

G. Certain benign tumours of the brain and spinal cord

Benign tumours occurring in the brain, brain stem, spinal cord or localised to the membranes of these organs (central nervous system)

- which surgically cannot be fully removed; or
- which, after radical surgical removal, leave the insured with sequels in the nervous system resulting in a degree of impairment of 15% or more according to the rating list issued by the Danish Labour Market Insurance (Arbejdsmarkedets Erhvervssikring). The degree of impairment can be assessed three (3) months after the surgery at the earliest; or
- where surgery is indicated, but where surgery cannot be performed for technical reasons.

The diagnosis is considered definite on the date of surgery.

If surgery is not technically feasible, diagnosis is considered definite on the date on which a neurological department in medical records has stated that there is indication for surgery, but that surgery cannot be performed for technical reasons.

The cover does **not** include:

- Cysts or granulomas
- Schwannomas/neuromas, including acoustic neuromas
- Adenomas of the pituitary gland.

H. Multiple sclerosis

A chronic disease clinically characterised by recurrent attacks, resulting in neurological deficits in various parts of the central nervous system.

The diagnosis must be documented by one or more well-defined episodes (attacks) of symptoms compatible with multiple sclerosis. Primary progressive sclerosis is also covered. The diagnoses must be confirmed by at least one of the following three (3) examinations:

- Elevated IgG index or oligoclonal bands in the cerebrospinal fluid
- Prolonged VEP latency (not sufficient if there is clinical affection of the optic nerve only)
- Typical changes detected by an MRI scan of the central nervous system, showing multiple lesions in the white matter.

The diagnosis is considered definite when the above conditions are met and a specialist in neurology has diagnosed multiple sclerosis.

I. Motor neurone disease (MND)

Motor neurone disease (MND) of one of the following types:

- Amyotrophic lateral sclerosis (ALS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Primary lateral sclerosis (PLS).

The diagnosis is considered definite when a specialist in neurology has diagnosed one of the conditions covered.

J. Certain muscular diseases and nervous disorders

Progressive muscular dystrophy of one of the following types:

- Facio-scapulo-humeral dystrophy
- Limb girdle muscular dystrophy
- Myaestenia gravis
- Hereditary motor sensory neuropathy (previously known as Charcot-Marie-Tooth Disease), or
- Inclusion body myositis.

The diagnosis is considered definite when a specialist in neurology has diagnosed one of the conditions covered.

K. HIV infection as a result of blood transfusion or occupational transmission

HIV infection as a result of a blood transfusion performed after the commencement date of the insurance policy.

Only persons who the Danish Health Authority (Sundhedsstyrelsen) has found eligible to receive compensation for transfusion-transmitted HIV infection meet the requirements to claim payment under the insurance policy.

The insurance also covers persons who, in the pursuit of their professional occupation, develop HIV infection due to work-related lesions or mucous membrane exposure.

To prove transmission, the incident must be reported as an occupational injury and presented together with a negative HIV test taken within the first week after exposure to infection, followed by a positive HIV test taken within the next 12 months.

The diagnosis is considered definite when the above conditions are met and a specialist in infectious diseases has diagnosed the HIV infection.

L. AIDS
A disease of the immune system caused by infection with human immunodeficiency virus (HIV).

The diagnosis must meet the Danish Health Authority's criteria for notifiable AIDS.

The diagnosis is considered definite when the above conditions are met and a specialist in infectious diseases has diagnosed AIDS.

If the insured was diagnosed HIV positive prior to the policy period, the insured is not entitled to claim under clause 7 L.

M. Chronic renal failure
Chronic irreversible failure of both kidneys, resulting in either permanent dialysis or a kidney transplant. In the case of a planned cadaveric kidney transplant, the insured must have been accepted onto an active waiting list.

The diagnosis is considered definite when permanent dialysis has been initiated.

In the case of a kidney transplant from a living donor, diagnosis is considered definite on the date of the transplant, and in the case of a planned cadaveric kidney transplant, the diagnosis is considered definite on the date of acceptance onto an active waiting list.

N. Major organ transplants
Planned or performed organ transplants, including heart, lung, liver, pancreas or stem cells/bone marrow where the insured is the recipient.

In the case of a planned organ transplant, the insured must have been accepted onto an active waiting list.

The diagnosis is considered definite on the date of the transplant. In the case of a planned organ transplant, it is the date of acceptance onto an active waiting list. In the case of an organ transplant with autologous stem cells/bone marrow, the diagnosis is considered definite on the date of the transplant.

P. Parkinson's disease (paralysis agitans)
Primary Parkinson's disease displaying the principal symptoms of muscle rigidity, tremor or slowed movements. Symptoms of Parkinson's disease induced by psychopharmacological drugs are not covered.

The diagnosis is considered definite when a specialist in neurology has diagnosed Parkinson's disease (paralysis agitans).

The diagnosis is covered from 1 January 2002.

Q. Blindness
Total and irreversible loss of vision in both eyes where visual acuity in the better eye is reduced to 1/60 or less.

The diagnosis is considered definite when a ophthalmologist has assessed and confirmed the loss of vision in the medical records.

The diagnosis is covered from 1 January 2002.

R. Deafness
Total and irreversible loss of hearing in both ears with a hearing threshold of 100 dB or more at all frequencies.

The diagnosis is considered definite when a specialist in audiology has assessed and confirmed the hearing loss in the medical records.

The diagnosis is covered from 1 January 2002.

S. Diseases of the aorta (coronary artery disease)
Diseases of the aorta disease comprise:

- Local dilation of the aorta (aortic aneurysm) to a diameter of more than 5 cm
- Local dilation of the aorta (aortic aneurysm) which has been corrected by surgery
- Rupture of the aorta (aortic rupture)
- Rupture of the inner layer of the aorta and bleeding into the aortic wall (aortic dissection), or
- Total aortic occlusion.

The term aorta includes both the thoracic and abdominal aorta, but not its branches.

The diagnoses must be supported by appropriate evidence based on either:

- Ultrasound scan
- Echocardiography or
- CT/MRI scans.

In the case of aortic aneurysm, the diagnosis is considered definite on the date of surgery or when the aorta is dilated to a diameter of 5 cm or more.

In the case of aortic rupture, aortic dissection and total aortic occlusion, the diagnosis is considered definite when documentation is available in the form of clinical findings and ultrasound, echocardiography or CT/MRI scans.

The diagnosis is covered from 1 January 2005.

T. After-effects of encephalitis or meningitis
Permanent neurological sequelae following an infection of the brain, cerebral nerve roots or meninges caused by bacteria, viruses or fungi. The permanent neurological sequelae must have resulted in a degree of impairment of 8% or more according to the rating list issued by the Danish Labour Market Insurance (Arbejdsmarkedets Erhvervs¬sikring).

The diagnosis must be based on:

- Detection of microbes in the spinal fluid, or
- A spinal fluid examination showing distinct inflammatory reaction (pleocytosis), including an increased number of white blood cells and protein and, if relevant, supplemented by a CT or MRI scan.

The degree of impairment can be assessed three (3) months, at the earliest, after the spinal fluid examination showing encephalitis or meningitis. The degree of impair¬ment must be assessed and confirmed by a specialist in neurology or infectious diseases.

When the above conditions are met, the diagnosis is considered definite three (3) months to the day after the spinal fluid examination showing encephalitis or meningitis.

The diagnosis is covered from 1 January 2005.

U. After-effects of borrelia infection or Tick-Borne Encephalitis (TBE)
Long-term or chronic neuroborreliosis following a tick bite which has caused permanent neurological sequelae. The permanent neurological sequelae must have resulted in a degree of impairment of 8% or more according to the rating list issued by the Danish Labour Market Insurance (Arbejdsmarkedets Erhvervssikring).

The diagnosis must be based on spinal fluid examinations with defection of borrelia/TBE-specific antibodies.

The degree of impairment can be assessed three (3) months, at the earliest, after the spinal fluid examination showing borrelia infection or Tick Borne Encephalitis (TBE). The degree of impairment must be assessed and confirmed by a specialist in neurology or infectious diseases.

When the above conditions are met, the diagnosis is considered definite three (3) months to the day after the spinal fluid examination showing borrelia infection or Tick Borne Encephalitis (TBE).

The diagnosis is covered from 1 January 2005.

V. Severe burns, frostbite or corrosive burns

Third-degree burns, frostbite or corrosive burns covering at least 20% of the insured's body surface area.

The diagnosis is considered definite when the above conditions are met and the medical records include an assessment and confirmation from a burns unit.

The diagnosis is covered from 1 January 2007.

W. Implantation of ICD unit (defibrillator)

Performed implantation of implantable cardioverter defibrillator (ICD) due to documented, previous life-threatening cardiac arrhythmia (secondary prophylaxis).

Cover is also provided for performed implantation of implantable cardioverter defibrillator (ICD) as primary prophylaxis for the following diagnoses:

- Sarcoidosis with cardiac involvement
- Hypertrophic cardiomyopathy
- Long QT syndrome.

The diagnosis is considered definite on the date of surgery.

Implantation of an ordinary pacemaker is not covered.

If the insured has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or clause 7 C (bypass surgery or balloon angioplasty) and/or clause 7 D (cardiac valve surgery) and/or clause 7 X (chronic heart failure), the insured is not entitled to claim under clause 7 W.

The diagnosis is covered from 1 January 2014. The diagnoses listed under primary prophylaxis are covered from 1 January 2023.

X. Chronic heart failure

Chronic heart failure with a decrease in ejection fraction (EF) of the left ventricle to 35% or lower in spite of optimised medical treatment. Implantation of an advanced pacemaker system (cardioverter defibrillator (ICD unit) or biventricular pacemaker (CRT unit)) or a durable mechanical heart pump, e.g. Heartmate, must have been performed.

The diagnosis is considered definite on the date of surgery when the above conditions are met.

Implantation of an ordinary pacemaker is not covered.

Cover is also provided for chronic heart failure without implantation of an ICD/CRT unit for the following diagnosis:

- Amyloidosis with cardiac involvement.

The diagnosis is considered definite when a specialist in cardiology has diagnosed amyloidosis with cardiac involvement.

If the insured has previously been diagnosed, cf. clause 7 B (coronary thrombosis) and/or clause 7 C (bypass surgery or balloon angioplasty) and/or clause 7 D (cardiac valve surgery) and/or clause 7 W (implantation of ICD unit), the insured is not entitled to claim under clause 7 X.

The diagnosis is covered from 1 January 2016. Implantation of a durable mechanical heart device, e.g. Heartmate, is covered from 1 January 2017. The diagnosis for amyloidosis with cardiac involvement is covered from 1 January 2023.

Y. Idiopathic pulmonary artery hypertension (IPAH1)

Pulmonary arterial hypertension group 1.1 receiving specific medical treatment targeting pulmonary arterial hypertension on an idiopathic basis (IPAH).

The diagnosis must be supported by appropriate evidence and based on cardiac catheterisation.

The diagnosis is covered from 1 January 2023.