



FORENEDE GRUPPELIV

COVERAGE ON SPECIFIED CRITICAL ILLNESSES IN CONNECTION WITH GROUP LIFE AGREEMENTS AND FG'S TERMS OF INSURANCE

VALID AS FROM 1 JANUARY 2009

Clause 1. Specified critical illnesses mean: cancer, coronary thrombosis, bypass surgery, balloon angioplasty, heart valve surgery, cerebral haemorrhage/thrombosis, sacculate aneurysm of the brain arteries, specified benign tumours in the brain and spinal cord, multiple sclerosis, ALS (amyotrophic lateral sclerosis), progressive muscular dystrophy, HIV infection as a consequence of a blood transfusion or occupational transmission, AIDS, renal failure, and major organ transplants, Parkinson's disease*, blindness*, deafness*, diseases of the great artery**, complications after encephalitis or meningitis**, Borrelia infection** and major burns*** cf. § 8, where the demands of the diagnoses are stated.

* Diagnosis obtained as per 1 January 2002. ** Diagnosis obtained as per 1 January 2005. *** Diagnosis obtained as per 1 January 2007.

Clause 2. For the insurance to cover a critical illness, it is a condition that the Insured Person is diagnosed during the period of the insurance, however, at the earliest after the expiration of any waiting period. The period of the insurance and any waiting period is shown in the Group Life Agreement. A diagnosis made after the termination of the insurance period is not covered by the insurance.

A diagnosis means one of the diseases mentioned in clause 8. A-V. As an example clause 8. A is one diagnosis, meaning that compensation can be paid only once even if the Insured Person will be subsequently diagnosed as suffering from another cancer disease.

The insurance does not cover the critical illnesses mentioned in clause 8, which have been diagnosed or treated in the Insured Person before the inception date of the policy (please note that it is the date of the diagnosis being made and not the date on which the Insured Person has been made aware of the diagnosis, that counts). However, in the case of clause 8. A (cancer), if the Insured Person has been diagnosed as suffering from cancer before the inception date of the insurance, and a minimum of 10 years have elapsed since the diagnosis was made, and no relapse has been seen in the course of these 10 years, on the diagnosis of a cancer disease, compensation will be able to be claimed.

Should the Insured Person be diagnosed according to clause 8. B (coronary thrombosis) or 8. C (bypass surgery/balloon angioplasty) before the inception date of the Policy, the Insured Person will be included in neither clause 8. B nor clause 8. C.

Should the Insured Person be diagnosed as HIV positive before the inception date of the Policy, the Insured Person is not covered by clause 8. K and L dealing with HIV and AIDS.

Clause 3. It is stated in the individual Group Life Agreement whether the coverage of a critical illness will cease upon payment of an insurance sum on a critical illness (see below under (a)), or whether critical illness will still be covered by the insurance (see below under (b)):

- (a) If a payment has been made according to clause 8, the Insured Person's right of further payment in case of critical illness will cease.
- (b) If a payment has been made according to clause 8, the insurance no longer covers the diagnosis(es) which caused an insurance sum on critical illness to be paid out. Has a payment been made according to clause 8. B or C, the insurance no longer covers clause 8. B or C.

It is a condition for the payment of more than one insurance sum that at least 6 months have elapsed since the latest diagnosis leading to compensation was made. If the payment of compensation was made based upon acceptance to the waiting list for operation, the 6 months' period of time will be counted only as of the date of the operation being performed.

Clause 4. If the Insured Person dies before the set off period assessed in the Group Life Agreement, the sum paid on critical illness will be set off against the sum on death

Clause 5. The right to receive the agreed insurance sum in connection with critical illness lapses upon the death of the Insured Person, unless prior to his/her death the Insured Person made a written request to FG to pay compensation.

Clause 6. If the Insured Person has retired from the Group Life Agreement, or if the Group Life Agreement has been terminated as a consequence of notice or other reasons, a written request for payment is to be presented to FG within 6 months upon the termination of the period of the insurance. Upon termination of this time limit the right of payment of an insurance sum for a non-notified critical illness will lapse.

Clause 7. Payment according to clause 8. includes the insurance sum on critical illness that was in force on the date on which the illness was diagnosed.

Clause 8. Critical illness means any of the following:

8. A. Cancer

A malignant tumour, which is microscopically characterised by the uncontrolled growth and spread of malignant cells, and the invasion of normal surrounding tissue, and clinically by a tendency of local recurrence and spreading to regional lymph nodes and other organs (metastases). The term cancer also includes serious forms of leukaemia, chronic lymphatic leukaemia requiring treatment in phase III and IV, (high risk/phase B and C), lymphoma (lymph node cancer) and Hodgkin's disease (phase II-IV). Furthermore malignant melanoma (birthmark cancer) is covered.

Exclusions: Initial stages of cancer (dysplasia and 'in situ cancer') such as changes of the cells in cervix, breast, or testes, all forms of skin cancer including Kaposi's sarcoma, benign papilloma of the urinary bladder, and finally, tumours arising as a consequence of infection by HIV.

Demands: The diagnosis must be based on a histological or cytological examination of the removed tumour or biopsy of the tumour, performed by a specialist in pathological anatomy.

8. B. Coronary thrombosis (coronary infarction)

An acutely arisen necrosis of the cardiac muscle as a result of insufficient supply of blood to the regional part of the heart. The diagnosis must be able to be documented and to be based on typical increase/decrease of the blood levels (TnT or CKMB) - together with at least one of the following criteria: Anamnesis with suddenly arisen typical, continuous chest pain and/or simultaneously arisen electro cardiographic changes compatible with the diagnosis: acute myocardial infarction.

Demands: The diagnosis must have been made at a department of cardiology or by a specialist in cardiology.

8. C. Bypass surgery of coronary thrombosis or balloon angioplasty (arteriosclerosis)

A planned or performed heart surgery of arteriosclerosis (revascularisation) including one or more coronary arteries with application of vein and/or artery grafts

Demands: On planned surgery it is a demand that the Insured Person has been accepted on the waiting list.

A balloon angioplasty with or without stenting compares to an operation, however, in this case the procedure must be performed before payment can be effected.

8. D. Heart valve surgery

A planned or open heart surgical treatment of inborn or acquired heart valve diseases with implantation of artificial, mechanical or biological heart valve prostheses and homeograft or plastic surgery of the heart valve.

Demands: On planned surgery it is a demand that the Insured Person has been accepted on the waiting list.

8. E. Cerebral haemorrhage/thrombosis (stroke) (apoplexy)

A lesion of the brain causing objective neurological symptoms of malfunction of a duration of more than 24 hours as a consequence of an infarction caused by an embolus or a thrombosis, by a haemorrhage or by an intra cerebral hematoma. Results of a brain scan (CT or MR) with findings compatible with the above diagnosis is to be available.

If a thrombosis has not been verified by a brain scan (CT/MR), the diagnosis will be covered if all classical signs of a thrombosis are present with permanent neurological symptoms of malfunction (paralysis, speech disorder, paropsis, or intellectual reduction). The objective neurological symptoms of malfunction can be assessed only after 3 months.

Transient cerebral ischaemia (TCI), Transient ischaemic attack (TIA), and cerebral infarction accidentally detected at a brain scan (CT/MR) performed in connection with another diagnosis are not covered by the insurance.

Demands: The diagnosis must have been made at a department of neurology or neuro-surgery or confirmed by a specialist in neurology.

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

Planned or performed surgery for sacculate aneurysm of the brain arteries (intracranial sacculus aneurysm) or intracranial arteriovenous vascular malformation or cavernous angioma, detected on the basis of an X-ray examination of the brain arteries (angiography) or a CT/MR scan. The coverage also includes cases where the treatment cannot be carried out due to technical reasons.

Demands: The diagnosis must have been made at a department of neurology or neuro-surgery or confirmed by a specialist in neurology. On planned surgery it is a demand that the Insured Person has been accepted on the waiting list.

8. G. Specified benign tumours in the brain and the spinal cord

Benign tumours in the brain and the spinal cord or the membranes of these organs which are impossible to remove totally by surgery or which after the surgery leave sequels in the nervous system, resulting in a degree of disablement of at least 15% according to the disablement table from Arbejds-skadestyrelsen (the Danish Board of Industrial Injury).

The extent of disablement can be assessed only after 3 months at the earliest.

8. H. Multiple sclerosis

A chronic disease, which is clinically characterised by continuous attacks of neurological symptoms of malfunction from various parts of the central nervous system.

The diagnosis is to be documented by one or several well defined attacks of symptoms, or a progressive course compatible with a diagnosis of multiple sclerosis. The diagnosis is to be confirmed by at least one of the following three examinations:

- Increased IgG index or oligoclonal band in the cerebrospinal fluid.
- Extended latency on VEP (not sufficient if clinically there is only affection of the optic nerve).
- Typical changes at MR-scanning of the central nervous system with multiple affections of the white matter.

Demands: The diagnosis must have been made at a department of neurology or neuro-surgery.

8. I. Amyotrophica lateralis Sclerosis (ALS)

A progressive disease causing a degeneration of the motoric nerve cells in the central nervous system

Demands: The diagnosis must have been made at a department of neuro-medicine or by a specialist in neurology and be confirmed by electromyography.

8. J. Specified types of progressive muscular atrophy

Progressive muscular dystrophy of one of the kinds: Facio-scapulohumeral Dystrophia, Limb-Girdle Muscular Dystrophia, Myaesthesia Gravis, Hereditary Motoric Sensory Neuropathy (previously called Charcot-Marie-Tooth Disease) or Inclusion Body Myositis.

Demands: The diagnosis must have been made at a department of neurology or by a specialist in neurology.

8. K. HIV-infection as a result of a blood transfusion or infections caused by occupational transmission

HIV infection as a result of blood transfusion performed after the inception date of the Policy.

Demands: Only individuals, who have been, according to Sundhedsstyrelsen (the Danish National Board of Health), found entitled to compensation for transfusion transmitted HIV infection, meet the demands for payment of the insurance.

Moreover, also included are individuals who develop HIV infection under performance of their professional occupation due to occupational lesions or mucous membrane exposure.

Demands: To prove transmission, the accident must have been notified as an occupational transmission and presented together with a negative HIV test performed within the first week after exposure and followed by a positive HIV test performed within the next 12 months.

8. L. AIDS

A disease in the immune system caused by an infection by human immunodeficiency virus (HIV).

Demands: The diagnosis must meet Sundhedsstyrelsen's (the Danish National Board of Health) criteria for notification of AIDS, and must have been made at a department of infectious diseases.

8. M. Irreversible renal failure

End stage renal failure with a chronic irreversible failure of both kidneys as a result of which haemodialysis must be instituted, or a kidney transplant performed.

Demands: On planned surgery it is a demand that the Insured Person has been accepted on the waiting list.

8. N. Major organ transplants

Planned or performed organ transplants including heart, lung, liver or bone marrow, where the Insured Person is the organ recipient.

Demands: On planned surgery it is a demand that the Insured Person has been accepted on the waiting list.

8. P. Parkinson's disease (Paralysis agitans)

Primary Parkinson's disease with the principal symptoms of muscle rigidity, tremor, and oligokinesia. Symptoms of Parkinson's disease secondary to treatment with psychopharmacological drugs are not covered.

Demands: The diagnosis must have been made at a department of neurology or by a specialist in neurology.

8. Q. Blindness

Total, permanent and irreversible loss of vision in both eyes, the visual power of the better eye being 1/60 or less.

Demands: The diagnosis must have been made by an optalmologist.

8. R. Deafness

Total and irreversible hearing loss in both ears.

Demands: The diagnosis must have been made at a clinic specialised in audiology.

8. S. Diseases of the aorta (diseases of the great artery)

The aorta – in the thoracic as well as the abdominal region, however not its branches, must be dilated locally (aneurism of the aorta) to more than 5 cm in diameter, or there must be a rupture or dissection of the aorta, with rupture into the inner layers of the aortic wall with bleeding, or a total occlusion of the aorta.

Demands: The diagnosis aneurism or dissection of the aorta must have been made based upon either ultra sound scan of the abdomen, ecco cardiografi, a CT/MR-scan or by aortography. Total occlusion of the aorta should be diagnosed upon clinical findings and an aortography or a MR angiography.

8. T. Sequels to encdephalitis or meningitis

Persistent neurological sequels to infection of the brain, nerve roots of the brain or meningii, caused by bacteria, virus, fungi, etc.

Demands: The diagnosis must have been made at a department of neurology or neuro-medicine and based upon:

- (a) detection of microorganisms in spinal fluid or
- (b) examination of the spinal fluid revealing a significant inflammatory reaction (pleocytosis), including an increased white cell count and increased level of protein and maybe supplemented by a MR/CT scan.

The lesion must have lead to persistent neurological deficits and be assessed and confirmed by a specialist in neurology after 3 months at the earliest.

8. U. Sequels to Borrelia infection

Persistent or chronic neuroborreliosis following a tick bite that has lead to persistent neurological sequels.

Demands: The diagnosis must have been made based upon examination of the spinal fluid, borrelia specific antibody assays. The neurological sequels should be assessed and confirmed by a specialist in neurology after 3 months at the earliest.

8. V. Major burns (ambustio)

Burns (and frost-bites and cauterizations) of third degree covering at least 20% of the Insured Person's body.

Demands: The diagnosis must be evident from the Insured Person's patient record or the commentary from a clinic for patients with burns.

This is a translated version of the original Danish terms of insurance. In case of any discrepancies, the original Danish text is the valid version

January 2009