Forenede Gruppeliv

Children's cover for certain critical illnesses

These insurance terms and conditions are effective from 1 January 2017 and replace the previous terms and conditions effective from 1 January 2016

The following is a translation of an original Danish document. The original Danish document is the governing document for all purposes, and in case of any discrepancy, the Danish wording will be applicable.

1. The terms and conditions below apply to this insurance policy in continuation of FG's group life agreements and insurance terms.

This insurance policy covers the illnesses/diagnoses listed in clause 6, sub-clauses A-L.

Moreover, the insurance policy may include:

- Cover in the event of death , cf. clause 7, and/or
- Cover in the event of type 1 diabetes, cf. clause 8

The group life agreement states whether the insurance is extended to cover death and/or type 1 diabetes.

When a diagnosis has been made according to clause 6 or 8, as required by the insurance terms, the sum insured may be paid out.

The sum insured will be paid out to the insured under the group life agreement.

The insurance terms and the sum insured applicable on the date of diagnosis or date of death will be applied and paid out, respectively.

2. Unless otherwise specified in the group life agreement, the right to payment commences if the child is diagnosed, between date of birth and its 18th birthday, with one of the listed illnesses or dies during the term of the policy. The term of the policy is stipulated in the group life agreement.

The insurance policy does not cover the illnesses stated in clauses 6 and 8 if the child was diagnosed with, or had been treated for, such illnesses before commencement of the term of the policy. However, the provisions in 6 (A) apply in the case of cancer.

Please note that the deciding factor is the date of diagnosis and not the date on which the insured or the child was informed of the diagnosis.

3. If a payment is made according to clause 6, the policy ceases to cover the diagnosis or diagnoses that caused payment of the sum insured for critical illness. However, the provisions in 6 (A) apply in the case of cancer.

In order to receive payment for more than one claim according to clause 6 or 8, it is a condition that at least six (6) months elapse between the date of diagnosis of the most recent illness covered by the policy and the date of the new diagnosis. If the sum insured was paid out when the insured or the child was added to a waiting list, this six-month period commences on the date of surgery.

4. The right to payment of the sum insured defined for critical illness or diabetes will lapse unless FG receives a written request for payment no later than six (6) months after the child's death.

5. If the insured has withdrawn from the group life agreement, or if the group life agreement has terminated due to cancellation or for other reasons, a written request for payment must be presented to FG within six (6) months of expiry of the term of the policy. On expiry of this deadline, the right to payment of the sum insured for a critical illness that has not been reported will lapse.

6. Critical illness comprises any of the following:

A. Cancer

A malignant tumour which is characterised microscopically by the uncontrolled growth and spread of malignant cells, and the invasion of normal surrounding tissue, and clinically by a tendency to local recurrence and spread to regional lymph nodes or other organs (metastases).

The following diseases of the blood, lymphoid system or haematopoietic cells of the bone marrow are also covered:

- Acute leukaemia
- Chronic myeloid leukaemia
- Multiple myeloma
- Lymphoma (cancer of the lymph nodes)
- Hodgkin's disease, stages II-IV
- High-risk myelodysplastic syndrome (MDS)
- Chronic myelomonocytic leukaemia (CMML)

as well as the following requiring treatment:

- Chronic lymphatic leukaemia stages III and IV (high-risk/stages B and C)
- Essential thrombocytosis
- Polycytaemia vera
- Myelofibrosis

"Requiring treatment" refers to illnesses requiring cytotoxic treatment (incl. chemotherapy and radiation therapy). Treatment with acetyl-salicylic acid and blood-letting are not considered cytotoxic treatment.

Malignant melanoma ('birthmark cancer') is also covered.

The diagnosis is considered confirmed once a specialist in pathological anatomy has assessed a histological or cytological examination. In the case of cancer types for which it is a requirement that the illness requires treatment, diagnosis is considered confirmed on the date on which it is stated in the medical records of a department of paediatric oncology or haematology that therapy for the illness is indicated.

The following are not covered:

- Initial stages of cancer (dysplasia and carcinoma in situ)
- Borderline changes
- All types of skin cancer
- Kaposi's sarcoma
- Benign papilloma of the urinary bladder
- Initial stages of cancer in the blood, lymphoid system or haematopoietic organs

If the child was diagnosed with cancer before commencement of the term of the policy, and the child has been cancer-free for a minimum of 10 years, the child will be entitled to payment if cancer is again diagnosed.

Payment may be made for up to two cancer diagnoses during the term of the policy, provided that such diagnoses meet the conditions in 6 (A). In order for the second cancer diagnosis to be covered, it is a condition that at least ten (10) years have elapsed between the first cancer diagnosis during the term of the policy and the second. A further condition for the second payment is that no recurrence of the cancer is diagnosed during the ten-year period.

B. Heart disease requiring surgery

Surgical treatment for heart disease or intervention via a blood vessel.

The heart disease must be diagnosed at a department of cardiology or thoracic surgery.

Surgery or intervention via a blood vessel must be performed subsequent to the child's birth and during the term of the policy.

The diagnosis is considered confirmed on the date of surgery.

C. Cerebral haemorrhage/thrombosis (stroke)

Acute lesion of the brain or brain stem with simultaneous evidence of objective neurological loss, lasting more than 24 hours, resulting from an infarction caused by an embolism or a thrombosis, by a haemorrhage or by an intra-cerebral haematoma. Results of a brain scan (CT or MR) with findings compatible with the above diagnosis must be available.

If a stroke is not verified by a brain scan (CT or MR), the diagnosis will be covered if all of the classic signs of a stroke are present as well as lasting objective neurological loss in the form of paralysis or disturbances of speech or vision. The objective neurological loss cannot be assessed until three (3) months after the event, at the earliest.

The diagnosis is considered confirmed when the above conditions have been met and a specialist in neurology or neurosurgery has confirmed objective neurological loss and diagnosed a stroke.

The following are not covered:

- Transient cerebral ischemia (TCI)/Transient ischemic attack (TIA)
- Brain infarctions detected by chance during a brain scan (CT or MR), for instance when diagnosing another illness
- Strokes or haemorrhages in the peripheral part of the nervous tissue, i.e. outside the brain, for instance in the eyes and ears

D. Sacculate aneurysm of the brain arteries (aneurysm) or intracranial arteriovenous vascular malformation (AV malformation) and cavernous angioma of the brain

Surgery performed for sacculate aneurysm of the brain arteries, intracranial arteriovenous vascular malformation or cavernous angioma, which must have been detected by X-ray examination of the brain arteries (angiography) or a CT or MR scan.

Cover also includes instances where there is indication for surgery but where surgery cannot be performed for technical reasons.

Surgery must be performed after the birth of the child and during the term of the policy.

The diagnosis is considered confirmed on the date of surgery. If surgery is not technically feasible, diagnosis is considered confirmed on the date on which the medical records of a department of neurology or neurosurgery state that there is indication for surgery but that surgery is not technically feasible.

E. Certain benign tumours in the brain and spinal cord

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

- which are surgically removed, or
- where there is indication for surgery but where surgery cannot be performed for technical reasons.

Surgery must be performed after the birth of the child and during the term of the policy.

The diagnosis is considered confirmed on the date of surgery. If surgery is not technically feasible, diagnosis is considered confirmed on the date on which the medical records of a department of neurosurgery state that there is indication for surgery but that surgery is not technically feasible.

The following are not covered:

- Cysts or granulomas
- Schwannomas/neurinomas, including acousticus neuromas
- Adenomas of the pituitary gland

F. Multiple sclerosis

A chronic disease which is characterised clinically by repeated attacks, showing neurological loss in various parts of the central nervous system.

The diagnosis must be documented by one or more well-defined 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:

- Increased 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 in MR scans of the central nervous system, showing multiple affections of the white matter.

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

G. Chronic renal failure

End stage renal failure with chronic irreversible failure of both kidneys, resulting in either permanent dialysis or a kidney transplant.

In the case of a planned cadaver kidney transplant, the child must be on an active waiting list.

The diagnosis is considered confirmed on commencement of permanent dialysis.

In the case of a kidney transplant from a living donor, diagnosis is considered confirmed on the date of the transplant, and in the case of a planned cadaver kidney transplant, the diagnosis is considered confirmed on the date of addition to an active waiting list.

H. Major organ transplants

Planned or performed organ transplants, including heart, lung, liver or stem cells/bone marrow for which the child is the recipient.

In the case of a planned organ transplant, the child must be on an active waiting list.

The diagnosis is considered confirmed on the date of the transplant.

In the case of a planned organ transplant, diagnosis is considered confirmed on the date of addition to an active waiting list. In connection with transplant with autologous stem cells/bone marrow, diagnosis is considered confirmed on the date of the transplant.

I. Sequels to encephalitis or meningitis

Persistent neurological sequels to infections of the brain, nerve roots of the brain or meninges caused by bacteria, viruses or fungi.

Diagnosis must be made based on:

- Detection of microorganisms in the spinal fluid, or
- Spinal fluid examination, showing distinct inflammatory reaction (pleocytosis), including an increased number of leucocytes and protein, if relevant supplemented by a CT or MR scan

Persistent objective neurological loss cannot be assessed until three (3) months after the first symptoms appear, at the earliest.

It is a condition that a specialist in neurology or paediatrics has assessed and confirmed that the infection has caused persistent objective neurological loss in the form of hearing loss, loss of vision, paralysis or hydrocephalus.

Once the above conditions have been met, the diagnosis is considered confirmed three (3) months to the day after the date of appearance of the first symptoms.

J. Sequels to Borrelia infection or Tick-Borne Encephalitis (TBE)

Prolonged or chronic neuroborreliosis following a tick bite, leading to persistent neurological sequels such as hearing loss, loss of vision, paralysis or hydrocephalus.

Diagnosis must be based on examinations of the spinal fluid with Borrelia/TBE-specific antibody assays.

Neurological sequels cannot be assessed until three (3) months after the first symptoms appear, at the earliest.

It is a condition that a specialist in neurology or paediatrics assesses and confirms persistent neurological sequels.

Once the above conditions have been met, the diagnosis is considered confirmed three (3) months to the day after the date of appearance of the first symptoms.

K. Severe burns, frostbite or corrosive burns

Second- and third-degree burns, frostbite or corrosive burns, covering at least 10% of the child's body surface.

The diagnosis is not considered confirmed until the above conditions have been met and the medical records include an assessment and confirmation from a burns unit.

L. Histiocytosis and fibromatosis

Histiocytosis and fibromatosis treated with chemotherapy and/or radiation therapy.

The diagnosis is considered confirmed when a specialist in paediatric oncology has diagnosed one of the conditions covered, and chemotherapy or radiation therapy has been initiated.

The diagnosis is covered from 1 January 2014.

The insurance policy may be extended to include the following:

7. Cover in the event of death

If the child dies during the term of the policy, the policy will pay out a sum equal to the sum insured for children's critical illness, as agreed in the group life agreement.

In order to receive payment of the death benefit if the sum insured for critical illness has been paid out, it is a condition that at least six (6) months have elapsed between the date of diagnosis of the critical illness that most recently caused payment and the date of death.

If a claim for critical illness is made after the death of the child, and less than six (6) months have elapsed between the date of diagnosis of the critical illness and the date of death, only the death benefit will be paid out, and not the critical illness benefit.

The sum insured will be paid out to the insured under the group life agreement.

No inheritance tax is payable on payments to the insured under the group life agreement.

No special preference may be registered.

8. Type 1 diabetes

Insulin-dependent diabetes mellitus type 1 (IDDM).

The diagnosis is considered confirmed when a specialist in paediatrics or endocrinology has diagnosed insulin-dependent diabetes mellitus type 1.