Pohjola Insurance

# Group accident insurance

## RT 01, product description as of 1 January 2020

## Group accident insurance terms and conditions

## Scope of application

These terms and conditions are applied to group accident insurance conforming to the Insurance Contracts Act. The insurance premium of group insurance is paid by other than the insured persons, usually by the policyholder specified in the group insurance contract. The insured persons in a group insurance contract are or can be the group members listed in the group insurance contract.

## 1 Insured person

The insured in a group insurance consists of the member or members of those listed in the group insurance contract.

The insured person's home municipality must be in Finland according to the population register and under the Municipality of Residence Act (201/1994).

## 2 Beneficiary

The Medical Treatment Cover beneficiary is the insured person. If the policyholder has paid the expenses, the expenses are refunded to the policyholder, however. The Daily Allowance Cover and Disability Cover beneficiary is the insured person unless a separate beneficiary clause has been added. Death Cover beneficiaries are the insured person's next of kin unless, with the policyholder's consent, the policyholder or the insured person has notified the insurance company of another beneficiary.

Such a beneficiary clause and relevant alterations to or cancellations of it must be submitted to the insurance company in writing.

## 3 Validity of insurance

### 3.1 Territorial limits

The insurance is valid throughout the country unless otherwise specified in the insurance policy.

### 3.2 Validity and its extent in various circumstances

The insurance policy shown the policy's validity period and extent.

### 3.3 Validity in sports and certain other activities

#### 3.3.1 Competitive sports

If an injury was caused during competitive sports or during training for it, no medical expenses or daily allowance compensation will be paid.

By competitive sports we mean sports games or matches arranged by a sports association or sports club and training arranged according to a training programme or other training typical of the sport, regardless of the level of competitiveness or the age of the insured person. However, we do not consider non-competitive or over-35 sports organised as part of a sports federation and sports club as competitive sports.

By training arranged according to a training programme we mean training carried out following either a written or verbal training plan (the coach does not have to be present). Other training typical of the sport refers to training that supplements the main sport when done as part of preparation to games or sports.

However, if it has been agreed upon and entered in the insurance policy, the insurance is also valid in competitive sports.

#### 3.3.2 Certain sports and activities

Medical expenses indemnity and daily benefit do not cover injuries sustained in sports or activities specified in clause 3.6.

However, if it has been agreed upon and entered in the insurance policy, the insurance is also valid in sports or high-risk activities specified in the insurance policy.

### 3.4 High risk areas, war, armed conflict, nuclear accident and aviation accident

Compensation is not paid if the accident occurred in a country or part of the country which the Ministry for Foreign Affairs of Finland recommends avoiding travelling to or which the Ministry for Foreign Affairs of Finland recommends leaving.

However, this exclusion will not apply

- during ten days from the date of such recommendation if the insured person has arrived in the country or a part of the country described above before the Ministry for Foreign Affairs' recommendation, unless a major war is concerned or the insured person has participated in the war or an armed conflict or the insured person has par-

ticipated in peace-keeping operations organised by the United Nations, the European Union or another community or organisation, or some other military operation
- if the insured person's injury or death is not due to the reason why the Ministry for Foreign Affairs issued its recommendation.

Cover is not provided for any illness, injury or death caused by a war or armed conflict in Finland. This exclusion will not apply during the 10 days from the beginning of armed operations, unless a major war is concerned or the insured person participated in a war or armed conflict.

Cover is not provided for any illness, injury or death caused by a nuclear accident as described in the Nuclear Liability Act, or caused by material, equipment or weapons based on nuclear reaction or ionising radiation, regardless of where the nuclear accident occurred.

In the event of injury or death occurring in connection with an aviation accident, the insurance does not, neither in hobby nor in professional aviation, cover pilots or any other persons who are members of the flight crew or persons carrying out other duties related to the flight.

However, if it has been agreed upon and entered in the insurance policy, the insurance is also valid in the activities specified in the policy document.

## 3.5 Effect of the insured person's age on validity

The insurance may be granted to the following age groups:

- Under 18 years
- 18 to 69 years
- Over 70 years

Insurance granted to persons between under 18 years of age expires at the end of the insurance period when they turn 18. However, if the person has also chosen the 18–69 age group, the policy will continue to be valid.

Insurance granted to persons between 18 and 69 years of age expires at the end of the insurance period when they turn 70. However, if the person has also chosen the over 70 age group, the policy will continue to be valid.

Daily allowance cover expires at the end of the insurance period during which the insured reaches 70 years of age. Daily allowance cover is not valid for insured persons over 70 years of age.

## 3.6 Specific sports and activities

Medical expenses indemnity and daily benefit do not cover or injury sustained in the following types of sports or activities:

- Combat, contact or self-defence sports
- Motor sports
- air sports
- climbing sports, such as mountain, rock, ice climbing
- scuba diving or free diving
- freestyle skiing, speed and downhill skiing, or skiing on unprepared slopes or outside marked slopes

# 4 Accident and exclusions

## 4.1 Accident, exertion and movement

### 4.1.1 Accident

An accident is a sudden, external occurrence which is beyond the control of the insured person and which causes bodily injury.

The following are also considered to be accidents: unintentional drowning, heatstroke, sunstroke, frostbite, injury caused by a considerable variation in atmospheric pressure, gas poisoning sustained by the insured person, and poisoning caused by a substance taken inadvertently.

### 4.1.2 Exertion and movement

In addition to accidental injuries, the insurance covers strains or ruptures of a tendon or muscle diagnosed by a doctor that were directly caused by a sudden, particular and singular exertion and movement, for which medical treatment was given within 14 days of the occurrence of the injury. Indemnity is paid for a maximum of six weeks from the occurrence of the strain injury. No more than one MRI scan will be indemnified following a strain injury caused by sudden exertion and movement. Coverable expenses do not include physiotherapy or surgical operations.

In other respects, strain or rupture injuries caused by sudden exertion or movement are covered according to the provisions and restrictions of group accident insurance terms and conditions on the coverage of injuries caused by an accident.

## 4.2 The following are not compensated as accidents:

The concept 'accident' does not include injury caused

- by an event arising from an illness, defect or injury of the insured
- by operation, treatment or other medical procedure, unless the procedure is undertaken for the treatment of an injury coverable under this insurance
- by poisoning due to medicine, alcohol or other intoxicant used by the insured or due to a substance taken as food
- Injury to a tooth or dentures caused by biting, even if an external factor has contributed to the damage
- suicide or attempted suicide.

The following are not coverable as accidents:

- hernia of the intervertebral disk, abdominal or inguinal hernia, a rupture of an Achilles tendon, long head of biceps tendon or rotator cuff, or recurrent dislocation unless the injury was caused by an accident that would also cause injury to healthy tissues
- infectious diseases caused by a bite or sting
- the psychic consequences of an accident.

## 4.3 Effect of illness, defect, injury or degeneration not related to accident

The insurance does not cover illness, defect, injury, or degeneration of the musculoskeletal system, which are not related to an accident, even if they had been symptomless before the accident. If these factors not related to the accident have materially contributed to the emergence of the injury or its delayed recovery after the accident, medical expenses indemnity, daily benefit and handicap benefit are only paid insofar as the treatment expenses, disability or permanent handicap are deemed to have been caused by the accident.

# 5 Insurance cover

The following types of coverage are available:

- Medical treatment cover
- Daily allowance cover

- Disability cover
- Death Cover.

The insurance cover selected is stated in the insurance policy.

## 5.1 Medical Treatment Cover

### 5.1.1 Right to compensation

The right to indemnity arises when treatment expenses are incurred from an accident sustained by the insured during the validity of the policy.

For any examination or treatment at a public healthcare unit, the insurance covers only the amount paid by the patient.

Treatment expenses are only covered insofar as they are not or would not have been coverable under the Health Insurance Act or under some other legislation.

Treatment expenses for a single accident are covered up to the sum insured valid at the time when the accident occurred.

The deductible recorded in the insurance policy is subtracted from coverable treatment expenses. The deductible will be subtracted once per injury.

### 5.1.2 Coverable treatment expenses

Treatment expenses are covered provided that the examination or treatment of the injury is prescribed by a physician. In addition, the examination or treatment procedures must be in accordance with generally accepted medical practice and necessary for the treatment of the injury in question.

Of these expenses, the following are coverable:

- daily hospital charges
- fees for examination and treatment procedures carried out by physicians or healthcare professionals
- expenses for physiotherapy prescribed by a physician to recover from an accidental fracture or surgery or cast treatment. Physiotherapy is also covered in knee and shoulder injuries in which the physiotherapy is applied instead of surgery. However, physiotherapy is only covered for a maximum of 10 sessions per injury
- costs for medicinal products and wound dressings sold in pharmacies
- reasonable travel expenses to a local physician, dentist or nursing institution, or to a medical institution designated by the insurance company on the basis of section 5.1.4.
- necessary extra costs of travel to and from school by an insured person of under 18 years of age using a vehicle that entails extra cost and which is used on a physicians order because of an accident
- necessary costs of repairing or replacing spectacles or contact lenses, a hearing aid, dentures or a safety helmet in use and broken when the accident occurred, provided that the accident called for medical treatment
- costs of an orthopaedic brace if it was the first orthopaedic brace that was acquired after a coverable operation or accident. These expenses are only covered up to EUR 500 per operation or accident.
- costs of dental injury examinations and treatments
- rental costs of forearm or underarm crutches.

### 5.1.3 Reasonableness of expenses

If it becomes evident that the expenses for which indemnity is claimed clearly exceed the generally accepted and reasonable level, the insurance company has the right to lower the amount of indemnity but not, however, below the reasonable level.

Costs incurred by the insured person using his/her own car are covered as reasonable or necessary expenses to the maximum amount of motor vehicle travel costs specified under the decree issued by the Ministry of Social Affairs and Health on the basis of the Health Insurance Act.

### 5.1.4 Choice of medical care provider

The insurance company can choose the medical centre, hospital or nursing institution in which examinations and treatment measures shall be undertaken, unless this is unreasonably inconvenient for the insured.

### 5.1.5 Expenses which are not covered

Expenses are not compensated if they are caused by

- examination or treatment provided by a physiotherapist, foot therapist, chiropractor, osteopath, naprapathy practitioner, masseur or other equivalent health care professional, with the exception of physiotherapy specified in clause 5.1.2
- purchase of spectacles or contact lenses, unless in situations referred to in clause 5.1.2
- purchase of nutritional products including clinical nutritional products
- purchase of micronutrient, mineral or vitamin preparations, unless they are considered medicinal products
- purchase of anthroposophic or homeopathic products
- spending time or staying at a place providing rehabilitation services or any actual services used
- medical equipment or other aids, orthotic insole or other insole or artificial limb (but the rental costs of forearm or underarm crutches are compensated)
- orthopaedic brace unless it was the first orthopaedic brace that was acquired after a coverable operation or accident. These expenses are only covered up to EUR 500 per operation or accident.

We do not compensate loss of income or indirect expenses, such as meal, parking or accommodation expenses.

## 5.2 Daily Allowance Cover

The right to compensation arises if the insured becomes disabled as a result of an accident which occurred during the validity of the cover.

The compensation paid for total disability is the daily allowance valid at the time the accident occurred, and the compensation paid for partial disability is the proportion of the daily allowance corresponding to the loss of working capacity.

Disability is total if the insured is wholly unable to carry out his/her normal activities at work, and partial if the insured is partially unable to carry out these activities.

Compensation is paid no sooner than from the date when a doctor has stated disability has begun. In policies that have a qualifying period, however, compensation payment does not begin until after the qualifying period. The qualifying period begins on the first day of the disability as stated by a physician.

Compensation is paid of the basis of a single accident only for up to 360 days.

### 5.3 Disability Cover

The right to benefit arises if the insured suffers permanent handicap caused by an accident which occurred during the validity of the cover and the permanent handicap has continued for three months.

Permanent handicap refers to a medically assessed general handicap which the insured has incurred through an injury and which, according to medical prognosis, is unlikely to be healed. In determining the handicap, only the nature of the injury is taken into account. The individual circumstances of the injured persons, such as their profession or leisure-time pursuits, do not affect the determination of the handicap.

The degree of disability is determined in accordance with the Government Decree on disability categories, issued on the basis of the Workers' Compensation Act and valid at the time when the accident occurred. Injuries are divided into handicap classes 1–20, with class 20 corresponding to full handicap and class 1 to the smallest coverable handicap.

The benefit for full, permanent handicap according to class 20 is paid as a lump sum equal to the sum insured valid at the time the accident occurred. For partial, permanent handicap, the benefit is paid as a lump sum equal to as many twentieths of the sum insured as indicated by the handicap class.

Permanent disability is determined within three years of the accident at the latest.

If the degree of disability changes by at least two disability categories before three years have elapsed since the accident, the amount of benefit must be revised correspondingly. However, no benefit already paid will be recovered.

### 5.4 Death Cover

The right to compensation arises if the insured becomes dies as a result of an accident which occurred during the validity of the cover.

The benefit paid is equal to the sum insured valid at the time the accident occurred.

The benefit will not be paid if the insured dies after three years have elapsed since the accident occurred.

## 6 Filing a claim

### 6.1 Notification of an accident

The claimant must notify the insurance company of the accident in writing. This must be done by filling in the insurance company's loss report. If requested, you must also provide additional information in order to settle the claim.

In order for the handicap benefit to be processed, the claimant must send upon request an E Doctor's statement to the insurance company, describing the handicap.

For the processing of death benefit, the claimant must provide the insurance company with a death certificate for the insured and official extracts from the population register, or equivalent, on beneficiaries. The insurance company must also be sent, upon request, further documentation by the authorities on the cause of death.

### 6.2 Receipts

The claimant must pay the medical treatment expenses him/herself before claiming for compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming for compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must upon request provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

Claimants must also pay for any other expenses and subsequently claim compensation they are entitled to by law from those responsible for them. If expenses have not been compensated by virtue of law, original receipts or equivalent documentation of them must be sent upon request to the insurance company.

### 6.3 Loss investigation costs

Only an E Doctor's Statement is compensated when dealing with a disability benefit and the insurance company has specifically requested for one.

No other fees charged by doctors for medical statements are compensated as loss inquiry costs. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

# General terms of contract

The General Terms of Contract contain the relevant provisions of the Insurance Contracts Act. The insurance contract is also subject to certain provisions of the Insurance Contracts Act not appearing from these General Terms of Contract. The clauses below apply to group insurance unless otherwise agreed in respect of a matter stipulated in the group insurance contract or the terms and conditions.

## 1 Key concepts

**Insurance of the person, or personal insurance**, is insurance by which a natural person is covered.

The essential content of an **insurance contract** is defined in the insurance policy and the insurance terms and conditions.

**The policyholder** is the party who has concluded an insurance contract with the insurer.

**The insurer** is the insurance company issuing the insurance. In these terms and conditions, the insurer is referred to as 'the insurance company`.

**The insured person** is a person who is covered by the insurance.

**The insurance period** is the agreed period recorded in the policy documents during which the insurance is valid. The insurance contract continues for one agreed insurance period at a time, unless either contracting party gives notice of termination.

**Premium period** is the period for which a premium is paid at regular intervals as agreed.

**An insurance event** is an event for which compensation is paid under the insurance.

**Group insurance** (§2) is insurance under which those insured are members of a group as defined in the insurance contract and the premium is paid in full by its policyholder.

# 2 Disclosure of information prior to concluding an insurance contract

## 2.1 Policyholders and insured party's obligation to disclose information

Prior to the insurance being granted, the policyholder and the insured must provide full and correct answers to all questions presented by the insurance company which may affect the assessment of the insurance company's liability. During the validity of the insurance period, the policyholder and the insured must also correct without undue delay any information provided to the insurance company by him/her which he/she has found to be incorrect or insufficient.

If the policyholder or the insured person has acted fraudulently with regard to the abovementioned obligation, the insurance contract is not binding on the insurance company. The insurance company has the right to withhold all premiums paid, even if the insurance is annulled.

## 2.2 Failure to disclose information

If the policyholder or the insured has wilfully or through negligence which cannot be deemed minor failed in his/her obligation to disclose information, and the insurance company would have refused to grant the insurance altogether had the full and correct information been provided, the insurance company is free from liability. If the insurance company had granted the insurance only against a higher premium or otherwise on terms other than those agreed, the insurance company's liability is restricted to what corresponds to the agreed premium or the terms on which the insurance would have been granted.

If the above-mentioned consequences of failure to disclose information would lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

# 3 Commencement of the insurance company's liability and validity of the insurance contract

## 3.1 Commencement of the insurance company's liability

If the Insurance Company has not agreed on any other date individually with the policyholder, the Insurance Company's liability will commence from the time when the Insurance Company or the policyholder has submitted or sent an affirmative reply to the offer/bid of the other contracting party.

If the policyholder has submitted or sent a written insurance application to the Insurance Company and if it is apparent that the Insurance Company would have approved the application, the Insurance Company will also assume liability for an insurance event occurring after the application was submitted or sent.

The insurance company's liability does not commence, however, until the premium for the insurance has been paid if the policyholder has outstanding premiums overdue on other insurances taken from the insurance company, or in case of fixed-term insurance.

The insurance bill contains a mention to this effect.

An insurance application or an affirmative reply which the policyholder has submitted or sent to the insurance company's representative is considered to have been submitted or sent to the insurance company. If there is no indication of the time of day when the reply or application was submitted or sent, it is considered to have taken place at 12.00 midnight.

## 3.2 Grounds for granting insurance

The insurance premium and other terms of contract are determined according to the policy anniversary.

## 3.3 Validity of insurance contract

An insurance contract is either continuous or for a fixed period.

A fixed-term insurance contract is valid for the agreed insurance period. The insurance can, however, be terminated during the insurance period on grounds specified below in sections 4.2, 13.1 and 13.2.

After the first insurance period, a continuous insurance contract is valid for one agreed insurance period at a time, unless the policyholder or the insurance company terminates the contract.

The insurance contract can also be terminated on other grounds, as specified below under sections 4.2 and 13.

# 4 Insurance premium

## 4.1 Premium payment

The insurance premium must be paid within one month of the date on which the bill for the premium was sent by the Insurance Company to the policyholder. However, the initial premium need not be paid before the commencement of the insurance company's liability, nor the subsequent premiums before the beginning of the agreed premium period or insurance period, except in circumstances described in section 3.1, in which payment of the premium is a precondition for the beginning of the insurance company's liability. If part of the insurance company's liability commences at a later date, the related premium need not be paid before said liability commences.

The premiums of the individual insurance policies included in the same insurance contract are combined into a single premium to be invoiced in one or several instalments as agreed. If a premium arising from a change in the insurance contract is not combined with the earlier agreed instalments, this premium will be invoiced separately. The insurance premium paid for the insurance contract is divided amongst all cover types included in the contract in proportion to the relationship between the payment and the invoice, so that all continuous insurance types are valid until the same date.

If a payment by the policyholder is not sufficient to cover all the insurance company's insurance premium receivables, the policyholder has the right to decide which of the outstanding premiums the money is to be used for. However, the payment is used for the insurance contract to which the bill refers and to pay for the oldest outstanding amount under this contract, unless the policyholder has specified otherwise in writing.

### 4.2 Delay in payment of premium

If the policyholder has neglected to pay the premium in part or in full by the due date as referred to under section 4.1, the insurance company has the right to terminate the entire insurance contract 14 days after sending a notice of termination.

However, if the policyholder pays the outstanding premium in full before the end of the notice period, the insurance contract will not be terminated at the end of the notice period. The insurance company will state this option in its notice of termination.

If the delay of payment is caused by the policyholders financial difficulties resulting from illness, unemployment or other special reason primarily beyond the policyholders control, then despite the notice given, the insurance will not expire until 14 days after the obstacle in question has ceased to exist. The contract will, however, expire three months from the end of the notice period, at the latest. The notice of termination will state this option concerning continuation of the insurance for a fixed period. The policyholder must notify the insurance company in writing of the financial difficulties referred hereto during the notice period at the latest.

If the premium is not paid by the due date referred to under section 4.1 above, penalty interest must be paid for the period of delay in accordance with the Interest Payment Act.

The insurance company is entitled to compensation for costs incurred due to collection of insurance premiums under the Act on the Collection of Debts. If the insurance company has to collect an unpaid insurance premium through legal action, it is also entitled to being recompensed for the statutory fees and charges incurred due to legal proceedings.

The insurance company may transfer outstanding amounts for collection by a third party.

### 4.3 Returning of premium at the termination of a contract

If the insurance terminates before the date agreed, the Insurance Company is entitled only to the premium for the period during which it was liable. The rest of the premium paid is returned to the policyholder.

When determining the amount of returnable premium, the validity is calculated in days according to the insurance period to which the premium pertains.

The insurance company will charge a minimum premium for each insurance period. This will not be returned even if the insurance was terminated in the middle of the insurance period.

However, the premium will not be returned to the policyholder in the case mentioned below or if the policyholder or the insured person has acted fraudulently in the circumstances referred to in clause 2.2 above. Yet no refund will be made if the sum to be returned is less than the sum in euros in the Insurance Contracts Act.

### 4.4 Setoff against premiums to be returned

The Insurance Company may deduct any outstanding premiums overdue and other overdue receivables from the premium to be returned.

## 5 Disclosure of group insurance policy information during validity of contract and at its termination

### 5.1 Insurance company's obligation to disclose information

If the terms and conditions of a group insurance contract include a provision to the effect that the insurer keeps a list of persons who are covered by the insurance, the insurer will, as soon as the contract takes effect and at reasonable intervals thereafter, dispatch the persons insured details of the scope of cover, major exclusions, obligations of the insured under the contract and how the validity of cover is dependent on the fact that the insured is a member of the group mentioned in the contract.

If the insurance company does not keep a list of insured persons, the above-mentioned information will be given to the insured in a manner specified in detail in the group insurance policy.

If the insurer or its representative has failed to provide the insured with necessary information or has provided the insured with erroneous or misleading information about it, the insurance will be considered valid in the form that he/she has had reason to understand it in the light of the information he/she was given. This does not, however, apply to information given by the insurer or its representative on compensation or benefits payable after the occurrence of an insured event.

The list of insured persons maintained by the insurance company for the purpose of calculating the insurance premium does not constitute a list of persons referred to in Section 76 of the Insurance Contracts Act.

### 5.2 Policyholders obligation to disclose information about any increase in risk

The policyholder must notify the insurance company of any changes in factors increasing risk that were reported when the insurance contract was concluded and that are relevant in terms of assessment of the insurance company's liability, such as changes in profession/occupation, leisure time activities or place of residence, or the termination of any other insurance cover. A change resulting in increased risk may be, for instance, residence abroad of the insured person for over a year on a continuous basis. The insurance company must be notified of any such changes no later than one month of receipt of the annual bulletin following such a change. Changes in the person's state of health do not have to be reported. The insurance company reminds policyholders in the annual bulletin of their disclosure obligation.

If a policyholder has wilfully or through negligence which cannot be deemed minor failed to notify the insurance company of increased risk as mentioned above, and the insurance company would not, as a result of the changed circumstances, have kept the insurance in force, the insurance company is released from liability. If, however, the insurance company would have continued the insurance but only for a higher premium or on other terms, the insurance company's liability is limited to that which corresponds to the insurance premium or the terms on which the insurance would have been continued.

If the above-mentioned consequences of failure to disclose information lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

### 5.3 Provision of information on the termination of group insurance

If a group insurance policy terminates as a result of action taken by the insurance company or the group insurance policyholder, the insurance company will notify the insured persons of such termination in the manner deemed appropriate in view of the circumstances. If agreed in the group insurance that the insurance company shall keep a list of the insured persons in the insurance, these persons will be notified of the termination of the insurance. If the insurance company does not keep a list of those insured, the notice of termination will be given in the manner agreed in the group insurance contract on providing the information specified in clause 5.1 above.

In respect of the insured, the insurance will terminate one month from the date on which the insurance company sent the insured a notice of termination or notified the insured of the termination of the insurance as agreed in the group insurance contract.

## 6 Causing an insurance event

### 6.1 Causing an insurance event

The insurance company is released from liability to any insured person who has wilfully caused a loss event.

If the insured has caused the insurance event through gross negligence, the insurance company's liability may be reduced, depending on what is deemed reasonable in the circumstances.

### 6.2 Insurance event caused by a person entitled to compensation

If a person entitled to compensation or benefit other than the insured person has wilfully caused the insurance event, the insurance company is released from liability to such party. If such a person has caused the insurance event through gross negligence or he/she was at an age or in a state of mind which meant that he/she could not be sentenced for a crime, the compensation or part of the compensation may be paid to him/her, but only when this is deemed reasonable considering the circumstances in which the insurance event was caused.

If the insured has died, the other parties entitled to compensation are paid that part of the compensation which is not paid to the person or persons who caused the insurance event.

## 7 Irresponsibility and emergency

The insurance company will not invoke clause 6 above to release itself from or restrict its liability if the insured person was under 12 years of age at the time he/she caused the insurance event or was in such a state of mind that he/she could not have been sentenced for a crime. The insurance company will not invoke clauses 5 and 6 above to release itself from or restrict its liability if the insured person was seeking to prevent injury to a person or damage to property in circumstances in which his/her negligence or action was justifiable at the time he/she increased the risk or caused the insurance event.

## 8 Beneficiary clause

### 8.1 Beneficiary

The insurance company and the policyholder agree on the beneficiary clause in the group insurance contract.

The policyholder may change the beneficiary if the right to do this has been agreed in the group insurance contract.

### 8.2 Form of the beneficiary clause

A beneficiary clause, its cancellation or amendment is null and void unless it has been submitted to the insurance company in writing.

## 9 Claims settlement procedure

### 9.1 Duties of claimant

The claimant must provide the insurance company with documents and information necessary for the assessment of the insurance company's liability.

These include documents and information which confirm whether an insurance event occurred, the extent of the loss or damage and who is to be indemnified. The claimant is required to obtain the documentation which he/she is best able to obtain, though taking into account that the insurance company may also acquire such documentation. (See clause 6 about filing a claim in the insurance terms and conditions.)

The insurance company is not required to pay compensation before it has received the above documentation.

If the claimant has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability, his/her compensation may be reduced or disallowed, depending on what is reasonable in the circumstances.

Insurance companies share a non-life insurance information system which can be used in processing claims to check claims submitted to different companies.

### 9.2 Limitation on right to obtain compensation

A claim for compensation must be presented to the insurance company within 12 months of the date when the claimant became aware of the insurance and was informed of the insurance event and the damaging consequences of that event. A claim for compensation must in any case be presented within 10 years of the date when the insurance event occurred or the damaging consequences were caused. Reporting an insurance event is comparable to presenting a claim. If the claim is not presented within the said period, the claimant loses his/her right to obtain compensation.

### 9.3 The insurance company's obligations

After the occurrence of an insurance event, the insurance company is under an obligation to provide the claimant, such as the insured person or the beneficiary, with information on the contents of the insurance and the claim procedure. No advance information given to the claimant on the compensation, its amount or method of payment will affect the payment obligation stated in the insurance contract.

The insurance company will pay the compensation resulting from the insurance event in accordance with the insurance contract or notify the claimant of non-payment of compensation without delay and, at the latest, in one

month's time of the date on which it received the documentation and information necessary for the assessment of its liability. If the amount of compensation is disputed, the insurance company will nonetheless pay any undisputed part of the compensation within the above-mentioned period.

If the total amount of compensation payable to a legally incompetent person for losses other than expenses or loss of property exceeds 1,000 euros, the insurance company will notify the guardianship authority in the locality of the legally incompetent person of such compensation.

The insurance company will pay penalty interest on any delayed payment of compensation in accordance with the Interest Act.

### 9.4 Setoff against compensation

Any one of the insurance companies may, on behalf of all of the insurance companies that may be acting as insurers in the agreement, deduct any outstanding premiums overdue and other outstanding overdue amounts from compensation.

### 9.5 Effect of sanctions on compensation

The insurance company, its subsidiary or a partner in a network underwriting insurance locally is under no obligation to pay indemnity, damages, prevention costs or investigation and legal expenses or any other financial resources if paying them is contrary to sanctions, other restrictive actions or legislation imposed by the Finnish government, the United Nations, the European Union, the United States of America or the United Kingdom or their competent authorities or governing bodies.

## 10 Lodging an appeal against decision taken by Insurance Company

### 10.1 Right to correct

If a policyholder or claimant suspects that the insurance company has made a mistake in its claim settlement decision, he/she has the right to obtain more information about matters which have led to the decision. The insurance company will revise the decision if the new investigations give cause to do so.

### 10.2 FINE

The Finnish Financial Ombudsman Bureau (www.fine.fi) offers free and independent advice and assistance. The Finnish Financial Ombudsman Bureau and the Finnish Insurance Complaints Board also give settlement recommendations in civil action cases. FINE does not handle a dispute pending in the Consumer Disputes Board or a court of justice or processed by the Consumer Disputes Board or a court of justice.

### 10.3 District court

If the policyholder or claimant is dissatisfied with the insurance company's decision, he/she may bring action against the insurance company in Finland.

Action against the insurance company's decision must be brought within three years of the policyholder or claimant being informed in writing about the insurance company's decision and the time limit. The right to bring action ceases once the time limit has expired.

Handling of a case by a board will interrupt the limitation period for the right to bring action.

## 11 The Insurance Company's right of recovery

The insured persons right to claim compensation from a liable third party for expenses arising from an illness or injury and for loss of property transfers to the insurance company up to the amount of compensation paid by the insurance company.

If the loss or damage was caused by a third party as a private person or as an employee, a civil servant or any other person comparable to these as referred to in chapter 3 of the Tort Liability Act, the right of recovery will be transferred to the insurance company only if the person in question caused the insurance event wilfully or through gross negligence or is held liable regardless of the nature of his/her negligence.

## 12 Altering an insurance contract

### 12.1 Altering the terms of contract during the insurance period

The insurance company has the right to alter the insurance premiums or other terms of contract during the insurance period to correspond with the changed circumstances if

1. the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed to observe his/her obligation to disclose information as referred to in clause 2.2 above, and if the insurance company, had it been given the correct and full information, had granted the insurance only against a higher premium or otherwise on terms other than those agreed; or
2. the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.2 above and, regardless of this, the insurance is binding on the insurance company on the basis of this clause due to the adjustment of the consequences of the failure to disclose information; or
3. during the insurance period, a change as referred to in clause 5.2 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would have granted the insurance only against a higher premium or on otherwise other terms in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance.

After being informed of the said change, the insurance company will notify the policyholder, in writing and without undue delay, of any change in the premium or other terms. The notification shall state that the policyholder has the right to cancel the insurance.

### 12.2 Altering the terms of contract of a continuous policy at the end of an insurance period

Reporting procedure

The Insurance Company has the right to alter the insurance terms and conditions, and premiums and other terms of contract at the end of the insurance period on the basis of

- new or amended legislation or a regulation issued by the authorities
- an unforeseeable change in circumstances (eg an international crisis, exceptional natural event and catastrophe)

- a change in the claims expenditure for the insurance
- age of insured person.

The insurance company also has the right to make minor changes to the insurance terms and conditions and other terms of contract provided that the changes do not affect the primary content of the insurance contract.

If the insurance company alters the insurance contract as outlined above, it will, when sending an insurance bill, notify the policyholder of the changes in the insurance premium or other terms of contract. The notification shall state that the policyholder has the right to cancel the insurance.

The change in the policy will take effect from the beginning of the next premium period or, if no premium period has been agreed, from the beginning of the next calendar year following one month from the date the notification was sent.

Changes requiring termination of insurance

If the insurance company alters the insurance terms and conditions, premiums or other terms of contract in cases other than those listed above or discontinues an actively marketed benefit, the insurance company must give written notice of termination of the insurance as of the end of the insurance period. The notice will be sent one month before the end of the insurance period at the latest.

# 13 Termination of group insurance contract

## 13.1 Policyholder's right to terminate the insurance

The policyholder has the right, at any time, to terminate the insurance contract during the insurance period. Notice of termination must be given in writing. Notice of termination given in any other manner shall be null and void. If the policyholder has not specified a later termination date, the insurance will terminate on the date the notice was submitted or sent to the insurance company.

## 13.2 Insurance company's right to terminate insurance during insurance period

During the insurance period, the insurance company has the right to terminate the insurance (or to terminate the cover for an individual insured person) if

1. the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor neglected his/her obligation to disclose information as referred to in clause 2.2 above, and the insurance company, had it been given correct and complete information, had refused to grant the insurance altogether;
2. the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.2 above and, regardless of this, the insurance contract is binding on the insurance company on the basis of that clause;
3. during the insurance period, a change as referred to in clause 5.2 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would not have granted the insurance in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance;
4. the insured person has wilfully caused the insurance event; or
5. the insured person has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability.

Having been informed of the grounds for permitting termination, the insurance company will give written notice of termination without undue delay. For an individual insured person, the insurance contract or insurance cover will terminate in one months time of the date on which the notice was sent.

## 13.3 Insurance company's right to terminate an insurance at the end of the insurance period

The insurance period and its continuation is specified in the group insurance contract. The insurance company has the right to terminate the insurance at the end of the insurance period by informing the policyholder in writing about it no later than one month before the insurance period comes to an end.

## 13.4 Termination of insurance in respect of the insured

In situations referred to above in this section, the insurance company will notify the insured person about the termination of the insurance using the procedure referred to under section 5.3.

In respect of the insured, the insurance will terminate one month from the date on which the insurance company sent the insured a notice of termination or notified the insured of the termination of the insurance as agreed in the group insurance contract.

# 14 Digital services

If the policyholder has concluded a corporate customer's digital services agreement, the policyholder may attend to his/her insurance matters in OP's digital services, such as the op.fi service. Using the services is possible to the extent determined by OP. This may include the right to view the details of insurance policies in force or to file loss reports. When the policyholder uses OP's digital services to attend to his/her insurance matters, the general terms and conditions for corporate customer's digital services, supplied to the customer when concluding the agreement, shall apply to the insurance in addition to these terms of contract.

The insurance company has the right to send all insurance-related information, such as decisions, messages, notifications, responses, changes and notices of termination only electronically to OP's online and mobile services. The policyholder has the right to receive the aforementioned information by post within reasonable time from the day on which the policyholder informed the insurance company that he/she wishes to receive the information by post.

# 15 Applicable law and calculation bases

The insurance is subject to Insurance Contracts Act and other Finnish law.

Pohjola Insurance Ltd, Business ID: 1458359-3

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Domicile: Helsinki, main line of business: non-life insurance companies
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