Critical Illness Insurance

Insurance terms no. LJ31

Valid from 18.10.2018

The insurance contract is governed by:

- The insurance policy including endorsements and special terms.
- These insurance terms, no. GH15.
- The company's General Terms, no. YY10.
- The Insurance Contracts Act No. 30/2004.

The provisions of the insurance policy and of the renewal receipt take precedence over the provisions of the insurance contract terms. The provisions of the insurance policy, renewal certificate, and insurance terms shall supersede any statutory provisions that may be derogated.

This is a translation of the authoritative Icelandic text. In the event of any discrepancies between the translation and the original Icelandic text, the original text shall prevail.

The insurer is Líftryggingarfélag Íslands hf.

Contents:

Introduction

The insurance covers the following illnesses, operations and other insurance events according to the further provisions of these terms and conditions:

- Cancer
- Bone marrow transplant
- Coronary thrombosis / myocardial infarction
- Coronary surgery / bypass surgery
- Valvular surgery
- Aortic surgery
- Stroke
- Renal impairment
- Multiple sclerosis (MS)
- Motor neuron disease (MND)
- Alzheimer's
- Parkinson's disease
- Benign brain tumours

- Deafness
- Meningitis caused by bacterial infection
- Blindness
- Severe head injuries
- Aphasia
- Paralysis
- HIV/AIDS
- Organ transplants
- Severe burns
- Loss of extremities

1. The insured and the co-insured

1.1 The insured is the party named in the insurance policy or policy renewal receipt.

1.2 The co-insured are the children of the insured, together with his stepchildren and foster children who have the same domicile and live in the same place as the insured.

2. Insurance policy's validity

The insurance is valid universally.

3. Commencement and end of liability

3.1 The company's coverage begins when the company has accepted and approved the application for critical illness insurance, unless otherwise negotiated. The insurance is renewed annually but no longer, however, then until the insured reaches the age of 70.

3.2 The company's coverage of the children, stepchildren and foster children of the insured begins when the child is aged 3 months and ends when the child reaches the age of 18.

3.3 Compensation is not paid unless a covered disease is diagnosed during the period that the insurance is in effect or if another insurance event covered by the insurance policy takes place during the period in which the insurance is in effect. In the event that a disease is diagnosed after the insurance has expired, the company is not liable even though it may be argued that the disease was present while the insurance was in effect.

3.4 Once the insured has been paid compensation, the insurance policy will expire. This does not apply if compensation was paid for a child, stepchild or foster child. When compensation has been paid for a child, stepchild or foster child, the child in question no longer enjoys insurance coverage from the policy.

4. Classification of insurance events and revival of insurance

4.1 Illnesses and other insurance events covered by the insurance are classified into four compensation categories, depending on their nature and type. The compensation categories are cancer, cardiovascular and kidney diseases, neurological and degenerative diseases, and other insurance events.

4.2 When the insurance policy expires in accordance with Article 3.4 due to the payment of compensation, the insured is entitled to revive the insurance policy without the disclosure of new state of health information, provided that the policy is revived in writing within three months from the date of expiry. When the insurance policy is revived, compensation is not paid:

4.2.1 Again from the compensation category from which the company has already paid compensation.

4.2.2 For illness or other insurance events that can be directly or indirectly traced to insurance events for which the company has already paid compensation.

4.3 The insured is not entitled to an increase in the insurance amount according to Article 7 once the insurance policy has been revived according to Article 4.

5. Scope of coverage

I. Cancer

From category one, the company will pay compensation for:

5.1 Cancer

5.1.1 Malignant tumours characterized by uncontrollable growth, distribution of malignant cells and invasive growth in tissue. The diagnosis must be confirmed by a cancer specialist and supported by a tissue analysis. Leukeamia, malignant lymphomas and myelodysplastic syndrome are included under this definition unless otherwise specified.

5.1.2 Microinvasive breast carcinoma, histologically defined as T1mic, if the condition requires breast removal, chemotherapy or radiotherapy.

5.1.3 Microinvasive carcinoma of the cervix uteri, histologically defined as IA1, if the condition requires a hysterectomy, chemotherapy or radiotherapy.

5.1.4 Lymphoma of the skin if the condition requires chemotherapy or radiotherapy.

5.1.5 Prostate cancer if histologically defined as having a Gleason score higher than 6 or has developed to TNM stage T2N0M0.

Exemptions:

5.1.6 All tumours histologically defined as pre-malignant and which do not grow invasively or in situ, including ductal and lobular carcinoma in situ of the breast and cervical dysplasia CIN-1, CIN-2 and CIN-3.

5.1.7 Chronic lymphocytic leukaemia (CLL), unless it has developed to at least Binet stage B.

5.1.8 Basal cell carcinoma, squamous cell carcinoma and malignant melanomas stage IA (T1aN0M0) unless there are signs of mestastises.

5.1.9 Thyroid tumours less than 1 cm in diameter and histologically defined as T1N0M0.

5.1.10 Polycythemia rubra vera and essential thrombocythemia.

5.1.11 Monoclonal gammopathy of undetermined significance (MGUS).

5.1.12 Gastric MALT Lymphoma if the disease can be treated by Helicobacter consolidation.

5.1.13 Gastrointestinal Stromal Tumour (GIST), stages I and II according to the AJCC Cancer Staging Manual, Seventh Edition – 2010.

5.1.15 Cancer when the human immunodeficiency virus (HIV) is present.

5.2 Bone marrow transplantation

Bone marrow transplantation when the insured has received bone marrow (allogeneic hematopoietic stem cell transplantation preceded by total bone marrow ablation).

II. Cardiovascular and kidney diseases

From category two, the company will pay compensation for:

5.3 Coronary thrombosis / myocardial infarction

5.3.1 Coronary thrombosis is necrosis in part of the heart muscle due to insufficient flow of blood. The diagnosis must be confirmed by a cardiologist. The diagnosis means that the coronary thrombosis is confirmed by measuring raised and/or lowered cardiac enzymes (Troponin or CKMB) and at least two of the following:

5.3.1.1 Symptoms of ischaemia, e.g. chest pain.

5.3.1.2 New characteristic changes to electrocardiogram that indicate ischaemia, such as new ST-T changes or new left bundle branch block.

5.3.1.3 Development of abnormal Q waves in electrocardiogram.

Exemptions:

5.3.4 Acute coronary syndrome (ACS), i.e. stable or unstable angina pectoris.

5.3.5 Elevated troponin without coronary heart disease, e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism and drug toxicity.

5.3.6 Coronary thrombosis / myocardial infarction caused by narcotics use.

5.3.7 Coronary thrombosis / myocardial infarction occurring within 14 days of undergoing coronary angioplasty) or bypass surgery.

5.4 Coronary artery bypass graft surgery

5.4.1 Heart surgery to correct a narrowing or blockage of one or more coronary arteries by using bypass grafts. Compensation is paid for heart surgery where the sternum is cloven and minor intervention operations (partial sternotomy or thoracotomy). Evidence for the necessity of the surgery must be provided based on the conclusions of cardiology specialists and must be supported by a coronary angiography.

Exemptions:

5.4.2 Coronary angioplasty or the insertion of a stent.

5.5 Heart valve surgery

Surgery to repair heart valves or insert prosthetic valves to replace one or more heart valves. The surgery must be defined a medical necessity by a cardiologist and supported by an echocardiogram or the results of cardiac catheterisation.

The following surgeries fall under the above definition:

5.5.1 Heart valve replacement or repair with full sternotomy, partial sternotomy or thoracotomy.

5.5.2 Ross surgery.

5.5.3 Repair of health valve by valvuloplasty.

5.5.4 Transcatheter aortic valve implantation.

Exemptions:

5.5.5 Transcatheter mitral valve clipping.

5.6 Surgery of the aorta

5.6.1 Surgery to fix a narrowing, obstruction, aneurysm or dissection of the aorta. Minor intervention surgery, such as endovascular repairs, are also compensated. The surgery must be defined as a medical necessity by a cardiologist and supported by radiograph investigations. Aorta refers to the actual aorta in the chest and abdomen and not its collateral branches.

Exemptions:

5.6.2 Aortic surgery due to hereditary connective tissue disease such as Marfan- and Ehlers-Danlos syndrome.

5.6.3 Surgery following injury to the aorta caused by an accident.

5.7 Stroke

5.7.1 Brain tissue necrosis due to acute ischaemia or bleeding in the brain, including subarachnoid bleeding or thromboembolisms originating outside the brain.

Neurological impairment must be in evidence for at least three months following diagnosis, which shows a sudden beginning of new neurological symptoms and new objective neurological symptoms on clinical examination.

Diagnosis must be confirmed by a neurologist and supported by radiograph investigations.

Exemptions:

5.7.2 Transient ischaemic attack and prolonged reversible ischaemic neurological deficit.

5.7.3 Injury to brain tissue or brain arteries.

5.7.4 Neurological impairment due to general ischaemia, infection, inflammatory diseases, migraine or medical intervention.

5.7.5 Incidental diagnosis of deviations during radiograph investigations without clear related clinical symptoms (silent stroke).

5.8 Renal disease

5.8.1 Chronic and irreversible kidney failure in both kidneys leading to either regular dialysis (haemodialysis or peritoneal dialysis) or a kidney transplant. The dialysis must be medically necessary and confirmed by a nephrologist.

Exemptions:

5.8.2 Acute reversible kidney failure requiring short-term dialysis.

5.9. Heart or kidney transplantation

Transplant surgery in which the insured has received a heart or kidney.

III. Neurological and degenerative diseases

From category three, the company will pay compensation for:

5.10 Multiple sclerosis (MS)

5.10.1 Unequivocal diagnosis of multiple sclerosis (MS) confirmed by a neurologist supported by all the following criteria:

5.10.1.1 Permanent clinical impairment of motor or sensory organs, which must be in evidence for at least six consecutive months.

5.10.1.2 MRI scan showing at least two demyelination patches in the brain or spinal cord that are typical for MS.

Exemptions:

5.10.2 Non-confirmed multiple sclerosis and neurological or radiograph-assessable isolated symptoms indicating MS but which are not typical to the disease.

5.10.3 Isolated optic neuritis and neuromyelitis optica.

5.11 Motor neuron disease (MND)

Definite diagnosis of motor neuron degeneration, i.e. amyotrophic lateral sclerosis (ALS), primary lateral sclerosis (PLS), progressive muscular atrophy (PMA) and progressive bulbar palsy (PBP). Diagnosis of the disease must be carried out by a neurologist and confirmation provided that the disease has persisted for at least three months with a significantly small chance of improvement.

5.12 Alzheimer's

5.12.1 Definite diagnosis of Alzheimer's disease before the age of 60 together with all the following aspects:

5.12.1.1 Loss of cognitive ability involving memory impairment and impairment of executive functioning, e.g. to connect, activate, organize, integrate and control, which causes significant deterioration of mental and social ability.

5.12.1.2 Personality changes.

5.12.1.3 Progressive impairment of cognitive ability.

5.12.1.4 No impairment of consciousness.

5.12.1.5 Typical results of neurological tests or radiograph assessment, e.g. CT scans.

5.12.2 The insured requires constant monitoring day and night. The diagnosis and care requirement must be confirmed by a neurologist or geriatrist.

Exemptions:

5.12.3 Other types of dementia caused by brain, systemic diseases or mental disorders.

5.13 Parkinson's disease

5.13.1 Unequivocal diagnosis of Parkinson's disease of unknown origin before the age of 60 carried out by an expert in neurological diseases. The diagnosis must be supported by at least two of the following clinical symptoms.

5.13.1.1 Muscle rigidity.

5.13.1.2 Tremors.

5.13.1.3 Bradykinesia, i.e. unnatural slowness of movement, poor physical and mental response rate.

5.13.2 The disease must have caused permanent disability to independently perform three or more of the following activities of daily life: bathe, get dressed/undressed, move between rooms, get out of bed and onto a chair or from a chair into bed, control excretion and urination and be able to eat on his own. Medical confirmation must be obtained that these conditions have persisted for at least three months despite receiving the appropriate drug therapy.

5.1.3.3 The insertion of neurostimulators which are intended by means of brain stimulators to control symptoms which are independent of the activities of daily life as defined under Article 5.13.2. The insertion of stimulators must be determined as a medical necessity by a neurologist.

Exemptions:

5.13.4 Derived parkinsonism, including that caused by narcotics or toxins.

5.13.5 Essential tremors.

5.13.6 Parkinsonism related to other neuron diseases.

5.14 Benign brain tumour

5.14.1 Confirmed diagnosis of benign brain tumour not defined as malignant growth located within skull and localised in brain, meninges or cranial nerves. Tumour must be treated with at least one of the following:

5.14.1.1 Surgery that removes the cancer fully or partially.

5.14.1.2 Stereotactic radiosurgery.

5.14.1.3 Radiotherapy (external beam radiation).

5.14.2 If none of the above treatments is possible for medical reasons, the tumour must have caused permanent cerebral or neurological impairment for at least three months prior to diagnosis. The diagnosis must be confirmed by a neurologist or neurology surgeon and supported by radiograph assessment.

Exemptions:

5.14.3 All cysts.

5.14.4 Granulomas.

5.14.5 Malformations of the brain's arteries or veins.

5.14.6 Haematomas.

5.14.7 Pituitary tumours.

5.15 Deafness

Unequivocal, permanent and irreversible loss of hearing in both ears due to illness or accident. The diagnosis must be confirmed by an otorhinolaryngologist and supported by hearing measurements where the limits of hearing are on average over 90 decibels at the 500, 1000 and 2000 Hz in the ear where hearing is better.

5.16 Bacterial Meningitis

Unequivocal diagnosis of bacterial infection in membranes covering the brain or spinal cord and leading to permanent neurological impairment confirmed as persisting for at least three consecutive months following diagnosis. The diagnosis must be confirmed by a neurologist and supported by the growth of pathogenic bacteria in cultivations from cerebrospinal fluids.

5.17 Profound Vision Loss

Complete, permanent and irreversible loss of sight in both eyes due to disease or accident that cannot be remedied by laser surgery (refractive correction), medicinal treatment or other surgery. Significant loss of sight confirmed with either optometry 3/60 or less (0.05 or less infractions) in the better eye after the most optimal correction, or less than 10° range of vision in the better eye after the most optimal correction. The diagnosis must be confirmed by an ophthalmologist.

5.18 Major head trauma

5.18.1 Unequivocal diagnosis of serious head trauma that causes disruption of brain function. The diagnosis must be confirmed by a neurologist and supported by radiograph assessment of the nervous system with either a CT scan or MRI scan. The head injury must have caused the insured to be permanently unable to independently perform three or more of the following activities of daily life: bathe, get dressed/undressed, move between rooms, get out of bed and onto a chair or from a chair into bed, control excretion and urination and be able to eat. Medical confirmation must be obtained that these conditions have persisted for at least three months with little or no hope of improvement.

Exemptions:

5.18.2 Severe head injury that can be traced to self-harm, alcohol or narcotics use.

5.19 Loss of speech

5.19.1 Complete and permanent loss of speech due to disease or accident. The loss of speech must have been persistent for six consecutive months. The diagnosis must be confirmed by a medical expert.

Exemptions:

5.19.2 Loss of speech that can be traced to mental disorders.

5.20. Paralysis of Limbs

5.20.1 Complete and irreversible paralysis of two or more extremities caused by an accident or spinal cord or cerebral disorder. Extremities are defined as a complete leg or arm. The paralysis must have persisted for three or more consecutive months. Diagnosis must be confirmed by a neurologist and supported by clinical diagnosis.

Exemptions:

5.20.2 Paralysis due to self-harm or mental disorders.

5.20.3 Guillain-Barré syndrome.

5.20.4 Temporary or hereditary paralysis.

IV. Other insurance events

From category four, the company will pay compensation for:

5.21 HIV/AIDS

5.21.1 Infection with HIV or confirmed diagnosis of AIDS, which can be traced to blood or blood component transfusion and fulfils all the following conditions:

5.21.1.1 The infection was due to a blood or blood component transfusion that was medically necessary and was performed prior to the entry into effect of the insurance policy.

5.21.1.2 The institution or blood bank that provided the blood or blood components is officially recognised as such by the health authorities.

5.21.1.3 The medical facility where the blood or blood component transfusion admits its responsibility.

5.21.1.4 The HIV virus must be detectable in the blood 12 months after the blood or blood transfusion.

5.21.2 The insured became infected with HIV/AIDS due to an event in the line of duty when working in health care services, nursing, fire brigade, prison guard duties or police force and occurring during the effective term of the insurance policy.

5.21.2.1 The employer must be notified of all incidents that could possibly lead to a claim for compensation due to HIV infection pursuant to Article 5.21.2.

5.21.2.2 Blood samples must be taken within 5 days from the event.

5.21.2.3 Another antibody test must be given, confirming that HIV antibodies were detected within 12 months.

Exemptions:

5.21.3 HIV infections due to infection vectors other than those mentioned in Articles 5.21.1 and 5.21.2 above, such as due to narcotics use or sexual activity.

5.21.4 HIV infection due to blood or blood component transfusion due to haemophilia or hereditary blood disease (thalassaemia).

5.22 Transplantation

5.22.1 Organ transplantation where the insured has received lungs, liver, pancreas or small intestine.

5.22.2 Organ transplants where the insured has received part of or an entire face, hand, arm or foot (composite tissue allograft transplantation).

5.22.3 Condition that leads to a graft or implant must be judged completely untreatable and confirmed as such by a medical specialist.

5.23 Third-degree burns

5.23.1 Third-degree skin burn consisting of full-thickness burn and extending into the underlying tissue. Third-degree burn must cover at least 20% of the body's surface according to the definition "The Rule of Nines" or the "Lund and Browder Chart" and occur against the will of the insured. The diagnosis must be confirmed by an expert with extensive experience in the treatment of burns.

5.24 Loss of Limbs

5.24.1 Permanent loss of two or more extremities above or at the wrist or ankle due to an accident or due to amputation for medical reasons. The diagnosis must be confirmed by a medical expert.

Exemptions:

5.24.2 Loss of limbs due to self-harm.

The company does not pay compensation for:

5.25 Illness, surgery or other insurance event that can be directly or indirectly traced to the condition of the insured's child, stepchild or foster child prior to the entry into effect of the insurance and which the insured knew about or should have known about. In the same manner, no compensation is paid due to the illness, surgery or other insurance event that may verifiably be traced to the condition of a child prior to the date on which the insurance enters into effect, i.e at the age of three months as provided for in Item c of the first paragraph of Article 86 of Act No. 30/2004 on Insurance Contracts, as the company does not collect information on the health of the child.

5.26 Cancer, multiple sclerosis, loss of hearing and meningitis, diagnosed during the first three months after the entry into effect of the insurance.

5.27 Illness, surgery or other insurance event if the insured does not survive for at least 30 days from being diagnosed with an illness, from having surgery performed or occurrence of another insurance event. The same applies to insured children, stepchildren and foster children.

5.28 Illness, surgery or other insurance event which directly or indirectly is caused by nuclear changes, ionising radiation, radioactive pollution, nuclear fuel and nuclear waste or caused by war, invasion, riots, strikes or similar actions.

5.29 Illness, surgery or other insurance event directly or indirectly caused by earthquakes, volcanic eruptions, landslides, avalanches or other natural disasters.

5.30 An illness, unless the diagnosis has been approved by an Icelandic expert in the speciality in question.

6. Insurance amount

6.1 The amount of insurance coverage is indicated in the insurance policy or in the renewal receipt.

6.2 The amount of insurance coverage for children is 50% of the insurance amount specified in the insurance policy or the renewal certificate. The maximum compensation for each child is ISK 12,350,000, based on a consumer price index of 430 points, irrespective of whether more than one insurance policy from which the child may be entitled to compensation is in effect with the company.

6.3 Payment of compensation from the insurance policy for children, stepchildren and foster children has no effect on the insurance coverage of others insured under the policy.

6.4 The amount of insurance coverage shall increase in accordance with changes in the consumer price index.

6.5 In the event that consumer price index decreases, this will not have the effect of decreasing the insurance amount.

7. Right to raise the insurance coverage amount without a state-of-health declaration

7.1 If the premium for the insurance is determined without a premium surcharge, the insured can apply, in writing, for an increase in the insurance amount without supplying further information on his state of health within three months from the date that either of the following events occur:

7.1.1 The insured has a child during the effective term of the insurance.

7.1.2 The insured adopts a child under the age of 18 during the effective term of the insurance.

7.2 The maximum increase of the insurance amount is 25% of the amount. This amount, however, is limited to a maximum of ISK 4,659,000, based on a consumer price index of 430 points, for each child. This right can only be exercised for four children.

7.3 This right is cancelled when the insured reaches the age of 45.

7.4 On the increase of the insurance coverage amount, the premium paid by the insured shall increase in accordance with the company's premium rates. The increase in premiums applies on the next due date after all conditions have been met.

7.5 This right cannot be exercised after compensation has been claimed or the insured has been diagnosed with any of the diseases or undergone any of the surgeries defined in Article 5.

8. Duty to inform when entering into an insurance contract

8.1 The policyholder or the insured, as the case may be, must provide the company with the information that it requests when entering into the insurance contract. Additionally, he should initiate the provision of information to the company about certain circumstances he knows or should know as being of considerable importance for the company's risk assessment.

8.2 If it becomes clear to the policyholder or the insured that he has provided incorrect or unsatisfactory information about the risk, he shall inform the company accordingly without undue delay.

8.3 If the policyholder or the insured has neglected his duty to provide information to an extent that is not deemed insignificant, the company's liability may become void in full or in part.

9. Change in risk

The company must be immediately informed of any changes that can have an impact on the company's risk, such as about smoking or particular risks connected to recreational activities. If the policyholder or the insured do not notify the company of the change in risk, this may result in the loss of entitlement to compensation, as provided for in Act No. 30/2004 on Insurance Contracts.

10. Premium calculation

10.1 The insurance premium is dependent on age and whether the insured smokes, and changes annually on renewal. In the event that premiums are paid on more than one due date per year, later payments will increase in the same proportion as the insurance amount. If the insurance amount increases by more than 35% within each year due to increases in the consumer price index, the company reserves the right to collect an additional premium for increases beyond that level.

10.2 The company reserves the right to determine a renewal premium with regard to general modifications of the risks involved, changes to the purchasing power of the Icelandic króna (ISK) and other causes which disrupt the compensation base.

11. Premium payment

11.1 The first insurance premium is due and payable upon demand. The renewal premium becomes due on the renewal date of the insurance.

11.2 Default in the payment of the premium may cause the loss of rights and the termination of an insurance contract, as provided for in Article 96 of the Act on Insurance Contracts No. 30/2004.

12. Premium refund

In the event that an insurance contract is cancelled before the period of insurance has expired, the company will return the premium for the period paid by the insured in proportion to the period when the insurance contract was not in effect. This does not apply if an insurance contract is invalid because the company has completed its duties by paying the agreed sum insured.

13. Premium discount due to loss of work capacity

13.1 In the event that the insured has lost his capacity to work or if such capacity has been reduced by at least half, the insured gains the right to a premium discount for the time that the loss of capacity persists in excess of six months but no longer, however, than to the age of 65 and not due to insurance events that are compensable according to Article 5 of these terms. Premium discounts are not granted for longer than one year retroactively from the date that a request for premium discount was received by the company.

13.2 Complete loss of capacity provides the right to full premium discount and a 50% or more loss of capacity the right to a proportionate premium discount. The insured, however, is not entitled to a premium discount if the loss of capacity is due to the abuse of alcohol, addictive or narcotic substances.

13.3 Requests for premium discounts must be in writing. Such requests must be accompanied by confirmation from Tryggingastofnun ríkisins (the Social Insurance Administration) with regard to the loss of capacity, at no cost to the company. The insured's ability to undertake his former work, and possibility of undertaking other work, must be used as the basis for the evaluation of the loss of capacity to work.

13.4 The insured must immediately notify the company if he regains his capacity to work in part or in full. During the period that the insured enjoys the premium discount, the company may at any time require information on the insured's health and may also require a medical examination at its own cost.

13.5 The company informs the insured of its decision on the premium discount in writing.

14. Netting

The company may set off a defaulted premium payment against the insurance benefits it must pay, as provided for in Article 122 of Act No. 30/2004 on Insurance Contracts.

15. Cancellation during period of insurance

15.1 The company may cancel the insurance:

15.1.1 With 14 days' notice if incorrect or unsatisfactory information is provided on the insured risk, as provided for in Article 84 of Act No. 30/2004 on Insurance Contracts.

15.1.2 Immediately, if the policyholder has fraudulently neglected his duty to provide information about the insured risk, as provided for in Article 84 of Act No. 30/2004 on Insurance Contracts.

15.2 The insured can cancel the insurance contract at any time with a written cancellation.

16. Insurance event notice

16.1 The insured must notify the company of any insurance event without undue delay.

16.2 The insured loses the right to compensation if he does not notify the company of his claim within one year from the date he knew about the circumstances upon which it is based or if the company has not received notification of the insurance event in another manner.

17. Intent

17.1 If an insurance event may be attributed to intent on behalf of the insured, he has no claim against the company for compensation unless he was unable to realise the consequences of his conduct due to his age or mental condition.

17.2 Compensation is not paid if the insurance event is the consequence of attempted suicide within one year from the date that the insurance came into effect, unless it is proven that the insurance was purchased with no intent of suicide.

18. Fraudulent conduct

Anyone acting fraudulently towards the company loses all his rights under the insurance contract. In the event of several insurance contracts, he may also lose his right to compensation under them in respect of the same insurance event, as provided for in Articles 83 and 120 of Act No. 30/2004 on Insurance Contracts.

19. Claim for compensation

The insured may demand payment of compensation 14 days after the company had the opportunity to obtain the necessary documentation in order to determine its liability, as provided for in Article 121 of Act No. 34/2004 on Insurance Contracts.

20. Interest on indemnification

Entitlement to interest on the compensation amount is in accordance with Article 123 of Act No. 30/2004 on Insurance Contracts.

21. Duty to inform when settling indemnity payments

21.1 When settling indemnity payments, the insured shall provide the company with information and deliver documentation to which he has access and which the company needs for assessing its liability and determining compensation.

21.2 If the insured intentionally provides incorrect or unsatisfactory information that he knows or should know will lead to him being paid compensation to which he is not entitled, all of his rights according to this and other insurance contracts because of the particular insurance event will become void. Under specific circumstances, however, the insured may have a right to partial compensation, as provided for in Article 120 of Act No. 30/2004 on Insurance Contracts. Moreover, such conduct may lead to the termination of the insurance contract, as provided for in Article 15.1.

22. Lapse of claim

The right to claim the insurance amount expires after ten years. The ten-year period begins at the end of the calendar year in which the claimant received the necessary information about the events on which his claim is based. However, the right to claim compensation expires no later than 20 years after the end of the calendar year in which an insured event took place.

23. Time limit to seek remedial action

If the company rejects, in full or in part, a claim by the insured, he loses his right to compensation if he has not begun litigation procedures or demanded that the case be referred to procedure before the Insurance Complaints Committee within one year after receiving written notification about the rejection of his claim, as provided for in Article 124 of Act No. 30/2004 on Insurance Contracts.

24. Pledges

The insured may pledge this insurance, as provided for in Article 107 of Act No. 30/2004 on Insurance Contracts.

25. Notice of change of address

The policyholder shall notify the company immediately if he changes his address.

26. Currency

All amounts pertaining to this insurance contract are in Icelandic currency (ISK) unless otherwise stated by law or negotiated separately.

27. Dispute handling

27.1 Disputes with the company may be presented to the Insurance Ruling Committee according to Act No. 30/2004 on Insurance Contracts.

27.2 The rulings by the Insurance Complaints Committee may be brought before courts of law.

28. Protection of personal privacy and processing of personal data

The company places great importance on security in the processing of personal data. The employees of the company are required to maintain professional secrecy and confidentiality as regards any processing of personal data, and all the company's processing of personal data is carried out in accordance with Act No. 90/2018 on the Protection of Personal Privacy and Processing of Personal Data and the rules established thereunder. Further information on the processing of personal information may be found in the rules that the company has established for itself on the website of the company, vis.is (in Icelandic only), including as regards what personal information the company collects, for what purpose and on the basis of what authorisations, how long the information is kept and what rights customers have as regards the company's processing of such information.

29. Venue

The domicile and venue of VÍS are in Reykjavík. Any disputes arising from this insurance policy shall be brought before the District Court of Reykjavík.