Personal Insurance Terms and Conditions
Condition HEN 100.25, valid as of 1 January 2024

This is a translation of the original Terms and Conditions in Finnish which, in case of discrepancies, are valid.

Personal Insurance products
If's personal insurance can include cover for treatment expenses (3.1) and temporary disability (3.4), covers for treatment expenses arising from an accident (3.2), temporary disability due to an accident (3.5), permanent handicap caused by an accident (3.9) and death caused by an accident (3.12), death cover (3.11), cover for permanent disability caused by a serious illness or accident (3.13) and readjustment cover (3.14). Cover for treatment expenses (3.1) can also include additional cover for physical therapy (3.1.1), cover for treatment expenses arising from an accident (3.2) and additional cover for treatment expenses arising from an accident (3.2.1). Of these covers, the following covers are offered for a child who is at least seven (7) days but less than 15 years of age: 3.2, 3.2.1, 3.9 and 3.12.

Sickness insurance for a young person (formerly Baby Insurance/Childhood Insurance) includes cover for treatment expenses (3.1), cover for permanent handicap caused by an accident (3.9) and cover for death caused by an accident (3.12). Insurance granted in 2017 also includes additional cover for physical therapy (3.1.1). The sale of this insurance has been discontinued on 31 December 2017.

If's child insurance includes cover for treatment expenses (3.1), additional cover for physical therapy (3.1.1), cover for permanent handicap caused by an accident (3.9) and cover for death caused by an accident (3.12). If insurance has been granted for an unborn baby, it also includes cover for a serious congenital illness or defect (3.15), cover for hospital care of a child (3.16) and cover for hospital care of a mother (3.3). The child insurance can also include a family readjustment cover (3.10).

If's child insurance granted prior to 1 January 2018 includes cover for treatment expenses (3.1), cover for permanent handicap (3.8), a family readjustment cover (3.10) and cover for death caused by an accident (3.12). Insurance granted in 2017 also includes additional cover for physical therapy (3.1.1).

According to the Trade Union Insurance Contract, accident insurance related to the **If's trade union insurance** can include cover for treatment expenses arising from an accident (3.2), cover for permanent handicap caused by an accident (3.9), and cover for death caused by an accident (3.12).

The contents of the **personal and baby insurance and sickness insurance for a young person** comprise the Policy Document, these Insurance Terms and Conditions and the General Terms and Conditions. The products and covers included in an Insurance Contract are stated in the Policy Document.

With respect to the **trade union insurance**, these terms and conditions, as well as the Trade Union Insurance Contract concluded with the trade union, are observed where applicable.

Key concepts used in the terms and conditions
Accident refers to a sudden and unforeseeable occurrence which arises from an external factor and causes bodily injury against the will of the Insured. In addition, the following occurrences, unintended by the Insured, are considered accidents: drowning, heat-stroke, sunstroke, frostbite, gas poisoning, sudden injury caused by considerable fluctuations in air pressure and intoxication caused by a substance taken inadvertently.

ICD-10 refers to the International Classification of Disease by the World Health Organisation (WHO), the application of which has been ordered by the Ministry of Social Affairs and Health in Finland.

1 Validity of the insurance
1.1 Territorial limits
The insurance covers are valid world-wide. However, compensation for treatment expenses on the basis of illness or from the additional cover for treatment expenses arising from an accident is only paid for treatment expenses incurred in Finland.

1.2 Period of validity
Continuous insurance covers under the **personal insurance** expire, at the latest, at the end of the insurance period during which the Insured reaches the following ages:
1) Coverage for treatment expenses expires at the age of 80 years. Additional cover for physical therapy (3.1.1) expires at the age of 80 years. If the treatment expenses cover to which the additional cover has been attached expires earlier, the additional cover will also expire.
2) Coverage for treatment expenses arising from an accident expires at the age of 100 years. When the Insured reaches the age of 80 years, the sum insured is reduced as of the beginning of the next insurance period in such a manner that the new sum insured is the remaining sum insured, however, not exceeding EUR 10,000. Additional cover for treatment expenses arising from an accident (3.2.1) expires at the age of 80 years. If the treatment expenses cover to which the additional cover has been attached expires earlier, the additional cover will also expire.
3) Coverage for temporary disability expires when the Insured retires, however, at the latest at the end of the insurance period during which the Insured reaches the age of 70.
4) Coverage for temporary disability caused by an accident expires when the Insured retires, however, at the latest at the end of the insurance period during which the Insured reaches the age of 70.
5) Coverage for hospital care expires at the age of 65 years.
6) Coverage for hospital care due to an accident expires at the age of 65 years.
7) Coverage for permanent handicap expires at the age of 60 years. It then becomes cover for permanent handicap caused by an accident (Cover 9).
8) Coverage for permanent handicap caused by an accident expires at the age of 100 years. When the Insured reaches the age of 80 years, the sum insured is reduced to EUR 20,000 as of the beginning of the next insurance period.

9) Death Cover expires at the age of 90 years. Joint cover for two people expires when the older Insured reaches the age of 90 or either Insured dies.
10) Coverage for death caused by accident expires at the age of 100 years. When the Insured reaches the age of 80 years, the sum insured is reduced to EUR 5,000 as of the beginning of the next insurance period.
11) Coverage for permanent disability caused by a serious illness or accident expires when the Insured retires, however, at the latest at the end of the insurance period during which the Insured reaches the age of 60.
12) Readjustment cover expires at the age of 65 years.

Sickness insurance for a young person expires at the end of the insurance period during which the Insured reaches the age of 25.

Child insurance and related covers expire at the end of the insurance period during which the Insured reaches the age of 80. However, the family readjustment cover expires at the end of the insurance period during which the Insured turned 18. If the insurance was taken out before the child's birth, the cover for a serious congenital illness or defect (3.15), the cover for hospital care of a child (3.16) and the cover for hospital care of a mother (3.3) expire when the baby is born. However, any compensation will be paid in accordance with the terms and conditions for the said insurance covers. Treatment expenses covered under the cover for treatment expenses (3.1) can only arise once the baby is officially considered as born alive.

The child insurance granted prior to 1 January 2018 and related covers expire at the end of the insurance period during which the Insured reaches the age of 25.

When If Baby Insurance or If Child Insurance expires due to the insured turning 25, the insured becomes entitled to accident insurance without having to fill in a new health declaration. This insurance must include cover for treatment expenses, permanent handicap and death caused by an accident. The maximum compensation payable under the accident insurance will not, however, exceed the remaining sum insured of the insurance at its expiry, and will not include any deductibles. More information on how to exercise the entitlement to continuation is provided in section 1.4.2.

Accident insurance related to the trade union insurance expires at the age specified in the Trade Union Insurance Contract.

The full-time insurance is valid twenty-four hours a day during both work and leisure time. **The leisure time insurance** is valid during leisure time only. If the insurance covers valid in case of accident (3.2, 3.5, 3.7, 3.9 and 3.12) are valid during leisure time only, this is stated in the Policy Document. When the Insured retires, insurance cover valid during leisure time only is amended to full-time insurance, and the insurance premium will be adjusted in accordance with the new period of validity. Accident insurance related to the trade union insurance is only valid during leisure time.

The leisure time insurance does not cover accidents referred to in the Employment Accidents Insurance Act, the Workers' Compensation Act or other corresponding legislation, which occur on the way to or from the workplace when the Insured is working in a gainful occupation or as an independent self-employed person or in some other corresponding activity.

1.3 Validity in sports activities

1.3.1 Exclusion concerning sports activities

The exclusion concerning sports activities does not apply to persons under 12 years of age. The exclusion is valid from the end of the insurance period during which the Insured turns 12 years of age.

The insurance is not valid in the case of accidents caused by
1) sports activities when the Insured participates in a competition, match or training organised by a sports federation or club, or when training in accordance with a training programme
2) climbing, e.g., mountain, wall, rock or ice climbing, or bouldering
   Of the aforementioned forms of climbing, the exclusion does not apply to wall climbing when protective and safety equipment to prevent falls is used.
3) glacier hiking
4) martial arts
5) motor sports
6) sports or scuba diving
7) air sports, e.g. parachuting, hang-gliding, parachute gliding, gliding, hot-air ballooning, bungee jumping, flying microlites or other aircraft for recreational purposes
8) strength sports, e.g. weightlifting, powerlifting and strongman sports
9) off-piste skiing.
10) roller derby
11) kitewing and kite surfing
12) downhill skating.

The exclusion concerning sports activities for the sports listed above may be eliminated by means of a separate agreement and by paying an additional premium (Sports cover).

Since the insurance will not be at all valid for the following sports activities, the exclusion concerning sports activities cannot be eliminated:
1) American and Australian football and rugby
2) base jumping
3) speed skiing and downhill racing
4) bodybuilding
5) free fighting

The exclusion concerning sports activities is applied to the following insurance covers:
1) Cover for treatment expenses
2) Cover for treatment expenses arising from an accident
3) Cover for temporary disability
4) Cover for temporary disability caused by an accident
5) Cover for hospital care
6) Cover for hospital care due to an accident
7) Cover for permanent disability caused by a serious illness or accident
8) Readjustment cover.

Other insurance covers are valid in sports activities.

The exclusion concerning sports activities may be eliminated from the covers referred to in sections 1–4 of the personal, baby and sickness insurance for a young person insurances (Sports cover). If the exclusion concerning sports activities has been eliminated, this is stated in the Policy Document. Sports activities have been divided into risk categories in accordance with their susceptibility to risk. Each risk category covers the sports activities listed therein and those in the lower risk categories. A valid list of risk categories is available on the Internet at www.if.fi/urheilu. However, the exclusion concerning sports activities cannot be eliminated from sports activities specified above in this Clause.

1.3.2 Accident cover for professional athletes

The insurance of professional athletes is regulated by the Act on Athletes' Accident and Pension Cover. If an insured event falls or would have fallen within the scope of professional athletes' statutory accident insurance, no compensation is paid from **If's personal, baby or sickness insurance for a young person** covers. However, this does not apply to the death cover.

1.4 Entitlement to continue and transfer the insurance
1.4.1 Entitlement to continue the insurance
An Insured who is not the Policyholder is entitled to continue his/her insurance cover without presenting a new health declaration if the Policyholder terminates the insurance cover of the Insured or allows the cover to expire unpaid. The insurance cover granted on the basis of the entitlement to continue the insurance is determined according to the rules applied at the time by the Insurance Company to private customers with regard to granting the insurance as well as the scope, Terms and Conditions and premiums of insurance cover. As a result, the insurance cover may change or it cannot be granted.

If the sum payable upon death by the **personal insurance** taken as joint cover for two people expires when the other Insured has reached the age of 90 or has died, the Insured under the age of 90 is entitled to continue his/her death cover through an individual insurance premium.

1.4.2 Exercising the entitlement to continue
A written notification of the use of the entitlement to continuation must be made within six (6) months of the expiry of the insurance cover. The notification of exercising the entitlement to continuation is deemed to have been made when it has arrived in writing at the Insurance Company. If the entitlement to continuation has been exercised, the Policyholder no longer has the right to bring the Insured's expired insurance cover into force.

If the Insured entitled to continue the insurance dies before the end of the time limit of six (6) months without having exercised the entitlement to continue the insurance, the insurance is deemed to have been valid with respect to the Insured under the former Terms and Conditions.

1.4.3 Entitlement to transfer the insurance
If the Policyholder is a private person, the Insured of age has the right to transfer his or her insurance cover to a corresponding insurance by notifying the Insurance Company thereof in writing. In such a case, the Policyholder is not entitled to keep the insurance valid with respect to the transferred cover.

2 Other clauses relating to insurance covers
2.1 The Insured
Unless otherwise agreed, the Insured are the persons specified in the Policy Document, who are within the scope of the Finnish Sickness Insurance Act, whose domicile according to the Act on the Municipality of Domicile is in Finland, and who also live permanently in Finland. However, a person residing for more than six (6) calendar months abroad is not considered to be living permanently in Finland.

When insurance is granted for an unborn baby, the mother must meet the requirements mentioned above. When the child insurance has been taken out for an unborn baby, and only one child insurance has been taken out, and more than one baby is born at the same time, the insurance applies only to the baby that was born first.

2.2 Beneficiary
The sum payable upon death is paid to the relatives, and any other compensation to the Insured, unless the Policyholder has informed the Insurance Company in writing of any other beneficiary.

2.3 Calculating the Insurance Premium
Premiums for personal insurances shall be calculated according to the time of granting the insurance, as well as the Insured’s age, place of residence, the scope of cover and whether the Policyholder is a member of the If Benefit Programme. The premium will also be influenced by the maximum compensations and the deductible. The premium for sports cover is also affected by its period of validity and the sport's risk category. Factors affecting the premium will vary from one personal insurance and cover to the next. If the Policyholder is a member of the If Benefit Programme and this affects the premium, more detailed information on this will be available in the Policy Document. When buying insurance cover for an unborn child through the cover for a serious congenital disease or defect, the cover for hospital care of a child or the cover for hospital care of a mother, the premium shall be calculated on the basis of the age of the mother upon the child’s due date.

The premium may also be affected by the Policyholder's insurance and claim history. However, the premium will not be adjusted due to a deterioration in the state of health of the Insured after the insurance is taken out, or due to the occurrence of an Insured event related to the relevant insurance.

The premiums for personal insurances are adjusted at the turn of the insurance period, when the Insured’s age increases and/or when the place of domicile has changed. The premiums will be adjusted in accordance with the risk of loss, damage or injury corresponding to the Insured's age. If the ratio between the Insured's age or residential area and the risk of loss, damage or injury changes, the premiums can be adjusted to better correspond to the risk. The premium may also be adjusted due to changes in the extent of insurance cover or changes in the If Benefit Program membership.

The scope and premiums of personal insurances can be adjusted due to the age or retirement of the Insured during the validity period of the insurance in a manner stated in these Terms and Conditions or in the Policy Document.

2.4 Index adjustments
The insured amounts, deductibles and premiums of insurances will be adjusted annually at the turn of the insurance period, according to an index. The adjustment figure of the index is the mark for July of the previous calendar year. No index adjustment is made if the index decreases or the new index value is below the value previously used in the adjustment. No index adjustment is made to the cover for a serious congenital illness or defect (3.15) and the covers for hospital care of a mother or child (3.3 and 3.16).

Medical treatment expenses covers (3.1 and 3.2) will be adjusted according to the consumer price index’ health and commodities category and the other covers according to the cost-of-living index.

2.5 The Insurance Company's right to determine the treatment location
The Insurance Company is entitled to refer the Insured for examination or treatment to a service provider determined by the Insurance Company.

However, if the Insured uses a service provider of their choice, the Insurance Company is entitled to reimburse only the part of the examination and treatment expenses which would have been payable by Insurance Company at a service provider chosen by the Insurance Company.

3 Insurance covers
3.1 Cover for treatment expenses
This insurance covers the reasonable treatment expenses arising from illness or accident as listed below insofar as such expenses have not or would not have been subject to compensation on the basis of any law. Compensation for treatment expenses on the basis of illness is only paid for treatment expenses incurred in Finland.

Compensation requires that the insurance cover is valid at the time of the occurrence of the expenses and the accident has occurred during the validity of the insurance cover. In case of illness, the compensation is paid according to valid insurance terms at the time of the occurrence of the expenses due to an illness, and in case of an accident, at the time of the occurrence of the accident.

Only treatment expenses that the Insured would be liable to pay him/herself are compensable. The deductible stated in the Policy Document is deducted from the amount of loss covered by the Insurance.

The total compensation for treatment expenses is the maximum amount stated in the Policy Document, after which the cover for treatment expenses expires.

The compensation of medical expenses requires that the examination or treatment was prescribed by a physician and performed by a health care professional. In addition, the treatment expenses must be in accordance with generally accepted medical knowledge and necessary and indispensable for the treatment of the illness or injury in question.

Compensable medical expenses include reasonable:
- medical fees, examination and treatment expenses
- expenses arising from the treatment of dental injury caused by an accident
- Expenses for medicines sold under a licence from the Finnish Medicines Agency and expenses for emollients manufactured by a pharmaceutical company and included in Kela's reimbursement system
- hospital care fees up to the maximum daily amount of compensation stated in the Policy Document
- repair costs for a crash helmet, hearing aids and dentures which were in use at the time of the accident for which medical treatment is required, or the original acquisition costs
- repair costs for spectacles which were in use at the time of the accident for which medical treatment is required, or the replacement cost of similar spectacles.
  When compensating for spectacles, an annual deduction of 15 per cent based on the age of the spectacles is applied. No deduction is made for the year the spectacles were taken into use or for the following calendar year. An age deduction is also made for the year during which the loss or damage occurred. The deduction is calculated as follows: the number of years x 15 per cent. The deduction is not made from repair costs based on an invoice. The maximum compensation paid for the repair costs is the amount of loss, less the deductible, if applicable.
- acquisition costs of primary medical equipment
- expenses arising from necessary physiotherapy prescribed by a physician subsequent to surgery or a plaster cast for an accident covered by this insurance. No more than one treatment set of 15 visits will be compensated per accident.
- expenses arising from a cosmetic surgical or non-surgical procedure for an injury covered by this insurance. The cosmetic surgical or non-surgical procedure must be agreed upon beforehand with the Insurance Company.

Compensation for treatment expenses is not paid for:
1) rehabilitation or physical treatment, excluding expenses for physical treatment listed as compensable
2) for psychotherapy or speech, food, occupational, psychological or neuropsychological therapy or some other comparable therapy, examination, treatment or rehabilitation
3) examinations or treatment of dental illnesses, teeth or the masticatory system
4) examinations, treatment or operations carried out in order to rectify a refractive error or deterioration of vision or complications or further procedures resulting from these, except as part of the treatment of a coverable injury
5) purchase of spectacles or contact lenses
6) travel and accommodation costs
7) day care, home care, household management and other indirect costs
8) medication intended for the treatment of addictions
9) medication affecting sexual performance or medication which is used for alleviating the adverse effects of baldness, menopausal problems or other physiological changes
10) preventive treatment, vaccinations, health inspections or examinations performed in order to diagnose or exclude an illness of which the Insured did not exhibit any symptoms prior to the onset of the examination
11) cosmetic or plastic examination, treatment, procedure or surgery or the related complications or later corrective procedures, excluding expenses for the types of plastic surgery listed as compensable. Plastic surgery refers to both corrective plastic surgery for medical reasons and plastic surgery for aesthetic reasons.
12) obesity examination, treatment or operations or the related complications
13) purchase of micronutrient, mineral or nutritive preparations, drugs or vitamins or anthroposophic or homeopathic products and examinations and treatments relating to these, or medication intended for the treatment of addictions
14) micronutrient, mineral and vitamin examinations or treatments, other corresponding examinations or treatments or anthroposophic or homeopathic examinations or treatment.

If the expenses to be compensated substantially exceed the generally accepted and observed reasonable local level, the compensation is paid on the basis of this reasonable level. No compensation is paid for a home visit or treatment in the Insured's home performed by a physician or other health care professional, to the extent that the expenses exceed the reasonable level of expenses arising from comparable treatment provided at a health care institution.

If the Insurance Company pays any treatment expenses which are compensable under a law, the Insurance Company retains the right to recover the part of the expenses stipulated under that law.

3.1.1 Additional cover for physical therapy
The additional cover for physical therapy attached to the cover for treatment expenses covers expenses arising from necessary physical therapy subsequent to an accident or illness, no more than five (5) treatment sessions per accident or illness. However, the maximum number of treatment sessions compensated during one insurance period is ten (10) sessions. The regulations specified in clause 3.1 and these Personal Insurance Terms and Conditions in their entirety shall be applied in the compensation of physical therapy.

The validity of an additional cover is subject to a separate agreement and an additional premium. The sum insured and deductible of the cover for treatment expenses to which the additional cover has been attached shall also apply to the additional cover. If the treatment expenses cover to which the addition cover has been attached expires, the additional cover will also expire.

The physical therapy expenses specified herein are not covered if
- the accident has occurred of the illness has begun prior to the entry into force of this additional cover
- the expenses arise from a visit to a physical therapy institution due to the acquisition of a medical appliance, other assistive or treatment device or supportive or other orthopaedic insoles.

3.2 Cover for treatment expenses arising from an accident
This insurance covers the reasonable treatment expenses arising from accident as listed below insofar as such expenses have not or would not have been subject to compensation on the basis of any law.

Compensation requires that the insurance cover is valid at the time of the occurrence of the expenses and the accident has occurred during the validity of the insurance cover. Compensation is paid on the basis of valid insurance terms and the time of the accident.

Only treatment expenses that the Insured would be liable to pay him/herself are compensable. The deductible stated in the Policy Document is deducted from the amount of loss covered by the Insurance.

The total compensation for treatment expenses is the maximum amount stated in the Policy Document, after which the cover for treatment expenses arising from the accident expires.

The compensation of medical expenses requires that the examination or treatment was prescribed by a physician and performed by a health care professional. In addition, the treatment expenses should be in accordance with generally accepted medical knowledge and necessary and indispensable for the treatment of the injury in question.

Compensable medical expenses include reasonable:
- medical fees, examination and treatment expenses
- expenses for medicines sold under a licence from the Finnish Medicines Agency and expenses for emollients manufactured by a pharmaceutical company and included in Kela's reimbursement system
- hospital care fees up to the maximum daily amount of compensation stated in the Policy Document

- repair costs for a crash helmet, hearing aids and dentures which were in use at the time of the accident for which medical treatment is required, or the original acquisition costs
- repair costs for spectacles which were in use at the time of the accident for which medical treatment is required, or the replacement cost of similar spectacles.
  When compensating for spectacles, an annual deduction of 15 per cent based on the age of the spectacles is applied. No deduction is made for the year the spectacles were taken into use or for the following calendar year. An age deduction is also made for the year during which the loss or damage occurred. The deduction is calculated as follows: the number of years x 15 per cent. The deduction is not made from repair costs based on an invoice. The maximum compensation paid for the repair costs is the amount of loss, less the deductible, if applicable.
- acquisition costs of primary medical equipment
- expenses arising from necessary physiotherapy prescribed by a physician subsequent to surgery or a plaster cast for an accident covered by this insurance. No more than one treatment set of 15 visits will be compensated per accident.
- expenses arising from a cosmetic surgical or non-surgical procedure for an injury covered by this insurance. The cosmetic surgical or non-surgical procedure must be agreed upon beforehand with the Insurance Company.

Compensation for treatment expenses is not paid for:
1) rehabilitation or physical treatment, excluding expenses for physical treatment listed as compensable
2) for psychotherapy or speech, food, occupational, psychological or neuropsychological therapy or some other comparable therapy, examination, treatment or rehabilitation
3) travel and accommodation costs
4) day care, home care, household management and other indirect costs.

If the expenses to be compensated substantially exceed the generally accepted and observed reasonable local level, the compensation is paid on the basis of this reasonable level. No compensation is paid for a home visit or treatment in the Insured's home performed by a physician or other health care professional, to the extent that the expenses exceed the reasonable level of expenses arising from comparable treatment provided at a health care institution.

If the Insurance Company pays any treatment expenses which are compensable under a law, the Insurance Company retains the right to recover the part of the expenses stipulated under that law.

3.2.1 Additional cover for treatment expenses arising from an accident
This additional cover, attached to the cover for treatment expenses arising from an accident, covers expenses for the treatment of the following strain- or illness-related injuries, discovered in connection with a sudden movement or physical effort:
- sprain or tear of a ligament, or a tendonitis
- muscular distension and tear
- umbilical and inguinal hernia
- rupture of the meniscus of the knee
- dislocation of a joint, or patellar dislocation
- shin splints
- stress fracture (stress osteopathies are not covered by the insurance)
- tennis and golfer's elbow
- achilles tendonitis or achilles tendon rupture
- shoulder tendon area inflammation
- inflammation of the bursa
- plantar fasciitis

Compensation requires that the sudden movement or exertion occurred during the validity of the insurance cover.

As treatment expenses, the insurance also covers expenses of physical treatment prescribed by a physician for a maximum of five (5) treatment sessions per injury as specified in this Clause or per accident as referred to in the insurance terms and conditions. However, the maximum number of treatment sessions compensated during one insurance period is ten (10) sessions.

The regulations specified in clause 3.2 and these Personal Insurance Terms and Conditions in their entirety shall be applied in the compensation of these specified injuries and physical therapy. In muscle and tendon sprains, compensation is paid for a maximum of six (6) weeks from the occurrence of the sprain.

The validity of an additional cover is subject to a separate agreement and an additional premium. The sum insured and deductible of the cover for treatment expenses to which the additional cover has been attached shall also apply to the additional cover. If the treatment expenses cover to which the addition cover has been attached expires, the additional cover will also expire.

If an injury specified in this Clause has exhibited symptoms prior to the entry into force of this additional cover, expenses arising from the injury shall not be paid from this additional cover.

The physical therapy expenses specified herein are not covered if the expenses arise from a visit to a physical therapy institution due to the acquisition of a medical appliance, other assistive or treatment device or supportive or other orthopaedic insoles.

3.3 Cover for hospital care of mother
This insurance covers the sum insured stated in the Policy Document to the child's mother if she receives at least 30 days of hospital care in a Nordic country during pregnancy or within three (3) months of the child's birth.

A day of hospital care means 24 hours of care in a hospital. The care does not have to be uninterrupted. A claim can be submitted when the mother has spent a total of at least 30 days in hospital care. However, when calculating the days of hospital care, the days during which the insurance was not in force will be excluded. Similarly, the days of hospital care after the child's birth will be excluded if the insurance was not in force when the child was born. The compensation is paid only once.

3.4 Cover for temporary disability
This insurance covers a daily allowance stated in the Policy Document for periods of disability caused by the Insured's illness or accident. If the Social Insurance Institution of Finland (KELA) pays part-sickness allowance, the payable sickness allowance is half (½) of the sickness allowance noted in the Policy Document. Compensation requires that the insurance cover is valid during the disability period and that the accident has occurred during the validity of the insurance cover.

The Insured is considered to be disabled if he/she is unable to perform the normal duties of his/her occupation.

Daily allowance is paid for as many days as disability has continuously lasted subsequent to the waiting period stated in the Policy Document. Daily allowance is paid and the waiting period is considered to begin, at the earliest, from the date of the commencement of medical care. The daily allowance is paid monthly in arrears.

The total compensation for a disability is the maximum amount and period of time stated in the Policy Document, after which cover for a temporary disability expires.

Daily allowance will not be paid if the disability is caused by symptoms reported by the Insured alone which, based on the findings of a medical examination, do not indicate any illness or injury.

3.5 Cover for temporary disability due to an accident
This insurance covers a daily allowance stated in the Policy Document for periods of disability due to an accident befalling the Insured. If the Social Insurance Institution of Finland (KELA) pays part-sickness allowance, the payable sickness allowance is half (½) of the sickness allowance noted in the Policy Document. Compensation requires that the accident has occurred during the validity of the insurance cover and that the insurance cover is valid during the disability.

The Insured is considered to be disabled if he/she is unable to perform the normal duties of his/her occupation.

Daily allowance is paid for as many days as disability has continuously lasted subsequent to the waiting period stated in the Policy Document. Daily allowance is paid and the waiting period is considered to begin, at the earliest, from the date of the commencement of medical care. The daily allowance is paid monthly in arrears.

The total daily allowance is the maximum amount and period of time stated in the Policy Document, after which the cover for temporary disability expires.

Daily allowance will not be paid if the disability is caused by symptoms reported by the Insured alone which, based on the findings of a medical examination, do not indicate any injury.

3.6 Cover for hospital care
This insurance cover is no longer for sale.

This insurance covers a daily hospital allowance stated in the Policy Document for periods of hospital care due to the Insured's illness or accident. Compensation requires that the insurance coverage is valid during the hospital care and the accident has occurred during the validity of the insurance cover.

Daily hospital allowance is paid for as many days as hospital care has continuously lasted subsequent to the waiting period stated in the Policy Document.

If the Insured has been treated in a Finnish health care institution other than a hospital and if, on medical grounds, the coverable treatment has been necessary and a substitute for hospital care, daily hospital allowance is paid for the treatment period in such an institution.
However, spa, natural health care or rehabilitation institutions are not regarded as such health care institutions.

Daily hospital allowance will not be paid if the treatment is given due to symptoms reported by the Insured alone which, based on the findings of a medical examination, do not indicate any illness or injury.

Daily hospital allowance is not paid for a period of time during which the Insured has been cared for at home or has been on vacation from the hospital.

Daily hospital allowance is paid for no longer than the maximum period stated in the Policy Document, after which cover for hospital care expires.

3.7 Cover for hospital care due to an accident
This insurance cover is no longer for sale.

This insurance covers daily hospital allowance stated in the Policy Document for periods of hospital care due to an accident befalling the Insured. Compensation requires that the accident has occurred during the validity of the insurance cover and that the insurance cover is valid during the hospital care.

Daily hospital allowance is paid for as many days as hospital care has continuously lasted subsequent to the waiting period stated in the Policy Document.

If the Insured has been treated in a Finnish health care institution other than a hospital and if, on medical grounds, the coverable treatment has been necessary and a substitute for hospital care, daily hospital allowance is paid for the treatment period in such an institution.
However, spa, natural health care or rehabilitation institutions are not regarded as such health care institutions.

Daily hospital allowance will not be paid if the treatment is given due to symptoms reported by the Insured alone which, based on the findings of a medical examination, do not indicate any injury.

Daily hospital allowance is not paid for a period of time during which the Insured has been cared for at home or has been on vacation from the hospital.

Daily hospital allowance is paid for no longer than the maximum period stated in the Policy Document, after which cover for hospital care due to an accident expires.

3.8 Cover for permanent handicap
This insurance cover is no longer for sale.

This insurance covers compensations for a permanent handicap arising from an accident or by a single illness suffered by the Insured. Compensation is paid if the **permanent handicap caused by an accident** is classified at a minimum as disability category 2 (10%). However, injuries to the eyes or fingers caused by an accident are compensated if the permanent disablement is classified as belonging to disability category 1 (5%) at a minimum. Compensation is paid if the **permanent handicap caused by an illness** is classified at a minimum as disability category 12 (60%). From the **child insurance** (granted prior to 1 January 2018), compensation for a permanent handicap arising from an illness is paid if the permanent handicap is classified at a minimum as disability category 6 (30%), unless the handicap is the result of a congenital deformity, deformation or chromosome deviation (ICD-10 codes Q00–Q99). In such cases, the disability category should be at least 10 (50%).

Compensation requires that the insurance cover is valid at the time of the discovery of the permanent handicap caused by illness and that the accident has occurred during the validity of the insurance cover.

Permanent handicap refers to a medically estimated general handicap caused by an injury or illness suffered by the Insured. In the determination of the handicap, only the nature of the illness or injury is taken into consideration, not the individual circumstances of the Insured, such as his or her occupation or hobbies.

The severity of a permanent handicap is determined in accordance with the Government Decree on the disability classification in the Workers' Compensation Act (768/2015). Thus, one disability category corresponds to a five (5) percent medical degree of disability. For example, disability category 2 corresponds to a 10 per cent medical degree of disability, and the highest disability category 20 corresponds to a 100 per cent handicap.

The percentage corresponding to the disability category determined shows the proportion of the sum insured accounted for by the compensation at the time when the accident occurred or the illness was diagnosed. If the permanent handicap is at least of disability category 10 (50%), permanent handicap, the compensation is paid twofold. However, twofold compensation for permanent handicap is not payable if the Policy Document states that the insurance does not cover twofold compensation. **Permanent handicap caused by an accident** is determined at the earliest only after one (1) year has passed after the occurrence of the accident. **Permanent handicap caused by an illness** is determined when the medical condition has stabilised, however, at the earliest after one (1) year from the beginning of the treatment and/or the diagnosis of the illness and at the latest three (3) years after the expiry of the insurance.

If the disability category of a permanent disability increases before three (3) years have elapsed from the Insurance Company's initial decision on the Insured's permanent handicap, a supplementary compensation corresponding to the increase in disability category is paid. A change in the degree of disability after the said time does not affect the amount of compensation.

As compensation for a permanent handicap, compensation according to disability category 20 (100%) is paid, after which the cover for permanent handicap expires.

Compensation for permanent handicap caused by an **accident** is not paid if
1) the permanent handicap is classified below disability category 2 (10%), except for injuries to the eyes and fingers
2) the permanent handicap to the eyes or fingers caused by an accident is classified below disability category 1 (5%)
3) the permanent handicap is discovered more than three (3) years after the accident.

Compensation for a permanent handicap caused by an **illness** is not paid if the permanent disability category is less than 12 (60%), unless the insurance is child insurance.

With respect to the **child insurance** (granted prior to 1 January 2018), compensation for a permanent handicap caused by an illness is not paid if
1) the permanent handicap is classified below disability category 6 (30%)
2) the permanent handicap has not been determined within three (3) years of the expiry of the insurance
3) the permanent disability is caused by mental, behavioural or emotional disorders. In diagnostics, the ICD-10 codes of the said disorders are F00–F99 or R48.
4) the permanent handicap is caused by cerebral palsy (CP) or some other paralysis syndrome. In diagnostics, the ICD-10 codes are G80–G83.
5) the permanent handicap is classified below disability category 10 (50%) for a congenital defect, malformation or a chromosome deviation. In diagnostics, the ICD-10 codes are Q00–Q99.

3.9 Cover for permanent handicap caused by an accident
This insurance covers compensations for a permanent handicap caused by an accident to the Insured. Compensation shall be payable if the disability category of the permanent handicap caused by an accident is at least 2 (10%). However, injuries to the eyes or fingers caused by an accident are compensated if the permanent disablement is classified as belonging to disability category 1 (5%) at a minimum.

Compensation requires that the accident has occurred during the validity of the insurance cover. Permanent handicap refers to a medically estimated general handicap caused by an injury to the Insured. In the determination of the handicap, only the nature of the injury is taken into consideration, not the individual circumstances of the Insured, such as his or her occupation or hobbies.

The severity of a permanent handicap is determined in accordance with the Government Decree on the disability classification in the Workers' Compensation Act (768/2015). Thus, one disability category corresponds to a five (5) percent medical degree of disability. For example, disability category 2 corresponds to a 10 per cent medical degree of disability, and the hightest disability category 20 corresponds to a 100 per cent handicap.

The percentage corresponding to the disability category determined shows the proportion of the sum insured accounted for by the compensation at the time when the accident occurred. If the permanent handicap caused by an accident corresponds to at least disability category 10 (50%), the compensation is paid twofold. However, twofold compensation for permanent handicap is not payable if the insurance was granted after 31 December 2021 or if the Policy Document states that the insurance does not cover twofold compensation. Permanent handicap is determined at the earliest only after one (1) year has passed after the occurrence of accident. If the disability category increases before three (3) years have elapsed from the Insurance Company's initial decision on the Insured's permanent handicap, supplementary compensation corresponding to the increase in disability category is paid. A change in the degree of disability after the said time does not affect the amount of compensation.

As compensation for a permanent handicap, at most, compensation according to disability category 20 (100%) is paid, after which the cover for a permanent handicap caused by an accident expires.

Compensation for a permanent handicap is not paid if
1) the permanent handicap caused by an accident is classified below disability category 2 (10%), except for injuries to the eyes and fingers
2) the permanent handicap to the eyes or fingers caused by an accident is classified below disability category 1 (5%)
3) the permanent handicap is discovered more than three (3) years after the accident.

3.10 Family readjustment cover
This insurance covers the sum payable stated in the Policy Document if it is detected during the validity of the Insurance that the Insured has one of the illnesses or conditions mentioned below in this Clause or if the Insured undergoes a medical procedure listed herein. The sum insured of an Insured who is under 18 years old is paid to the Policyholder. The sum insured of an Insured who is 18 years or older is paid to him- or herself.

The sum insured will be paid after the illness has been diagnosed or the defect has been confirmed or after a medical procedure has been carried out. Compensation requires that the Insured is alive for at least 24 hours after the diagnosis has been confirmed. The sum insured is paid separately for each diagnosis, defect or procedure specified in this Clause, but no more than once for each group of diagnoses. A benign tumour of the brain and juvenile rheumatoid arthritis must have been diagnosed and an organ transplant performed on or after 1 January 2018.

If a diagnosis or medical procedure listed in this Clause leads to another diagnosis or procedure mentioned in this Clause, compensation is paid based only on the first diagnosis or procedure.

Groups of diagnoses as well as related illnesses, defects and procedures referred to in this Clause and based on which compensation is paid include the following:

- **A malignant tumour**
A malignant tumour discovered through a tissue examination. This group includes leukaemia, malignant tumours in the lymphoid tissue (lymphoma) and malignant cancer in melanocytes (melanoma).

The insurance does not cover normal skin cancer (basalioma and spinalioma), the histologically determined pre-stages of cancer (premalignant tumours) or incipient malignant cell changes or tumours limited to the outermost layers of skin (carcinoma in situ).

The diagnosis must comply with ICD-10 codes C00–43 or C45–C97.

- Benign tumour of the brain
A tumour developing from brain tissue or the meninges that requires surgery. The diagnosis must be made by a specialist in child neurology, neurology or neurosurgery and comply with ICD-10 codes D32.0, D33.0–D33.3 or D35.2–D35.4.

- **Type I Diabetes**
Type I diabetes treated with insulin and diagnosed by a specialist of paediatrics or internal medicine. The fasting blood sugar levels must be permanently over 7 mmol/l. The diagnosis must comply with ICD-10 code E10.

- **Renal failure**
The functioning of the kidneys is heavily reduced, with complications including anaemia and disturbances in the lipid metabolism. Dialysis needed. The diagnosis must be made by a paediatrician specialising in renal failures or a specialist in nephrology and comply with ICD-10 codes N17–N19.

- Juvenile rheumatoid arthritis
Juvenile idiopathic arthritis (JIA). The diagnosis must be made by a specialist in paediatric rheumatology or rheumatology and comply with ICD-10 code M08.

- **Amputation** The loss of a lower extremity, at least at the height of the upper tarsal joint, or of an upper extremity, at least at the height of the wrist.

- **Severe brain damage**
Contusions on the brain which have caused a significant lowering in the level of consciousness and have been diagnosed as sever either clinically or using radiology (3–7 on the Glasgow coma scale or an unconscious state lasting for at least one hour or the lowering of the level of consciousness for 10 days and requiring a period of at least 4 days of intensive care). The diagnosis must comply with ICD-10 codes I60–I69 or S06.

- **Severe burns**
The insured is under 10 years of age: at least 10% of the body surface is covered with second or third degree burns.

The insured is at least 10 years of age: at least 15% of the body surface is covered with second or third degree burns.

- Organ transplants
Includes transplant of a heart, liver, kidney or lung, an intestinal transplant or a stem cell transplant. The transplant must have been performed in Finland or through a referral by the Finnish health care services.

3.11 Death cover
The sum payable upon death valid at the time of death is paid to the beneficiaries after the Insured's demise. The compensation is paid only on condition that the insurance cover is valid at the time of death.

The sum insured is not paid if the Insured has committed suicide within one year after the commencement of the Insurance Company's liability or subsequent to the last time the Insurance was renewed with a health declaration. This exclusion is applied regardless of the Insured's age or state of mind.

The sum payable upon death may be provided on the basis of a level cover system or a decreasing cover system. In the case of the level cover system, the premium is increased according to the Insured's age during the validity of the Insurance. In the case of the decreasing cover system, the sum payable upon death is decreased according to the Insured's age during the validity of the Insurance.

The death cover may be a single-person cover or a joint two-person cover.

If persons insured under joint two-person cover die at the same time and the sums payable upon death are equal, the sum payable is paid in half to the beneficiaries of both insured persons, unless otherwise instructed. If the sums payable upon death are unequal, the smaller sum payable is paid in half to the beneficiaries of both persons insured and, in addition, the difference between the sums payable is paid to the beneficiaries of the larger sum payable.

3.12 Cover for death caused by an accident
The sum payable upon death valid at the time of death is paid to the beneficiaries after the accidental death of the Insured. Compensation requires that the accident has occurred during the validity of the insurance cover.

The sum insured is not paid if the Insured dies later than three (3) years after the accident occurred. With respect to If Baby Insurance and If Child Insurance, the sum insured is not paid if the baby is stillborn.

3.13 Cover for permanent disability caused by a serious illness or accident
This insurance covers a lump-sum compensation stated in the Policy Document for permanent disability if the Insured becomes permanently disabled due to an illness, injury or procedure mentioned in this Clause. Compensation requires that the insurance cover is valid when the permanent disability is discovered and that the accident has occurred during the validity of the insurance cover. Determining a permanent disability requires that the Insured has been granted a permanent disability pension according to the earnings-related pensions acts.

However, already earlier, the Insured will be entitled to a partial compensation of 10 per cent of the sum insured if he or she is granted a rehabilitation subsidy based on the earnings-related pensions acts for at least 12 months due to an illness, injury or procedure mentioned in this Clause. The required 12-month period can be uninterrupted or consist of several consecutive periods. The Insured is entitled to a partial compensation only once during the validity of the insurance cover. A partial compensation paid on the basis of a rehabilitation subsidy will be deducted from any lump-sum compensation payable for permanent disability. Compensation requires that this insurance cover is valid when the payment of a rehabilitation subsidy begins and that the accident has occurred during the validity of this insurance cover. No partial compensation based on a rehabilitation subsidy shall be paid if the Insured has been granted such subsidy prior to 1 January 2017 due to an illness, injury or procedure mentioned in this Clause.

When applying for insurance compensation, the Insured must submit a confirmed rehabilitation subsidy or pension decision and medical statement to the insurance company, based on which the authorised pension provider has granted a rehabilitation subsidy or permanent disability pension. The date of commencement of the rehabilitation subsidy or permanent disability pension is regarded as the insured event. Permanent disability pension does not refer to partial disability pension, and rehabilitation subsidy does not refer to partial rehabilitation subsidy.

The sum insured decreases annually according to the Insured's age, as of the beginning of the insurance period during which the Insured reaches the age of 50 and the premium remains constant, excluding changes caused by index and payment adjustments. When the Insured has reached the age of 55, the sum insured no longer decreases.

The cover for permanent disability caused by a serious illness or accident expires when the compensation for permanent disability has been paid.

The cause (main diagnosis) of permanent disability and rehabilitation subsidy must be one of the following illnesses, injuries or procedures:

- **A malignant tumour**
A malignant tumour discovered through a tissue examination. This group includes leukaemia, malignant tumours in the lymphoid tissue (lymphoma) and malignant cancer in melanocytes (melanoma).

The insurance does not cover normal skin cancer (basalioma and spinalioma), the histologically determined pre-stages of cancer (premalignant tumours) or incipient malignant cell changes or tumours limited to the outermost layers of skin (carcinoma in situ).The diagnosis must comply with ICD-10 codes C00–C43 or C45–C97.

- **Benign tumour of the brain**
A tumour developing from brain tissue or the meninges that requires surgery. The diagnosis must comply with ICD-10 codes D32.0, D33.0–D33.3 or D35.2–D35.4.

- **Schizophrenia**
The diagnosis must meet the valid criteria for the classification of disease and be made by a specialist in psychiatry and comply with ICD-10 code F20.

- **Motor neuron disease (such as ALS)**
A progressive degenerative disease, characterised by the destruction of motor neurons in the spinal cord, the brain stem and the motor cortex. Includes the diagnosis of amyotrophic lateral sclerosis (ALS), primary lateral sclerosis, progressive spinal muscular atrophy and progressive bulbar palsy. The diagnosis must comply with ICD-10 code G12.2.

- **Parkinson's disease**
The phased degeneration of neurons using dopamine (important motor skills transmitter). The diagnosis must be made by a specialist in neurology and comply with ICD-10 code G20.

- **Alzheimer's disease**
Meeting the general criteria of dementia. In addition, the patient has specific problems in understanding words and speech (aphasia, agraphia, alexia, acalculia) or motor disorders in the hands/legs (apraxia). The diagnosis must be made by a specialist in neurology or geriatrics and comply with ICD-10 codes G30, G30.1, G30.8 or G30.9.

- **Multiple sclerosis (MS)**
Scattered and extensive damage to the neurons of the brains and the spinal cord, usually resulting in the loss of motor and other functions.

Prerequisite: a typical neurological period of illness lasting more than 6 months (manifestation of the disease) or periods of illness occurring more than once. The diagnosis must be made by a specialist in neurology, and confirmed on the basis of typical symptoms, an analysis of cerebrospinal fluid and MRI and must comply with ICD-10 code G35.

- **Epilepsy**
Repeated attacks, during which worsening spasms and electric malfunction of the brain cause a lowered level of consciousness. The diagnosis must be made by a specialist in neurology and confirmed through EEG and comply with ICD-10 code G40.

- **Myocardial infarction (heart attack)**
Part of the heart muscle tissue is dead due to insufficient blood circulation in the area. The diagnosis must be performed on the basis of changes that are fresh and typical for a heart attack and discovered during ECG, as well as on the basis of typically increased myocardial tracers, and must comply with ICD-10 codes I21–I23.

- **Cerebral haemorrhage or cerebral infarction**
A cerebral haemorrhage or cerebral infarction, followed by the paralysis of an arm or a leg or a speech disorder lasting more than 6 weeks. The damage must be verifiable using computed tomography (CT) or magnetic resonance imaging (MRI). The diagnosis must be made by a specialist in neurology and comply with ICD-10 codes I60–I63.

- **Aortic aneurysm and/or an aortic dissection**
An aortic aneurysm treated through surgery. The diagnosis must comply with ICD-10 code I71.

- **Chronic inflammatory condition of the intestines**
Includes the disease classifications for Crohn's disease and ulcerative colitis. The diagnosis has been made and confirmed by a radiologist or through endoscopic changes and confirmed histopathologic findings and must comply with ICD-10 codes K50 or K51.

- **Rheumatoid arthritis**
Chronic inflammatory rheumatoid arthritis, which leads to a reduction of joint functions. The diagnosis must be made by a specialist in rheumatology and according to valid classifications of disease and comply with ICD-10 codes M05 or M06.

- **Renal failure**
The functioning of the kidneys is heavily reduced, with complications including anaemia and disturbances in the lipid metabolism. Dialysis needed. The diagnosis must be made by a specialist in nephrology and comply with ICD-10 codes N17–N19.

- **Blindness**
Permanently reduced vision in both eyes. The visual acuity on the better eye after correction of refractive error is 0.03 or weaker.

- **Deafness**
A permanent hearing impairment of 60 dB or more on voice frequency (500-2,000 Hz) in both ears, determined with an audiometer.

- **Severe burns**
The burns must cover at least 30% of the body surface and be second or third degree burns.

- **Paralysis and amputation**
Injury to the spinal cord or an amputation of the limb, resulting in a malfunction of the arm and/or leg, equivalent to at least a 50% medical handicap. The injury to the spinal cord must be objectively discoverable. Functional/psychogenic paralysis is not compensated.

- **Organ transplants**
Includes transplant of a heart, liver, kidney or lung, an intestinal transplant or a stem cell transplant. The transplant must have been performed in Finland or through a referral by the Finnish health care services.

- **Heart surgery**
A precondition for compensation is that the procedure involve an opened chest.

3.14 Readjustment cover
This insurance covers the sum insured stated in the Policy Document if, during the validity of the insurance cover, it is detected that the Insured has an illness or defect mentioned in this Clause or if the Insured undergoes a medical procedure listed herein. This insurance may include a qualifying period specified in the Policy Document for malignant tumours and benign tumours of the brain entitling to insurance. The qualifying period begins at the signing of the health declaration and means that no compensation will be paid during the validity of the insurance for a tumour that is detected during the qualifying period or if the examinations leading to its diagnosis begin during this period. For the purpose of calculating the qualifying period, the first qualifying date is considered to be the day following the signing of the health declaration. The qualifying period only applies if it has been separately agreed and mentioned in the Policy Document.

The sum insured will be paid after the illness or defect
diagnosis has been confirmed or after a medical procedure has been carried out. Compensation requires that the Insured is alive for at least 24 hours after the diagnosis has been confirmed. The sum insured is paid separately for each diagnosis made or medical procedure performed as listed in this Clause, but no more than once for each group of diagnoses or medical procedures.

If a diagnosis or medical procedure listed in this Clause leads to another diagnosis or procedure mentioned in this Clause, compensation is paid based only on the first diagnosis or procedure.

Groups of diagnoses and medical procedures referred to in this Clause and based on which compensation is paid, and the related illnesses, defects and medical procedures, include the following:

- **A malignant tumour**
A malignant tumour discovered through a tissue examination. This group includes leukaemia, malignant tumours in the lymphoid tissue (lymphoma) and malignant cancer in melanocytes (melanoma).

The insurance does not cover normal skin cancer (basalioma and spinalioma), the histologically determined pre-stages of cancer (premalignant tumours) or incipient
malignant cell changes or tumours limited to the outermost layers of skin (carcinoma in situ). The diagnosis must comply with ICD-10 codes C00–C43 or C45–C97.

- **Benign tumour of the brain**
A tumour developing from brain tissue or the meninges that requires surgery. The diagnosis must comply with ICD-10 codes D32.0, D33.0–D33.3 or D35.2–D35.4.

- **Motor neuron disease (such as ALS)**
A progressive degenerative disease, characterised by the destruction of motor neurons in the spinal cord, the brain stem and the motor cortex. Includes the diagnosis of amyotrophic lateral sclerosis (ALS), primary lateral sclerosis, progressive spinal muscular atrophy and progressive bulbar palsy. The diagnosis must comply with ICD-10 code G12.2.

- **Multiple sclerosis (MS)**
Scattered and extensive damage to the neurons of the brains and the spinal cord, usually resulting in the loss of motor and other functions.

Prerequisite: a typical neurological period of illness lasting more than 6 months (manifestation of the disease) or periods of illness occurring more than once. The diagnosis must be made by a specialist in neurology, and confirmed on the basis of typical symptoms, an analysis of cerebrospinal fluid and MRI and must comply with ICD-10 code G35. The disease must have been diagnosed on or after 26 May 2018.

- **Myocardial infarction (heart attack)**
Part of the heart muscle tissue is dead due to insufficient blood circulation in the area. The diagnosis must be performed on the basis of changes that are fresh and typical for a heart attack and discovered during ECG, as well as on the basis of typically increased myocardial tracers, and must comply with ICD-10 codes I21–I23.

- **Cerebral haemorrhage or cerebral infarction**
A cerebral haemorrhage or cerebral infarction, followed by the paralysis of an arm or a leg or a speech disorder lasting for more than 6 weeks. The damage must be verifiable using computed tomography (CT) or magnetic resonance imaging (MRI). The diagnosis must be made by a specialist in neurology and comply with ICD-10 codes I60–I63.
,
- **Aortic aneurysm and/or an aortic dissection**
An aortic aneurysm treated through surgery. The diagnosis must comply with ICD-10 code I71.

- **Severe burns**
The burns must cover at least 30% of the body surface and be second or third degree burns.

- **Organ transplants**
Includes transplant of a heart, liver, kidney or lung, an intestinal transplant or a stem cell transplant. The transplant must have been performed in Finland or through a referral by the Finnish health care services.

- **Heart surgery**
A precondition for compensation is that the procedure involve an opened chest.

3.15 Cover for a serious congenital disease or defect
This insurance covers the sum insured stated in the Policy Document to the Policyholder if the Insured is diagnosed as having a congenital disease or defect listed in this Clause within six (6) months of his or her birth. The sum insured is paid only on the basis of one diagnosis.

Compensation requires that the insurance is in force when the baby is born. Compensation is not paid if the Insured dies before the diagnosis is confirmed.

The prerequisites for compensation referred to in this clause comprise the following congenital diseases and defects:

- **Spinal bifida**
A malformation occurring in the spinal cord, in which the vertebral arches have not fused at the back. The prerequisite for compensation is a spinal hernia protruding from an unclosed foramen of the skull or spinal cord. A spinal membrane hernia (Meningoseele) does not entitle to compensation. The diagnosis must comply with ICD-10 code Q05.

- **Congenital hydrocephalus**
Hydrocephalus in a new-born baby, caused by a circulation disturbance of the brain and spinal cord fluids. The diagnosis must comply with ICD-10 code Q03.

- **Cerebral mental disability**
The prerequisite for compensation is a severe or deep congenital mental disability, diagnosed no later than six (6) months after birth. The diagnosis must be made by a specialist in child neurology and The diagnosis must comply with ICD-10 codes F72 or F73.

- **Cerebral palsy (CP)**
The prerequisite for compensation is a severe congenital CP syndrome, diagnosed no later than six (6) months after birth. The prerequisite for compensation is the paralysis of all four extremities (tetraplegia), both lower extremities (paraplegia) or a severe atethosis. The diagnosis must be made by a specialist in child neurology. The diagnosis must comply with ICD-10 codes G80 or G82.

- **Down's syndrome**
A developmental disorder caused by a chromosome deviation. The diagnosis must comply with ICD-10 code Q90.

- **Transient global amnesia (TGA)**
A congenital dystopia of the large arterial veins of the heart. The diagnosis must comply with ICD-10 code Q20.3.

- **Univentricular heart (UVH)**
The diagnosis must comply with ICD-10 code Q20.48.

- **Fallot's tetralogy**
A combination of congenital heart defects. The diagnosis must comply with ICD-10 codes Q21.30–Q21.33.

- **Hypoplastic left heart syndrome (HLHS)**
The atresia or considerable hypoplasia of the aorta orifice or valve. The diagnosis must comply with ICD-10 code Q23.4.

- **Atresia of pulmonary artery (PA)**
An atresis in the pulmonary artery, impeding the blood circulation in the lungs. The diagnosis must comply with ICD-10 code Q25.5.

- **Missing upper extremities**

The prerequisite for compensation is a congenital lack of upper extremities, a lack of an upper arm and a forearm, a forearm and a hand, or a hand and all fingers. The diagnosis must comply with ICD-10 codes Q71.0–Q71.3.

- **Missing lower extremities**
The prerequisite for compensation is the congenital lack of a lower extremity, a lack of a thigh and a leg, a leg and a foot or a foot and all of the toes. The diagnosis must comply with ICD-10 codes Q72.0–Q72.3.

- **Blindness**
A congenital permanent blindness in both eyes, causing visual disability, diagnosed within six (6) months of birth. The diagnosis must be made by a specialist in eye diseases. The diagnosis must comply with ICD-10 code H54.0.

3.16 Cover for hospital care of child
This insurance covers the sum insured stated in the Policy Document to the Policyholder if the insured child receives at least 30 days of hospital care in a Nordic country within three (3) months of his or her birth.

A day of hospital care means 24 hours of care in a hospital. The care does not have to be uninterrupted. A claim can be submitted when the child has spent a total of at least 30 days in hospital care. However, when calculating the days of hospital care, the days during which the insurance was not in force will be excluded. The compensation is paid only once.

Compensation requires that the insurance is in force when the baby is born.

4 General exclusions
4.1 General exclusions applying to all covers
4.1.1 Alcohol, drugs, intoxicants and nicotine
Compensation is not paid if the illness or disability arises from the Insured's consumption of alcohol or another intoxicating substance, or abuse of medication. Nor is
compensation paid for an addiction resulting from the use of alcohol, medicine, drugs, nicotine or other substances, or the treatment of such an addiction. These exclusions do not apply to the death cover (3.11).

4.1.2 Influence of other illness or defect
If the occurrence of a bodily injury or the delayed recovery from the injury has been essentially affected by an illness or defect not relating to the coverable injury, compensation for treatment expenses, daily allowance, daily hospital allowance or handicap compensation is paid only insofar as the treatment expenses, disability, hospital care and permanent handicap can be considered to have been caused by the injury covered.

If the occurrence of an illness or the delayed recovery from the illness has been essentially affected by an illness or defect not relating to the coverable illness, compensation for treatment expenses, daily allowance, daily hospital allowance or handicap compensation is paid only insofar as the treatment expenses, disability, hospital care and permanent handicap can be considered to have been caused by the illness covered.

Compensation is paid for the restoration of teeth damaged in an accident to their pre-accident state.

4.1.3 Pregnancy, delivery and infertility
Compensation for treatment expenses, daily allowance and daily hospital allowance is not paid if the treatment expenses, disability or hospital care are caused by:
1) pregnancy or delivery
2) contraception, termination of pregnancy, infertility examination or treatment, artificial insemination, sterilisation or foetal examination.

4.1.4 War and armed conflict
The insurance **is not valid when the Insured is participating** in a war or armed conflict **or serving** in international peace-keeping or related operations. However, this exclusion is not applied to death cover when the Insured is serving in international peace-keeping or related operations, providing that the time of death of the Insured occurred at least one year after the insurance company's liability had begun and the insurance came into force when a health declaration was submitted.

Compensation is not paid for loss due to war, mutiny, armed conflict or similar events, even if the Insured has not participated in said activities. If the Insured has started the journey abroad prior to the beginning of the military activity or armed conflict and has not participated in said activities, this clause is not applied until 14 days following the beginning of the armed activities. In the case of a major war, this clause applies immediately. A major war refers to a war between two or several permanent members of the UN Security Council. This exclusion does not apply to the death cover (3.11).

The Finnish Insurance Contracts Act contains specific legal provisions on insurance companies' liabilities when the death or disability of an insured person who is a Finnish citizen or a resident of Finland results from war or an armed attacked directed at Finland.

4.2 Additional exclusions concerning covers valid for accident
If the cover is only valid for accidents (Covers 3.2, 3.5, 3.7, 3.9 and 3.12), the exclusions mentioned below are applied in addition to the exclusions mentioned in Clause 4.1.

4.2.1 Injury does not comprise
1) any injury or death caused by an illness, injury or defect of the Insured. If an illness or defect unrelated to the accident has fundamentally affected the injury or death, no compensation will be paid.
2) any illness, injury or defect unrelated to the accident, or a deterioration of the musculoskeletal system, even if no symptoms of these were present before the accident
3) any infectious disease or illness caused by an insect or tick bite or sting, or their consequences
4) poisoning due to the Insured's consumption of medication, alcohol or some other substance for intoxication purposes, or their consequences
5) damage caused to teeth or dentures through biting, even if an external factor had affected it
6) psychological consequences which are not caused by brain damage arising from an accident
7) death caused by suicide
8) injuries incurred by the baby in connection with childbirth. An injury incurred before the baby is officially considered as born alive is not considered an injury.

4.2.2 Surgery, treatments and other medical procedures
This Insurance does not cover any injury, illness or death caused by surgery, treatment or some other medical procedure performed to treat an illness or bodily defect, unless the procedure has been performed to treat an injury or a travel illness covered by this Insurance.

4.2.3 Pre-existing conditions
If the If's personal and trade union insurance policies have been granted without a health declaration, no compensation is paid from the covers for treatment expenses arising from an accident, for temporary disability caused by an accident and for permanent handicap caused by an accident if the illness or injury must be considered to have arisen prior to the entry into force of the insurance, and the first clear symptoms occurred prior to the entry into force of the insurance.

5 Claiming compensation for treatment expenses
The person entitled to compensation shall pay the treatment expenses and then claim the share of compensation in accordance with the Sickness Insurance Act from the local office of the Social Insurance Institution of Finland (Kela) within six (6) months of the payment of the expenses. Please retain Kela's calculation of the compensation, copies of the original receipts sent to Kela, and the original receipts, for which Kela does not pay compensation. If requested, these shall be submitted to If P&C Insurance Company. Compensation shall be claimed from If no later than one year from the end of the insurance period during which treatment expenses were incurred.

The insurance company shall pay compensation of which the deductible and any elements compensated by Kela have been deducted.

If the entitlement to compensation in accordance with the Sickness Insurance Act has been forfeited due to neglect of the time limits mentioned above or for some other reason, that proportion of the compensation which would have been paid by Kela on the basis of the Sickness Insurance Act will be deducted.