skandia

Cover for children for certain critical illnesses

- Special terms and conditions for 'General terms and conditions of insurance for certain critical illnesses'

Special terms and conditions valid from 1 September 2017

No. 01-09-2017

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1. About cover for children for certain critical illnesses

The insurance for certain critical illnesses is taken out with Skandia Link Livsforsikring A/S, CVR: 20 95 22 37, hereinafter called Skandia. Cover for children for certain critical illnesses is an integral part of the insurance for certain critical illnesses.

The present special terms and conditions govern cover for children for certain critical illnesses and represent special terms and conditions for the 'General terms and conditions of insurance for certain critical illnesses' that apply to insurance for certain critical illnesses in other respects.

The cover for children for certain critical illnesses entails a right to payment of a sum insured for certain critical illnesses for children if the conditions applicable at the time of diagnosis are met.

The term 'critical illness' is used in these special terms and conditions on the basis of the diagnosis groups below and the specific definition provided in section 3, 'Critical illnesses covered by the insurance'.

Cover for children includes the following critical illnesses:

1 a	Cancer
1 b	Certain benign tumours in the brain or spinal cord
2 a	Cerebral haemorrhage or a blood clot in the brain (apoplexy)
2 b	A bulge in cerebral arteries (aneurysm) or intracranial arteriovenous malformation (AVM)
3	Heart disease requiring surgery
4	Chronic renal failure
5	Major organ transplants
6	Major burns, frostbite or corrosive burns
7	Meningitis or cerebrospinal meningitis (incl. borrelia and TBE)

2. How the cover works

2.1. Which children are covered by cover for children for certain critical illnesses?

Cover for children for certain critical illnesses is provided for the insured's children aged from 6 months until they turn 18.

Children means the insured's:

A. Biological children and adoptive children

B. Stepchildren, i.e. the insured's spouse's/registered partner's biological children and adoptive children if they

   1. are registered in the population register at the same address as the insured.

C. Cohabitant's biological children and adoptive children if

   1. they are registered in the population register at the same address as the insured, and
   2. the insured and the insured's cohabitant live together without interruption in the last two years before the time of diagnosis, have had a common address and have lived in marriage-like conditions without there having been any impediments to marriage (or impediments to making a registered partnership) during this time under the legislation.

For children covered by B and C, the right to payment lapses if the insured and the child's parent (the insured's spouse) are separated or divorced or if the insured and the child's parent (the insured's cohabitant) no longer have a common address.

2.2. When does the cover apply?

The insurance period starts no earlier than on the date on which it is agreed that the insurance contract commences, and ends when the insurance contract is terminated, regardless of the reason for termination.

Insurance cover for individual children starts no earlier than when the child is 6 months old and ends no later than on the date on which the child turns 18.

2.3. Reporting critical illness

When a child covered by these special terms and conditions receives a diagnosis that is expected to be covered by the cover for children for certain critical illnesses, Skandia should be contacted for the insured to be sent an application form for payment for critical illness for children and a consent form. The application form is also available at skandia.dk.

2.4. Terms and conditions of cover

The insured is entitled to payment for certain critical illnesses for children when a child covered by these special terms and conditions receives an eligible diagnosis in the period from when the insurance enters into force until the insurance is terminated (hereinafter called the 'insurance period'), and no earlier than after the end of any waiting period. The time of diagnosis is decisive, not the time at which the insured or the child learned of the diagnosis.

The right to payment for certain critical illnesses is assessed in accordance with the special terms and conditions applicable at the time of diagnosis.

The right to payment for certain critical illnesses lapses when the child dies, with the exception of cases in which the insured has requested Skandia in writing, before the death, for payment and, at that time, the child meets the other conditions for payment for certain critical illnesses.

2.5. For individual insurance cover

Cover for children for certain critical illnesses is conditional on the illness being diagnosed no earlier than when the cover has been in force for three months without interruption (waiting period). However, the cover must have been in force for six months without interruption (waiting period) for a diagnosis covered under 1 a (Cancer).

Other limitations to the right to cover are described in 4 'Exclusions'.

2.6. Payment

Payment for cover for children for certain critical illnesses comprises the sum insured for certain critical illnesses for children applicable on the date on which the illness was diagnosed. The sum insured for certain critical illnesses for children is DKK 50,000.

Payment is made to the insured.

Once payment of a sum insured for certain critical illnesses for children has been made, cover lapses for the diagnosis group that resulted in payment for the child in question. The same applies to any other diagnoses made in the waiting period.

However, for diagnosis 1 a (Cancer), the insured is entitled to payment if a child covered by these special terms and conditions receives a new, unrelated cancer diagnosis during the insurance period if ten years have passed since the first cancer diagnosis was made in the insurance period.

2.7. Specialists, etc.

It is a requirement that the diagnoses, examinations, etc. listed under 'Eligible critical illnesses' 1a – 7 are made by specialists and hospital departments that are recognised and authorised by the health authorities in the country in Scandinavia (Denmark, Sweden or Norway) in which they practise.

3. Critical illnesses that are covered

The insurance covers the following diagnosis groups:

1 a. Cancer

A malignant tumour diagnosed histologically and characterised by uncontrolled growth of malignant cells that have a tendency to invade surrounding tissue and a tendency to local relapse and spread to regional lymph glands and other organs (metastasising).

The following are not covered:

- Tumours classified as premalignant, non-invasive, carcinoma in situ, borderline or with low malignant potential (regardless of the treatment chosen).
- All forms of skin cancer (including lymphoma in the skin), apart from melanoma stages 1b-4 (malignant melanoma).
- Bladder papillomas.
- Tumours arising during the course of HIV infection, including Kaposi's sarcoma.

The diagnosis is deemed to have been made when a histological or cytological examination has been assessed by a specialist in tissue analysis (pathological anatomy).

Cancer of the blood, lymphatic system and blood-forming cells of the bone marrow is also covered:

Malignant illnesses in the blood, lymphatic system or blood-forming cells of the bone marrow, characterised by an atypical blood profile with uncontrolled growth of blood cells and a tendency to progression and relapse.

Cover includes the following, where they require treatment*:

- Acute leukaemia, chronic myeloid leukaemia (CML) in the accelerated phase or blast crisis and chronic lymphatic leukaemia (CLL) requiring treatment
- Hodgkin's lymphoma stages II to IV and non-Hodgkin's lymphoma with the exception of less aggressive forms such as localised MALT lymphoma, mucosis fungoides in the plaque stage and skin lymphomas such as localised CD30 positive lymphoma and cutaneous B-cell lymphoma localised in the skin.
- High-risk myelodysplastic syndrome (MDS) and chronic myelomonocystic leukaemia (CMML).
- Myelomatosis/solitary myeloma requiring treatment.

*) Requiring treatment means cytocidal treatment (including chemotherapy, biological means (designer drugs) and radiotherapy) and/or transplantation with stem cells/bone marrow from another person (allogenic bone marrow transplantation).

The following blood disorders are not covered:

- Chronic lymphatic leukaemia stages I and II.
- Hodgkin's lymphoma stage I.
- Monoclonal gammopathy (MGUS) or myeloproliferative neoplasms (MPN) such as primary myelofibrosis, essential thrombocytopenia and polycythemia vera.

For the cancers of the blood, lymphatic system and blood-forming cells of the bone marrow that are covered and require treatment, a diagnosis is deemed to have been made on the date on which a paediatric oncology or haematology department has stated in the patient records that there is a treatment indication for the disease.

1 b. Certain benign tumours in the brain or spinal cord which progress aggressively and have severe permanent consequences

A tumour arising in and originating from the brain, brain stem, spinal cord or the membranes of these organs (the central nervous system) that causes significant neurological symptoms (paralysis, sensory disturbance, visual disturbance or speech disturbance) and reduced mobility equivalent to at least 15% permanent injury, assessed using the permanent injury table issued by Labour Market Insurance.

The insurance is paid out only when the resulting condition is assessed as being reasonably stable, i.e. no earlier than six months after diagnosis or operation.

The diagnosis must be made at a neurosurgical department or by a neurosurgical specialist. An operation must be carried out during the insurance period.

The following are not covered:

- Tumours in cranial/cerebral nerves.
- Cysts or granulomas.
- Pituitary adenomas.

2 a. Cerebral haemorrhage or a blood clot in the brain (apoplexy) with permanent consequences

Acute injury to the brain or brain stem with simultaneously resulting objective neurological symptoms (paralysis, sensory disturbance, visual disturbance or speech disturbance) lasting more than 24 hours due to either:

- Spontaneous or traumatic accumulation of blood in the brain or between the cerebral membranes as a consequence of a burst artery or a malformation in the vessels of the brain.

or

- A narrowing or occlusion of an artery in the brain on account of thrombosis or embolism.

In both cases, cover is subject to the condition having had permanent consequences that have been present without interruption (assessed after 3 months) in the form of neurological symptoms (paralysis, sensory disturbance, visual disturbance or speech disturbance) corresponding to the brain injury demonstrated using brain scans (CT/MR).

The diagnosis must be made at a neurological or neurosurgical department or be confirmed by a neurological specialist, and any other cause of the neurological symptoms must have been excluded.

If a blood clot in the brain cannot be confirmed using a brain scan (CT or MR), the child is covered if all clinical signs of a blood clot in the brain are present and there are permanent resulting objective neurological symptoms (assessed no earlier than after 6 months) corresponding to a brain injury in the form of paralysis, sensory disturbance, visual disturbance or speech disturbance.

Consequences in the form of cognitive general fatigue alone are not sufficient for cover.

The following are not covered:

- Transitory Cerebral Ischaemia (TCI)/Transitory Ischaemic Attack (TIA).
- Previous cerebral infarctions demonstrated using a brain scan (CT or MR).
- Blood clots or bleeding in the peripheral part of nerve tissue, i.e. outside the brain (for example eyes, ears and pituitary gland).

2 b. A bulge in cerebral arteries (aneurysm) or intracranial arteriovenous malformation (AVM)

A planned or implemented operation for a defect in cerebral vessels in the form of one or more bulges in cerebral arteries or arteriovenous malformations (including cavernous angioma) that have been demonstrated using an X-ray of cerebral arteries (angiography) or a CT/MR scan.

The diagnosis must be made at a neurological or neurosurgical department, and the diagnosis is deemed as having been made on the date of the operation. For a planned operation, the diagnosis is deemed as having been made when the child is accepted on the waiting list.

Cover also includes cases in which an operation is indicated, but the operation cannot be implemented for technical reasons.

3. Heart disease requiring surgery

Treatment carried out for heart disease by means of an operation or intervention via the bloodstream.

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

Operation or intervention via the bloodstream must be carried out during the insurance period.

The diagnosis is deemed to have been made on the date of the operation or the date of the intervention via the bloodstream. For a planned operation, the date of acceptance on the waiting list is deemed to be the diagnosis date.

4. Chronic renal failure

A condition with bilateral renal failure in which both kidneys have chronically and irrevocably ceased to function, with the need for permanent dialysis treatment or kidney transplant.

The diagnosis must be made by a renal specialist.

The diagnosis is deemed to have been made when permanent dialysis has been started or on the date of the operation. For a planned transplant, the diagnosis is deemed as having been made when the child is accepted on the active waiting list.

5. Major organ transplant

Planned or implemented receipt of a heart, lung, liver, heart/lung or heart/lung/liver transplant on the basis of organ failure in the child.

The diagnosis is deemed to be made on the date of the operation. For a planned operation, the date of acceptance on the waiting list is deemed to be the diagnosis date.

The diagnosis must be made by a specialist in the field.

The cover also includes transplantation with stem cells/bone marrow from another person (allogenic bone marrow transplantation) for conditions other than those described under cover for blood cancer, cf. 1 a.

The following are not covered:

- Transplantation of other organs, parts of organs, tissue or cells.

6. Major burns, frostbite or corrosive burns
A second/third-degree burn injury (including frostbite or corrosive burns) covering at least 10 per cent of the child's body area.

The diagnosis must be contained in patient records from the burns department providing treatment.

7. Meningitis or cerebrospinal meningitis (incl. borrelia and TBE)
An infection in the brain, cranial nerve roots or cerebral membranes caused by bacteria, viruses, fungi or other microbes that has resulted in permanent objective neurological symptoms (paralysis, sensory disturbance, visual disturbance or speech disturbance) equivalent to at least 15% permanent injury according to the permanent injury table issued by Labour Market Insurance (assessed by a neurological specialist).

For meningitis or cerebrospinal meningitis, there must be clinical indications of the diagnosis and at least one of the following criteria must be met:

- Evidence of microbes in the spinal fluid.
- Evidence of clear inflammatory reaction (pleocytosis) in the spinal fluid, with an increased number of white blood corpuscles, possibly supplemented with MR/CT scans.

For neuroborreliosis, the diagnosis must be verified by evidence of borrelia-specific antibodies (IgM/IgG) in the spinal fluid, compared with blood (spinal/serum index or intrathecal antibody synthesis).

For Tick-Borne-Encephalitis (TBE), the diagnosis must be verified with evidence of TBE-specific antibodies (IgM/IgG) in blood or spinal fluid.

In all cases, the neurological symptoms (paralysis, sensory disturbance, visual disturbance or speech disturbance) can be assessed no earlier than after 3 months, and the consequences must be confirmed by a neurological specialist.

4. Exclusions

4.1. General limitations

If, before the insurance entered into force or during any waiting period, a child covered by cover for children for certain critical illnesses has

- been given a diagnosis,
- received treatment, or
- been investigated for a diagnosis,

that would be covered by these special terms and conditions or is related to diseases/conditions covered by these special terms and conditions, cover does not apply for the diagnosis(es) in question.

If a child covered by these special terms and conditions receives more than one eligible diagnosis in the insurance period, payment for the subsequent critical illness(es) is conditional on the diagnosis for the subsequent critical illness(es) being made at least 6 months after the most recent eligible diagnosis. If payment is made on acceptance on a waiting list, the 6 month period only begins when the operation has been performed.

The insurance does not cover critical illnesses that are directly or indirectly related to a previous illness that was diagnosed or treated before the insurance period or within the described waiting periods.

However, for diagnosis group 1 a (Cancer), if, before the insurance entered into force, the child received a diagnosis that would have been covered by the specified diagnosis, the insurance entails a right to payment for a new, unrelated cancer diagnosis if at least 10 years have passed since the first cancer diagnosis was made.

5. Limitation

A claim for payment for certain critical illnesses must be made within 3 years after the time at which an eligible illness was diagnosed. If the claim is made 3 or more years after the time of diagnosis, the right to payment in connection with the specific eligible illness lapses.

5.1. Liability period in connection with termination

In the event of termination of cover for one of the critical illnesses described above, an application for payment must be made no later than 6 months after cover was terminated. Otherwise, the right to payment lapses.

6. Amendment of the special terms and conditions

Skandia may amend the present special terms and conditions at one month's written notice.

7. Legislation and complaints

7.1. Legislation

The insurance complies with the general rules of Danish law, including the regulations in the tax legislation, Insurance Contracts Act and Financial Business Act in force from time to time, and the rules issued in pursuance of them, unless specified otherwise in the contractual basis or other terms and conditions linked to the contract.

7.2. Complaints about case processing

The insured is able to complain if the insured disagrees with Skandia's decision in a case. Complaints must be sent as soon as possible, and no later than 6 months after a decision has been made in the case, to:

Skandia
Østbanegade 135
DK-2100 København Ø
Att.: Den klageansvarlige

See more about complaint options at skandia.dk.

7.3. Complaints Board

If Skandia and the insured are unable to agree, they can complain to:

The Insurance Complaints Board
Anker Heegaards Gade 2
DK-1572 København V
Phone +45 33 15 89 00

A fee is payable for a complaint to the Complaints Board. The fee will be refunded if the insured has their complaint upheld.

7.4. Venue

Disputes arising out of the insurance contract must be settled under Danish law. Disputes that cannot be settled by arbitration must be settled at the Danish courts. The venue is Copenhagen.