skandia

General terms and conditions of insurance for certain critical illnesses

Terms and conditions of insurance valid from 1 January 2015.

No. 2015-01-01

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1. About the insurance

The insurance is established with Skandia Link Livsforsikring A/S, CVR number 20952237 – hereinafter called Skandia.

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

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

The insurance covers certain critical illnesses:

1 a	Cancer
1 b	Cancer of the blood, lymphatic system and blood-forming cells of the bone marrow
1 c	Certain benign tumours in the brain and spinal cord which progress aggressively and have severe permanent consequences
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 a	A blood clot in the heart (type 1 AMI)
3 b	Operation on cardiac vessels as a consequence of severe narrowing of coronary arteries (bypass operation (CABG) or PCI)
4 a	Heart valve operation on account of heart valve failure
4 b	Implantation of an ICD as secondary prophylaxis as a consequence of cardiac arrest
5	Chronic renal failure
6	Major organ transplant
7	Aortic disease
8 a	Multiple sclerosis with two or more (repeated) attacks
8 b	Amyotrophic lateral sclerosis (ALS) or another similar non-inherited motor neurone disease (MND) before the age of 60
8 c	Primary Parkinson's disease before the age of 60
8 d	Myasthenia gravis
8 e	Alzheimer's disease before the age of 60
8 f	Progressive muscular atrophy (myopathy and neuropathy) – with constant symptoms
9 a	HIV infection by blood transfusion or work-related infection
9 b	AIDS
10	Blindness
11	Deafness
12	Major burns or frostbite
13 a	Consequences of meningitis or cerebrospinal meningitis (incl. tick-borne encephalitis, Japanese encephalitis and cerebrospinal meningitis caused by malaria)
13 b	Borrelia infection in the nervous system following a tick bite

2. How the insurance provides cover

2.1. Reporting critical illness

When the insured receives a diagnosis that is expected to be covered by the terms and conditions of the insurance, they should contact Skandia to be sent an application form for payment for certain critical illnesses and a consent form. The application and consent forms are also available at skandia.dk.

2.2. Terms and conditions of cover

Payment of a sum insured for certain critical illnesses is conditional on the insured receiving 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 learned of the diagnosis.

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

Any limitations to the right to cover are described in section 4.

2.3. For individual insurance cover

Cover 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 diagnosis groups 1 a (Cancer) and 1 b (Cancer of the blood, lymphatic system and blood-forming cells of the bone marrow).

Any limitations to the right to cover are described in section 4.

2.4. Information to help with assessment

When Skandia has received the consent form, Skandia may, at any time, request patient records and certificates that Skandia finds necessary to assess whether the insured is entitled to payment for certain critical illnesses.
Skandia may also ask the insured for necessary information. Skandia may also ask the insured to review medical examinations to assess the right to payment for certain critical illnesses.

Skandia pays all expenses for the certificates and patient records requested by Skandia.

2.5. Payment

Payment for certain critical illnesses is made in accordance with the sum insured applicable on the date on which the illness was diagnosed.

Payment is made to the insured.

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

See under 4.2 'Limitations to insurance cover' the illnesses that are deemed to be the same critical illness.

However, for diagnosis groups 1 a (Cancer) and 1 b (Cancer in blood and blood-forming organs), the insured is entitled to payment for a new, unrelated cancer diagnosis made during the insurance period if 7 years have passed since the treatment for the first diagnosis was completed, and no relapse has been ascertained within this 7-year period (check-ups do not count as treatment).

3. The insurance covers

The insurance covers the following diagnosis groups

Eligible illnesses:

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 1-4 (malignant melanoma).
- Prostate cancer with a Gleason score of 6 or less (regardless of the treatment chosen).
- Bladder papillomas.
- Tumours arising during the course of HIV infection, including Kaposi's sarcoma.

1 b. Cancer of the blood, lymphatic system and blood-forming cells of the bone marrow

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[1]:

- 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.

The following are not covered:

- Chronic lymphatic leukaemia stages I and II.
- Hodgkin's lymphoma stage I.

1 c. 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 has caused significant neurological consequences (dysfunction) and reduced mobility equivalent to at least 15% permanent injury, assessed using the table issued by the National Board of Industrial Injuries.

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.

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)

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.
- Spontaneous or traumatic accumulation of blood 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.

Injury to the brain must be demonstrated using a brain scan (CT or MR).

[1] 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 diagnosis must be made at a neurological or neurosurgical department or be confirmed by a neurological specialist.

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

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. For a planned operation, the insured must be 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 a. A blood clot in the heart – spontaneous myocardial infarction related to ischaemia (type 1 AMI)
Acute necrosis of part of the heart's muscular tissue as a consequence of the blood supply to that part of the heart suddenly ceasing.

The diagnosis must be clear and unambiguous for acute myocardial infarction (MI) type 1 based on a typical increase and/or decrease in cardiac biomarkers (preferably troponin), where at least one value is clearly diagnostically raised, plus evidence of AMI with at least two of the following criteria:

- Symptoms of myocardial ischaemia (sudden, sustained chest pain).
- ECG changes indicating new ischaemia (new ST-T changes, new left bundle branch block) or development of pathological Q waves on the ECG.
- Diagnostic imaging evidence (echocardiograph, myocardial scintigraphy or MR scan) for new loss of muscular tissue/regional dyskinesia.

The diagnosis must be made at a hospital or by a cardiological specialist.

The following are not covered:

- MI in connection with PCI.
- MI in connection with bypass operation.

3 b. Operation on cardiac vessels as a consequence of severe narrowing of coronary arteries (bypass operation (CABG) or PCI treatment (coronary angioplasty)
Revascularisation treatment in the event of coronary artery calcification in the form of:

- PCI treatment on two or more coronary arteries,

or

- Performed or planned open-heart coronary artery bypass graft (CABG) on one or more coronary arteries.

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

4 a. Heart valve operation on account of heart valve failure
Planned or implemented cardiac surgery for heart valve failure with narrowing or a leak, involving the insertion of a mechanical or biological artificial heart valve and homograft or repair of the valve with plastic surgery.

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

4 b. Implantation of an ICD as secondary prophylaxis as a consequence of cardiac arrest
Planned or implemented implantation of an implantable cardioverter defibrillator (ICD) in connection with cardiac arrest.

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

5. 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 be made on the date of the operation. For a planned operation, the date on which the insured is accepted on the waiting list is deemed to be the diagnosis date.

6. 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 insured.

The diagnosis is deemed to be made on the date of the operation. For a planned operation, the date on which the insured is accepted 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 blood cancer, cf. 1 b.

The following are not covered:

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

7. Aortic disease
A rupture or local bulge of the aorta (aneurysm) to over 5 cm in diameter, an occlusion of the aorta (occlusion) or an aortic dissection with rupture of the inner layer of the aorta and bleeding into the wall of the aorta.

The diagnosis of aneurysm or dissection must be made using an MR scan or aortagram and an ultrasound examination, echocardiograph or CT scan of the abdomen.

The term aorta includes the thoracic and abdominal aorta but not their branches.

8 a. Multiple sclerosis with two or more (repeated) attacks
A chronic disorder of the central nervous system that has manifested itself through:

- two or more (repeated) episodes of resulting neurological symptoms from different parts of the central nervous system, followed by full or partial remission, combined with at least two characteristic lesions in the white substance of the brain (with demonstrated dissemination in time and space) in MR scans.

or

- An attack with a clear progressive course (Primary Progressive MS) or a severe attack in which the McDonald diagnostic criteria for MS are met.

Cover also includes neuromyelitis optica (NMO) with bilateral optic neuritis or myelopathy and optic neuritis, and MR changes centrally in the medulla over more than three segments.

The diagnosis must be made by a neurological specialist.

The following are not covered:

- Cases with just optic nerve impact (optic neuritis) or transverse myelitis.

8 b. Amyotrophic lateral sclerosis (ALS) or another similar non-inherited motor neurone disease (MND) diagnosed before the age of 60
A chronic disease caused by progressive degeneration of motor cells of the nervous system in the spinal cord, brain stem and brain, resulting in paralysis, muscular atrophy and spasticity.

The diagnosis must be made by a neurological specialist using the El Escorial criteria with lower motor neurone symptoms (LMN) and upper motor neurone symptoms (UMN) in at least three regions and progression of the symptoms and abnormal findings with electromyography (EMG) in clinically normal muscle.

Payment is subject to the diagnosis being made before the insured turns 60.

The cover does not include hereditary MND, including SMA.

8 c. Primary Parkinson's disease (paralysis agitans, shaking palsy) diagnosed before the age of 60
A chronic disease characterised by permanent increased muscular rigidity, tremor and reduction in spontaneous movements (oligokinesia).

The diagnosis must be made by a neurological specialist, and cover is subject to the presence of all classic main symptoms (tremor, rigidity and oligokinesia).

Payment is subject to the diagnosis being made before the insured turns 60.

The following are not covered:

- Symptoms of Parkinson's disease caused, for example, by psychoactive drugs, infections, blood clot or similar.
- Atypical Parkinson's (Parkinson+).
- Secondary Parkinson's.
- Parkinson's symptoms in connection with Dementia with Lewy Bodies.

8 d. Myasthenia Gravis
An autoimmune neuromuscular disease characterised by reduction in strength and rapid exhaustion.

The diagnosis must be made at a neurological department or by a neurological specialist and must be confirmed by at least two of the following examinations:

- EMG showing defective neuromuscular transmission.
- Acetylcholine receptor antibodies in the blood.
- A clear response to relevant medical treatment.

8 e. Alzheimer's disease diagnosed before the age of 60
A degenerative brain disease characterised by progressive loss of memory and loss of cognitive, linguistic and problem-solving ability.

The diagnosis must be made at a neurological department using the internationally recognised criteria for probable Alzheimer's disease.

(NINCDS-ADRDA) and MR scans must support the diagnosis with findings of progression of cerebral atrophy in medial temporal lobe structures.

Payment is subject to the diagnosis being made before the insured turns 60.

The following are not covered:

- Dementia accompanied by motor disturbance, for example as in Huntington's chorea and Parkinson's disease.
- Dementia as a result of cerebrovascular calcification (vascular dementia), trauma or infections.

8 f. Progressive muscular atrophy (myopathy and neuropathy) – with constant symptoms
A muscular disorder characterised by progressive loss of muscle mass and strength of facioscapulohumeral type, limb-girdle type or Charcot-Marie-Tooth disease.

The diagnosis must be made at a neurological department.

9 a. HIV infection by blood transfusion or work-related infection
Infection with HIV as a result of:

- A blood transfusion or other medical treatment, received after the commencement of the insurance period, for which the insured is entitled to compensation from the Danish Health Authority.

or

- A work-related lesion or exposure to infection of the mucous membranes during the performance of the insured's occupation after the start of the insurance period. Cover is subject to the accident being reported as an occupational injury and there being a negative HIV test, carried out within the first week after exposure to infection, followed by a positive test within the next 12 months.

9 b. AIDS
An acquired immune deficiency syndrome as a result of infection with HIV, acquired after commencement of the insurance period.

Cover is subject to documentation that the insured was infected during the insurance period and that the diagnosis was made at an infectious diseases department following the Danish Health Authority's criteria for notifiable AIDS.

10. Blindness
Permanent loss of vision in both eyes, where the visual acuity in the best eye is 1/60 (0.01666) or lower or tunnel vision is present with limitation of visual field to under 10 per cent.

The diagnosis must be made by an eye specialist.

11. Deafness
Total permanent loss of hearing in both ears with a hearing threshold of 100 dB or higher.

The diagnosis must be made by an ear specialist.

12. Major burns or frostbite
A third-degree burn injury (including frostbite or corrosive burns) covering at least 20 per cent of the insured's body area.

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

13 a. Consequences of meningitis or cerebrospinal meningitis (incl. tick-borne encephalitis, Japanese encephalitis and cerebrospinal meningitis caused by malaria)
An infection in the brain, cranial nerve roots or cerebral membranes caused by bacteria, viruses, fungi, etc. that has resulted in permanent neurological consequences, assessed by a neurological specialist, equivalent to permanent injury of 15 per cent or more using the table issued by the National Board of Industrial Injuries.

The insurance is paid out only when the neurological consequences are assessed as being stable, i.e. no earlier than after six months, and the consequences must be confirmed by a neurological specialist.
The diagnosis must be made at a neurological or medical department based on:

- Evidence of microbes in the spinal fluid.

or

- A spinal fluid examination with evidence of clear inflammatory reaction (pleocytosis) with an increased number of white blood corpuscles, possibly supplemented with MR/CT scans.

Tick-Borne-Encephalitis (TBE) must be verified with evidence of virus antibodies in serum and spinal fluid.

Japanese Encephalitis (JE) must be confirmed with evidence of Japanese Encephalitis virus in blood and spinal fluid.

Cerebrospinal meningitis caused by malaria must be confirmed by evidence of parasites in the blood.

13 b. Borrelia infection in the nervous system following a tick bite
Long-term or chronic neuroborreliosis (duration of more than 6 months) as a consequence of a tick bite that has resulted in permanent neurological consequences equivalent to permanent injury of 15 per cent or more using the table issued by the National Board of Industrial Injuries.

The insurance is paid out only when the neurological consequences are assessed as being stable, i.e. no earlier than after six months, and the consequences must be confirmed by a neurological specialist.

The diagnosis must be made on the basis of spinal fluid examinations, borrelia-specific antibody examinations, CT/MR scans, etc. and be assessed and confirmed by a neurological specialist.

4. The insurance does not cover

4.1. General exclusions

If, before the insurance entered into force or during any waiting period (see 2.2 'Terms and conditions of cover'), the insured

- was given a diagnosis,
- received treatment, or
- was being investigated for a diagnosis,

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

If the insured 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 six months after the most recent eligible diagnosis. If payment is made on acceptance on a waiting list, the six month period only begins when the operation has been performed. Diagnoses/diagnosis groups, cf. 4.2 'Limitations to insurance cover', that are not eligible for payment because they were made less than six months after the most recent eligible diagnosis will not be eligible later in the insurance period.

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.

In this connection, a number of illnesses are deemed to be one and the same critical illness. See 4.2 'Limitations to insurance cover' for these illnesses.

However, for diagnosis groups 1 a (Cancer) and 1 b (Cancer in blood and blood-forming organs), if, before the insurance entered into force, the insured received a diagnosis that would have been covered by one of the two specified diagnosis groups, the insurance entails a right to payment for a new, unrelated cancer diagnosis if

- at least 7 years have passed since treatment for the first disease was completed (checkups do not count as treatment) and
- no relapse was ascertained in the 7 years since the treatment was completed.

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

4.2. Limitations to insurance cover

The following illnesses are deemed, in these terms and conditions of insurance, to be one and the same critical illness and entail the invalidity of the associated diagnosis group(s):

- Diagnosis groups 1a (Cancer) and 1b (Cancer in blood and blood-forming organs), regardless of whether there may be another eligible cancer diagnosis.
- Diagnosis groups 2a (Cerebral haemorrhage or a blood clot in the brain (apoplexy)), 3a (Major blood clot in the heart), 3b (Operation on cardiac vessels on account of coronary artery calcification (bypass/PCI)) and 4a (Heart valve operation on account of heart valve failure).
- Diagnosis groups 2a (Cerebral haemorrhage or a blood clot in the brain (apoplexy)) and 2b (A bulge in cerebral arteries (aneurysm) or intracranial arteriovenous malformation (AVM)).
- Diagnosis groups 3a (Major blood clot in the heart), 3b (Operation on cardiac vessels on account of coronary artery calcification (bypass/PCI)) and 4b (Implantation of an ICD as a consequence of cardiac arrest).
- Diagnosis groups 4a (Heart valve operation on account of heart valve failure) and 7 (Aortic disease).
- Diagnosis groups 4b (Implantation of an ICD as a consequence of cardiac arrest) and 6 (Major organ transplant).
- Diagnosis groups 8d (Myasthenia Gravis) and 8f (Progressive muscular atrophy).
- Diagnosis groups 9 a (HIV infection by blood transfusion or work-related infection) and 9b (AIDS).

Cover for diagnosis group 13a (Consequences of meningitis or cerebrospinal meningitis) also does not apply if the diagnosis/condition is caused by neuroborreliosis and the insured has, at some stage, received payment for diagnosis group 13b (Borrelia infection in the nervous system following a tick bite).

4.3. Amendment of the terms and conditions of insurance

Skandia may amend the 'General terms and conditions of insurance for certain critical illnesses' at one month's written notice.

5. Limitation

A claim for payment for certain critical illnesses must be made within three years after the time at which an eligible illness was diagnosed. If the claim is made three 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 six months after cover was terminated. Otherwise, the right to payment lapses.

6. Legislation and complaints

6.1. 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.

6.2. Complaints about case processing

The policyholder or the insured is able to complain if they disagree with Skandia's decision in a case. Complaints must be sent as soon as possible, and no later than six 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.

6.3. Complaints Board

If Skandia and the policyholder or 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. Skandia will refund the fee if the policyholder or the insured has their complaint upheld.

6.4. 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.