Euro Accident Liv

Insurance for certain critical illnesses

Insurance terms

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Euro Accident Liv
CVR 39727412
Ørestads Boulevard 67 1. tv.
2300 København S, Danmark
Tel. +45 88 626 626
www.euroaccident.dk

Danish branch of Euro Accident Livförsäkring AB
Organisationnumber: 516401-6783

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1 Insurance for certain critical illnesses

1.1 Scope of the terms

The conditions in this section apply if the insurance policy includes insurance for certain critical illnesses.

The covers of the insurance and any clauses applicable to such covers are specified in the insurance certificate.

Euro Accident's General Insurance Terms shall also apply to the insurance.

In the event of any inconsistencies or disputes concerning the interpretation of this contract, the version in Danish shall take precedence, and its provisions shall apply.

1.2 Cover

The insurance is paid to the insured when the insured is diagnosed with one of the disorders or illnesses defined in clause 1.8 and the other cover conditions are fulfilled.

The insurance terms and the sum insured that apply at the time where the diagnosis is made and the other cover conditions are fulfilled shall be applied.

1.3 Time of cover

It is a requirement for payment of cover that the illness has been diagnosed and the other conditions for cover are fulfilled during the policy period. It is thus the time of diagnosis that is important and not the onset of the illness or the time where the insured becomes aware of the illness.

1.4 Illnesses before the policy period

The insurance shall not provide cover if, before the start of the policy period, the insured is diagnosed with, treated or examined for one of the critical illnesses and disorders or similar diseases and disorders defined in clause 1.8. However, see clause 1.8.1.4 regarding cancer.

The insurance does not entitle the insured to payment if an illness or disorder can be directly or indirectly associated with an illness or disorder with which the insured was diagnosed before the policy period.

1.5 Limited cover

Compensation for a specific critical illness is only paid once. Cover for the relevant illness and for similar illnesses/disorders as defined in clause 1.8 then lapses, with the exception of cancers, see clause 1.8.1.4.

1.6 Several diagnoses

The insured is entitled to payment of benefits for several diagnoses covered by the insurance if the diagnosis for the other illness covered by the insurance was made no earlier than 6 months after the diagnosis that previously entitled the insured to payment of benefits.

The 6-month time-limit is counted from completed operation if payment has been made upon inclusion of the insured on a waiting list.

If the insured is diagnosed with another illness covered under the insurance less than 6 months after the previous diagnosis covered, this illness will entitle the insured to payment of benefits later in the policy period.

1.7 Lapse on death

The right to compensation lapses on the death of the insured unless a written application for payment has been submitted to Euro Accident beforehand.

1.8 Illnesses covered under the insurance

The insurance includes the following critical illnesses:

1.8.1 Cancer and certain benign tumours

1.8.1.1 General cancers

The insurance covers malignant tumours that are diagnosed histologically and characterised by uncontrolled, infiltrating growth of malignant cells into adjacent tissue and tendency to local recurrence and spreading to regional lymph nodes and more remote organs.

The insurance does not include:

- Tumours that may be designated as premalignant, non-invasive, carcinoma in situ, borderline or as having low malignant potential
- Tumours arising in connection with HIV infection, including Kaposis sarcoma
- Skin cancer of any type, including skin lymphomas. However, stage 1-4 malignant melanoma is covered under the insurance
- Prostate cancer with a Gleason score of 6 or lower
- Bladder papilloma
- Neuroendocrine (carconoid) tumors grade 1 with no signs of invasive growth
- The diagnosis is considered made when the specialist has made the diagnosis based on a tissue sample.

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.1.2 Certain specific cancers.

1.8.1.2 Certain specific cancers

The insurance covers malignant cancers which arise in the blood, lymph nodes or in the blood-forming cells in the bone marrow and which have an atypical blood chemistry with uncontrolled growth of blood cells and a tendency towards progression and recurrence.

The insurance covers the use of cytotoxic (cell-killing) therapy such as chemotherapy, radiotherapy and therapy with biological drugs and/or transplant with stem cells/bone marrow from another human being for the following diseases:

- Acute leukaemia, chronic myeloid leukaemia in accelerated phase or blast crisis and chronic lymphatic leukaemia requiring treatment
- High-risk myelodysplastic syndrome and chronic myelomonocytic leukaemia
- Multiple myeloma/solitary myeloma requiring treatment
- Burkitt lymphoma, stage 2-4 Hodgkins lymphoma and non-Hodgkins lymphoma, except for less aggressive forms such as localised MALT lymphoma, Waldenström macroglobulinemia, mucosis fungides in the plaque stage and skin lymphoma such as localised CD30 positive lymphoma and cutaneous B-cell lymphoma localised in the skinThe diagnosis is considered made when the specialist has made the diagnosis based on a tissue sample.

The insurance does not include:

- Stage 1 Hodgkins lymphoma
- Stage 1 or 2 chronic lymphatic leukaemia

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.1.1 General cancers.

1.8.1.3 Certain benign tumours with serious sequelae

The insurance covers tumours which arise in and originate from the brain, brain stem, bone marrow or central nervous system in general and which involve severe neurological dysfunction and sequelae in the nervous system resulting in a degree of permanent injury of at least 15% according to the permanent injury rating list prepared by the National Board of Industrial Injuries.

It is a prerequisite for cover that a department of neurosurgery or a neurosurgeon assesses that the sequela is stable, and the right to cover cannot be exercised earlier than 3 months after diagnosis or surgery.

The insurance does not include:

- Cysts or granulomas
- Pituitary adenomas
- Acoustic neuromas (Schwannoma)
- Tumours in cranial/brain nerves

1.8.1.4 Special rules for cancers

However, it applies to cancers mentioned in clause 1.8.1. that even if the insured has been diagnosed with one of these cancers before the start of the policy period, the insured is still entitled to payment of benefits if:

- the cancer diagnosis is made no earlier than 7 years after completion of any treatment for the first diagnosis, and
- no recurrence has been diagnosed during this 7-year period

1.8.2 Cerebral thrombosis etc.

1.8.2.1 Cerebral thrombosis and cerebral haemorrhage

The insurance covers acute injury to the brain or brain stem resulting in neurological symptoms such as paralysis and/or vision,speech or sensory disturbances for more than 24 hours that may be confirmed on a CT or MRI scan of the brain. The injury may be due to:

- narrowing or blocking of an artery in the brain as a result of thrombosis or embolism;
- a spontaneous or traumatic accumulation of blood in the brain; or
- a spontaneous or traumatic accumulation of blood between the meninges as a result of a ruptured artery or a deformity in the brain's vascular system.

The diagnosis must have been made by a department of neurology or department of neurosurgery or confirmed by a neurologist.

Although a CT or MRI scan of the brain cannot confirm a thrombus, the insurance will provide cover if the insured has all the classical clinical symptoms of cerebral thrombosis and after 3 months has permanent objective neurological symptoms in the form of paralysis and/or vision, speech or sensory disturbances that may be caused by brain damage. Fatigue or cognitive symptoms do not entitle to cover under the insurance.

The insurance does not include:

- Transient ischaemic attack/Transitory cerebral ischaemia
- Cerebral infarctions or cerebral haemorrhage identified accidentally on a brain scan, for example as part of examination for another illness
- Thromboses or haemorrhage in the peripheral part of the nerve tissue, i.e. outside the brain, for example in the eyes and ears

If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.2.2 AV malformation and aneurysm
- 1.8.3.1 Acute coronary thrombosis
- 1.8.3.2 Coronary artery bypass surgery or balloon angioplasty
- 1.8.4.1 Heart valve surgery

1.8.2.2 AV malformation and aneurysm

In connection with arteriovenous vessel malformations, including cavernous angioma and aneurysms - confirmed by a CT or MRI scan or x-ray examination of the cerebral arteries - the insurance will cover planned or completed surgery if:

- the diagnosis is made by a department of neurology or department of neurosurgery
- the insured is included on a waiting list before planned surgery

The insurance also provides cover in cases where there is medical indication for surgery but the procedure cannot be performed for technical reasons

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.2.1 Cerebral thrombosis and cerebral haemorrhage

1.8.3 Coronary thrombosis etc.

1.8.3.1 Acute coronary thrombosis

The insurance provides cover for acute myocardial infarction of type 1 with necrosis in parts of the heart muscle tissue due to sudden stop of the blood supply to the relevant part of the heart. The diagnosis must be documented and be based on a clear increase and decrease in the cardiac biomarkers (especially troponin); of these, at least one value must be significantly increased.

There must also be evidence of acute myocardial infarction based on at least 2 of the following criteria:

- Classical symptoms of sudden typical persistent chest pain
- Changes on ECG that indicate new ischaemia or alternatively development of pathological Q waves
- Imaging evidence of regional dyskinesia/new loss of muscle tissue

The diagnosis must be unambiguous and made by a cardiologist or at a hospital.

The insurance does not include:

- myocardial infarction in connection with PCI
- myocardial infarction in connection with coronary artery bypass surgery

If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.2.1 Cerebral thrombosis and cerebral haemorrhage
- 1.8.3.2 Coronary artery bypass surgery or balloon angioplasty
- 1.8.4.1 Heart valve surgery
- 1.8.4.2 Implantation of ICD device

1.8.3.2 Coronary artery bypass surgery or balloon angioplasty

The insurance provides cover for planned or completed bypass surgery to one or more of the coronary arteries or completed balloon angioplasty to one or more of the coronary arteries

The diagnosis is considered to be made on the day of surgery.

Bypass surgery is covered when the insured is included on a waiting list before planned surgery.

If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.2.1 Cerebral thrombosis and cerebral haemorrhage
- 1.8.3.1 Acute coronary thrombosis
- 1.8.4.1 Heart valve surgery
- 1.8.4.2 Implantation of ICD device

1.8.4 Heart valve surgery etc.

1.8.4.1 Heart valve surgery

The insurance provides cover for planned or completed treatment for heart valve disease in the form of leak or narrowing with surgical insertion of biological or mechanical heart valve prosthesis and homograft or repair of the valve with plastic.

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The diagnosis is considered to be made on the day of surgery.

In case of planned surgery, the insured must be included on a waiting list.If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.2.1 Cerebral thrombosis and cerebral haemorrhage
- 1.8.3.1 Acute coronary thrombosis
- 1.8.3.2 Coronary artery bypass surgery or balloon angioplasty
- 1.8.7 Critical aortic disease.

1.8.4.2 Implantation of ICD device

The insurance covers planned or completed implantation of implantable cardioverter defibrillator (ICD) as secondary prophylaxis.

The diagnosis is considered to be made on the day of surgery.

If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.3.1 Acute coronary thrombosis
- 1.8.3.2 Coronary artery bypass surgery or balloon angioplasty
- 1.8.6 Organ transplant.

1.8.4.3 Chronic heart failure with severe symptoms at rest and functional impairment.

The insurance covers condition with chronically reduced left ventricular ejection fraction (EF) of 30% or less, with functional limitation during rest (e.g. dyspnoea, fatigue, palpitations) and which worsens during any kind of activity, corresponding to NYHA III or IV of the New York Heart Association, and where:

- the effects are present despite sufficient treatment for more than 6 months, or
- a cardioverter defibrillator (ICD device) has been implanted

The diagnosis must have been made by a cardiologist.

1.8.5 Bilateral chronic kidney failure

The insurance provides cover for bilateral, chronic and irrevocable kidney failure at such a stage that kidney transplantation or permanent dialysis is carried out.

The diagnosis must have been made by a nephrologist.

In case of surgery, the diagnosis is considered to be made on the day of surgery.

In case of planned surgery, the insured must be included on an active waiting list.

In case of dialysis, permanent dialysis must have been initiated.

1.8.6 Organ transplant

In case of organ failure in the insured, the insurance provides cover for planned or completed transplantation of heart, liver, lung, heart-lung, heart-lung-liver, kidney or pancreas.

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

The diagnosis is considered to be made on the day of surgery.

In case of planned surgery, the insured must be included on a waiting list.

The insurance also provides cover for completed transplantation with bone marrow or stem cells from another human being in other conditions than those stated in clause 1.8.1.2.

The insurance does not include:

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

If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.4.2 Implantation of ICD device

1.8.7 Critical aortic disease

The insurance provides cover for aortic rupture or local aortic expansion to more than 5 cm in diameter, blockage of aorta or aortic dissection with rupture in the inner layers of the aorta with bleeding into the aortic wall. Cover comprises both thoracic and abdominal aorta but not their branches.

In case of aneurysm or dissection, it is a prerequisite for cover that the diagnosis has been made by either:

- MRI/CT scan,
- Aortography,
- echocardiography or
- abdominal ultrasound

If the insured has previously been diagnosed with the following or received the following treatment, the insured is not entitled to payment of benefits under this clause, see clauses 1.4 and 1.5:

- 1.8.4.1 Heart valve surgery

1.8.8 Disseminated sclerosis etc.

1.8.8.1 Multiple sclerosis

The insurance covers chronic disease of the central nervous system confirmed *either* by one or several episodes of neurological functional deficiency in various parts of the central nervous system followed by complete or partial remission in combination with at least two characteristic lesions in the white matter of the brain (with confirmed dissemination in time and space) on an MRI scan or by a clearly progressive attack *or* a severe attack where the diagnostic criteria for MS according to McDonald have been fulfilled.

The insurance also covers neuromyelitis optica with bilateral opticus neuritis or myelopathy and opticus neuritis as well as MRI changes in the central part of the medulla in more than three segments.

The diagnosis must have been made by a neurologist.

The insurance does not include:

- Cases solely of transverse myelitis or optic nerve atrophy
- Diagnosis of CIS

1.8.8.2 ALS and non-hereditary MND (Motor neuron disease)

The insurance covers chronic illness characterised by progressive degeneration of the nervous system motor cells in the brain, the brain stem and the bone marrow resulting in paralysis, spinal muscular atrophy and spasticity.

It is a condition that:

- the diagnosis was made according to the El Escorial criteria with LMN and UMN in at least 3 regions and progressive symptoms and abnormal findings on electromyography in normal muscles, and
- the diagnosis was made by a neurologist

The insurance does not include:

- Hereditary MND and SMA.

1.8.8.3 Primary parkinsonism

The insurance covers chronic illness resulting in tremor, persistent increased rigidity and poverty of movement. It is a condition that:

- the insured has the main symptoms of the illness, namely tremor, rigidity or oligokinesia, and
- the diagnosis was made by a neurologist

The insurance does not include:

- Secondary Parkinson
- Atypical Parkinson
- Parkinson symptoms in connection with Lewy Body dementia
- Parkinson symptoms in connection with psychoactive drugs, infections, trombosis and the like.

1.8.8.4 Myasthenia gravis

The insurance covers autoimmune neuromuscular disease characterised by loss of muscular strength and rapid exhaustion. It is a condition that the diagnosis has been verified by at least 2 of the following examinations:

- Positive response to relevant medical treatment
- Acetylcholine receptor antibodies found in the blood
- Defective neuromuscular transmission confirmed by EMG

The diagnosis must have been made by a neurologist or at a department of neurology.

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.8.6 Muscular atrophy

1.8.8.5 Creutzfeldt-Jacob disease (CJD and vCJD)

The insurance covers progressive degenerative disease in the central nervous system caused by prions.

The diagnosis must have been made by a relevant hospital department and assessed as very likely based on:

- Typical clinical symptoms with progressive dementia, impaired speech, rigidity etc.
- Changes on EEG, MRI/CT scan and
- Laboratory analysis of cerebrospinal fluid (highly increased total-tau protein without changes in Alzheimer markers and prion markers (including PrP mutations, the 14-3-3 protein, neuron specific enolasis etc.).

1.8.8.6 Muscular atrophy

The insurance covers muscular disorders - either the Limb girdle type, the facioscapulohumeral type, Duchenne muscular dystrophy, Becker's muscular dystrophy, oculopharyngeal muscular dystrophy, dystrophia myotonica or Charcot-Marie-Tooth disease - that result in persistent, progressive loss of muscle mass.

The diagnosis must have been made by a department of neurology.

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.8.4 Myasthenia gravis

1.8.9 HIV and Aids

1.8.9.1 HIV infection

The insurance covers infection with HIV virus contracted after the start of the policy period which is either due to a work-related exposure to infection or a blood transfusion or other medical treatment where the insured is entitled to compensation from the Danish Health Authority. It is a condition that:

- the episode has been reported as an industrial injury,
- there is a negative HIV test within the first week after exposure to infection, and
- there is a positive HIV test within the next 365 days

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.9.2 AIDS

1.8.9.2 AIDS

Immunodeficiency syndrome due to infection with HIV virus. It is a prerequisite for cover that:

- it can be documented that the insured was infected after the start of the policy period, and
- the diagnosis has been made by a department of infectious diseases according to the AIDS criteria of the Danish Health Authority.

If the insured was already HIV positive when the insured became covered under the insurance, AIDS in flare-up is only covered if this diagnosis was made more than five years after the insured became covered under the insurance.

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.9.1 HIV infection

1.8.10 Blindness

Permanent loss of vision in both eyes. Visual acuity in the best eye must not exceed 0.01666. Alternatively, the insured has tunnel vision with a reduction of the field of vision to less than 10 %.

The diagnosis must have been made by an eye specialist.

1.8.11 Deafness

Permanent and irreversible hearing loss on both ears. It is a condition that the threshold of hearing is at least 100 dB.

It is a prerequisite for cover that the diagnosis is made by an ear specialist.

1.8.12 Major burns, frostbites and caustic burns

Third degree burns, frostbites or caustic burns covering at least 20% of the body.

The diagnosis must be confirmed by medical records from burn unit.

1.8.13 Meningo-encephalomyelitis, etc.

1.8.13.1 Sequelae from encephalitis or meningitis

An infection in the brain, meninges or cranial nerve roots caused by bacteria, viruses, fungus, etc. which has caused permanent objective neurological injury, corresponding to a degree of permanent injury of 8% or more according to the permanent injury rating list prepared by the National Board of Industrial Injuries. It is a condition that:

- the diagnosis was made by a department of neurology or medical department where microorganisms in the cerebrospinal fluid can be identified, alternatively that a cerebrospinal fluid analysis can reveal an obvious inflammatory reaction with increased number of white blood cells
- a neurosurgeon has assessed that the sequela is stable. However, cover cannot be obtained until 3 months after diagnosis, at the earliest.

It applies especially to the following three diseases that:

- encephalitis due to malaria must be verified by parasites in the blood
- Tick-borne encephalitis must be verified by the presence of virus antibodies in serum and cerebrospinal fluid
- Japanese encephalitis must be verified by Japanese encephalitis virus in blood and cerebrospinal fluid.

If the insured has previously been diagnosed with the following, the insured is not entitled to payment of benefits under this clause, see clause 1.4 and 1.5:

- 1.8.13.2 Borreliosis infection after tick bite.

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1.8.13.2 Borreliosis infection after tick bite

Neuroborreliosis due to tick bite – which causes permanent objective neurological injury of 8% or more according to the permanent injury rating list prepared by the National Board of Industrial Injuries. It is a condition that:

- the diagnosis was based on analyses of cerebrospinal fluid or borreliosis specific antibodies or on MRI/CT scan and it must be confirmed by a neurologist, and
- a neurosurgeon has assessed the sequela. As stable. However, cover cannot be obtained until 3 months after diagnosis, at the earliest.

1.8.14 Terminal disease

Terminal incurable disease where, despite possible medical treatment, there is medical documentation of an expected remaining life expectancy of less than 12 months from the date of diagnosis. It must be a condition that is not caused by conditions included by the Insurance for certain critical illnesses or due to an accident. There must be documentation from a specialist within the relevant specialty.