OP Critical Illness and Life Cover

Insurance terms and conditions valid as of 22 September 2021

Insurance issued by

Pohjola Insurance Ltd
Gebhardinaukio 1
00510 Helsinki, Finland

OP Life Assurance Company Ltd
Gebhardinaukio 1
00510 Helsinki, Finland

Insurance Services and Claims Settlement provided by AXA

PL 67, 00501 Helsinki
Insurance services and claims settlement, tel. 010 802 842

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Cover for critical illnesses is issued by Pohjola Insurance Ltd, which is a non-life insurance company owned entirely by OP Financial Group. The company is headquartered at Gebhardinaukio 1, 00510 Helsinki. The company is entered in the Finnish Trade Register under Business ID 1458359-3.

Life insurance cover and cover against permanent disability caused by an accident are issued by OP Life Assurance Company Ltd, a life insurer owned entirely by OP Financial Group. The company is headquartered at Gebhardinaukio 1, 00510 Helsinki. The company is entered in the Finnish Trade Register under business ID 1030059-2.

Insurance companies in Finland are supervised by the Financial Supervisory Authority, P.O. Box 103, 00101 Helsinki, Finland, Tel. 010 831 51. www.finanssivalvonta.fi.

OP Critical Illness and Life Cover

The insurance provides cover for critical illnesses defined in the insurance terms and conditions, permanent disability caused by an accident and death.

The lump-sum compensation for a critical illness or a permanent disability due to an accident is paid to the insured person themself. In case the insured dies, the life insurance benefit will be paid to the beneficiaries chosen by the policyholder.

The language of the contractual relationship is Finnish or Swedish.

The insurers are Pohjola Insurance Ltd (hereinafter "Pohjola Insurance") and OP Life Assurance Company Ltd (hereinafter "OP Life Assurance Company"), later referred to herein also as the insurance company or, collectively, the insurance companies.

Insurance against critical illnesses is issued by Pohjola Insurance Ltd.

Life cover and cover against accidental permanent disability are issued by OP Life Assurance Company Ltd.

AXA handles insurance and claims settlement services on behalf of and under the authorisation of Pohjola Insurance and OP Life Assurance Company.

1. Eligibility criteria

At the time of signing the insurance application, the insured must

- have resided in Finland for the past twelve (12) months;
- be at least 18 and no more than 64 years of age;
- be healthy and not suffer from any condition, injury, disease or chronic or occasional illness;
- have not undergone examination or received treatment due to any condition, injury, disease or illness by a physician within 12 months preceding the date of the insurance application and, to the knowledge of the insured person, have any need for such examinations or treatment;
- not be under any regular medication prescribed by a physician (e.g. blood pressure, cholesterol or antidepressant medication);
- not be aware of any scheduled medical treatment, examinations or procedures;
- not be under monitoring by a physician due to any health-related finding; and
- have never suffered from heart disease, circulatory disturbance, hypertension, paralysis, kidney disorder, cancer, immunological deficiency or disorder, liver or pancreatic disease.

2. Validity, insurance period, termination of insurance

2.1 Validity

2.1.1 Unless otherwise agreed and provided that the insurance company has received an insurance application with all required information and accepts the application and grants the insurance, the insurance will start from the date of signing the insurance application.

2.1.2 The insurance is valid 24/7 during both work and leisure time.

2.1.3 The insurance is valid worldwide.

2.1.4 In the event of cancer, the insurer pays compensation only when the illness is diagnosed no earlier than six (6) months after the start date of the validity of the insurance contract, as accepted by the insured in the insurance application.

2.2 Insurance period and premium period

Unless otherwise specified in the insurance contract, the insurance period is one year. The insurance contract is non-fixed term and is renewed automatically, unless either party terminates the insurance in writing. The annual due date of the insurance is specified in the insurance contract.

The insurance premium period is one month.

2.3 Termination of insurance

The validity of the insurance ends

2.3.1 when the insured turns 65; or

2.3.2 when the insurance company has paid out the full amount of compensation; or

2.3.3 when the policyholder terminates the insurance; or

2.3.4 after a notice period when the insurance company terminates the insurance in accordance with clause 2.4.2.

2.4 Termination

2.4.1 The policyholder has the right to terminate the insurance at any time. The termination must be done in writing.

2.4.2 The insurance company has the right to terminate the insurance in accordance with the Insurance Contracts Act

2.4.2.1 During the insurance period

- if, prior to issuing the insurance or after an insurance event, the insured has provided inaccurate or incomplete information (see 9.6); or
- if the insured person has wilfully caused the insurance event; or
- as the result of failure to pay the insurance premium (see 8.2);

3. Compensation and conditions for payment

3.1 Sum insured

The amount of compensation is the sum insured specified in the insurance contract; however, no more than EUR 100,000.

3.2 Simultaneous insurance coverage

The insured cannot be granted OP Critical Illness and Life Cover if, at the time of filing the insurance application, the insured has a similar policy or policies issued by AXA or Pohjola Insurance Ltd and OP Life Assurance Company Ltd and the combined insurance sum of the existing and applied insurance cover exceeds EUR 100,000.

3.3 Payment of compensation

Compensation for a critical illness is paid to the insured if the serious illness as defined in the terms and conditions is diagnosed or the operation related to it takes place after the insurance policy enters into force and during its validity.

Compensation for permanent disability due to an accident (minimum disability category 8) is paid to the insured if the permanent disability as defined in the terms and conditions is diagnosed during the validity of the insurance. The definition of an accidental permanent disability and the restrictions on compensation are listed in clause 5 of the terms and conditions.

Compensation for death is paid to the insured person's beneficiaries in accordance with clause 6.1. The restrictions on compensation related to the life cover are listed in clause 6.2 of the terms and conditions.

3.4 Beneficiaries

In the event of death, the beneficiaries are the insured's next of kin, unless the policyholder has notified the insurance company in writing of another beneficiary.

3.5 Partial compensation

If the insured has been paid a partial compensation for an individual coronary artery bypass operation (50%) or percutaneous transluminal coronary angioplasty (20%) in accordance with sections 4.3 and 4.5, and the insured wishes to continue the validity of the insurance, the insured and/or their beneficiary are entitled to compensation from the remaining sum insured in the event of a new loss event referred to in these terms and conditions. A partial compensation does not impact the insurance premium.

4. Critical illnesses

4.1 Cancer

meaning a malignant tumour (also leukaemia, Hodgkin's disease and malignant lymphoma) which has been diagnosed by a method approved by the insurance company histologically from a tissue or cell sample.

The following illnesses are excluded from the cover:

- all skin cancers, except invasive malignant melanoma
- all histologically classified precancerous conditions or neoplasms classified as carcinoma in situ (with the exception of ductal carcinomas in situ treated with total mastectomy and radiotherapy)
- all histologically confirmed precancerous conditions or neoplasms classified as carcinoma in situ
- 1st degree Hodgkin's disease
- all tumours appearing in connection with any virus causing immunodeficiency.

4.2 Myocardial infarction

meaning necrosis caused by insufficient blood circulation in the heart muscle. Early infarctions treated with blood thinning medication are excluded, unless the infarction has been diagnosed by means of angiography in addition to the criteria specified below.

The diagnosis of a myocardial infarction should be based on

- typical chest pain and
- recent changes in cardiogram pattern or
- increase in tracer concentrations or
- new damage to the heart muscle detected by medical imaging.

4.3 Coronary artery disease bypass operation

meaning surgical operation to bypass one or more narrowed or constricted coronary arteries using an arterial or venous transplant. If the treatment concerns the individual bypass of a single coronary artery, the insurance pays out 50% of the sum insured specified in the insurance contract.

4.4 Aortic valve or mitral valve surgery

meaning a prosthesis operation on the aorta, aortic valve or mitral valve. In the prosthesis operation on the aorta, the affected section of the aorta is removed and replaced with a transplant to correct the aortic stenosis, wall rupture or aneurysm. The insurance covers open-heart artificial valve replacement surgery on the aortic or mitral valve.

However, the following operations are not included in the cover:

- surgery on an aortic artery
- fitting stents or treating valvular insufficiency intravenously
- surgery due to accidental aortic injury.

4.5 Percutaneous transluminal coronary angioplasty

meaning internal treatment of a narrowed or constricted artery with a balloon dilation method. Compensation for the treatment is 20% of the sum insured up to two (2) times during the validity of the insurance.

4.6 Renal insufficiency

meaning severe, irreversible impairment in the function of both kidneys which had caused regular dialysis treatment to be instigated.

4.7 Stroke

meaning a necrosis of brain tissue, cerebral haemorrhage or a blood clot from outside the brain associated with permanent, at least moderate to severe (in accordance with the Workers' Compensation Insurance Act disability classification, a minimum disability category of 6) neurophysiologic deficiency, such as one-sided paralysis or extensive disturbance in sensation, and which can be diagnosed by a neurological examination.

Temporary disturbances in the cerebral blood circulation (TIA attacks) are excluded.

The claim settlement decision can be delayed by up to 12 months in order to ascertain the permanency of the changes caused by the illness.

4.8 Organ or bone marrow transplant

in which the insured is the recipient of a heart, lung, liver, pancreas, kidney or bone marrow transplant.

Pancreatic cell transplant is excluded.

4.9 Paralyses: paraplegia, hemiplegia, quadriplegia

meaning a complete and permanent loss of muscle power and sensation of at least two limbs, caused by an accident or illness. The diagnosis must be based on neurological examination. The claim settlement decision can be delayed by up to 12 months in order to ascertain the permanency of the changes caused by the illness.

4.10 Multiple sclerosis

meaning multiple sclerosis diagnosed by a neurologist on the basis of a clinical picture of the disease (at least two episodes of illness which include symptoms from at least two areas of the central nervous system, or at least two episodes of illness and a finding in the MRI scan or spinal fluid examination which supports the diagnosis).

The condition for the payment of compensation is that the illness has caused symptoms which have been continuous for a period of at least six (6) months immediately preceding the claim application.

4.11 Major burns

meaning 3rd-degree burns that cover at least 20% of the skin area as defined by "Rule 9" (Lund and Browder skin area map). In addition, major burns of the facial area (more than 50% of the facial skin is malformed).

4.12 Blindness

meaning complete, clinically diagnosed loss of sight in both eyes due to a sudden illness or accident. The loss of sight must be at least 90% and must be confirmed by an examination performed by an ophthalmologist.

4.13 Coma

meaning a loss of higher brain function (such as consciousness, observation ability and irritability) lasting at least one (1) month.

Coma caused directly by the use of alcohol, drugs or intoxicants as well as brain death are excluded.

4.14 ALS motor neurone disease (amyotrophic lateral sclerosis)

meaning amyotrophic lateral sclerosis diagnosed unequivocally by neurological examinations. The diagnosis must be made by a neurologist.

4.15 Alzheimer's Disease

meaning unequivocally diagnosed Alzheimer's Disease that causes permanent and significant cognitive impairment. The diagnosis must be made by a neurologist. Compensation can only be paid if the insured scores no more than 20 points in the MMSE test (mini-mental state examination) measuring cognitive performance.

Compensation will not be paid for Alzheimer's Disease caused by the insured person purposefully using

- prescription medicine or other intoxicating substance without a doctor's prescription
- a toxic substance or intoxicant, including alcohol.

4.16 Parkinson's Disease

meaning unequivocally diagnosed Parkinson's Disease. The diagnosis must be made by a neurologist and based on the diagnostic criteria and typical signs of a progressive and permanent neurological injury in accordance with generally accepted medical practice. The symptoms must include resting tremor, muscle stiffness, slowness of movement and difficulties with balance.

Other motoric symptoms and forms of illness similar to Parkinson's Disease are not compensated regardless of them being a result of medication, toxic substances or other illnesses that degenerate the nervous system.

4.17 Benign brain tumour

meaning tumour or a cyst in the brain, cranial nerves or intracranial cerebral membrane that has benign cells. Compensation can only be paid if the tumour causes permanent neurological disability and clinical symptoms that are equivalent to at least category 11 in the disability category.

The following illnesses are excluded from the cover:

- pituitary tumours
- intracranial granulomas and angiomas (vascular tumours).

4.18 Restrictions

No compensation is paid for a critical illness resulting from:

4.18.1 poisoning due to medication, alcohol or other intoxicant used by the insured or due to a substance taken as food; or

4.18.2 a symptom, associated disease or condition caused by AIDS or HIV infection; or

4.18.3 unrest, riots, uprising, service in peacekeeping forces, military coup or other coup d'état, war or military operation (regardless of whether the war has been officially declared); or

4.18.4 ionising radiation or radioactive contamination due to nuclear fuel or waste from burning of it; or

4.18.5 radioactive, toxic, explosive or other dangerous property of nuclear explosive or part of it.

5. Permanent disability caused by accident

5.1 Definition of an accident

An accident is a sudden, unpredictable, external occurrence beyond the control of the insured person and which causes bodily injury during the validity of the insurance. Drowning, heatstroke, sunstroke and frostbite beyond the control of the insured person are also considered accidents.

Conditions not arising from accidents include illnesses, diseases, naturally occurring disorders and degenerative diseases.

5.2 Definition of accidental permanent disability

Accidental permanent disability means a medical and general disability (disability) which is caused to the insured as a result of an accident. The right to compensation is established when the disability has been confirmed to be permanent and irreversible. The disability must be directly and independently resulting from an accident. Permanent disability may be determined 12 months after the occurrence of the disability at the earliest, unless its permanency and irreversibility can be determined with certainty at a sooner date. The permanent disability entitling to compensation must appear within 24 months since the accident. The degree of handicap is determined in accordance with the disability category decree issued by the Government on the basis of the Workers' Compensation Act. The degree of handicap of the permanent disability entitling to compensation must be at least 40% (equivalent to disability category 8 of the decree). The disability category is not affected by the profession or leisure time activities of the insured.

5.3 Restrictions

The permanent disability entitling to compensation must be a result of an accident that took place during the validity of the insurance. The permanent disability must also be diagnosed during the validity of the insurance.

No compensation is paid on the basis of this insurance if the bodily injury to the insured person is caused by:

5.3.1 injury resulting from surgery or other medical procedure, unless said procedure was performed for the purpose of treating an injury caused by an accident; or

5.3.2 poisoning due to medication, alcohol or other intoxicant used by the insured or due to a substance taken as food; or

5.3.3 unrest, riots, uprising, service in peacekeeping forces, military coup or other coup d'état, war or military operation (regardless of whether the war has been officially declared); or

5.3.4 ionising radiation or radioactive contamination due to nuclear fuel or waste from burning of it; or

5.3.5 radioactive, toxic, explosive or other dangerous property of nuclear explosive or part of it.

6. Death

6.1 Life insurance benefit

The benefit will be paid upon death of the insured person during the validity of the insurance.

6.2 Restrictions

No benefit will be paid if the cause of the insured person's death was:

6.2.1 the insured person's suicide committed within one year of the inception of the insurance cover. The age and state of mind of the insured person have no bearing on the application of this exclusion; or

6.2.2 the insured person's participation in an act of terrorism or civil uprising; or

6.2.3 the insured person's participation in a war, armed conflict or peacekeeping forces abroad; or

6.2.4 sudden impact of a weapon or device of mass destruction based on a nuclear reaction.

7. Claim procedure and payment

7.1 Clarifications and powers of attorney

To obtain compensation, the insured or the beneficiary must supply AXA with the claim application form duly filled in, as well as other appropriate clarifications required by AXA and powers of attorney needed by AXA to obtain clarifications from third parties to decide on the claim.

7.2 Medical certificates

If compensation is sought on the basis of a critical illness or permanent disability caused by an accident, the insured must, at their own expense, supply AXA with medical certificates and other information required to confirm the critical illness or permanent disability caused by an accident. If the physician appointed by the insurance company requires that the insured undergo examination, the insurance company will pay the incurred medical expenses. The insured is obliged to undergo such examinations in order to obtain compensation.

If compensation is claimed for death, the claim application should include a death certificate or post mortem report, as well as the estate inventory or an extract from the population register for the purpose of executing the estate inventory.

7.3 Claiming period

The claim or notification of the occurred insurance event must be submitted to AXA within one year from when the claimant has received information about the validity of insurance, the insurance event and the damaging consequence resulting from the insurance event, and no later than 10 years after the damaging consequence.

7.4 Payment term of compensation

The insurance company shall pay the compensation within 30 days of receiving sufficient clarification on the grounds for the claim. If the payment is delayed, the insurance company shall pay penalty interest on the compensation in accordance with the Interest Act in force at the time.

7.5 Filing a claim

You can claim for compensation for a critical illness or accidental permanent disability via AXA's online service. You can claim for life insurance benefits with a claim application form only. Claim application forms are available at OP cooperative bank branches, OP eServices at op.fi, and AXA at the address P.O. Box 67, FI-00501 Helsinki, tel. 010 802 842.

Completed claim forms should be sent to the above address with the recipient "AXA/Korvauspalvelut".

7.6 Appeal procedure

The primary appeal procedure is to request that the claim be processed again by AXA.

After this option has been used, the claim settlement decision may also be appealed by contacting FINE for advice and recommendations regarding a resolution at the address Porkkalankatu 1, FI-00180 Helsinki, tel. 09 6850 120, fine.fi/tunnistaudu, or to the Consumer Disputes Board, which provides recommendations on resolutions, P.O. Box 306, FI-00531 Helsinki, online at kuluttajariita.fi. Claim settlement decisions issued by the insurance company include detailed instructions on the appeal procedure.

If the claimant is dissatisfied with the insurance company's claim settlement decision or other decision affecting the position of the policyholder, insured person or other beneficiary, the claimant has the right to initiate legal proceedings in the Helsinki District Court or in the court of first instance of their domicile within three (3) years after having received written notice of the decision issued by the insurance company.

8. Insurance premiums

The insurance premium is determined by the insured person's age and use of tobacco products (incl. snus and e-cigarettes) and the selected sum insured. The insurance premium is adjusted annually as of the start of the insurance premium period following the birthday of the insured person. The premium period is one month.

8.1 Effects of smoking

The insurance premium is higher for smokers.

8.1.1 Definition of a smoker

The insured person is considered a smoker if they use or have used tobacco products (including snus and e-cigarettes) in the past 12 months before the start of the insurance.

8.1.2 Effects of taking up and quitting smoking on the insurance premium

If the insured person takes up the use of tobacco products during the insurance period, the insurance premium shall be increased to correspond to that charged from a smoker. Upon receiving written notice that the insured has taken up smoking, AXA will send the insured a notice on the increase in insurance premium and changes in other terms and conditions, and shall inform the policyholder of the right to terminate the insurance. The insurance premium will rise after 30 days of the date of sending the notification.

If the insured quits the use of tobacco products during the insurance period, the insurance premium will be lowered to correspond to that charged from a non-smoker 12 months after quitting smoking.

The insured is obligated to notify the insurance company of changes (see section 9.4). A written notice that the insured person has quit smoking may be made 12 months after quitting smoking at the earliest.

8.2 Payment of insurance premiums

The insurance premium is charged in the manner specified in the insurance contract.

If payment of the insurance premium is delayed more than 30 days, the insurer has the right to terminate the insurance to end after a 14-day notice period. However, the insurance is not terminated if the insurance premium is paid before the end of the notice period. In the event that the unpaid insurance premium serving as the basis for termination, with the exception of the premium for the first premium period, is paid within six months after the date when the insurance ended, the insurance will again become valid and the insurer's liability shall commence on the day following the payment. If the delay in payment of the premium is due to the policyholder's insolvency resulting from illness, unemployment or other special reason primarily beyond the policyholder's control, the insurance shall not expire, despite notice, until 14 days after the said obstacle has ceased to exist; however, no later than three (3) months after the end of the notice period.

The insurance company may deduct unpaid due premiums and other due payments from the compensation to the insured.

8.3 Refund of insurance premiums

If the insurance ends before the agreed date, the insurance company refunds the policyholder a part of the paid insurance premium. The refund is equal to that part of the insurance premium that concerns the time following the termination of the insurance. No refunds amounting to less than 8 euros are paid.

9. Giving inaccurate or fraudulent information

9.1 Before the insurance may be granted, the insured must provide correct and full responses to questions asked by the insurance company. During the insurance period, the policyholder and insured must, without undue delay, correct any information which the insured has discovered to be incorrect or incomplete.

9.2 If the insured person has acted fraudulently with regard to the abovementioned obligation, the insurance contract shall not be binding on the insurance company. The insurance company has the right to withhold all insurance premiums even if the insurance is annulled.

9.3 If the insured has, wilfully or through negligence which cannot be deemed minor, failed in their obligation to disclose information, and the insurance companies would have refused to grant the insurance altogether had the full and correct information been provided, the insurance companies are relieved from liability.

9.4 If the insured has taken up smoking while the insurance is valid or the policyholder has, wilfully or through negligence which cannot be deemed minor, failed to notify the insurance company, the compensation payable shall be reduced by the amount equal to the difference of the insurance compensation for smokers and non-smokers.

9.5 The sanctions specified above for negligence of the obligation to provide information or for fraudulent conduct may be arbitrated in the event that they would result in manifest unfairness for the insured or other beneficiary.

9.6 If the insurance company is informed during the validity of the insurance that the obligation to provide information specified in clause 9.1 has been neglected in a manner specified in clause 9.3, or the insured has given inaccurate or incomplete information, as specified in clause 9.7, the insurance company is entitled to terminate the insurance in one month from giving notice of termination to the policyholder.

9.7 If the insured has, when claiming for compensation, fraudulently given incorrect or incomplete information that are relevant for determining the liability of the insurer, the compensation can be reduced or refused in accordance with what would be reasonable under the circumstances.

10. Causing an insurance event

10.1 Insurance event caused by the insured

The insurance company is released from liability to any insured person who has wilfully caused an insurance event.

If the insured has caused the insurance event through gross negligence, the insurance company's liability may be reduced, depending on what is deemed reasonable in the circumstances.

If the insured person has committed suicide, the insurance company is liable for compensation under life insurance, provided that the liability began more than one year before the suicide.

10.2 Insurance event caused by the beneficiary

If a person entitled to compensation or benefit other than the insured has wilfully caused the insurance event, the insurance company is released from liability to such party.

If such a person has caused the insurance event through gross negligence or they were at an age or in a state of mind which meant that they could not be sentenced for a crime, the compensation or part of the compensation may be paid to them, but only when this is deemed reasonable considering the circumstances in which the insurance event was caused.

If the insured has died, the other parties entitled to compensation are paid that part of the compensation which is not paid to the person(s) who caused the insurance event.

11. Applicable law

This insurance and the interpretation of its terms and conditions are governed by Finnish law.

12. Disclosure of information

The insured person authorises the insurance companies, AXA, the Social Insurance Institution of Finland (Kela), employee pension institutions, physicians, hospitals and health centres to disclose and receive information about the insured person's health and any other information necessary for processing and investigating the claim application. The insurance companies also have the right to disclose relevant information to their reinsurers, if this is necessary for providing the reinsurance.

12.1 Personal data processing

The insurance companies and AXA handle their customers' personal data in compliance with the Personal Data Act and insurance legislation, and ensure privacy protection in processing their customers' personal data. Insurance companies and AXA process their customers' personal data to manage various insurance-related tasks, such as when drafting the insurance contract, during the insurance period, and in settling insurance claims. Personal data is collected from their customers themselves, parties authorised by customers, registers maintained by public authorities, and from the credit information register.

Due to the provision of the Insurance Companies Act on confidentiality, the insurance companies and AXA will not divulge information about their customers to third parties, except with the customer's consent, or when the disclosure has a legal basis.

The privacy statements of the insurance companies are available online at http://clp.partners.axa/fi (AXA) (see tietosuoja 'privacy statement') and http://op.fi/dataprotection (OP Life Assurance Company and Pohjola Insurance), and at the companies' branch offices and OP cooperative bank and Helsinki OP Bank Plc branches.

13. Key concepts

The insured person is a person who is covered by the insurance which the insurance contract concerns.

A policyholder is the party that enters into the insurance contract with the insurance company and manages the insurance.

14. Amending the insurance terms and conditions

The insurance companies have the right to amend the insurance terms and conditions and premiums and other terms of contract at the end of each calendar year on the basis of:

- new or amended legislation or a regulation issued by the authorities or
- an unforeseen change in circumstances (e.g. an international crisis, exceptional natural event, catastrophe) or
- changes in insurance claims expenditure.

With respect to death cover, the insurance terms and conditions and insurance premium may only be changed provided that

- there is a special reason for the amendment due to changes in the general trend in claims expenditure or interest rates and
- the content of the insurance contract does not change essentially from that of the original contract.

The insurance company also has the right to make minor changes to the insurance terms and conditions, provided that the changes do not affect the essential content of the insurance contract.

Pohjola Insurance Ltd, Business ID 1458359-3
OP Life Assurance Company Ltd, Business ID 1030059-2

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Domicile: Helsinki, main line of business: insurance
Regulatory authority: Financial Supervisory Authority, www.fiva.fi

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