Pohjola Insurance

Comprehensive Health Insurance Group policy

Insurance terms and conditions valid as of 1 January 2020

Read the cover restrictions and exclusions carefully.

CONTENTS

COMPREHENSIVE HEALTH INSURANCE GROUP INSURANCE

The insurance terms and conditions comprise the following two sets of terms and conditions: these terms and conditions and the general terms of contract.

1 Those insured

Those insured are the persons or group of persons named in the insurance policy.

2 Content of insurance

The insurance comprises three kinds of cover:

- medical treatment expenses cover
- crisis cover
- medical examination cover

The medical examination cover is optional in Comprehensive Health Insurance and is included in the insurance only if so indicated in the insurance policy. The crisis cover as supplementary cover is an integral part of the medical treatment expenses cover and is valid as long as but no longer than the medical treatment expenses cover.

3 Validity of insurance and key concepts

The insurance contract is valid as stated in the general terms of contract.

The insurance cover for those insured will terminate in the following cases:

- The insurance will terminate at the end of the insurance period during which the insured person reaches the age of 80.
- The insurance cover for the insured will terminate on the date when the insured moves from Finland or his Kela card expires.
- The insurance will terminate when compensation equalling the sum insured in the insurance policy has been paid out for the benefit of the insured person.
- The insurance will terminate when the insured persons employment with the policyholder terminates. The last day of validity for the insurance is the insured persons last day of employment.
- The insurance will terminate on the same date when occupational healthcare arranged for those insured by the policyholder, corresponding to at least compensation class II specified in the Health Insurance Act, terminates.
- The insurance will terminate upon death of the insured person.

In respect of the insured person, in cases other those stated above the insurance terminates in one month's time of the date the policyholder or the insurance company sent the insured person a notice of termination or notified him/her of the termination of the insurance as agreed in the group insurance.

The insurance only covers examination and treatment performed and given in Finland.

Accident and illness as concepts

An accident is a sudden, external occurrence which is beyond the control of the insured person and which causes bodily injury.

The following are also considered to be accidents: unintentional drowning, heatstroke, sunstroke, frostbite, injury caused by a considerable variation in atmospheric pressure, gas poisoning sustained by the insured person, and poisoning caused by a substance taken inadvertently.

An illness refers to a person's condition requiring medical treatment, which, on the basis of a report received, has been detected to occur in a way other than accidentally and which, according to an official diagnosis, is classified as an illness.

If there is a clear medical connection between an illness or injury caused by an accident, these are regarded as the one and same illness or injury.

An injury or illness caused by an attempted suicide is not coverable as an accident or illness.

Examination

Examination refers to a medical examination.

4 Medical treatment expenses cover

4.1 Medical treatment expenses cover compensates

4.1.1 Coverable expenses consist of those incurred due to examination and treatment performed or prescribed by a specialist physician and arising from the insured persons illness or injury caused by an accident.

If the insurance has been granted **without a health declaration**, the insurance will cover illnesses or accidental injuries that are in accordance with the scope of coverage but rather have been diagnosed or sustained before the insurance took effect.

If the insurance has been granted **with a health declaration**, the insurance will not cover illnesses or accidental injuries that are in accordance with the scope of coverage but rather have been diagnosed or sustained before the insurance took effect.

The insurance will cover only costs incurred during the validity of the insurance.

4.1.2 The examination and treatment must be carried out in a nursing institution specified or separately approved by the insurance company. An instrument must also be acquired from a firm or place specified or separately approved by the insurance company.

4.1.3 A referral given by the insured persons company doctor is required for an appointment with a specialist. The company doctor must receive feedback on the examination and treatment performed and prescribed by the specialist.

4.1.4 Expenses are coverable provided that the examination or treatment of the illness or injury caused by an accident is performed or prescribed by a specialist. Furthermore, the examination or treatment must be in accordance with generally accepted medical practice and necessary for the treatment of the illness or injury caused by an accident. Of these expenses, the following are coverable:

a) costs of examination and treatment performed by healthcare professionals

b) costs of medicinal products and wound dressings sold at pharmacies are covered only when specifically agreed in the insurance policy. In this case, medicinal products are also covered if pharmaceutical treatment initiated by a specialist is continued by a general practitioner.

c) daily hospital charges up to the daily maximum specified in the insurance policy. A daily hospital charge refers to a payment charged by a nursing institution, which is based on the insured person being recorded as an overnight inpatient. If the insurance covers daily hospital charges, the daily maximum specified in the insurance policy will be paid for the first day the insured person is an inpatient

d) costs of examination and treatment of dental injury caused by an accident

e) costs of physiotherapy, foot therapy or occupational therapy necessary for recovery from a surgical operation or plaster treatment. Physiotherapy is also covered in knee and shoulder illnesses or injuries in which physiotherapy is applied instead of surgery. A maximum of one therapy series consisting of up to ten (10) sessions of physiotherapy, foot therapy or occupational therapy is coverable per surgical operation or plaster treatment, or when physiotherapy is applied instead of surgery.

f) charges for psychotherapy given by a psychotherapist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira). A maximum of 20 psychotherapy sessions per insured person are coverable during the validity of the medical treatment expenses insurance

g) rental charges for temporary medical appliances required for recovery by the surgical operation's after-treatment. Rental charges are coverable for a maximum of three months. Rental charges for an appliance for permanent or long-standing use are not coverable.

h) costs of the acquisition of the first orthopaedic brace or bandage acquired owing to a coverable operation or accident. In cases like this, these expenses are only covered up to EUR 500 per operation or accident.

If the surgical treatment of the insured person coverable illness or injury caused by an accident requires organ or tissue donation from another person, surgery costs incurred by this person in Finland and the related direct hospitalisation expenses will also be coverable within the maximum limits of the remaining sum insured, as follows:

- costs of an organ or tissue donators surgical operation performed by a physician
- costs of hospital care directly connected with the operation

In addition, the following costs are covered for any of the serious illnesses listed below, provided that the illness has been diagnosed:

i) costs of a maximum of 20 physiotherapy sessions per insured person during the validity of the medical treatment expenses insurance.

j) charges for psychotherapy given by a psychotherapist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira). A maximum of 20 psychotherapy sessions per insured person are coverable during the validity of the medical treatment expenses insurance.

k) costs of neuropsychotherapy, occupational therapy and speech therapy given by a healthcare professional. A maximum of 20 sessions of these therapies per insured person are coverable during the validity of the medical treatment expenses insurance.

Serious illness

Serious illnesses refer to the following illnesses and injuries diagnosed during the valid period of the insurance policy:

- **Cancer**

  Cancer refers to any malignant growth or tumour caused by abnormal and uncontrolled cell division that may spread to the other part of the body. Cancer also includes leukaemia, Hodgkin's disease and malignant lymphomas. In order for the insured person to be entitled to compensation, the diagnosis must be based on a histological tissue or cell sample.

  The insurance does not cover skin cancer, except invasive malignant melanoma, or growths histologically classified as pre-cancer or ca in situ, or Stage 1 Hodgkin's lymphoma. Nor does the insurance cover prostate pre-cancer, which histologically belongs to TNM classification T1, and papillary microcarcinoma of the thyroid or bladder. Cancer related to a viral infection is not covered by the insurance.

- **Myocardial infarction**

  Myocardial infarction refers to the destruction of heart tissue resulting from obstruction of the blood supply to the heart muscle. In order for the insured to be entitled to compensation, a diagnosis must be performed in the acute phase in a nursing institution, based on typical chest pain symptoms, fresh changes in cardiogram and an increase in heart marker levels.

  I. Clinical symptoms suggestive of the acute phase of myocardial infarction

  II. Fresh changes in EKG suggestive of myocardial infarction

  III. Enzyme changes typical of myocardial infarction, a rise in CK-Mbm and/or troponin level or some other marker of myocardial injury.

- **Stroke**

  Stroke (brain attack) refers to a freshly diagnosed cerebral haemorrhage or brain tissue necrosis (cerebral infarction) caused by the blockage or rupture of a blood vessel in the brain, or a clot formed in some part of the body outside the brain, or by an accident. In order for the insured to be entitled to indemnity, the diagnosis

  A transient ischemic attack (TIA) showing symptoms for less than 24 hours is not covered by the insurance.

- **Multiple sclerosis**

  Multiple sclerosis (MS) refers to a disease diagnosed by a neurological clinic as MS in accordance with generally accepted nursing practice.

4.2 Maximum indemnity

During the validity of the medical treatment expenses insurance, expenses are coverable up to a maximum of the sum insured specified in the insurance policy per insured person. Benefits paid to each insured person will reduce his/her remaining sum insured.

Expenses caused by the one and same illness suffered or the one and same accident sustained by the insured are covered up to the maximum amount of compensation entered in the insurance policy. If there is a clear medical connection between an illness or injury caused by an accident, these are regarded as the one and same illness or injury.

For any examination or treatment at a public healthcare unit, the insurance covers only the patient fees charged from the insured person.

4.3 Exclusions related to payment of compensation

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act or under some other legislation.

For any examination or treatment at a public healthcare unit, the insurance covers only the statutory client fees charged from the insured person.

Compensation will be paid only if the expenses have incurred during the validity of the insurance.

The insurance does not cover expenses incurred by the employer, the company or anyone else but the insured person.

Medical treatment expenses insurance does not cover costs of

- examination or treatment of a person who has no employment contract with the policyholder
- examination or treatment included in other occupational healthcare provided by the policyholder
- examination and treatment performed without a company doctors referral
- examination or treatment of teeth or the periodontium or related to bite correction or orthodontic treatment, unless the purpose is to treat a dental injury caused by an accident. Injury caused by biting a tooth or dentures is not coverable, even if an external factor has contributed to the damage
- examination or treatment provided by a physiotherapist, foot therapist, occupational therapist, chiropractor, osteopath, naprapathy, practitioner, masseur or equivalent health care professional, with the exception of the situation specified in clause 4.1.4 e) or i) above
- examination or treatment related to pregnancy, its prevention, childbirth, abortion or infertility or complications caused by these events or conditions
- examination and treatment related to an illness or accident caused by consumption of alcohol, other intoxicant, medicinal or narcotic substances
- examination and treatment related to addiction to narcotic substances, alcohol, medicinal substances, nicotine or other similar substances, or some other addiction
- treatment for snoring, unless the treatment concerns sleep apnea verified by means of sleep registration
- rehabilitation
- psychotherapy, neuropsychotherapy, occupational therapy or speech therapy or other equivalent treatment, with the exception of treatment as referred to in f), j) and k) of Clause 4.1.4 above
- micronutrient, mineral, nutritive or vitamin preparations or basic creams/lotions or anthroposophic or homeopathic products

- correction of refractive errors
- examination or treatment related to outward appearance or looks
- examinations or treatments related to breast reduction, enlargement or modification, skin peeling or dermabrasion or the lifting or rejuvenation of eyelids, areas around the eyes or other facial feature
- medicinal treatment of obesity, liposuction, gastric bypass or sleeve operation or other weight-loss surgery or other obesity examination and treatment, unless it is a case of obesity surgery that fulfils the criteria for public health care
- examination or treatment related to transsexuality, other sexual identity disorder or disorder of sexual preference
- treatment whose primary reason is to improve the person's quality of life; this includes medication that enhances sexual performance. This restriction is not applied, however, in case of medicinal products that have been compensated under the Health Insurance Act
- examination or treatment of generally hazardous and monitored communicable diseases, as defined in the Communicable Diseases Decree
- acquisition of medical equipment, other aids or artificial limbs, with the exception of aids and braces in cases referred to in Clause 4.1.4 g) or h) above.
- examination or treatment of an illness or injury caused by an accident arising from a nuclear accident referred to in the Nuclear Liability Act, irrespective of the site of the nuclear accident
- examination or treatment of an illness or injury caused by an accident arising from war or armed conflict. This exclusion will not apply during the 10 days from the beginning of armed operations, unless a major war is concerned or the insured person participated in said operations.

Medical treatment expenses insurance does not cover

- fees for doctors statements unless the company has requested such a statement.
- other indirect expenses, such as travel and accommodation expenses.

Neither does the medical treatment expenses insurance cover expenses arising from examination or treatment, if the illness or injury caused by an accident was sustained in

- sport games or matches arranged by a sports association or club, or in training arranged according to a training programme or in training typical of the sports. By competitive sports we mean sports games or matches arranged by a sports association or sports club and training arranged according to a training programme or other training typical of the sport, regardless of the age of the insured person. However, we do not consider non-competitive or over-35 sports organised as part of a sports federation and sports club as competitive sports.

  By training arranged according to a training programme we mean training carried out following either a written or verbal training plan (the coach does not have to be present). Other training typical of the sport refers to training that supplements the main sport when done as part of preparation to games or sports. However, if it has been agreed upon and entered in the insurance policy, the insurance is also valid in competitive sports.
- the following sports or activities:
  - combat, contact or self-defence sports
  - motor sports
  - airborne sports
  - climbing sports, such as mountain, rock, ice climbing
  - scuba diving or free diving
  - freestyle skiing, speed and downhill skiing, or skiing on unprepared slopes or outside marked slopes.

4.4 Reasonableness of expenses

If it becomes apparent that the claimed expenses substantially exceed the generally accepted and applied reasonable level, the insurance company has the right to lower the amount of compensation but not, however, below the reasonable level.

5 Crisis cover

5.1 Crisis Cover compensation

5.1.1 Coverable expenses include those arising from a group crisis therapy session held by a psychologist or other healthcare professional and arranged following a death of an employee on duty or because of co-determination procedures underway. Such codetermination negotiations must concern more than half of the personnel insured by the insurer under this insurance or statutory workers' compensation insurance.

The death must have occurred or the co-determination procedures must have begun during the validity of the insurance.

5.1.2 The insurance cover is valid in Finland. The crisis therapy must start no later than one week of the death or the beginning of the co-determination negotiations.

5.1.3 Expenses are coverable provided that the company has officially decided to provide therapy.

Such coverable expenses include a psychologists or other healthcare professionals fee for a crisis therapy session.

5.2 Maximum compensation and maximum compensation period

Crisis therapy expenses incurred by the policyholder are coverable up to three therapy sessions held for the same group over a maximum period of two months. This period begins from the date when the first expense was incurred.

The policyholders crisis therapy expenses are coverable up to the limit specified in the insurance policy.

Compensation paid will not reduce the sum insured stated in the insurance policy

5.3 Exclusions related to payment of compensation

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act or under some other legislation.

Compensation will be paid only if the expenses have incurred during the validity of the insurance.

Coverable expenses exclude those arising from other therapy or individual therapy such as psychotherapy.

Indirect expenses, such as travel and accommodation expenses, are not coverable.

5.4 Reasonableness of expenses

If it becomes apparent that the claimed expenses substantially exceed the generally accepted and applied reasonable level, the insurance company has the right to lower the amount of compensation but not, however, below the reasonable level.

6 Medical examinations cover

The medical examination cover is optional in Comprehensive Health Insurance and is included in the insurance only if so indicated in the insurance policy.

6.1 Coverable expenses

Coverable expenses include those arising from a medical examination of the insured person performed in order to prevent

- diabetes, arterial hypertension, lipoidosis
- intestinal, cervical, breast and prostatic cancer, and
- medical examinations performed to prevent the insured person from going down with a mental illness.

Medical examination must be carried out in a nursing institution specified or separately approved by the insurance company.

A referral given by the insured persons occupational healthcare professional is required for such a medical examination.

For using this insurance cover, the occupational healthcare service provider must draw up a plan for the need of medical examinations in order to prevent the above-mentioned illnesses. The plan must take account of the age and gender of the insured person and examinations/tests performed previously regarding the same illness in accordance with generally accepted nursing practice, which means that the extent of the examination/test may be smaller and the period between examinations may be longer than two years.

Regardless of the extent of the medical examination, no more than one medical examination within two years per insured person is covered.

The medical examination for diabetes, arterial hypertension and lipoidosis include body mass index, waist measurement, arterial hypertension, blood glucose and lipid tests.

The medical examination for intestinal cancer includes a faecal blood test, for cervical cancer a Pap test, for breast cancer mammography, and for prostatic cancer a PSA blood serum test.

The medical examination for mental illness includes charting symptoms during a single session using a standardised questionnaire or through a clinical interview.

Examination procedures must be based on generally accepted medical practice and necessary in terms of screening for the illness in question.

6.2 Exclusions related to payment of compensation

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act or under some other legislation.

For any medical examination at a public healthcare unit, the insurance covers only the patient fees charged from the insured person.

Compensation will be paid only if the expenses have incurred during the validity of the insurance.

The insurance does not cover expenses incurred by the employer, the company or anyone else but the insured person.

Expenses not coverable are those arising from

- medical examination of a person who has no employment contract with the policyholder
- medical examination performed without a referral given by the occupational healthcare service provider
- a test or medical examination that is included in other occupational healthcare service provided by the policyholder.

Coverable expenses exclude

- fees for doctors statements
- other indirect expenses, such as travel and accommodation expenses.

6.3 Reasonableness of expenses

If it becomes evident that the expenses for which indemnity is claimed clearly exceed the generally accepted and reasonable level, the insurance company has the right to lower the amount of indemnity but not, however, below the reasonable level.

7 Claiming compensation under medical treatment expenses cover and medical examination cover

7.1 Notification of an insurance event

Claimants must notify the insurance company in writing of the insurance event by filling in the insurance company's claims form accompanied by receipts and documents submitted to the insurance company.

7.2 Receipts

The claimant must pay the expenses him/herself before claiming for compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming for compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution (Kela) within six months of paying the expenses. The claimant must upon request provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

If the insured person has a customer card enabling direct debiting, it may be used on the condition that the provider of the healthcare service or some other party billing treatment expenses deducts from the bill the portion compensated under the Health Insurance Act, after which the remaining amount may be charged to the insurance

company. Users of customer cards must also present their valid Kela card (social security card). In addition, a referral to a specialist, or a copy of it, given by the occupational health care provider, must be sent to the insurance company.

7.3 Period for claiming compensation

A claim for expenses must be submitted to the insurance company within one year of the date when the expenses incurred.

8 Claiming compensation under crisis cover

8.1 Statement of crisis therapy and receipts

The policyholder must send the insurance company a written statement of the crisis therapy given. This can be performed by filling in the insurance company's claims form accompanied by receipts and documents submitted to the insurance company.

The claimant must pay the expenses him/herself and send original receipts to the insurance company. A copy of the official decision on the provision of crisis therapy must also be sent to the insurance company.

8.2 Period for claiming compensation

A claim for expenses must be submitted to the insurance company within one year of the date when the expenses incurred.

HEALTH INSURANCE, GENERAL TERMS OF CONTRACT

The General Terms of Contract contain the relevant provisions of the Insurance Contracts Act. The insurance contract is also subject to certain provisions of the Insurance Contracts Act not appearing from these General Terms of Contract. The clauses below apply to group insurance unless otherwise agreed in respect of a matter stipulated in the group insurance contract or the terms and conditions.

Insurance for companies and institutions comply with clauses pertaining to them in policies that commenced on 1 January 2015 or later. If the policy commenced before 1 January 2015, clauses concerning policyholders who are consumers or comparable to consumers are applied.

YLT 1 Key concepts

Insurance of the person, or personal insurance, is insurance by which a natural person is covered,

The essential content of an **insurance contract** is defined in the insurance policy and the insurance terms and conditions.

The policyholder is the party who has concluded an insurance contract with the insurer.

The insurer is the insurance company issuing the insurance. In these terms and conditions, the insurer is referred to as 'the insurance company'.

The insured is a person who is covered by personal insurance.

Consumer is a person who acquires consumer goods mainly for a purpose other than his/her business activity.

A policyholder comparable to a consumer is a natural or legal person who, considering the nature and extent of his/her business or other activity as well as other circumstances, is comparable to a consumer as a contracting party of the insurer.

The insurance period is the agreed period recorded in the policy during which the insurance is valid. The insurance contract continues for one agreed insurance period at a time, unless either contracting party gives notice of termination.

Premium period is the period for which a premium is paid at regular intervals as agreed.

An insurance event is an event for which compensation is paid under the insurance.

Group insurance is insurance under which those insured are members of a group as defined in the insurance contract and the premium is paid in full by its policyholder.

YLT 2 Disclosure of information prior to concluding an insurance contract

2.1 Insurance company's obligation to disclose information

Prior to concluding an insurance contract, the insurance company will provide the insurance applicant with essential information on such matters as the insurance company's own types of insurance, premiums and insurance terms and conditions, so that the applicant can evaluate his/her insurance needs and choose the most suitable insurance cover.

The insurance company will also bring to the applicants attention the most important restrictions on the insurance cover.

2.1.1 Insurance company's failure to disclose information

2.1.1.1 Corporate and institutional insurance

If the insurance company or its representative has given the policyholder incomplete, incorrect or misleading information when marketing the insurance, the insurance company will correct the incorrect information promptly as soon as the error is detected. The insurance contract is considered valid in the corrected form as of the time when the policyholder is informed of the correction.

2.1.1.2 Insurance policies of consumers and policyholders comparable to consumers

If the insurance company or its representative has failed to provide the policyholder with any necessary information when marketing its insurance or has provided him/her with erroneous or misleading information, the insurance contract will be considered valid in the form that the policyholder has had reason to understand it in the light of the information he/she received.

2.2 Policyholders and insured person's obligation to disclose information

2.2.1 Corporate and institutional insurance

The policyholder means here also the insured and a representative of the policyholder or the insured.

Prior to the insurance being granted, the policyholder must provide full and correct answers to all questions presented by the insurance company which may be relevant to the assessment of the insurance company's liability. During the insurance period, the policyholder and the insured must

also correct without undue delay any information provided to the insurance company by him/her which he/she has found to be incorrect or insufficient.

2.2.2. Insurance policies of consumers and policyholders comparable to consumers

Prior to the insurance being granted, the policyholder and the insured must provide full and correct answers to all questions presented by the insurance company which may affect the assessment of the insurance company's liability. During the validity of the insurance period, the policyholder and the insured must also correct without undue delay any information provided to the insurance company by him/her which he/she has found to be incorrect or insufficient.

2.3 Failure to disclose information

2.3.1 Corporate and institutional insurance

In this clause, the policyholder also means the insured and a representative of the policyholder or the insured.

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

If the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed in his/her obligation to disclose information for the insurance, and the insurance company would have refused to grant the insurance altogether had the full and correct information been provided, the insurance company is free from liability. In cases like this, the insurance company has the right to keep any premiums already paid. If the insurance company had granted the insurance only against a higher premium or otherwise on terms other than those agreed, the insurance company's liability is restricted to what corresponds to the agreed premium or the terms on which the insurance would have been granted.

If the above-mentioned consequences of failure to disclose information would lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

The insurance company has the right to incorporate an exclusion clause into the insurance cover of an individual insured person if the policyholder or the insured person has given incorrect or insufficient information on the state of health of the insured person at the time of his/her inclusion in the insurance.

2.3.2. Insurance policies of consumers and policyholders comparable to consumers

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

If the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed in his/her obligation to disclose information for the insurance, and the insurance company would have refused to grant the insurance altogether had the full and correct information been provided, the insurance company is free from liability. If the insurance company had granted the insurance only against a higher premium or otherwise on terms other than those agreed, the insurance company's liability is restricted to what corresponds to the agreed premium or the terms on which the insurance would have been granted.

If the above-mentioned consequences of failure to disclose information would lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

The insurance company has the right to incorporate an exclusion clause into the insurance cover of an individual insured person if the policyholder or the insured person has given incorrect or insufficient information on the state of health of the insured person at the time of his/her inclusion in the insurance.

YLT 3 Commencement of the insurance company's liability and validity of the insurance contract

3.1 Commencement of the insurance company's liability

If the insurance company has not agreed on any other date individually with the policyholder, the insurance company's liability will commence from the time when the insurance company or the policyholder has submitted or sent an affirmative reply to the offer/bid of the other contracting party.

The insurance company's liability does not commence, however, until the premium for the insurance has been paid if the policyholder has outstanding premiums overdue on other insurances taken from the insurance company The insurance bill contains a mention to this effect.

If the policyholder has submitted or sent a written insurance application to the insurance company and if it is apparent that the insurance company would have approved the application, the insurance company will also assume liability for an insurance event occurring after the application was submitted or sent.

An insurance application or an affirmative reply which the policyholder has submitted or sent to the insurance company's representative is considered to have been submitted or sent to the insurance company. If there is no indication of the time of day when the reply or application was submitted or sent, it is considered to have taken place at 12.00 midnight.

In the case of an individual insured person, insurance cover begins on the inception date of the policy. If the policyholder subsequently notifies the insurance company of the inclusion of a person in the insurance, the insurance cover for this particular insured person will begin as soon as the written notification has been submitted or sent to the insurance company. In order for the insurance cover to commence, the insured person must meet the criteria for inclusion in the insurance in accordance with the risk selection principles applied by the insurance company. If separately agreed, the inception date of the insurance cover may be another date.

3.2 Grounds for granting insurance

The insurance premium and other terms of contract are determined according to the policy anniversary. If new cover or insurance is added to the contract, the premium and other terms of contract for this cover or insurance are determined in accordance with the date of inception of the added cover or insurance.

The insured's health will be assessed on the basis of the time of submitting a health declaration or work ability report.

The age of the insured person is calculated by subtracting his/her year of birth from the year of commencement of the insurance.

The insurance company will not reject an application for personal insurance on the grounds that an insurance event has occurred or that the state of health of the person for whom the application is made deteriorated after the application documents were submitted or sent to the insurance company.

3.3 Validity of insurance contract

After the first insurance period, the insurance contract is valid for one agreed insurance period at a time unless the policyholder or the insurance company terminates the contract or part of it.

The insurance contract may also terminate for other reasons referred to in clauses 4.2 (Delayed premium payment) and 12 (Termination of insurance contract).

YLT 4 Insurance premium

4.1 Payment of insurance premium

4.1.1 Corporate and institutional insurance

Premiums must be paid by their due date indicated on the invoice sent by the insurance company. However, the initial premium need not be paid before the commencement of the insurance company's liability, nor the subsequent premiums before the beginning of the agreed premium period or insurance period, except in circumstances described in section 3.1, in which payment of the premium is a precondition for the beginning of the insurance company's liability. If part of the insurance company's liability commences at a later date, the related premium need not be paid before said liability commences.

If payment made by the policyholder is not sufficient to cover all the insurance company's insurance premium receivables, the insurance company has the right to decide for which of the outstanding premiums his/her payments are to be used.

The insurance premium is determined on the basis of the composition of the group of those insured and the extent of the insurance cover, in accordance with the bases of calculation applied to the insurance.

4.1.2 Insurance policies of consumers and policyholders comparable to consumers

Premiums must be paid by their due date indicated on the invoice sent by the insurance company. However, the initial premium need not be paid before the commencement of the insurance company's liability, nor the subsequent premiums before the beginning of the agreed premium period or insurance period, except in circumstances described in section 3.1, in which payment of the premium is a precondition for the beginning of the insurance company's liability. If part of the insurance company's liability commences at a later date, the related premium need not be paid before said liability commences.

If payment made by the policyholder is not sufficient to cover all the insurance company's insurance premium receivables, the policyholder has the right to decide for which of the outstanding premiums his/her payments are to be used.

However, the payment is used for the insurance contract to which the bill refers and to pay for the oldest outstanding amount under this contract, unless the policyholder has specified otherwise in writing.

The insurance premium is determined on the basis of the composition of the group of those insured and the extent of the insurance cover, in accordance with the bases of calculation applied to the insurance.

4.2 Delayed insurance premium payment

If the policyholder has not paid the premium in part or in full by the due date as referred to in clause 4.1 above, the insurance company has the right to terminate the insurance no earlier than14 days of the date of sending a notice of termination.

However, if the policyholder pays the outstanding premium in full before the end of the notice period, the insurance contract will not be terminated at the end of the notice period. The insurance company will state this option in its notice of termination.

If the premium is not paid by the due date referred to under section 4.1 above, penalty interest must be paid for the period of delay in accordance with the Interest Payment Act.

The insurance company is entitled to compensation for costs incurred due to collection of insurance premiums under the Act on the Collection of Debts. If the insurance company has to collect an unpaid insurance premium through legal proceedings, it is also entitled to the statutory fees for court proceedings and legal expenses.

The insurance company may transfer outstanding amounts for collection by a third party.

4.3 Reinstatement of terminated insurance of the person

If the policyholder pays an overdue premium in full after the insurance has expired, the insurance company's liability commences on the day following such payment. In such a case, the insurance is valid from the date of its reinstatement until the end of the insurance period originally agreed.

However, if the insurance company is against the reinstatement of the insurance policy, it will notify the policyholder within 14 days of the payment of the premium that it will not accept the payment.

4.4 Returning premium upon termination of contract

If the insurance terminates before the date agreed, the insurance company is entitled only to the premium for the period during which it was liable. The rest of the premium paid is returned to the policyholder.

When determining the amount of returnable premium, the validity is calculated in days according to the insurance period to which the premium pertains.

However, the premium will not be returned to the policyholder in the case mentioned below or if the policyholder or the insured person has acted fraudulently in the circumstances referred to in clause 2.2 above. However, the premium will not be returned separately if the returnable sum is smaller than the amount stated in the Insurance Contracts Act.

The insurance company will charge the minimum premium specified in the insurance policy, insurance terms and conditions or other contract made between the insurance company and the policyholder.

4.5 Setoff against premiums to be returned

The insurance company may deduct any outstanding premiums overdue and other outstanding amounts from the premium to be returned.

YLT 5 Disclosure of information during validity of contract

5.1 Insurance company's obligation to disclose information

5.1.1 Corporate and institutional insurance

On conclusion of an insurance contract, the insurance company issues the policyholder with an insurance policy, any other agreement made concerning the content of the insurance and the insurance terms and conditions, unless they have already been given previously, or unless otherwise agreed.

During the validity of the insurance, the insurance company will notify the policyholder annually in writing of the sum insured and any other insurance-related matters with obvious relevance to the policyholder.

If, during the validity of the insurance, the insurance company or its representative has provided incomplete, incorrect or misleading information on the insurance, the insurance company will correct the incorrect information without delay as soon as the error is detected. The insurance contract is considered valid in the corrected form as of the time when the policyholder is informed of the correction.

The provisions of Section 9, Subsection 2 of the Insurance Contracts Act apply to provision of information after the occurrence of an insurance event.

5.1.2 Insurance policies of consumers and policyholders comparable to consumers

Upon entering into an insurance contract, the insurance company issues the policyholder with an insurance policy and the insurance terms and conditions, if these terms and conditions have not already been given to the policyholder. During the validity of the insurance, the insurance company will notify the policyholder annually in writing of the sum insured and any other insurance-related matters with obvious relevance to the policyholder.

If, during the validity period of the insurance, the insurance company or its representative has provided insufficient, incorrect or misleading information on the insurance, the insurance contract will be considered valid in the form that the policyholder has had reason to understand it in the light of the information he/she was given, provided that such insufficient, incorrect or misleading information can be regarded as having influenced the policyholder's conduct. However, this does not apply to information provided by the insurance company or its representative on future compensation payable after an insurance event has occurred.

5.2 Obligation to disclose information to those insured

If the terms and conditions of a group insurance contract include a provision to the effect that the insurer keeps a list of persons who are covered by the insurance, the insurer will, as soon as the contract takes effect and at reasonable intervals thereafter, provide those insured information on the scope of the cover, major exclusions, obligations of the insured person under the contract and how the validity of cover depends on the fact that the insured person is a member of the group mentioned in the contract.

If the insurance company does not keep a list of those insured, the abovementioned information will be given to them in a suitable manner agreed in the group insurance contract, taking circumstances into account.

The list of insured persons maintained by the insurance company for the purpose of calculating the insurance premium does not constitute a list of persons referred to in Section 76 of the Insurance Contracts Act.

5.3 Policyholder's obligation to disclose information about any increase in risk

The policyholder and the insured person must notify the insurance company of any changes in factors increasing risk that were reported when the insurance contract was concluded and that are relevant in terms of assessment of the insurance company's liability, such as changes in profession/occupation, leisure time activities or place or residence, or the termination of any other insurance cover.

The insurance company must be notified of any such changes no later than one month of receipt of the annual bulletin following such a change. Changes in the person's state of health do not have to be reported. The insurance company reminds policyholders in the annual bulletin of their disclosure obligation.

If a policyholder has wilfully or through negligence which cannot be deemed minor failed to notify the insurance company of increased risk as mentioned above, and the insurance company would not, as a result of the changed circumstances, have kept the insurance in force, the insurance company is released from liability. If, however, the insurance company would have extended the validity of the insurance but only for a higher premium or on other terms, the insurance company's liability is limited to what corresponds to the insurance premium paid or the terms on which the insurance would have been extended.

If the above-mentioned consequences of failure to disclose information lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

5.4 Provision of information on termination of group insurance

If a group insurance policy terminates as a result of action taken by the insurance company or the group insurance policyholder, the insurance company will notify the insured persons of such termination in the manner deemed appropriate in view of the circumstances. If agreed in the group insurance that the insurance company shall keep a list of the insured persons in the insurance, these persons will be notified of the termination of the insurance. If the insurance company does not keep a list of those insured, the notice of termination will be given in the manner agreed in the group insurance contract on providing the information specified in clause 5.2 above.

YLT 6 Occurrence of the insurance event

6.1 Causing an insurance event

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

6.2 Insurance event caused by a person entitled to compensation

If a person entitled to compensation or benefit other than the insured person 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 if he/she was at an age or in a state of mind which means that he/she could not be sentenced for a crime, the compensation or part of the compensation may be paid to him/her, but only if this is deemed reasonable considering the circumstances in which the insurance event was caused.

YLT 7 Irresponsibility and emergency

The insurance company will not invoke clause 6 above to release itself from or restrict its liability if the insured person was under 12 years of age at the time he/she caused the insurance event or was in such a state of mind that he/she could not have been sentenced for a crime.

The insurance company will not invoke clauses 5 and 6 above to release itself from or restrict its liability if the insured person was seeking to prevent injury to a person or damage to property in circumstances in which his/her negligence or action was justifiable at the time he/she increased the risk or caused the insurance event.

YLT 8 Claims settlement procedure

8.1 Claimant's obligations

The claimant shall observe the instructions on making a claim stated in the terms and conditions of personal insurance and submit the documents mentioned therein to the insurance company. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense, unless otherwise specified in the terms and conditions or otherwise specified.

The claimant must provide the insurance company with documents and information necessary for the assessment of the insurance company's liability. These include documents and information which confirm whether an insurance event occurred, how large the loss or damage was and what expenses are coverable under the policy. The claimant is required to obtain the documentation which he/she is best able to obtain, yet taking account of the insurance company's opportunity to acquire such documentation.

All crimes must be reported to the local police without delay.

The insurance company is not obliged to pay compensation before it has received the documentation stated above and that laid down in the special terms and conditions.

If the claimant has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability, compensation can be reduced or disallowed, depending on what is reasonable in the circumstances.

8.2 Time limitation on claims

A claim for compensation must be presented to the insurance company within 12 months of the date when the claimant became aware of the insurance and was informed of the insurance event and the damaging consequences of that event. A claim for compensation must in any case be presented within 10 years of the date when the insurance event occurred or the damaging consequences were caused. Reporting an insurance event is comparable to presenting a claim. If the claim is not presented within the said period, the claimant loses his/her right to obtain compensation.

8.3 Insurance company's obligations

After the insurance event, the insurance company is under an obligation to provide the claimant with information on the contents of the insurance and the claim procedure. No advance information given to the claimant on the compensation, its amount or method of payment will affect the payment obligation stated in the insurance contract.

The insurance company will pay the compensation resulting from the insurance event in accordance with the insurance contract or notify the claimant of non-payment of compensation without delay and, at the latest, in one month's time of the date on which it received the documentation and information necessary for the assessment of its liability. If the amount of compensation is disputed, the insurance company will nonetheless pay any undisputed part of the compensation within the above-mentioned period.

The insurance company will pay penalty interest on any delayed payment of compensation in accordance with the Interest Act.

8.4 Setoff against compensation

The insurance company may deduct from compensation any outstanding premiums overdue and other outstanding amounts in accordance with general set-off requirements, should the beneficiary be the policyholder.

8.5 Effect of sanctions on compensation

The insurance company, its subsidiary or a partner in a network underwriting insurance locally is under no obligation to pay indemnity, damages, prevention costs or investigation and legal expenses or any other financial resources if paying them is contrary to sanctions, other restrictive actions or legislation imposed by the Finnish government, the United Nations, the European Union, the United States of America or the United Kingdom or their competent authorities or governing bodies.

YLT 9 Appeal against insurance company's decision

The policyholder or claimant has several ways of appealing against a decision taken by the insurance company. If the matter remains unsettled after he/she has contacted the insurance company, he/she can ask for advice and counselling from the Finnish Financial Ombudsman Bureau

or request a decision recommendation from the relevant board. A policyholder or claimant who is dissatisfied with the insurance company's decision may also bring action against the insurance company in court.

9.1 Right to correct

If a policyholder or claimant suspects that the insurance company has made a mistake in its claim settlement decision, he/she has the right to obtain more information about matters which have led to the decision. The insurance company will revise the decision if the new investigations give cause to do so.

9.2 Finnish Financial Ombudsman Bureau and boards issuing recommendations

Policyholders or claimants dissatisfied with the insurance company's decision may ask the Finnish Financial Ombudsman Bureau for advice and counselling.The Bureau is an impartial body whose function is to advise consumers in insurance and claim matters.

The insurance company's decision can be submitted to the Finnish Insurance Complaints Board operating in conjunction with the Finnish Financial Ombudsman Bureau. The Board's function is to make recommendations for decisions in disputes which concern interpretation and application of the law and insurance terms and conditions in an insurance relationship.

These boards will not handle a case while it is pending or when a ruling has been given in court.

The counselling services and board statements are free of charge.

9.3 District court

Policyholders, insured persons or other claimants dissatisfied with the insurance company's decision may bring action against the insurance company in the district court of their domicile in Finland, of the insurance company's domicile or of the place of loss in Finland, unless otherwise provided by Finland's international agreements.

Action against the insurance company's claim settlement decision must be brought within three years of the policyholder or claimant being informed in writing of the insurance company's decision and the time limit. The right to bring action ceases once the time limit has expired.

Handling of a case by a board will interrupt the limitation period for the right to bring action.

YLT 10 Insurance company's right of recovery

The insured persons right to claim compensation from a liable third party for expenses arising from an illness or injury and for loss of property transfers to the insurance company up to the amount of compensation paid by the insurance company.

If the loss or damage was caused by a third party as a private person or as an employee, a civil servant or any other person comparable to these as referred to in chapter 3 of the Tort Liability Act, the right of recovery will be transferred to the insurance company only if the person in question caused the insurance event wilfully or through gross negligence or is held liable regardless of the nature of his/her negligence.

YLT 11 Altering an insurance contract

11.1 Altering the terms of contract during the insurance period

The insurance company has the right to alter the insurance premiums or other terms of contract during the insurance period to correspond with the changed circumstances if

- the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed to observe his/her obligation to disclose information as referred to in clause 2.2 above, and if the insurance company, had it been given the correct and complete information, had granted the insurance only against a higher premium or on terms other than those agreed, or
- the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.2 above and, regardless of this, the insurance is binding on the insurance company on the basis of this clause due to the adjustment of the consequences of the failure to disclose information; or
- during the insurance period, a change as referred to in clause 5 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would have granted the insurance only against a higher premium or on otherwise other terms in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance.

After being informed of said change, the insurance company will notify the policyholder without undue delay of any change in the premium or other terms. The notification shall state that the policyholder has the right to cancel the insurance.

11.2 Altering the terms of contract at the end of an insurance period

11.2.1 Corporate and institutional insurance

The insurance company has the right to alter the insurance terms and conditions and premiums and other terms of contract at the end of the insurance period.

These alterations will apply as of the beginning of the following insurance period. The insurance company must inform policyholders of any changes no later than one month before the beginning of the new insurance period. The insurance continues in its new form unless the policyholder terminates it in writing before the beginning of the new insurance period.

11.2.1 Insurance policies of consumers and policyholders comparable to consumers

A Notification procedure

The insurance company has the right to alter the insurance terms and conditions and premiums and other terms of contract at the end of the insurance period on the basis of

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

- a change in an index mentioned in the policy which affects the insurance
- a change in the claims expenditure for the insurance.

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

If the insurance company alters the insurance contract as outlined above, it will, when sending the invoice for the premium, notify the policyholder of how and as of when the premium or other terms of contract will be altered. The notification shall state that the policyholder has the right to cancel the insurance.

The change will take effect from the beginning of the next premium period or, if no premium period has been agreed, from the beginning of the next calendar year following one month of the date the notification was sent.

The insurance contract may also change in accordance with clause 11.3 below concerning index regulations.

B. Changes requiring termination of insurance

If the insurance company alters the insurance terms and conditions, premiums or other terms of contract in cases other than those listed in section A above or discontinues an actively marketed benefit, the insurance company must give written notice of termination of the insurance as of the end of the insurance period. Notice shall be given in writing one month before the end of the insurance period at the latest.

If the insurance company alters the insurance contract as outlined above, it will, when sending an insurance bill, notify the policyholder of the changes in the insurance premium and other terms of contract. The notification shall state that the policyholder has the right to cancel the insurance.

11.3 Effect of the index

The insurance premium and the remaining sum insured under the special terms and conditions will be raised on the main due date basis, corresponding to price increases in healthcare and medical treatment commodity group based on the consumer price index, based on the index for September.

YLT 12 Termination of insurance contract

12.1 Policyholders right to terminate insurance during the insurance period

12.1.1 Corporate and institutional insurance

The policyholder has the right to terminate a continuous insurance policy by giving a notice of termination in writing

- one month before the end of the insurance period or
- within 30 days of the date when the information concerning an alteration of the terms and conditions or a premium increase was sent.

If the notice of termination is not given in writing, the termination is invalid.

A fixed-period insurance is terminated without notice at the end of the period in question. The policyholder has no right to terminate the insurance before that unless otherwise agreed.

12.1.2 Insurance policies of consumers and policyholders comparable to consumers

The policyholder has the right, at any time, to terminate the insurance contract during the insurance period. Notice of termination must be given in writing. Notice of termination given in any other manner shall be null and void. If the policyholder has not specified a later termination date for the insurance, the insurance will terminate on the date the notice was submitted or sent to the insurance company.

12.2 Insurance company's right to terminate insurance during the insurance period

12.2.1 Corporate and institutional insurance

The insurance company has the right to give notice of termination of the insurance during the insurance period if

1. the policyholder or the insured has wilfully or through negligence which cannot be deemed minor failed to observe his/her obligation to disclose information as referred to under section 2.2, and the insurance company, had it been given the correct and complete information, would have refused to grant the insurance altogether
2. the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.2 above and, regardless of this, the insurance contract is binding on the insurance company on the basis of that clause;
3. during the insurance period, a change as referred to in clause 5.3 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would not have granted the insurance in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance
4. the insured has wilfully caused the insurance event
5. the insured person has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability.
6. the policyholder has been declared bankrupt.

The insurance company may give notice of termination of the insurance cover of an individual insured person during the insurance period if the policyholder or the insured, at the time the insured was included in the insurance, provided the insurance company with incorrect or insufficient information and the insured would not have been included in the insurance had correct or complete information been provided.

Having been informed of the grounds for permitting termination, the insurance company will give written notice of termination without undue delay. The notice of termination will have a mention of the grounds for termination. The insurance contract will terminate one month from the time the notice was sent.

The insurance company's right to give notice of termination of insurance owing to an outstanding insurance premium is defined in clause 4.2 above.

12.2.2. Insurance policies of consumers and policyholders comparable to consumers

The insurance company has the right to give notice of termination of the insurance during the insurance period if:

1. the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor neglected his/her obligation to disclose information as referred to in clause 2.2 above, and the insurance company, had it been given correct and complete information, had refused to grant the insurance altogether;
2. the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.2 above and, regardless of this, the insurance contract is binding on the insurance company on the basis of that clause;
3. during the insurance period, a change as referred to in clause 5.3 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would not have granted the insurance in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance
4. the insured has wilfully caused the insurance event
5. the insured person has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability.

The insurance company may give notice of termination of the insurance cover of an individual insured person during the insurance period if the policyholder or the insured, at the time the insured was included in the insurance, provided the insurance company with incorrect or insufficient information and the insured would not have been included in the insurance had correct or complete information been provided.

Having been informed of the grounds for permitting termination, the insurance company will give written notice of termination without undue delay. The notice of termination will have a mention of the grounds for termination. The insurance contract will terminate one month from the time the notice was sent.

The insurance company's right to give notice of termination of insurance owing to an outstanding insurance premium is defined in clause 4.2 above.

12.3 Insurance company's right to terminate insurance at the end of the insurance period

The insurance company has the right to give notice of termination of an insurance effective as of the end of the insurance period. If the insurance period is less than one year or its length has not been agreed, the insurance company has the right to terminate the insurance effective as of the end of the calendar year. The written notice of termination will be given one month before the end of the insurance period at the latest or, if the period's length has not been agreed, one month before the end of the calendar year at the latest. Notice of termination has a mention of the grounds for termination.

12.4 Termination of insurance in respect of the insured

The insurance company will notify those insured of termination of the insurance in writing or using the procedure referred to in clause 5.4.

In respect of the insured person, the insurance terminates in one month's time from the date the insurance company sent him/her a notification of termination or notified him/her of such termination as agreed in the group insurance.

YLT 13 Digital services

If the policyholder has concluded a corporate customer's digital services agreement, the policyholder may attend to his/her insurance matters in OP's digital services, such as the op.fi service. Using the services is possible to the extent determined by OP. This may include the right to view the details of insurance policies in force or to file loss reports. When the policyholder uses OP's digital services to attend to his/her insurance matters, the general terms and conditions for corporate customer's digital services, supplied to the customer when concluding the agreement, shall apply to the insurance in addition to these terms of contract.

The insurance company has the right to send all insurance-related information, such as decisions, messages, notifications, responses, changes and notices of termination only electronically to OP's online and mobile services. The policyholder has the right to receive the aforementioned information by post within reasonable time from the day on which the policyholder informed the insurance company that he/she wishes to receive the information by post.

YLT 14 Insurance contract and applicable law

The content of the insurance contract is defined in the insurance policy and the following two sets of insurance terms and conditions: general terms and conditions and special terms and conditions. In addition, the Finnish Insurance Contracts Act and other relevant Finnish legislation apply to the contractual relationship.

Pohjola Insurance Ltd, Business ID: 1458359-3
A-Insurance Ltd, Business ID: 1715947-2

Helsinki, Gebhardinaukio 1, 00013 OP, Finland
Domicile: Helsinki, main line of business: non-life insurance companies
Regulatory authority: Financial Supervisory Authority, finanssivalvonta.fi/en

Pohjola Insurance