Terms and Conditions Group Life Insurance

Insurance terms
Valid from 01.12.2025

1. Introductory provision

This group life insurance is a death risk insurance that a company, union, association or similar organization can take out for selected groups of employees or members or, where applicable, their spouses, registered partners, cohabitants and children. This benefit is payable in the event of the death of the insured person. The events covered by the group life insurance are described in more detail in the insurance certificate. A group life insurance policy may also include disability cover. The conditions for disability cover are described in a separate booklet of terms and conditions.
The insurance contract is based on these terms and conditions and on the insurance certificate, which confirms the conclusion of the insurance contract and provides a detailed description of the cover under the contract concluded between the policyholder and Quantum Leben AG.
The Norwegian Insurance Contracts Act of 16 June 1989 No. 69 (the Norwegian Insurance Contracts Act) and other relevant legislation also apply, but the insurance terms and conditions take precedence over the statutory provisions in the event of any conflict between the terms and conditions and the statutory provisions that may be deviated from.

2. Definitions

Agent: Norwegian Underwriting Agency AS, an insurance intermediary established as a limited company incorporated in Norway, with its registered office at Fru Kroghs Brygge 8, 0252 Oslo, Norway, registered in the Brønnøysund Register Center with company registration number 991 073 892 and authorized by the Financial Supervisory Authority of Norway to operate as an insurance intermediary in Norway.
The agent has been appointed by the insurance company to provide services in connection with the distribution and marketing of this insurance product, in particular to provide insurance mediation in connection with the offering and marketing of this product and to provide other services to policyholders.

Fit for work: Fit for work means that the employee insured under the insurance contract performs his/her normal work and works the normal number of hours stipulated in accordance with his/her employment contract, either at his/her normal place of work or at a location to which he/she is required to travel for business purposes.
In the case of coverage for spouses, registered partners, cohabitants and/or children, fit for work means that the spouse, registered partner, cohabitant and/or child is healthy and in good health and not incapacitated as a result of illness or injury. If they are not healthy and in good health, they are not considered fit for work.

Children: Children are defined as the insured person's own children, stepchildren and adopted children, provided they are under the age of 20. Other children who, according to a public authority, are dependent on the insured person and have been included in the insured person's family are also covered.

Spouse/registered partner: The insured person's spouse is the person who is married to the insured person. A person who has entered into a registered partnership with the insured person is treated as a spouse. A person is not considered a spouse or registered partner after the date of separation or divorce granted by a court decision or an administrative decision by the relevant authorities, even if this decision is not legally binding or final.

Unit rates: An average premium rate is used for all insured persons. With the exception of any guaranteed premiums, the unit rate will be recalculated on each renewal date.

Provider: The insured person who has a spouse, cohabiting partner, registered partner and/or children under the age of 20.

Renewal date: The first and subsequent anniversaries of the date on which the insurance contract first came into force. The effective date of the insurance contract (the start date of the insurance contract) is stated in the insurance certificate.

Insured: The insured person covered by the insurance contract, who is either (i) a member of the policyholder, (ii) an employee of a company that is a member of the policyholder (corporate membership), or (iii) directly employed by the policyholder and receives regular wages from the policyholder. The insured person's age must be lower than the normal retirement age defined in the insurance certificate. The insurance company may also agree to cover spouses, registered partners, cohabitants and children of the insured persons.

Insurance year: The insurance year is the 12-month period starting on the effective date/renewal date of the insurance contract.

Insurance Contracts Act: The Norwegian Insurance Contracts Act of 16 June 1989 No. 69.

Insurance contract: The contract concluded between the policyholder and Quantum Leben AG regarding group life insurance.

Effective date of the insurance contract: The date of entry into force of the insurance contract as stated in the insurance certificate.

Insurance certificate: An insurance certificate is a document that confirms that the insurance contract has been entered into and contains information about the agreed benefits and the applicable terms and conditions.

Insurance broker: A person or legal entity appointed by the policyholder to act on its behalf and represent the policyholder vis-à-vis the insurance company and the agent.

Insurance company: Quantum Leben AG.

Policyholder: The employer specified in the insurance certificate and who is the contracting party entering into the insurance contract with the insurance company.

Insured event: An insured event occurs upon the death of the insured person within the relevant insurance year.
In order for the sum insured to be paid out, the insurance contract must be valid, and the deceased must be covered by the insurance on the date of death. If the sum insured is calculated using G, the amount of G applicable on the date of the insured event shall be used as a basis.

G: The basic amount of the National Insurance Scheme, which is determined by the Norwegian Parliament on 1 June each year and applies retroactively from 1 May each year.

Health check: The procedure whereby the insurance company obtains health information about employees for the purpose of evaluating the employee's insurance cover under the insurance contract.

Individual/age-related rates: Premiums which are calculated individually for each insured person/age-related rate, depending, among other things, on the age of the insured person. With the exception of any guaranteed premiums, the premium rates may be revised each year on the renewal date of the insurance contract.

Salary: Salary refers to the fixed annual basic salary. All other benefits and income, including but not limited to commissions and bonuses, are not included unless agreed with the insurance company.

Maximum coverage: The maximum amount of coverage under an insurance contract that applies collectively to all insured persons on a given date.

Normal retirement date: This refers to the insured person's 70th birthday or an earlier retirement date agreed with the insurance company. The normal retirement date is confirmed in the insurance certificate.

Premium rates: The rates for each individual group member that are used to calculate the premiums for a benefit. The rates may be individual/age-dependent or appear as flat rates.

Cohabiting partner: A cohabiting partner is either (i) a person with whom the insured person lives in a marriage-like or partnership-like relationship, provided that the National Population Register can confirm that these two persons have shared the same home for the past two years, or (ii) a person with whom the insured person has children and shares a home.
If, on the date on which the insured event occurred, circumstances existed that prevented a legal marriage and/or registered partnership from being entered into, the person in question cannot be considered a cohabitant.
Nor is a person considered to be a cohabitant after the date of actual termination of cohabitation, or the date on which the conditions, regardless of cause, for the above definition of a cohabitant are no longer met.

Benefit: The benefit is a one-off payment corresponding to the sum insured or part thereof, which is paid as a result of an insured event. The sum insured is stated in the insurance certificate.

3. Insurance cover

3.1 Types of cover

3.1.1 Mandatory coverage

The insurance contract automatically covers all insured persons who are eligible for a specific type of cover without them having to submit a medical certificate. It is not possible to opt out of membership.

The insurance company reserves the right to ask the insured person to undergo a medical examination, typically either for smaller groups of insured persons or for insured persons with a particularly high sum insured.

3.1.2 Voluntary cover

For voluntary cover, the insured must meet the requirements to be covered, but only some of them will be covered based on a selection process. Typically, this process involves the insurance company requiring the insured to undergo a medical examination in order to obtain cover.

3.2 Fitness for work

3.2.1 If an insured person does not meet the requirements for being fit for work on the effective date of the insurance contract, the insured person will not be covered by this insurance contract.

3.2.2 However, the person will be covered under the insurance contract after having been back in their normal position for 30 consecutive days after returning to their normal work, unless the policyholder/insured person provides satisfactory documentation for the insurance company to accept coverage for the person.

3.2.3 Employees will be considered fit for work if they are absent with the prior approval of the policyholder, for reasons other than illness or injury, and the absence does not exceed 12 months in duration, such as parental leave, sabbatical leave or holiday, unless their medical records show that they suffer from a medical condition that could reasonably be expected to have prevented them from working.

3.2.4 As soon as a person meets all the requirements for fitness for work, he/she shall be insured.

3.2.5 When a policyholder applies for the spouse, registered partner, cohabiting partner or children of an insured person to be included in the insurance, the insured person must be covered by the insurance himself/herself.

3.2.6 Insurance cover applies to incidents that may occur anywhere in the world, 24 hours a day during the insurance year, subject to the exceptions specified in these terms and conditions and any additional exceptions defined in the insurance certificate.

3.2.7 The cover is designed for insured persons residing in Norway and will cease for individual insured persons who live in areas outside Norway and the European Economic Area (EEA) for more than 13 consecutive weeks during a 12-month period, unless otherwise agreed.

3.3 Exclusion from coverage

3.3.1 Exclusions are causes or events that are not covered by the insurance terms and conditions. No benefits will be paid if a claim arises from a cause or event that is excluded from the cover. The following causes and/or events are excluded:

a. Active participation in war, invasion, acts of foreign enemies, hostilities or war-like operations (whether war is declared or not), civil insurrection, rebellion, revolution, resistance, riots, use of military force or coups; or

b. Active participation in terrorist activities, which may include, but is not limited to, the actual use of force or violence and/or threats to use such force. Perpetrators of terrorist activities may act alone or on behalf of or in connection with one or more organizations or governments. The perpetrators are dedicated to political, religious, ideological or similar beliefs with the aim of influencing a government and/or spreading fear among the civilian population or parts of the general public.

c. Nuclear, biological or chemical incidents, including incidents arising directly or indirectly from any of the following (i) nuclear fission, nuclear fusion or radioactivity, (ii) atomic, biological and chemical weapons and/or equipment, and/or (iii) attacks on or sabotage of facilities and storage depots, leading to the release of radioactivity or nuclear, biological or chemical weapons.

3.3.2 In the event that any part of this provision is deemed invalid or unenforceable, the remaining part shall remain fully valid.

4. Health check

4.1 For voluntary cover, as well as compulsory cover for small groups of 4 members or less, a health check is required. In cases involving a particularly high sum insured (or an increase in the previously agreed sum insured), a health check may also be required if the insurance agent requests so. In such cases, the insured persons must undergo a health check, either by completing a medical questionnaire or by undergoing a medical examination.

4.2 During the assessment process, the insured will not be covered. If a health check is required in order to increase the previously agreed sum insured, the insured will be covered during this period in accordance with the previously agreed sum insured. The new sum insured will only apply once the health check has been completed.

4.3 The policyholder will be informed in writing by the agent of the insurance company's final decision on the question of insurance cover. Based on the medical questionnaire submitted or the report from the medical examination, the insurance company reserves the right to limit coverage for certain illnesses or diagnoses, refuse coverage or increase the premium. If special conditions are applied, the sum insured, and the conditions will only be valid from the date of receipt of the policyholder's written acceptance. Should the policyholder reject the revised conditions, or if there is no written acceptance of the conditions, the insured will not be covered.

4.4 If an insured person is unable to work on the date of application for an increase in the sum insured, the current sum insured will continue to apply until the insured person has returned to work and meets the requirements for fitness for work.

4.5 An increase in the sum insured that is solely due to a change in the basic amount (G) for social security purposes under the Norwegian National Insurance Scheme will be accepted automatically, regardless of whether the insured person is fit for work or not.

4.6 If an insured person is requested to undergo a medical examination or provide additional medical documentation, such costs will be covered provided that satisfactory invoices are received from the agent. Such costs must be agreed in advance.

5. Duration, changes and termination of the insurance contract

5.1 When will the cover start?
Coverage will commence on the effective date of the insurance contract as stated in the insurance certificate.

5.2 Can the policyholder terminate the insurance contract?
The policyholder may terminate the insurance contract and its associated cover within a period of 30 days after receiving the insurance certificate. To be valid, the termination must be in writing and sent to the agent by registered mail before the end of the 30-day period. If the policyholder does not exercise their right to terminate the insurance contract within the 30-day period, the policyholder may only terminate the insurance contract within the time limits described in section 5.5.

5.3 When will the cover cease?

5.3.1 Coverage for an insured person (and their spouse, registered partner, cohabitant and/or children) will cease when one of the following events occurs:

a. On the renewal date of the insurance contract immediately after the insured person reaches normal retirement age or, for children, immediately after they turn 20.
b. When the insurance is terminated.
c. If the premium has not been paid by the policyholder in accordance with the provisions set out in clause 6.5. Should this occur, the policyholder is obliged to inform the employees of this and cover any claims that may arise during the period of cover.
d. 14 days after the insured person is no longer employed and therefore no longer meets the requirements for cover under the insurance contract, provided that the policyholder has given the insured person prior written notice in accordance with sections 5.3.2 and 9.2. If no written notification has been given, the cover shall cease 2 months after the insured person is no longer employed and therefore no longer meets the requirements for cover under the insurance.

5.3.2 In the event that coverage ceases (for reasons other than reaching the normal retirement age or the 20-year limit for children), the insured person is entitled to continue the insurance contract individually (continuation insurance) with individual calculation and without the requirement for a new health declaration. The policyholder is obliged to notify the insured person of this so that the insured person can apply to continue the cover. The insured person must make use of this offer within 6 months from the date on which the insurance company's liability expired in accordance with section 5.3.1 above.

5.4 Changes to the insurance contract

5.4.1 he insurance company reserves the right to change the rates (unless otherwise agreed) each year on the renewal date of the insurance contract.

5.4.2 The insurance company reserves the right to change the insurance terms and conditions. Changes to the insurance terms and conditions will be communicated to the policyholder in advance and no later than one month before such changes take effect. The policyholder has the right to terminate the insurance contract in accordance with the restrictions defined in section 5.2.

5.4.3 In the event of objections to the new insurance terms and conditions provided by the insurance company. If the insurance contract is not terminated before the changes take effect, the new insurance terms and conditions are considered to have been accepted by the policyholder.

5.4.4 The insurance company reserves the right to demand an immediate adjustment of the premium if there are significant changes in the circumstances of the insured.

5.4.5 The policyholder must notify the insurance company immediately via the agent of any significant changes. A change is considered significant when one or more of the following events occur:

a. The number of insured persons varies by more than 10% from what was previously notified;
b. The coverage criteria or eligibility conditions must be changed in relation to the conditions previously agreed upon;
c. Significant changes in the insured person's living conditions, as described in section 6.4.

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5.5 Termination of the insurance contract and the effect of termination

5.5.1 The effective date of the insurance contract and the renewal date of the insurance contract are defined in the insurance certificate. The terms and conditions of the insurance contract are guaranteed to apply until the renewal date of the insurance contract.

5.5.2 The policyholder may terminate the insurance contract at any time provided that written notice is given at least 30 days in advance.

5.5.3 The insurance company may terminate the insurance contract if the policyholder fails to comply with the duty of disclosure and the policyholder or the insured is not only slightly at fault, with 14 days' notice or with immediate effect if the policyholder has acted fraudulently. With the exception of situations where fraud has been committed, the insurance company can only invoke non-compliance with the duty of disclosure if the insured event has occurred or the insurance company has given 14 days' notice within two years of the insurance company's liability commencing.

5.5.4 If the policyholder or the insurance company terminates the insurance contract, or if the insurance company's liability ceases to apply due to the policyholder's failure to pay the premium, the policyholder shall send written notice to the insured persons. For each insured person, cover shall cease one month after the notice was sent, or the insured person became aware of the circumstances in some other way.

5.5.5 Upon termination, all mutual obligations under the insurance contract shall cease on the date of termination, with the exception of benefits that are being paid and claims that have arisen but not yet been reported, or premium adjustments that are due but not yet paid.

5.5.6 In the event of termination of the insurance contract, the insured persons have the same right to apply for an individual continuation of the insurance contract (continuation insurance) as applies in cases of termination of individual cover. This does not apply in the event of transfer of the insurance contract to another insurance company.

6. Currency unit and premiums of the insurance contract

6.1 The currency unit of the insurance contract is NOK.

6.2 The policyholder shall pay the premium in advance and in total for all insured persons covered by the insurance contract to the bank account specified by the agent.

6.3 Premiums shall be paid when due each year. The premium due date is the effective date of the insurance contract and thereafter on the renewal date of the insurance contract each year as specified in the insurance certificate. The premium under the insurance contract shall be paid in the currency unit of the insurance contract. Under certain circumstances, the insurance company may accept half-yearly, quarterly or monthly instalments/payments. The agreed intervals for premium payments are specified in the insurance certificate and can only be changed on the renewal date of the insurance contract.

6.4 The premium is determined based on the insured person's employment and professional circumstances. Any significant changes in this regard must be reported to the agent as soon as possible. If the policyholder fails to report such circumstances and this failure results in the premium not being increased, the company may demand that its liability be reduced proportionally, cf. section 13-7 of the Insurance Contracts Act.

6.5 The policyholder is granted a 30-day deferral of payment of the premium after the date on which the premium notice is sent to the policyholder. If the premium is not paid on the due date, the insurance company's cover and thus its obligation shall cease, and the insurance contract shall be terminated, unless the premium is paid within 14 days after a further written notice has been sent by the agent (in accordance with sections 14-1 and 14-2 of the Insurance Contracts Act).

6.6 Upon expiry, there will be no refund or additional invoicing of supplementary premiums as a result of minor changes in the number of insured persons within the insurance year (up to a 10% increase or reduction in the number of insured persons) from what was previously specified on the insurance contract 's effective date/renewal date, in order to simplify the administration of the insurance contract. The following applies to other circumstances:

6.6.1 A proportionate share of the premium must be paid for the period between the insured person's enrolment in the insurance contract (unless this coincides with the insurance contract's effective date (or renewal date) and the insurance contract's next renewal date).

6.6.2 If the insured person's cover under the insurance contract ceases before the renewal date of the insurance contract, the insurance company must give a proportional refund to the policyholder for the period between the date on which the insured person's cover ceased and the next renewal date. No refund shall be paid if the insured person dies during the insurance year.

6.6.3 In the event of significant changes as described in section 5.4.5, proportional payment of premium and/or refund may be made outside the annual invoicing and charged/refunded separately during the insurance year.

6.6.4 The sum of the additional premium to be paid by the policyholder to cover new insured persons in the event of an increase in the sum insured accepted by the insurance company on special terms shall be determined by the insurance company and normally invoiced separately.

6.6.5 Notwithstanding the provisions of clause 6.6, the policyholder is entitled to request a detailed premium calculation and to request a refund of premiums in the event of a reduction in the number of insured persons of less than 10% during the insurance year. The insurance company also reserves the right to charge proportional premiums as a result of an insignificant increase in the number of insured persons.

7. Claims

7.1 Notification of an insurance claim

7.1.1 A claimant who wishes to make a claim for compensation against the insurance company must provide the agent with the information and documentation necessary to assess the claim as soon as possible.

7.1.2 The insurance company will require satisfactory documentation that the insured event occurred, as well as the insured person's name, title and position, personal identification number and salary, if relevant.

7.1.3 After a claim for compensation has been received, the claimant will be informed of the medical and other evidence required by the insurance company in order to assess the claim.
The insurance company reserves the right to obtain additional health documentation and other documentation in order to assess the claim.

7.1.4 Failure to provide the documentation required to substantiate the claim will result in the claim not being considered.

7.1.5 Medical documentation will only be accepted from an approved doctor. All expenses incurred by the claimant in obtaining medical or other documentation originally required by the insurance company must be borne by the claimant.

7.1.6 A claimant who provides false or incomplete information in connection with a claim settlement, which he/she knows or must understand may result in a claim settlement being paid that he or she is not entitled to receive, will lose any claim against the insurance company under this insurance contract.

7.1.7 Section 18-4 of the Insurance Contracts Act regulates the insurance company's obligation to pay interest. If the claimant fails to provide information or documents as mentioned in sections 7.1.2 and 7.1.3, he or she cannot claim interest for loss of

time due to this. The same applies if the claimant refuses settlement in whole or in part without reason.

7.2 Limitation

In accordance with these insurance terms and conditions, a claim for insurance settlement shall become time-barred after 10 years in accordance with the Limitation Act of 1979. This period shall commence at the end of the calendar year in which the claimant/entitled party becomes sufficiently aware of the circumstances justifying the claim (in accordance with section 18-6 of the Insurance Contracts Act).

7.3 Payment of a claim

7.3.1 Provided that the premium has been paid and the insurance company agrees that the claim is covered based on the evaluation of the evidence presented, the company will approve and pay the claim. Payment will be made in accordance with the provisions of sections 8.7 and 8.8.

7.3.2 The insured person has the right to appoint a beneficiary by completing a separate form provided by the agent. If no beneficiary has been appointed, sections 7.3.3 and 7.3.4 shall apply.

7.3.3 If the insured person is the provider of a family, the benefit will be paid to:

a. Spouse/registered partner/cohabitant; or
b. In the absence of a spouse/registered partner/cohabitant, the payment will be divided equally between all the children of the insured person.

7.3.4 If the insured person is not the provider of the family, the benefit shall be paid to his/her legal heirs.

7.3.5 Payment shall fully release the insurance company from all obligations and liabilities under the insurance contract in relation to this claim.

8. Takeover from previous insurance company

If we can take over the benefit level of the current insurance, this section will apply in full as defined below.

8.1 When transferring insurance cover from a previous insurance company, the insurance company may agree to take over the level of insurance benefits provided to the existing group of members by the previous insurance company, provided that the benefits are comparable to those offered by the insurance company. The takeover of current insurance benefits will be subject to:

a. receipt and acceptance of all transfer information specified by the agent; and
b. the insurance company's agreement to take over the current insurance benefits for existing group members. The insurance company may request additional medical documentation regarding previously enrolled group members.

8.1.1 If the takeover is accepted, all employees (group members) who were covered under the previous insurance contract with the former insurance company will be considered fit for work regardless of whether they were on sick leave or other leave approved by the policyholder (employer) at the time of issue of this insurance policy. This definition of fitness for work takes precedence over the definition set out in section 2 Definitions, and applies only to group members who were covered by the previous insurance with the former insurance company.

8.1.2 When taking over existing cover, there is in principle no requirement for a new health check for persons insured under the previous insurance policy with the former insurance company (subject to takeover).

8.1.3 The takeover of small groups of 4 or fewer members can only be accepted if the members underwent a health check under the previous insurance contract with the former insurance company (subject to takeover).

8.1.4 For increases in coverage or when registering new members, sections 4.1–4.6 apply accordingly.

8.2 Right to compensation in the event of death
The responsibility for paying compensation in the event of death lies with the company that is the insurer when the death occurs, regardless of the cause of death.

8.3 Processing of claims
The claim will be processed by the company responsible for the possible compensation payment.

8.4 Disputes
In the event of a dispute concerning the interpretation and application of clause 8, the policyholder and the insurance companies may jointly refer the matter to a dispute resolution committee under the auspices of Finance Norway, which may issue advisory statements.

9. Provision in the contract

9.1 Duty of disclosure and consequences of failure to comply with the duty of disclosure.

9.1.1 On the effective date of the insurance contract and upon any renewal thereof, the policyholder and the insured persons are obliged to provide accurate and complete information and to answer questions asked by the insurance company concerning the health of the insured persons. The policyholder and the insured persons must also, on their own initiative, provide information about special circumstances that they understand to be of great importance to the company's assessment of risk.

9.1.2 If this duty of disclosure is neglected, the insurance company's liability shall be as described in sections 13-2 to 13-4 of the Insurance Contracts Act.

9.2 Information requirements
The policyholder is obliged to keep a list of all insured persons. The policyholder is also obliged to inform and notify the insured persons of relevant events.

This includes, but is not limited to:

- The policyholder's obligation to ensure that those who are or may become insured persons are informed about the insurance contract, including the terms and conditions and the insurance plan, including any changes thereto.
- In the event that employees are no longer covered, the policyholder is obliged to inform them as soon as possible that they are no longer covered.
- The policyholder is obliged to ensure without undue delay that all employees covered by the insurance receive their insurance certificates and the terms and conditions of cover applicable under this insurance.

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9.3 The insurance company's right to indemnification

If the policyholder fails to fulfil their obligations under the agreement entered into between the policyholder and the insurance company, and the latter has nevertheless been obliged to pay insurance benefits in accordance with the provisions, the insurance company may seek indemnification from the policyholder.

9.4 Transfer and changed circumstances

Neither the insurance contract nor any unmatured benefits payable under it may be transferred by the policyholder and/or the insured. From the date of maturity, the beneficiaries are entitled to transfer the sum. The insurance claim under the insurance contract cannot be transferred, pledged or otherwise used as security for debt. The deceased's creditors cannot seize the insurance benefits in the event of death, unless this has been determined by an appointed beneficiary.

The policyholder must notify the agent immediately of any changes in circumstances relevant to this insurance contract (e.g. mergers, acquisitions, new company address), as this may affect the insurance company's ability to fulfil the terms and conditions of the insurance contract.

9.5 Force majeure

The insurance company and/or agent shall not be liable for any delay or consequences of any delay in performing their obligations under the insurance contract if such delay is due to a cause beyond their reasonable control. The insurance company and/or agent shall be entitled to a reasonable extension of the time for performing their obligations if an event beyond their control causes a delay.

9.6 Applicable law and jurisdiction

The insurance contract is governed by and interpreted in accordance with Norwegian law and is subject to the exclusive jurisdiction of the Norwegian courts.

If any provision of these terms and conditions is deemed unlawful or unenforceable as a result of a change in the law, the invalidity shall only extend to the extent of the invalidity. The validity and legality of the remaining provisions and terms shall not be affected.

9.7 Obligations under money laundering regulations

As an insurance company, the company is subject to strict regulations to prevent their products and services from being used for financial crime and/or to finance terrorist activities. As a result, it is required to obtain information about its customers in order to fulfil its obligations under the money laundering regulations. Before the agreement can be established, it must have received the information and documentation that the company deems necessary to comply with money laundering regulations.

The company may choose not to enter into the agreement or change the scope of the agreement if the aforementioned requirements are not met or if there is suspicion of money laundering, terrorist financing or financial crime. Furthermore, the company may terminate existing customer relationships if there are objective grounds/suspicion that the company's products or services are being used as a tool for money laundering, terrorist financing or financial crime.

9.8 Financial or business sanctions

All financial transactions, including but not limited to the acceptance of payment of premiums, claims and other reimbursements, require compliance with applicable laws and regulations governing trade or economic sanctions. The insurance company may, depending on the circumstances, comply with laws and regulations governing sanctions issued by other countries' jurisdictions and organizations.

Furthermore, the insurance company is not obliged to provide cover to the policyholder and reserves the right not to include an employee or provide a service or benefit under this insurance contract if this puts the insurance company at risk of violating applicable laws and regulations concerning laws or other sanctions rules.

The insurance company reserves the right to terminate the insurance contract at any time if the policyholder, including an affiliated superior or director, becomes involved in a trade or economic sanctions that the insurance company deems relevant.

9.9 Privacy

Information relating to privacy can be found at norua.com or quantumleben.com

9.10 How notice is given under the insurance contract

Any notice required to be given under the insurance contract must be in writing. All notices should preferably be sent to the agent at the following address:

Norwegian Underwriting Agency AS
Fru Kroghs Brygge 8
0252 Oslo Norway
Telephone: 22 120 130
Email post@norua.com

All notices to the policyholder will be sent to the address provided during the application process and confirmed in the insurance certificate. If the policyholder instructs the agent/insurance company to send notices to a third party, such notices received by a third party shall be deemed to have been received by the policyholder.

9.11 Complaints and dispute resolution

Should the policyholder have any complaints regarding the insurance contract or services, notification may be sent to:

Norwegian Underwriting Agency AS Complaints Department
Fru Kroghs Brygge 8
0252 Oslo Norway
Telephone: 22 120 130
Email post@norua.com

The notice may also be sent directly to the insurance company at the address given in section 9.10. The foregoing does not affect the right to bring legal proceedings.

9.12 What is the surrender value of this insurance contract, and has profit sharing been agreed?

This product only provides risk insurance without investment value. There is no surrender value for this insurance contract, and no profit sharing has been agreed.

10. Assistance in complaints

If a dispute arises between the policyholder and the company, the dispute may be brought before the Norwegian Financial Services Complaints Board. The Board's decision is not final, and the dispute may be brought before the courts. Further information on this can be obtained by contacting the company or the Norwegian Financial Services Complaints Board, PO Box 53 Skøyen, 0212 Oslo, tel. 23 13 19 60.

Any disputes between the parties arising from the insurance relationship shall be brought before the district court/conciliation board.