# Insurance Terms and Conditions for Critical Illness Insurance

Valid from 01.12.2025

## 1. Introductory provision

This insurance can be taken out by a company, union, association or similar organization for selected groups of employees or members. Critical illness insurance is a type of insurance where the agreed sum insured is paid out as a lump sum if, during the insurance period, the insured is diagnosed with one of the illnesses/conditions listed in these terms and conditions. For each diagnosis, there are criteria for the severity of the illness. These must be met to be entitled to payment.

Some of the diagnoses refer to ICD-10. This is an abbreviation for the International Classification of Diseases.

The insurance contract consists of the terms and conditions for critical illness and the insurance certificate confirming the conclusion of the insurance contract and providing a detailed description of the cover under the agreement entered into between the policyholder and Quantum Leben NUF. 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.

**The company**: Quantum Leben AG.

**Insurance certificate**: Document describing what the insurance covers, the sum insured and the most important limitations, who is the policyholder, the insured and, where applicable, the beneficiary (see definition below).

**Policyholder**: The person who enters into an insurance contract with the company. The policyholder has ownership rights to the insurance and can dispose of it.

**Insured**: The person whose life or health is insured.

**Insured event**: An insured event occurs when the actual conditions that trigger rights under the insurance policy are met.

**Insured sum**: The amount or amounts that, according to the insurance certificate, can be paid out when an insured event occurs.

**Symptom clause**: A symptom clause means that the company is not liable for compensation for illnesses/ailments that have been diagnosed or have shown signs and/or symptoms within a certain period of time after a complete application for a specific insurance policy has been submitted. For our insurance policies, the period for the symptom clause is set at three months.

**Waiting period**: The period from when an event occurs until the insured is entitled to payment from the insurance. Waiting period means the same as waiting time.

## 3. Who is covered by the insurance

The insurance applies to the person named in the insurance certificate. The insurance is valid until the insured reaches the age of 67, unless another termination age is specified in the insurance certificate.

The insured must be permanently resident in Norway, unless otherwise is stated in the insurance certificate.

The insurance only applies to employees who were 100% fit for work when they joined the insurance scheme.

A declaration of fitness for work is required regardless of how many employees are covered by the insurance scheme.

For employees who become 100% fit for work at a later date, the insurance applies from the date on which they became 100% fit for work.

## 4. Scope of the insurance

### 4.1 Heart attack

Final diagnosis of acute heart attack, permanent destruction of heart muscle tissue as a result of reduced or lack of blood supply. This must be confirmed by detection of an increase and/or reduction in cardiac biomarkers (Troponin I, Troponin T or CK-MB) with at least one value above the 99th percentile of the upper reference limit, together with at least one of the following criteria as evidence of impaired blood supply to the heart muscle:

- Cardiac symptoms and findings consistent with acute myocardial infarction.
- New ECG changes typical of myocardial infarction.

In special cases, if there is doubt about the diagnosis, the following may be used as additional criteria:

- Imaging (ultrasound or other) showing an acquired weakening of the heart muscle.

The diagnosis must be made by a cardiologist or internist.

### 4.2 Stroke

A lesion of the brain caused by insufficient blood supply or bleeding, which meets the following criteria:

- Acute onset of neurological symptoms typical of a diagnosis of stroke.
- New objective neurological symptoms, confirmed by clinical examination, lasting more than 60 days.
- CT or MRI scan of the brain confirming new lesions consistent with the diagnosis of stroke. The diagnosis must be made by a specialist in internal medicine or neurosurgery.

The insurance does not cover:

- Transient ischemic attack (TIA).
- Traumatic damage to brain tissue or blood vessels in the brain.
- Abnormal scan findings in the brain that cannot be related to the observed objective neurological outcomes.

### 4.3 Cancer

The insurance covers malignant tumors and the diagnosis must be based on the results of a histological examination. The following are also covered:

- Leukemia.
- Malignant lymphomas.
- Hodgkin's disease.
- Bone marrow cancer.
- Sarcomas.

In the case of leukemia, the diagnosis must be made by a specialist in hematology or oncology.

The insurance does not cover:

- All tumors that are described in histological examinations as precancerous (premalignant) or that only show early malignant changes, such as cancer in situ.
- All forms of skin cancer, including melanoma with a thickness of 0.5 mm or less.
- Chronic lymphocytic leukemia Binet stage A.
- Cancer arising as a result of HIV infection.
- Prostate cancer unless it has developed to at least T2N0M0 in TNM or has a Gleason score of 7 or higher.
- Papillary thyroid cancer stage 1.

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**4.4 Multiple sclerosis**

Confirmed diagnosis of multiple sclerosis. Lesions in the brain or spinal cord confirmed by MRI scans of different parts of the central nervous system and at different times, either in the form of new neurological outcomes or new lesions in the brain or spinal cord confirmed by MRI scans. The disease must have caused objective neurological outcomes lasting more than 6 months, and examinations must have been carried out to rule out other diseases as the cause of the symptoms. The diagnosis and the objective neurological outcomes must be confirmed by a specialist in neurology or neurosurgery.

**4.5 Coronary artery bypass surgery**

Cardiac surgery performed on one or more narrow or blocked coronary arteries with the use of vein and/or artery grafts, performed as open heart surgery, or surgical intervention on persons with symptoms consistent with myocardial ischemia (ischemic heart disease). The diagnosis must be made at a cardiology clinic or hospital department or by a specialist in cardiology.

**4.6 Organ transplantation**

Performed transplantation or listed on the waiting list for transplantation in Norway of heart, liver, lung, kidney or bone marrow from a donor.

**4.7 Hearing loss**

Total and permanent hearing loss in both ears due to acute illness or accident. The results of an audiometry test must be available, showing a hearing threshold of 95 decibels or higher across the entire frequency spectrum.
The diagnosis must be made by a specialist in ear, nose and throat diseases.

**4.8 Loss of sight**

Total and permanent loss of sight in both eyes as a result of illness or accident. Total loss of sight corresponds to visual acuity of 1/60 or worse in the best eye with the best correction. Blindness must be confirmed by a specialist in eye diseases.

**4.9 Transverse paralysis**

Spinal cord injuries/disorders leading to permanent paralysis of both legs and/or both arms, or at least one arm and one leg, with persistent and complete interruption of the spinal cord's conductivity. A definitive diagnosis by a specialist in neurology or neurosurgery is required. Claims for compensation may be submitted at the earliest time after the paralysis has persisted for three months after diagnosis.

**4.10 Benign brain tumor**

Benign tumors in the brain that require surgery. If surgery cannot be performed for medical or technical reasons, the tumor is still covered. The tumor must be detected by CT or MRI scan and assessed as requiring surgery by a specialist in neurosurgery.2

**4.11 ALS and other motor neuron diseases**

Motor neuron disease of unknown cause. Includes the following diagnoses:

- Spinal muscular atrophy (SMA).
- Progressive muscular atrophy (PMA).
- Progressive bulbar palsy (PBP).
- Amyotrophic lateral sclerosis (ALS).
- Primary lateral sclerosis (PLS).
- Pseudobulbar palsy.

The diagnosis must be based on typical symptoms and confirmed findings from clinical examinations or MRI scan. The symptoms must either have persisted for more than 6 months or drug treatment to modify the course of the disease must have been initiated. The diagnosis must be made by a specialist in neurology.,

**4.12 Kidney failure**

Chronic renal impairment requiring regular dialysis treatment.

**4.13 Amputation**

Amputation of the foot at the ankle joint or a larger part of the leg. Amputation of the hand at the wrist or a larger part of the arm.

**4.14 Heart valve surgery**

Open heart surgery performed to treat acquired heart valve disease with the insertion of artificial mechanical or biological heart valve prostheses.

**4.15 Severe angina pectoris**

Angina pectoris where surgery (bypass) or unblocking (PCI) is considered necessary, even where surgical treatment cannot be performed for medical or technical reasons. The need for surgery/unblocking must be assessed by a cardiology specialist.

**4.16 Parkinson's disease**

Primary Parkinson's disease, ICD-10 code 20. The diagnosis must be made by a specialist in neurology. Parkinsonism resulting from medication use is not covered.

**4.17 Severe burns**

Third-degree burns (thermal or chemical) covering more than 20% of the body surface area measured using the "rule of nines" or equivalent method. The diagnosis must be made by a specialist in plastic surgery.

**4.18 Alzheimer's disease before the age of 65**

Alzheimer's disease with progressive memory loss and loss of thinking, language and problem-solving abilities, ICD-10 code 30. The diagnosis must be confirmed by an MRI scan of the brain. The diagnosis must be made by a specialist in neurology or geriatrics. The insurance does not cover dementia accompanied by movement disorders, such as Huntington's chorea or Parkinson's disease. Dementia resulting from calcification of the brain vessels (vascular dementia), trauma or infections is also not covered.

**4.19 Aortic Aneurysm**

An aortic aneurysm, defined as a localized dilation (aneurysm) of the aorta (the main artery) in its course through the chest or abdomen, if it requires surgical intervention. If surgery cannot be performed for medical-technical reasons, the condition is still covered provided the need for surgery has been assessed by a specialist in vascular surgery. Branches of the aorta are not covered.

**4.20 Cerebral Artery Aneurysms**

Aneurysms of the cerebral blood vessels that require surgery. If surgery cannot be performed for medical-technical reasons, the condition is still covered, provided that the necessity of surgery has been assessed by a specialist in neurosurgery or neuroradiology. Surgery on the carotid artery is not covered.

### 4.21 Benign tumor in the spinal cord

Benign tumors of the spinal cord that require surgery. If surgery cannot be performed due to medical-technical reasons, the tumor is still covered. The tumor must be confirmed by CT or MRI examination and assessed as requiring surgical intervention by a specialist in neurosurgery

### 4.22 Schizophrenia

The diagnosis must be made by a specialist in psychiatry and includes diagnoses with codes F20.0 - F20.9 (schizophrenia) in ICD-10.

### 4.23 Connective tissue disease

Autoimmune, chronic disease that damages tissue in internal organs. The insurance covers the diseases systemic lupus erythematosus (SLE; ICD-10 code M32) and systemic sclerosis (SSc, scleroderma; ICD-10 code M34). The diagnosis must be made by a specialist in rheumatology and must meet the applicable criteria according to the ACR (American College of Rheumatology) or SLICC (Systemic Lupus International Collaborating Clinics) guidelines.

The insurance does not cover discoid lupus erythematosus, drug-induced lupus/scleroderma or other atypical immunological disorders or early changes that give rise to suspicion of the disease but do not meet the above criteria.

### 4.24 HIV/AIDS as a result of blood transfusion or occupation

Infection with Human Immunodeficiency Virus (HIV) or diagnosed Acquired Immune Deficiency Syndrome (AIDS), if it can be documented to the company that the infection occurred due to one of the following causes:

- Transfusion of infected blood or blood products from a blood bank that is publicly registered and approved by the health authorities. The HIV infection as a result of blood transfusion must have occurred after the insurance came into effect. Seroconversion to HIV infection must occur within 6 months of the transfusion.
- As a result of an accidental needle stick injury while performing a person's normal professional duties (as a practicing doctor, practicing dentist, nurse, nursing assistant, social worker, laboratory technician, hospital employee, rescue service or ambulance service employee, prison service employee or police employee). Any incident that may lead to a claim for compensation must have occurred during the insurance period and must be reported to the company within seven days of the incident. As documentation of transmission, the accident must be reported as an occupational injury and a negative HIV test must be performed within 10 days of transmission, followed by a positive HIV test within the next 6 months.
- Receipt of a transplanted organ that has previously been infected with the AIDS virus. The insurance does not cover HIV infection as a result of sexual transmission or intravenous drug use.

The circumstances surrounding the infection must be fully documented (by a doctor, hospital and/or laboratory) and the results of a negative HIV test prior to or within 10 days of the incident must be provided. This must be followed by a positive HIV test within 12 months of the insured being exposed to infection.

### 4.25 Infectious disease of the brain or meninges

Contagious meningitis (meningitis) caused by bacteria (ICD-10 codes G00 and G01), encephalitis caused by viruses or bacteria (ICD-10 codes G05.0 and G05.1), as well as abscess (accumulation of pus) in the brain (ICD-10 code G06.0).

The diagnosis must be made by a neurological, neurosurgical or internal medicine hospital department, based on typical medical history and findings on MRI of the brain and spinal fluid.

The insurance does not cover myelitis (inflammation of the spinal cord only) unless this results in paraplegia, which is covered under a separate section.

## 5. Who the insured sum is paid to

The insured sum is paid to the insured.

## 6. Health check

For groups of four members or fewer, a health check is required. In cases involving a particularly high sum insured (or an increase in a previously agreed sum insured), a health check may also be required if the insurance agent requests so. In such cases, the insured must undergo a health check, either by completing a medical questionnaire or by undergoing a medical examination.

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

## 7. Change of risk and safety regulations

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

When transferring insurance coverage 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 from 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:

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

If the transfer 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.

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).

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 previous insurance company (subject to takeover).

For increases in coverage or the enrolment of new members, section 6 applies accordingly.

## 8. Restrictions

The company is not liable for compensation if:

**8.1** The insured has intentionally or through gross negligence caused an insured event, the right to compensation may be completely lost or reduced. However, the company is liable if the insured, due to their state of mind or age, was unable to understand the consequences of their actions, cf. section 13-8 and 13-9 in the Norwegian Insurance Contracts Act.

**8.2** Illness, condition or disorder has been diagnosed or has shown signs and/or symptoms within 3 months of the insurance coming into force, cf. section 13-5 in the Norwegian Insurance Contracts Act.

**8.3** Critical illness is due to health conditions for which the company has made a reservation. Any reservation will be stated in the insurance certificate.

**8.4** An illness falls under more than one diagnosis group, the insurance will still only entitle the insured to compensation for one of them.

**8.5** The insured dies within 30 days after the diagnosis has been made, the operation has been performed or the insured has been placed on a waiting list.

**8.6** The insured stays for more than one month in an area outside Norway where war or serious unrest breaks out, calculated from the date on which the war or unrest broke out.

**8.7** The insured travels to areas outside Norway where there is war or serious unrest.

**8.8** The insured participates in war or serious unrest outside Norway.

**8.9** The insured commits criminal acts.

**8.10** The insured participates in expeditions to the Arctic, Antarctic, Greenland and the Himalayas.

The restrictions in section 8.2 do not apply to insured who transfer equivalent insurance policies from another company, provided that the previous insurance policy had been in force for at least 12 months before it was terminated.

The symptom clause in section 8.2 then only applies to any increase in the scope of cover and/or increase in the sum insured.

## 9. Termination

The critical illness insurance shall terminate for the insured:

- When the insured reaches the age of 67.
- If the insured has received payment from the insurance.
- If the insured leaves the policyholder's service or withdraws from an association that has an agreement with the company. Termination is calculated from the date of resignation. See section 19-6 in the Norwegian Insurance Contracts Act.

## 10. Notification deadline

In order for the right to compensation to take effect, the person entitled to compensation must notify the company of the claim after he/she became aware of the circumstances giving rise to the claim, cf. section 18-5 in the Norwegian Insurance Contracts Act.

## 11. Privacy

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

## 12. 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.

## 13. Obligations under the 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.