Insurance Terms and Conditions for Critical Illness Insurance

Insurance terms
Valid from 01.12.2025

1. Introductory provision

Coverage for permanent disability can be offered to a company, union, association, club or similar organization and can be taken out for all employees and members, or selected groups of employees and members.

The sum insured for permanent disability is paid in cases of incapacity for work as a result of an injury or illness not covered by the Occupational Injury Insurance Act of 16 June 1989 No. 65, unless otherwise stated in the insurance certificate.

The insurance contract consists of the terms and conditions for permanent disability and the insurance certificate confirming the conclusion of the insurance contract and providing a detailed description of the cover under the contract concluded between the policyholder and Quantum Leben AG.

The Act of 16 June 1989 No. 69 on insurance contracts (the 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 derivable statutory provisions.

The text of the insurance certificate takes precedence over the insurance terms and conditions. The insurance certificate and the insurance terms and conditions take precedence over 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 with company 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.

Maximum entry age
The maximum age at which the insured person can be included in the insurance policy. As standard, this corresponds to the normal retirement date, minus the waiting period of 24 months.

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.

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 maximum entry age defined in the insurance certificate in order to be insured. This cover is not available to spouses, registered partners, cohabitants and children of the insured person.

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

Insurance Contracts Act
Act of 16 June 1989 No. 69 on insurance contracts.

Insurance contract
The contract entered into between the policyholder and Quantum Leben AG regarding cover for permanent disability.

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

Insurance certificate
The insurance certificate is a document confirming that the insurance contract has been entered into and containing information about the agreed benefits and the applicable insurance terms and conditions.

Insurance broker
A person or legal entity appointed by the policyholder to act on its behalf and represent the policyholder in dealings with the insurance company and the agent.

Insurance company
Quantum Leben AG.

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

Insured event
An insured event occurs when the insured person becomes unable to work as a result of an injury or illness that is not covered by the Norwegian Occupational Injury Insurance Act of 16 June 1989 No. 65. The insurance company may offer to cover occupational injury and occupational illness as voluntary additional cover. Such voluntary supplementary cover will in that case be confirmed in the insurance certificate, stating the type of cover. Where such voluntary supplementary cover is confirmed, these insurance terms and conditions will also apply to the cover of occupational injury and occupational illness.
Incapacity for work exists in the event of complete or partial loss of the insured person's ability to perform gainful work. The degree of incapacity is determined on the basis of the insured person's ability to perform gainful work. In order to determine whether and to what extent the insured person's ability to perform gainful work is permanently reduced, a comparison will be made between the income opportunities in any type of job that the insured person may have and the income opportunities that the person had before the insured event occurred.
The insurance certificate describes the cover and insurance benefits. Loss of license to practice a specific profession is in any case excluded from the cover of the insurance contract.
The insurance contract also does not cover incapacity for work as a result of a non-occupational illness that has been confirmed or symptoms of which have been observed within a period of three months from the date on which the insurance application was signed (the symptom period).
In order for a benefit to be paid, the insurance contract must have come into force and the individual must have been insured from the date on which he or she became permanently incapacitated for work due to an illness or injury that forms the basis of a claim.

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.

Non-occupational injury
A non-occupational injury is an accidental injury that:
a. is not an occupational injury covered by the Norwegian Occupational Injury Insurance Act of 16 June 1989 No. 65; or
b. has not occurred while working for another employer or while performing work as a self-employed person.

Non-occupational illness
A non-occupational illness is defined as an illness that has not been recognized as an occupational illness by NAV.

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 67th 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.

Illness
Illness or impairment of the insured person's normal physical functioning. For assessment under this insurance, the illness must be serious enough to require consultation with an approved doctor and prevent the insured person from participating normally in daily life.

Accidental injury
Accidental injury means injury to the body caused by a sudden external physical event – an accident – that occurs during the insurance year. Emotional distress, such as shock, is not considered an accidental injury unless it is accompanied by physical injury that leads to incapacity for work entitling the insured to cover under the insurance.

Occupational injury/occupational illness
Occupational injury and occupational illness are physical injuries or illnesses covered by the Norwegian Occupational Injury Insurance Act of 16 June 1989 No. 65.

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.

Waiting period
The period that begins when the insured person meets the definition of disability, and throughout the period that the insured person meets the definition of disability, until a final decision has been made regarding disability benefits. The standard waiting period is 24 months. Waiting period means the same as qualifying period.

3. Insurance cover

3.1 Types of cancer

3.1.1 Mandatory cover

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.

3.1.3 The types of cover are described in the insurance certificate.

3.2 Consent

It is the policyholder's responsibility to obtain the necessary consent from the insured persons (including their spouses and any other guardians of the children, if applicable) so that they can be insured under the insurance contract.

3.3 fitness for work

3.3.1 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. 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.

3.3.2 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.

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

3.3.4 Disability cover is only provided for insured persons who are 100% fit for work.

3.4 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.

3.5 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.

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3.6 Exclusion from coverage

3.6.1 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, in addition to the specific exclusions listed in the insurance certificate (including both symptomatic and existing exclusion clauses):

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.

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 organisations 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.

d. Illegal acts. No insurance benefit will be paid for claims arising from an accident or illness caused directly or indirectly by the insured person's participation in an illegal act.

e. Physical injury caused by medical treatment or use of medication. The insurance contract does not cover accidental injury caused by medical treatment, examination or similar, or the intake of medication, unless the insured person was treated for an accidental injury covered by the insurance company. Under no circumstances does the insurance contract cover accidental injury caused directly or indirectly by the intake of sleeping pills, painkillers or narcotic substances.

f. Intentional physical injury. If the insured person has intentionally caused the insured event, the insurance company shall not be liable, unless the insured person was unable to understand the extent of their actions due to their age or state of mind. The insurance company shall not be liable in the event of attempted suicide unless the person concerned can prove that the cause was acute mental disturbance – as a result of external influences – and not as a result of a state of mind, see section 13-8 of the Insurance Contracts Act.

g. Negligent causation of an insurance event. If the insured has caused the insurance event through gross negligence or increased the extent of the damage, the insurance company's liability may be reduced or waived. In making the decision, emphasis shall be placed on the degree of fault, the course of the damage, whether the insured was under the influence of self-induced intoxication, the effect that a reduction or lapse of the company's liability will have on the person entitled to the payment or on other persons who are financially dependent on him or her and the circumstances, see section 13-9 of the Insurance Contracts Act. The insurance company cannot invoke these exceptions if the insured person, due to age or mental state, was unable to understand the scope of his/her actions.

3.6.2 If 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
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 cover cease?

5.3.1 Coverage for an insured person will cease when one of the following events occurs:

a. When the insured person reaches the maximum entry age.
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 insured parties of this and to 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 prior written notice to the insured person in accordance with sections 5.3.2 and 10.2. 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 the cover ceases (for reasons other than reaching the normal retirement date), 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 expires in accordance with section 5.3.1 above.

5.4 Changes to the insurance contract

5.4.1 The 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 provisions defined in section 5.2 if the policyholder objects to the new insurance terms and conditions. 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.

5.4.3 The insurance company reserves the right to demand an immediate adjustment of the premium if significant changes occur in relation to the insured persons.

5.4.4 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 circumstances, as described in section 6.4.

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 The insurance company may also terminate the insurance contract on each renewal date, with two months' written notice, cf. section 12-9 of the Insurance Contracts Act.

5.5.5 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.

5.5.6 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 have not yet been reported, or premium adjustments that are due but have not yet been paid.

5.5.7 If the insurance contract is terminated, 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 to the 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 they are 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 semi-annual, 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 change in this regard must be notified to the agent as soon as possible. If the policyholder fails to notify the agent of 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 shall be no refund or additional invoicing of additional 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 5.4.4, proportional payment of premiums or refunds may be made outside of 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 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. Right to compensation

7.1 An insurance event occurs when all of the following conditions are met:

a. The insured person has been at least 40% incapacitated for work for a period of not less than 24 months, as specified in the insurance certificate; and

b. The non-occupational injury or illness has resulted in the insured person being at least 40% incapacitated for work, and NAV has decided to award a minimum of 40% disability benefit; and

c. The incapacity for work is considered permanent by the insurance company.

7.2 No benefit will be paid if the degree of disability is less than 40% and 50% medical disability.

7.3 No benefit will be paid for incapacity for work in the event of the insured person's death.

7.4 If the insured person's incapacity for work is less than 100%, the benefit will be reduced accordingly.

7.5 In the event of an increase in the degree of disability, the insurance company reserves the right to require a new continuous period of sick leave (waiting period) of 24 months in order to pay benefits, unless it is due to the same cause.

7.6 When assessing disability, short periods of less than two months with a disability rating of less than 40% do not interrupt the “continuous” sick leave, as long as the disability before and after the interruption is due to the same cause.

7.7 No benefits will be paid under the insurance if the insured person has already received 100% disability compensation. Full payment will only be made once during the insured person's lifetime, unless the insured person is completely healthy.

7.8 Any payment under the disability cover will reduce the sum insured under the group life insurance policy accordingly, unless otherwise agreed and stated in the insurance certificate.

7.9 If it is obvious that the insured person's condition can be improved by surgery or other treatment, and the insured person refuses to undergo such surgery or treatment without special reasons, the possible improvement in the insured person's condition that such surgery or treatment may have shall be taken into account when assessing the degree of disability.

7.10 The calculation of the benefit to be paid must be linked to the insured person's age at the time of settlement and must be linked to G at the time of payment (in cases where G is used to calculate the benefit) as stated in the insurance certificate.

7.11 A calculation based on G assumes that the insured person is a member of the National Insurance Scheme.

7.12 Unless otherwise agreed and confirmed by the insurance certificate, no benefit is offered after the insured person reaches the age of 67 (and no disability cover is provided when the insured person has reached the maximum entry age).

7.13 The right to payment for incapacity for work only arises when the insured person has reached the age of 18.

7.14 The following restriction applies to insured persons who are not members of the National Insurance Scheme:

- The degree of incapacity for work must be assessed by a doctor in Norway in accordance with applicable Norwegian regulations; and
- Expenses incurred by the insured in connection with the assessment of the degree of incapacity for work will not be covered by the insurance company; and
- No additional and future expenses incurred will be covered by the insurance company.

7.15 Advance payment will be made in the following cases:

a. 1G to the insured person if they have been at least 40% incapacitated for work for a continuous period of 18 months.

b. An additional 10% of the benefit under the insurance contract based on the degree of disability or 1G (whichever is higher), but not exceeding 2G, if the insured has been at least 40% disabled for a continuous period of 24 months.

c. An additional 10% of the benefit under the insurance contract based on the degree of disability or 1G (whichever is higher), but not exceeding 3G, if the insured has been 40% incapacitated for work for a continuous period of 36 months.

These payments shall be considered an advance payment of the benefits listed in the insurance certificate and not as a supplement to these. The right to advance payment is reserved for insured persons who are members of the National Insurance Scheme.

The insurance company reserves the right to submit a claim for reimbursement if it is subsequently determined by the Norwegian Labour and Welfare Administration (NAV) that the insured person does not meet the conditions for entitlement to the benefit, or if the date of the insured event leading to at least 40% disability falls within the insurance period covered by another insurance company that was the insurer at the time of the insured event (including symptomatic and existing exclusion clauses).

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7.16 Disability benefits with a gradual reduction from the age of 25

In cases where the insurance certificate refers to benefits in the range of 6-80% of the benefits in group life insurance, the table below applies to the payment of disability benefits.

In the event of incapacity for work, the benefits stated in the insurance certificate must be reduced in accordance with this section:

Age at the time the disability benefit falls due for payment	Disability payment as a % of the benefits under the insurance contract
15-25 years old	80%
26 years old	78%
27 years old	76%
28 years old	74%
29 years old	72%
30 years old	70%
31 years old	68%
32 years old	66%
33 years old	64%
34 years old	62%
35 years old	60%
36 years old	58%
37 years old	56%
38 years old	54%
39 years old	52%
40 years old	50%
41 years old	48%
42 years old	46%
43 years old	44%
44 years old	42%
45 years old	40%
46 years old	38%
47 years old	36%
48 years old	34%
49 years old	32%
50 years old	30%
51 years old	28%
52 years old	26%
53 years old	24%
54 years old	22%
55 years old	20%
56 years old	18%
57 years old	16%
58 years old	14%
59 years old	12%
60 years old	10%
61 years old	8%
62-66 years old	6%

7.17 Other illness – Future loss of income

If other illness – future loss of income cover is included in the insurance certificate, the following applies:

The basic compensation is specified in the insurance certificate. The basis for calculating future income is pensionable income, cf. section 3-15 of the National Insurance Act for the income year in which the illness occurred. The restrictions in section 3-13, fourth paragraph of the National Insurance Act, do not apply.

In the event of 100% incapacity for work, disability cover shall be calculated in accordance with the following table for the age group 45/46 with the following disability cover options:

Pensionable income	Basic compensation		
	Full coverage	Half coverage	One-quarter coverage
Earnings up to and including 7 G	22 G	11 G	5.5 G
Earnings above 7 G and up to and including 8 G	24 G	12 G	6.0 G
Earnings above 8 G and up to and including 9 G	26 G	13 G	6.5 G
Earnings above 9 G and up to and including 10 G	28 G	14 G	7.0 G
Earnings over 10G	30 G	15 G	7.5 G

The compensation is reduced proportionally in accordance with this table if other insurance sums
are selected. The calculation shall be linked to the insured person's age at the time of settlement.

- If the insured person is 45 or 46 years old, the compensation is equal to the basic compensation.
- For each year the insured person is older than 46, 5% of the basic compensation is deducted. However, the compensation shall amount to at least 10% of the basic compensation.
- If the insured person is aged 35-44, the compensation shall be increased by 3.5% of the basic compensation for each year they are younger than 45.
- If the insured person is 34 years of age or younger, the compensation is increased by 2.5% of the basic compensation for each year they are younger than 35. In addition to this, the compensation is increased by 35% of the basic compensation.

7.18 Medical disability

If medical disability benefits are specified in the insurance certificate, the following applies:

The insured event is deemed to have occurred at the time when the insured person has been medically disabled for a continuous period of two years, and the medical disability is assessed as permanent.

Compensation for medical disability is paid in the event of permanent medical disability of 15% or more (for accidents) and 50% or more (for illness), and will be calculated according to the following table:

Degree of medical disability	Basic compensation
15-24%	0.75 G
25-34%	1.00 G
35-44%	1.50 G
45-54%	2.00 G
55-64%	2.50 G
65-74%	3.00 G
75-84%	3.75 G
85-100%	4.50 G
Injury resulting in medical disability exceeding 100% in total	5.50 G

The same proportional scaling as in the table above applies where other insured amounts have been agreed and confirmed in the insurance certificate.
The calculation shall be based on the insured person's age at the time when the medical disability was diagnosed. Unless otherwise agreed and stated in the insurance certificate, the following rules apply:

- If the insured person is 45 or 46 years old, the compensation is equal to the basic compensation. For each year that the insured person is older than 46, 2% of the basic compensation is deducted. However, the compensation must still amount to at least 50% of the basic compensation.
- For each year that the insured person is younger than 45, the compensation will be increased by 2% of the basic compensation.

8. Claims

8.1 Notice of claim

8.1.1 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.

8.1.2 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.

8.1.3 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.

8.1.4 Claims should be submitted to:
Norwegian Underwriting Agency AS
Fru Kroghs Brygge 8
0252 OSLO

Email: post@norua.com

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

8.1.6 Health 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.

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

8.1.8 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 8.1.2 and 8.1.3, 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.

8.1.9 In the event of any claims for compensation, the insurance company shall be free from any liability if the insured fails to inform the company of the occurrence of the insured event within one year of the beneficiary becoming aware of the circumstances giving rise to the claim (in accordance with section 18-5 of the Insurance Contracts Act).

8.2 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).

8.3 Payment of a claim

8.3.1 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 10.7 and 10.8.

8.3.2 The benefit shall be paid to the insured unless otherwise agreed.

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

9. 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.

9.1 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: .

a. receipt and acceptance of all transfer information specified by the agent;
b. and 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.

9.2 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.

9.3 Both the symptomatic and existing exclusion clauses apply from the time the insured person was first included in the insurance contract that is subject to transfer. For new members who join after the transfer, the symptomatic and existing exclusion clauses apply from the time they are included in the insurance policy.

9.4 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).

9.5 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).

9.6 For increases in cover or the enrolment of new members, sections 4.1–4.6 apply accordingly.

9.7 Right to compensation in the event of disability due to illness:

9.7.1 The insurance event is deemed to have occurred when the group member has been at least 40% disabled for a continuous period of two years, and the disability is considered permanent.

9.8 Quantum Leben is responsible for paying disability benefits if we were the insurer on the first day of the last continuous period of sick leave with a degree of disability (incapacity for work) of at least 40% prior to the insured event. For the avoidance of doubt, it is specified that Quantum Leben does not assume responsibility for existing claims that have been paid or are in the process of being paid, and claims where the insured person (group member) is covered by the previous insurance company (subject to takeover).

9.8.1 In cases where there is not at least 40% incapacity for work at the same time, responsibility for the payment of disability benefits shall lie with the insurance company that is the insurer at the time when the degree of permanent medical disability is at least 50%.

9.8.2 When assessing the degree of disability over a continuous period of 24 months (two years), any short periods with a degree of disability lower than 40 per cent shall be disregarded. Short periods are defined as a maximum of two (2) consecutive months. It is a prerequisite that the disability before and after the interruption is due to the same cause.

9.9 Entitlement to compensation for disability due to injury

The insurance company that was the insurer at the time of the accident that led to the insured event is responsible for paying disability benefits.

9.10 Special rules for increase in permanent disability

9.10.1 Insured persons (group members) who are on sick leave at the time of issue of this policy shall be covered by the previous insurance with the previous insurer (subject to takeover).

9.10.2 When the insured person returns to work, they will be entitled to benefits based on an increase and/or change in disability, provided that they were included in the previous insurance when it was taken out with the previous insurer.

9.10.3 An increase in permanent disability before final settlement of an insurance claim has taken place shall be taken into account in the settlement by the insurance company covering the claim in question.

9.10.4 An increase in permanent disability after final settlement of an insurance claim shall be considered a new insurance claim regardless of the cause. In the event of such an increase, there are no minimum requirements for the size of the increase in the degree of disability. However, this does not apply if the group member has received 100% disability compensation from the previous insurer. In such cases, Quantum Leben has no further obligations, and the group member is no longer covered by the permanent disability insurance.

9.11 Processing of the claim

The claim will be processed by the company responsible for the potential compensation payment.

9.12 Disputes

In the event of a dispute concerning the interpretation and application of clause 9, 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.

10. Provisions in the contract

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

10.1.1 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.

10.1.2 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.

10.2 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 amendments thereto.
- In the event that employees are no longer covered, the policyholder has a duty 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 who are covered receive proof of insurance and the terms and conditions of cover applicable under this insurance.
- The policyholder is obliged to ensure without undue delay that all employees covered by the insurance receive information about specific exclusions and symptomatic and existing exclusion clauses. Any individual exclusions will be communicated directly to the person concerned in order to comply with data protection legislation.

10.3 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

10.4 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.

10.5 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.

10.6 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.

10.7 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.

10.8 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.

10.9 Privacy

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

10.10 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 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.

10.11 Complaints and dispute resolution 2

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

10.12 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.

11. 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.