Group Scheme Insurance

Conditions and General Underwriting Guidelines 2021

This is a translation of the original version in Swedish. The original shall always prevail in the case of any conflict.

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EURO ACCIDENT försäkring + hälsa

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1 General conditions

1.1 Introduction

These insurance conditions describe the insurance products available under the insurance scheme. The insurance conditions also contain information about the individual insurance products included in the insurance scheme, requirements for joining, entry into force, cessations and premiums. The insurance statement contains information about the insurance products purchased.

The General Conditions may apply to insurance products, and contain the information about such products, that are not included in the individual group scheme agreement.

Euro Accident provides insurance conditions and all other information in Swedish. Certain information may also be provided in English in special cases when Euro Accident considers it appropriate.

The insurance conditions are divided into:

- General conditions including general underwriting guidelines
- Explanation of terms
- Product conditions.

1.1.1 Insurer

Insurer for all subscribed group insurances are Euro Accident Livförsäkring AB.

The insurer are the insurance companies that enter into the insurance agreement and are the carriers of the insurance risk.

Corporate Headquarters: Danderyd
Address: Svärdvägen 3 a
SE-182 33 Danderyd
Sweden

This insurance is, unless otherwise stated, classified as a capital insurance (K) according to the Income Taxes Act. This means that the premium is not tax deductible for a private citizen but amounts paid out are exempt from income tax according to Swedish tax law. Disability Business Interruption Insurance is an exception where compensation must be declared as business income and the insurance premium is tax deductible.

1.2 The group scheme agreement

A group scheme agreement is the basis for the group scheme insurance. The group scheme agreement is agreed upon between the insurer and a representative of the group. A requirement for the validity of the individual insurance is that the group scheme agreement is still in effect. The preconditions of the group scheme agreement supersedes the provisions of the insurance conditions.

1.3 The insurance agreement

1.3.1 Parties to the agreement

Voluntary group scheme insurance

In the case of voluntary group scheme insurance, the insurance agreement is agreed upon between the insurer and the group member based on the group scheme agreement. Such an agreement can also be agreed upon by a group member omitting to decline the insurance within a particular period, provided this is stated in the group scheme agreement. A group member who joins a voluntary group scheme insurance is both a policyholder and insured unless otherwise agreed.

Mandatory group scheme insurance

In the case of mandatory insurance, the insurance agreement is concluded between the insurer and a representative of the group members, e.g. a company for its employees or an association for its members. The group representative, that is the company/organisation, is the policyholder for a mandatory group scheme insurance.

1.3.2 Content

The provisions set out in the insurance agreement apply to the insurance. The insurance agreement is based on the information provided in writing or in some other manner to Euro Accident by the policyholder and the insured where appropriate.

Swedish law applies to the insurance agreement. The Insurance Contracts Act contains the currently applicable provisions.

1.3.3 Contract period

The group scheme agreement has, unless otherwise agreed, a common main due date for all insurances. In the case of an insured that has newly joined a group with a common main due date, the first contract period is the period from the date joined to the group's main renewal date. Thereafter each contract period is one year.

1.3.4 Renewal of/amendment to the insurance agreement

If the insurance agreement or the group scheme agreement is not terminated by any of the parties, the insurance agreement will automatically be renewed

one year at a time, based on the conditions stated by the insurer.

The conditions and premium of the insurance can consequently be changed at the end of a contract period. Information about changes is provided in conjunction with the requested premium for the new contract period.

The insurer is also entitled to change the conditions for the insurance agreement during the term of the insurance if the preconditions for the agreement change due to amended legislation or other enactment, changed legal practice or through public authority regulations.

1.4 General underwriting guidelines

Group scheme insurance applies to a person who has attained the age of 16 up to the date when the person attains the age of 65, is living and registered as resident in any of the Nordic countries, excluding Iceland, and who is also entitled to compensation from a Swedish social insurance agency or a corresponding social insurance agency in a Nordic country, unless otherwise agreed.

If the person is living and registered as a resident in a Nordic country other than Sweden, excluding Iceland, and is entitled to compensation from another social insurance agency than the Swedish agency, it is required that the person is stationed abroad by a Swedish company. The company shall be a customer of Euro Accident and the employees shall have been offered group scheme insurance within the framework of these underwriting guidelines and associated conditions.

The company may have a maximum of 25 per cent of their employees stationed in a Nordic country other than Sweden, excluding Iceland.

Use of the term 'corporate group'

In the case of a 'corporate group' it is necessary for the group to have at least five persons fully capable of working. In order to be considered part of a 'corporate group' the parent company must own at least 50 per cent of the subsidiary/subsidiaries. Franchise companies, together with their employees, are not considered as part of a corporate group and cannot be included to qualify for being fully capable of working.

In the case of a 'corporate group' all companies within the group must apply for insurance agreements, with the same arrangements with regards to agreements and products, at one and the same time and be subject to the same effective date. If companies are added to the corporate group at a later date, these become affiliated, subject to the requirements for being fully capable of working, at the time when such companies were acquired/affiliated.

Sports teams or sports associations cannot as a group apply for insurance, either on a mandatory or voluntary basis.

In order for Euro Accident to grant group scheme insurance it is normally required that the applicant is fully capable of working, see Clause 1.4.1. A person who is not fully capable of working at the time of affiliation may join the insurance later.

Underwriting and health status review guidelines may vary between different group scheme agreements and are specified in the application documents or the group scheme agreement.

Following a health status review the insurance may be:

- granted with standard premiums and conditions
- granted with exemptions and/or added premium
- rejected.

The same health status review guidelines, as apply for the application for a new insurance, also normally apply in the case of:

- an increase of the sum insured
- other extension of the insurance cover.

1.4.1 Fully capable of working

'Fully capable of working' means that your normal work can be performed without restriction and that sick pay from the employer or compensation from the Social Insurance Agency is not being paid out.

'Compensation from the Social Insurance Agency' means sickness or rehabilitation benefit, activity compensation, sickness compensation or other compensation owed to the inability to work. In order to be fully capable of working it is also required that no occupational injury annuity is being paid or that employment with subsidised wage or dormant activity compensation/sickness compensation or corresponding compensation has not been granted.

'Social insurance agency' and 'compensation' also means the corresponding agencies and benefits in the Nordic countries.

Parental leave/leave of absence

Persons who are on parental leave/leave of absence are deemed to be fully capable of working provided the above mentioned requirements (concerning none of the mentioned forms of compensation being paid) are satisfied. A person is not considered to be fully capable of working if the leave of absence results from the employee testing other work for health reasons.

1.4.2 Maximum sum insured

The aggregate maximum sum insured for the combination Life Insurance with child protection and Life Insurance with total permanent disability and child protection is 50 price base amounts.

The aggregate maximum sum insured for the combination Life Insurance with total permanent disability and child protection and Total permanent disability insurance is 50 price base amounts.

The aggregate maximum sum insured for the combination Accidental Death and Dismemberment Insurance and Sickness and Accidental Death and Dismemberment Insurance is 50 price base amounts.

The aggregate maximum sum insured for Child and Youth Insurance is 50 price base amounts.

1.4.3 Co-insured

A group member may coinsure their husband/wife, registered partner, cohabitee or children unless otherwise agreed, stated in the application documents or indicated by other provisions of these conditions.

The children who can be insured are those children of the group member/insured and of the husband/wife, registered partner, cohabitee who are entitled to inherit. The child can be added to the insurance up to the age of 20 and can stay on the insurance up to and including the end of the month in which the child attains the age of 25, unless otherwise agreed.

1.4.4 Total permanent disability insurance

An application for Total permanent disability insurance may be made up to the 57th birthday. The requirements set out in Clause 1.4 otherwise apply.

1.4.5 Private medical insurance PrivatAccess

Private medical insurance PrivatAccess silver without a pre-existing condition clause:

Can only be applied on a mandatory basis for a defined group of 50 people or more.

An insured who has themselves chosen to give notice terminating the insurance but remains within the group eligible for insurance may not rejoin a group scheme agreement without a pre-existing condition clause. It is only possible to rejoin a corresponding insurance with a pre-existing condition clause. The same applies to an insured who on being newly employed has chosen to decline such insurance.

Private medical insurance PrivatAccess gold

Can be applied to individuals fully capable of working subject to certification. Children may not be coinsured.

Change of group agreement area within Euro Accident

An insured who has a valid voluntary or mandatory Private medical insurance PrivatAccess applied for through an intermediary, partner or directly via Euro Accident, and who changes group agreement area and applies for a new Private medical insurance PrivatAccess with an uninterrupted term of insurance, may be credited with the preceding term of insurance with Euro Accident. This also applies if the insured had a privately taken out insurance and makes a new application within the framework of a valid voluntary or mandatory group scheme agreement via Euro Accident.

1.4.6 Basic Disability Business Interruption Insurance and Disability Business Interruption Insurance

Basic Disability Business Interruption Insurance is available with a maximum sum insured of four price base amounts.

Disability Business Interruption Insurance is only available with a sum insured exceeding four price base amounts.

1.5 Conversion from previous insurer

General

If a group scheme agreement is transferred from another insurer, the group member/coinsured shall be fully capable of working at the time of joining, in order to be converted to a similar product.

A group member/coinsured who later becomes fully capable of working may join the insurance subject to the health status review guidelines applicable at the time for new applications for insurance relating to the new agreement in question.

Private medical insurance PrivatAccess

In order to convert a group scheme agreement, it is required that the number of persons amount to at least five and that everyone at the company have been offered insurance.

Conversion as referred to above is possible from voluntary insurance to voluntary insurance, and from mandatory insurance to mandatory insurance.

A policyholder who has applied for mandatory Private medical insurance PrivatAccess without a pre-existing condition clause, or corresponding healthcare insurance with another insurer, may not apply for a group scheme agreement so as to include Private medical insurance PrivatAccess with a pre-existing condition clause. However, the policyholder can apply for a new group scheme agreement including Private medical insurance PrivatAccess with a pre-existing condition clause. Such a new group scheme

agreement may only include those individuals who have become group members after the time at which an application was made for the group scheme agreement in respect of Private medical insurance PrivatAccess with a pre-existing condition clause.

If a group scheme agreement that only consists of Private medical insurance PrivatAccess, is transferred from another insurer, the group member/coinsured shall be fully capable of working at the time of joining.

A group member/coinsured who later becomes fully capable of working may join the insurance no later than within 30 days from the time the group scheme agreement is transferred from another insurer.

The above time limit of 30 days does not apply if the group scheme agreement covers 500 or more insured.

If the group scheme agreement is transferred from the immediately preceding insurer to Euro Accident the insurance will provide reimbursement for covered medical expenses related to continued care needs for a sickness/injury/complaint that has been notified, approved and settled by the immediately preceding insurer after their term of cover, liability period, has expired.

If the group scheme agreement is transferred from the immediately preceding insurer to Euro Accident, the insurance will also provide reimbursement for covered medical expenses related to continued care needs for a sickness/injury/complaint that was the subject of treatment but has not been notified to them.

One precondition for reimbursement is that the sickness/injury/complaint was covered according to the conditions of the immediately preceding insurer and also that the sickness/injury/complaint is covered by these insurance conditions.

1.6 Entry into force of the insurance

Voluntary group scheme insurance

The insurance is in effect on the date following the date the application was made to Euro Accident, or to another party who receives documents on behalf of Euro Accident, subject to the precondition that:

- the requirements for joining the insurance are satisfied
- complete application documents have been submitted
- the insurance can be approved according to Euro Accident's health status review guidelines.

If the group scheme agreement states that a group member is covered under the insurance for a period free of charge, and the insurance agreement thereafter is entered into by the group member due to omitting to decline the insurance, the insurance agreement starts to apply when the time for declining, and similarly the time for the insurance cover without charge, ceases.

Mandatory group scheme insurance

The insurance starts to apply from the date specified in the group scheme agreement. Unless otherwise agreed, the agreement shall be deemed to have been entered into on the date following the date the application was made to Euro Accident, subject to the precondition that insurance can be granted according to Euro Accident's underwriting and health status review guidelines.

For a group member and coinsured who join later, the liability of the insurer arises on the date following the date the application was made to Euro Accident, subject to the precondition that Euro Accident has received complete application documents and that the insurance can be granted according to the conditions applicable to the group scheme agreement and the underwriting and health status review guidelines applicable at the time.

New employment after agreement made

With regards to the affiliation of newly employed persons, the insurance applies from and including the start of the employment, provided that:

- the application was received at the earliest one (1) month before and at the latest three months after the start of the employment
- the insurance, in accordance with the underwriting guidelines applicable at the time, may be granted subject to approved health status review
- complete application documents have been received by Euro Accident.

If the application is received later than three months, counted from the start of the employment, the insurance applies from and including the date after the date when the application was made to Euro Accident subject to the requirements that the insurance, in accordance with the rules applicable at the time, may be granted subject to an approved health status review and that complete application documents have been received by Euro Accident.

Voluntary and mandatory insurance

Both voluntary and mandatory insurance can be offered without restriction (with standard conditions and standard premiums) alternatively with restrictions, known as exclusions and/or added premium.

In the event that the sum insured is changed, the change applies unless otherwise agreed as of the date following the date on which notice of the change was given to Euro Accident or some other party who

receives documents on behalf of Euro Accident, subject to that the requirements for the change are satisfied and complete application documents have been received and that insurance can be granted according to Euro Accident's health status review guidelines.

1.7 Premium

Unless otherwise stated in the group scheme agreement, the premium is calculated for one year at a time. In the event that the insured's age constitutes the entire or part of the information base for the calculation of premium, the premium is determined on the insured's age upon the immediately following birthday and calculated for one year at a time.

An invoicing charge is taken in the event of invoicing by post. This charge is specified in the tariff applicable at any given time, as shown on our website.

1.7.1 Premium payment

An insurance' first premium payment shall be made no later than 30 days after the date Euro Accident sent a premium bill.

If the insured under the group scheme agreement is covered by an introductory cover without charge and an insurance agreement is thereafter concluded through the group member omitting to decline the insurance, the agreed premium shall be paid no later than the end of the free period.

Renewal premium for insurance that already applies shall be paid no later than on the effective date of the new term. However, the premium does not need to be paid earlier than one month following the date Euro Accident sends a premium bill.

In the case of mandatory insurance, it is also required that the company or organisation that has concluded the group scheme agreement shall, without any cost to Euro Accident, make the premium payments in one lump sum for all insured, unless otherwise agreed.

1.7.2 Notice of termination

If the premium is not paid when due Euro Accident, is entitled to give notice terminating the insurance. Notice of termination takes effect 14 days after a message concerning termination is sent out, subject to the requirement that the premium is not paid on time.

1.7.3 Premium payment respite

If a group member has not been able to pay the premium for a voluntary group scheme insurance when due because of severe illness, impaired work capacity by at least half, deprivation of liberty, failure to receive pension or failure to receive salary from their main employment or similar impediment, the insurance shall nonetheless continue to apply. The insurance ceases two weeks after the time at which the impediment is removed, but no later than three months after the date on which the insurance would have ceased according to the notice of termination.

Premium for periods when a premium respite applied shall be paid in the manner determined by Euro Accident.

1.7.4 Reinstatement

If the insurance has been terminated due to premium payment delay, the insurance can be reinstated, without a new health status review, by the premium being paid within three months from the date the insurance was terminated.

The insurance then starts to apply as of the date following the date the premium was paid. This right does not apply to a coinsured if the group member chooses not to utilise their right to reinstatement. Nor does this right apply if the first premium for the insurance is delayed.

If the insurance is reinstated, due to the above, the insurance does not cover losses that occurred during the time the insurance was not in effect, or for losses that occurred after the time the insurance was reinstated if the loss originates from an event that occurred when the insurance was not in effect. The liability of the insurer commences as of the date following the date the premium amount is paid.

The right of reinstatement may be limited by the group scheme agreement if this is necessary due to the nature of the insurance or other special circumstances.

1.7.5 Premium waiver

There is no right to premium waiver under the insurance.

1.7.6 Repayment of premium

The policyholder and/or the insured is obligated to notify Euro Accident as soon as possible:

- if the insured group member or coinsured withdraws from the group eligible for insurance
- when the youngest child, who is covered by the Child and Youth Insurance and/or Private medical insurance PrivatAccess, attains the stipulated termination age.

If the above-mentioned is not notified on time, a maximum of the last twelve months' premium will be repaid.

If a premium has been paid for a period after the time that the insurance ceased, a repayment will always be made of that part of the premium corresponding to the period that occurs after the insurance ceased. Euro

Accident reserves the right to charge administrative fees in conjunction with repayment.

Euro Accident can, during the term of the insurance, without preceding notice change the repayment procedure.

1.8 Cessation of the insurance

General

The insurance is effective for at most up to and including the end of the month in which the group member or coinsured attains the age of 67, unless otherwise stated in the group scheme agreement.

The insurance will cease to be effective before:

- the group scheme agreement ceases to be effective
- the end of the month in which the group member no longer belongs to the group of persons who can be insured, as defined in the group scheme agreement
- according to a written notice of termination by a group member or coinsured
- according to a notice of termination given by Euro Accident
- when the premium is not paid when due.

Euro Accident reserves the right to give notice terminating the insurance if the policyholder or the insured has grossly neglected their obligations in relation to the company or if there are other exceptional reasons to do so.

Co-insured

A co-insured's insurance ceases to be effective, besides as provided above, at the end of the month when:

- the group member dies
- the marriage, registered partnership or cohabitee relationship with the group member ceases.

Insured children

Other than what is stated above, the following applies for children who are insured under Child and youth insurance and coinsured children under Private medical insurance PrivatAccess bronze and silver:

- the children of the group member/insured and of the husband/wife, registered partner, cohabitee who are entitled to inherit are covered by the insurance at most up to and including the end of the month in which the child attains age of 25, unless otherwise agreed, subject to the requirement that the premium is paid.

Duty of disclosure

It is an obligation of the policyholder and/or the insured to notify Euro Accident as soon as possible:

- if the insured group member or coinsured withdraws from the group eligible for insurance
- when the youngest child, who is covered by the Child and Youth Insurance and/or Private medical insurance PrivatAccess, attains the stipulated termination age.

The right to premium repayment regarding time after the expiry of the term of the insurance is governed by Clause 1.7.5.

If the policyholder fails, during the term of the insurance, to give notice of changes in time, these will start to apply according to the general provisions for the effective date of the insurance, that is to say at the earliest from the date after the date the notice was given to Euro Accident.

1.8.1 Extended cover protection

If an insured has been covered by the insurance for at least six months, an extended insurance cover ('extended cover protection') applies for three months after withdrawal from the group. If a wife, husband. registered partner or cohabitee is coinsured and the relationship is dissolved, the extended cover protection ceases for the coinsured three months after the marriage/partnership/cohabitee relationship ended.

Extended cover protection does not apply:

- if notice has been given terminating the group scheme agreement by an authorised representative of the group or by the insurer
- if the insured them self has chosen to give notice terminating the insurance but remains within the insured group
- if notice has been given terminating the insurance due to the non-payment of premium
- if the insured, during the extended cover protection period, joins another group scheme insurance or takes out continued insurance
- when the insured withdraws from the group due to having attained the termination age.

If the insured during the extended cover protection period attains the age of 67, or the termination age stated in the group scheme agreement, a limited extended cover protection applies for three months from the withdrawal from the group as follows:

- Life Insurance with death benefit 0.5 price base amount
- Accidental Death and Dismemberment Insurance with sum insured 5 price base amounts.

The limited extended cover protection only covers a person who upon withdrawal from the group is covered by Life Insurance and Accidental Death and Dismemberment Insurance respectively.

1.8.2 Continuation insurance

A group member and coinsured who have been covered by group scheme insurance with Euro Accident for at least six*) months are entitled to apply for continuation insurance if:

- the group scheme agreement ceases
- the group member leaves the group eligible for insurance.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the requirement that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

A co-insured is also entitled to apply for continuation insurance if:

- the group member dies
- the marriage, registered partnership or cohabitee relationship with a group member is dissolved
- the group member attains the termination age of the insurance before the co-insured.

The right to apply for continuation insurance does not apply if:

- the group member and/or coinsured has chosen to give notice terminating the group scheme insurance separately and/or for the co-insured but remains within the group eligible for insurance
- the group member and/or coinsured received, or undoubtedly can receive, cover of the same kind as before with another insurer.

The application for continuation insurance shall be made no longer than within three months from the date on which the group scheme insurance ceased to apply. Continuation insurance is applied for without health status review.

Continuation insurance applies for at most up to and including the end of the month the insured attains the age of 67, unless otherwise stated in the group scheme agreement.

An insured who has been covered by Private medical insurance PrivatAccess under a group scheme or continuation insurance with Euro Accident for at least six months and attains the group scheme agreement's termination age is entitled to apply for senior insurance without health status review.

An insured who has been covered by mandatory Private medical insurance PrivatAccess without a deductible and leaves the insured group is offered to apply for Continuation Insurance PrivatAccess with a deductible.

An insured who has been covered by mandatory Private medical insurance PrivatAccess with Euro Accident for at least six months and has a notified, approved and settled the need of care for sickness/injury/complaint and who intends to apply for a voluntary group scheme insurance Private medical insurance PrivatAccess can also apply for continuation insurance.

Continuation insurance can have at most the same cover and benefits which last applied for the group scheme insurance.

The continuation insurance can have other insurance conditions. The premium for continuation insurance is determined according to the insured's age and calculated according to a special rate.

1.8.3 Continued insurance

Continued insurance accidental death and dismemberment

A child who has been covered by the Child and Youth Insurance, under the group scheme insurance with Euro Accident, for at least six*) months, is entitled to within three months from the end of the month in which the child attains the age of 25 (unless another termination age is stated in the group scheme agreement) apply for continued insurance accidental death and dismemberment with up to 30 price base amounts as sum insured, without a health status review.

*) A period during which the child was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement which has been converted from another insurer and not when an individual insured has changed insurer.

Continued insurance accidental death and dismemberment applies to the conditions, premiums and other rules applicable at that time.

Continued insurance PrivatAccess bronze or silver

A child who has been coinsured under Private medical insurance PrivatAccess, a group scheme insurance or

senior insurance with Euro Accident for at least six*) months is entitled to apply for continued insurance PrivatAccess bronze or silver within three months from the end of the month in which the child attains the age of 25, unless another termination age is stated in the group scheme agreement. It is necessary to be fully capable of working at the time when the insurance is applied for.

*) A period during which the child was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement which has been converted from another insurer and not when an individual insured has changed insurer.

Continued insurance PrivatAccess bronze or silver applies on the conditions, premiums and other rules applicable at that time.

1.8.4 Senior insurance

A group member, insured and coinsured who have been covered by Life Insurance and/or Accidental Death and Dismemberment Insurance and/or Private medical insurance PrivatAccess, under group scheme or continuation insurance with Euro Accident for at least six*) months, is entitled to apply for senior insurance in conjunction with withdrawal from the group scheme agreement or attaining the termination age under the continuation insurance.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement which has been converted from another insurer and not when an individual insured has changed insurer.

The withdrawal shall be due to either the group member's old age or collectively agreed pension or at the latest upon attaining the termination age for the group scheme agreement. Even coinsured shall withdraw from the group when the group member attains the termination age for the group scheme agreement.

In those cases where the insured, who has been covered by Private medical insurance PrivatAccess according to the above, has had a coinsured child aged under 25, there is a possibility to also co-insure children aged under 25 under the senior insurance. The insurance for a co-insured child applies in this case at most up to and including the end of the month in which the co-insured attains the age of 25.

The application for senior insurance shall be made at the latest within three months from the date the group scheme or continuation insurance ceased to apply. Senior insurance is applied for without health status review.

Senior insurance applies to the conditions, premiums and other rules applicable at that time.

1.9 Assignment

The group scheme insurance cannot be assigned or pledged unless otherwise prescribed by the group scheme agreement.

1.10 Restrictions

1.10.1 Incorrect or incomplete information

The provisions of the Insurance Contracts Act apply if any information that has been provided by the policyholder or the insured is incorrect or incomplete.

If incorrect or incomplete information have been provided concerning circumstances that are of relevance to the assessment of the insurance risk this may mean the insurance will be terminated or amended and the right to insurance compensation lapses completely or in part and the insurer is released from liability for losses which have occurred. Premium paid will not be repaid in these cases.

If such information has been provided by the insured's custodian, the same applies as if such person was the policyholder.

1.10.2 Intent and gross negligence

If the insured has by intent or gross negligence induced a bodily injury, accidental injury or sickness, or aggravated its consequences, the compensation may be reduced or lapse completely in accordance with the Insurance Contracts Act. The compensation will be reduced to the extent reasonable considering the circumstances.

The compensation will never be reduced if the insured was under the age of 18 or suffered from a serious mental disorder at the time the bodily injury, accidental injury or sickness was induced or aggravated.

If the insured has committed suicide, the insurer is liable if more than one year has elapsed from when the insurance agreement was effective or extended or, in the event of a shorter period, if it must be assumed that the insurance was applied for without any thought of suicide.

1.10.3 Criminal act and influence of intoxicants

Compensation may be reduced, cease or lapse completely in the event sickness or accidental injury occurred in conjunction with the insured:

- performed or participated in a criminal act which according to Swedish law can lead to imprisonment
- was influenced by alcohol or other intoxicants, soporifics, narcotic substances or as a consequence of the use of pharmaceuticals in an improper way.

1.10.4 Certain communicable diseases and/or epidemics

The insurance does not apply for losses which completely or partially, directly or indirectly, were caused by or are a result of, or have been aggravated by an epidemic/pandemic announced by the World Health Organisation (WHO), and/or disease subject to the Communicable Diseases Act.

1.10.5 Force majeure

The insurance does not apply to a loss which arises if the assessment of the right to insurance, investigation of the loss or payment of compensation is delayed or made impossible due to war, warlike event, civil war, revolution, rebellion, due to official measure, strike, lockout, blockade or similar event or due to a natural disaster.

1.10.6 War, warlike political unrest, armed conflict or the like in Sweden

The insurance does not apply for losses which occur due to war, warlike political unrest, armed conflict or similar situations in Sweden.

1.10.7 War, warlike political unrest, armed conflict or similar in countries or areas outside Sweden

The insurance does not apply for losses that are connected to war, warlike political unrest, armed conflict or similar in countries or areas outside Sweden.

However, if the insured is staying in countries or areas outside Sweden where war, warlike political unrest, armed conflict or similar breaks out during the stay, the insurance applies during the first four weeks subject to the precondition that the insured does not in any way participate in, or report on, the war, the warlike political unrest or the armed conflict. However, this does not apply to countries or areas to which the Swedish Ministry for Foreign Affairs (UD) advises against travel due to war, warlike political unrest, armed conflict or the like.

1.10.8 Terrorism and mass destruction

The insurance does not cover losses that are connected to an act of terrorism which have been caused by the dispersal of weapons of mass destruction in the form of biological, chemical or nuclear material in or outside Sweden.

'Act of terrorism' means an act initiated by a person or group of persons with political, religious, ideological or similar purposes, with intention to influencing governments or to put the general public, or parts of the general public, in danger. An act of terrorism may include, but is not limited to, the actual use of power, violence or threat of such. The perpetrators may either act individually, or on the assignment of, or in collusion with another organisation or government.

1.10.9 Nuclear processes

The insurance does not apply to sickness or accidental injury that has directly or indirectly been caused by nuclear processes.

1.10.10 Sport

The insurance does not apply to losses as a consequence of the insured participating in sports activities that yield an income for the insured due to the sport of an amount that exceeds one (1) price base amount per year (sports income). 'Participate' means both training and competing.

Wages, costs allowance, winnings due to competing, appropriations for pension obligation, so-called appearance money, contribution by sponsors, income from advertising assignments and similar remuneration are regarded to be 'sports' income. Income from capital due to the management of sports income is not counted as sports income.

Nor does the insurance apply for losses as a consequence of a sport that the insured has been enrolled to engage in at a national sports college (RIG) or on a nationally approved sports programmes (NIU) to engage in. Consequently, the insurance does not apply to participation in either a competition or training of the sport in question.

1.10.11 Hazardous activities

The insurance does not apply to losses as a consequence of the insured participating in adventure, expedition or other hazardous activities such as:

- engaging in martial arts, boxing, karate, Thai boxing, kick-boxing or similar activities
- professional diving, diving with heavy equipment and all leisure diving at depths greater than 18 metres and/or leisure diving with planned decompression stops
- stunt activities, air acrobatics or similar activities
- engagement in mountain climbing, sky-diving bungee jumping, gliding, ballooning, hang-gliding,

extreme skiing (off-piste skiing), rock climbing (including on snow and ice) or participation in expeditions of a similar 'adventurous nature' engaging in motor sports
- operations on an oil platform
- activities at high heights above12 metres
- flying, other than in the capacity as passenger, of a licensed multi-engine aircraft run by a commercial airline which is subject to government control.

1.10.12 Costs which are reimbursed in other ways

Compensation will not be paid out for costs that can or shall be reimbursed in other ways according to a special law or enactment, international convention, other insurance or collective agreement.

Compensation will not be paid out for cost that can be reimbursed by patient or drug insurance or otherwise where there is a care provider or drug liability.

1.11 Validity abroad

An explanation of how the insurance applies in the event of a stay outside the Nordic countries is provided below.

'The Nordic countries' below means Sweden, Finland, Denmark (except Greenland), Norway (except the Svalbard Archipelago) and Iceland.

A stay outside the Nordic countries is not deemed to be discontinued by temporary presence in the Nordic countries to visit doctors, hospital care, for business, holiday or the like. A stay outside the Nordic countries is deemed to have been discontinued when the insured returns to the Nordic countries with the intention of staying.

The life insurance component of Life Insurance with child protection and Life Insurance with total permanent disability and child protection applies in the event of a stay outside the Nordic countries regardless of the length of the stay.

The total permanent disability component of Total permanent disability insurance, Life Insurance with total permanent disability, Short-term and Long-term Disability Insurance, Basic Disability Business Interruption Insurance and Disability Business Interruption Insurance apply in the event of a stay outside the Nordic countries for up to twelve months.

When processing a claim for total permanent disability and the insured at the time of the loss occurrence did not belong to the Social Insurance Agency, Euro Accident will pay compensation only if it is probable that the insured would have been granted at least a half sickness compensation or activity compensation if they had belonged to the Social Insurance Agency. The assessment will be made in conjunction with Euro Accident's consultant physician.

Accidental Death and Dismemberment Insurance, Sickness and Accidental Death and Dismemberment Insurance and Child and Youth Insurance apply in the event of a stay outside the Nordic countries for up to twelve months. However, there is no limitation to the length of the stay abroad with respect to the invalidity allowance and compensation for death components of these insurance products if the insured group member or coinsured is:

- in stationed abroad by the Swedish state, a Swedish company or a Swedish NGO
- in service with a foreign company with a permanent link to Sweden
- in service with an international organisation with a permanent link to Sweden.

Reimbursement for expenses in the event of an accidental injury abroad will be settled in the same way as if the accidental injury occurred in Sweden.

In case of staff stationed abroad, compensation for crisis treatment costs will be paid for up to ten occasions of treatment with a registered psychologist or psychotherapist in the country of stay. Compensation will be paid upon submission of an original receipt, up to the tariff approved by the Swedish Psychological Association per occasion of treatment. Staff stationed abroad will arrange contact with an appropriate psychologist themselves in the country of stay. Travelling expenses in conjunction with treatment outside Sweden are not reimbursed.

The insurance will not reimburse costs for home transportation in the event of accidental injury abroad or costs that are reimbursed by a separate travel insurance alternatively the travel cover component.

In the event of acute sickness or acute injury, as a consequence of an accidental injury and in conjunction with temporary travel outside Sweden, Private medical insurance PrivatAccess will cover any deductible paid by the insured to the travel insurance company or home insurance company. One precondition for a right to compensation is that the amount of the loss exceeds the deductible under the travel or home insurance. Reimbursement is limited to SEK 5,000 per deductible requested. The respective insurance conditions of the travel or home insurance company indicate what is meant by 'temporary travel outside Sweden'.

Employee Assistance Program (EAP) under Private medical insurance PrivatAccess gold applies within Sweden.

1.12 Action for payment

Losses, which may lead to compensation, shall be reported to Euro Accident as soon as possible or, if stated on the claim form, via the insurance intermediary who represents the insured group.

Forms can be obtained from Euro Accident or the insurance intermediary representing the insured group.

Those documents and other information that Euro Accident considers relevant to the assessment of the right to compensation shall be obtained and submitted without cost to Euro Accident.

If Euro Accident requests, consent shall be granted for Euro Accident or the companies that Euro Accident engages for medical risk assessment or claims handling, in order to assess Euro Accident's liability, gather information, records, certificates etc. from a physician or other medical staff, hospital or other medical establishment, the Social Insurance Agency or other insurance establishment.

A requirement for a right to compensation in the case of sickness or accidental injury is that the insured:

- should be able to verify that sickness or an accidental injury has occurred
- gives notice of sickness and/or accidental injury to Euro Accident
- consults a physician or other medical staff registered by the National Board of Health and Welfare as soon as possible
- is continuously under the supervision of a physician during the period of sickness
- observes the directions of the physician or other medical staff registered by the National Board of Health and Welfare
- cooperates by participating in a rehabilitation plan as directed by Euro Accident
- otherwise complies with Euro Accident's regulations.

If Euro Accident requests, the insured shall attend an examination at a specially assigned physician. Such examination shall be paid for by the insurer.

Original receipts and/or certificates of compensation paid from the care provider/region shall be submitted.

Disability Business Interruption Insurance

In the event of a loss covered by Disability Business Interruption Insurance, the policyholder is responsible for assisting Euro Accident in connection with a claims investigation and upon request verify the demand for compensation and provide vouchers, evidence, certificates concerning sick leave and other documents that are needed to assess insurer's liability and the amount of the compensation.

In the event of a loss, Euro Accident may request that the business' fixed costs, according to the latest audited annual accounts, are certified by the business's auditor.

The above does not apply to Basic Disability Business Interruption Insurance.

1.12.1 Time of payment and provisions concerning interest

Losses will always be settled according to the conditions applicable for the contract period when the loss occurred.

Payment shall be made no later than one month after the right to compensation arose and Euro Accident has received information, records, certificates, etc. from a physician or other medical staff, hospital or other medical establishment, the Social Insurance Agency or other insurance establishment and provided that the party requesting payment has:

- performed the measures stipulated for the payment to be made
- submitted the investigation that may reasonably be required to determine the insurer's liability to pay compensation
- given notice of to whom the payment is to be made.

If payment is made later, interest for the delay shall be paid according to the Interest Act. Euro Accident is not liable for any amounts above this for a loss that may arise if the investigation is delayed.

Interest for delay is not paid if the delay results from circumstances referred to in Clause 1.10.5.

1.12.2 Period of limitation

A party who wishes to make a claim for insurance compensation or other insurance cover must institute proceedings against Euro Accident within ten years of the time when the circumstance arose that, according to the insurance agreement, would afford an entitlement to such cover or compensation. Otherwise the right to compensation or other insurance cover lapses.

If a claim has been presented within this period, the time limit to appeal is always six months from when Euro Accident has declared that the company has adopted a final position on the claim.

1.12.3 Subrogation

Euro Accident takes over the insured's right to damages, or other compensation from a third party, to the extent that the insurer has paid compensation due to the insurance agreement.

1.13 Processing of personal data

As a Controller, Euro Accident processes personal data to be able to offer and provide the insurance and services on which we have agreed and for other purposes such as, for example, compliance with laws and other rules. Further detailed information about the processing of personal data is available from Euro Accident's Integrity Policy available at euroaccident.se or by contacting Euro Accident.

Our Integrity Policy not only includes information about how Euro Accident collects and uses your personal data, but also information about your rights in conjunction with the processing of personal data, such as the right to information, rectification, data portability, right to be forgotten and to object, etc.

1.14 Loss notification register

Euro Accident is authorized to register reported losses that were incurred under this insurance in a joint loss notification register (GSR) of the insurance industry. The register is only used in conjunction with claims handling.

The personal data controller for GSR is:
Försäkringsförbundet (The Swedish Insurance Association)
Box 24043
SE-104 50 Stockholm.
Telephone: +46 (0)8-522 785 00
Visiting address: Karlavägen 108, Stockholm
Website: svenskforsakring.se

1.15 Consideration of decision in an insurance matter

If the insured is not satisfied with Euro Accident's decision on an insurance matter, a request shall be made in the first instance to Euro Accident to have the matter reconsidered. The request shall be sent to the administrative officer who made the decision in the matter or to the administrative officer's immediate superior.

Euro Accident has also appointed a Complaints Officer to whom the insured can refer for assistance and an independent review of its matter. Contact details for the Complaints Officer are available on Euro Accident's website: euroaccident.se.

Euro Accident's Review Committee

A final decision in a claims case can be considered by Euro Accident's Review Committee. The committee comprises one external expert with extensive experience from the personal injury area, one lawyer and Euro Accident's claims and risk assessment manager.

If the insured is nevertheless not satisfied, the insured can refer to:

Allmänna Reklamationsnämnden (The Swedish National Board for Consumer Disputes) (ARN)
Box 174
SE-101 23 Stockholm.
Telephone: +46 (0)8-508 860 00
Visiting address: Kungsholmstorg 5, Stockholm
Website: arn.se

ARN does not consider matters concerning medical issues, where special medical knowledge is required. Such matters are instead considered by:

Personförsäkringsnämnden (The Personal Insurance Board)
Box 24067
SE-104 50 Stockholm.
Telephone: +46 (0)8-522 787 20
Visiting address: Karlavägen 108, Stockholm
Website: forsakringsnamnder.se/PFN

For advice without charge contact:

Konsumenternas försäkringsbyrå (The Swedish Consumers' Insurance Bureau)
Box 24215
SE-104 51 Stockholm
Telephone: +46 (0)200-22 58 00
Visiting address: Karlavägen 108, Stockholm
Website: bankforsakring.konsumenternas.se

Disputes resulting from the insurance agreement are to be considered by a Swedish court, in the first instance at a district court, applying Swedish law. Costs for a legal representative are not paid by the insurance.

2 Explanation of terms

Accidental injury under Accidental Death and Dismemberment Insurance and Sickness and Accidental Death and Dismemberment Insurance

An 'accidental injury' means the bodily injury the insured sustains involuntary upon a sudden, unforeseen external occurrence.

Bodily injury due to frostbite, heatstroke or sunstroke, and infection as a consequence of a tick bite are equated to accidental injury. Such bodily injury is deemed to have occurred on the date that it manifests itself. Bodily injury which has been caused by a sudden knee twist injury, an Achilles tendon rupture, retinal detachment, sudden deafness, heart attack or stroke are also considered an accidental injury.

In order for retinal detachment, sudden deafness, heart attack and stroke to be equated to accidental injury it is required that the insured has not been medicated and/or treated for a complaint which may be considered to be linked with the accidental injury.

A link between a bodily injury and one of the above mentioned kind of causes shall be determined to exist where prevailing reasons suggest this is the case.

Accidental Death and Dismemberment Insurance under Child and Youth Insurance:

An 'accidental injury' means the bodily injury the insured sustains involuntary upon a sudden, unforeseen external occurrence.

Bodily injury due to frostbite, heatstroke or sunstroke, or infection as a consequence of a tick bite are equated to accidental injury. Such bodily injury is deemed to have occurred on the date that it manifests itself. Bodily injury which has been caused by sudden knee twist injury or an Achilles tendon rupture are also considered an accidental injury.

A link between a bodily injury and one of the above mentioned kind of causes shall be deemed to exist where prevailing reasons suggest this is the case.

Acute treatment and healing period

The period from when the insured receives care and treatments after having sustained an accidental injury, up to the time the insured has recovered or the condition is considered to be static.

Beneficiary

The person who has been designated beneficiary contained in these insurance conditions or through a separate designation of beneficiary, receives payment of the insurance' face amount upon the death of an insured.

If the insurance applies to the policyholder's own life, the policyholder should nominate a beneficiary. Payment upon death will then be made to this person. A nomination or change of nomination shall be made by a personally signed form to Euro Accident. Such nomination applies even if Euro Accident has not made any note in the insurance policy.

With regards to 'companion insurance' and 'keyman insurance', where the insurance is applied to the life of a person other than the policyholder's own life, the payment will be made to the policyholder upon the death of the insured.

BMI (Body Mass Index)

– 18.4 Underweight
18.5 – 24.9 Normal weight
25.0 — 29.9 Overweight
30.0 — Obesity

Children in Child and Youth Insurance and in Private medical iInsurance PrivatAccess bronze and silver

The children who can be insured are those children of the group member/insured, and of the husband/wife, registered partner, cohabitee who are entitled to inherit up to and including the end of the month in which the child attains the age of 25, unless otherwise agreed.

Cohabitee

A person with whom the insured cohabits according to the Cohabitees Act (2003:376).

Co-insured

The group member's husband/wife/registered partner, cohabitee or child who is in that capacity insured under the group scheme agreement.

Companion insurance

Life insurance which is applied for by a actual person (A) (policyholder) on the life of another actual person (B) (insured), for their own (A) benefit and where the other person (B) normally, but not always, applies for corresponding life insurance on the life of the first person (A), for their own (B) benefit.

Consultant physician care

Health and medical care which covers medical investigation, treatment and care which require specialised resources and major technical or personnel resources. Such care shall be performed by a consultant physician.

Corporate group scheme insurance
Life insurance which is applied for by a legal entity on the life of the owner, for the benefit of the legal entity (keyman insurance).

Defined group
A pre-determined and clearly limited group of people. The limitation may be of a geographical and/or organisational nature.

Diagnosis benefit
A lump-sum which is paid out if the insured contracts any of the diagnosed illnesses or conditions defined in the conditions.

Extended medical care services
In the event the sickness/injury/complaint is not covered by the insurance due to a restriction contained in the insurance conditions or an individual restriction (exclusion), the insurance will still cover advice and booking of private medical care. The cost of care will be the financial responsibility of the insured under such circumstances.

Fully capable of working
'Fully capable of working' means your normal work can be performed without restriction and that sick pay from the employer or compensation from the Social Insurance Agency is not being paid out.

'Compensation from the Social Insurance Agency' means sickness or rehabilitation benefit, activity compensation, sickness compensation or other compensation due to inability to work.

In order to be fully capable of working it is also required that no occupational injury annuity is being paid or that employment with a wage subsidy, dormant activity compensation/sickness compensation or corresponding compensation has not been granted.

'Social insurance agency' and 'compensation' also means the corresponding agencies and benefits in the Nordic countries.

Group
A company, business operator or organisation which has entered into a group scheme agreement with the insurer.

Group eligible for insurance
A specific group of people who according to a group scheme agreement are entitled to apply for or join group scheme insurance.

Group member
A person who belongs to the group specified in the group scheme agreement and can be insured according to the group scheme agreement.

Group representative
In the case of voluntary group scheme insurance, the group representative is the person with whom Euro Accident has entered into a group scheme agreement governing the pre-conditions for and scope of the insurance offered to the group members.

In the case of mandatory group scheme insurance, the group representative is the person with whom Euro Accident has entered into an insurance agreement covering all group members eligible for insurance.

Group scheme agreement
An agreement concluded between the insurer and a representative of a group concerning insurance for the group members. The group scheme agreement contains provisions based on the composition of the group, which insurance is offered to those entitled to insurance, the effective date of the group scheme agreement and its term and the extension and termination of the group scheme agreement.

Husband/wife
Person with whom the insured is married.

ICD code
ICD codes refer to the International Statistical Classifications of Sicknesses and Related Health Problems ICD-10, issued in Sweden 1997, approved by the World Health Organisation. ICD-10 will also be applied if the classification is changed or if diagnosis codes are amended or added. The classification is available on the Swedish National Board of Health and Welfare's website (www.socialstyrelsen.se).

In-patient care
Means care provided to a patient who has been admitted to a hospital or another care unit for at least one night. However, in-patient care does not include time outside the institution for which temporary leave has been granted.

Insurance agreement
The agreement applicable for each individual insurance. The scope of the insurance agreement is stated in the application documents for the insurance, group scheme agreement, the general terms and conditions of insurance, the product conditions, the insurer's underwriting guidelines, the Insurance Contracts Act (FAL 2005:104) and Swedish law in general.

Insured
The person whose life or health an insurance applies.

Liability period
The longest period for which payments can be made on a loss.

Mandatory group scheme insurance
Insurance where employees are automatically covered due to actions taken by the employer and according to the group scheme agreement's requirements for joining.

Medically justified
Which is based on science and best practice and also evidence should it be available.

Open care
Means care provided at a clinic or hospital without the patient staying overnight.

Policyholder
The policyholder is the person who entered into the insurance agreement with the insurer. Each insured, including both group members and coinsured, are considered policyholders with regards to insurance compensation and the right to specify a beneficiary. This does not apply to key man insurance or companion insurance. If ownership transfers to another person, this other person is thereafter considered to be the policyholder.

In case of Basic Disability Business Interruption Insurance and Disability Business Interruption Insurance the policyholder is the business in respect of which the Disability Business Interruption Insurance has been applied for.

Pre-existing condition clause
Explains the period of time which must have elapsed without the insured having any symptoms of, receiving care for or being medicated for a sickness/injury/complaint, or consequences thereof, before the insurance applies to such sickness/injury/complaint, or consequences thereof, under Private medical insurance PrivatAccess.

Price base amount
The price base amount is an amount calculated on the basis of the changes to general price levels in accordance with the provisions of the Social Insurance Code (SFS 2010:110). This calculation is made on the basis of the change to the consumer price index and fixed for the entire calendar year.

Qualifying period
The period of time of inability to work which must have elapsed before compensation may be paid under total permanent disability, Long-term and Short-term Disability Insurance, Basic Disability Business Interruption Insurance, and Disability Business Interruption Insurance,

Registered partner
A person with whom the insured has entered into a registered partnership according to the Registered Partnership (Family Law) Act (1994:1117).

Relative
Parents, husband, wife, cohabitee, registered partner, children and siblings are considered relatives.

Sickness
'Sickness' means a deterioration of the state of health, physical or mental, which has been observed for the first time by a physician or a registered psychologist, which is not to be regarded as an accidental injury according to these conditions. The sickness is deemed to have occurred on the date when the deterioration was observed by a physician or a registered psychologist. A bodily injury which has been caused voluntarily is not regarded as sickness. Sicknesses which are medically linked are counted as one and the same sickness claim.

Voluntary group scheme insurance
Group scheme insurance for which group members apply themselves through a personal application or by not declining insurance.

Waiting period
Waiting period is the period the insurance must have been in force before the right to compensation arises.

Work disablement
'Work disablement' means that the work capacity of the insured has been eliminated or impaired due to sickness or accidental injury. Euro Accident's assessment will normally follow the rules for national insurance and the decision of the Social Insurance Agency of the right to sickness or rehabilitation benefit, activity compensation, sickness compensation or other compensation due to inability to work. Periods with sick pay are also regarded as inability to work. The impairment is assessed, unless otherwise stated, in accordance with Chapter 7, Section 3 of the National Insurance Act. In order to establish the right to compensation Euro Accident may request that the insured attends an examination at a specially assigned physician.

3 Life insurance with child protection

The insurance will pay:	The insurance will not pay:
– a lump sum upon the death of the insured – one (1) price base amount in the event of the death of a child entitled to inherit from a group member.	– for child protection, if the child entitled to inherit has attained the age of 18 – for child protection, if the child has attained the age of 16 or been granted nursing allowance at the time when the insurance is applied for. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

3.1 Right to compensation

Life insurance

If the insured dies during the term of the insurance, a payment will be made of a lump sum (death benefit). The death benefit is the sum insured reduced by any age reduction according to the insurance agreement. The sum insured is stated in the insurance statement.

Child protection

Child protection is included as a component of the insurance, unless otherwise stated in the group scheme agreement. The child protection will only be paid from one (1) insurance.

The child protection ceases when the insurance ceases.

3.2 The insurance will pay – Life Insurance

A death benefit is paid to the beneficiary upon the death of the insured.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year in which the right to compensation arises.

As regards 'companion insurance' and 'keyman insurance', where the insurance is applied for on the life of a person other than the policyholder's own life, the payment will be made to the policyholder upon the death of the insured.

3.3 Nomination of beneficiary under Life Insurance

The beneficiaries for the death benefit to be paid are the persons shown in the order stated below, unless the insured has given notice in writing to Euro Accident of another nomination, see Clause 3.3.3:

a) The insured's husband/wife, registered partner or cohabitee
b) The insured's heirs. In the event that the heirs have been nominated, the sum insured is apportioned according to the rules of law of inheritance.

3.3.1 Declination

If a beneficiary has died, or completely or partially declines their right, the/those person(s) who according to the nomination would be next entitled take the place of the party who has died/declined. A declination must be made before the death benefit is paid to the beneficiary.

3.3.2 Divorce

A nomination for the benefit of a husband/wife alternatively registered partner ceases to apply when an application for divorce alternatively an application for dissolution of partnership has been received by a court.

3.3.3 Special nomination of beneficiary

A form for special nomination of beneficiary can be obtained from Euro Accident or the insurance intermediary representing the insured group.

The nomination of beneficiary cannot be changed by will.

A special nomination of beneficiary lapses when the insurance, to which the nomination is linked, ceases.

3.4 Restrictions

3.4.1 Suicide

The first paragraph of Clause 1.10.2 does not apply if the insured has committed suicide.

In the case of suicide, the insurer is liable if more than one year has elapsed from when the insurance agreement was concluded or extended, or in the event of a shorter period, if it is assumed that the insurance was applied for without any thought of suicide.

3.5 The insurance will pay – child protection

3.5.1 Right to child protection

The child protection covers those children of the group member/insured, and of the husband, wife, registered partner, cohabitee who are entitled to inherit up to and including the end of the month in which the child attains the age of 18, unless otherwise agreed.

Even a stillborn child who has died after the end of the 22nd week of pregnancy is covered by the child protection. Compensation will then be paid to the group member or co-insured.

3.5.2 Child protection compensation

If a child who is covered by the child protection dies before the end of the month the child attains the age of 18, one (1) price base amount will be paid to the child's estate.

A 'price base amount' means the price base amount applicable in the year the right to compensation arises.

3.5.3 Transitional rules for child protection

Special transitional rules apply for children who were covered by the child protection on 28 February 2007.

3.5.4 Adopted children

A foreign child, which a group member intends to adopt, is insured as soon as they arrived in Sweden, provided a consent according to the Social Services Act is in place. If the adoption is not confirmed, the insurance ceases as soon as the child leaves Sweden, though at the latest after one year from when the child arrived in Sweden. Compensation for death will be paid to the group member or co-insured.

3.5.5 Restrictions

Child protection does not cover a child who, at the time when the insurance enters into force has:

- attained the age of 16
- been granted nursing allowance, according to the National Insurance Act.

The child protection will only be paid from one (1) insurance.

3.6 Validity abroad

See Clause 1.11 regarding validity abroad.

4 Life insurance with total permanent disability and child protection

The insurance will pay:	The insurance will not pay:
– a lump sum upon the death of the insured – one (1) price base amount in the event of the death of a child entitled to inherit from a group member – a lump sum in the event of work disablement ≥ 50%, that lasted for a certain period, before the age of 60.	– in the event of work disablement < 50% – misuse-related illness – chronic fatigue syndrome – compensation in respect of mental or stress-related illness that has manifested itself within 24 months after the insurance was applied for – for child protection, if the child entitled to inherit has attained the age of 18 – for child protection, if the child has attained the age of 16 or been granted nursing allowance at the time when the insurance is applied for. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

4.1 Right to compensation

Life insurance

If the insured dies during the term of the insurance, a payment will be made of a lump sum (death benefit). The death benefit is the sum insured reduced by any age reduction according to the insurance agreement. The sum insured is stated in the insurance statement. The death benefit is reduced if the total permanent disability has been paid out.

Total permanent disability

One precondition for the right to compensation is that the work capacity has been permanently impaired by at least 50 per cent. The right to payment of total permanent disability arises at the time when the qualifying period of 18 months and 30 months respectively has been reached. An insured loss is deemed to have occurred when the right to compensation arose.

The right to partial payment of total permanent disability corresponding to 25 per cent of the sum insured, taking into account any age reduction, arises if the insured has, before attaining the age of 60, been incapable of working to a level amounting to at least 50 per cent for 18 of the last 19 months, and all possibilities for vocational training and rehabilitation have been investigated and the period of work disablement commenced during the term of the insurance, unless otherwise indicated by the group scheme agreement. This right to payment is allowed only once (1 time) per insured.

The right to the remaining sum insured, taking into account any age reduction, arises when the insured has, before attaining the age of 60, been incapable of working to a level amounting to at least 50 per cent for 30 of the last 36 months.

If the qualifying period of 18 months is not achieved, 100 per cent of the sum insured will be paid out, taking into account any age reduction when the qualifying period of 30 months has been achieved.

The maximum compensation payable per insured is the sum insured applied for, taking into account any age reduction.

If a period of work disablement commenced during the former insurer's liability period, in respect of the same or similar insurance, such a period of work disablement can be included in the current insurance, provided Euro Accident has consented to all persons in a group being entitled to join the insurance.

The percentage rate for a full total permanent disability is shown by the table in Clause 4.5.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Child protection

Child protection is included as a component of the group member's insurance, unless otherwise stated in the group scheme agreement. The child protection will only be paid from one (1) insurance.

The child protection ceases when the insurance ceases.

4.2 The insurance will pay – Life Insurance

A death benefit is paid to the beneficiary upon the death of the insured.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year in which the right to compensation arises.

As regards 'companion insurance' and 'keyman insurance', where the insurance is applied for on the life of a person other than the policyholder's own life, the payment will be made to the policyholder upon the death of the insured.

The amount of the death benefit is calculated in relation to the sum insured for Life Insurance. The amount of the death benefit also depends upon whether a total permanent disability has been made.

If a total permanent disability has been paid, the death benefit is the share of the sum insured for Life Insurance as stated in the table below. The percentage figure is determined by the insured's age upon death and any age reduction.

Age attained	Per cent of sum insured after any age reduction, if a total permanent disability has been paid
-39	25
40	31
41	37
42	43
43	49
44	55
45	36
46	42
47	48
48	54
49	60
50	66
51	69
52	72
53	75
54	78
55	81
56	84
57	87
58	90
59	93
60-	100

4.3 Nomination of beneficiary under Life Insurance

The beneficiaries for the death benefit to be paid are the persons shown in the order stated below, unless the insured has given notice in writing to Euro Accident of another nomination, see Clause 4.3.3:

a) The insured's husband/wife, registered partner or cohabitee
b) The insured's heirs. In the event that the heirs have been nominated, the sum insured is apportioned according to the rules of law of inheritance.

4.3.1 Declination

If a beneficiary has died, or completely or partially declines their right, the/those person(s) who according to the nomination would be next entitled take the place of the party who has died/declined. A declination must be made before the death benefit is paid to the beneficiary.

4.3.2 Divorce

A nomination for the benefit of a husband/wife alternatively registered partner ceases to apply when an application for divorce alternatively an application for dissolution of partnership has been received by a court.

4.3.3 Special nomination of beneficiary

A form for special nomination of beneficiary can be obtained from Euro Accident or the insurance intermediary representing the insured group.

The nomination of beneficiary cannot be changed by will. A special nomination of beneficiary lapses when the insurance, to which the nomination is linked, ceases.

4.4 Restrictions

4.4.1 Suicide

The first paragraph of Clause 1.10.2 does not apply if the insured has committed suicide.

In the case of suicide, the insurer is liable if more than one year has elapsed from when the insurance agreement was concluded or extended, or in the event of a shorter period, if it is assumed that the insurance was applied for without any thought of suicide.

4.5 The insurance will pay– total permanent disability

The total permanent disability is determined by the insured's age at the time the right to total permanent disability arose and is calculated as a per cent of the sum insured for the Life Insurance in accordance with the table below.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year in which the right to compensation arises.

Age attained	Per cent of sum insured
-39	100
40	94
41	88
42	82
43	76
44	70
45	64
46	58
47	52
48	46

49	40
50	34
51	31
52	28
53	25
54	22
55	19
56	16
57	13
58	10
59	7
60-	0

4.6 Restrictions

4.6.1 Misuse-related illness

The insurance does not cover work disablement caused by an illness or condition related to drug misuse, alcohol dependency or pharmaceuticals misuse.

4.6.2 Chronic fatigue syndrome

The insurance does not cover work disablement caused by chronic fatigue syndrome, e.g. myalgic encephalomyelitis.

4.6.3 Mental or stress-related illness

The insurance does not cover work disablement caused by mental or stress-related illness or condition such as, for example, depression, anxiety disorder, exhaustion syndrome and concentration problems.

The restriction regarding mental and stress-related illness or condition is not applicable if:

- the insurance has been in force with Euro Accident without interruption for at least 24 months*) before the sickness occurred and the insured has been fully capable of working without interruption for the same period
- the insured became sick with any of the above illnesses/complaints during the first 24 months, then recovered and has been free of complaint for more than 24 months after the last occasion of sickness.

Periods of work disablement that are shorter than 15 days are not taken into account, unless the work disablement is due to a mental and/or stress-related illness.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

4.7 The insurance will pay – child protection

4.7.1 Right to child protection

The child protection covers those children of the group member/insured, and of the husband/wife, registered partner, cohabitee who are entitled to inherit up to and including the end of the month in which the child attains the age of 18, unless otherwise agreed.

Even a stillborn child who has died after the end of the 22nd week of pregnancy is covered by the child protection. Compensation will then be paid to the group member or co-insured.

4.7.2 Child protection compensation

If a child who is covered by the child protection dies before the end of the month the child attains the age of 18, one (1) price base amount will be paid to the child's estate.

A 'price base amount' means the price base amount applicable in the year the right to compensation arises.

4.7.3 Transitional rules for child protection

Special transitional rules apply for children who were covered by the child protection on 28 February 2007.

4.7.4 Adopted children

A foreign child, which a group member intends to adopt, is insured as soon as they arrived in Sweden, provided a consent according to the Social Services Act is in place. If the adoption is not confirmed, the insurance ceases as soon as the child leaves Sweden, though at the latest after one year from when the child arrived in Sweden. Compensation for death will be paid to the group member or co-insured.

4.7.5 Restrictions

Child protection does not cover a child who, at the time when the insurance enters into force has:

- attained the age of 16
- been granted nursing allowance, according to the National Insurance Act.

The child protection will only be paid from one (1) insurance.

4.8 Validity abroad

See Clause 1.11 regarding validity abroad.

5 Total permanent disability insurance

The insurance will pay:	The insurance will not pay:
– a lump sum in the event of work disablement ≥ 50%, that lasted for a certain period, before the age of 60.	– in the event of work disablement < 50% – misuse-related illness – compensation in respect of mental or stress-related illness that has manifested itself within 24 months after the insurance was applied for. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

5.1 Right to compensation

Total permanent disability

One precondition for the right to compensation is that the work capacity has been permanently impaired by at least 50 per cent. The right to payment of total permanent disability arises at the time when the qualifying period of 18 months and 30 months respectively has been reached. An insured loss is deemed to have occurred when the right to compensation arose.

The right to partial payment of total permanent disability corresponding to 25 per cent of the sum insured taking into account any age reduction, arises if the insured has, before attaining the age of 60, been incapable of working to a level amounting to at least 50 per cent for 18 of the last 19 months, and all possibilities for vocational training and rehabilitation have been investigated and the period of work disablement commenced during the term of the insurance, unless otherwise indicated by the group scheme agreement. This right to payment is allowed only once (1 time) per insured.

The right to the remaining sum insured, taking into account any age reduction, arises when the insured has, before attaining the age of 60, been incapable of working to a level amounting to at least 50 per cent for 30 of the last 36 months.

If the qualifying period of 18 months is not achieved, 100 per cent of the sum insured will be paid out, taking into account any age reduction when the qualifying period of 30 months has been achieved.

The maximum compensation per insured is the sum insured applied for, taking into account any age reduction.

If a period of work disablement commenced during the former insurer's liability period, in respect of the same or similar insurance, such a period of work disablement can be included in the current insurance, provided Euro Accident has consented to all persons in a group being entitled to join the insurance.

The percentage rate for a full total permanent disability is shown by the table in Clause 5.2.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Compensation is not paid if the insured has died.

5.2 The insurance will pay

The total permanent disability is determined by the insured's age at the time the right to total permanent disability arose and is calculated as a per cent of the sum insured in accordance with the table below.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year in which the right to compensation arises.

Age attained	Per cent of sum insured
-39	100
40	94
41	88
42	82
43	76
44	70
45	64
46	58
47	52
48	46
49	40
50	34
51	31
52	28
53	25
54	22
55	19
56	16
57	13
58	10

59	7
60-	0

5.3 Option right

Option right means that a person who does not have a husband/wife, registered partner, cohabitee or child at the time the insurance is applied for, and whose family situation later changes, that is to say gets married, enters into a registered partnership, commences a cohabitee relationship or has children is entitled to, within one year from when their family situation changed, apply for Life Insurance with child protection without providing a new health declaration, unless otherwise agreed. The insured is personally responsible for giving notice of a new family situation to Euro Accident.

5.4 Restrictions

5.4.1 Misuse-related illness

The insurance does not cover work disablement caused by an illness or condition related to drug misuse, alcohol dependency or pharmaceuticals misuse.

5.4.2 Chronic fatigue syndrome

The insurance does not cover work disablement caused by chronic fatigue syndrome, e.g. myalgic encephalomyelitis.

5.4.3 Mental or stress-related illness

The insurance does not cover work disablement caused by mental or stress-related illness or condition such as, for example, depression, anxiety disorder, exhaustion syndrome and concentration problems.

The restriction regarding mental and stress-related illness or condition is not applicable if:

- the insurance has been in force with Euro Accident without interruption for at least 24 months*) before the illness occurred and the insured has been fully capable of working without interruption for the same period
- the insured became sick with any of the above illnesses/complaints during the first 24 months, then recovered and has been free of complaint for more than 24 months after the last occasion of sickness.

Periods of work disablement that are shorter than 15 days are not taken into account, unless the work disablement is due to a mental and/or stress-related illness.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

5.5 Validity abroad

See Clause 1.11 regarding validity abroad.

6 Accidental death and dismemberment insurance

The insurance will pay:	The insurance will not pay:
– medical expenses – dental injury expenses – travelling expenses – additional costs – costs for rehabilitation and medical devices – daily compensation – medical disability – professional disability – scars or other change in respect of appearance – crisis treatment – death benefit.	– private care or private treatment – dental injury as a consequence of chewing, biting or inflammation/dental illnesses – additional costs in business activities – costs caused by deterioration to health status that are not linked to the accidental injury – costs for home transport in the event of accidental injury outside the home district and abroad. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

6.1 Right to compensation

The insurance applies for accidental injury that occurs during the term of the insurance.

'Accidental injury' means the bodily injury that the insured sustains involuntary upon a sudden, unforeseen external occurrence.

Accidental injury is equated to bodily injury due to:

- frostbite, heatstroke or sunstroke
- infection as a consequence of a tick bite
- sudden knee twist injury
- achilles tendon rupture
- retinal detachment
- sudden deafness
- heart attack
- stroke.

In order for retinal detachment, sudden deafness, heart attack and stroke to be equated to accidental injury it is required that the insured has not been medicated and/or treated for a complaint which may be considered to be linked with the accidental injury.

A link between a bodily injury and one of the above-mentioned kinds of cause shall be deemed to exist where predominant reasons suggest this to be the case.

6.2 The insurance will pay

6.2.1 Medical expenses

The insurance will pay the insured's patient fee under public health care up to the limit for the high-cost protection for the necessary and reasonable costs in respect of:

- medical care
- treatment prescribed by a physician to heal the injury
- physiotherapy
- treatment by a naprapath or chiropractor, following referral by a physician. The referral may not be older than six months.

The insurance will pay the insured's daily charge under public health care for hospital care.

The insurance will pay compensation for up to three years after the accidental injury occurred. In cases where the injury has resulted in a disability and the degree of disability cannot be determined within three years, medical expenses will be paid until the degree of disability can be determined.

Reimbursement for medical expenses will not be paid after a degree of disability has been determined.

6.2.2 Dental injury expenses

The insurance will pay the insured's patient fee under public dental care for the necessary and reasonable costs regarding treatment of a dental injury.

'Dental injury' also means damage to implant and damage to a denture which was fitted in the mouth when it was damaged.

Compensation will not be paid for implant treatment that is not covered by public dental care.

The insurance will pay compensation for up to five years after the accidental injury occurred. If treatment has to be postponed due to the insured's age, compensation will be paid for such postponed treatment that is implemented before the insured attains the age of 25.

Costs and treatment must be approved in advance by Euro Accident.

The insurance will not pay further compensation if the insurance has paid compensation for the final treatment of the dental injury.

If there is a need of treatment already at the time of the injury of the damaged teeth, Euro Accident is entitled to reduce the amount of the compensation to a corresponding extent.

6.2.3 Travelling expenses

The insurance will reimburse travelling expenses to and from:

- care and treatment prescribed by a physician, up to the amount that corresponds to the 'personal contribution charge' for the region in question
- work or school, when the need has been confirmed by a physician, comprising the additional cost for the least expensive mode of transport possible considering the health status.

Reimbursement is paid in accordance with the rules of the Tax Agency for travel using own car.

Reimbursement for travelling expenses is paid for at most three years from the loss occurrence, or until the degree of disability has been determined, and only in those cases where it was not possible to obtain compensation from the employer, social insurance office, region or other insurance.

6.2.4 Additional costs

If the accidental injury has resulted in the insured receiving medical or dental care, the insured's:

- damaged clothes, spectacles and disability aids and devices which were carried or worn at the time of the accident will be compensated. Compensation of up to SEK 2,000 can be paid as a once and for all payment. If a higher amount is claimed, the damage and age of the damaged objects must be verified. Compensation will be paid of up to 0.5 price base amount. If the damaged object can be repaired, compensation is paid for the cost of repair.

The following valuation table shall be used for the valuation of clothes and spectacles. The table shows the compensation as a per cent of the purchase price for new ones considering the age of the object.

Age	0-1 year	1-2 years	2-3 years	3 years and older
Per cent	100	80	60	40

- unavoidable additional costs during the acute treatment and healing period of the accidental injury. Compensation of up to SEK 2,000 can be paid as a once and for all payment. If a higher compensation is claimed, the necessary and reasonable additional costs must be verified. Compensation will then be paid of at most three price base amounts.

6.2.5 Costs for rehabilitation and medical devices

The insurance will compensate the insured for measures needed following the acute treatment and healing period of the accidental injury, in order to reinstate lost functional capacity and living conditions through paying for:

- care and treatment following referral by a physician, up to ten occasions of treatment. The referral may not be older than six months
- employability assessment, vocational training or retraining. In the case of retraining, compensation will not be paid for costs that arise due to education that enhances the level of skill
- medical devices intended to increase mobility and reduce possible disability. If the insurance has paid compensation for an impairment of function, medical or professional disability, the insurance cannot at the same time pay compensation for medical device to ameliorate impairment to function already compensated
- changes to the one-time nature of ordinary home environment, or other living conditions, intended to facilitate the most normal life possible. Costs for improvement of standard will not be compensated.

Compensation will be paid for up to two price base amounts for measures that have been approved in advance by Euro Accident. For measures during the acute treatment period, compensation will be paid instead according to Clause 6.2.4.

Reimbursement for costs for rehabilitation and medical device will not be paid after the degree of disability has been determined.

6.2.6 Daily compensation

In the case of accidental injury that results in at least 25 per cent work disablement, daily compensation will be paid during the period of work disablement, as of and including day 29 of the work disablement for at most up to and including day 90 of the work disablement. SEK 200 per day will be paid in the case of 100 per cent work disablement. The daily compensation will be adjusted in relation to the degree of work disablement.

6.2.7 Invalidity allowance

'Disability' means that the accidental injury resulted in a permanent impairment of the insured's bodily function or that the work capacity for the future has

reduced by at least 50 per cent as a result of the injury.

Disability that already existed when the insurance was applied for never affords a right to compensation.

A distinction is made between medical and professional disability when assessing the degree of disability.

If the insured is entitled to compensation for both medical and professional disability, one amount of compensation is paid for both types of disability, which will amount to the higher of the two compensation amounts as calculated under these conditions.

Medical disability
Medical disability is the physical or mental disability that has been confirmed regardless of the insured's profession, work conditions or leisure interests. It shall be possible for a physician to objectively determine the disability. Loss of an internal organ also counts as medical disability.

Professional disability
Professional disability is the permanent impairment of the insured's work capacity as a consequence of the accidental injury. Work capacity is deemed to be permanently impaired when all opportunities of work in another occupation have been tried. One precondition for the right to compensation for professional disability is that the future work capacity is considered to be permanently reduced by at least 50 per cent.

However, Euro Accident always reserves the right to obtain a further independent opinion, alternatively request that the insured attends for a medical examination with a physician specially assigned by Euro Accident.

6.2.7.1 Compensation in the case of medical disability

If the accidental injury has resulted in a permanent impairment of the insured's bodily function and this impairment has transformed into a static yet not life-threatening condition, invalidity allowance will be paid, though at the earliest twelve months from the time of the accidental injury. A precondition for the right to compensation is that the accidental injury within three years has resulted in any measurable disability.

Determination of degree of disability
The definitive degree of medical disability shall be determined within three years from the time of the accidental injury. However, this determination may be postponed for as long as there is a possibility for further medical rehabilitation.

The degree of disability will also be assessed taking into account the function of the prosthesis if the functional capacity is improved through the use of prosthesis.

The degree of medical disability is determined in accordance with the current sector jointly approved table, issued by Insurance Sweden, applicable at any given time.

Determining the amount of compensation
Compensation is paid in relation to first the age and second the degree of disability at the time of the accidental injury.

If the insured at the time of the accidental injury has attained the age of 56, the sum insured will be reduced by 5 percentage points for each year that their age exceeds 55.

If the degree of disability amounts to at least 80 per cent, compensation will be paid of 100 per cent of the sum insured, reduced by any deduction for age. If the accidental injury resulted in injuries to several parts of the body, so that the total degree of disability exceeds 100 per cent, the compensation will be limited to the sum insured applicable in the case of complete disability, reduced by any deduction for age.

The sum insured in the case of 100 per cent medical disability is the amount stated in the insurance statement.

6.2.7.2 Compensation in the case of professional disability

If the accidental injury has resulted in a permanent impairment of the insured's future work capacity of at least 50 per cent of full capability of working, invalidity allowance will be paid, though at the earliest two years from the time of the accidental injury and/or at the earliest at the age of 19.

The accidental injury must have resulted in medical disability in order to be afforded a right to compensation for professional disability.

Determination of degree of disability
The definitive degree of professional disability shall be determined within five years from the time of the accidental injury. However, the determination may be postponed for as long as there is a possibility for further professional rehabilitation.

The assessment of the degree of disability is to be made on the basis of the loss of work capacity that the accidental injury has resulted in. This means that it is only the accidental injury's part of the work disablement that is to be assessed and that the insurance only reimburses that part.

If the insured has sustained several injuries on different occasions, one of those injuries that are covered by the insurance must alone result in a

permanent impairment of the insured's work capacity of at least 50 per cent of full capability of working for there to be a right to compensation.

Determining the amount of compensation

Compensation is paid in relation to first the age and second the degree of permanent work disablement at the time of the accidental injury.

If the insured at the time of the accidental injury has attained the age of 46, the sum insured will be reduced by 5 percentage points for each year that their age exceeds 45.

The sum insured in the case of total permanent work disablement is the amount stated in the insurance statement.

Sickness or activity compensation in place at the time of the accidental injury

If the insured was receiving at the time of the accidental injury partial temporary sickness compensation, partial sickness compensation, partial activity compensation or other corresponding compensation according to the National Insurance Act due to a permanent work disablement, professional invalidity allowance will be paid of an amount that at most corresponds to the loss of the remaining work capacity.

If the insured was receiving at the time of the accidental injury full temporary sickness compensation, full sickness compensation, full activity compensation or other corresponding compensation according to the National Insurance Act due to a total permanent work disablement, no compensation will be paid for professional disability.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Special rules after attaining the age of 60

If the permanent work disablement arises as of and including attaining the age of 60 or later, compensation will be paid for professional disability only if the degree of medical disability as a consequence of the accidental injury is at least 50 per cent. The corresponding also applies if the insured, prior to the age of 60, became permanently work disabled to some extent and after attaining the age of 60 became totally permanently work disabled.

6.2.7.3 Indexation and paying out

The final settlement of the injury will only be effected when the medical, or when applicable professional, disability has been determined. In those cases where medical disability has arisen before the definitive degree of disability can be assessed and the condition is not life-threatening, a payment may be made in advance. This advance shall correspond to the medical disability that can be confirmed. Such an advance, expressed in SEK, will be deducted from the compensation that is paid out when the degree of disability has been determined.

If the insured dies before one (1) year has elapsed from the date the accidental injury occurred, compensation will not be paid for medical disability.

If the insured dies after one (1) year has elapsed from the date the accidental injury occurred, compensation will be paid for the insured's medical disability that can be securely determined to have existed at the time of death. The compensation will be paid to the estate of the insured. No compensation will be paid for professional disability.

If the sum insured is governed by the price base amount, the sum insured will be related to the price base amount applicable at the time Euro Accident pays out the compensation.

6.2.7.4 Possibility of reconsideration

If the accidental injury entails that the insured's bodily function significantly deteriorates or that the insured loses further ability to work after the final adjustment has taken place, the insured has the right to return and have the degree of disability reconsidered.

Deterioration regarding medical and financial disability that occurs 10 years or later after the accident does not entitle to additional disability compensation.

It must be possible to determine the significantly impaired bodily function or the increased incapacity for work objectively. Euro Accident decides which assessment documents are to be procured.

6.2.8 Scars or other change in respect of appearance

Compensation may be paid for a scar or other change in respect of appearance that remains one year after the loss. One precondition for compensation is that the injury required treatment by a physician or nurse. The compensation shall be calculated as a percentage of the sum insured maximised to 10 price base amounts. The assessment is made on the basis of Euro Accident's set of schedules for scar compensation. 'Treatment' means for instance sores that needed to be stitched, taped or glued

6.2.9 Crisis treatment

Compensation will be paid for psychologist consultations and for travelling expenses in

conjunction with treatment, when the insured has been afflicted by a crisis response as a result of:

- covered accidental injury
- death of husband/wife, registered partner, cohabitee
- death of insured child
- robbery, threat, attack or rape of the insured, which has been reported to the police. Also applies if the insured is a victim of their husband/wife, registered partner, cohabitee, child, parent or sibling provided the matter has been reported to the police.

Crisis treatment applies to the insured as a private person that is to say not for injuries sustained in service.

The insurance will reimburse up to ten occasions of treatment per insured and injury. All crisis therapy should take place in Sweden. In the event of a need for crisis therapy, Euro Accident shall be contacted and the treatment be approved in advance.

6.2.10 Compensation in the case of death

If the insured dies due to an accidental injury, within three years of the accidental injury, one (1) price base amount will be paid out to the estate of the insured. A certificate of estate inventory will not be issued. A 'price base amount' means the price base amount applicable in the year the payment is made.

6.3 Restrictions

6.3.1 General restrictions

Accidental injury does not mean bodily injury if it arose through:

- complaints in respect of bones, joints, muscles, nerves, discs, cartilage, tendons or connective tissue which may be assumed to be linked with overloading, monotonous movements, repetitive strain, pathological change or change due to age
- infection/contagion through bacteria or virus*). Also applies to infection/contagion as a consequence of food poisoning
- a deterioration of the health status caused by the use of medical preparations, intervention, treatment or examination
- complaint caused by pregnancy, childbirth and/or consequences thereof,
- such a condition which, even if it was observed after an accidental injury, according to medical experience cannot be deemed to result from the accidental injury but from the sickness, change due to age, physical defect or pathological changes.

*) However, the insurance applies to infection as a consequence of tick bite.

The insurance will not pay:

- private care or private treatment in Sweden or abroad and care costs associated therewith
- dental injury as a consequence of chewing or biting
- dental injury as a consequence of inflammation and/or other sicknesses to a tooth or gum
- travel with service car or company car where no costs arose
- additional costs in business activities.

6.4 Validity abroad

See Clause 1.11 regarding validity abroad.

7 Sickness and accidental death and dismemberment insurance

The insurance will pay:	The insurance will not pay:
In the case of accidental injury: – medical expenses – dental injury expenses – travelling expenses – additional costs – costs for rehabilitation and medical devices – daily compensation – medical disability – professional disability – scars or other change in respect of appearance – crisis treatment – death benefit. In the case of sickness: – medical disability – scars or other change in respect of appearance.	– private care or private treatment – dental injury as a consequence of chewing, biting or inflammation/dental illnesses – additional costs in business activities – costs caused by deterioration to health status that are not linked to the accidental injury – costs for home transport in the event of accidental injury outside the home district and abroad – costs that are reimbursed by some other means. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

7.1 Right to compensation

The insurance applies for sickness or accidental injury that occurs during the term of the insurance.

'Sickness' means a deterioration of the state of health, physical or mental, that has been observed for the first time by a physician or registered psychologist that is not to be regarded as an accidental injury according to these conditions. The sickness is deemed to have occurred on the date when the deterioration was observed by a physician registered psychologist. A bodily injury that has been caused voluntarily is not regarded as sickness. Sicknesses that are medically linked are counted as one and the same sickness claim.

'Accidental injury' means the bodily injury that the insured sustains involuntary upon a sudden unforeseen external occurrence.

Accidental injury is equated to bodily injury due to:

- frostbite, heatstroke or sunstroke
- infection as a consequence of a tick bite
- sudden knee twist injury
- achilles tendon rupture
- retinal detachment
- sudden deafness
- heart attack
- stroke.

In order for retinal detachment, sudden deafness, heart attack and stroke to be equated to accidental injury it is required that the insured has not been medicated and/or treated for a complaint which may be considered to be linked with the accidental injury.

A link between a bodily injury and one of the above-mentioned kinds of cause shall be deemed to exist where predominant reasons suggest this to be the case.

7.2 The insurance will pay compensation for accidents

7.2.1 Medical expenses

The insurance will pay the insured's patient fee under public health care up to the limit for the high-cost protection for the necessary and reasonable costs in respect of:

- medical care
- treatment prescribed by a physician to heal the injury
- physiotherapy
- treatment by a naprapath or chiropractor, following referral by a physician. The referral may not be older than six months.

The insurance will pay the insured's daily charge under public health care for hospital care.

The insurance will pay compensation for up to three years after the accidental injury occurred. In cases where the injury has resulted in a disability and the degree of disability cannot be determined within three years, medical expenses will be paid until the degree of disability can be determined.

Reimbursement for medical expenses will not be paid after a degree of disability has been determined.

7.2.2 Dental injury expenses

The insurance will pay the insured's patient fee under public dental care for the necessary and reasonable costs regarding treatment of a dental injury.

'Dental injury' also means damage to implant and damage to a denture which was fitted in the mouth when it was damaged.

Compensation will not be paid for implant treatment that is not covered by public dental care.

The insurance will pay compensation for up to five years after the accidental injury occurred. If treatment has to be postponed due to the insured's age, compensation will be paid for such postponed treatment that is implemented before the insured attains the age of 25.

Costs and treatment must be approved in advance by Euro Accident.

The insurance will not pay further compensation if the insurance has paid compensation for the final treatment of the dental injury.

If there is a need of treatment already at the time of the injury of the damaged teeth, Euro Accident is entitled to reduce the amount of the compensation to a corresponding extent.

7.2.3 Travelling expenses

The insurance will reimburse travelling expenses:

- to and from care and treatment prescribed by a physician, up to the amount that corresponds to the 'personal contribution charge' for the region in question
- to and from work or school, when the need has been confirmed by a physician, comprising the additional cost for the lease expensive mode of transport possible considering the health status.

Reimbursement is paid in accordance with the rules of the Tax Agency for travel using own car.

Reimbursement for travelling expenses is paid for at most three years from the loss occurrence, or until the degree of disability has been determined, and only in those cases where it was not possible to obtain compensation from the employer, social insurance office, region or other insurance.

7.2.4 Additional costs

If the accidental injury has resulted in the insured receiving medical or dental care, the insured's:

- damaged clothes, spectacles and disability aids and devices which were carried or worn at the time of the accident will be compensated. Compensation of up to SEK 2,000 can be paid as a once and for all payment. If a higher amount is claimed, the damage and age of the damaged objects must be verified. Compensation will be paid of up to 0.5 price base amount. If the damaged object can be repaired compensation is paid for the cost of repair.

The following valuation table shall be used for the valuation of clothes and spectacles. The table shows the compensation as a per cent of the purchase price for new ones considering the age of the object.

Age	0-1 year	1-2 years	2-3 years	3 years and older
Per cent	100	80	60	40

- unavoidable additional costs during the acute treatment and healing period of the accidental injury. Compensation of up to SEK 2,000 can be paid as a once and for all payment. If a higher compensation is claimed, the necessary and reasonable additional costs must be verified. Compensation will then be paid of up to three price base amounts.

7.2.5 Costs for rehabilitation and medical devices

The insurance will compensate the insured for measures needed following the acute treatment and healing period of the accidental injury, in order to reinstate lost functional capacity and living conditions through paying for:

- care and treatment following referral by a physician, up to ten occasions of treatment. The referral may not be older than six months
- employability assessment, vocational training or retraining. In the case of retraining, compensation will not be paid for costs that arise due to education that enhances the level of skill
- medical devices intended to increase mobility and reduce possible disability. If the insurance has paid compensation for an impairment of function, medical or professional disability, the insurance cannot at the same time pay compensation for medical device to ameliorate impairment to function already compensated
- changes to the one-time nature of ordinary home environment, or other living conditions, intended to facilitate the most normal life possible. Costs for improvement of standard will not be compensated.

Compensation will be paid for up to two price base amounts for measures that have been approved in advance by Euro Accident. For measures during the acute treatment period, compensation will be paid instead according to Clause 7.2.4.

Reimbursement for costs for rehabilitation and medical device will not be paid after the degree of disability has been determined.

7.2.6 Daily compensation

In the case of accidental injury that results in at least 25 per cent work disablement, daily compensation will be paid during the period of work disablement, as of and including day 29 of the work disablement for at most up to and including day 90 of the work disablement. SEK 200 per day will be paid in the case of 100 per cent work disablement. The daily compensation will be adjusted in relation to the degree of work disablement.

7.2.7 Invalidity allowance

'Disability' means that the accidental injury resulted in a permanent impairment of the insured's bodily function or that the work capacity for the future has reduced by at least 50 per cent as a result of the injury.

A distinction is made between medical and professional disability when assessing the degree of disability.

If the insured is entitled to compensation for both medical and professional disability, one amount of compensation is paid for both types of disability, which will amount to the higher of the two compensation amounts as calculated under these conditions.

Medical disability

Medical disability is the physical or mental disability that has been confirmed regardless of the insured's profession, work conditions or leisure interests. It shall be possible for a physician to objectively determine the disability. Loss of an internal organ also counts as medical disability.

Professional disability

Professional disability is the permanent impairment of the insured's work capacity as a consequence of the accidental injury. Work capacity is deemed to be permanently impaired when all opportunities of work in another occupation have been tried. One precondition for the right to compensation for professional disability is that the future work capacity is considered to be permanently reduced by at least 50 per cent.

However, Euro Accident always reserves the right to obtain a further independent opinion, alternatively request that the insured attends for a medical examination with a physician specially assigned by Euro Accident.

7.2.7.1 Compensation in the case of medical disability

If the accidental injury or sickness has resulted in a permanent impairment of the insured's bodily function and the condition is static yet not life-threatening, invalidity allowance will be paid, though at the earliest twelve months from the time of the accidental injury or when the sickness is deemed to have occurred. In the case of sickness medical disability is deemed to have occurred at the earliest when the sickness has transformed into a static not yet life-threatening condition. A precondition for the right to compensation is that the accidental injury or sickness within three years has resulted in any measurable disability.

Determination of degree of disability

The definitive degree of medical disability shall be determined within three years from the time of the accidental injury. However, this determination may be postponed for as long as there is a possibility for further medical rehabilitation.

The degree of disability will also be assessed taking into account the function of the prosthesis if the functional capacity is improved through the use of prosthesis.

The degree of medical disability is determined in accordance with the current sector jointly approved table, issued by Insurance Sweden, applicable at any given time.

Determining the amount of compensation

Compensation is paid in relation to first the age and second the degree of disability at the time of the accidental injury.

If the insured at the time of the accidental injury has attained the age of 56, the sum insured will be reduced by 5 percentage points for each year that their age exceeds 55.

If the degree of disability amounts to at least 80 per cent, compensation will be paid of 100 per cent of the sum insured, reduced by any deduction for age. If the accidental injury resulted in injuries to several parts of the body, so that the total degree of disability exceeds 100 per cent, the compensation will be limited to the sum insured applicable in the case of complete disability, reduced by any deduction for age.

The sum insured in the case of 100 per cent medical disability is the amount stated in the insurance statement.

7.2.7.2 Compensation in the case of professional disability

When the accidental injury has resulted in a permanent impairment of the insured's future work capacity of at least 50 per cent of full capability of working, invalidity allowance will be paid, though at the earliest two years from the time of the accidental injury and/or at the earliest at the age of 19.

The accidental injury must have resulted in medical disability in order to be afforded a right to compensation for professional disability.

Determination of degree of disability

The definitive degree of professional disability shall be determined within five years from the time of the accidental injury. However, the determination may be postponed for as long as there is a possibility for further professional rehabilitation.

The assessment of the degree of disability is to be made on the basis of the loss of work capacity that the accidental injury has resulted in. This means that it is only the accidental injury's part of the work disablement that is to be assessed and that the insurance only reimburses that part.

If the insured has sustained several injuries on different occasions, one of those injuries that are covered by the insurance must alone result in a permanent impairment of the insured's work capacity of at least 50 per cent of full capability of working for there to be a right to compensation.

Determining the amount of compensation

Compensation is paid in relation to first the age and second the degree of permanent work disablement at the time of the accidental injury.

If the insured at the time of the accidental injury has attained the age of 46, the sum insured will be reduced by 5 percentage points for each year that their age exceeds 45.

The sum insured in the case of total permanent work disablement is the amount stated in the insurance statement.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Sickness or activity compensation in place at the time of the accidental injury

If the insured was receiving at the time of the accidental injury partial temporary sickness compensation, partial sickness compensation, partial activity compensation or other corresponding compensation according to the National Insurance Act due to a permanent work disablement, professional invalidity allowance will be paid of an amount that at most corresponds to the loss of the remaining work capacity.

If the insured was receiving at the time of the accidental injury full temporary sickness compensation, full sickness compensation, full activity compensation or other corresponding compensation according to the National Insurance Act due to a total permanent work disablement, no compensation will be paid for professional disability.

Special rules after attaining the age of 60

If the permanent work disablement arises as of and including attaining the age of 60 or later, compensation will be paid for professional disability only if the degree of medical disability as a consequence of the accidental injury is at least 50 per cent. The corresponding also applies if the insured, prior to the age of 60, became permanently work disabled to some extent and after attaining the age of 60 became totally permanently work disabled.

7.2.7.3 Indexation and paying out

In the case of sickness

The final settlement of the injury will only be effected when the medical, and when applicable professional, disability has been determined. In those cases where medical disability has arisen before the definitive degree of disability can be assessed and the sickness is not life-threatening, a payment may be made in advance. This advance shall correspond to the medical disability that can be confirmed. An advance will only be paid for sicknesses that are considered to have become static. Any such advance, expressed in SEK, will be deducted from the compensation that is to be paid out when the degree of disability has been determined.

If the insured has been diagnosed during the term of the insurance with any of the illnesses or conditions described below, the insurance will pay compensation of one (1) price base amount.

- Cancer ICD C00-C43, C45-97 (Malignant)
- Motor neuron syndrome ICD G12.2
- Parkinson's disease ICD G20
- Alzheimer's disease ICD G30.0, G30,8, G30.9

The diagnosis must be made by a physician with specialist competence (consultant) in respect of the diagnosis concerned.

Compensation will only be paid for one (1) diagnosed illness even if the insured has been diagnosed for several illnesses. Diagnosis that already existed when the insurance was applied for never affords a right to compensation. In the event that the payment due to the above-mentioned diagnoses is made such compensation will be deducted from future disability compensation.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year Euro Accident pays out compensation.

In the case of accidental injury

The final settlement of the injury will only be effected when the medical, and when applicable professional disability has been determined. In those cases where medical disability has arisen before the definitive degree of disability can be assessed and the condition is not life-threatening, a payment may be made in advance. This advance shall correspond to the medical disability that can be confirmed. Any such advance, expressed in SEK, will be deducted from the compensation that is to be paid out when the degree of disability has been determined.

If the insured dies after one (1) year has elapsed from the date on which the accidental injury occurred, compensation will be paid for the insured's medical disability that can be securely determined to have existed at the time of death. The compensation will be paid to the estate of the insured. No compensation will be paid for professional disability.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year Euro Accident pay out compensation.

7.2.7.4 Possibility of reconsideration

If the accidental injury entails that the insured's bodily function significantly deteriorates or that the insured loses further ability to work after the final adjustment has taken place, the insured has the right to return and have the degree of disability reconsidered.

Deterioration regarding medical and financial disability that occurs 10 years or later after the accident does not entitle to additional disability compensation.

It must be possible to determine the significantly impaired bodily function or the increased incapacity for work objectively. Euro Accident decides which assessment documents are to be procured.

7.2.8 Scars or other change in respect of appearance

Compensation may be paid for a scar or other change in respect of appearance that remains one year after the loss. One precondition for compensation is that the injury required treatment by a physician or nurse. The compensation shall be calculated as a percentage of the sum insured maximised to 10 price base amounts. The assessment is made on the basis of Euro Accident's set of schedules for scar compensation. 'Treatment' means for instance sores that needed to be stitched, taped or glued.

7.2.9 Crisis treatment

Compensation will be paid for psychologist consultations and for travelling expenses in conjunction with treatment, when the insured has been afflicted by a crisis response as a result of:

- covered accidental injury
- death of husband/wife, registered partner, cohabitee
- death of insured child
- robbery, threat, attack or rape of the insured, which has been reported to the police. Also applies if the insured is a victim of their husband/wife, registered partner, cohabitee, child, parent or sibling provided the matter has been reported to the police.

Crisis treatment applies to the insured as a private person that is to say not for injuries sustained in service.

The insurance will reimburse up to ten occasions of treatment per insured and injury. All crisis therapy should take place in Sweden. In the event of a need for crisis therapy, Euro Accident shall be contacted and the treatment be approved in advance.

7.2.10 Compensation in the case of death

If the insured dies due to an accidental injury, within three years of the accidental injury, one (1) price base amount will be paid out to the estate of the insured.

A certificate of estate inventory will not be issued.

A 'price base amount' means the price base amount applicable in the year the payment is made.

7.3 The insurance will pay compensation for sickness

7.3.1 Invalidity allowance

'Disability' means that the sickness has resulted in a permanent impairment of the insured's bodily function.

Medical disability

Medical disability is the physical or mental disability that has been confirmed regardless of the insured's profession, work conditions or leisure interests. It shall be possible for a physician to objectively determine the disability. Loss of an internal organ also counts as medical disability.

The provisions contained in Clause 7.2.7.1 regarding 'Compensation', Clause 7.2.7.3 regarding 'Indexation and paying out' and Clause 7.2.7.4 'Possibility of reconsideration' apply in general.

7.3.2 Scars or other change in respect of appearance

Compensation will be paid if the sickness resulted in such consequences as described under Clause 7.2.8.

7.4 Restrictions

7.4.1 General restrictions

Sickness or accidental injury does not mean:

- a deterioration of the health status that is deemed to result from misuse of alcohol, narcotic substances, soporifics, other pharmaceuticals or intoxicants
- a deterioration of the health status caused by the use of medical preparations, intervention, treatment or examination
- complaint caused by pregnancy, childbirth and/or consequences thereof
- complaints in respect of bones, joints, muscles, nerves, discs, cartilage, tendons or connective tissue which may be assumed to be linked with overloading, monotonous movements, repetitive strain or change due to age for example arthritis.

Accidental injury does not mean bodily injury if it arose through:

- infection/contagion through bacteria or virus*). Also applies to infection/contagion as a consequence of food poisoning
- such a condition which, even if it was observed after an accidental injury, according to medical experience cannot be deemed to result from the accidental injury but from a change due to age, physical defect or pathological changes.

*) However, the insurance applies to infection as a consequence of tick bite.

The insurance will not pay:

- private care or private treatment in Sweden or abroad and care costs associated therewith
- dental injury as a consequence of chewing or biting
- dental injury as a consequence of inflammation and/or other sicknesses to a tooth or gum
- travel with service car or company car where no costs arose
- additional costs in business activities
- disability or costs linked to chronic fatigue syndrome and conditions comparable thereto, e.g. myalgic encephalomyelitis.

7.4.2 Symptoms before the insurance enters into force

The insurance does not apply to sickness, physical defect or mental developmental disorder, nor to the consequences of such condition, where the symptom had manifested itself before the insurance entered into force, even if a diagnosis could only be confirmed at a later point in time.

Disability that already existed when the insurance was applied for never affords a right to compensation.

This restriction does not apply if Euro Accident, at the time when the insurance was granted, knew of the situation and did not include any special restriction in the insurance agreement in the light of it.

7.5 Validity abroad

See Clause 1.11 regarding validity abroad.

8 Child and youth insurance

The insurance will pay:	The insurance will not pay:
In the case of accidental injury: – medical expenses – dental injury expenses – travelling expenses – additional costs – costs for rehabilitation and medical devices. In the case of sickness and accidental injury: – medical disability – professional disability – scars or other change in respect of appearance – crisis treatment – compensation in the case of hospital stay/care at home – death benefit – costs allowance.	– private care or private treatment – dental injury as a consequence of chewing, biting or inflammation/dental illnesses – costs caused by deterioration to health status that are not linked to the accidental injury – costs for home transport in the event of accidental injury outside the home district and abroad – certain kinds of sickness that showed symptoms before the age of six – costs allowance for a period longer than three years and after the age of 19. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

8.1 Who can be covered by the insurance

The children who can be insured are those children of the group member/insured and of the husband/wife, registered partner, cohabitee who are entitled to inherit. The insurance can be applied for up to the age of 20 and applies up to and including the month the child attains the age of 25, unless otherwise agreed.

Children born outside the Nordic countries

In the case of sickness:

Children born outside the Nordic countries are covered by the insurance only after one (1) year has elapsed since the child having arrived in Sweden.

In the case of accident

An adoptive child from a country outside the Nordic countries will be covered by the insurance as soon as the child arrived in Sweden provided consent under Chapter 6, Section 12 of the Social Welfare Act (1980:620) is in place at that time. If the adoption is not confirmed, the insurance ceases as soon as the child leaves Sweden, though at the latest after one (1) year from when the child having arrived in Sweden.

8.2 Right to compensation

The insurance applies for sickness or accidental injury that occurs during the term of the insurance.

'Sickness' means a deterioration of the state of health, physical or mental, that has been observed for the first time by a physician or registered psychologist that is not to be regarded as an accidental injury according to these conditions. The sickness is deemed to have occurred on the date when the deterioration was observed by a physician or registered psychologist. A bodily injury that has been caused voluntarily is not regarded as sickness. Sicknesses that are medically linked are counted as one and the same sickness claim.

'Accidental injury' means the bodily injury that the insured sustains involuntary upon a sudden, unforeseen external occurrence.

Accidental injury is equated to bodily injury due to:

– frostbite, heatstroke or sunstroke
– infection as a consequence of a tick bite
– sudden knee twist injury
– achilles tendon rupture.

A link between a bodily injury and one of the above-mentioned kinds shall be deemed to exist where predominant reasons suggest this to be the case.

8.3 The insurance will pay compensation for accidents

8.3.1 Medical expenses

The insurance will pay the insured's patient fee under public health care up to the limit for the high-cost protection for the necessary and reasonable costs in respect of:

– medical care
– treatment prescribed by a physician to heal the injury
– physiotherapy
– treatment by a naprapath or chiropractor following referral by a physician. The referral may not be older than six months.

The insurance will pay the insured's daily charge under public health care for hospital care.

The insurance will pay compensation for up to three years after the accidental injury occurred. In cases where the injury has resulted in a disability and the degree of disability cannot be determined within three years, medical expenses will be paid until the degree of disability can be determined.

Reimbursement for medical expenses will not be paid after a degree of disability has been determined.

8.3.2 Dental injury expenses

The insurance will pay the insured's patient fee under public dental care for the necessary and reasonable costs regarding treatment of a dental injury.

'Dental injury' also means damage to implant and damage to a denture which was fitted in the mouth when it was damaged.

Compensation will not be paid for implant treatment that is not covered by public dental care.

The insurance will pay compensation for up to five years after the accidental injury occurred. If treatment has to be postponed due to the insured's age, compensation will be paid for such postponed treatment that is implemented before the insured attains the age of 25.

Costs and treatment must be approved in advance by Euro Accident.

The insurance will not pay further compensation if the insurance has paid compensation for the final treatment of the dental injury.

If there is a need of treatment already at the time of the injury of the damaged teeth, Euro Accident is entitled to reduce the amount of the compensation to a corresponding extent.

8.3.3 Travelling expenses

The insurance will reimburse travelling expenses to and from:

- care and treatment prescribed by a physician, up to the amount that corresponds to the 'personal contribution charge' for the region in question
- work or school, when the need has been confirmed by a physician, comprising the additional cost for the least expensive mode of transport possible considering the health status.

Reimbursement is paid in accordance with the rules of the Tax Agency for travel using own car.

Reimbursement for travelling expenses is paid for at most three years from the loss occurrence, or until the degree of disability has been determined, and only in those cases where it was not possible to obtain compensation from the employer, social insurance office, region or other insurance.

8.3.4 Additional costs

If the accidental injury has resulted in the insured receiving medical or dental care, the insured's:

- damaged clothes, spectacles and disability aids and devices which were carried or worn at the time of the accident will be compensated. Compensation of up to SEK 2,000 can be paid as a once and for all payment. If a higher amount is claimed, the damage and age of the damaged objects must be verified. Compensation will be paid of up to 0.5 price base amount. If the damaged object can be repaired, compensation is paid for the cost of repair.

The following valuation table shall be used for the valuation of clothes and spectacles. The table shows the compensation as a per cent of the purchase price for new ones considering the age of the object.

Age	0-1 year	1-2 years	2-3 years	3 years and older
Per cent	100	80	60	40

- unavoidable additional costs during the acute treatment and healing period of the accidental injury. Compensation of up to SEK 2,000 can be paid as a once and for all payment. If a higher compensation is claimed, the necessary and reasonable additional costs must be verified. Compensation will then be paid of up to three price base amounts.

8.3.5 Costs for rehabilitation and medical devices

The insurance will compensate the insured for measures needed following the acute treatment and healing period of the accidental injury, in order to reinstate lost functional capacity and living conditions through paying for:

- care and treatment following referral by a physician, up to ten occasions of treatment. The referral may not be older than six months
- employability assessment, vocational training or retraining. In the case of retraining, compensation will not be paid for costs that arise due to education that enhances the level of skill
- medical devices intended to increase mobility and reduce possible disability. If the insurance has paid compensation for an impairment of function, medical or professional disability, the insurance cannot at the same time pay compensation for medical device to ameliorate impairment to function already compensated

– changes to the one-time nature of ordinary home environment, or other living conditions, intended to facilitate the most normal life possible. Costs for improvement of standard will not be compensated.

Compensation will be paid for up to two price base amounts for measures that have been approved in advance by Euro Accident. For measures during the acute treatment period, compensation will be paid instead according to Clause 8.3.4.

Reimbursement for costs for rehabilitation and medical device will not be paid after the degree of disability has been determined.

8.4 The insurance will pay compensation for sickness and accidents

8.4.1 Invalidity allowance

'Disability' means that the sickness or accidental injury resulted in a permanent impairment of the insured's bodily function or that the work capacity for the future has reduced by at least 50 per cent as a result of the injury.

A distinction is made between medical and professional disability when assessing the degree of disability.

If the insured is entitled to compensation for both medical and professional disability, one amount of compensation is paid for both types of disability, which will amount to the higher of the two compensation amounts as calculated under these conditions.

Further medical or professional disability that occurs entirely or to some extent after having attained the age of 30 is not covered by the insurance.

Medical disability

Medical disability is the physical or mental disability that has been confirmed regardless of the insured's profession, work conditions or leisure interests. It shall be possible for a physician to objectively determine the disability. Loss of an internal organ also counts as medical disability.

Professional disability

Professional disability is the permanent impairment of the insured's work capacity as a consequence of the sickness or accidental injury. Work capacity is deemed to be permanently impaired when all opportunities of work in another occupation have been tried. One precondition for the right to compensation for professional disability to be considered is that the future work capacity is considered to be permanently reduced by at least 50 per cent.

The sickness or accidental injury must have resulted in medical disability in order to be afforded a right to compensation for professional disability.

However, Euro Accident always reserves the right to obtain a further independent opinion, alternatively request that the insured attends for a medical examination with a physician specially assigned by Euro Accident.

8.4.1.1 Compensation in the case of medical disability

If the accidental injury or sickness has resulted in a permanent impairment of the insured's bodily function and the condition is static yet not life-threatening, invalidity allowance will be paid, though at the earliest twelve months from the time of the accidental injury or when the sickness is deemed to have occurred. In the case of sickness medical disability is deemed to have occurred at the earliest when the sickness has transformed into a static yet not life-threatening condition. A precondition for the right to compensation is that the accidental injury or sickness within three years has resulted in any measurable disability.

Determination of degree of disability

The definitive degree of medical disability shall be determined within three years from the time when the sickness occurred or within three years from the time of the accidental injury. However, this determination may be postponed for as long as there is a possibility for further medical rehabilitation.

The degree of disability will also be assessed taking into account the function of the prosthesis if the functional capacity is improved through the use of prosthesis.

The degree of medical disability is determined in accordance with the current sector jointly approved table, issued by Insurance Sweden, applicable at any given time.

Determining the amount of compensation

Compensation will be paid in relation to the degree of disability.

If the degree of disability amounts to at least 80 per cent, compensation will be paid of 100 per cent of the sum insured.

If the sickness or accidental injury resulted in injuries to several parts of the body, so that the total degree of disability exceeds 100 per cent, the compensation will be limited to the sum insured applicable in the case of complete disability.

The sum insured in the case of complete medical disability is the amount stated in the insurance statement.

8.4.1.2 Compensation in the case of professional disability

When the sickness or accidental injury has resulted in a permanent impairment of the insured's future work capacity of at least 50 per cent of full capability of working, invalidity allowance will be paid, though at the earliest two years from the time of the sickness or accidental injury and/or at the earliest at the age of 19.

Determination of degree of disability

The definitive degree of professional disability shall be determined within five years from the time of the sickness or accidental injury. However, the determination may be postponed for as long as there is a possibility for further professional rehabilitation. 'Full capability of working' means that the insured can perform work corresponding to a full-time service.

The assessment of the degree of disability is to be made on the basis of the loss of work capacity that the sickness or accidental injury has resulted in. This means that it is only the sickness or accidental injury's part of the work disablement that is to be assessed and that the insurance only compensates that part.

If the insured has sustained several injuries on different occasions, one of those injuries that are covered by the insurance must alone result in a permanent impairment of the insured's work capacity of at least 50 per cent of full capability of working for there to be a right to compensation.

Determining the amount of compensation

The invalidity allowance comprises such a proportion of the sum insured as corresponds to the level of activity compensation.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Activity compensation in place at the time of the loss

If the insured was receiving at the time when the sickness occurred or at the time of the accidental injury partial activity compensation or other corresponding compensation according to the National Insurance Act due to a permanent work disablement, professional disability compensation will be paid of an amount that at most corresponds to the loss of the remaining work capacity.

If the insured was receiving at the time when the sickness occurred or at the time of the accidental injury full activity compensation or other corresponding compensation according to the National Insurance Act due to a total permanent work disablement, no compensation will be paid for professional disability.

8.4.1.3 Indexation and paying out

In the case of sickness

The final settlement of the injury will only be effected when the medical, and when applicable professional, disability has been determined. In those cases where medical disability has arisen before the definitive degree of disability can be assessed and the sickness is not life-threatening, a payment may be made in advance. This advance shall correspond to the medical disability that can be confirmed. An advance will only be paid for sicknesses that are considered to have become static. Any such advance, expressed in SEK, will be deducted from the compensation that is to be paid out when the degree of disability has been determined.

If the insured has been diagnosed with Cancer ICD C00- 43, C45-97 (malignant) during the term of the insurance the insurance will pay compensation of one (1) price base amount.

The diagnosis must be made by a physician with specialist competence (consultant) in respect of the diagnosis concerned.

Compensation will only be paid for one (1) diagnosed illness even if the insured has been diagnosed for several illnesses. Diagnosis that already existed when the insurance was applied for never affords a right to compensation. In the event that the payment due to the above-mentioned diagnoses is made such compensation will be deducted from future disability compensation.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year Euro Accident pay out compensation.

In the case of accidental injury

The final settlement of the injury will only be effected when the medical, and when applicable professional disability has been determined. In those cases where medical disability has arisen before the definitive degree of disability can be assessed and the condition is not life-threatening, a payment may be made in advance. This advance shall correspond to the medical disability that can be confirmed. Any such advance, expressed in SEK, will be deducted from the compensation that is to be paid out when the degree of disability has been determined.

If the insured dies after one (1) year has elapsed from the date on which the accidental injury occurred, compensation will be paid for the insured's medical disability that can be securely determined to have existed at the time of death. The compensation will be

paid to the estate of the insured. No compensation will be paid for professional disability.

If the sum insured is governed by the price base amount, the sum insured is determined by the price base amount applicable for the year Euro Accident pay out compensation.

8.4.2 Scars or other change in respect of appearance

Compensation may be paid for a scar or other change in respect of appearance that remains one year after the loss. One precondition for compensation is that the injury required treatment by a physician or nurse. The compensation shall be calculated as a percentage of the sum insured maximised to 10 price base amounts. The assessment is made on the basis of Euro Accident's set of schedules for scar compensation. 'Treatment' means for instance sores that needed to be stitched, taped or glued.

8.4.3 Crisis treatment

Compensation is provided for crisis therapy with a registered psychologist or psychotherapist, assigned by Euro Accident, in conjunction with treatment when the insured, during the term of the insurance, has been afflicted by a crisis response a result of:

- a covered sickness or accidental injury,
- the death of a relative (husband/wife, registered partner, cohabitee, child, parent, sibling)
- robbery, threat, attack, rape, sexual offence or violence against the insured, even within the family
- mobbing.

In order to assess the right to compensation, the above-mentioned occurrences shall be documented with, for instance, the School Health Service, the Swedish Schools Inspectorate, the Equality Ombudsman, the Police or other care provider/care establishment.

The treatment must commence within one year from when the injury was incurred and be concluded within three years.

The insurance will reimburse up to ten occasions of treatment per insured and injury. All crisis therapy should take place in Sweden. In the event of a need for crisis therapy, Euro Accident shall be contacted and the treatment be approved in advance.

8.4.4 Compensation in the case of hospital stay

Compensation for sickness or accidental injury that results in the insured being admitted for care at a hospital will be paid from the first date of admission and for as long as the insured is admitted for such care.

Compensation will be paid as of and including the first day and for each day of the hospital stay, including the days of admission and discharge. The sickness or accidental injury must have occurred during the period the insurance was in force.

Daily compensation comprises 0.75 per cent of the price base amount applicable for January in the calendar year when the admission took place.

The right to compensation lasts for at most 365 days in respect of the same sickness or accidental injury.

Payment will be made to the insured's custodian if the insured is under the age of 18. Payment will be made to the insured as of and including the age of 18.

Compensation will not be made if the insured has made a normal visit to hospital in non-institutional care.

Compensation for hospital stay will not be paid after the degree of disability has been determined.

8.4.5 Compensation for care at home

Compensation will be paid for care at home up to 30 days with the same amount as for hospital care.

Preconditions for compensation are that:

- there was a hospital stay, that is to say that the child was admitted for care at a hospital
- a medical certificate confirming that the care of the child by a relative at home is medically justified
- the care need still remains after two weeks, counted from the first day of hospital care
- the child is aged under 16.

The medical certificate shall also state how long the care by a relative is required due to the sickness or accidental injury.

Compensation is paid as of and including the date following return home from hospital. Compensation will be paid to the custodian, following the end of the care period.

Compensation for care at home will not be paid after the degree of disability has been determined.

8.4.6 Compensation in the case of death

If the child dies during the term of the insurance, one (1) price base amount will be paid to the estate of the child. A certificate of estate inventory will not be issued.

A 'price base amount' means the price base amount applicable in the year the payment is made.

8.4.7 Costs allowance at most up to the age of 19

For a sickness or accidental injury that results in the custodian of the child becoming entitled to nursing allowance from national insurance, compensation is paid for ongoing additional costs for special supervision and care.

Furthermore, the nursing allowance must have been granted as a result of a deterioration to health status that arose during the period the insurance applied.

Amount of the compensation:

- 1 price base amount per year in the case of full nursing allowance
- 0.75 price base amount per year in the case of 75 per cent nursing allowance
- 0.5 price base amount per year in the case of 50 per cent nursing allowance
- 0.25 price base amount per year in the case of 25 per cent nursing allowance.

The compensation will be paid monthly in arrears. Compensation will be paid for the period during which the custodian is entitled to nursing allowance, though at most for three years. If the insured child attains the age of 19 during the three-year period for payments, the compensation will cease upon the end of the month of June the year in which the child attains the age of 19.

If the nursing allowance ceases, the costs allowance also ceases. If the level of nursing allowance changes, the level of costs allowance will also change in a corresponding way. However, a precondition for an increase is that the insurance is applicable when the nursing allowance is increased. If the level of the nursing allowance changes, this must be notified to Euro Accident without delay.

If a decision for nursing allowance from national insurance relates to more than one child, the compensation will be calculated according to the level of nursing allowance that would probably have been granted if the decision only related to the insured child.

A 'price base amount' means the price base amount applicable in the year the payment is made.

8.5 Restrictions

8.5.1 General restrictions

Sickness or accidental injury does not mean:

- a deterioration of the health status that is deemed to result from misuse of alcohol, narcotic substances, soporifics, other pharmaceuticals or intoxicants
- a deterioration of the health status caused by the use of medical preparations, intervention, treatment or examination
- complaint caused by pregnancy, childbirth and/or consequences thereof
- complaints in respect of bones, joints, muscles, nerves, discs, cartilage, tendons or connective tissue which may be assumed to be linked with overloading, monotonous movements, repetitive strain or change due to age.

Accidental injury does not mean bodily injury if it arose through:

- infection/contagion through bacteria or virus*). Also applies to infection/contagion as a consequence of food poisoning
- such a condition which, even if it was observed after an accidental injury, according to medical experience cannot be deemed to result from the accidental injury but from a change due to age, physical defect or pathological changes.

*) However, the insurance applies to infection as a consequence of tick bite.

The insurance will not pay:

- private care or private treatment in Sweden or abroad and care costs associated therewith
- dental injury as a consequence of chewing or biting
- dental injury as a consequence of inflammation and/or other sicknesses to a tooth or gum
- travel with service car or company car where no costs arose
- additional costs in business activities
- refractive error and squint except when caused by sickness or accidental injury.

8.5.2 Symptoms before the insurance enters into force

The insurance does not apply to sickness, physical defect or mental developmental disorder, nor to the consequences of such condition, where the symptom had manifested itself before the insurance entered into force, even if a diagnosis could only be confirmed at a later point in time.

Disability that already existed when the insurance was applied for never affords a right to compensation.

This restriction does not apply if Euro Accident, at the time when the insurance was granted, knew of the situation and did not include any special restriction in the insurance agreement in the light of it.

8.5.3 Consequences of a congenital condition

The insurance does not apply to sickness, physical defect or mental developmental disorder, nor to the consequences of such condition, where the symptom had manifested itself after the insurance entered into force, if it according to medical experience is probable that:

- the condition existed since birth or originates from a sickness that arose during the first month of life
- a predisposition for the condition existed upon birth
- the condition arose as a consequence of injury or sickness during pregnancy or childbirth.

Examples of conditions that are deemed to have existed since birth:

- haemophilia (haemophilia UNS) ICD D66
- cystic fibrosis ICD E84
- epilepsy ICD G40
- disorder of muscle ICD M62
- neurological hearing losses (hearing loss UNS) ICD H91
- nystagmus and other irregular eye movement ICD H55
- sensorineural hearing loss ICD H90
- retinal disorders ICD H35.

The above-mentioned restrictions for among other things the listed conditions do not apply if the insured has attained the age of six and had undergone their final mandatory check at the child healthcare centre or other comparable medical examination with a paediatrician and no symptoms of such condition were found upon such examination.

In the case of an insured who has not undergone the final mandatory check at the child healthcare centre or other comparable medical examination, the exemption applies to the above-mentioned conditions until such time as the insured attains the age of eight.

Sicknesses that are completely exempted from compensation:

- adrenogenital disorders ICD E25
- other congenital infectious and parasitic diseases ICD P37
- cerebral palsy ICD G80
- dyslexia ICD R48.0, acalculia and other learning difficulties
- delayed speech and language development (developmental disorders of speech and language, unspecified) ICD F80
- haemangioma and lymphangioma ICD D18
- hereditary ataxia ICD G11
- hereditary and idiopathic neuropathy ICD G60
- hydrocephalus ICD G91
- childhood autism ICD F84 and illnesses similar to autism, for example Asperger's syndrome, ICD F84
- infertility due to congenital disease ICD N46, ICD N97
- chronic fatigue syndrome and conditions comparable thereto, e.g. myalgic encephalomyelitis ICD G93
- congenital malformations, deformations and chromosomal abnormalities ICD Q00-99
- congenital viral diseases ICD P35
- hyperkinetic disorders, for example ADHD ICD F90, autism ICD F84.0, delayed milestone (delayed attainment of expected physiological developmental stage, late talker/walker) ICD R62, DAMP ICD F90, ADD ICD F90 and comparable disorders
- primary disorder of muscles ICD G71
- psychomotor delay/developmental disorder, for example Rett syndrome ICD F84
- spinal muscular atrophy ICD G12.

The restrictions above regarding the exempted conditions are not applied regarding compensation in the event of death, Clause 8.4.6.

8.5.4 Restrictions in respect of insurance that started to apply after the age of ten

There is no right to compensation under the insurance in respect of mental and behavioural disorders in accordance with ICD F00-F69 that arise within four years from the commencement date of the insurance.

The above-mentioned limitation is not applied if the insured has had an insurance in force with another insurer, without interruption, since before the age of ten.

8.6 Validity abroad

See Clause 1.11 regarding validity abroad.

9 Private medical insurance PrivatAccess bronze

The insurance covers:	The insurance does not cover:
– healthcare advice – care planning – extended medical care services – consultant physician care – second opinion – hospital care and surgery – post surgical aftercare and rehabilitation – travel and accommodation – medical devices – patient fees – dietician – psychologist or psychotherapist – elimination of deductible in the case of acute injury abroad.	– pharmaceuticals – physiotherapist/naprapath/chiropractor/osteopath – eye infections – ear, nose and throat infections – respiratory tract infections – E-care service. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

9.1 Right to compensation

The insurance applies to examination, treatment or other medical service covered by the insurance and which is performed during the period that the insurance is in force, that is to say during the term of the insurance.

Examination, treatment or other medical service is deemed to have been performed:

- on the day when the care planning or healthcare advice was conducted
- on the day when the examination, treatment or medical service was performed
- on the day when the medical devices were paid for
- on the day when the travel or overnight stay for the examination, treatment or medical service took place.

The insurance does not cover:

- examination, treatment or other medical service that is otherwise covered by the insurance but which is performed before the effective date of the insurance
- examination, treatment or other medical service that is performed after the expiry of the term of the insurance, even if the sickness or accidental injury made its début or occurred during the term of the insurance.

In order to be entitled to care it is required that the insured is resident and registered as resident in a Nordic country and registered with the Swedish social insurance agency or the corresponding in a Nordic country. The care is always provided in Sweden.

9.2 The insurance cover

The insurance covers reasonable costs for medically motivated, planned private care within Euro Accident's current care provider network in Sweden and medically motivated medical devices, travel and accommodation in conjunction with such care as referred to below. The insurance also reimburses costs for public care, including emergency care, up to the high-cost protection limit.

Covered medical services, supplies, travel and accommodations will not automatically be considered medically motivated because they are prescribed by an eligible provider. Euro Accident reserves the right to consult with professional medical consultants, peer review committees or other appropriate sources for recommendations on whether the services, supplies or accommodations an insured receives are considered to be medically motivated.

One precondition for being covered by the insurance is that the insured always contacts Euro Accident's Medical Call Center for advice, planning and for booking of care and treatment. If the insured does not contact Euro Accident's Medical Call Center in advance, compensation under this Insurance may be reduced or denied completely.

'Reasonable costs' means the price that similar care providers in that district normally request for a particular medical service or treatment.

9.2.1 Healthcare advice

The insurance covers healthcare advice by registered nurses.

9.2.2 Care planning

The insurance covers care planning and booking of private medical care. Care planning and booking of care can only take place during office hours.

Emergency medical care cannot be booked by Euro Accident's Medical Call Center.

9.2.3 Extended medical care services

In the event that the sickness/injury/complaint is not covered by the insurance due to a restriction contained in the insurance conditions or an individual restriction, the insurance will still cover advice and booking of private medical care. The cost for care under such circumstances shall be the financial responsibility of the insured. Payment must be received by Euro Accident before the time for the appointment/treatment.

9.2.4 Consultant physician care

The insurance will compensate necessary and reasonable costs for medical investigation, treatment and advice by a consultant physician.

9.2.5 Second opinion – further assessment

The insurance will compensate necessary and reasonable costs for a second medical opinion when the insured has been diagnosed with a life-threatening or particularly serious sickness.

9.2.6 Hospital care and surgery

The insurance will compensate necessary and reasonable costs for hospital care, pre-operation examination and surgery.

9.2.7 Post surgical aftercare – medical rehabilitation

The insurance will compensate necessary and reasonable costs for medical care and rehabilitation prescribed by a physician in conjunction with a covered surgery.

Aftercare and rehabilitation shall, if possible, take place in the home district but may, if it is determined medically necessary by the insurer, take place at the hospital where the insured has been cared for.

The insurance does not cover costs that are paid by the region. Reimbursement will not be paid for stays at a health resort, spa or similar facility.

9.2.8 Travel and accommodation

The insurance will reimburse necessary and reasonable travel and accommodation costs within Sweden in conjunction with covered medical care and treatment.

Reimbursement for travel and accommodation is only provided when travel exceeds 100 km per one-way trip. The insurance will in that case pay reimbursement for the entire travelling expense. If the insured has not attained the age of 20, travel and accommodation for a relative who travels with the insured will also be reimbursed, provided this is medically justified.

9.2.9 Medical devices

The insurance will reimburse necessary and reasonable costs for medical devices. Reimbursement is limited to one (1) diagnostic testing and one (1) medical device of up to SEK 2,500 per diagnosis. Reimbursement is only provided for one (1) diagnostic testing and one (1) medical device for diagnoses that have a medical link. The medical device must be prescribed by the treating physician.

For medical devices in conjunction with surgery the insurance will reimburse reasonable costs for medical devices that are considered necessary to heal the sickness or injury. Reimbursement is provided for one (1) diagnostic testing and one (1) medical device per diagnosis.

Reimbursement is only provided for one (1) diagnostic testing and one (1) medical device for diagnoses that have a medical link. The medical device must be prescribed by the treating physician and shall be reimbursed by up to 0.5 price base amount. However, post-surgical diagnostic testing of medical devices for permanent use are not reimbursed.

9.2.10 Patient fees

The insurance will reimburse necessary and reasonable costs for patient fees within public care. Reimbursement will be provided up to the limit for the high-cost protection. The deductible does not need to be paid by the insured in the case of a sickness or injury where the appointment took place within the public medical care services.

Costs for hospital care will be reimbursed according to the daily charge approved by the region.

9.2.11 Dietician

The insurance will reimburse necessary and reasonable costs for up to ten consultations per diagnosis, by a dietician following referral by a physician. Up to ten consultations will be paid for in the case of diagnoses that have a medical link. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

9.2.12 Psychologist/psychotherapist

The insurance will reimburse necessary and reasonable costs for up to ten treatments per diagnosis, by a registered psychologist or registered psychotherapist for an illness/complaint of psychological disorders, such as crisis and grief reaction, reactions to stress, exhaustion syndrome, depression and anxiety disorder. Up to ten treatments will be paid for in the case of diagnoses that have a medical link.

Other costs, for example, for doctor's appointments, other specialist care, hospital care, travel or

pharmaceuticals in respect of illness/complaint of psychological disorders will not be reimbursed.

The insurance does not cover diagnostics and treatment of hyperkinetic conditions or intellectual disability. Nor does the insurance cover treatment of eating disorders, psychosis, bipolar syndrome, personality disorder, specific phobic conditions or chronic fatigue syndrome.

Problems where it is considered that it is not possible to treat the symptoms within ten treatments will not be reimbursed by the insurance. In these cases the insured will be given advise concerning alternative care options.

Nor does the insurance cover misuse-related complaints or if the insured has performed or participated in a criminal act.

The treatment must be approved and arranged by Euro Accident's Medical Call Center.

9.3 Restrictions

The insurance does not cover:

- eye infections
- ear, nose and throat infections
- respiratory tract infections.

9.3.1 Voluntary and mandatory insurance with a pre-existing condition clause

The insurance will not compensate expenses for sickness/injury/complaint, or consequences thereof that the insured had symptoms of, received care for or had been medicated for before the insurance started to apply.

However, the insurance does apply where a medical investigation shows that at least one year has elapsed since the existing condition was last subject to treatment, check, examination or medication and the insured has been without symptoms during the same period.

9.3.2 The insurance does not cover

- emergency medical or intensive care, besides patient fees up to the high-cost protection limit in accordance with Clause 9.2.10
- congenital diseases, birth injuries or consequences thereof
- sicknesses that are included in the Communicable Diseases Act or consequences thereof
- conditions involving chronic pain, fibromyalgia or electrosensitivity
- organ transplant and organ donation or complications thereof
- dialysis treatment
- back problems, where a physician considers that the sickness/injury/complaint is not treatable
- snoring problems, unless sleep apnoea has been diagnosed
- surgical procedures including laser surgery, spectacles and contact lenses with the aim of correcting vision or squint
- surgical procedures for insured who smokes, unless the insured has refrained from smoking for six weeks before the operation and up to six weeks after, or from the time that the operation is booked if this is closer in time
- examination, treatment of varicose veins in the leg
- checks, treatment and surgery for underweight, overweight and obesity or consequential illnesses that have an established medical link with the insured's underweight, overweight and obesity, although the insured is offered one (1) life style programme, to be nominated by Euro Accident, see Explanation of terms BMI
- checks during pregnancy, treatment and complications in conjunction with pregnancy, childbirth, abortion or consequences thereof
- sterilisation including reversal thereof, examination or treatment related with involuntary childlessness
- sexual dysfunction
- dementia diseases
- see Clause 9.2.12 for exemptions relating to illnesses of a psychological nature
- diagnostics and treatment of hyperkinetic conditions or intellectual disability
- treatment of eating disorders, psychosis, bipolar syndrome, personality disorder, specific phobic conditions or chronic fatigue syndrome.

The insurance does not cover sickness/injury/complaint, or consequences of sickness/injury/complaint caused by:

- the insured using substances to enhance the performance including, but not limited to, anabolic steroids, stimulants and corticosteroids, irrespective of whether or not these have been prescribed by an accredited physician. Medication prescribed by a physician for a specific sickness or accidental injury is not covered by the restriction
- attempted suicide or self-inflicted bodily injury or when the insured was not in full possession of all of their senses
- misuse of for example pharmaceuticals, alcohol, other intoxicants, narcotic substances (unless these have been prescribed by an accredited physician for the insured), gambling abuse or sex misuse
- injury that arose in conjunction with health and medical care, for example in conjunction with

investigation, treatment, advice, care or pharmaceuticals.

The insurance does not cover costs that relate to:

- in-patient care for a period longer than one (1) month
- preventive care including health checks in addition to what is stated in the respective product conditions
- non-symptomatic diagnostic tests and examinations
- cosmetic surgery or treatment, or consequences thereof
- alternative forms of treatment performed by an unauthorised care provider who is not licensed by the National Board of Health and Welfare and products
- vaccinations including desensitization,
- hearing aid, CPAP or the diagnostic testing of such medical devices
- dental treatment, jaw and bite physiology including the making of appointments, regardless of cause
- geriatric care, that is to say care and nursing aimed at affording old people financial security, housing, medical devices and personal care such as domestic assistance, home nursing and homes for the elderly
- personal expenses during hospital care, and also costs of relatives or other persons in conjunction with the hospital care
- reimbursement by some other means according to a special law or enactment, international convention, other insurance or collective agreement
- an appointment regarding medical care, treatment or surgery that has been cancelled too late, or not attended. Cancellation must be made no later than 24 hours before the appointment regarding medical care, treatment or surgery. Euro Accident reserves the right to recover costs from the insured.

9.4 Care guarantee

From the time when Euro Accident has obtained all necessary medical documentation, the insured is guaranteed:

- within seven working days to receive a first consultation, via a visit or by telephone, by a care provider with specialist competence
- within 14 working days of the insurer's decision in respect of adequate medical services, have surgery or other treatment, where this is medically possible.

The guarantee does not apply if surgery or other treatment must be postponed for medical reasons, or because the insured does not accept the time for the admission.

The guarantee applies to the care that is possible to access within the private sector in Sweden.

If the care guarantee is not met, SEK 1,000 per day will be paid until the date of admission for surgery or other treatment, subject to the precondition that the insured has made contact within the guarantee period and made a claim concerning compensation for non-compliance with the care guarantee to Euro Accident. The maximum reimbursement is one (1) annual premium relating to the insured. Repayment will be made to the party paying the premium.

The insurance covers additional costs for travel and accommodation if care in another district is necessary in order to comply with the care guarantee.

9.5 Liability period

The liability period, in respect of sickness or accidental injury, is unlimited up to and including the end of the month in which the insured attains the age of 67, unless otherwise indicated by the group scheme agreement.

It is a precondition that the insurance is in force. If the insurance has expired, the liability period and consequently the cover cease to apply.

9.6 Deductible

The insurance can be applied for with or without a deductible. One deductible is always applied for voluntary insurance or co-insured child. The deductible shall be paid on a per diagnosis basis; with a maximum of one (1) deductible applied for any diagnoses that have a medical link.

The deductible shall be paid by the insured. A reminder in accordance with law (1981: 739) on compensation for collection costs, etc, will be charged in the event of delay in payment of the deductible.

9.7 Sum insured

The sum insured is unlimited unless otherwise is stipulated in the respective reimbursement section of the product conditions.

9.8 Validity abroad

See Clause 1.11 regarding validity abroad.

10 Private medical insurance PrivatAccess silver

The insurance covers:	
– healthcare advice – care planning – extended medical care services – consultant physician care – E-care service – second opinion – hospital care and surgery – post surgical aftercare and rehabilitation	– travel and accommodation – medical devices – pharmaceutical expenses and patient fees – physiotherapist, naprapath or chiropractor – acupuncture – osteopath – dietician – psychologist or psychotherapist – elimination of deductible in the case of acute injury abroad.

10.1 Right to compensation

The insurance applies to examination, treatment or other medical service covered by the insurance and which is performed during the period that the insurance is in force, that is to say during the term of the insurance.

Examination, treatment or other medical service is deemed to have been performed:

- on the day when the care planning or healthcare advice was conducted
- on the day when the examination, treatment or medical service was performed
- on the day when the pharmaceuticals or medical devices were paid for
- on the day when the travel or overnight stay for the examination, treatment or medical service took place.

The insurance does not cover:

- examination, treatment or other medical service that is otherwise covered by the insurance but which is performed before the effective date of the insurance
- examination, treatment or other medical service that is performed after the expiry of the term of the insurance, even if the sickness or accidental injury made its début or occurred during the term of the insurance.

In order to be entitled to care it is required that the insured is resident and registered as resident in a Nordic country and registered with the Swedish social insurance agency or the corresponding in a Nordic country. The care is always provided in Sweden.

10.2 The insurance cover

The insurance covers reasonable costs for medically motivated, planned private care within Euro Accident's current care provider network in Sweden and medically motivated pharmaceuticals, medical devices, travel and accommodation in conjunction with such care as referred to below. The insurance also reimburses costs for public care, including emergency care, up to the high-cost protection limit.

Covered medical services, supplies and accommodations will not automatically be considered medically motivated because they are prescribed by an eligible provider. Euro Accident reserves the right to consult with professional medical consultants, peer review committees or other appropriate sources for recommendations on whether the services, supplies or accommodations an insured receives are considered to be medically motivated.

One precondition for being covered by the insurance is that the insured always contacts Euro Accident's Medical Call Center for advice, planning and for booking of care and treatment. If the insured does not contact Euro Accident's Medical Call Center in advance, compensation under this Insurance may be reduced or denied completely. However, this does not apply if the insured seeks care directly through the e-care service, via Euro Accident's website.

'Reasonable costs' means the price that similar care providers in that district normally request for a particular medical service or treatment.

10.2.1 Healthcare advice

The insurance covers healthcare advice by registered nurses.

10.2.2 Care planning

The insurance covers care planning and booking of private medical care. Care planning and booking of care can only take place during office hours.

Emergency medical care cannot be booked by Euro Accident's Medical Call Center.

10.2.3 Extended medical care services

In the event that the sickness/injury/complaint is not covered by the insurance due to a restriction contained

in the insurance conditions or an individual restriction, the insurance will still cover advice and booking of private medical care. The cost for care under such circumstances shall be the financial responsibility of the insured. Payment must be received by Euro Accident before the time for the appointment/treatment.

10.2.4 Consultant physician care

The insurance will compensate reasonable costs for necessary medical investigation, treatment and advice by a consultant physician.

10.2.5 E-care service

The insurance will reimburse necessary and reasonable costs for Euro Accident's E-care service. A digital service with the possibility of a web-based investigation where the insured may, if necessary, meet a doctor or nurse online, who can recommend appropriate care and treatment. It is a precondition that the sickness/injury/complaints are covered by the insurance.

10.2.6 Second opinion – further assessment

The insurance will compensate reasonable costs for a necessary second medical opinion when the insured has been diagnosed with a life-threatening or particularly serious sickness.

10.2.7 Hospital care and surgery

The insurance will compensate reasonable costs for necessary hospital care, pre-operation examination and surgery.

10.2.8 Post surgical aftercare – medical rehabilitation

The insurance will compensate reasonable costs for necessary medical care and rehabilitation, for example physiotherapy, prescribed by a physician in conjunction with a covered surgery.

Aftercare and rehabilitation shall, if possible, take place in the home district but may, if it is determined medically necessary by the insurer, take place at the hospital where the insured has been cared for.

The insurance does not cover costs that are paid by the region. Reimbursement will not be paid for stays at a health resort, spa or similar facility.

10.2.9 Travel and accommodation

The insurance will reimburse necessary and reasonable travel and accommodation costs within Sweden in conjunction with covered medical care and treatment.

Reimbursement for travel and accommodation is only provided when travel exceeds 100 km per one-way trip. The insurance will in that case pay reimbursement for the entire travelling expense. If the insured has not attained the age of 20, travel and accommodation for a relative who travels with the insured will also be reimbursed, provided this is medically justified.

10.2.10 Medical devices

The insurance will reimburse reasonable costs for necessary medical devices. Reimbursement is limited to one (1) diagnostic testing and one (1) medical device of up to SEK 2,500 per diagnosis.

Reimbursement is only provided for one (1) diagnostic testing and one (1) medical device for diagnoses that have a medical link. The medical device must be prescribed by the treating physician.

For medical devices in conjunction with surgery the insurance will reimburse reasonable costs for medical devices that are considered necessary to heal the sickness or injury.

Reimbursement is provided for one (1) diagnostic testing and one (1) medical device per diagnosis. Reimbursement is only provided for one (1) diagnostic testing and one (1) medical device for diagnoses that have a medical link. The medical device must be prescribed by the treating physician and shall be reimbursed by up to 0.5 price base amount. However, post-surgical diagnostic testing of medical devices for permanent use are not reimbursed.

10.2.11 Pharmaceutical expenses and patient fees

The insurance will reimburse reasonable costs for necessary publicly subsidised, prescription pharmaceuticals (own charge) covered by the insurance and for patient fees within public care. Reimbursement will be provided up to the limit for the respective high-cost protection. The deductible does not need to be paid by the insured in the case of a sickness or injury where an appointment takes place within the public medical care services or where E-care service is used.

Costs for hospital care will be reimbursed according to the daily charge approved by the region.

10.2.12 Physiotherapist/naprapath/chiropractor

The insurance will compensate reasonable costs for medically motivated treatment/consultation by a registered physiotherapist/naprapath/chiropractor. The treatment is intended to result in an improvement. However, the insurance does not compensate treatment of sickness/injury/complaint that is considered to be a permanent condition that is to say that the insured's medical condition will not be permanently improved by the treatment. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

If the physiotherapist so considers, the insurance may pay alternative treatment, such as the substitution of treatment by a physiotherapist with a gym card intended for rehabilitation. The training programme should be documented and be effected under the guidance of the treating physiotherapist. The scope of the gym card must be assessed by a physiotherapist and be approved by Euro Accident.

10.2.13 Acupuncture

The insurance will compensate reasonable costs for medically motivated treatment that shall be performed by a registered care provider who is licensed by the National Board of Health and Welfare. The treatment is intended to result in an improvement. However, the insurance does not compensate treatment of sickness/injury/complaint that is considered to be a permanent condition that is to say that the insured's medical condition will not be permanently improved by the treatment. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

10.2.14 Osteopath

The insurance will compensate reasonable costs for medically motivated treatment/consultation by an osteopath. The treatment is intended to result in an improvement. However, the insurance does not compensate treatment of sickness/injury/complaint that is considered to be a permanent condition that is to say that the insured's medical condition will not be permanently improved by the treatment.

It is a precondition that the treating osteopath is a member of the Swedish Osteopathic Association. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

10.2.15 Dietician

The insurance will reimburse necessary and reasonable costs for up to ten consultations per diagnosis, by a dietician following referral by a physician. Up to ten consultations will be paid for in the case of diagnoses that have a medical link. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

10.2.16 Psychologist/Psychotherapist

The insurance will reimburse necessary and reasonable costs for up to ten treatments per diagnosis, by a registered psychologist or registered psychotherapist for an illness/complaint of psychological disorders, such as crisis and grief reaction, reactions to stress, exhaustion syndrome, depression and anxiety disorder. Up to ten treatments will be paid for in the case of diagnoses that have a medical link.

Other costs, for example, for doctor's appointments, other specialist care, hospital care, travel or pharmaceuticals in respect of illness/complaint of psychological disorders will not be reimbursed.

The insurance does not cover diagnostics and treatment of hyperkinetic conditions or intellectual disability. Nor does the insurance cover treatment of eating disorders, psychosis, bipolar syndrome, personality disorder, specific phobic conditions or chronic fatigue syndrome.

Problems where it is considered that it is not possible to treat the symptoms within ten treatments will not be reimbursed by the insurance. In these cases the insured will be given advise concerning alternative care options.

Nor does the insurance cover misuse-related complaints or if the insured has performed or participated in a criminal act.

The treatment must be approved and arranged by Euro Accident's Medical Call Center.

10.3 Restrictions

10.3.1 Voluntary and mandatory insurance with a pre-existing condition clause

The insurance will not compensate expenses for sickness/injury/complaint, or consequences thereof that the insured had symptoms of, received care for or had been medicated for before the insurance started to apply.

However, the insurance does apply where a medical investigation shows that at least one year has elapsed since the existing condition was last subject to treatment, check, examination or medication and the insured has been without symptoms during the same period.

10.3.2 Mandatory insurance without a pre-existing condition clause

If the insurance has been applied for subject to the condition that the restriction above relating to sickness/injury/complaint that existed before the insurance was applied for shall not be applied, the insurance will cover the renewed need for care in accordance with the condition otherwise.

10.3.3 The insurance does not cover

- emergency medical or intensive care, besides patient fees up to the high-cost protection limit in accordance with Clause 10.2.11
- congenital diseases, birth injuries or consequences thereof
- sicknesses that are included in the Communicable Diseases Act or consequences thereof
- conditions involving chronic pain, fibromyalgia or electrosensitivity

- organ transplant and organ donation or complications thereof
- dialysis treatment
- back problems, where a physician considers that the sickness/injury/complaint is not treatable
- snoring problems, unless sleep apnoea has been diagnosed
- surgical procedures including laser surgery, spectacles and contact lenses with the aim of correcting a vision or squint
- surgical procedures for insured who smokes, unless the insured has refrained from smoking six weeks before the operation and up to six weeks after, or from the time that the operation is booked if this is closer in time
- examination or treatment of varicose veins in the leg
- checks, treatment and surgery for underweight, overweight and obesity or consequential illnesses that have an established medical link with the insured's underweight, overweight and obesity, although the insured is offered one (1) life style programme, to be nominated by Euro Accident, see Explanation of terms BMI
- checks during pregnancy, treatment and complications in conjunction with pregnancy, childbirth, abortion or consequences thereof
- sterilisation including reversal thereof, examination or treatment related with involuntary childlessness
- sexual dysfunction
- dementia diseases
- see Clause 10.2.16 for exemptions relating to illnesses of a psychological nature
- diagnostics and treatment of hyperkinetic conditions or intellectual disability
- treatment of eating disorders, psychosis, bipolar syndrome, personality disorder, specific phobic conditions or chronic fatigue syndrome.
-

The insurance does not cover sickness/injury/complaint, or consequences of sickness/injury/complaint caused by:

- the insured using substances to enhance the performance including, but not limited to, anabolic steroids, stimulants and corticosteroids, irrespective of whether or not these have been prescribed by an accredited physician. Medication prescribed by a physician for a specific sickness or accidental injury is not covered by the restriction
- attempted suicide or self-inflicted bodily injury or when the insured was not in full possession of all of their senses
- misuse of for example pharmaceuticals, alcohol, other intoxicants, narcotic substances (unless these have been prescribed by an accredited physician for the insured), gambling abuse or sex misuse
- injury that arose in conjunction with health and medical care, for example in conjunction with investigation, treatment, advice, care or pharmaceuticals.

The insurance does not cover costs that relate to:

- in-patient care for a period longer than one (1) month
- preventive care including health checks in addition to what is stated in the respective product conditions
- non-symptomatic diagnostic tests and examinations
- cosmetic surgery or treatment or consequences thereof
- alternative forms of treatment performed by an unauthorised care provider who is not licensed by the National Board of Health and Welfare or an osteopath who is not a member of the Swedish Osteopathic Association and alternative treatment products and preparations
- vaccinations including desensitization
- hearing aid, CPAP and the diagnostic testing of such medical devices
- dental treatment, jaw and bite physiology including the making of appointments, regardless of cause
- geriatric care, that is to say care and nursing aimed at affording old people financial security, housing, medical devices and personal care such as domestic assistance, home nursing and homes for the elderly
- personal expenses during hospital care, and costs of relatives or other persons in conjunction with the hospital care
- reimbursement by some other means according to a special law or enactment, international convention, other insurance or collective agreement
- an appointment regarding medical care, treatment or surgery that has been cancelled too late, or not attended. Cancellation must be made no later than 24 hours before the appointment regarding medical care, treatment or surgery. Euro Accident reserves the right to recover costs from the insured.

10.4 Care guarantee

From the time when Euro Accident has obtained all necessary medical documentation, the insured is guaranteed within:

- seven working days to receive a first consultation, via a visit or by telephone, by a care provider with specialist competence

– 14 working days of the insurer's decision in respect of adequate medical services, have surgery or other treatment, where this is medically possible.

The guarantee does not apply if surgery or other treatment must be postponed for medical reasons, or because the insured does not accept the time for the admission.

The guarantee applies to the care that is possible to access within the private sector in Sweden.

If the care guarantee is not met, SEK 1,000 per day will be paid until the date of admission for surgery or other treatment, subject to the precondition that the insured has made contact within the guarantee period and made a claim concerning compensation for non-compliance with the care guarantee to Euro Accident. The maximum reimbursement is one (1) annual premium relating to the insured. Repayment will be made to the party paying the premium.

The insurance covers additional costs for travel and accommodation if care in another district is necessary in order to comply with the care guarantee.

10.5 Liability period

The liability period, in respect of sickness or accidental injury, is unlimited up to and including the end of the month in which the insured attains the age of 67 unless otherwise indicated by the group scheme agreement.

It is a precondition that the insurance is in force. If the insurance has expired, the liability period and consequently the cover cease to apply.

10.6 Deductible

The insurance can be applied for with or without a deductible. One deductible is always applied for voluntary insurance and co-insured child. The deductible shall be paid on a per diagnosis basis; with a maximum of one (1) deductible applied for any diagnoses that have a medical link.

The deductible shall be paid by the insured. A reminder in accordance with law (1981: 739) on compensation for collection costs, etc, will be charged in the event of delay in payment of the deductible.

10.7 Sum insured

The sum insured is unlimited unless otherwise is stipulated in the respective reimbursement section of the product conditions.

10.8 Validity abroad

See Clause 1.11 regarding validity abroad.

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The insurance covers:	
– healthcare advice	– medical devices
– care planning	– pharmaceutical expenses and patient fees
– extended medical care services	– Employee Assistance Program (EAP)
– consultant physician care	– physiotherapist, naprapath or chiropractor
– E-care service	– acupuncture
– second opinion	– osteopath
– hospital care and surgery	– dietician
– post surgical aftercare and rehabilitation	– psychologist or psychotherapist
– travel and accommodation	– elimination of deductible in the case of acute injury abroad.

11.1 Right to compensation

The insurance applies to examination, treatment or other medical service covered by the insurance and which is performed during the period that the insurance is in force, that is to say during the term of the insurance.

Examination, treatment or other medical service is deemed to have been performed:

- on the day when the care planning or healthcare advice was conducted
- on the day when the examination, treatment or medical service was performed
- on the day when the pharmaceuticals or medical devices were paid for
- on the day when the travel or overnight stay for the examination, treatment or medical service took place.

The insurance does not cover:

- examination, treatment or other medical service that is otherwise covered by the insurance but which is performed before the effective date of the insurance
- examination, treatment or other medical service that is performed after the expiry of the term of the insurance, even if the sickness or accidental injury made its début or occurred during the term of the insurance.

In order to be entitled to care it is required that the insured is resident and registered as resident in a Nordic country and registered with the Swedish social insurance agency or the corresponding in a Nordic country. The care is always provided in Sweden.

11.2 The insurance cover

The insurance covers reasonable costs for medically motivated, planned private care within Euro Accident's current care provider network in Sweden and medically motivated pharmaceuticals, medical devices, travel and accommodation in conjunction with such care as referred to below. The insurance also reimburses costs for public care, including emergency care, up to the high-cost protection limit.

Covered medical services, supplies and accommodations will not automatically be considered medically motivated because they are prescribed by an eligible provider.

Euro Accident reserves the right to consult with professional medical consultants, peer review committees or other appropriate sources for recommendations on whether the services, supplies or accommodations an insured receives are considered to be medically motivated.

One precondition for being covered by the insurance is that the insured always contacts Euro Accident's Medical Call Center for advice, planning and for booking of care and treatment. If the insured does not contact Euro Accident's Medical Call Center in advance, compensation under this Insurance may be reduced or denied completely. However, this does not apply if the insured seeks care directly through the e-care service, via Euro Accident's website.

'Reasonable costs' means the price that similar care providers in that district normally request for a particular medical service or treatment.

11.2.1 Healthcare advice

The insurance covers healthcare advice by registered nurses.

11.2.2 Care planning

The insurance covers care planning and booking of private medical care. Care planning and booking of care can only take place during office hours.

Emergency medical care cannot be booked by Euro Accident's Medical Call Center.

11.2.3 Extended medical care services

In the event that the sickness/injury/complaint is not covered by the insurance due to a restriction contained in the insurance conditions or an individual restriction, the insurance will still cover advice and booking of private medical care. The cost for care under such circumstances shall be the financial responsibility of the insured. Payment must be received by Euro Accident before the time for the appointment/treatment.

11.2.4 Consultant physician care

The insurance will compensate necessary and reasonable costs for medical investigation, treatment and advice by a consultant physician.

11.2.5 E-care service

The insurance will reimburse necessary and reasonable costs for Euro Accident's E-care service. A digital service with the possibility of a web-based investigation where the insured may, if necessary, meet a doctor or nurse online, who can recommend appropriate care and treatment. It is a precondition that the sickness/injury/complaints are covered by the insurance.

11.2.6 Second opinion – further assessment

The insurance will compensate necessary and reasonable costs for a second medical opinion when the insured has been diagnosed with a life-threatening or particularly serious sickness.

11.2.7 Hospital care and surgery

The insurance will compensate necessary and reasonable costs for hospital care, pre-operation examination and surgery.

11.2.8 Post surgical aftercare – medical rehabilitation

The insurance will compensate necessary and reasonable costs for medical care and rehabilitation, for example physiotherapy, prescribed by a physician in conjunction with a covered surgery.

Aftercare and rehabilitation shall, if possible, take place in the home district but may, if it is determined medically necessary by the insurer, take place at the hospital where the insured has been cared for.

The insurance does not cover costs that are paid by the region. Reimbursement will not be paid for stays at a health resort, spa or similar facility.

11.2.9 Travel and accommodation

The insurance will reimburse necessary and reasonable travel and accommodation costs within Sweden in conjunction with covered medical care and treatment.

If the insured has not attained the age of 20, travel and accommodation for a relative who travels with the insured will also be reimbursed, provided this is medically justified.

11.2.10 Medical devices

The insurance will reimburse necessary and reasonable costs for medical devices. Reimbursement is limited to one (1) diagnostic testing and one (1) medical device of up to SEK 2,500 per diagnosis. Reimbursement is only provided for one (1) diagnostic testing and one (1) medical device for diagnoses that have a medical link. The medical device must be prescribed by the treating physician.

For medical devices in conjunction with surgery the insurance will reimburse reasonable costs for medical devices that are considered necessary to heal the sickness or injury.

Reimbursement is provided for one (1) diagnostic testing and one (1) medical device per diagnosis. Reimbursement is only provided for one (1) diagnostic testing and one (1) medical device for diagnoses that have a medical link. The medical device must be prescribed by the treating physician and shall be reimbursed by up to 0.5 price base amount. However, post-surgical diagnostic testing of medical devices for permanent use are not reimbursed.

11.2.11 Pharmaceutical expenses and patient fees

The insurance will reimburse necessary and reasonable costs for publicly subsidised, prescription pharmaceuticals (own charge) covered by the insurance and for patient fees within public care. Reimbursement will be provided up to the limit for the respective high-cost protection.

Costs for hospital care will be reimbursed according to the daily charge approved by the region.

11.2.12 Employee Assistance Program (EAP)

There is a right of reimbursement in the event that a need arises for the insured to have counselling support.

The insurance covers consultations by telephone and/or digital visits concerning psycho-social, financial, legal or lifestyle-related issues and manager support.

Total confidentiality applies regarding the insured in relation to their employer.

Counselling support includes up to 5 calls, per case and year, with the following competencies:

- consultations by telephone or digital visits to a registered psychologist

- consultations by telephone concerning manager support
- consultations by telephone on issues related to practical or strategic HR work
- consultations by telephone with an economist
- consultations by telephone with a lawyer
- consultations by telephone with a health coach on lifestyle-related issues

It is possible to combine, for example, three consultations with a psychologist, one consultation with a lawyer and one consultation with an economist. At most five consultations in the same matter regardless of whether the insured has more than one insurance where counselling support is included.

11.2.13 Physiotherapist/naprapath/chiropractor

The insurance will compensate reasonable costs for medically motivated treatment/consultation by a registered physiotherapist/naprapath/chiropractor. The treatment is intended to result in an improvement. However, the insurance does not compensate treatment of sickness/injury/complaint that is considered to be a permanent condition that is to say that the insured's medical condition will not be permanently improved by the treatment. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

If the physiotherapist so considers, the insurance may pay alternative treatment, such as the substitution of treatment by a physiotherapist with a gym card intended for rehabilitation. The training programme should be documented and be effected under the guidance of the treating physiotherapist. The scope of the gym card must be assessed by a physiotherapist and be approved by Euro Accident.

11.2.14 Acupuncture

The insurance will compensate reasonable costs for medically motivated treatment, which shall be performed by a registered care provider who is licensed by the National Board of Health and Welfare. The treatment is intended to result in an improvement. However, the insurance does not compensate treatment of sickness/injury/complaint that is considered to be a permanent condition, which is to say that the insured's medical condition will not be permanently improved by the treatment. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

11.2.15 Osteopath

The insurance will compensate reasonable costs for medically motivated treatment/consultation by an osteopath. The treatment is intended to result in an improvement. However, the insurance does not compensate treatment of sickness/injury/complaint that is considered to be a permanent condition, which is to say that the insured's medical condition will not be permanently improved by the treatment.

It is a precondition that the treating osteopath is a member of the Swedish Osteopathic Association. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

11.2.16 Dietician

The insurance will reimburse necessary and reasonable costs for up to 25 consultations, per diagnosis, by a dietician following referral by a physician. Up to 25 consultations will be paid for in the case of diagnoses that have a medical link. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

11.2.17 Psychologist/psychotherapist

The insurance will reimburse necessary and reasonable costs for up to 25 treatments per diagnosis, by a registered psychologist or registered psychotherapist for an illness/complaint of psychological disorders, such as crisis and grief reaction, reactions to stress, exhaustion syndrome, depression and anxiety disorder.. Up to 25 treatments will be paid for in the case of diagnoses that have a medical link.

Other costs, for example, for doctor's appointments, other specialist care, hospital care, travel or pharmaceuticals in respect of illness/complaint of psychological disorders will not be reimbursed.

The insurance does not cover diagnostics and treatment of hyperkinetic conditions or intellectual disability. Nor does the insurance cover treatment of eating disorders, psychosis, bipolar syndrome, personality disorder, specific phobic conditions or chronic fatigue syndrome.

Problems where it is considered that it is not possible to treat the symptoms within ten treatments will not be reimbursed by the insurance. In these cases the insured will be given advise concerning alternative care options.

Nor does the insurance cover misuse-related complaints or if the insured has performed or participated in a criminal act. The treatment must be approved and arranged by Euro Accident's Medical Call Center.

11.3 Restrictions

11.3.2 Voluntary and mandatory insurance with a pre-existing condition clause

The insurance will not compensate expenses for sickness/injury/complaint, or consequences thereof that the insured had symptoms of, received care for or

had been medicated for before the insurance started to apply.

However, the insurance does apply where a medical investigation shows that at least one year has elapsed since the existing condition was last subject to treatment, check, examination or medication and the insured has been without symptoms during the same period.

11.3.3 The insurance does not cover

- emergency medical or intensive care, besides patient fees up to the high-cost protection limit in accordance with Clause 11.2.11
- congenital diseases, birth injuries or consequences thereof
- sicknesses that are included in the Communicable Diseases Act or consequences thereof
- organ transplant and organ donation or complications thereof
- dialysis treatment
- snoring problems, unless sleep apnoea has been diagnosed
- surgical procedures including laser surgery, spectacles and contact lenses with the aim of correcting vision or squint
- surgical procedures for insured who smokes, unless the insured has refrained from smoking six weeks before the operation and up to six weeks after, or from the time that the operation is booked if this is closer in time
- checks, treatment and surgery for underweight, overweight and obesity and consequential illnesses that have an established medical link with the insured's underweight, overweight and obesity, although the insured is offered one (1) life style programme, to be nominated by Euro Accident, see Explanation of terms BMI
- checks during pregnancy, treatment and complications in conjunction with pregnancy, childbirth, abortion or consequences thereof
- sterilisation including reversal thereof, examination or treatment related with involuntary childlessness
- sexual dysfunction
- dementia diseases
- see Clause 11.2.17 for exemptions relating to illnesses of a psychological nature
- diagnostics and treatment of hyperkinetic conditions or intellectual disability
- treatment of eating disorders, psychosis, bipolar syndrome, personality disorder, specific phobic conditions or chronic fatigue syndrome.

The insurance does not cover sickness/injury/complaint, or consequences of sickness/injury/complaint caused by:

- the insured using substances to enhance the performance including, but not limited to, anabolic steroids, stimulants and corticosteroids, irrespective of whether or not these have been prescribed by an accredited physician. Medication prescribed by a physician for a specific sickness or accidental injury is not covered by the restriction
- attempted suicide or self-inflicted bodily injury or when the insured was not in full possession of all of their senses
- misuse of for example pharmaceuticals, alcohol, other intoxicants, narcotic substances (unless these have been prescribed by an accredited physician for the insured), gambling abuse or sex misuse
- injury that arose in conjunction with health and medical care, for example in conjunction with investigation, treatment, advice, care or pharmaceuticals.

The insurance does not cover costs that relate to:

- in-patient care for a period longer than three months
- preventive care including health checks in addition to what is stated in the respective product conditions
- non-symptomatic diagnostic tests and examinations
- cosmetic surgery or treatment, or consequences thereof
- alternative forms of treatment performed by an unauthorised care provider who is not licensed by the National Board of Health and Welfare or an osteopath who is not a member of the Swedish Osteopathic Association and alternative treatment products and preparations
- vaccinations including desensitization
- hearing aid, CPAP and the diagnostic testing of such medical devices
- dental treatment, jaw and bite physiology including the making of appointments, regardless of cause
- geriatric care, that is to say care and nursing aimed at affording old people financial security, housing, medical devices and personal care such as domestic assistance, home nursing and homes for the elderly
- personal expenses during hospital care, and costs of relatives or other persons in conjunction with the hospital care

- reimbursement by some other means according to a special law or enactment, international convention, other insurance or collective agreement
- an appointment regarding medical care, treatment or surgery that has been cancelled too late, or not attended. Cancellation must be made no later than 24 hours before the appointment regarding medical care, treatment or surgery.

Euro Accident reserves the right to recover costs from the insured.

11.4 Care guarantee

From the time when Euro Accident has obtained all necessary medical documentation, the insured is guaranteed within:

- seven working days to receive a first consultation, via a visit or by telephone, by a care provider with specialist competence
- 14 working days of the insurer's decision in respect of adequate medical services, have surgery or other treatment, where this is medically possible.

The guarantee does not apply if surgery or other treatment must be postponed for medical reasons, or because the insured does not accept the time for the admission.

The guarantee applies to the care that is possible to access within the private sector in Sweden.

If the care guarantee is not met, SEK 1,000 per day will be paid until the date of admission for surgery or other treatment, subject to the precondition that the insured has made contact within the guarantee period and made a claim concerning compensation for non-compliance with the care guarantee to Euro Accident. The maximum reimbursement is one (1) annual premium relating to the insured. Repayment will be made to the party paying the premium.

The insurance covers additional costs for travel and accommodation if care in another district is necessary in order to comply with the care guarantee.

11.5 Liability period

The liability period, in respect of sickness or accidental injury, is unlimited up to and including the end of the month in which the insured attains the age of 67 unless otherwise indicated by the group scheme agreement.

It is a precondition that the insurance is in force. If the insurance has expired, the liability period and consequently the cover cease to apply.

11.6 Deductible

The insurance can be applied for without a deductible.

11.7 Sum insured

The sum insured is unlimited unless otherwise is stipulated in the respective reimbursement section of the product conditions.

11.8 Validity abroad

See Clause 1.11 regarding validity abroad.

12 Short-term disability insurance

The insurance will pay:	The insurance will not pay:
– monthly compensation for at most 36 months, in the event of work disablement ≥ 25 per cent – diagnosis benefit in the form of a lump sum if the insured contracts any of the illnesses or conditions described below.	– monthly compensation for a longer period than 36 months – monthly compensation after having attained the termination age – misuse-related illness – chronic fatigue syndrome – compensation in respect of mental or stress-related illness that has manifested itself within 24 months after the insurance was applied for – monthly compensation during the qualifying period. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

12.1 Right to compensation

Monthly compensation in the case of work disablement

If the insured, due to a sickness or accidental injury, is afflicted by at least 25 per cent work disablement during the term of the insurance, the insurance provides a right to compensation for the time that the work disablement endures beyond the agreed qualifying period. One precondition for the right to compensation is that the insured pays the premium.

When the right to compensation referred to in Clause 12.2 ceases, the insurance also ceases.

The insured's right to re-entry into the insurance is governed by Clause 12.2 below.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Diagnosis benefit

If the insured has been diagnosed during the term of the insurance with any of the illnesses or conditions described below, the insurance will pay compensation of one (1) price base amount.

- Cancer ICD C00-C43, C45-C97 (malignant)
- Myocardial infarction (acute myocardial infarction, unspecified) ICD I21.9
- Stroke ICD I60-63
- Surgery of the coronary artery (other surgery on coronary arteries) ICD FNW96
- Aortic aneurysm surgery (other operation on aortic valve) ICD FMW96
- Surgery on heart valves (other operation on aortic valve) ICD FMW96
- Collapse of kidney function (kidney failure, unspecified as acute or chronic) ICD N19.9
- Organ transplant (transplanted UNS) ICD Z94.9
- Primary adrenocortical insufficiency ICD E27.1
- Motor neuron disease (ALS) ICD G12.2
- Multiple sclerosis ICD G35.9
- Parkinson's disease ICD G20.9
- Alzheimer's disease ICD G30.9
- Systemic lupus erythematosus (SLE) ICD M32.9

The diagnosis must be made by a physician with specialist competence (consultant) in respect of the diagnosis concerned.

Compensation will only be paid for one (1) diagnosed illness even if the insured has been diagnosed for several illnesses. Diagnosis that already existed when the insurance was applied for never affords a right to compensation.

12.2 The insurance will pay – monthly compensation

The insurance provides ongoing compensation, though at most until the first of the following circumstances have occurred:

- compensation has been paid for 36 months
- the insured has attained the termination age according to the group scheme agreement.

The compensation will be paid monthly in arrears. One month is equated to 30 days when calculating compensation.

The entire sum insured will be paid out in the event of total loss of work capacity. If work capacity is impaired by at least 25 per cent, such proportion of the sum

insured will be paid out as corresponds to the impairment of work capacity.

If the insured resumes their work capacity after a shorter period than the longest possible compensation period, the remaining compensation days can be utilised in the event of a later period of sickness.

Application for re-entry into the insurance
When the insurance has ceased as referred to above, an application for re-entry into the insurance can only be made after the insured has been fully capable of working, except for periods of work disablement of at most 14 days, for a consecutive period of twelve months from the preceding period of work disablement. Euro Accident's rules on health status review apply for re-entry.

12.3 Qualifying period

The disability insurance has a qualifying period of three months, unless otherwise agreed or indicated by these insurance conditions.

12.3.1 Recurrent work disablement

The following applies when compensation is paid for a preceding period under this insurance and the insured once again becomes work disabled if the:

- insured becomes work disabled once again after 24 months from the end of the preceding period of work disablement, the new period is to be regarded as a new loss and a new qualifying period will then be counted.
- insured becomes work disabled once again within 24 months from the end of the preceding period of work disablement, the new period is to be regarded as a continuation of the preceding period and no new qualifying period will be counted.

Compensation is not paid in any case for a period of work disablement that is less than 14 consecutive days.

12.4 Restrictions

12.4.1 Misuse-related illness

The insurance does not cover work disablement caused by an illness or condition related to drug misuse, alcohol dependency or pharmaceuticals misuse.

12.4.2 Chronic fatigue syndrome

The insurance does not cover work disablement caused by chronic fatigue syndrome, e.g. myalgic encephalomyelitis.

12.4.3 Mental or stress-related illness

The insurance does not cover work disablement caused by mental or stress-related illness or condition such as, for example, depression, anxiety disorder, exhaustion syndrome and concentration problems.

The restriction regarding mental and stress-related illness or condition is not applicable if the:

- insurance has been in force with Euro Accident without interruption for at least 24 months*) before the illness occurred and the insured has been fully capable of working without interruption for the same period
- insured became sick with any of the above illnesses/complaints during the first 24 months, then recovered and has been free of complaint for more than 24 months after the last occasion of sickness.

Periods of work disablement that are shorter than 15 days are not taken into account, unless the work disablement is due to a mental and/or stress-related illness.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

12.4.4 Limitation of the compensation period

If the insured has during the last 24 months before the insurance started to apply, been work disabled for more than 30 consecutive days and becomes sick once again with the same sickness within 24 months from the date when the insurance started to apply, compensation will be paid at most for such a period of time as has elapsed from the work disablement prior to joining until the time when the insured became work disabled once again due to the same illness, though never for a longer period than as stated in Clause 12.2.

An accidental injury occurred earlier is equated with 'previous sickness'.

If a period of good health lasts for longer than 24 months, the above-mentioned restrictions do not apply if the insured is subsequently afflicted by impaired work capacity due to the same sickness or accidental injury.

If the insured is work disabled after the age of 65 the compensation may be limited in accordance with the

applicable rules and assessment of the Social Insurance Agency.

12.5 Compensation rule

Disability insurance provides ongoing compensation in the event of work disablement after a certain qualifying period. The qualifying period of the insurance is stated in the group scheme agreement and the insurance statement.

12.5.1 Fixed annual amount

The insurance can be applied for with a fixed annual amount. If the insurance is not applied for with a fixed annual amount, compensation will be calculated in accordance with Clause 12.5.2 below.

12.5.2 Proportion of pay

The compensation is determined with the aid of a table which shows for various pay levels the differences between 90 per cent of pay and the compensation that is paid according to statutory and collective agreement-related insurance, computed after tax (municipal tax is assumed to be the average for Sweden). The compensation is based on the notified level of pay that the insured has at the time they became sick.

Changes to the compensation according to statutory and collective agreement-related insurance may mean a change of the compensation amount and premium for the disability insurance.

The highest level of pay carrying rights to compensation is 20 price base amounts per year, unless otherwise agreed.

Compensation in lieu of annual leave is not included in the pay.

12.6 Over-insurance

Should the compensation under this insurance in the event of work disablement result in the insured receiving an income after tax that is higher than 90 per cent of their pay in the event of full work capacity after tax, compensation will only be paid up to a level of 90 per cent. Consequently, if this level has already been achieved through other insurance, no compensation will be paid under this insurance. In this case the premium corresponding to the over-insured part will not be repaid.

12.7 The insurance pays - diagnosis benefit

Diagnosis benefit is paid out as a lump sum corresponding to one (1) price base amount, based on the price base amount applicable when the right to compensation arose.

Compensation is paid out when one month has elapsed from when the illness or condition was first diagnosed. Compensation will not be paid if the insured dies within this period of time.

12.8 Validity abroad

See Clause 1.11 regarding validity abroad.

13 Long-term disability insurance

The insurance will pay:	The insurance will not pay:
– ongoing monthly compensation in the event of work disablement ≥ 25 per cent – diagnosis benefit in the form of a lump sum if the insured contracts any of the illnesses or conditions described below.	– monthly compensation after having attained the termination age – misuse-related illness – chronic fatigue syndrome – compensation in respect of mental or stress-related illness that has manifested itself within 24 months after the insurance was applied for – monthly compensation during the qualifying period. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

13.1 Right to compensation

Monthly compensation in the case of work disablement

If the insured, due to a illness or accidental injury, is afflicted by at least 25 per cent work disablement during the term of the insurance, the insurance provides a right to compensation for the time that the work disablement endures beyond the agreed qualifying period. One precondition for the right to compensation is that the insured pays the premium.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

Diagnosis benefit

If the insured has been diagnosed during the term of the insurance with any of the illnesses or conditions described below, the insurance will pay compensation of one (1) price base amount.

- Cancer ICD C00-C43, C45-C97 (malignant)
- Myocardial infarction (acute myocardial infarction, unspecified) ICD I21.9
- Stroke ICD I60-63
- Surgery of the coronary artery (other surgery on coronary arteries) ICD FNW96
- Aortic aneurysm surgery (other operation on aortic valve) ICD FMW96
- Surgery on heart valves (other operation on aortic valve) ICD FMW96
- Collapse of kidney function (kidney failure, unspecified as acute or chronic) ICD N19.9
- Organ transplant (transplanted UNS) ICD Z94.9
- Primary adrenocortical insufficiency ICD E27.1
- Motor neuron disease (ALS) ICD G12.2
- Multiple sclerosis ICD G35.9
- Parkinson's disease ICD G20.9
- Alzheimer's disease ICD G30.9
- Systemic lupus erythematosus (SLE) ICD M32.9

The diagnosis must be made by a physician with specialist competence (consultant) in respect of the diagnosis concerned.

Compensation will only be paid for one (1) diagnosed illness even if the insured has been diagnosed for several illnesses. Diagnosis that already existed when the insurance was applied for never affords a right to compensation.

13.2 The insurance will pay – monthly compensation

The insurance provides ongoing compensation, however, until the insured has reached the final age according to the group agreement.

The compensation will be paid monthly in arrears. One month is equated to 30 days when calculating compensation.

The entire sum insured will be paid out in the event of total loss of work capacity. If work capacity is impaired by at least 25 per cent, such proportion of the sum insured will be paid out as corresponds to the impairment of work capacity.

13.3 Qualifying period

The disability insurance has a qualifying period of three months, unless otherwise agreed.

13.3.1 Recurrent work disablement

The following applies when compensation is paid for a

preceding period under this insurance and the insured once again becomes work disabled if the:

- insured becomes work disabled once again after 24 months from the end of the preceding period of work disablement, the new period is to be regarded as a new loss and a new qualifying period will then be counted.
- insured becomes work disabled once again within 24 months from the end of the preceding period of work disablement, the new period is to be regarded as a continuation of the preceding period and no new qualifying period will be counted.

Compensation is not paid in any case for a period of work disablement that is less than 14 consecutive days.

13.4 Restrictions

13.4.1 Misuse-related illness

The insurance does not cover work disablement caused by an illness or condition related to drug misuse, alcohol dependency or pharmaceuticals misuse.

13.4.1 Chronic fatigue syndrome

The insurance does not cover work disablement caused by chronic fatigue syndrome, e.g. myalgic encephalomyelitis.

13.4.2 Mental or stress-related illness

The insurance does not cover work disablement caused by mental or stress-related illness or condition such as, for example, depression, anxiety disorder, exhaustion syndrome and concentration problems.

The restriction regarding mental and stress-related illness or condition is not applicable if:

- the insurance has been in force with Euro Accident without interruption for at least 24 months*) before the illness occurred and the insured has been fully capable of working without interruption for the same period
- the insured became sick with any of the above illnesses/complaints during the first 24 months, then recovered and has been free of complaint for more than 24 months after the last occasion of sickness.

Periods of work disablement that are shorter than 15 days are not taken into account, unless the work disablement is due to a mental and/or stress-related illness.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

13.4.3 Limitation of the compensation period

If the insured has during the last 24 months before the insurance started to apply, been work disabled for more than 30 consecutive days and becomes sick once again with the same sickness within 24 months from the date when the insurance started to apply, compensation will be paid at most for such a period of time as has elapsed from the end of the last work disablement prior to joining until the time when the insured became work disabled once again due to the same illness, though never for a longer period than as stated in Clause 13.2.

An accidental injury occurred earlier is equated with ‘previous sickness’.

If a period of good health lasts for longer than 24 months, the above-mentioned restrictions do not apply if the insured is subsequently afflicted by impaired work capacity due to the same sickness or accidental injury.

If the insured is work disabled after the age of 65 the compensation may be limited in accordance with the applicable rules and assessment of the Social Insurance Agency.

13.5 Compensation rule

Disability insurance provides ongoing compensation in the event of work disablement after a certain qualifying period. The qualifying period of the insurance is stated in the group scheme agreement and the insurance statement.

13.5.1 Fixed annual amount

The insurance can be applied for with a fixed annual amount. If the insurance is not applied for with a fixed annual amount, compensation will be calculated in accordance with Clause 13.5.2.

13.5.2 Proportion of pay

The compensation is determined with the aid of a table which shows for various pay levels the differences between 90 per cent of pay and the compensation that is paid according to statutory and collective agreement-related insurance, computed after tax (municipal tax is assumed to be the average for Sweden). The compensation is based on the notified level of pay that the insured has at the time they became sick.

Changes to the compensation according to statutory and collective agreement-related insurance may mean a change of the compensation amount and premium for the disability insurance.

The highest level of pay carrying rights to compensation is 20 price base amounts per year, unless otherwise agreed.

Compensation in lieu of annual leave is not included in the pay.

13.6 Over-insurance

Should the compensation under this insurance in the event of work disablement result in the insured receiving an income after tax that is higher than 90 per cent of their pay in the event of full work capacity after tax, compensation will only be paid up to a level of 90 per cent. Consequently, if this level has already been achieved through other insurance, no compensation will be paid under this insurance. In this case the premium corresponding to the over-insured part will not be repaid.

13.7 Index supplement

If the price base amount has increased, the compensation will be increased through an index supplement for the continued period of sickness when a period of sickness has lasted for 36 months. The index supplement corresponds to the percentage increase of the price base amount after the compensation amount was last fixed. However, increases of the price base amount exceeding ten per cent are not taken into account.

13.8 The insurance will pay – diagnosis benefit

Diagnosis benefit is paid out as a lump sum corresponding to one (1) price base amount, based on the price base amount applicable when the right to compensation arose.

Compensation is paid out when one month has elapsed from when the illness or condition was first diagnosed. Compensation will not be paid if the insured dies within this period of time.

13.9 Validity abroad

See Clause 1.11 regarding validity abroad.

14 Basic disability business interruption insurance

The insurance will pay:	The insurance will not pay:
– monthly compensation for one (1) period of twelve months in the event of a business interruption due to work disablement.	– compensation for business interruption due to pregnancy, childbirth or consequences thereof – compensation for business interruption as a consequence of alcohol and/or other intoxicants – misuse-related illness – chronic fatigue syndrome – compensation in respect of mental or stress-related illness that has manifested itself within 24 months after the insurance was applied for – compensation during the qualifying period. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

14.1 Right to compensation

The insurance covers those persons who have been notified as insured within the policyholder's business. If such ownership or employment relationship that formed the basis of the insurance agreement ceases, the insurance cover ceases at the end of the quarter in which such change took place.

The insurance applies in the case of business interruption in the policyholder's business caused by an insured person during the term of the insurance being afflicted by at least 25 per cent work disablement due to illness or accidental injury.

A precondition for the insurance applying is that the insured business has not been disposed of or wound up.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

14.2 The insurance will pay

In the case of work disablement, compensation is paid during a compensation period corresponding to the period during which the work disablement endures beyond the qualifying period.

In the case of work disablement, the compensation period is computed from the date following the date when the insured has been work disabled without interruption for 30 days.

The insurance will pay one (1) compensation period of twelve months.

The insurance ceases after the maximum payment has been made. Compensation is not paid in any case for a period of work disablement that is less than 14 consecutive days.

Compensation under Basic Disability Business Interruption Insurance shall be declared as business income and the insurance premium is a deductible business expense.

Application for re-entry into the insurance

When the insurance has ceased as referred to above, an application for re-entry into the insurance can only be made after the insured has been fully capable of working, except for periods of work disablement up to 14 days, for a consecutive period of twelve months from the preceding period of work disablement. Euro Accident's rules on health status review apply for re-entry.

14.2.1 Recurrent work disablement

The following applies when the insurance has paid a compensation for a period shorter than twelve months and the insured recovered but becomes work disabled once again:

- If the insured becomes work disabled once again within 30 days from the end of the preceding period of work disablement, the new period is to be regarded as a continuation of the preceding period and no new qualifying period will be counted. However, the aggregate compensation period is in such cases counted as if the work disablement was uninterrupted. Compensation will not be paid during the period of good health.
- If the insured becomes work disabled once again after 30 days from the end of the preceding period of work disablement, the new period is to be regarded as a continuation of the preceding

period and a new qualifying period will then be counted.

14.2.2 Calculation of insurance compensation

The compensation amount corresponds to the sum insured applied for. In the event of partial work disablement, compensation will be paid to a corresponding extent.

Compensation will be paid out to the policyholder monthly in arrears.

14.3 Qualifying period

The qualifying period is 30 days unless otherwise agreed. 'Qualifying period' means the period during which compensation for business interruption is not paid. The qualifying period is computed from the date when the work disablement occurred.

No new qualifying period will be counted in the event of new work disablement within 30 days after being declared to be in good health. However, the aggregate compensation period is in such cases counted as if the work disablement was uninterrupted.

14.4 Restrictions

The insurance does not cover work disablement caused by:

- pregnancy, childbirth or consequences thereof
- illness or condition related to drug misuse, alcohol dependency or pharmaceuticals misuse
- chronic fatigue syndrome, e.g. myalgic encephalomyelitis.

14.4.1 First six months after the insurance was applied for

The insurance only applies for work disablement caused by an accidental injury during the first six months after the insurance was applied for.

14.4.2 Mental or stress-related illness

The insurance does not cover work disablement caused by mental or stress-related illness or condition such as, for example, depression, anxiety disorder, exhaustion syndrome and concentration problems.

The restriction regarding mental and stress-related illness or condition is not applicable if the:

- insurance has been in force with Euro Accident without interruption for at least 24 months*) before the illness occurred and the insured has been fully capable of working without interruption for the same period
- insured became sick with any of the above illnesses/complaints during the first 24 months, then recovered and has been free of complaint for more than 24 months after the last occasion of sickness.

Periods of work disablement that are shorter than 15 days are not taken into account, unless the work disablement is due to a mental and/or stress-related illness.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

14.5 Validity abroad

See Clause 1.11 regarding validity abroad.

15 Disability business interruption insurance

The insurance will pay:	The insurance will not pay:
– monthly compensation for up to three periods of twelve months in the event of a business interruption due to work disablement – a lump sum in the event of death.	– compensation for business interruption due to pregnancy, childbirth or consequences thereof – compensation for business interruption as a consequence of alcohol and/or other intoxicants – misuse-related illness – chronic fatigue syndrome – compensation in respect of mental or stress-related illness that has manifested itself within 24 months after the insurance was applied for – compensation exceeding five price base amounts during the first operational year – compensation during the qualifying period. Note The above are examples of the most commonly occurring restrictions, for a complete description see below.

15.1 Right to compensation

The insurance covers those persons who have been notified as insured within the policyholder's business. If such ownership or employment relationship that formed the basis of the insurance agreement ceases, the insurance cover ceases at the end of the quarter in which such change took place.

The insurance applies in the case of business interruption in the policyholder's business caused by an insured person during the term of the insurance:

- being afflicted by at least 25 per cent work disablement due to illness or accidental injury
- dying as a consequence of sickness or accidental injury.

A precondition for the insurance applying is that the insured business has not been disposed of or wound up.

The Social Insurance Agency's decision regarding applicable sickness benefit, rehabilitation benefit, activity compensation, temporary sickness compensation or sickness compensation is an important though not decisive circumstance for Euro Accident's assessment in respect of the issue of compensation.

15.2 The insurance will pay

In the case of work disablement, compensation is paid during a compensation period corresponding to the period during which the work disablement endures beyond the qualifying period. In the case of death compensation is paid as long as the business has costs that are covered, up to six months from the death.

In the case of work disablement, the compensation period is computed from the date following the date when the insured has been work disabled without interruption for 30 days.

The insurance will pay up to three compensation periods each of at most twelve months.

The insurance ceases after the maximum payment has been made. Compensation is not paid in any case for a period of work disablement that is less than 14 consecutive days.

Compensation under Disability Business Interruption Insurance shall be declared as business income and the insurance premium is a deductible business expense.

Application for re-entry into the insurance

When the insurance has ceased as referred to above, an application for re-entry into the insurance can only be made after the insured has been fully capable of working, except for periods of work disablement up to 14 days, for a consecutive period of twelve months from the preceding period of work disablement. Euro Accident's rules on health status review apply for re-entry.

15.2.1 Recurrent work disablement

The following applies when the insurance has paid compensation for a period shorter than twelve months and the insured recovered but becomes work disabled again:

- If the insured becomes work disabled once again within 30 days from the end of the preceding period of work disablement, the new period is to be regarded as a continuation of the preceding period and no new qualifying period will be

counted. However, the aggregate compensation period is in such cases counted as if the work disablement was uninterrupted. Compensation will not be paid during the period of good health.
- If the insured becomes work disabled once again within twelve months from the end of the preceding period of work disablement, the new period is to be regarded as a continuation of the preceding period and a new qualifying period will then be counted.
- If the insured becomes work disabled once again after twelve months from the end of the preceding period of work disablement, the new period is to be regarded as a new loss and a new qualifying period will then be counted.

When the insurance has paid one compensation period for twelve months the insured must in order for there to be a right to compensation for a new compensation period, have been fully capable of working without interruption for at least twelve months. Periods of work disablement that are shorter than 14 days are not taken into account.

15.2.2 Calculation of insurance compensation

The insurance provides compensation for the insured person's proportion of the business's fixed costs.

The compensation amount is maximised at 100 per cent of the business's fixed costs according to the latest audited annual accounts preceding the loss.

However, the compensation amount may never exceed the amount stated in the insurance statement.

In the event of partial work disablement, compensation will be paid to a corresponding extent.

If the insured dies during an ongoing compensation period, the remaining part of the compensation amount will be paid, for the compensation period involved, as a lump sum.

'Business's fixed costs' means those costs that are defined in the annual accounts under the heading 'Operating expenses' as 'Other external expenses' and 'Personnel costs', according to the Annual Accounts Act (1995:1554).

Covered costs are:

- agreed pay and payroll expenses to those who are permanently engagement in the business
- rent for premises and other fixed costs for premises
- fixed electricity and telecom costs
- fixed costs for bookkeeping and audit
- fixed membership charges for sector and employer organisations
- premiums for business insurance
- interests for the business
- fixed contracted rent costs under leasing contracts
- tax and insurance premiums for means of transport in the business.

Pay and social security expenses and costs for individual insurance for the insured person shall not be included in fixed costs.

Compensation will be paid out to the policyholder monthly in arrears.

15.3 Qualifying period

The qualifying period is 30 days unless otherwise agreed. 'Qualifying period' means the period during which compensation for business interruption is not paid. The qualifying period is computed from the date when the work disablement occurred.

No new qualifying period will be counted in the event of new work disablement within 30 days after being declared to be in good health. However, the aggregate compensation period is in such cases counted as if the work disablement was uninterrupted.

15.4 Restrictions

The insurance does not cover work disablement caused by:

- pregnancy, childbirth or consequences thereof,
- illness or condition related to drug misuse alcohol dependency or pharmaceuticals misuse
- chronic fatigue syndrome, e.g. myalgic encephalomyelitis.

15.4.1 Suicide

The first paragraph of Clause 1.10.2 does not apply if the insured has committed suicide.

In the case of suicide, the insurer is liable if more than one year has elapsed from when the insurance agreement was concluded or extended, or in the event of a shorter period, if it is assumed that the insurance was applied for without any thought of suicide.

15.4.2 First six months after the insurance was applied for

The insurance only applies for work disablement and death caused by an accidental injury during the first six months after the insurance was applied for.

15.4.3 Mental or stress-related illness

The insurance does not cover work disablement caused by mental or stress-related illness or condition such as, for example, depression, anxiety disorder, exhaustion syndrome and concentration problems.

The restriction regarding mental and stress-related illness or condition is not applicable if the:

- insurance has been in force with Euro Accident without interruption for at least 24 months*) before the illness occurred and the insured has been fully capable of working without interruption for the same period
- insured became sick with any of the above illnesses/complaints during the first 24 months, then recovered and has been free of complaint for more than 24 months after the last occasion of sickness.

Periods of work disablement that are shorter than 15 days are not taken into account, unless the work disablement is due to a mental and/or stress-related illness.

*) A period during which the insured was insured with the same or similar cover under a group scheme insurance with the immediately preceding insurer, may be included provided that the term of such insurance links immediately and without interruption to the term of the current insurance. This applies subject to the precondition that the insured is covered by a group scheme agreement that has been converted from another insurer and not when an individual insured has changed insurer.

15.4.4 Newly started business

In the case of a newly started business, the insurance will compensate up to five price base amounts during the first operational year. An older business that changes orientation of its principal operation is to be regarded as newly started from the time of the change. A business that changes corporate form without this affecting the orientation of the operation is not regarded as a newly started business.

15.5 Over-insurance

If it transpires in conjunction with payment that the policyholder has insured an amount that corresponds to more than 100 per cent of the business's fixed costs, only such proportion of the sum insured as corresponds to up to 100 per cent of the business's fixed costs according to the latest audited annual accounts will be paid until further notice.

15.6 Validity abroad

See Clause 1.11 regarding validity abroad.

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