GROUP INSURANCE A4

2022

INSURANCE CONDITIONS
EFFECTIVE AS OF 1 APRIL 2022

Bliwa

PURPOSE OF THE INSURANCE

Bliwa's Group Insurance A:4 includes several different insurance products that provide financial protection for the insured in the event of sickness, accident or death. All of the insurance products within Group Insurance A:4 are pure risk insurance, which have no value if they cease before an insurance event has occurred. An individual person may be covered by group insurance with Bliwa if a group agreement entitling them to such insurance has been concluded between Bliwa and a group to which they belong, for instance as an employee or member of an organisation.

INSURER

Bliwa Livförsäkring, ömsesidigt, corporate identity number 502006-6329 (referred to below as 'Bliwa'), is the insurer for the insurance products. Bliwa is a mutual insurance company, which means that the company is owned by the policyholders. It means in its turn that the policyholders are entitled to a bonus from the surplus that may arise from Bliwa's operations; see Sub-clause 1.18.

Bliwa's insurance activities are subject to the supervision of the Swedish Financial Supervisory Authority (Finansinspektionen), postal address Box 7821, SE-103 97 Stockholm, Sweden. Visiting address: Brunnsgatan 3, Stockholm, Sweden. Email address: *finansinspektionen@fi.se*. Telephone number +46 (0)8-408 980 00. Website: *www.fi.se*. Bliwa's marketing is subject to the supervision of the Swedish Consumer Agency (Konsumentverket), postal address Box 48, SE-651 02 Karlstad, Sweden. Visiting address: Tage Erlandergatan 8A. Email address: *konsumentverket@konsumentverket.se*. Telephone number +46 (0)771–42 33 00. Website: *www.ko.se*.

You can obtain information about Bliwa's financial status from our latest adopted annual report. The annual report is available at *www.bliwa.se* and can also be ordered by contacting Bliwa. Bliwa's contact details are shown at the end of these conditions.

Bliwa provides insurance conditions and all other information in Swedish. Any legal proceedings concerning these conditions or the insurance in some other respect shall take place in Sweden, applying Swedish law.

INFORMATION ABOUT THE CONDITIONS, ETC., GOVERNING THE INSURANCE

These insurance conditions apply from and including 1 April 2022. This means that the conditions apply to insurance taken out or renewed from 1 April 2022 onwards. The conditions also apply to an insurance event that occurs from 1 April 2022 onwards. The insurance is also governed by the group agreement concluded for each group and the insurance statement issued for the insurance. Furthermore, the Insurance Business Act (2010:2043), the Insurance Contracts Act (2005:104) and Swedish law in general also apply. A provision specially agreed in a group agreement takes precedence over these conditions.

TAX RULES

The insurance products constitute capital insurance according to the Income Tax Act (1999:1229). As the insurance products are capital insurance for tax purposes, this means, among other things, that compensation paid through the insurance is exempted from tax.

COOLING OFF PERIOD

If the policyholder is a consumer, they are entitled to withdraw from the insurance agreement ('cooling-off period') within 30 days from the date on which they received the insurance documents and information that the insurance agreement has started to apply. The policyholder must notify Bliwa if they wish to exercise their cooling off right. A policyholder is also entitled to decline or give notice terminating the insurance at any time; see Sub-clause 1.9. The policyholder is always obligated to pay the premium for the period during which the insurance was in force.

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Definitions

APPLICATION DOCUMENTS

In these insurance conditions, ‘application documents’ means both the application document itself and its appendices in the form of good-health declaration and group insurance plan.

WORK INCAPACITY

In these insurance conditions, and unless otherwise specified in the group agreement, ‘work incapacity’ means that a person has lost their capacity to work or that their capacity has reduced by at least a quarter owing to sickness or an accidental injury and as a consequence of this has been granted sickness benefit or other compensation by the Swedish Social Insurance Agency owing to work incapacity on the grounds of sickness or an accidental injury.

BENEFIT PERIOD

The longest period during which the benefit can be paid to the insured under the group agreement.

FULLY CAPABLE OF WORKING

The person in question should be able to perform their normal work without limitation in order to be considered ‘fully capable of working’. A person who to some extent is on sick leave, has been granted sick pay, sickness or rehabilitation benefit, activity compensation, sickness compensation or similar compensation or at least half occupational injury annuity is not ‘fully capable of working’.

A person receiving dormant activity compensation, dormant sickness compensation or at least half of dormant occupational injury annuity is not considered to be ‘fully capable of working’ for the period during which the compensation or occupational injury annuity is dormant.

BENEFICIARY

The person entitled to benefit under an insurance product upon the death of the insured through a nomination of beneficiary in these insurance conditions or through a separate nomination of beneficiary.

INSURED

The person in respect of whose life or health the insurance product applies. However, each insured is deemed to be a policyholder as regards: the right to make a nomination of beneficiaries; their relationship with creditors; and the right to insurance compensation in general if the insurance applies to the insured’s life or health for the benefit of the insured personally or their rightholders.

INSURANCE STATEMENT

An insurance statement will be issued when insurance is taken out, including details about the fundamental rights and obligations ensuing under the insurance together with important limitations to the insurance protection. An insurance statement will also be issued when the insurance is amended or renewed, provided the change is significant or if the new insurance conditions include a limitation to the insurance protection.

INSURANCE EVENT

An event that may afford entitlement to insurance compensation under the insurance conditions for the respective insurance product. A description is provided below in conjunction with each respective insurance product, specifying the times at which an insurance event is deemed to have occurred.

POLICYHOLDER

A policyholder is the person who has entered into an insurance agreement with Bliwa.

TERM OF INSURANCE

The period during which the insured is covered by the insurance.

GROUP AGREEMENT

The agreement concluded between Bliwa and a group representative that specifies, among other things, the person entitled to the insurance, the insurance products included in the agreement, what is required in order to be covered by or to take out each insurance, what the insurance costs and how the premium should be paid. It is a precondition that a valid group agreement has been concluded and continues to apply in order for it to be possible to grant a particular insurance and for it to be valid.

GROUP REPRESENTATIVE

The natural or legal person representing the group entitled to insurance in relation to Bliwa.

GROUP MEMBER

A person belonging to the group specified in the group agreement and who is thereby entitled to apply for or, when applicable, be covered by the insurance.

QUALIFYING PERIOD

Applies to health insurance and is the time for which a sickness period should run before the insured is entitled to benefit.

RESERVATION CLAUSE

A special exemption clause for a particular disease or symptom that Bliwa may have notified is to apply for a certain insured or insurance product. In such

cases, the reservation clause is communicated to the insured by separate letter. The letter therefore constitutes part of the insured's insurance statement.

HUSBAND/WIFE

'Husband/wife' also means registered partner in these insurance conditions.

CO-INSURED

The husband, wife or cohabitee of an insured group member who is insured in that capacity.

PRICE BASE AMOUNT

The price base amount determined each year under Chapter 2, Section 7 of the Social Insurance Code (2010:110).

SICKNESS PERIOD

Applies to health insurance and is the period during which the insured is incapable of working owing to sickness or an accident.

MARRIAGE

'Marriage' also means registered partnership in these insurance conditions.

1. Common provisions

1.1 INFORMATION ABOUT THE GROUP AGREEMENT AND VOLUNTARY AND COMPULSORY INSURANCE

GROUP AGREEMENT

Under the Insurance Contracts Act, a valid group agreement is a precondition for an individual group insurance agreement. The group agreement is concluded between Bliwa and a group representative. The group agreement determines whether the insurance is compulsory or voluntary and also the general scope of the insurance. The agreement also governs who belongs to the group entitled to insurance, the earliest date on which the insurance can start to apply, how the insurance is to be administered, the term of validity of the group agreement, the right to give notice terminating the agreement, etc. The group agreement also specifies the premium if the agreement relates to compulsory insurance. The group representative or Bliwa may give notice terminating the group agreement. If notice is given terminating the group agreement, this means that all insurance issued on the basis of the agreement ceases to apply, except for insurance subject to a premium waiver prior to notice of termination; see Sub-clause 1.8.

VOLUNTARY GROUP INSURANCE

If the insurance is voluntary, those covered by the group agreement are entitled to make their own decisions about whether or not they want to have insurance protection. The insurance agreement is then concluded between the group member, as the policyholder, and Bliwa. This is done by the group member applying for and being granted insurance or, if 'automatic enrolment' applies under the group agreement, through the group member not actively declining the insurance protection within the period set.

COMPULSORY GROUP INSURANCE

If the group insurance is compulsory, those specified in the group agreement as being entitled to the insurance are automatically covered by the insurance with Bliwa. The insurance agreement is concluded between the group representative, as the policyholder, and Bliwa. However, each insured is deemed to be a policyholder in terms of the right to insurance compensation, their relationship with creditors and also the right to control the insurance, for example by making a nomination of beneficiaries.

1.2 THE INSURANCE CONDITIONS AND THE INDIVIDUAL INSURANCE AGREEMENT

Unless otherwise indicated by the group agreement, these insurance conditions apply to each individual group insurance concluded on the basis of a group agreement with Bliwa. Any deviations from these insurance conditions are agreed in the group agreement and have precedence over these conditions. If a deviation has been made in the group agreement, this will also be shown in Bliwa's application documents, pre-sale information or insurance statement issued. The applicable application documents and health certificates, Bliwa's pre-sale information and insurance statement issued apply for each individual group insurance product where applicable.

1.3 TERM OF VALIDITY OF THE INSURANCE

The insurance applies for no more than one year at a time unless otherwise specified in the group agreement. The first term of insurance for new policies runs until the end of the year, i.e. up to and including 31 December of the year in which the insurance was taken out. The term of insurance subsequently runs for one year at a time, from 1 January to 31 December each year. The insurance will be renewed annually provided neither the insurance nor the group agreement has been terminated at the end of the term of the insurance. Bliwa is then entitled to amend the insurance conditions; see Sub-clause 1.19. The insurance will

be renewed for at most up to and including the date on which the insured attains the age at expiry for the insurance. The age at expiry is indicated by the application documents or pre-sale information and the insurance statement issued.

1.4 WHO CAN APPLY FOR GROUP INSURANCE

The group agreement defines who comprise group members and who can thus apply for or be covered by the insurance products. For compulsory insurance, the group members are automatically covered by the insurance; no application is required. For voluntary insurance, those entitled to apply for insurance are specified in Bliwa's application documents, and those affiliated to the insurance through 'automatic enrolment' are specified in Bliwa's pre-sale information. Group members are often all of the employer's permanent employees or all members of the organisation or association that concluded the group agreement. The application documents for the group indicate those persons entitled to apply for insurance, the insurance products for which an application can be made and in which cases an insured group member can co-insure their husband, wife or cohabitee and also insure the children of their husband, wife or cohabitee. In the case of automatic enrolment, the group member will receive special information, among other things about the possibility to decline the insurance. The application documents also indicate whether Bliwa has imposed health requirements as a precondition for granting the insurance.

A precondition for affiliation to the voluntary group insurance is that the policyholder and the insured are permanently resident in Sweden.

1.5 WHEN THE INSURANCE ENTERS INTO FORCE

VOLUNTARY GROUP INSURANCE

Upon application
Voluntary group insurance can enter into force no earlier than the date specified in the group agreement. For applications on physical forms, the insurance enters into force on the date on which Bliwa received the application. In the case of other forms of application, for example via the Internet, the insurance only enters into force on the day after the date on which Bliwa received the application. The insurance enters into force subject to the precondition that the insurance can be granted according to the provisions of these insurance conditions and Bliwa's health requirements; see Sub-clause 1.6.

Bliwa's health requirements are specified in the application documents. The same provisions apply when the insurance protection is extended.

If the insurance is to be completely or partly reinsured, the insurance does not enter into force before the reinsurance has been granted, provided this has been stipulated in the group agreement.

Automatic enrolment
If agreed in the group agreement, affiliation to the insurance may be effected through 'automatic enrolment'. In the case of automatic enrolment, the insurance enters into force upon expiry of the period for declining ('enrolment period'). During the enrolment period, the insured is covered by the insurance protection agreed in advance through the group agreement. During the enrolment period, the insured may apply to supplement the insurance protection, both for their own part and for co-insured and children, provided this is allowed under the group agreement. Bliwa may impose health requirements for such supplement, which in that case will be indicated by the application documents. Persons covered by automatic enrolment will receive separate information about this at the time of affiliation.

Initial premium-free coverage period
Some agreements afford entitlement to an 'initial premium-free coverage period'. This means that each group member is entitled upon application or by automatic enrolment to be covered by a particular insurance protection, without having to pay a premium, for the period set in the group agreement. The insurance protection provided by the initial coverage period is indicated by the application documents or by Bliwa's pre-sale information. During the initial premium-free coverage period, the group member may also apply to supplement the insurance protection both for their own part and for co-insured and children. Bliwa may impose health requirements for such supplement, which in that case will be indicated by the application documents. The supplementary insurance protection will also be premium-free during the initial coverage period.

COMPULSORY GROUP INSURANCE

Compulsory group insurance enters into force on the date stipulated in the group agreement and applies to those who are group members at that point in time. The insurance for those who subsequently become group members enters into force on the day after they joined the group, unless otherwise specified in the group agreement.

1.6 HEALTH REQUIREMENTS

VOLUNTARY INSURANCE

A group member or co-insured is normally required to be fully capable of working on the date on which the insurance enters into force in order to be covered by the voluntary group insurance. A higher health requirement applies for some insurance products. This means that those entitled to insurance should answer Bliwa's questions about health and that Bliwa will grant or reject the insurance application following a risk assessment. In certain cases, 'reservation clauses' may be applied to insurance for *medical invalidity in the event of sickness* if the insurance could not otherwise be granted. Health requirements may vary between group agreements and are indicated by Bliwa's application documents.

Health requirements are usually also imposed when the sum insured is increased or the insurance protection is otherwise extended. Health requirements may vary between group agreements and are shown in Bliwa's application documents for the increase and extension.

Bliwa is entitled to request the information and documents required to enable Bliwa to assess the group member's entitlement to insurance, extension of insurance or increase of sum insured. Such a document often comprises an authorisation entitling Bliwa to request information from a third party, for example from the health services. The insurance or extension/increase may not be granted if Bliwa does not receive the documents requested.

A person who is not fully capable of working and who haw as a consequence been denied an increase of their sum insured or other extension or improvement of the insurance protection may be granted the increase, extension or improvement requested when they are once again fully capable of working and have certified this and also satisfy any other health requirements.

COMPULSORY INSURANCE

Group members for compulsory insurance are covered without any health requirements. They are automatically and immediately affiliated to the insurance on the basis of the group agreement. However, in order for a group member to be entitled to insurance compensation in connection with an insurance event, requirements may be imposed in certain agreements in respect of a group member's health at the time of affiliation to the insurance. In such cases this will be indicated by Bliwa's pre-sale information and the insurance statement issued.

1.7 PREMIUM

The price for the insurance products ('the premium') is calculated and determined by Bliwa for one year at a time. The size of the premium may, for example, depend on the distribution of ages among those insured and the development of claims within the group. The premium for voluntary insurance is indicated by the application documents. The premium for compulsory insurance is specified in or in conjunction with the group agreement.

PREMIUM PAYMENT

The premium for the insurance products should normally be paid by the policyholder. This means that the group member is responsible for paying for voluntary insurance. The group representative may have assumed responsibility for acting as intermediary for the premium payments to Bliwa. If this is the case, the group member will pay the premium through deductions from pay or together with a membership charge to the group representative. If the group representative does not act as intermediary for the premium, the premium should be paid by direct debit/autogiro or a paying-in slip. In some group agreements, the group representative will assume responsibility for paying the premium. The applicable provisions for each group are always indicated by the group agreement or by Bliwa's application documents.

For compulsory insurance, the group representative is always responsible for paying the premium.

NOTICE OF TERMINATION OWING TO UNPAID PREMIUM

The first premium must be paid within 14 days from the date on which Bliwa, or the party engaged by Bliwa, sent a premium payment demand. The premium for subsequent premium periods must be paid by no later than the first day of the period. The same applies for the first premium for an insurance product renewed under Sub-clause 1.3. If the premium relates to a period of more than one month, the premium must be paid no later than one month from the date on which Bliwa, or the party engaged by Bliwa, sent a premium payment demand. Bliwa is entitled to give notice terminating the insurance or limiting its liability in accordance with the provisions of these conditions if the premium is not paid on time and the delay is not insignificant.

Notice of termination takes effect 14 days after Bliwa issued the notice, unless the premium is paid within this time limit.

If it has not been possible to pay the voluntary group insurance premium within the time limit of fourteen days because the group member was seriously ill,

has been deprived of their liberty, has not received their pension or wages from their main employment or because of another similar unexpected impediment, the notice of termination takes effect one week after the impediment has ceased, though no later than three months after expiry of the time limit of fourteen days.

If delay in payment of a premium for voluntary group insurance is due to the omission of a party acting as intermediary for the premium under the group agreement, the notice of termination only takes effect for the group member and any co-insured one week after the group member has become aware of this delay.

In the case of compulsory insurance, each insured is entitled to continuation insurance (see Sub-clause 1.11 below) if Bliwa's liability ceases because the policyholder has not paid the premium. The same applies for a co-insured for voluntary group insurance.

REVIVAL OF INSURANCE

If notice of termination has been given and has taken effect in accordance with Sub-clause 1.7.2 and the delay in premium payment does not relate to the first premium for the insurance product, the voluntary group insurance will be revived if the outstanding premium amount is paid within three months from notice of termination taking effect. This applies subject to the precondition that the applicable group agreement is still in force. In the event of revival, the insurance will start to apply again from and including the day following the date on which the premium was paid. Revival cannot be effected solely for a co-insured.

The above-mentioned also applies to compulsory insurance, although this can only be revived for the entire group.

Bliwa is not liable for claims that occurred or that are due to an event that occurred during the period when the insurance did not apply.

REPAYMENT OF PREMIUM

If a premium has been paid for a period after the term of the insurance has expired, Bliwa will repay the premium paid in error, though no more than the premiums for the past twelve months. This period is counted from the day on which Bliwa received a request to repay the premiums. If a premium has been paid in error owing to an oversight (for example, for a co-insured despite the group member and the co-insured no longer being lawful spouses or cohabitees), a corresponding right to repayment of premiums applies, namely that no more than the premiums for twelve months will be repaid.

Premiums will only be repaid if the aggregate amount exceeds 0.3 per cent of the price base amount applicable on the date of repayment.

1.8 PREMIUM WAIVER

The group agreement and application documents show whether or not premium waiver is included. The following applies if premium waiver is included, unless otherwise agreed in the group agreement:

Premium waiver for group members

- A group member who has been granted payment of a lump-sum benefit from Bliwa as a result of sickness compensation granted by the Swedish Social Insurance Agency is entitled to a premium waiver for all insurance that the member has taken out or is covered by under these conditions. The right to a premium waiver applies from the same date as when the group member is granted the right to the lump-sum benefit. A group member who has been granted a lump-sum benefit as a consequence of long-term sick leave and sickness benefit being granted by the Swedish Social Insurance Agency is not entitled to a premium waiver under these conditions.
- A group member who owing to sickness or accidental injury draws full sickness compensation or has drawn full activity compensation for 36 months without interruption is entitled to a premium waiver for all insurance that the member has taken out or is covered by with Bliwa pursuant to one and the same group agreement. The insurance becomes subject to a premium waiver from the date on which the sickness compensation was granted. A group member who has received activity compensation for 36 months without interruption becomes entitled to a premium waiver from and including the month after which they have received activity compensation for 36 months.
- The premium waiver applies for as long as the insured is incapable of working. An insured must immediately notify Bliwa when they once again become fully capable of working. The premium waiver applies for at most up to and including the month when the insured attains the age at expiry of the respective insurance product.
- However, child insurance subject to a premium waiver applies no longer than up to and including the month in which the child attains the age of 25.

Premium waiver for co-insured

A co-insured who has been granted payment of a lump-sum benefit from Bliwa as a consequence of sickness compensation being granted by the Swedish Social Insurance Agency is entitled to a premium waiver for their group insurance with Bliwa

as long as they are incapable of working. The premium waiver applies for at most up to and including the month when the co-insured attains the age at expiry of the respective insurance product. A co-insured who has been granted a lump-sum benefit on account of long-term sick leave and sickness benefit being granted by the Swedish Social Insurance Agency is not entitled to a premium waiver under these conditions.

Insurance protection during the period when the premium waiver applies:

- If an insurance event occurs while the insured is entitled to a premium waiver, benefits will be paid out according to the insurance conditions and sum insured that applied for the month before the insured became entitled to a premium waiver. However, the sum insured for life insurance is index-linked in accordance with the provisions of Sub-clause 2.1.
- If the insurance conditions mean that the sum insured should be reduced owing to the insured's age, the insurance compensation is determined considering the insured's age when the insurance event occurred.
- The insurance protection cannot be extended during the period when the insured group member is entitled to a premium waiver. Children or co-insured cannot be affiliated or the insurance protection extended during the period when the insured group member is entitled to a premium waiver. A co-insured cannot extend their insurance protection during the period when they are entitled to a premium waiver.

If the agreement includes a premium waiver, the insurance event is deemed to have occurred on the date on which the above-mentioned premium waiver conditions for the insured group member or co-insured respectively have been fulfilled.

1.9 WHEN THE INSURANCE CEASES TO APPLY

The insurance applies for at most up to and including the month in which the insured attains the age at expiry for the insurance. The age at expiry for the insurance is shown in Bliwa's application documents and insurance statement. The insurance may cease to apply prior to that if the group agreement ceases owing to notice of termination by Bliwa or the group representative. If Bliwa gives notice terminating the group agreement, the insurance cannot cease to apply any earlier than upon the end of the current calendar year. If the group representative gives notice terminating the group agreement, the insurance cannot cease to apply any earlier than one month after Bliwa has received the notice of termination. The insurance also ceases to apply if the policyholder, the insured or Bliwa gives notice terminating the agreement owing to an unpaid premium or incorrect information. The insurance shall also cease to apply when the insured is no longer a member of the group entitled to be covered by the insurance under the group agreement.

The co-insured's insurance also ceases to apply when the group member's insurance ceases to apply, if the marriage or cohabitee relationship with the group member ceases or when the co-insured attains the age at expiry for the insurance.

Child insurance ceases to apply at the end of the month in which the child attains the age of 25 and when the group member's insurance ceases to apply because they are no longer a group member.

The insurance cannot be extended by paying the premium for the period after the insurance has ceased to apply for any of the above-mentioned grounds.

A person covered by compulsory insurance can waive the insurance at any time by notifying Bliwa or the group representative.

1.10 EXTENDED COVER PROTECTION

An insured is entitled to extended insurance protection ('extended cover protection') for three months if they have been covered by the respective Bliwa insurance for a period of at least six months and the insurance ceases to apply because the insured is no longer a member of the group. A co-insured is also entitled to extended cover protection on the same conditions if the marriage or cohabitee relationship with the group member ceases or if the group member dies.

However, the insured is not entitled to extended cover protection if notice has been given terminating the group agreement completely or partly or if they have opted to terminate the insurance but remain within the group. Nor is the insured entitled to extended cover protection if they have been granted, or can obviously be granted, insurance protection of the same kind as before in some other way.

Extended cover protection means that an insurance event that occurs during the extended cover protection period and before the insured attains the age at expiry for the insurance is regulated in accordance with the insurance conditions (for life insurance, health insurance, *medical invalidity in the event of sickness,* critical illness insurance, personal accident insurance and child insurance respectively)

and at the sum insured applicable immediately preceding the extended cover protection period.

If the person covered by the insurance during the extended cover protection period attains, or has already attained prior to this, the age at expiry for the insurance, the extended cover protection is limited as follows:

- Death benefit amounts to the amount applicable for life insurance in Bliwa's senior insurance.
- Extended cover protection for accident insurance is limited to the scope applicable for accidents in Bliwa's senior insurance.
- Extended cover protection for the lump-sum benefit ceases.
- Extended cover protection for critical illness insurance ceases.
- Extended cover protection for health insurance ceases.
- Extended cover protection for insurance of medical invalidity in the event of sickness ceases.
- Extended cover protection for child insurance ceases.

1.11 CONTINUATION INSURANCE

If the group agreement ceases owing to notice of termination by the group representative or Bliwa, each insured is entitled to be granted equivalent protection, without a health check, through Bliwa's continuation insurance. For some group agreements, an insured group member who leaves the group for some other reason than having attained the age at expiry for the insurance is also entitled to continuation insurance. Bliwa will provide information about continuation insurance in conjunction with notice terminating the group agreement. An application for continuation insurance must be made within three months from when the insurance ceased.

A co-insured is entitled to take out continuation insurance if the group member dies or if the marriage or cohabitee relationship with the group member ceases. The right to continuation insurance also applies for a co-insured if Bliwa, in the case of voluntary insurance, has given notice terminating the insurance agreement as a result of the group member's delay in paying the premium. A co-insured is also entitled to take out continuation insurance if the group member's insurance ceases to apply owing to the group member having attained the age at expiry for the insurance. However, this applies subject to the precondition that the co-insured has not themselves attained the age at expiry.

In the case of compulsory insurance, each insured is entitled to continuation insurance if Bliwa's liability ceases because the policyholder has not paid the premium. A person who has been insured under the respective insurance product for less than six months, or who has chosen to give notice terminating the insurance but remains within the group, is not entitled to continuation insurance. This is also the case for a person who has been granted, or can obviously be granted, insurance protection of the same kind as before in some other way. A person who has attained the age at expiry for the group insurance cannot take out continuation insurance.

The insurance conditions, sum insured and premiums for continuation insurance differ to those for group insurance.

1.12 SENIOR INSURANCE

An insured who has been covered by life or personal accident insurance for at least six months, and who has attained the age at expiry for the insurance, is entitled to take out similar insurance protection, without a health check, through Bliwa's senior insurance.

Bliwa must have received the application for senior insurance (insurance for senior citizens) no later than within three months from leaving the group agreement, i.e. during the extended cover protection period; see Sub-clause 1.10. The insurance conditions, sum insured and premiums for senior insurance differ to those for group insurance.

1.13 MEASURES REQUIRED FOR PAYMENT

An insurance event must be reported and payment of compensation requested as soon as possible. Reports should be made online via Bliwa's website or on the form provided by Bliwa.

The documents and other information that Bliwa considers are necessary to assess the insured's right to insurance compensation must be submitted to Bliwa. Bliwa does not compensate any costs for arranging this. If required for Bliwa to be able to assess the right to insurance compensation, and if Bliwa so requests, the insured shall submit an authorisation so that Bliwa can obtain information from the policyholder, insured, employer or other group representative, physician, hospital, other care establishment, the Swedish Social Insurance Agency or another insurance establishment. If the insured does not submit such an authorisation, Bliwa may refuse to pay insurance compensation. Clause 10 describes how Bliwa processes the information obtained.

In the event of sickness or an accident, the insured shall seek health and medical care as soon as possible and comply with the instructions provided by the care provider, the Swedish Social Insurance Agency and Bliwa. If Bliwa so requests, the insured shall agree to be examined by a physician appointed by Bliwa at the expense of Bliwa.

If the insured does not assist in the manner described above, the benefit that would otherwise have been paid will be reduced according to what is reasonable considering the circumstances.

1.14 DATE OF PAYMENT

When Bliwa has established that an insurance event has occurred and the person requesting compensation has presented or assisted with the investigation in the manner that may reasonably be requested to enable Bliwa to determine its payment obligation and the person to whom payment should be made, the insurance event is to be settled speedily through Bliwa paying compensation.

1.15 INTEREST ON LATE PAYOUT OF BENEFIT

Bliwa will pay interest under Section 6 of the Interest Act (1975:635) on a sum insured that has not been paid on time according to these insurance conditions. The right to interest applies if the delay in payout was more than 30 days. Bliwa is not responsible for other losses that may arise if investigation of the insurance event or payment of the insurance compensation is delayed. Interest for delay is not paid if the delay is due to an event in the nature of *force majeure*; see Sub-clause 9.7.

Irrespective of whether or not payment was delayed, Bliwa may pay interest on a death benefit or lump-sum benefit that has fallen due for payment but remains under Bliwa's administration. The right to interest then applies from and including one month from when the sum insured should have been paid. The rate of interest that is then applied is the reference interest rate less two percentage points and, when applicable, reduced by the notional yield tax that Bliwa must pay in respect of such amount. This interest is deducted from the interest for delay. No interest is payable if the aggregate interest amount for the sum insured referable to the same insurance event is less than 0.5 per cent of the price base amount for the year in which the sum insured was paid.

1.16 TIME LIMIT

A party who wishes to receive insurance compensation or other insurance cover must institute proceedings against Bliwa within ten years from the date on which the circumstance in respect of which the insurance agreement affords a right to such cover occurred.

If a party who wishes to have insurance cover has presented a claim to Bliwa within the period prescribed by the first paragraph, the time limit to institute proceedings is always at least six months from when Bliwa has given notice of the final position it has adopted on the claim.

The right to insurance cover will lapse if proceedings are not instituted in accordance with this clause.

1.17 DEALINGS WITH THE INSURANCE

The insured may not transfer or pledge the insurance. Dealings in violation of this provision are ineffective.

1.18 RULES FOR ALLOCATING SURPLUSES AND COVERING LOSSES

If a surplus should arise in Bliwa's insurance operations, the annual gain will be appropriated to a 'consolidation reserve'; see Sub-clause 1.18.1. However, it is not necessary for all surpluses to be appropriated for consolidation but they may instead be distributed to the policyholders through a bonus, in the first instance in the form of a reduction of future premiums. If a deficit should arise in the operation, an appropriation from Bliwa's consolidation reserve may be made to cover the loss.

Any decisions on appropriations from the consolidation reserve to cover losses or for a bonus from the surplus will be made by Bliwa's general meeting in accordance with Bliwa's Articles of Association and also Bliwa's Technical Guidelines and Technical Data for Calculations applicable at any given time. Both Bliwa's Articles of Association and the Technical Guidelines and Data for Calculations may be amended in the future as regards the right to any surplus.

HOW THE CONSOLIDATION RESERVE MAY BE USED

According to Bliwa's Articles of Association, the company's consolidation reserve may be used to cover losses, to allocate bonuses to the policyholders or to make donations for the public benefit or comparable purposes. The Articles of Association may be amended in the future as regards how the consolidation reserve is to be used.

1.19 AMENDMENT OF THE INSURANCE CONDITIONS

Bliwa is entitled to amend these insurance conditions during an ongoing insurance period if an amendment is needed owing to the nature of the insurance or owing to some other special

circumstance such as, for instance, amended law, application of law or official regulation. An amendment that may need to be made owing to the nature of the insurance may, for example, be due to an amendment to a collective agreement forming the basis of the insurance. An amendment that is due to an amended law, application of law or official regulation, and trivial amendments, may start to apply immediately. Other amendments start to apply one month after Bliwa notified the amendment. Bliwa is also entitled to apply new insurance conditions in connection with renewal of the insurance.

1.20 REPRESENTATION SYSTEM

Bliwa Livförsäkring is a mutual insurance company. This means that the company is owned by its policyholders and that it is normally the policyholders that decide on the company's affairs. Bliwa has a representation system whereby the powers to make decisions are exercised by special delegate members appointed at Bliwa's general meeting. According to Bliwa's Articles of Association, half of the delegate members are appointed through direct election by the policyholders of Bliwa together with a small number of named organisations entitled to each appoint one delegate member. The other half of the delegate members are appointed by those customers of Bliwa who have paid the highest premiums during the immediately preceding financial year.

More information about the representation system, election of delegates and the general meeting of the company is available at *bliwa.se*.

2. Life insurance – death benefit

This insurance product provides for an amount to be paid to the insured's beneficiary if the insured dies during the term of the insurance. This insurance product always includes insurance in the event of a child's death; see Sub-clause 2.4.

The exact scope of the insurance is shown in each group agreement and also in Bliwa's application documents and the insurance statement issued. The date of the insurance event is the date on which the insured died.

Death benefit is paid out if the insured dies during the term of the insurance. The sum insured is set in the group agreement and shown in the application documents and insurance statement issued. The sum insured is normally reduced in pace with the age of the insured. However, this does not apply if the insured has children entitled to inherit who are under the age of 20 on the date of death. The application documents and the insurance statement issued include information about when and by how much the sum insured is reduced.

2.1 OPTION ENTITLEMENT IN LIFE INSURANCE

It is agreed in the group agreement whether an option entitlement is to be included. The application documents indicate whether an option entitlement has been included. The following applies for an option entitlement, unless otherwise agreed in the group agreement:

'Option entitlement' in life insurance means that the policyholder, in the event of a particular family event and once (1) a year, upon certification of full work capacity, is entitled to increase the sum insured by one (1) level. Under some group agreements a maximum amount for the option entitlement applies, in which case this is shown in the special application document.

The possibility of exercising an option entitlement applies one year from the particular family event having occurred and before the insured attains the age of 60.

The particular family events that afford a right to exercise an option entitlement are if the insured enters into a cohabitation relationship, gets married, has a child entitled to inherit or receives a child with the intention to adopt the child. To exercise your right to an option entitlement, 12 months also must have passed since this entitlement was last exercised. The policyholder (group member) is the person who applies to increase the sum insured.

2.2 INDEXATION OF LIFE INSURANCE SUBJECT TO A PREMIUM WAIVER

During the period of entitlement to a premium waiver, the sum insured for life insurance is adjusted annually in relation to changes in the price base amount under the Social Insurance Code. Reductions of the price base amount are taken into full account. However, the sum insured for life insurance may not be increased by any more than ten per cent in any one year. Indexation ceases when the insured attains the age of 65.

2.3 NOMINATION OF BENEFICIARIES FOR GROUP LIFE INSURANCE

Beneficiaries of the death benefit are, unless a written nomination has been reported to Bliwa:

- in the first instance, the insured's husband, wife or cohabitee
- in the second instance, all of the insured's children entitled to inherit

- in the third instance, the insured's heirs.

Beneficiaries can waive their rights completely or in part. The person(s) next in priority in the nomination of beneficiaries then become(s) a beneficiary instead. Waivers should be made before the beneficiary may be deemed to have taken possession of the benefit they acquired and before an estate inventory has been submitted to the Swedish Tax Agency.

A nomination for the benefit of a husband or wife ceases to apply when an application for divorce has been received by a court, unless it is indicated by the circumstances that the insured had a different intention.

In the event that heirs are nominated, the sum insured will be allocated in accordance with the rules of the Inheritance Code.

However, the insured can notify Bliwa of a different nomination of beneficiary through a personally signed written communication (separate nomination of beneficiaries). The insured is at liberty to choose who should be a beneficiary by such a nomination. A standard form for a separate nomination of beneficiaries can be printed out from Bliwa's website bliwa.se or ordered from Bliwa.

The nomination of beneficiaries cannot be amended through a will.

No payout will be made under the insurance if there are no beneficiaries.

2.4 LIFE INSURANCE – DEATH BENEFIT – CHILDREN

Life insurance – death benefit – children is included as part of life insurance – death benefit, unless otherwise agreed in the group agreement and shown in the insurance statement and, when applicable, application documents. Children, who are entitled to inherit from a person who is insured with 'life insurance – death benefit', are insured under 'life insurance – death benefit – children'. Still-born children who died after the end of the 22nd week of pregnancy are equated to children entitled to inherit.

The insurance means that if an insured child under the age of 20 dies during the term of the insurance, the sum insured is paid out to the child's estate.

Benefits can only be paid out once per child and agreement. The sum insured is one price base amount.

The insurance applies for at most up to and including the month in which the child attains the age of 20 (age at expiry for the insurance). If the insured group member's life insurance ceases to apply prior to this, the child's insurance also ceases to apply. The same applies to children of a co-insured, if the co-insured's insurance ceases to apply.

3. Lump-sum benefit

A lump-sum benefit is paid as a single payment if the insured suffers an incapacity to work as a consequence of sickness or an accident and is granted at least 25 per cent sickness compensation, or similar compensation for permanently reduced capacity to work as a consequence of sickness or accident, by the Swedish Social Insurance Agency, or alternatively has had an impaired work capacity during the term of the insurance for a consecutive period of three years or a total of three years over a five-year period. In the event of impaired work capacity for three years, it is also required that the Swedish Social Insurance Agency has granted the insured at least 25 per cent sickness benefit, or similar compensation for reduced capacity to work as a consequence of sickness or accident. For benefits as a consequence of sickness benefit from the Swedish Social Insurance Agency, the lump-sum benefit is based on the lowest level of sickness benefit that has applied for 11 of the last 12 months before the right to receive benefits arose.

Entitlement to a lump-sum benefit also requires the insured to have been fully capable of working for the last three months before the insurance started to apply or that the insured has subsequently been fully capable of working for at least three consecutive months during the term of the insurance.

The sum insured is set in the group agreement and shown in the application documents and insurance statement issued. The sum insured is reduced in pace with the age of the insured. The reduction (decrease) of the sum insured is set in the group agreement and is also shown in the application documents and the insurance statement issued. Benefits will be paid out corresponding to 25, 50, 75 or 100 per cent work incapacity. Benefits are based on the full sum insured for 100 per cent work incapacity, on half the sum insured for 50 per cent work incapacity, and so on. The size of the benefit is calculated as a percentage of the insured's sum insured that applied for the month before the right to a lump-sum benefit arose considering the level of work incapacity and also the age of the insured.

An insured previously entitled to a full lump-sum benefit from Bliwa at some time previously cannot be paid a lump-sum benefit again under the same

group agreement or continuation insurance as a consequence of this group agreement.

An insured who previously received a partial lump-sum benefit may receive an additional lump-sum benefit if they subsequently become incapable of working during the term of the insurance to a higher extent and if the Swedish Social Insurance Agency decides for this reason to grant the insured a higher level of sickness compensation or sickness benefit. For benefits based on a higher level of sickness benefit, the insured is required for a consecutive period of 11 of the past 12 months, before the right to additional benefits arose, to have had a higher level of work incapacity and have been granted a corresponding level of sickness benefit from the Swedish Social Insurance Agency.

The size of this additional lump-sum benefit is calculated as a percentage of the sum insured for one (1) full lump-sum benefit applicable to the insured when entitlement to the new payment arises. Bliwa takes into account previous payments of lump-sum benefit when paying such extended lump-sum benefit. No more than one (1) full lump-sum benefit can be made in total.

The date of the insurance event is the date on which the insured is entitled to payment of a lump-sum benefit.

A lump-sum benefit is paid upon a request from the insured.

The age at expiry for the insurance is set in the group agreement and shown in the application documents and insurance statement issued.

3.1 TRANSITIONAL RULE FOR THE LUMP-SUM BENEFIT

New rules for the lump-sum benefit apply from and including 1 January 2015.

To satisfy the requirements for entitlement to a lump-sum benefit, the period of work incapacity for which the Swedish Social Insurance Agency has granted sickness benefit is counted at the earliest from and including 1 January 2015. The period of work incapacity for which sickness benefit was granted prior to 1 January 2015 cannot thus be counted in the consecutive three years or total of three years over a five-year period.

4. Health insurance

Health insurance can only be taken out by a group member unless otherwise agreed in the group agreement and shown in the application documents.

Health insurance may entitle the insured to a monthly benefit if the insurance event occurs during the term of the insurance. A payment is made from the health insurance upon a request from the insured. The insured must have suffered lost income for the monthly benefit to be paid from the health insurance. This lost income should be based on an incapacity to work due to sickness or an accident that occurred during the period when the insurance applied (term of the insurance).

The monthly benefit is paid to the insured in the event of a long-term incapacity to work that they have suffered as a consequence of sickness or an accident. A precondition for the right to benefits is, among other things, that the Swedish Social Insurance Agency has granted the insured sickness benefit, sickness compensation or activity compensation. The insurance applies at the sums insured, benefit periods and qualifying periods agreed in the group agreement and shown in the application documents and insurance statement issued.

The monthly benefit from the health insurance shall compensate lost income for the insured as a consequence of an incapacity to work owing to sickness or an accident. A lump sum may also be paid if the insured is given certain diagnoses. The insured must personally apply for compensation under the insurance. This means that if the insured has died, their survivors cannot apply for compensation under the health insurance.

4.1 ASSESSMENT OF WORK CAPACITY

Bliwa's decision to grant a monthly benefit under these insurance conditions is based primarily on a decision made by the Swedish Social Insurance Agency about the insured's incapacity to work. However, Bliwa may decide to make its own assessment of the insured's incapacity to work and consequently make a different decision to the Swedish Social Insurance Agency if there are special reasons to do so. In such a case, the benefit will be based on the incapacity to work that Bliwa has assessed that the insured has suffered.

In the event of sickness or an accident, the insured shall seek health and medical care without delay and comply with the instructions provided by this care provider, the Swedish Social Insurance Agency and Bliwa. If Bliwa so requests, the insured must agree to be examined by a physician appointed by Bliwa at the expense of Bliwa.

If the insured does not assist in the above-mentioned way, the benefit that would otherwise have been paid will be reduced according to what is reasonable considering the circumstances.

4.2 WHEN HEALTH INSURANCE CEASES TO APPLY

The age at expiry for the insurance has been agreed in the group agreement and shown in the application documents and insurance statement issued.

4.3 MONTHLY BENEFIT UNDER HEALTH INSURANCE

The insured must have suffered at least 25 per cent incapacity to work during the term of the insurance as a consequence of sickness or an accident in order to be entitled to a monthly benefit from the health insurance. There is also a requirement for the Swedish Social Insurance Agency to have granted the insured sickness benefit (or corresponding benefit) as a result of the sickness or accident.

An insurance event is deemed to have occurred on the date on which the sickness period started.

4.3.1 AMOUNT OF BENEFIT

Benefits under health insurance will be paid as a monthly amount, the size of which depends on the insured's level of incapacity to work and the sum insured taken out. The amount that the insured is entitled to receive for full (100 per cent) incapacity to work is shown in the insurance statement issued.

If the insured's incapacity to work increases after the insurance ceased to apply and the increased incapacity to work does not have a direct medical link with the previous sickness or accident, the increased level of incapacity to work does not afford entitlement to benefit under this insurance. Nor is there any entitlement to benefit after the agreed benefit period or after having attained the age at expiry.

Irrespective of the insured's level of incapacity to work, one full day is deducted from the benefit period for each day that the insured is entitled to, and receives, benefits under the insurance. One month always corresponds to 30 days when calculating benefits. Benefits are paid monthly in arrears.

4.3.2 QUALIFYING PERIOD

The monthly benefit from Bliwa's health insurance is paid after the qualifying period has expired. The length of the qualifying period is agreed in the group agreement and shown in the application documents and insurance statement issued.

4.3.3 SHORTENED QUALIFYING PERIOD

If the insured has had a period of sickness and within 12 months becomes incapable of working again, by at least a quarter, the qualifying period for the new sickness period is shortened by as many days as correspond to those, if any, of the insured's sickness periods that exceed 15 days and that completely or partly fall within the last 12 months. However, a precondition for this is that the new sickness period lasts for at least 15 days and occurs during the term of the insurance.

The insured can only be accredited time for a shortened qualifying period for sickness periods that have arisen while the insured was covered by Bliwa's insurance and that have not been compensated under collective agreements or other corresponding insurance.

4.3.4 BENEFIT PERIOD

Benefits will be paid out for as long as the sickness period lasts, though at most for the period agreed in the group agreement (benefit period). If the insured attains the age at expiry for the insurance before benefits have been paid for the entire benefit period, the payments and the insurance shall cease on the date on which the age at expiry is attained. The length of the benefit period is shown in the insurance statement. If the insured becomes capable of working after a shorter period than the maximum possible benefit period, the remaining benefit days may be used for a subsequent sickness period that occurs within 12 months. This applies subject to the precondition that the insured is still covered by the insurance.

The insured is entitled to further compensation under the insurance in the event of a new sickness period if benefits have been paid for the entire benefit period and the insured is subsequently fully capable of working for more than 12 months, provided the insured is still covered by the insurance. Any new sickness period should then be regarded as a new insurance event. This means, among other things, that a new qualifying period applies before benefits can start to be paid.

4.3.5 LIMITATION OF BENEFIT PERIOD

The benefit period is limited if the insured for the last two years prior to the health insurance starting to apply has been incapable of working for more than 30 consecutive days and, after the insurance entered into force and before it had applied for two years, becomes incapable of working again owing to the same sickness or accident. The insured may receive benefits for at most the same number of days that they have been healthy between the two sickness periods. If there are several previous periods that result in the limitation becoming applicable, the period is counted from the last sick day of the last sickness period.

This limitation to the benefit period also applies if the incapacity to work is only partly due to the previous sickness or accident.

4.3.6 OVERINSURANCE

Bliwa will never pay benefits as a consequence of incapacity to work at an amount whereby the insured receives overall an amount exceeding their actual pay after tax. Bliwa will not pay any benefits if the insured already receives other insurance compensation as a consequence of incapacity to work at a level of benefit that exceeds the above-mentioned level. The insured is obliged to inform Bliwa about any other insurance benefits or compensation received in conjunction with the claims report/request for payment. If Bliwa does not pay out benefits as a consequence of this provision, Bliwa will repay to the insured premiums already paid for up to the past twelve months.

4.3.7 INDEXATION OF MONTHLY BENEFITS UNDER HEALTH INSURANCE

An agreement is made in the group agreement as to whether or not indexation is included. This is also indicated by the insurance statement issued.

Indexation means that benefits under the health insurance are adjusted to changes in the price base amount under the Social Insurance Code. The monthly benefit from the health insurance is indexed annually on 1 January by adjusting the benefit amount to the percentage change in the price base amount since the benefit amount was last determined. Full account is taken of reductions in the price base amount, while increases are considered up to a maximum of ten per cent for any individual year. Indexation takes place annually for as long as payment from the health insurance is ongoing. Indexation ceases when the insured attains the age of 65.

4.3.8 OPTION ENTITLEMENT IN HEALTH INSURANCE

It is agreed in the group agreement whether an option entitlement is to be included. The application documents indicate whether an option entitlement has been included. The following applies for an option entitlement, unless otherwise agreed in the group agreement:

’Option entitlement’ in health insurance means that the policyholder, in the event of the insured’s pay rise and once (1) a year, is entitled to increase the sum insured by one (1) level upon certification of full work capacity.

An option entitlement applies if the application for an increase is submitted to Bliwa within three months from the latest of the following two points in time:

a) when the insured became aware of the change in income,

b) when the new income started to apply.

To exercise your right to an option entitlement, 12 months also must have passed since this entitlement was last exercised. The policyholder (group member) is the person who applies to increase the sum insured.

5. Medical invalidity in the event of sickness

The insurance for medical invalidity in case of sickness may provide the insured with financial support in the event of sickness that has resulted in an impaired physical or mental functional capacity (‘medical invalidity’) and also for scars and other appearance-related consequences of an injury.

5.1 TERM OF VALIDITY

This insurance product applies in the event of sickness that occurs during the term of the insurance. The insurance applies full-time, that is to say, around the clock.

5.2 DEFINITION OF THE TERM ‘SICKNESS’

In these conditions, ‘sickness’ means a deviation from normal health status that requires health and medical care and is not to be regarded as an accidental injury in accordance with the definition contained in the personal accident insurance. Sickness is deemed to have occurred when the insured’s physical or mental functional capacity has manifestly deteriorated owing to the sickness. ‘Sickness’ does not mean a bodily injury caused voluntarily.

5.3 LIMITATIONS AS REGARDS SICKNESS, ETC.

The insurance does not cover sickness, bodily defect or mental illness, or the consequences of such conditions, where the symptoms manifested themselves before the insurance started to apply. This applies even if a diagnosis can only be made after the insurance started to apply.

This insurance only pays benefits for consequences that have an adequate connection to a sickness that required treatment within the health services. There is never entitlement to benefits for an invalidity that existed before the insurance entered into force.

5.4 RESERVATION CLAUSES

The insurance may sometimes be granted subject to a reservation clause if Bliwa receives information about your health whereby the risk of future ill health is so high that Bliwa considers that the insurance

could not otherwise be granted. The grant of insurance subject to a reservation clause means that it provides cover with an exclusion for consequences originating from the injury, symptom or sickness that has been excluded. The clause will in such a case be communicated through a separate letter, which constitutes part of your insurance statement.

5.5 SCOPE OF THE INSURANCE

- The insurance can provide the following compensation as a consequence of sickness:
- Scars and other appearance-related consequences of an injury – see Sub-clause 5.6
- Medical invalidity - see Sub-clause 5.7.

5.6 COMPENSATION FOR SCARS AND OTHER APPEARANCE-RELATED CONSEQUENCES OF AN INJURY

The insurance compensates scars and other appearance-related consequences of an injury as a result of a sickness that occurred during the term of the insurance. Compensation is only paid after treatment has been completed and when the scar or appearance-related consequence of the injury is considered to be permanent for the future, though no earlier than one year after the sickness happened. Bliwa compensates scars that are considered to be at least of the category *very noticeable* according to the Traffic Injuries Commission’s compensation table for appearance-related consequences of injuries. The amount of the compensation is determined independently of the chosen sum insured for invalidity.

A precondition for entitlement to compensation is that the sickness was so serious that it required treatment within the health services.

5.7 BENEFIT IN THE EVENT OF MEDICAL INVALIDITY

The insured is entitled to benefits in the event of invalidity if the sickness resulted in a permanent impairment of the insured’s bodily function as confirmed by a physician.

Benefits are paid out when the level of invalidity has been finally determined by Bliwa.

Medical invalidity is a confirmed physical or mental impairment, irrespective of the insured’s profession, working conditions or leisure interests. Medical invalidity also includes loss of an internal organ and loss of a sensory function. It should be possible to determine the impairment objectively.

A precondition for entitlement to benefits is that the sickness was so serious that it required treatment within the health services.

Bliwa pays benefits for medical invalidity if the insured has suffered a sickness that has resulted in a permanent impairment of a bodily function and if the condition is stationary but not life-threatening.

The sickness must have resulted in a measurable invalidity within three years from when the sickness is deemed to have occurred for the insured to be entitled to benefits. Medical invalidity cannot normally be finally determined until one year has elapsed from the date when the sickness manifested itself. A final assessment of entitlement to benefits shall only be made when the level of invalidity has been finally determined, which may be postponed for as long as there is a possibility of further medical rehabilitation.

Bliwa will never pay more than the sum insured for 100 per cent invalidity even if the sickness has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent. If a lost body part can be replaced by a prosthesis, the level of invalidity will be determined considering the prosthesis and its importance to the bodily function of the insured.

The level of invalidity is determined with the guidance of the applicable industry rating scale at the time of payment.

AMOUNT OF THE INVALIDITY BENEFIT

The amount of the sum insured for voluntary group insurance is specified in the insurance application. The sum insured for compulsory group insurance is specified in the group agreement. The amount of the sum insured is also specified in the insurance statement issued when the insurance was taken out and subsequently if there is a significant change to the insurance conditions, for example, through the insurance protection being limited.

LIMITATION TO THE AMOUNT OF THE SUM INSURED – REDUCTION

If the insured had attained the age of 55 at the time of the injury, the sum insured for medical invalidity is reduced by 5 percentage points for each year by which the age of the insured exceeds 54. This applies unless otherwise indicated by the insurance statement.

Benefits are paid out in proportion to the level of invalidity and the sum insured.

5.8 PAYMENT OF INVALIDITY BENEFITS

The sum insured is determined by the price base amount applicable for the year in which Bliwa provides the benefit.

The claim will only be finally settled when the medical invalidity has been finally determined. However, an advance payment of invalidity benefit may be paid out prior to this. This advance will correspond to the minimum level of invalidity expected. The advance, expressed in Swedish kronor, will subsequently be deducted from the benefit paid out when the level of invalidity has been finally determined.

If the insured dies before Bliwa has finally settled the claim, and the invalidity was determined by Bliwa prior to this, an amount will be paid out corresponding to the insured's medical invalidity. The payment will be made to the insured's estate.

5.9 POSSIBILITY TO REVIEW BENEFITS IF INVALIDITY INCREASES

The insured is entitled, following a written request to Bliwa, to have their level of invalidity reconsidered if the injury has resulted in the insured's bodily function having deteriorated significantly after Bliwa has finally settled the claim.

Bliwa will reconsider the level of invalidity if the insured requests this in writing and provides details of the circumstances that, according to the above, may afford entitlement to reconsideration. In order to make a new assessment of the level of invalidity Bliwa requires that the circumstances supporting such new assessment can be determined objectively. Bliwa decides what supporting information is required for such an objective assessment. The insured must personally furnish Bliwa with the supporting information requested by Bliwa. The insured shall pay for the cost of any new invalidity certificate. However, Bliwa will subsequently pay compensation for such new invalidity certificates if a deterioration of the insured's bodily functions has actually been objectively demonstrated and a new level of invalidity determined. A reconsideration may never be conducted when more than ten years have elapsed from the date of the accident or the date on which the sickness manifested itself; see Sub-clause 1.16 above.

6. Critical illness insurance

Benefits under Bliwa's critical illness insurance will be paid as a lump sum if the insured is diagnosed with any of the diagnoses or suffers any of the events shown in Sub-clause 6.4 during the term of the insurance. The insured must personally apply for benefits under the insurance. This means that if the insured has died, the survivors cannot apply for benefits under the critical illness insurance.

6.1 IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFIT

If any of the indemnifiable diagnoses had already been made for the insured before the insurance entered into force, they are not entitled to benefits under the insurance in the case that they become sick with the same diagnosis (for example breast cancer (malignant neoplasm of breast: C50)) during the term of the insurance. The same applies to consequential sicknesses, spread of a sickness (e.g. metastasization), complications following a sickness or operation and other consequences of a diagnosis for which the insured person was diagnosed before the insurance entered into force.

The above also applies to a diagnosis for which Bliwa has paid benefits to the insured during the term of the insurance with Bliwa.

If the insured is undergoing examination for a certain diagnosis at the time the insurance is taken out, he or she is not entitled to benefits for such a diagnosis even if it is made after the insurance has entered into force.

No benefits are paid if the insured dies within seven days of the diagnosis having been made.

Benefits are only paid for one diagnosis of the same kind. If the insured has already received benefits for a diagnosis, it is not possible to receive benefits for a new diagnosis under the same item. However, in the case of cancer, benefits are paid for a different kind of primary cancer that is not connected to the previous cancer diagnosis. Benefits can be paid for no more than three different diagnoses during the period the insurance applies. See also special limitations under each diagnosis/event. Benefits are paid according to either item 13 or 14 (i.e. not according to both of these items) in respect of the failure of kidney function or transplantation of a kidney.

The date of an insurance event is the same as the date on which the diagnosis was made or the operation performed.

Benefits are only paid for the diagnoses specified in Sub-clause 6.4

6.2 BENEFIT

Entitlement to benefits under the insurance arises no earlier than seven days after:

- the diagnosis was made (items 1 to 9 and 14 to 19 of 6.4)

- the operation was performed (items 10 to 13 of 6.4).

Entitlement to benefits requires the diagnosis to have been made or confirmed by a physician in Sweden or the operation to have been performed by a physician in Sweden.

6.3 AMOUNT OF BENEFIT

Benefits under the insurance will be paid as a lump sum. The amount of the benefit is set in the group agreement and is also shown in the application documents and last insurance statement issued.

6.4 DIAGNOSES AND EVENTS THAT AFFORD ENTITLEMENT TO BENEFITS

1. Cancer
A malignant tumour characterised by the uncontrolled growth of cells and invasion of surrounding tissue. Leukaemia is also covered. Skin cancer, which is classed as a malignant melanoma, is also covered. The insured is required to be registered with the Swedish Cancer Registry to be entitled to benefits.

The following conditions are not covered by the insurance:

- preliminary stage of cancer (non-invasive cancer *in situ*)
- all skin cancer other than that specified above
- secondary tumours (metastases). Benefits may in certain cases be paid for metastases in those cases where it was not possible to localise the primary tumour.

2. Acute heart attack
An electrocardiogram (ECG) and/or elevated heart markers as laboratory tests are required to have demonstrated clear changes to an ongoing or recently suffered myocardial infarction (heart attack). Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

3. Stroke
A cerebrovascular (blood clot or haemorrhage) accident (CVA). The term ‘cerebrovascular accident’ includes thromboses, embolisms and ruptures of blood vessels in the brain. Exemptions from entitlement to benefits apply for Transient Ischaemic Attacks (TIA) and Reversible Ischaemic Neurologic Deficit (RIND).

4. Motor neurone disease
Progressive paralysis as a consequence of motor neurone disease – for example, amyotrophic lateral sclerosis (ALS). Entitlement to benefits requires that a diagnosis has been made by a physician.

5. Multiple sclerosis (MS)
A diagnosis made by a physician after more than one episode of neurological impact that demonstrated well-defined neurological disease confirmed by recognised investigation methods at the time of the insurance event affords entitlement to benefits.

6. Parkinson’s disease
The diagnosis must have been made according to the diagnostic criteria applicable at any given time. Entitlement to benefits requires that there is a permanent impact on the motor function that is typical of Parkinson’s disease.

7. Neuroborreliosis
Neuroborreliosis as a consequence of a tick bite. The diagnosis should be made after borrelia-specific antibodies have been detected in the cerebrospinal fluid or in the blood. Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

8. Bacterial meningitis
Entitlement to benefits requires that the diagnosis has been made through the presentation of bacteria in the insured’s blood or spinal fluid. The spinal fluid shall include clear signs of an inflammatory reaction. Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

9. Tick-borne encephalitis (TBE)
Entitlement to benefits requires that the diagnosis has been made after TBE-specific antibodies have been detected in the insured’s cerebrospinal fluid or blood. Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

10. Coronary bypass operation
Coronary bypass operation carried out where a heart-lung machine was used to maintain the insured’s blood circulation during the operation. Entitlement to benefits requires at least one of the heart’s coronary vessels, owing to narrowing or obstruction, to have been replaced by a new artery or vein for the heart muscle’s supply of blood (by-pass grafting). No other method affords entitlement to benefits.

11. Operation for aortic stenosis or aneurysm
Surgical replacement of an aorta or a segment of an aorta.

12. Heart valve surgery
Operation on one or more heart valves through open heart surgery.

13. Organ transplant
Heart, liver, lungs, pancreas, kidney or bone marrow transplant received. The insurance does not cover the organ donor. Autologous bone marrow transplant does not afford entitlement to benefits. Benefits for kidney transplantation are not paid if the insured has received benefits in accordance with item 14 for the same insurance event.

14. Kidney failure
The failure of both kidneys. Use of peritoneal dialysis or haemodialysis or a kidney transplant is a medical necessity. The date on which such dialysis starts corresponds to the date on which the diagnosis was made. Benefits are not paid if the insured has received benefits for kidney transplantation in accordance with item 13 for the same insurance event.

15. Deafness
Entitlement to benefits requires the insured to have suffered a permanent loss of hearing in both ears that has resulted in total loss of hearing.

16. Blindness
Entitlement to benefits requires the insured to have suffered a complete and permanent loss of sight in both eyes.

17. Loss of arm or leg
Entitlement to benefits requires loss of an arm above the wrist or leg above the ankle.

18. Loss of speech
Entitlement to benefits requires that the insured has suffered a total and permanent loss of speech as a consequence of physical damage to vocal cords.

20. Paralysis
Entitlement to benefits requires that the insured has suffered complete and permanent paralysis of one or both arms or one or both legs.

7. Personal accident insurance

Personal accident insurance can provide the insured with financial compensation in the event of an accident that has resulted in costs or caused invalidity. This insurance product covers, for example, medical costs, travelling costs, costs for rehabilitation and aids and costs for crisis therapy. A maximum benefit amount applies for some injuries/costs.

An insurance event is deemed have occurred on the date of the accident.

7.1 TERM OF VALIDITY

This insurance product covers accidental injury that occurs during the term of the insurance. The insurance may be taken out on a full-time or leisure-time basis. The scope applicable is indicated by the application documents and insurance statement. Injuries that have occurred at work or on the way to or from work must be reported to the Swedish Social Insurance Agency. If the insured is covered by industrial injuries insurance (for example, work injury insurance for private employees (TFA), work injury insurance for employees of municipal, county and regional authorities, the Church of Sweden and certain municipally-owned companies (TFA-KL) or compensation for Personal Injury Agreement work injury insurance for government employees (PSA)), the injury should also be reported to AFA Försäkring; see also 7.3.1.

7.2 DEFINITION OF THE TERM ‘ACCIDENT’

An accident that affords entitlement to compensation under this insurance product must have comprised an external event. The accident must also have been caused by a sudden and unexpected event that resulted in the insured involuntarily suffering a bodily injury. The person making the claim for benefits must prove that an accidental injury has occurred.

A precondition for entitlement to benefits in the case of an accidental injury is that the injury is so serious that it requires treatment within the health services.

INJURIES EQUATED TO ACCIDENTAL INJURY

Bodily injury that has arisen through frostbite, heatstroke, sunstroke, borrelia infection and TBE owing to a tick bite is equated to accidental injury. The date on which such injury presented itself is deemed to be the date of the accidental injury. The rupture of an Achilles tendon or knee twist injury is also equated to an accidental injury without a requirement regarding an external event.

INJURIES THAT ARE NEVER DEEMED TO BE AN ACCIDENTAL INJURY

Only injuries that satisfy the preconditions of Sub-clauses 7.2 and 7.2.1 are ‘accidental injuries’. Accidental injuries therefore do not include, for example, a bodily injury that has arisen through the insured intentionally having injured themselves or having demonstrated manifest indifference to the risk of getting injured. Nor do they include injuries that have arisen through, for example:

- overexertion or repetitive movements (repetitive strain injury), stretching, twisting or pathological changes
- infection through bacteria, viruses or other contagion, infection or poisoning through ingesting food or drink or hypersensitivity reaction
- use of medicinal preparations, operations, treatment or examinations that have not resulted

from an accidental injury covered by this insurance

- nuclear explosion or radiation (nuclear reaction).

7.3 SCOPE OF THE INSURANCE COMPENSATION

Unless otherwise agreed in the group agreement or shown in the insurance statement, benefits may be provided for the following items:

- medical costs – see Sub-clauses 7.3.1 and 7.4.1
- costs for dental injuries – see Sub-clauses 7.3.1 and 7.4.2
- travelling costs – see Sub-clauses 7.3.1 and 7.4.3
- additional costs – see Sub-clauses 7.3.1 and 7.4.4
- costs for rehabilitation and aids – see Sub-clauses 7.3.1 and 7.4.5
- costs for crisis therapy/psychology services – see Sub-clauses 7.3.1 and 7.4.6
- compensation for pain and suffering – see Sub-clause 7.5
- compensation for scars and other appearance-related consequences of an injury – see Sub-clause 7.6
- compensation for defect and disablement – see Sub-clause 7.7
- invalidity – medical or financial invalidity– see Sub-clause 7.8 including sub-headings
- compensation for waiting – see Sub-clause 7.9
- death benefit – see Sub-clause 7.10.

Limitations to amounts and other limitations to the size of the benefit amount are specified below.

IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFITS

This insurance product only pays benefits for consequences that have an adequate connection to an accidental injury that required treatment within the health services. If the insured's health status has deteriorated after the accident owing to a bodily defect that was either pre-existing at the time of the accident or subsequently arose and is unconnected to the accidental injury, no benefits are provided for the costs, the pain and suffering and/or the invalidity resulting from such deterioration in health status. Nor is death benefit provided in such a case. 'Bodily defect' means sickness, pathological change and also defect and disablement.

As regards compensation for costs, the insurance only compensates necessary and reasonable costs that the insured has incurred as a consequence of the accident. Bliwa does not compensate costs that should be compensated by another party according to law, statute, convention or collective agreement. Costs that have been compensated through other insurance are not compensated from this insurance. This applies irrespective of whether such compensation is paid according to a flat-rate model or against an original receipt. Nor does Bliwa compensate costs that are to be compensated under patient or healthcare insurance that has been taken out separately. If an accident occurred outside the insured's place of residence or abroad, the insurance does not compensate the costs compensated by separate travel insurance or a travel component of home insurance. This restriction and other important limitations that apply to the right to compensation in the case of an accident that occurred abroad are shown in Sub-clause 9.3.

Bliwa only compensates costs that can be verified by an original receipt. If the insured is not covered by the social welfare insurance and is not registered with the Swedish Social Insurance Agency, compensation is only paid for those costs that would have been compensated if they had been registered and had fully utilised the benefits provided under the social welfare insurance.

Benefits are not provided for lost income from work.

If the injury has been reported as an occupational injury, the insured must notify Bliwa of this as soon as possible. What is deemed to be 'work' and 'time for travel to or from work' are determined according to the definitions applied by the Swedish Social Insurance Agency and AFA Försäkring. If the injury has been classified as an occupational injury by the Swedish Social Insurance Agency or AFA Försäkring, Bliwa will not pay compensation for the costs, etc., as a consequence of an occupational injury for which compensation has been paid by the Swedish Social Insurance Agency or AFA Försäkring.

Benefits are not paid for both medical and financial invalidity. When financial invalidity benefits are paid, the amount is reduced corresponding to the amount previously paid for the same claim matter for medical invalidity.

There is never entitlement to benefits for an invalidity that existed before the insurance entered into force.

7.4 COMPENSATION FOR COSTS

MEDICAL COSTS

Compensation is paid for the cost of essential medical care, hospital care, treatment and aids

prescribed by a physician for treatment of the injury. Costs are only compensated for care or treatment up to the level of the Swedish high cost protection.

Compensation is only paid for the cost of care or treatment abroad if the accident occurred abroad; see Sub-clause 9.3 regarding when compensation is paid for accidents abroad.

Compensation is paid for medical costs if they have arisen within five years from the date of the accident. If the accidental injury resulted in medical invalidity but it was not possible for Bliwa to make a final settlement within five years, compensation is paid for medical costs until Bliwa has announced that a final settlement has been made. Compensation is never paid for costs that arise after the final medical invalidity benefit has been determined.

COSTS FOR DENTAL INJURIES
This insurance product does not compensate costs for a dental injury that has arisen as a consequence of chewing or biting.

Compensation is paid for the cost of essential treatment for dental injuries as a consequence of an accident. ‘Dental injuries’ also means damage to dental plates that were in the mouth when they were damaged. Treatment and costs of dental injuries must be approved by Bliwa in advance. However, compensation is paid for reasonable emergency treatment costs even if there was no time to obtain approval before treatment.

If there was already a need to treat teeth damaged in the accident at the time of the injury, Bliwa is entitled to make an appropriate reduction to the amount of the benefit.

Compensation is only paid for dental treatment expenses in Sweden if the treatment is covered by the dental care insurance under the Social Insurance Code. Compensation is not paid for the cost of implant treatment that is not covered by the dental care insurance. Compensation is only paid for the cost of treating damage to implants if this treatment is covered by the dental care insurance.

Compensation is paid for treatment costs within five years from the date of the accident.

For persons who, owing to their age, are entitled to free dental care, compensation is only paid for possible emergency treatment costs.

If treatment needs to be postponed to a later date owing to the insured’s age, because not all of the insured’s teeth are fully developed, compensation is paid for the cost of the postponed treatment if it is carried out before the insured has attained the age of 25. If the postponed treatment is carried out later, but before the insured has attained the age of 30, compensation is only paid for the cost of the postponed treatment subject to the precondition that Bliwa approved the postponed treatment before the insured had attained the age of 25.

No further compensation is paid if Bliwa has paid compensation for final treatment costs for a dental injury.

Compensation is only paid for the cost of treatment abroad if the accident occurred abroad; see Sub-clause 9.3 regarding when compensation is paid for accidents abroad.

TRAVELLING COSTS
Compensation is paid for travelling costs in conjunction with care and treatment prescribed by a physician to heal the injury.

Compensation is paid for reasonable additional travelling costs between the insured’s permanent home and workplace or school if the insured has to engage special means of transport to be able to carry out their ordinary professional work or schooling/employment training. However, compensation for additional travelling costs between a permanent home and normal workplace should be paid in the first instance by the employer or the Swedish Social Insurance Agency.

Compensation is paid for the cost of the least expensive means of travel that the insured’s health status allows. This need must be verified by a physician. Compensation is not paid for travel using a private, official or company car and the like where no additional costs have arisen.

Compensation is paid for travelling costs using their own car to and from care and treatment in accordance with the flat-rate model applicable at any given time that Bliwa has issued for this purpose.

Compensation is paid for the cost of trips made within five years from the date of the accident. However, if the accidental injury resulted in medical invalidity but it was not possible for Bliwa to make a final settlement within five years, compensation is paid for travelling costs until Bliwa has announced that a final settlement has been made. Compensation is never paid for costs that arise after the final medical invalidity benefit has been determined.

ADDITIONAL COSTS
Compensation is paid for the following items under general law of tort rules if the insured suffers a

bodily injury as a consequence of an accident that required treatment within the health services:

- Clothes normally worn and other personal belongings normally carried that were damaged in the course of the accident: spectacles/prescription lenses, wristwatches, plain wedding bands, handbag and helmet. Compensation is only paid for the cost of repair if it is possible to repair the damaged object. Compensation is paid for costs up to no more than 0.6 price base amounts in total unless otherwise indicated by a group agreement or insurance statement.
- Other unavoidable and reasonable additional costs that have arisen as a consequence of the accidental injury during the emergency treatment and healing period for the injury. Compensation is paid for costs up to no more than three price base amounts in total unless otherwise indicated by a group agreement or insurance statement.

Compensation is paid for destroyed clothes based on what equivalent clothes cost to buy at the time of the injury. If the clothes are more than one year old, an age deduction is made from the repurchase cost. Compensation for destroyed clothes is paid in accordance with the following table. ‘Clothes’ also means wristwatches and handbags in this context. The table shows compensation as a percentage of the repurchase price.

Age	0 to 1 year	1-2 years	2-3 years	3-4 years	4 years and older
Per cent	100	80	60	40	20

Compensation is paid for the cost of a pair of equivalent spectacles if the insured used spectacles that were destroyed at the time of the injury. The insured must send in a receipt for the purchase of new spectacles in order to receive compensation. Furthermore, the insured shall enclose a certificate from an optician proving that the new spectacles purchased were equivalent to the destroyed spectacles or enclose a receipt for the damaged spectacles.

Compensation can only be paid for additional costs that the insured incurs in their capacity as a private individual. Compensation is never paid for additional costs for a business activity.

‘Price base amount’ means the price base amount for the year in which the accident occurred.

COSTS FOR REHABILITATION AND AIDS
If an accidental injury entails a need for rehabilitation or special aids, compensation is paid for reasonable costs for this. Costs must have arisen after the emergency treatment period and must be approved by Bliwa in advance.

‘Rehabilitation’ means the care, treatment, training and re-education required to enable the insured to recover the best possible functional capacity and be able to live as normal a life as possible. Rehabilitation does not include treatment that aims to maintain functional capacity that was acquired after the accident (treatment maintenance). There should be a time limit for rehabilitation. Compensation is paid for the cost of the following rehabilitation measures:

- Care and treatment (maximum ten sessions) for which a treating physician has given a referral for the insured. In order to grant compensation Bliwa needs to see the referral and approve the care/treatment before it starts.
- Employability assessments, occupational rehabilitation and re-education. However, Bliwa does not pay compensation for the cost of training that increases the level of competence.
- Aids that are intended to increase the insured’s ability to move and reduce the risk of any future invalidity.

Unless otherwise indicated by a group agreement or insurance statement, compensation is paid for costs up to no more than two price base amounts in total for each insurance event. ‘Price base amount’ means the price base amount applicable for the year in which the rehabilitation started.

Compensation is not paid for the cost of rehabilitation if the need has arisen through an accident at work or harmful effect owing to work. Bliwa does not pay compensation for the cost of raising the standard of aids.

Compensation is never paid for costs that arise after the final medical invalidity benefit has been determined.

Compensation is only paid for the cost of rehabilitation abroad in the event that a Swedish national health service manager has approved and is largely funding the treatment.

COSTS FOR CRISIS THERAPY/PSYCHOLOGY SERVICES
Compensation is paid for the cost of treatment by a psychologist and travelling costs in conjunction with such treatment for an insured affected by a traumatic condition as a consequence of:

- an accidental injury for which there is an entitlement to benefits in accordance with these insurance conditions

- the death of a close relative (‘close relative’ means husband, wife, cohabitee, child and grandchild in these insurance conditions), including miscarriage
- robbery, threat or assault on the insured personally and that has been reported to the police
- rape or other sexual offences
- violence in the family
- involuntary unemployment for at least six months.

Bliwa only grants compensation subject to the precondition that the event occurred during the term of the insurance and the need for treatment arose within five years from when the event occurred. Bliwa should be contacted to approve the treatment before it starts. Bliwa will only approve treatment in Sweden. The insurance pays for no more than ten treatment sessions with a registered psychologist for each insured and injury.

The cost of therapy and psychology services is primarily only compensated for treatment within the national healthcare service. However, Bliwa may also grant the cost of therapy and psychology services within the private healthcare service if there are special reasons to do so.

The insurance product only covers therapy and psychology services as a consequence of trauma that affected the insured as a private individual during the term of the insurance. Compensation is not paid for the cost of treatment by a psychologist as a consequence of a traumatic condition that the insured suffered at work.

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 7.4.3.

For staff stationed abroad who are covered by the insurance, Bliwa pays compensation for the cost of no more than ten treatment sessions in the country in which they are residing. Compensation is paid on production of an original receipt. Compensation is not paid for travelling costs in conjunction with treatment outside Sweden.

7.5 COMPENSATION FOR PAIN AND SUFFERING

Bliwa pays compensation for pain and suffering if the insured suffers an accidental injury that resulted in at least 25 per cent sick leave for 30 days or more during the normal emergency treatment and healing period for the injury. In order to be entitled to compensation it is required that the emergency treatment and healing period for the injury is at least 30 days. If Bliwa considers that the injury has been severe, compensation may also be paid for a sick leave period of less than 30 days.

The amount of the compensation is set and calculated in accordance with the Traffic Injuries Commission’s applicable auxiliary table for calculating compensation for pain and suffering at the time of payment.

If compensation for pain and suffering as a consequence of the accidental injury should be compensated by another party as a consequence of law, statute, convention or collective agreement, Bliwa will not also pay compensation for pain and suffering. The same applies if the insured has already received compensation for pain and suffering or corresponding compensation from other insurance.

Bliwa will not pay compensation to cover the difference if the compensation for pain and suffering from other insurance has been adjusted owing to the insured’s negligence.

7.6 COMPENSATION FOR SCARS AND OTHER APPEARANCE-RELATED CONSEQUENCES OF AN INJURY

The insurance product compensates scars and other appearance-related consequences of an injury as a result of accidental injury that occurred during the term of the insurance. Compensation is only paid after treatment has been completed and when the scar or appearance-related consequence of the injury is considered to be permanent for the future, though no earlier than one year after the accident happened. Bliwa compensates scars that are considered to be at least of the category *very noticeable* according to the Traffic Injuries Commission’s compensation table for appearance-related consequences of injuries. The amount of the compensation is independent of the chosen sum insured for invalidity.

A precondition for entitlement to benefits is that the injury was so serious that it required treatment within the health services.

7.7 COMPENSATION FOR DEFECT AND OTHER PERMANENT DISABLEMENT

An accidental injury that has resulted in invalidity provides compensation for defect and disablement. The amount of the compensation is calculated according to the level of medical invalidity and with the guidance of the applicable industry rating scale on each occasion of payment.

Compensation is paid out when the level of medical invalidity has been finally determined.

7.8 BENEFIT IN THE EVENT OF INVALIDITY

The insured is entitled to benefits in the event of invalidity if the accidental injury resulted in a permanent impairment of the insured's bodily function or at least a 50 per cent reduction of the insured's future work capacity, as confirmed by a physician.

Benefits are paid out when the level of invalidity has been finally determined by Bliwa.

A distinction is made between medical and financial invalidity when assessing invalidity. Benefits are never paid for both medical and financial invalidity. When paying out financial invalidity benefits, the amount is reduced by the amount previously paid for the same claim matter for medical invalidity.

Medical invalidity is a confirmed physical or mental impairment, irrespective of the insured's profession, working conditions or leisure interests. Medical invalidity also includes loss of an internal organ and loss of a sensory function. It should be possible to determine the impairment objectively; see further information below.

Financial invalidity is a 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 for occupational rehabilitation have been exhausted and the Swedish Social Insurance Agency has granted at least 50 per cent sickness compensation under the Social Insurance Code; see further information below.

BENEFIT IN THE EVENT OF MEDICAL INVALIDITY

Bliwa pays benefits for medical invalidity if the insured has suffered an accidental injury that has resulted in a permanent impairment of a bodily function and if the condition is stationary but not life-threatening.

The accidental injury must have resulted in a measurable invalidity within three years from the date of the accident for the insured to be entitled to benefits. Medical invalidity cannot normally be finally determined until one year has elapsed from the date of the accident. A final assessment of entitlement to benefits shall only be made when the level of invalidity has been finally determined, which may be postponed for as long as there is a possibility of further medical rehabilitation.

Bliwa will never pay more than the sum insured for 100 per cent invalidity even if the accidental injury or sickness has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent. If a lost body part can be replaced by a prosthesis, the level of invalidity will be determined considering the prosthesis and its importance to the bodily function of the insured.

The level of invalidity is determined with the guidance of the applicable industry rating scale at the time of payment.

BENEFIT IN THE EVENT OF FINANCIAL INVALIDITY

Bliwa pays benefits for financial invalidity if the insured person suffers an accidental injury that has resulted in a permanent impairment of their work capacity by at least 50 per cent of full work capacity (100 per cent) and if the condition is stationary. For Bliwa to provide benefits also requires the Swedish Social Insurance Agency to have granted at least 50 per cent sickness compensation as a consequence of the accidental injury.

The accidental injury must have resulted in a measurable loss of work capacity within five years from the date of the accident for the insured to be entitled to benefits. Furthermore, the accidental injury is required to have resulted in medical invalidity before the financial invalidity arose and that this occurred within three years from the date of the accident. Benefits can never be provided for both medical and financial invalidity.

The insured's level of invalidity is established on the basis of the loss of work capacity resulting from the accidental injury. It is only the portion of the incapacity to work due to the accident that is assessed, and the insurance product only compensates this portion.

If the insured has suffered several injuries that are covered by the insurance and these injuries occurred at different times, one of these injuries must alone result in a permanent impairment of the insured's work capacity by at least 50 per cent of full work capacity for the insured to be entitled to benefits.

The amount to be paid out as invalidity benefit is an equally large portion of the sum insured as the level of sickness compensation granted by the Swedish Social Insurance Agency. Benefits are provided at 50 per cent of the sum insured in the case of half sickness compensation. Compensation is paid at 75 per cent of the sum insured in the case of three-quarters sickness compensation and at 100 per cent of the sum insured for full sickness compensation. In the first instance, the decision of the Swedish Social Insurance Agency concerning the insured's work incapacity forms the basis of Bliwa's decision concerning benefits under these insurance conditions. However, Bliwa may decide to make its own assessment of the insured's incapacity to work and consequently make a different decision to the

Swedish Social Insurance Agency if there are special reasons to do so.

If the insured was entitled to sickness compensation, activity compensation or other corresponding benefits under the Social Insurance Code at the time of the injury owing to a permanent incapacity to work, the financial invalidity benefits from Bliwa will correspond to no more than the loss of the remaining work capacity. This means that an insured who was already entitled to full sickness compensation, full activity compensation or other corresponding benefits under the Social Insurance Code at the time of the accident cannot receive any financial invalidity benefits.

An insured who, as a consequence of an accident during the term of the insurance, suffers a permanent incapacity to work after they have attained the age of 60 may only receive financial invalidity benefits from Bliwa if the level of medical invalidity as a consequence of the accidental injury is at least 50 per cent. The same applies if the insured to some extent had a permanent incapacity to work prior to the age of 60 and incurs a full permanent incapacity to work during the term of the insurance after attaining the age of 60.

AMOUNT OF THE INVALIDITY BENEFIT
The amount of the sum insured for voluntary group insurance is specified in the insurance application. The sum insured for compulsory group insurance is specified in the group agreement. The amount of the sum insured is also specified in the insurance statement issued when the insurance was taken out and subsequently if there is a significant change to the insurance conditions, for example, through the insurance protection being limited.

LIMITATION TO THE AMOUNT OF THE SUM INSURED – REDUCTION
If the insured had attained the age of 46 at the time of the injury, the sum insured for medical invalidity is reduced by 2.5 percentage points and for financial invalidity by 5 percentage points for each year by which the age of the insured exceeds 45. This applies unless otherwise indicated by the insurance statement.

Benefits are paid out in proportion to the level of invalidity and the sum insured. In the case of accidental injury that has resulted in financial invalidity, benefits paid are calculated in accordance with the insured's level of medical invalidity, if this results in a higher amount. Benefits are never paid for both medical and financial invalidity.

PAYMENT OF INVALIDITY BENEFIT
The sum insured is determined by the price base amount applicable for the year in which Bliwa provides the benefit.

The claim will only be finally settled when the medical or, when applicable, financial invalidity has been finally determined by Bliwa. However, an advance payment of invalidity benefit may be paid out prior to this. This advance will correspond to the minimum level of invalidity expected. The advance, expressed in Swedish kronor, will subsequently be deducted from the benefit paid out when the level of invalidity has been finally determined.

If the insured dies before Bliwa has finally settled the claim, and the invalidity was determined by Bliwa prior to this, an amount will be paid out corresponding to the insured's medical invalidity. The payment will be made to the insured's estate.

POSSIBILITY TO REVIEW THE BENEFIT IF INVALIDITY INCREASES
The insured is entitled to have the level of their invalidity reconsidered, following a written request to Bliwa, provided:

- the accidental injury resulted in a significant deterioration in the insured's bodily functions after Bliwa finally settled the claim, or
- the insured lost further work capacity after Bliwa finally settled the claim.

Bliwa will reconsider the level of invalidity if the insured requests this in writing and provides details of the circumstances that, according to the above, may afford entitlement to reconsideration. In order to make a new assessment of the level of invalidity Bliwa requires that the circumstances supporting such new assessment can be determined objectively. Bliwa decides what supporting information is required for such an objective assessment. The insured must personally furnish Bliwa with the supporting information requested by Bliwa. The insured shall pay for the cost of any new invalidity certificate. However, Bliwa will subsequently pay compensation for such new invalidity certificates if a deterioration of the insured's bodily functions has actually been objectively demonstrated and a new level of invalidity determined. A reconsideration may never be conducted when more than ten years have elapsed from the date of the accident; see Sub-clause 1.16 above.

7.9 COMPENSATION FOR WAITING

When benefits for medical invalidity, defect and other permanent disablement or compensation for scars and other appearance-related consequences

of an injury have been determined, compensation for waiting is paid corresponding to 2.5 per cent per year of the benefits paid. Compensation is paid for the period from when the invalidity condition/defect and other permanent disablement/scars and other appearance-related consequences of the injury arose, though no earlier than from and including two years after the injury occurred, up to and including the day on which payment is made.

Entitlement to compensation does not apply if the delay is due to the insured being late in sending the application or other documents required for Bliwa to be able to assess the right to benefits.

7.10 BENEFIT IN THE EVENT OF DEATH

One price base amount is paid to the insured's beneficiaries if the insured dies as a consequence of an accidental injury within three years from the date of the accident.

'Price base amount' means the price base amount applicable on the date of death.

The beneficiaries are the insured's estate in the first instance, unless Bliwa is notified of a different nomination in writing. However, the insured can notify Bliwa of a different nomination of beneficiary through a personally signed written communication (a separate nomination of beneficiaries). The insured is at liberty to choose who should be a beneficiary by such a nomination. A standard form for a separate nomination of beneficiaries can be printed out from *www.bliwa.se* or ordered from Bliwa.

A nomination of beneficiaries cannot be amended through a will.

8. Child and pregnancy insurance

Pregnancy insurance together with accident and health insurance for children and young people.

COMMON PROVISIONS

The insurance applies with a 'single-child premium' (i.e. you pay a premium for each insured child). New insurance should be taken out in the event of a new pregnancy even if a group member already has a child insured under child insurance with Bliwa.

Child insurance may be taken out at three different levels: BASIC, PREMIUM AND PREMIUM EXTRA. The level that may be taken out for each group has been agreed in the group agreement and is shown in the application documents. The difference between the different levels is shown in Sub-clause 8.6.1 below. The insurance can only be taken out by a group member. Regardless of the level of the child insurance taken out, pregnancy insurance applies with the scope described below in Sub-clause 8.3 subject to the precondition that the insurance was taken out before the 36th week of pregnancy.

Child insurance may provide financial benefits in the event that an insured child has an accident or sickness that occurred or manifested itself during the term of the insurance, if such an event resulted in costs, led to invalidity or the making of certain diagnoses. There are two parts to the insurance – pregnancy insurance and child insurance (accident and health insurance for children and young people). The insurance covers, for example, travelling costs, care expenses and costs for crisis therapy. A maximum benefit amount or deductible applies to some injuries and expenses.

Pregnancy insurance applies for at most up to the date on which the child has attained the age of six months. Child insurance enters into force when the child has been born and applies for at most up to and including the end of the month in which the insured attains the age of 25 or the end of the month in which the group member attains the age at expiry for the group insurance.

Compensation is paid from either the pregnancy insurance or the child insurance during the period when the pregnancy insurance and child insurance apply in parallel. Compensation can never be paid from both insurance products for the same injury.

The date of the insurance event is the date on which the sickness manifested itself or the date of the accident, depending on the kind of injury.

8.1 DEFINITION OF THE TERM 'ACCIDENT'

An accident that affords entitlement to compensation under this insurance product must have comprised an external event. The accident must also have been caused by a sudden and unexpected event that resulted in the insured involuntarily suffering a bodily injury. The person making the claim for benefits must prove that an accidental injury has occurred.

A precondition for entitlement to benefits in the case of an accidental injury is that the injury is so serious that it requires treatment within the health services.

INJURIES EQUATED TO ACCIDENTAL INJURY

Bodily injury that has arisen through frostbite, heatstroke, sunstroke, borrelia infection and TBE owing to a tick bite is equated to accidental injury. The date on which such injury presented itself is deemed to be the date of the accidental injury. The rupture of an Achilles tendon or knee twist injury is also equated to an accidental injury without a requirement regarding an external event.

INJURIES THAT ARE NEVER DEEMED TO BE AN ACCIDENTAL INJURY
Only injuries that satisfy the preconditions of Sub-clauses 8.1 and 8.1.1 are ‘accidental injuries’. Accidental injuries therefore do not include, for example, a bodily injury that has arisen through the insured intentionally having injured themselves or having demonstrated manifest indifference to the risk of getting injured. Nor do they include injuries that have arisen through, for example:

- overexertion or repetitive movements (repetitive strain injury), stretching, twisting or pathological changes
- infection through bacteria, viruses or other contagion, infection or poisoning through ingesting food or drink or hypersensitivity reaction
- use of medicinal preparations, operations, treatment or examinations that have not resulted from an accidental injury covered by this insurance
- nuclear explosion or radiation (nuclear reaction).

However, if the insured commits suicide this is treated under this insurance as being an accidental injury.

8.2 DEFINITION OF THE TERM ‘SICKNESS’

In these conditions, ‘sickness’ means a deviation from normal health status that requires health and medical care and is not to be regarded as an accidental injury as referred to above. Sickness is deemed to have occurred when the insured’s physical or mental functional capacity has manifestly deteriorated owing to the sickness. ‘Sickness’ does not mean a bodily injury caused voluntarily.

8.3 PREGNANCY INSURANCE

VALIDITY
Pregnancy insurance can only be taken out by a group member who is a policyholder. Pregnancy insurance must have been taken out before the 36th week of pregnancy for the insurance to apply. Pregnancy insurance can start to apply no earlier than from and including the 10th week of pregnancy for the mother, father and siblings of the unborn child and no earlier than from and including the 23rd week for the unborn child or children.
If pregnancy insurance is taken out after the 23rd week of pregnancy, the insurance applies with a qualifying period of 14 days. This means that Bliwa does not pay compensation under the pregnancy insurance for insurance events that occur within 14 days of the date on which the insurance was taken out.

The group member pays a premium for one (1) child insurance, regardless of the number of children expected, for the term of the pregnancy insurance. When the child or children have been born, the group member shall submit the child’s or children’s personal identity (ID) number(s) within six months. The insurance then starts to apply with one premium for each insured child.

INSURED
Pregnancy insurance applies for the mother, her expected child (regardless of the number of children) and the child’s father or the mother’s husband/wife or cohabitee. These are insured under pregnancy insurance. The crisis insurance component applies to the whole family.

PRECONDITIONS FOR ENTITLEMENT TO COMPENSATION
The accident or sickness must have occurred or manifested itself during the term of the insurance for there to be entitlement to compensation. The term of the pregnancy insurance is from when the insurance was taken out, though no earlier than from and including the 23rd week for the unborn child (see also Sub-clause 8.3.1). The term of the insurance ceases no later than the date on which the child attains the age of six months.

SCOPE OF THE INSURANCE
Unless otherwise agreed in the group agreement or shown in the insurance statement, compensation under the pregnancy insurance will be paid for the following if it was taken out before the 36th week of pregnancy:

- Medical costs for the child – see Sub-clause 8.4.1
- Travelling costs for the child – see Sub-clause 8.4.2
- Costs for crisis therapy/psychology services – see Sub-clause 8.4.3
- Hospital stay for mother and child – see Sub-clause 8.4.4
- Care expenses benefit – see Sub-clause 8.4.5
- Critical illness compensation – see Sub-clause 8.4.6
- Medical invalidity in the event the child has an accident – see Sub-clause 8.4.7
- Death benefit – see Sub-clause 8.4.8.

8.4 COMPENSATION FOR COSTS

MEDICAL COSTS FOR THE CHILD
Compensation is paid for the cost of essential medical care, hospital care, treatment and aids prescribed by a physician for treatment of the injury.

Costs are only compensated for care or treatment up to the level of the Swedish high cost protection. Compensation is only paid for the cost of care or treatment abroad if the accident or sickness occurred abroad; see Sub-clause 9.3 for when compensation is paid for accidents abroad.

Compensation is paid for medical costs if they have arisen within five years from the date of the accident or the date on which the sickness manifested itself.

A deductible corresponding to three per cent of the price base amount is payable in the case of compensation for medical and travelling costs for one and the same sickness.

TRAVELLING COSTS FOR THE CHILD

Compensation is paid for travelling costs, as a consequence of sickness or an accident, in conjunction with care and treatment prescribed by a physician to heal the injury.

Compensation is paid for the cost of the least expensive means of travel that the insured's health status allows. This need must be verified by a physician. Compensation is not paid for travel using a private, official or company car and the like where no additional costs have arisen. Compensation is paid for travelling costs using their own car to and from care and treatment in accordance with the flat-rate model applicable at any given time that Bliwa has issued for this purpose.

Compensation is paid for the cost of trips made within five years from the date of the accident or from the date on which the sickness manifested itself.

A deductible corresponding to three per cent of the price base amount is payable in the case of compensation for medical and travelling costs for one and the same sickness.

COSTS FOR CRISIS THERAPY/PSYCHOLOGY SERVICES

Compensation is paid for the cost of treatment by a psychologist and travelling costs in conjunction with such treatment if the insured (the child's siblings, mother and/or father) has suffered a mental health problem as a consequence of:

- the expected child dying during the term of the insurance
- the mother, father or partner dying during the term of the insurance
- the child being disabled
- the mother being affected by postpartum psychosis.

In order to be granted benefits, the event needs to have occurred during the term of the insurance the need for treatment arose within five years from when the event occurred. Bliwa should be contacted to approve the treatment before it starts. Bliwa will only approve treatment that takes place in Sweden. The insurance compensates reasonable costs for no more than ten treatment sessions with a registered psychologist for each insured and injury.

The cost of therapy and psychology services is primarily only compensated for treatment within the national healthcare service. However, Bliwa may also grant the cost of therapy and psychology services within the private healthcare service if there are special reasons to do so.

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 8.4.2.

HOSPITAL STAY FOR MOTHER AND CHILD

If an accidental injury or sickness means that the child and/or mother is admitted to hospital for inpatient care treatment for at least three consecutive days, SEK 300 is provided in benefits for each day of the hospital stay. 'Hospital stay' includes the day of admission and discharge and leave of absence days without pay.

The insurance may also pay benefits for care at a Neonatal Department owing to a premature birth. The pregnancy, prior to the application for insurance and before the 23rd week of pregnancy, must have been normal for compensation to be paid for such care. Nor may the mother have been checked or treated for diabetes, heart/kidney disease or high blood pressure prior to the application for insurance and before the 23rd week of pregnancy.

The sickness or accidental injury must be linked to the childbirth or pregnancy for the mother to be entitled to benefits for a hospital stay.

Benefits for no more than 365 days in total are paid for the child and mother, though for at most up to when the child has attained the age of one.

No benefits are provided for outpatient care treatment.

CARE EXPENSES BENEFIT

A care expenses benefit may be paid of at most one price base amount per year. Entitlement to care expenses benefit arises from and including the first day when the mother or other custodian has been granted a child carer's allowance of at least 25 per cent or alternatively at least one-eighth temporary parental benefit for care of a seriously ill child from the Swedish Social Insurance Agency for the child

who is insured under the pregnancy insurance. The child's sickness that affords entitlement to a child carer's allowance or temporary parental benefit for care of a seriously ill child shall have manifested itself during term of the insurance and before the child is six months. Entitlement to care expenses benefit lasts for as long as the above-mentioned benefits are paid by the Swedish Social Insurance Agency, but for no more than one year from the first day of the child carer's allowance or alternatively temporary parental benefit for one and the same loss. If the insured child dies, the right to care expenses benefit ceases at the end of the calendar month in which the death occurred.

SPECIAL INFORMATION ABOUT BENEFITS WHEN A CHILD CARER'S ALLOWANCE HAS BEEN GRANTED

The care expenses benefit is paid monthly in arrears at one-twelfth of the annual amount as soon as there is entitlement to a child carer's allowance from the Swedish Social Insurance Agency and the application for benefits has been received by Bliwa. Care expenses benefit is paid to the insured's custodian who has been granted a child carer's allowance by the Swedish Social Insurance Agency.

If the maximum child carer's allowance is paid by the Swedish Social Insurance Agency, the benefits under Bliwa's child insurance are one price base amount per year. If a reduced child carer's allowance is paid by the Swedish Social Insurance Agency, the care expenses benefit from Bliwa's child insurance is reduced to a corresponding extent. The amount of the child carer's allowance may be 25, 50, 75 or 100 per cent. If the child carer's allowance is shared between several children, the injured/sick child's portion of the child carer's allowance shall be at least 25 per cent for Bliwa to pay care expenses benefit.

No benefits are provided for additional cost allowance.

SPECIAL INFORMATION ABOUT BENEFITS WHEN TEMPORARY PARENTAL BENEFIT FOR A SERIOUSLY ILL CHILD HAS BEEN GRANTED

A precondition for entitlement to benefits is that the Swedish Social Insurance Agency has granted temporary parental benefit for care of a seriously ill child for at least 14 days. The sum insured is one price base amount. Benefits are paid monthly in arrears at 1/365th of the sum insured for each day when the temporary parental benefit for care of a seriously ill child is received, regardless of whether both custodians have been granted temporary parental benefit for care of a seriously ill child. 1/365th is paid if full parental benefit for care of a seriously ill child has been granted. If only three-quarters, half, a quarter or an eighth parental benefit has been granted, a corresponding portion of benefits is paid.

Care expenses benefit from pregnancy insurance may never be paid for the same period as care expenses benefit from child insurance.

CRITICAL ILLNESS COMPENSATION FOR THE CHILD

Critical illness compensation is paid as a lump sum if the insured child, during the term of the insurance, and before the child has attained the age of six months, has been diagnosed with any of the diagnoses indicated below. Entitlement to benefits under the insurance arises no earlier than seven days after the diagnosis has been made. No critical illness compensation is paid if the insured dies within seven days of the diagnosis having been made.

Entitlement to benefits requires the diagnosis to have been made or confirmed by a physician in Sweden.

The date of the insurance event is the same as the date on which the diagnosis was made.

Amount of benefit

Critical illness compensation is paid as a lump sum. The amount of the critical illness compensation is dependent on the scope of the child insurance taken out. The sum insured is one price base amount if the Basic Level has been taken out, two price base amounts for Premium Level and three price base amounts for Premium Extra Level. This applies unless otherwise agreed in the group agreement and shown in the application documents and insurance statement.

Benefits are only paid for one of the following diagnoses made during the insured's first six months of life:

Down's syndrome (ICD Q90)
Developmental disorder due to a chromosomal anomaly.

Congenital hydrocephalus, hydrocephalus (ICD Q03)
Congenital hydrocephalus in a newborn caused by a disruption in fluid circulation.

Spina bifida, myelocele (ICD Q05)
A malformation of the spine where the vertebral arches have not fused. A precondition for benefits is myelocele that protrudes through the cleft in the skull or the spine.

Congenital malformations of the heart's chambers, junctions and cardiac septa (ICD Q20-21)

Congenital malformations of the valves of the heart (ICD Q23)

Congenital malformations of the great arteries (ICD Q25)

Reduction defects of the upper and lower limbs (ICD Q71-72)

Blindness and low vision (ICD H54)

Intellectual disabilities (ICD F72-73)
A precondition for benefits is a severe or profound congenital developmental disorder. The diagnosis should be made by a specialist physician in paediatric neurology.

Cerebral Palsy, CP (ICD G80)
The damage should be congenital or have arisen as a consequence of a lack of oxygen in conjunction with delivery.

Cancer (ICD C00-97)
The following conditions are not covered by the insurance protection: 1) preliminary stage of cancer (non-invasive cancer in situ), although critical illness compensation applies for breast cancer *in situ*. 2) all skin cancer if it has not been classified as a malignant melanoma.

Haemophilia (ICD D66-67)

The ICD codes specified refer to ICD-10 Classification of Diseases and Health Problems, 1997 (KSH97).

ICD-10 shall also be applied if the classification or diagnosis codes change or new ones are added. This Classification is available on the website of the National Board of Health and Welfare (*www.sos.se*).

MEDICAL INVALIDITY IN THE EVENT OF AN ACCIDENT FOR THE CHILD

Medical invalidity is a physical or mental impairment. Medical invalidity also includes loss of an internal organ and loss of a sensory function as a consequence of an accident.

Benefits for medical invalidity are paid if the insured child has suffered an accidental injury that has resulted in a permanent impairment of a bodily function and if the condition is stationary but not life-threatening.

The accidental injury must have occurred during the term of the insurance and before the child had attained the age of six months for the insured to be entitled to benefits. The accidental injury must have resulted in a measurable invalidity within three years from the insurance event. Medical invalidity cannot normally be finally determined until one year has elapsed from the date of the accident. A final assessment of entitlement to benefits shall only be made when the level of invalidity has been finally determined, which may be postponed for as long as there is a possibility of further medical rehabilitation.

Bliwa will never pay more than the sum insured for 100 per cent invalidity even if the accidental injury or sickness has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent. If a lost body part can be replaced by a prosthesis, the level of invalidity is determined considering the prosthesis and its importance to the bodily function of the insured.

It should be possible to determine the impairment objectively. The level of invalidity is determined with the guidance of the applicable industry rating scale at the time of payment.

BENEFIT IN THE EVENT OF DEATH

Benefits of one price base amount may be paid from pregnancy insurance if the insured child dies during the term of the insurance, from and including the 23rd week of pregnancy and before the age of six months.

Benefits of ten price base amounts are paid if a custodian dies during the term of the insurance and before the child has attained the age of six months.

If the death relates to a still-born child, the payment is made to the deceased's estate or to the group member.

8.5 CHILD INSURANCE – BASIC, PREMIUM AND PREMIUM EXTRA

Child insurance can only be taken out by a group member who is a policyholder. The insurance applies to the child for whom the insurance has been taken out and the group member pays a premium for each child for whom they have taken out insurance ('single-child premium'). The insurance applies full-time, that is to say, around the clock.

If the child insurance is taken out during the pregnancy, the child insurance enters into force when the child is born. The group member must submit the personal identity (ID) number of the child or children to be covered by the child insurance no later than six months from the child's birth.

Child insurance may be taken out for children who have not attained the age of 25 for children who have not been covered by pregnancy insurance.

The insurance applies for at most up to and including the month in which the insured child attains the age of 25 or the end of the month in which the group member attains the age at expiry for the insurance.

The children who may be insured are all children of the group member and the group member's husband/wife or cohabitee who are entitled to inherit. Children placed in a foster home with a group member may also be insured under the child insurance. The group member is the policyholder and the child for whom the insurance has been taken out is the insured, subject to the precondition that they satisfy other requirements according to these conditions.

PERSONAL ACCIDENT INSURANCE

A child, who a group member intends to adopt and who is not resident in Sweden, is insured as soon as they have come to Sweden provided that consent is granted under Chapter 6, Section 12 of the Social Services Act (2001:453). If the adoption is not completed, the insurance ceases when the child leaves Sweden or no later than one year after the date on which the child came to Sweden.

HEALTH INSURANCE

A child born outside the Nordic countries is not covered by the health insurance until the child has been resident in Sweden for at least one year and has undergone an adopted child investigation or corresponding investigation followed by visits to a child healthcare centre or paediatrician.

8.6 COMMON PROVISIONS

SICKNESSES THAT ARE COMPLETELY OR PARTLY EXCLUDED FROM BENEFITS

CHILD INSURANCE – BASIC LEVEL

The insurance does not apply to the following sicknesses, intellectual disabilities or impairment – and nor to the consequences of such conditions – regardless of when the symptoms presented themselves or a diagnosis could be made:

- ICD F00-F99 (for example, ADHD, autism, developmental delay, depression, phobias, eating disorders, etc.).

CHILD INSURANCE – PREMIUM LEVEL

The insurance applies to a limited extent for the following sicknesses, intellectual disabilities or impairment – and for the consequences of such conditions:

- ICD F00-F99 (for example, ADHD, autism, developmental delay, depression, phobias, eating disorders, etc.).

This limitation means that medical and financial invalidity benefits are calculated on the basis of an amount corresponding to ten per cent of the sum insured.

CHILD INSURANCE – PREMIUM EXTRA LEVEL

The insurance applies without exclusions or limitations for the diagnoses described above under child insurance – BASIC LEVEL and PREMIUM LEVEL.

8.6.1.1 Common limitations

Sickness, disability or bodily defect that manifested itself before the insurance entered into force

The insurance does not cover sickness, disability or bodily defect – or the consequences of such conditions – if the symptoms manifested themselves before the insurance entered into force. This applies even if a diagnosis can only be made after the insurance started to apply. There is never entitlement to benefits for an invalidity that existed before the insurance entered into force.

Compensation is only paid for the consequences of sickness, both direct and indirect, if the underlying sickness first manifested itself during the period when the sickness affords entitlement to benefits under this insurance.

8.6.1.2 Limitations for child insurance for the first six months of life

If the child is affected by a sickness, the child must have attained the age of six months before the sickness manifested itself for the first time for benefits to be paid from the following components from the child insurance:

- Care expenses benefit
- Medical invalidity
- Financial invalidity.

The need for hospital care is required to have arisen for the first time after the child has attained the age of six months in order to be able to pay compensation under the *hospital stay* and *care at home* components. This limitation in respect of hospital care does not apply if the child was previously covered by pregnancy insurance.

8.7 HEALTH REQUIREMENTS

Bliwa may possibly impose health requirements on the person being insured. This means that the

policyholder and/or the insured should answer Bliwa's questions about health and that Bliwa will grant or reject the insurance application following a risk assessment.

Health requirements may also be imposed when the sum insured is increased or the insurance protection is otherwise extended. Health requirements may vary between group agreements and are indicated by Bliwa's application documents.

8.8 SCOPE OF THE INSURANCE

The insurance may be taken out at three different levels: BASIC, PREMIUM AND PREMIUM EXTRA. The difference between the different levels is shown in Sub-clause 8.6.1 above.

Compensation is paid for the following unless otherwise agreed in the group agreement or indicated by the application documents and the insurance statement:

In the event of an accidental injury

- Medical costs – see Sub-clauses 8.9 and 8.10.1
- Costs for dental injuries – see Sub-clauses 8.9 and 8.10.2
- Travelling costs – see Sub-clauses 8.9 and 8.10.3
- Additional costs – see Sub-clauses 8.9 and 8.10.4
- Costs for rehabilitation and aids – see Sub-clauses 8.9 and 8.10.5
- Care expenses benefit – see Sub-clauses 8.9 and 8.10.6
- Costs for crisis therapy/psychology services – see Sub-clauses 8.9 and 8.10.7
- Benefit in connection with hospital care – see Sub-clauses 8.9 and 8.10.8
- Benefit in connection with care at home – see Sub-clauses 8.9 and 8.10.9
- Critical illness compensation – see Sub-clauses 8.9 and 8.10.10
- Compensation for scars and other appearance-related consequences of an injury – see Sub-clauses 8.9 and 8.10.11
- Invalidity – medical and/or financial invalidity – see Sub-clauses 8.9 and 8.10.12 including sub-headings
- Death benefit – see Sub-clauses 8.9 and 8.11.

In the event of sickness

- Medical costs – see Sub-clauses 8.9 and 8.10.1
- Travelling costs – see Sub-clauses 8.9 and 8.10.3
- Costs for rehabilitation and aids – see Sub-clauses 8.9 and 8.10.5
- Care expenses benefit – see Sub-clauses 8.9 and 8.10.6
- Costs for crisis therapy/psychology services – see Sub-clauses 8.9 and 8.10.7
- Benefit in connection with hospital care – see Sub-clauses 8.9 and 8.10.8
- Benefit in connection with care at home – see Sub-clauses 8.9 and 8.10.9
- Critical illness compensation – see Sub-clauses 8.9 and 8.10.10
- Compensation for scars and other appearance-related consequences of an injury – see Sub-clauses 8.9 and 8.10.11
- Invalidity – medical and/or financial invalidity – see Sub-clauses 8.9 and 8.10.12 including sub-headings
- Death benefit – see Sub-clauses 8.19 and 8.11.

Limitations to amounts and other limitations to the size of the benefit are specified below for each item.

8.9 IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFITS

Depending on the level of the child insurance taken out, certain sicknesses are excluded or limited in accordance with the provisions of Sub-clause 9.6.1.

This insurance product only pays benefits for consequences that have an adequate connection to an accident or sickness that required treatment within the health services and occurred during the term of the insurance.

If the insured's health status has deteriorated owing to a bodily defect that was either pre-existing at the time of the accident or subsequently arose and is unconnected to the accidental injury, no benefits are provided for the costs and/or the invalidity resulting from such deterioration. 'Bodily defect' means sickness, pathological change, defect and disablement.

In the case of sickness, compensation can only be paid under the insurance if the sickness manifested itself for the first time during the term of the insurance with Bliwa. This applies to both the underlying sickness and any consequential sicknesses, direct and indirect. Sicknesses with a medical connection are counted as one and the same sickness.

As regards compensation for costs, the insurance only compensates necessary and reasonable costs

as a consequence of the accident or sickness. Bliwa does not compensate costs that should be compensated by another party according to law, statute, convention or collective agreement. Costs that have been compensated through other insurance are not compensated from this insurance. This applies irrespective of whether such compensation is paid according to a flat-rate model or against an original receipt. Nor does Bliwa compensate costs that are to be compensated under patient or healthcare insurance that has been taken out separately. If an accident or sickness occurred outside the insured's home district or abroad, the insurance does not compensate the costs compensated by separate travel insurance or a travel component of home insurance. This restriction and other important limitations that apply to the right to compensation in the case of an accident or sickness that occurred abroad are indicated by Sub-clause 9.3.

Bliwa only compensates costs that can be verified by an original receipt. If the insured is not covered by the social welfare insurance and is not registered with the Swedish Social Insurance Agency, compensation is only paid for those costs that would have been compensated if they had been registered and had fully utilised the benefits provided under the social welfare insurance.

Benefits are not provided for lost income from work. Compensation is not paid for costs for dental care and additional costs.

Injuries that have occurred at work or on the way to or from work must be reported to the Swedish Social Insurance Agency. If the insured is covered by industrial injuries insurance (for example, work injury insurance for private employees (TFA), work injury insurance for employees of municipal, county and regional authorities, the Church of Sweden and certain municipally-owned companies (TFA-KL) or compensation for Personal Injury Agreement work injury insurance for government employees (PSA)), the injury should also be reported to AFA Försäkring.

If the injury has been reported as an occupational injury, the insured must notify Bliwa of this as soon as possible. What is deemed to be 'work' and 'time for travel to or from work' are determined according to the definitions applied by the Swedish Social Insurance Agency and AFA Försäkring. If the injury has been classified as an occupational injury by the Swedish Social Insurance Agency or AFA Försäkring, Bliwa will not pay compensation for the costs, etc., as a consequence of an occupational injury for which compensation has been paid by the Swedish Social Insurance Agency or AFA Försäkring.

8.10 COMPENSATION FOR COSTS

MEDICAL COSTS

Compensation is paid for the cost of essential medical care, hospital care, treatment and aids prescribed by a physician for treatment of the injury. Costs are only compensated for care or treatment up to the level of the Swedish high cost protection .

Compensation is only paid for the cost of care or treatment abroad if the accident or sickness occurred abroad; see Sub-clause 9.3 for when compensation is paid for accidents abroad.

Compensation is paid for medical costs if they have arisen within five years from the date of the accident or from the date on which the sickness manifested itself.

If the damage resulted in medical invalidity but it was not possible for Bliwa to make a final settlement within five years from the date on which the sickness manifested itself or from the date of the accident, compensation is paid for medical costs until Bliwa has announced that a final settlement has been made. Compensation is never paid for costs that arose after the final medical invalidity benefit has been determined.

A deductible corresponding to three per cent of the price base amount is payable in the case of compensation for medical and travelling costs for one and the same sickness.

COSTS FOR DENTAL INJURIES AS A CONSEQUENCE OF AN ACCIDENT

This insurance product does not compensate costs for a dental injury that has arisen as a consequence of chewing or biting.

Compensation is paid for the cost of essential treatment for dental injuries as a consequence of an accident. 'Dental injuries' also means damage to dental plates that were in the mouth when they were damaged. Treatment and costs of dental injuries must be approved by Bliwa in advance. However, compensation is paid for reasonable emergency treatment costs even if there was no time to obtain approval before treatment.

If there was already a need to treat teeth damaged in the accident at the time of the injury, Bliwa is entitled to make an appropriate reduction to the amount of the benefit.

Compensation is only paid for dental treatment expenses in Sweden if the treatment is covered by the dental care insurance under the Social

Insurance Code. Compensation is not paid for the cost of implant treatment that is not covered by the dental care insurance. Compensation is only paid for the cost of treating damage to implants if this treatment is covered by the dental care insurance.

Compensation is paid for the cost of treatment undertaken within five years from the date of the accident.

For persons who, owing to their age, are entitled to free dental care, compensation is only paid for possible emergency treatment costs.

If treatment needs to be postponed to a later date owing to the insured's age, because not all of the insured's teeth are fully developed, compensation is paid for the cost of the postponed treatment if it is carried out before the insured has attained the age of 25. If the postponed treatment is carried out later, but before the insured has attained the age of 30, compensation is only paid for the cost of the postponed treatment subject to the precondition that Bliwa approved the postponed treatment before the insured had attained the age of 25.

No further compensation is paid if Bliwa has paid compensation for final treatment costs for a dental injury.

Compensation is only paid for the cost of treatment abroad if the accident occurred abroad; see Sub-clause 9.3 regarding when compensation is paid for accidents abroad.

Compensation is not paid for consequences of sickness.

TRAVELLING COSTS

Compensation is paid for travelling costs, as a consequence of sickness or an accident, in conjunction with care and treatment prescribed by a physician to heal the injury.

Compensation is paid for reasonable additional travelling costs between the insured's permanent home and workplace or school if the insured has to engage special means of transport to be able to carry out their ordinary professional work or schooling/employment training. However, compensation for additional travelling costs between a permanent home and normal workplace should be paid in the first instance by the employer or the Swedish Social Insurance Agency. The municipal authority's responsibility to attend to transport between the permanent home and school applies in the first instance for children at compulsory school.

Compensation is paid for the cost of the least expensive means of travel that the insured's health status allows. This need must be verified by a physician. Compensation is not paid for travel using a private, official or company car and the like where no additional costs have arisen. Compensation is paid for travelling costs using their own car to and from care and treatment in accordance with the flat-rate model applicable at any given time that Bliwa has issued for this purpose.

Compensation is paid for the cost of trips made within five years from the date of the accident or from the date on which the sickness manifested itself. If the damage resulted in medical invalidity but it was not possible for Bliwa to make a final settlement within five years from the date on which the sickness manifested itself or from the date of the accident, compensation is paid for travelling costs until Bliwa has announced that a final settlement has been made. Compensation is never paid for costs that arise after the final medical invalidity benefit has been determined.

A deductible corresponding to three per cent of the price base amount is payable in the case of compensation for medical and travelling costs for one and the same sickness.

ADDITIONAL COSTS AS A CONSEQUENCE OF AN ACCIDENT

Compensation is paid for the following items under general law of tort rules if the insured suffers a bodily injury as a consequence of an accident that requires treatment by a physician:

- Clothes normally worn and other personal belongings normally carried that were damaged in the course of the accident: spectacles/prescription lenses, wristwatches, plain wedding bands, handbag and helmet. Compensation is only paid for the cost of repair if it is possible to repair the damaged object. Compensation is paid for costs up to no more than 0.6 price base amounts in total unless otherwise indicated by a group agreement or insurance statement.
- Other unavoidable and reasonable additional costs that have arisen as a consequence of the accidental injury during the emergency treatment and healing period for the injury. Compensation is paid for costs up to no more than three price base amounts in total unless otherwise indicated by a group agreement or insurance statement.

Compensation is paid for destroyed clothes based on what equivalent clothes cost to buy at the time of the injury. If the clothes are more than one year old, an age deduction is made from the repurchase cost. Compensation for destroyed clothes is paid in accordance with the following table. 'Clothes' also means wristwatches and handbags in this context.

The table shows compensation as a percentage of the repurchase price.

Age	0 to 1 year	1-2 years	2-3 years	3-4 years	4 years and older
Per cent	100	80	60	40	20

Compensation is paid for the cost of a pair of equivalent spectacles if the insured used spectacles that were destroyed at the time of the injury. The insured must send in a receipt for the purchase of new spectacles in order to receive compensation. Furthermore, the insured shall enclose a certificate from an optician proving that the new spectacles purchased were equivalent to the destroyed spectacles or enclose a receipt for the damaged spectacles.

Compensation can only be paid for additional costs that the insured incurs in their capacity as a private individual. Compensation is never paid for additional costs for a business activity. Compensation is not paid for lost income from work or other financial losses.

'Price base amount' means the price base amount for the year in which the accident occurred.

Sickness does not afford entitlement to compensation for additional costs under this Clause.

COSTS FOR REHABILITATION AND AIDS

If an accident or sickness that occurs entails a need for rehabilitation or special aids during the term of the insurance, compensation is paid for reasonable costs for this. Costs must have arisen after the emergency treatment period and must be approved by Bliwa in advance.

'Rehabilitation' means the care, treatment, training and re-education required to enable the insured to recover the best possible functional capacity and be able to live as normal a life as possible.

Rehabilitation does not include treatment that aims to maintain functional capacity that was acquired after the accident or sickness (treatment maintenance).

There should be a time limit for rehabilitation. Compensation is paid for the cost of the following rehabilitation measures:

- Care and treatment (maximum ten sessions) for which a treating physician has given a referral for the insured. In order to grant compensation Bliwa needs to see the referral and approve the care/treatment before it starts.
- Employability assessments, occupational rehabilitation and re-education. However, Bliwa does not pay compensation for the cost of training that increases the level of competence.
- Aids that are intended to increase the insured's ability to move and reduce the risk of any future invalidity.

Compensation is paid for costs up to three price base amounts in aggregate for each insurance event. 'Price base amount' means the price base amount applicable for the year in which the rehabilitation started.

No compensation is paid for the cost of rehabilitation if the need of rehabilitation has arisen through an accident at work or harmful effect owing to work. Bliwa does not pay compensation for the cost of raising standards.

Compensation is never paid for costs that arose after the final medical invalidity benefit has been determined. Compensation is only paid for the cost of rehabilitation abroad in the event that a Swedish national health service manager has approved and is largely funding the treatment.

CARE EXPENSES BENEFIT

Entitlement to care expenses benefit for the person insured under Bliwa's child insurance starts from and including the first day on which the Swedish Social Insurance Agency granted the custodian at least one quarter child carer's allowance for care and supervision or alternatively at least one-eighth temporary parental benefit for care of a seriously ill child. Entitlement to care expenses benefit lasts for as long as the above-mentioned benefits are paid by the Swedish Social Insurance Agency, but for no more than six years from the first day of the child carer's allowance or alternatively temporary parental benefit for one and the same loss.

For entitlement to benefits, the insurance event must have occurred during the term of the insurance and after the insured child has attained the age of six months. See also Sub-clause 8.6.1.2.

Care expenses benefit as a consequence of a child carer's allowance granted by the Swedish Social Insurance Agency are paid for at most up to and including June of the year in which the child attains the age of 19. Care expenses benefit as a consequence of temporary parental benefit for care of a seriously ill child from the Swedish Social Insurance Agency are paid for at most up to the end of the month in which the child attains the age of 18. The total care expenses benefits may never exceed the maximum amount even if a decision on the child carer's allowance or temporary parental benefit

relates to several insured within the same family. This means that the care expenses benefit from Bliwa's child insurance may not in any event exceed the sum insured indicated by the applicable documents and the insurance statement.

If the child carer's allowance or the temporary parental benefit for care of a seriously ill child is only due to the sickness/injury that, according to these insurance conditions, affords entitlement to benefits, benefits are only paid in relation to the amount of the child carer's allowance or the temporary parental benefit in accordance with the following.

If the child carer's allowance or the temporary parental benefit for care of a seriously ill child also relates to sickness/injury that does not afford entitlement to benefits according to the insurance conditions, the benefits are calculated according to the level that would have been granted if the decision only related to the indemnifiable loss. The indemnifiable loss's portion of the child carer's allowance or the temporary parental benefit for care of a seriously ill child must amount to at least one quarter or alternatively one-eighth of the benefits that could be paid.

Care expenses benefit from child insurance may never be paid for the same period as care expenses benefit from pregnancy insurance.

Benefits are paid in the first instance to the custodian to whom the Swedish Social Insurance Agency pays the child carer's allowance or alternatively temporary parental benefit for care of a seriously ill child.

SPECIAL INFORMATION ABOUT BENEFITS WHEN A CHILD CARER'S ALLOWANCE HAS BEEN GRANTED

The care expenses benefit is paid monthly in arrears at one-twelfth of the annual amount as soon as there is entitlement to a child carer's allowance from the Swedish Social Insurance Agency and the application for benefits has been received by Bliwa. Care expenses benefit is paid to the insured's custodian who has been granted a child carer's allowance by the Swedish Social Insurance Agency.

If the maximum child carer's allowance is paid by the Swedish Social Insurance Agency, the benefits under Bliwa's child insurance are one price base amount per year. If a reduced child carer's allowance is paid by the Swedish Social Insurance Agency, the care expenses benefit from Bliwa's child insurance is reduced to a corresponding extent. The amount of the child carer's allowance may be 25, 50, 75 or 100 per cent. If the child carer's allowance is shared between several children, the injured/sick child's portion of the child carer's allowance shall be at least 25 per cent for Bliwa to pay care expenses benefit.

No benefits are provided for additional cost allowance.

Benefits are paid for at most up to and including June of the year in which the child attains the age of 19.

If the insured dies, the right to care expenses benefit ceases at the end of the calendar month in which the death occurred.

SPECIAL INFORMATION ABOUT BENEFITS WHEN TEMPORARY PARENTAL BENEFIT FOR A SERIOUSLY ILL CHILD HAS BEEN GRANTED

A precondition for entitlement to benefits is that the Swedish Social Insurance Agency has granted temporary parental benefit for care of a seriously ill child for at least 14 days. If full parental benefit for care of a seriously ill child has been granted by the Swedish Social Insurance Agency, the benefits under Bliwa's child insurance are one price base amount per year. Benefits are paid monthly in arrears at 1/365th of the sum insured for each day when the temporary parental benefit for care of a seriously ill child is received, regardless of whether both custodians have been granted temporary parental benefit for care of a seriously ill child. 1/365th is paid if full parental benefit for care of a seriously ill child has been granted. If only three-quarters, half, a quarter or an eighth parental benefit has been granted, a corresponding portion of benefits is paid. Benefits are paid for at most up to and including the end of the month in which the child attains the age of 18. If the insured dies, the right to benefits ceases from and including the day after the day on which the death occurred.

COSTS FOR CRISIS THERAPY/PSYCHOLOGY SERVICES

Compensation is paid for the cost of treatment by a psychologist and travelling costs in conjunction with such treatment if the insured has been affected by a traumatic condition as a consequence of:

- an accidental injury or sickness for which there is an entitlement to benefits in accordance with these insurance conditions
- the death of a close relative parent, sibling, grandparent, husband/wife, cohabitee, the insured's child), including miscarriage
- robbery, threat or assault on the insured personally and that has been reported to the police
- rape or other sexual offences

- violence in the family
- the involuntary unemployment of an insured adult that has lasted for at least 6 months.

In order to be granted benefits, the event needs to have occurred during the term of the insurance and that the need for treatment arose within five years from when the event occurred. Bliwa should be contacted to approve the treatment before it starts. Bliwa will only approve treatment that takes place in Sweden. The insurance pays for no more than ten treatment sessions with a registered psychologist for each insured and injury.

The cost of therapy and psychology services is primarily only compensated for treatment within the national healthcare service. However, Bliwa may also grant the cost of therapy and psychology services within the private healthcare service if there are special reasons to do so.

The insurance only covers therapy and psychology services that the insured needs as a consequence of trauma that the insured suffered as a private individual. If the insured suffers a traumatic condition at work, compensation is not paid for the cost of treatment by a psychologist as a consequence of this event.

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 8.10.3.

BENEFIT IN THE EVENT OF HOSPITAL CARE

If an accidental injury or sickness means that the insured child is admitted to hospital for inpatient care treatment for at least three consecutive days, benefits are paid for each day of the hospital stay. ‘Hospital stay’ includes the day of admission and discharge and leave of absence days without pay.

Compensation is paid for no more than 365 days from the first day on which the insured stayed in hospital. Benefits of SEK 300 per day are paid.

In case of sickness, the need for medical care must only have arisen for the first time after the child has attained the age of six months. This does not apply if the child has been covered by pregnancy insurance.

No benefits are provided for outpatient care treatment.

CARE AT HOME

If an insured child, who is younger than 16, is being cared for at home immediately after indemnifiable hospital care, and benefits from the *Hospital care* component have been paid, a daily benefit for at most 30 care days at home is paid for each individual sickness or accidental injury. Benefits of SEK 300 per day are paid. A precondition is that the need for care at home is medically justified and can be proven with medical certificates and that the need for care lasts for at least 14 days counted from the first day of hospital care. The medical certificate should also specify for how long the care is required.

If at least half the child carer’s allowance has been granted by the Swedish Social Insurance Agency for the same sickness, no benefits under the Care at home component are paid.

The insurance pays benefits in aggregate for the Hospital care and Care at home components for no more than 365 days for each individual sickness or accidental injury.

CRITICAL ILLNESS COMPENSATION

Critical illness compensation is paid as a lump sum if the insured child during the term of the insurance has been diagnosed with any of the diagnoses or adversely affected by any of the events indicated below. Entitlement to benefits under the insurance arises no earlier than seven days after the diagnosis has been confirmed or the event has occurred. No critical illness compensation is paid if the insured dies within seven days of the diagnosis having been made or the event having occurred.

Entitlement to benefits requires the diagnosis to have been made or confirmed by a physician in Sweden.

The date of an insurance event is the same as the date on which the diagnosis was made, the operation performed or Bliwa made the assessment that the insured was still suffering discomfort.

If the insured is diagnosed with several diagnoses at the time, benefits are only paid for one of the diagnoses specified in the conditions. When an entitlement to insurance compensation has arisen, a consecutive period of 90 days is then required to qualify for further compensation under the insurance.

Benefits under the insurance can be paid on no more than three occasions and only for different diagnoses.

If the insured had already received one of the indemnifiable diagnoses before the insurance entered into force, they are not entitled to benefits under the insurance in the case that they become sick with the same diagnosis (for example breast cancer (malignant neoplasm of breast: C50)) during the term of the insurance.

If the insured is undergoing examination for a certain diagnosis at the time the insurance is taken out, he or she is not entitled to benefits for such a diagnosis even if it is made after the insurance has entered into force.

AMOUNT OF BENEFIT

The benefit will be paid as a lump sum. The scope of the critical illness insurance is dependent on the scope of the child insurance taken out. The sum insured is one price base amount if the Basic Level has been taken out, two price base amounts for Premium Level and three price base amounts for Premium Extra Level. This applies unless otherwise agreed in the group agreement or indicated by the application documents and the insurance statement.

DIAGNOSES AND EVENTS THAT AFFORD ENTITLEMENT TO BENEFITS

1. Cancer
A malignant tumour characterised by the uncontrolled growth of cells and invasion of surrounding tissue. Leukaemia is also covered. Skin cancer, which is classed as a malignant melanoma, is also covered. The insured is required to be registered with the Swedish Cancer Registry to be entitled to benefits.

The following conditions are not covered by the insurance:

- preliminary stage of cancer (non-invasive cancer *in situ*)
- all skin cancer other than that specified above
- secondary tumours (metastases). Benefits may in certain cases be paid for metastases in those cases where it was not possible to localise the primary tumour.

2. Residual disablement from meningitis
Entitlement to benefits requires impact on brain, meninges or nerves caused by bacteria, viruses or other microorganisms. The diagnosis shall be verified by identifying microorganisms in the blood or spinal fluid. For it to be deemed that disablement is still being suffered, the disablement should persist for at least six months from the date on which the diagnosis was made. Furthermore, it is required that the child has had the complaint cared for at a hospital.

3. Tick-borne encephalitis (TBE)
Entitlement to benefits requires that the diagnosis has been made after TBE-specific antibodies have been detected in the insured's cerebrospinal fluid or blood. Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

4. Neuroborreliosis
Neuroborreliosis as a consequence of a tick bite. The diagnosis should be made after borrelia-specific antibodies have been detected in the cerebrospinal fluid or in the blood. Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

5. Kidney failure
The failure of both kidneys. Use of peritoneal dialysis or haemodialysis or a kidney transplant is a medical necessity. The date on which such dialysis starts corresponds to the date on which the diagnosis was made. Benefits are not paid if the insured has received benefits for kidney transplantation in accordance with item 6 for the same insurance event.

6. Organ transplant
Heart, liver, lungs, pancreas, kidney or bone marrow transplant received. The insurance does not cover the organ donor. Autologous bone marrow transplant does not afford entitlement to benefits. Benefits for kidney transplantation are not paid if the insured has received benefits in accordance with item 5 for the same insurance event.

7. Deafness
Entitlement to benefits requires the insured to have suffered a permanent loss of hearing in both ears that has resulted in total loss of hearing.

8. Blindness
Entitlement to benefits requires the insured to have suffered a complete and permanent loss of sight in both eyes.

9. Loss of arm or leg
Entitlement to benefits requires loss of an arm above the wrist or leg above the ankle.

10. Loss of speech
Entitlement to benefits requires that the insured has suffered a total and permanent loss of speech as a consequence of physical damage to vocal cords.

11. Paralysis
Entitlement to benefits requires that the insured has suffered complete and permanent paralysis of one or both arms or one or both legs.

12. Stroke
A cerebrovascular (blood clot or haemorrhage) accident (CVA). The term 'cerebrovascular accident' includes thromboses, embolisms and ruptures of blood vessels in the brain. Exemptions from entitlement to benefits apply for Transient Ischaemic Attacks (TIA) and Reversible Ischaemic Neurologic Deficit (RIND).

13. Multiple sclerosis (MS)
A diagnosis made by a physician after more than one episode of neurological impact that demonstrated well-defined neurological disease confirmed by recognised investigation methods at the time of the insurance event affords entitlement to benefits.

COMPENSATION FOR SCARS AND OTHER APPEARANCE-RELATED CONSEQUENCES OF AN INJURY
The insurance compensates scars and other appearance-related consequences of an injury as a result of accidental injury or sickness that occurred during the term of the insurance. The change must have occurred after the child was born and when the child insurance is in force. Compensation is only paid after treatment has been completed and when the scar or appearance-related consequence of the injury is considered to be permanent for the future, though no earlier than one year after the accident or sickness happened. Bliwa compensates scars that are considered to be at least of the category *very noticeable* according to the Traffic Injuries Commission's compensation table for appearance-related consequences of injuries. The amount of the compensation is determined independently of the chosen sum insured for invalidity.

A precondition for entitlement to benefits is that the injury was so serious that it required treatment within the health services.

BENEFIT IN THE EVENT OF INVALIDITY
There is entitlement to benefits in the event of invalidity if the accidental injury or sickness resulted in a permanent impairment of the insured's bodily function, medical invalidity, or at least a 50 per cent reduction of the insured's current and/or future work capacity, financial invalidity, as a consequence of the accidental injury or sickness, as confirmed by a physician. Benefits are paid when the level of invalidity has been finally determined.

The following limitations apply for entitlement to compensation in the event of invalidity as a consequence of sickness: the sickness or a manifest symptom of sickness shall have manifested itself for the first time during the term of the insurance and after the insured child has attained the age of six months. See also Sub-clause 8.6.1.2.

Medical invalidity is a physical or mental impairment as a consequence of the accidental injury or sickness that has been confirmed irrespective of the insured's profession, working conditions or leisure interests. Medical invalidity also includes loss of an internal organ and loss of a sensory function. It should be possible to determine the impairment objectively; see further information below.

Financial invalidity is an impairment of the insured's work capacity as a consequence of the accidental injury or sickness. For Bliwa to pay benefits, it is required that the Swedish Social Insurance Agency, as a consequence of the accidental injury or sickness, has granted at least 50 per cent activity compensation or sickness compensation for at least five years and/or at least 75 per cent child carer's allowance for the insured from and including the age of ten for at least five years. Entitlement to benefit for financial invalidity requires that the accidental injury or sickness has resulted in permanent medical invalidity.

8.10.12.1 Benefit in the event of medical invalidity
Invalidity benefits for medical invalidity are paid if the insured has suffered an accidental injury or sickness that has resulted in a permanent impairment of a bodily function and if the condition is stationary but not life-threatening.

For the insured to be entitled to benefits, the sickness or accidental injury is required to have occurred during the term of the insurance and also have resulted in a measurable invalidity within three years from the insurance event. Medical invalidity cannot normally be finally determined until one year has elapsed from the date of the accident or from the date on which the sickness manifested itself. A final assessment of entitlement to benefits shall only be made when the level of invalidity has been finally determined, which may be postponed for as long as there is a possibility of further medical rehabilitation.

Bliwa will never pay more than the sum insured for 100 per cent invalidity even if the accidental injury or sickness has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent. If a lost body part can be replaced by a prosthesis, the level of invalidity is determined considering the prosthesis and its importance to the bodily function of the insured.

The level of invalidity is determined with the guidance of the applicable industry rating scale at the time of payment.

8.10.12.2 Benefit in the event of financial invalidity
Bliwa pays benefits for financial invalidity if the insured person suffers an accidental injury or sickness that has resulted in or may be expected to result in an impairment of the insured's work capacity by at least 50 per cent of full work capacity (100 per cent).

For Bliwa to pay benefits, it is required that the Swedish Social Insurance Agency, as a consequence of the accidental injury or sickness, has granted at least 50 per cent activity compensation or sickness compensation for at least five years and/or at least 75 per cent child carer's allowance for the insured from and including the age of ten for at least five years. The above condition should be satisfied before the end of the year in which the insured attained the age of 30.

Periods of at least 75 per cent child carer's allowance and/or 50 per cent activity compensation/sickness compensation can be aggregated for a five-year period. Benefits can be paid at the earliest when the insured has attained the age of 15. The five-year period is deemed to have started when the Swedish Social Insurance Agency has granted at least 75 per cent child carer's allowance for the insured from and including the age of ten or the insured is granted at least 50 per cent activity compensation for the first time.

For the insured to be entitled to benefits, the accidental injury or sickness is required to have resulted in permanent medical invalidity before the financial invalidity arose.

The insured's level of invalidity is established on the basis of the amount of the activity compensation/sickness compensation or the child carer's allowance resulting from the accidental injury or sickness that has afforded entitlement to benefits. Only the accident's or sickness's portion of the activity compensation/sickness compensation /child carer's allowance should be assessed and the insurance only compensates this portion.

If the insured has suffered several injuries that are covered by the insurance and these injuries occurred at different times, one of these injuries must alone result in a permanent impairment of the insured's work capacity by at least 50 per cent or 75 per cent of full work capacity respectively for the insured to be entitled to benefits.

The amount to be paid as invalidity benefit is an equally large portion of the sum insured as the level of activity compensation/sickness compensation granted by the Swedish Social Insurance Agency. Benefits are provided for 50 per cent of the sum insured if half activity compensation/sickness compensation is granted, 75 per cent of the sum insured for three-quarters activity compensation/sickness compensation and 100 per cent of the sum insured for full activity compensation/sickness compensation. Bliwa's assessment of work incapacity as a consequence of the accidental injury or sickness may differ from that made by the Swedish Social Insurance Agency if there are special reasons to do so.

If the insured was already entitled to activity compensation/sickness compensation or other corresponding benefits under the Social Insurance Code at the time of the injury owing to a permanent incapacity to work, the financial invalidity benefits from Bliwa will correspond to no more than the loss of the remaining work capacity. This means that an insured who was already entitled to full activity compensation/sickness compensation or other corresponding benefits under the Social Insurance Code at the time of the accident cannot receive any financial invalidity benefit.

8.10.12.3 Additional benefits

Additional benefits for financial invalidity may be paid if the insured receives a higher level of the child carer's allowance or activity compensation/sickness compensation for a consecutive period of at least two years as a consequence of an accidental injury or sickness covered by the insurance and where financial invalidity benefit has previously been paid.

A deduction is made for the percentage level of invalidity previously paid in the case of additional payments of financial invalidity.

No further financial invalidity benefits can be paid from the insurance if 100 per cent financial invalidity was paid. A payment is made if the preconditions for benefits have been satisfied no later than before the end of the year in which the insured attains the age of 30.

8.10.12.4 Payment of invalidity benefit

The sum insured is determined by the price base amount applicable for the year in which Bliwa provides the benefit. The amount of the sum insured is indicated by the insurance statement.

The claim will only be finally settled when the medical or, when applicable, financial invalidity has been finally determined by Bliwa. However, an advance payment of invalidity benefit may be paid out prior to this. This advance will correspond to the minimum level of invalidity expected. The advance, expressed in Swedish kronor, will subsequently be deducted from the benefit paid out when the level of invalidity has been finally determined.

If the insured dies before Bliwa has finally settled the claim, and the medical invalidity was determined by Bliwa prior to this, an amount will be paid out corresponding to the insured's medical invalidity. The payment will be made to the insured's estate.

8.10.12.5 Possibility to review the benefit if invalidity increases
The insured is entitled to have the level of their invalidity reconsidered, following a written request to Bliwa, provided:

- the injury or sickness resulted in a significant deterioration in the insured's bodily functions after Bliwa finally settled the claim
- the insured lost further work capacity or alternatively has received a higher level of the child carer's allowance or activity compensation/sickness compensation after Bliwa finally settled the claim.

Bliwa will reconsider the level of invalidity if the insured requests this in writing and provides details of the circumstances that, according to the above, may afford entitlement to reconsideration. In order to make a new assessment of the level of invalidity Bliwa requires that the circumstances supporting such new assessment can be determined objectively. Bliwa decides what supporting information is required for such an objective assessment. The insured must personally furnish Bliwa with the supporting information requested by Bliwa. The insured shall pay for the cost of any new invalidity certificate. However, Bliwa will subsequently pay compensation for such new invalidity certificates if a deterioration of the insured's bodily functions has actually been objectively demonstrated and a new level of invalidity determined. A reconsideration may never be conducted when more than ten years have elapsed from the date of the accident or the date on which the sickness first manifested itself; see Sub-clause 1.16.

8.11 BENEFIT IN THE EVENT OF DEATH

As a result of an accident
One price base amount is paid to the insured's estate if the insured dies as a consequence of an accidental injury within three years from the date of the accident.

However, if the insured commits suicide, this is treated under this insurance as being an accidental injury.

As a result of sickness
One price base amount is paid to the insured's estate if the insured dies as a consequence of sickness that first manifested itself during term of the insurance.

Benefits cannot be paid both from pregnancy insurance and child insurance for the same insurance event.

The beneficiaries are the insured's estate in the first instance, unless Bliwa is notified of a different nomination in writing. However, the insured can notify Bliwa of a different nomination of beneficiary through a personally signed written communication (a separate nomination of beneficiaries). For child insurance, the insured may make their own nomination of beneficiaries if they have attained the age of 18. The insured is at liberty to choose who should be a beneficiary by such a nomination. A standard form for a separate nomination of beneficiaries can be printed out from *www.bliwa.se* or ordered from Bliwa.

A nomination of beneficiaries cannot be amended through a will.

9. Limitations to Bliwa's liability

9.1 DUTY OF DISCLOSURE

The policyholder and the insured are obliged to provide, at the request of Bliwa, information that may be relevant to the issue if insurance is to be concluded, amended or otherwise processed. The policyholder and the insured shall provide correct and complete answers to Bliwa's questions. Bliwa must be notified immediately if the insured was reported to Bliwa as incapable of working and subsequently returns to work. The insured is also obliged to immediately notify Bliwa if they receive benefits from the Swedish Social Insurance Agency and if these benefits are changed or cease. The insured should also provide Bliwa with information about other circumstances that may affect entitlement to benefits under the insurance products.

Bliwa may demand and be entitled to repayment of insurance compensation paid incorrectly as a consequence of incorrect information. If the policyholder, insured or anyone else to their knowledge has provided incorrect or incomplete information that is relevant to the assessment of the insured's entitlement to compensation under the insurance, this may result in the insurance agreement being invalid or the benefit amounts reduced in accordance with the provisions of the Insurance Contracts Act.

9.2 CONSEQUENCE OF INCORRECT INFORMATION

If the policyholder has acted fraudulently or in bad faith when performing their duty of disclosure under Sub-clause 9.1, the insurance agreement may be invalid and Bliwa released from its liability for an insurance event that subsequently occurs. Bliwa may in such case retain the premium paid in respect of the preceding periods.

If the policyholder or the insured – intentionally or through carelessness that is not insignificant – provided incorrect or incomplete information that was relevant to Bliwa's risk assessment, Bliwa's liability may be limited to the liability that would have applied if correct and complete information had been provided. This may mean that Bliwa is released from liability for an insurance event that has occurred.

Bliwa may give notice of termination or amend the insurance if Bliwa becomes aware that the duty of disclosure has been disregarded in such a way as mentioned above. Notice of termination is given in writing with a three-month term of notice. If Bliwa would have issued insurance on different conditions if it had been aware of the correct information, the policyholder is entitled to continued insurance at the sum insured corresponding to the premium and conditions otherwise agreed. In such a case, the policyholder must request continued insurance before the period of notice of termination expires.

9.3 VALIDITY OF INSURANCE IN THE EVENT OF STAYS ABROAD

STAYS ABROAD THAT ARE NOT AFFECTED BY LIMITATIONS IN THE EVENT OF A STATE OF WAR OR POLITICAL UNREST

These insurance products (lump-sum benefit, health insurance, medical invalidity in the event of sickness, critical illness insurance, personal accident insurance, child insurance and premium waiver) also cover work incapacity, sickness and accident that the insured incurs when staying abroad if the stay is for no longer than one year. The insurance also cover stays abroad for a period of more than one year, although this is then limited to stays within the Nordic countries. Furthermore, the insurance also cover stays outside the Nordic countries for a period of more than one year, although in this case only if the stay is due to the fact that the insured or the insured's husband, wife or cohabitee has:

- a post abroad with the Swedish central government, a Swedish company or a Swedish non-profit association,
- a post with a non-Swedish undertaking that is a parent company, subsidiary or fellow subsidiary of a Swedish company, or
- a post with an association of states of which Sweden is a member.

If the insured is staying abroad as a consequence of a post abroad, the insurance also applies to a co-insured husband, wife or cohabitee and also children of the insured or their wife/husband or cohabitee if they are co-insured.

Life insurance – death benefit and Life insurance – death benefit – children also applies if the insured dies abroad, irrespective of the length of the foreign stay.

A stay outside the Nordic countries is not deemed to have been interrupted owing to a temporary break in the Nordic countries for a doctor's appointment, hospital care, business, a vacation or the like.

Furthermore, Bliwa does not pay compensation for expenses for an accident, or sickness in child insurance, that are compensated under separate travel insurance, a travel component of home insurance or other insurance. Compensation for costs as a result of an accident, or sickness under child insurance, that occurred abroad is dealt with as if the accident or sickness had occurred in Sweden. This means, for instance, that compensation is only paid for medical care and pharmaceuticals up to the level of the Swedish high cost protection. Compensation is only paid for costs of care and treatment within the national healthcare service. The insurance does not compensate costs as a consequence of the homeward transport (repatriation) of the insured. Nor does it compensate treatment costs for dental injuries or other medical costs, if the costs arose abroad after the date or time when the homeward journey was originally planned.

For stays abroad, compensation is always paid solely for the costs that arose within the first year of the stay. Compensation is never paid for expenses that arose during a stay abroad that lasted more than one year. This applies regardless of the country in which the insured is residing or the reasons for the stay abroad.

9.4 VALIDITY OF INSURANCE IN THE EVENT OF STATE OF WAR AND POLITICAL UNREST

IN THE EVENT OF A STATE OF WAR IN SWEDEN

A 'state of war in Sweden' means a war or situation for which special legislation applies.

Life insurance - death benefit
Special legislation applies to matters relating to Bliwa's liability and right to charge a war premium.

Lump-sum benefit, health insurance and medical invalidity in the event of sickness
These insurance products do not cover an incapacity to work suffered by the insured while a state of war prevails in Sweden if this incapacity to work may be deemed to be due to the state of war.

The same rule applies if the insured suffers an incapacity to work within one year after the state of war has ceased.

Critical illness insurance, personal accident insurance and child insurance
These insurance products do not cover an accident or sickness that occurs while a state of war prevails in Sweden and that may be deemed to be due to the state of war.

IN THE EVENT OF PARTICIPATION IN A FOREIGN WAR OR POLITICAL UNREST OUTSIDE SWEDEN

Life insurance – death benefit, lump-sum benefit, health insurance and medical invalidity in the event of sickness
These insurance products do not cover death or incapacity to work that occurs when the insured participates in a war or political unrest outside Sweden. Nor does the insurance cover death or an incapacity to work that occurs within one year after such participation and that may be deemed to be due to the war or unrest.

Critical illness insurance, personal accident insurance and child insurance
These insurance products do not cover sickness or an accident that occurs when the insured participates in a war (that is unrelated to a state of war in Sweden) or political unrest outside Sweden. Participation in military peace-keeping activities under the auspices of the UN or according to a decision by OSSE (Organization for Security and Co-operation in Europe) are not counted as participation in war or political unrest. Instead the provisions regarding stays outside Sweden apply during a war or warlike political unrest (see below).

IN THE EVENT OF STAYS OUTSIDE SWEDEN IN THE EVENT OF WAR OR WARLIKE POLITICAL UNREST

Life insurance – death benefit, lump-sum benefit, health insurance, medical invalidity in the event of sickness, critical illness insurance, personal accident insurance and child insurance.
The following applies if the insured is staying outside Sweden in an area where war or warlike political unrest prevails – but is not personally participating: If the insurance was taken out in conjunction with the outward journey to, or during the stay in, the area and the war or unrest was already underway or there was a manifest risk of war, this insurance does not cover death, work incapacity, sickness or accident that occurs during the stay in the area. Nor does the insurance cover an insurance event that occurs within one year after the end of the stay and that may be deemed to be due to the war or unrest.

9.5 DAMAGE CAUSED BY A NUCLEAR REACTION AND ALSO BIOLOGICAL, CHEMICAL AND NUCLEAR SUBSTANCES

These insurance products do not cover an insurance event whose occurrence or scope is directly or indirectly linked to a nuclear reaction.

Nor do these insurance products cover an insurance event that has arisen through the spread of biological, chemical or nuclear substances in conjunction with an act of terrorism. ‘Act of terrorism’ means a harmful act that is penalised where it is committed or where the insurance event occurs and that appears to have been performed with a view to:

- seriously frightening the population
- inappropriately compelling a public body or international organisation to implement or refrain from implementing certain action
- seriously destabilising or destroying the fundamental political, constitutional, financial or social structures in a country or in an international organisation.

9.6 VALIDITY OF THE INSURANCE IN THE EVENT OF CRIMINAL ACTS, INFLUENCE OF ALCOHOL, ETC.

CRITICAL ILLNESS INSURANCE, PERSONAL ACCIDENT INSURANCE AND CHILD INSURANCE
In the event of an accidental injury, compensation will be reduced or denied completely if:

- the insured through gross negligence has induced an insurance event or aggravated its consequences or otherwise must be assumed to have acted or omitted to act even though they knew that this entailed a significant risk of the damage occurring
- the insured has performed or contributed to a criminal act that may result in imprisonment under Swedish law
- the insured was under the influence of alcohol, other intoxicants, soporifics, narcotic substances or it was a consequence of them having used a pharmaceutical in an improper way.

It is required that the event that caused the injury was a direct consequence of, or may be deemed to be linked to, one of the above for these limitations to apply. These limitations do not apply if the insured was under the age of 18 or was seriously mentally disturbed at the time of the injury.

9.7 FORCE MAJEURE

Bliwa is not responsible for loss that may arise if the processing of an insurance application, investigation of an insurance event, payment or similar commitment of Bliwa is delayed owing to an event that lies outside the control of Bliwa. Bliwa should also have taken such action as may reasonably be required of Bliwa to mitigate the consequences of such an event. Examples of such events that may lead to a release from liability as provided above are war, warlike conditions or political unrest, natural disaster, restrictions to public communications or energy supply, Riksdag (Swedish Parliament) decision, measure taken or omitted by a public authority, industrial conflict, blockade, fire, flooding, sickness or major accident or extensive loss or destruction of property.

The reservation in respect of industrial conflict and blockade also applies if Bliwa itself is the subject of or has itself taken such a measure.

9.8 LEGAL REPRESENTATIVE

Compensation is not paid under Bliwa's group insurance for the cost of engaging a legal representative.

9.9 JOINT CLAIMS REPORT REGISTER

Bliwa is entitled to register claims in connection with this insurance in a joint claims report register (GSR) for the insurance industry. GSR AB is the controller of personal data for processing personal data in the GSR register.

10. Processing of personal data

Bliwa protects your personal privacy. All processing of personal data is performed on the basis of applicable legislation, recommendations issued for the industry and Bliwa's internal rules. You can find out more about how Bliwa processes your personal data at *www.bliwa.se/personuppgifter*. Here you can also find out what rights you have in relation to us. Please contact Bliwa if you would prefer to have this information sent to your home.

11. Bliwa's insurance distribution

Bliwa's insurance may be distributed by Bliwa or another distributor engaged by Bliwa to deal with the distribution. The party distributing the insurance must provide the customer with information about the distribution. For this reason, the following information applies in the event that Bliwa is the insurance distributor.

Name of employee who participated in the distribution

Insurance is normally distributed to natural persons digitally or via a standard form, i.e. without the direct assistance of an employee. Insurance may be distributed to legal persons digitally, via a standard form or by communication with an employee at Bliwa. The name of such employee will be indicated, when applicable, by the insurance agreement or notified separately in conjunction with the conclusion of the agreement.

Advice

Bliwa does not provide insurance advice to private individuals.

Information about remuneration

Remuneration is not payable to Bliwa's employees as a consequence of the distribution of individual insurance agreements.

12. If we do not agree

RECONSIDERATION BY BLIWA

You should in the first instance contact Bliwa if you are dissatisfied with Bliwa's decision in order to have the matter reconsidered. A complaint or request for reconsideration must be presented to Bliwa within six months from Bliwa's final notice in the matter. However, if new circumstances have occurred, Bliwa will reconsider a matter even after this period has expired. Reconsideration is conducted in accordance with Bliwa's guidelines for dealing with complaints applicable at the time. In the first instance we would like you to contact the person who dealt with your matter to have it reconsidered. You should contact the Complaints Officer at Bliwa if you are still dissatisfied with the case officer's decision. You can also contact the Complaints Officer or some other instance for dispute resolution in accordance with the following if you are not satisfied with Bliwa's distribution.

Bliwa's Complaints Officer will consider your matter free of charge; write to: Bliwa, Klagomålsansvarig (Complaints Officer), Box 13076, SE-103 02 Stockholm, Sweden or send an email to: *klagomalsansvarig@bliwa.se*.

THE SWEDISH CONSUMERS' INSURANCE BUREAU

The Swedish Consumers' Insurance Bureau can provide general information and guidance on insurance issues. Address: Konsumenternas försäkringsbyrå, Box 24215, SE-104 51 Stockholm, Sweden.
Telephone number: +46 (0)200-22 58 00.

MUNICIPAL CONSUMER ADVICE OFFICER

The consumer advice officer in your municipality can help consumers with general advice and information.

THE BOARD FOR INSURANCE OF PERSONS

The Board for Insurance of Persons only considers matters that involve insurance-medical issues and where the Board therefore needs to have support by a consultant physician. Matters at the Board for Insurance of Persons can therefore normally only relate to Bliwa’s health, personal accident or life insurance policies.

Address: Personförsäkringsnämnden, Box 24067, SE-104 50 Stockholm, Sweden. Telephone number: +46 (0)8-522 787 20.

THE NATIONAL BOARD FOR CONSUMER DISPUTES (ARN)

ARN is a government authority that considers without charge disputes between private individuals and business operators. The Board applies limits in respect of values that may mean that disputes involving low values are not considered. Nor does the Board conduct any medical assessments. Address: Allmänna reklamationsnämnden, Box 174, SE-101 23 Stockholm, Sweden. Telephone number: +46 (0)8-508 860 00.

JUDICIAL REVIEW

A dispute can also be considered by a general court. A Swedish district court (*tingsrätt*) is the first instance.

Bliwa

Bliwa Livförsäkring, ömsesidigt
Box 13076
SE-103 02 Stockholm, Sweden
kund@bliwa.se, bliwa.se
Telephone: +46 (0)8-696 22 80