SUPPLEMENTARY INSURANCE CONDITION CI22:

Valid as of: 01.07.2022

Type of Insurance: **Supplementary Illness Insurance**

Insured Events

1. Insured event shall be a critical illness diagnosed and treatment or surgery has been performed to the Insured during the period of validity of the insurance coverage and named in the list of critical illnesses indicated in the Insurance Contract.
   The list of critical illnesses covered and diagnostic criterions are presented in the Annex 1 to this Supplementary Insurance Condition. The diagnosis of the critical illness must completely meet the requirements indicated in the Annex 1.
2. An event shall be considered an insured event if it occurs while the insurance coverage is valid and if it is confirmed by official documents and suitable evidence.
3. After the insurance benefit is paid, the validity of this Supplementary Insurance Condition expires.

Uninsured Events

4. A critical illnesses shall be considered an uninsured event if it:
   - 4.1. was diagnosed during first 3 months this Supplementary Insurance Condition was valid;
   - 4.2. is related to the deliberate self-inflicted injury, self-administered poisoning, or attempted suicide of the Insured;
   - 4.3. caused the Insured to die within 30 days of the critical illness diagnosis;
   - 4.4. is related to war (whether declared or unannounced), military actions, participation in riots and revolution, nuclear radiation impact.
   - 4.5. Additional uninsured events related to some critical illness have been described in Annex 1 to this Supplementary Insurance Condition.

Insurance Benefits Paid in Case of an Insured Event

5. In case of an insured event, the Insurer shall pay a lump-sum insurance benefit the size of which shall be equal to the sum insured that is specified for critical illness in the Insurance Contract.
6. If the sum insured that is specified for critical illness was increased and an insured event occurs in the first 3 months after said increase, the payable insurance benefit shall be equal to the least sum insured that was valid for a critical illness during the last 3 months.
7. The insurance benefit for a critical illness shall be paid only once, regardless of how many and which critical illnesses were diagnosed in respect to Insured.
8. While the Insurance Contract is valid, the Insurer shall be entitled to amend the List of Critical Illnesses presented in Annex 1 to this Supplementary Insurance Condition, by adding new illnesses, cancelling existing ones, and amending the diagnostic criteria. The Insurer shall inform the Policyholder in writing at least one month prior to the effective date of said amendment to Annex 1. If the Policyholder does not agree with the amendment, he must notify the Insurer in writing about this. In this case the Policyholder shall be entitled to amend the conditions relating to this Supplementary Insurance Condition free of charge or to terminate the Insurance Contract. If the Policyholder does not notify the Insurer in writing about the termination of the Insurance Contract or the amendment of its conditions by the date specified in the written notice, it shall be considered that the Policyholder agrees with the change.

Insurance Benefits Paid in Case of an Uninsured Event

9. In cases of an uninsured event the Insurer shall pay out no insurance benefits.

Deadlines for Reporting an Insured Event

10. An insured event must be reported to the Insurer in a form enabling written reproduction as soon as possible, but no later than within one month of the date the diagnosis was made or the last day of the in-patient treatment, when the diagnosis was made.

Documents to be Submitted When Applying for an Insurance Benefit

11. The application to the Insurer to receive the insurance benefit should be supported with the following documents:
    11.1. Identification document of the person who is applying for the insurance benefit;
    11.2. An application indicating the date, place and nature of the insured event, character and duration of inpatient or outpatient treatment, as well as bank's account where the insurance benefit shall be transferred;
    11.3. Detailed medical certificates from a healthcare institution describing exact diagnosis, anamnesis, tests, and treatment, that can be used to determine whether the diagnosis precisely satisfies the criteria specified in Annex 1 to this Supplementary Insurance Condition;
    11.4. Document confirming the disability or the loss of the ability to work of the Insured, if such document has been issued;
12. The Insurer may request for other documents not indicated in paragraph 11, if such documents are necessary to justify the insurance benefit and determine its amount.
13. The Insurer may require that the diagnosis be confirmed at the Insurer's expense in a healthcare institution selected by the Insurer.
14. In case a document is issued by a foreign institution, the Insurer shall have the right to ask for a properly certified translation of this document into Estonian language. The Insurer shall not cover expenses of the translation.

Recipient of the Insurance Benefit

15. If Insured person is at least 18 years of age at the moment of insured event the insurance benefit shall be paid to the Insured, unless a separate Beneficiary entitled to receive insurance benefits of this Supplementary Insurance Condition has been specified in the Insurance Contract. If the Insured is less than 18 years of age at the moment of insured event the insurance benefit shall be paid to the Policyholder.
16. The insurance benefit may not be paid to a person, whose deliberate actions (as established by a court) caused the insured event. In this case, the part of the payable insurance benefit belonging to the culprit shall be paid as follows:
    16.1. Proportionally to other Beneficiaries indicated in the Insurance Contract;
    16.2. To the Insured, if no other Beneficiaries have been appointed.
17. If the insurance benefit recipient dies after the insured event but before he has an opportunity to accept the insurance benefit, the insurance benefit shall be paid to the deceased recipient's legal heirs.

ANNEX 1 TO SUPPLEMENTARY INSURANCE CONDITION NO. CI22: CRITICAL ILLNESS

LIST OF CRITICAL ILLNESSES:

1. Myocardial Infarction
2. Coronary artery by-pass surgery
3. Stroke
4. Cancer
5. Kidney failure
6. Major organ transplant
7. Loss of limbs
8. Blindness
9. Third degree burns
10. Surgery to aorta
11. Heart valve replacement or repair
12. Deafness
13. Loss of speech
14. Multiple sclerosis
15. Parkinson's disease
16. Benign brain tumour
17. Alzheimer's disease
18. Diabetes mellitus type 1
19. Encephalitis
20. Bacterial Meningitis
21. Total and permanent disability

DEFINITIONS

1. Myocardial infarction

Myocardial infarction is irreversible damageof a portion of the heart muscle (necrosis) as a result of abrupt interruption of adequate blood supply to that area.
The diagnosis should be based upon at least two of the three following criteria:

1) experience of typical chest pain
2) new electrocardiographic changes, characteristic to myocardial infarction;
3) an elevation of the values of biochemical markers in the blood, specific to myocardial infarction.

2. Coronary artery bypass surgery

Open heart surgery to correct narrowing or blockage of one or more coronary arteries with insertion of bypass graft(s).
Narrowing or blockage of the coronary artery must be supported by angiographic evidence.
The insurance benefit is not paid for angioplasty, other intra-arterial or laser procedures.

3. Stroke

Acute non-traumatic cerebrovascular incident resulting in irreversible death of brain tissue due to intracranial haemorrhage, thrombosis in an intracranial vessel or due to embolism.
Insurance benefit is paid only if **permanent neurological deficit*** persists for at least 3 (three) months after the stroke.

4. Cancer

Cancer is the presence of uncontrolled growth and spread of malignant cells and invasion of tissue. The term "cancer" also includes leukaemias and lymphomas. Indisputable evidence of the invasion of tissue and histological confirmation of a malignant growth must be produced
Insurance benefit is not paid in case of localized non-invasive tumours showing only early malignant changes (carcinomas in situ), precancerous condition, tumours in the presence of HIV / AIDS and any skin cancer except malignant melanomas.

5. Kidney failure
Chronic and endstage failure of both kidneys to function. , as a result of which regular dialysis is permanently required. Insurance benefit is not paid in case of acute renal failure when only temporary dialysis is needed.

6. Major organ transplant
The undergoing as a recipient of a transplant of bone marrow or of a heart, kidney, liver, lung or pancreas or inclusion of the Insured on an official waiting list for such a procedure. Insurance benefit is not paid for donors.

7. Loss of limbs / loss of use of limbs
The complete and permanent loss of two or more limbs as a result of injury or disease. Loss of limb is considered loss of limb or its function above the wrist or ankle joint. In some cases loss of limb function may be temporary, in which case insurance benefit is paid if loss of limb function persists after 3 months from its occurrence and is confirmed by a specialist on the basis of clinical symptoms and diagnostic tests.

8. Blindness
Permanent and irreversible loss of sight of both eyes due to accident or disease. Loss of sight is defined as a case where even when tested with the use of visual correction aids the visual acuity of the better-seeing eye is less than 6/60 if measured by the metric system or 0.1 on a decimal scale of visual acuity, or a decrease in the visual field of both eyes to 20° or less. Insurance benefit is not paid in cases when condition can be corrected by therapeutic or surgical treatment.

9. Third degree burns
Third degree burns resulting in full thickness skin destruction of at least 20% of the total skin area. Diagnosis and the total area involved must be confirmed by a specialist using standardized, clinically accepted methods for determining body surface area.

10. Surgery to aorta
The undergoing of surgery to remove an aneurysm, narrowing, obstruction or dissection of the aorta. The definition of aorta includes thoracic and abdominal parts of aorta, but not its branches. Insurance benefit is paid in case of both open and minimally invasive procedures such as endovascular surgeries.

11. Heart valve replacement or repair
The undergoing of surgery to replace or repair one or more heart valve. Insurance benefit is paid in case of both open and minimally invasive procedures such as endovascular surgeries.

12. Deafness
Permanent and irreversible loss of hearing in both ears due to accident or disease. Loss of hearing is defined as a case where based on audiometric examination there is at least 90 db hearing threshold in a better hearing ear in all frequency ranges. Insurance benefit is not paid in cases when condition can be corrected by medical treatment, including with help of hearing aids or surgical procedures.

13. Loss of speech
Total permanent and irreversible loss of the ability to speak due to accident or disease. Cases arising as a consequence of surgery or medical treatment for an illness are also covered. Loss of speech diagnosis must be confirmed by a specialist.
Insurance benefit is paid if total loss of speech remains after 6 months since diagnosis. Insurance benefit is not paid in case of loss of speech due to mental disorders.

14. Multiple sclerosis
A definite diagnosis of Multiple sclerosis which satisfies all of the following criteria:
1. There must be clinically confirmed impairment of motor or sensory function, which have persisted for a continuous period of at least six (6) months.
2. The diagnosis must be confirmed by diagnostic techniques current at the time of the claim.

15. Parkinson's disease
A definite diagnosis of Parkinson's disease confirmed using diagnostic techniques current at the time of the claim. Insured must experience permanent impairment of motor function with associated tremor or muscle rigidity.

Insurance benefit is paid if condition lasts for at least three (3) months. Insurance benefit is not paid for parkinsonian syndromes, including those caused by toxic factors or alcohol or drug abuse.

16. Benign brain tumour
A non-malignant tumour of the brain, cranial nerves or meninges within the skull, resulting in any of the following consequences:
1) tumour that causes **permanent neurological deficit*** that persists for at least 3 (three) months;
2) undergoing invasive surgery to remove part or all of the tumour;
3) undergoing stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.
Insurance benefit is not paid in case of cysts, granulomas, hematomas, malformations of the arteries or veins of the brain, in case of tumours in the pituitary gland and in case of tumour in presence of HIV / AIDS.

17. Alzheimer's
A definite diagnosis of Alzheimer's disease confirmed using diagnostic techniques current at the time of the claim. Disease must be resulting in permanent symptoms and supported by evidence of progressive loss of ability to remember, reason and to perceive, understand, express and give effect to ideas.

18. Diabetes mellitus type 1
A definite diagnosis of Type 1 diabetes mellitus, requiring the permanent use of insulin injections. The insurance benefit is not paid in case of Type 2 diabetes (including Type 2 diabetes that is treated with insulin), gestational diabetes and in case of other impairments of glucose tolerance.

19. Encephalitis
A definite diagnosis of encephalitis resulting in **permanent neurological deficit*** that persists for at least 3 months after diagnosis.
The diagnosis should be based on typical clinical symptoms and results of cerebrospinal fluid tests.
Insurance benefit is not paid if the Insured is diagnosed with HIV / AIDS and in case of myalgic or paraneoplastic encephalomyelitis

20. Bacterial Meningitis
A definite diagnosis of bacterial meningitis resulting in **permanent neurological deficit*** that persists for at least 3 months after diagnosis.
The diagnosis should be based on typical clinical symptoms and results of cerebrospinal fluid tests.
Insurance benefit is not paid in case of all other forms of meningitis including viral meningitis.

21. Total and permanent disability.
Significant loss of physical or mental capacity due to an accident or illness that severely limits the Insured's ability to perform any job or take care of himself / herself.
When the Insured is 16 years of age or older, insurance benefit is paid in cases when competent Estonian state institution determines that Insured has no work ability at all. When the Insured is under 16 years, insurance benefit is paid if competent Estonian state institution determines profound disability degree of the Insured.
Insurance benefit is paid only in cases when no work ability or profound disability lasts for a continuous period of 12 months or more.
The insurance benefit is not paid if no work ability or profound disability is determined due to mental or behavioural disorders.
If official methods of determining no work ability or profound disability in Estonia change, in case of the insured event Insurer may follow changed criteria for determining no work ability or profound disability.

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* **Permanent neurological deficit** refers to symptoms of dysfunction in the nervous system that are identified during clinical examination by a neurologist. Symptoms include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.