MANDATUM LIFE

SUPPLEMENTARY INSURANCE CONDITION CI20-1:

CRITICAL ILLNESS

Valid as of: 05.09.2020

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. appeared when the Insured was HIV positive;
4.3. is related to the deliberate self-inflicted injury, self-administered poisoning, or attempted suicide of the Insured;
4.4. caused the Insured to die within 30 days of the critical illness diagnosis;
4.5. is related to war (whether declared or unannounced), military actions, participation in riots and revolution, nuclear radiation impact.
4.6. 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. CI20-1: CRITICAL ILLNESS

LIST OF CRITICAL ILLNESSES:

1. Heart attack (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 before the age of 60
16. Benign brain tumour
17. Alzheimer's disease before the age of 60
18. Total and permanent disability

DEFINITIONS

1. Heart attack (Myocardial infarction)

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

1) a history of typical chest pain
2) new electrocardiographic changes, typical to myocardial infarction and
3) an elevation in cardiac enzyme levels in blood.

2. Coronary artery bypass surgery

Open heart surgery to correct narrowing or blockage of two or more coronary arteries by the use of saphenous vein grafts, internal mammary grafting, but excluding all non-surgical procedures such as balloon angioplasty and laser techniques. Angiographic evidence of the underlying disease must be provided.

3. Stroke

Acute cerebrovascular incident producing neurological sequelae lasting more than 24 hours, including:

1) infarction of brain tissue
2) haemorrhage from an intracranial vessel and
3) embolization from an extracranial source.

Insurance benefit shall be paid only in case evidence of permanent neurological deficit exists. Permanent neurological deficit should be confirmed by doctor neurologist, not earlier than 6 weeks after the stroke.

4. Cancer

Cancer is the presence of uncontrolled growth and spread of malignant cells and invasion of tissue. Incontrovertible evidence of the invasion of tissue and definite histology of a malignant growth must be produced. The term "cancer" also includes malignant tumours of the lymphatic, hematopoietic and related tissues.

Excluded are:

- localized non-invasive tumours showing only early malignant changes (carcinomas in situ), precancerous condition (or premalignant condition),
- any skin cancer except malignant melanomas,
- I stage of lymphogranulomatosis,
- chronic lymphocytic leukaemia;
- and tumours in the presence of HIV / AIDS.

5. Kidney failure

End stage renal failure due to chronic irreversible failure of both kidneys to function. This must be evidenced by the Insured undergoing regular renal dialysis or having had renal transplantation. Insurance benefit is not paid in case of one-sided nephrectomy and acute renal failure (when temporary dialysis is needed).

6. Major organ transplant

The actual undergoing of a transplant of heart, lung, liver or bone marrow as a recipient or when the Insured is included into the official organ transplant waiting list one of the above mentioned operations. Insurance benefit is not paid for donors.

7. Loss of limbs / loss of use of limbs

The complete and permanent loss of use of two or more limbs as a result of injury or disease. Loss of limb is considered loss of limb or its function above of elbow or knee articulation. In cases when loss of use of limbs seems to be temporal, complete and permanent loss of use is insurable condition, when it lasts at least 6 months after establishment of this diagnosis.

8. Blindness

The total and irrecoverable loss of sight of both eyes due to traumatic injury or disease. This condition cannot be cured by any medical treatment and/or surgical procedures. The diagnosis must be clinically confirmed by an appropriate consultant. In cases when blindness seems to be temporal, total and irrecoverable loss of sight of both eyes is insurable condition, when it lasts at least 6 months after establishment of this diagnosis.

9. Third degree burns

Third degree burns resulting in full thickness skin destruction of at least 20% of the total skin area.

10. Surgery to aorta

The actual undergoing of open-heart surgery for disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean thoracic and abdominal aorta, but not its branches. Traumatic injury to the aorta is excluded.

11. Heart valve replacement or repair

Undergoing open-heart surgery from medical necessity to replace or repair one or more heart valves. This includes the replacement or repair of aortic, mitral, pulmonary or tricuspid valves due to stenosis or incompetence or a combination of these factors. Keyhole surgery is not therefore covered.

12. Deafness

Total permanent and irreversible loss of all hearing in both ears. This condition cannot be cured by medical treatment and/or surgical procedures. An appropriate consultant must clinically confirm the diagnosis. In cases when deafness seems to be temporal, total permanent and irreversible loss of all hearing in both ears is insurable condition, when it lasts at least 6 months after establishment of this diagnosis.

13. Loss of speech

Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease. Cases arising as a consequence of surgery or medical treatment for an illness are also covered. This condition cannot be cured by medical treatment and/or surgical procedures. An appropriate consultant must clinically confirm the diagnosis. In cases when loss of ability to speak seems to be temporal, total permanent and irreversible loss of speech is insurable condition, when it lasts at least 6 months after establishment of this diagnosis.

14. Multiple sclerosis

A definite diagnosis by a consultant neurologist of Multiple Sclerosis, which satisfies all of the following criteria:

- There must be current impairment of motor or sensory function, which must have persisted for a continuous period of at least six (6) months.
- The diagnosis must be confirmed by diagnostic techniques current at the time of the claim.

15. Parkinson's disease before the age of 60

Parkinson's disease that causes involuntary tremor of the hands, muscle rigidity and the slowing of body movements must be confirmed by a consultant neurologist using diagnostic techniques current at the time of the claim before the age of 60. However, Parkinson's disease caused by consuming too much alcohol, taking an overdose of drugs, prescribed or otherwise, taking controlled drugs unless lawfully prescribed is not covered. This condition must be confirmed by medical documents and last at least three (3) months.

16. Benign brain tumour

Removal of a non-cancerous growth of tissue in the brain under general anaesthesia leading to permanent neurological deficit or if inoperable also leading to a permanent neurological deficit. Excluded are all cysts, granulomas, and malformations in or of the arteries or veins of the brain, hematomas and tumours in the pituitary gland or spine. Diagnosis has to be confirmed by doctor neurologist or neurosurgeon and CT or MRI.

17. Alzheimer's disease before the age of 60

A consultant neurologist using diagnostic techniques current at the time of the claim before the Insured's age of 60 must confirm Alzheimer's disease. This condition must be confirmed by medical documents and last at least three (3) months.

18. Total and permanent disability.

The Insured has become permanently, totally and irreversibly disabled before his or her 60th birthday, as a result of a sickness or injury. The Insured must be totally incapable of being employed or engaged in any work or occupation whatsoever for remuneration or profit. The Insurer shall be provided with evidence that the Insured has been totally disabled for six (6) consecutive months and will remain totally disabled after this period.