Working Capacity Insurance Individual

Contents

LOCALTAPIOLA

1 Overview

Working capacity insurance is a form of group insurance that supplements occupational health care. The insurance will enter into force and remain valid on the provision that the policyholder has a general practitioner occupational health care contract approved by LocalTapiola and LocalTapiola provides the policyholder with statutory accident insurance.

Working capacity insurance includes the following:

- Medical treatment expenses cover

The policyholder may choose to include one or both of the following forms of cover in the insurance contract in addition to Medical treatment expenses cover:

- Pharmaceutical expenses cover
- Therapy cover

The selected forms of cover are stated in the insurance policy.

2 The insured and the recipient of compensation

2.1 Insured

The insured are employees referred to in the insurance policy aged between 15 and 80 who have an employment relationship with the policyholder and who are entitled to health care services on the basis of an occupational health care contract.

The insured must be permanently resident in Finland and their domicile in accordance with valid legislation must be Finland. The insured must also fall within the scope of the Finnish Health Insurance Act.

2.2 The recipient of compensation

The compensation is paid to the insured if not otherwise stated in the insurance contract. The policyholder may subsequently change the beneficiary with written notification. The policyholder can authorise the insured to specify their own beneficiaries.

3 Validity of insurance

3.1 Entry into force

The commencement of the insurance company's liability and the validity of the insurance contract are described under section 3 of the general terms and conditions.

The decision to grant insurance cover to an individual insured party is made on the basis of the declaration of health provided by the insured. For an individual insured party, the insurance cover commences on the day on which the declaration of health was signed, providing that the prerequisites for granting the insurance cover are fulfilled.

3.2 Territory and period of validity

The insurance is valid 24 hours per day during working time and leisure time anywhere in the world.

3.3 Validity for sports activities

The insurance is valid during all types of sporting activity with the exception of professional sports.

Sporting activity is considered professional when the sportsperson takes part in an individual or team sport professionally and receives remuneration for sporting activity in excess of the sum specified in the Act on Sportspeople's Accident and Pension Cover or if the sportsperson must take out insurance in accordance with the Act on Sportspeople's Accident and Pension Cover.

3.4 Nuclear damage, war and criminal activity

No compensation is paid under the insurance for damage caused by the following:

- War, insurgency, rioting, armed conflict or equivalent, or service in peace-keeping duties organised by the United Nations, the European Union or any other association, or other military activities. If the insured has commenced his/her journey abroad prior to the commencement of an armed conflict and has not participated in it personally, this section shall be applicable only after 14 days has elapsed from the commencement of such armed conflict. If the insured has participated in armed conflict or in the event of a major war, this section shall be adopted immediately. Major war refers to war between two or more permanent members of the UN security council.
- The effects of a nuclear weapon or device causing mass injury to humans.
- Damage caused by a nuclear accident as described in the Nuclear Liability Act or by material, devices or weapons based on nuclear reactions or ionising radiation, regardless of where the damage occurs.
- Criminal activity on the part of the insured.

3.5 The insurance company's entitlement to select a clinic

Examinations and treatments that are subject to compensation under working capacity insurance must be provided by a service provider that LocalTapiola has selected or by a medical institution that has been expressly approved by LocalTapiola.

3.6 Termination of the insurance

The insurance ceases to cover individual insured persons under any of the following conditions:

- At the end of the day on which the insured's entitlement to medical treatment services on the basis of an occupational health care contract ceases
- At the end of the insurance period in which the insured has reached the age of 80
- When the insurance contract expires because the policyholder or insurance company has terminated the contract
- The policyholder is declared bankrupt
- The insured person dies

When the Medical treatment expenses cover expires, the other forms of cover included in the insurance contract also expire.

Termination of the insurance contract is described in detail under section 12 of the General terms and conditions.

4 Sum insured

Unless otherwise stated in the insurance policy, there is a combined insured sum for the forms of cover included in the insurance contract to the effect that a total of up to EUR 10,000 can be paid in compensation under the various forms of cover for the same illness, accident or other insured event that is subject to compensation.

5 Indexation

The insurance premiums are tied to sub-index 86 ("Human health activities") of an index known as the "Producer price indices for services". The premium is reviewed annually with reference to an index at the beginning of the insurance period. The basic index is the index figure for the first quarter of the year preceding the commencement of the insurance. The review index is the index figure for the first quarter of the year preceding the commencement of the insurance period as stated in the insurance policy. The review date is the first day of the insurance period.

6 Terminology related to accidents and illnesses

6.1 Accident

"Accident" refers to a sudden event caused by external factors that results in bodily injury to the insured against his/her will.

6.2 Other insured events subject to compensation

The insurance covers involuntary drowning, sunstroke, heatstroke, frostbite, gas poisoning and poisoning caused by a substance mistakenly consumed by the insured.

The insurance also covers the following:

- Injury caused by a significant variation in air pressure.
- Muscle or tendon strain injury resulting from a sudden movement or exertion whose principal reason was not related to an illness or physical defect of the insured.

6.3 Illness

"Illness" refers to a situation in which medical treatment is required and for which the insurance company has been provided with a report confirming that the situation has arisen during the validity of the insurance without the insured's intent in a manner that cannot be described as an accident.

6.4 Exclusions to the compensability of insured events

If circumstances unrelated to the insured event subject to compensation have materially contributed to the onset of injury or illness or prolonged the recovery from an injury or illness, compensation is payable only insofar as the need for treatment can, on the basis of medical knowledge, be deemed to have resulted from the relevant insured event.

No compensation is paid if the insured event has been caused by any of the following:

- Poisoning caused by any substance consumed as food
- The insured's use of narcotics, alcohol, medication, nicotine or other substances unless stated as a treatment expense subject to compensation under the cover in question
- The suicide or attempted suicide of the insured
- Illness or bodily defect of the insured
- Any injury sustained during surgery, treatment or other medical procedure to treat an illness or bodily injury unless the procedure was performed to treat an illness, accidental injury or other insured event subject to compensation under this insurance

No compensation is paid in the following circumstances:

- Injury to teeth, joints in the jaw or dentures in the process of occluding, even if the accident was influenced by external elements
- Examination or treatment of a dental illness, teeth or occlusion organs, even in the event that the symptoms of such illness or injury have occurred in locations other than the teeth
- Psychological consequences of an accident or other insured event subject to compensation unless related to therapeutic treatment subject to compensation under therapy cover

7 Exclusions to compensation

Compensation may be reduced in accordance with the General terms and conditions if the insured or any other party entitled to compensation has contributed to the injury or insured event through gross negligence. Compensation may be refused if the insured or another party entitled to compensation has wilfully caused the occurrence of an insured event.

8 Claim

A compensation claim must be submitted to LocalTapiola within one year of the claimant becoming aware of the validity of insurance, the insured event and the damaging consequences of the insured event. In any event the claim must be presented within 10 years of the damaging consequences being caused. Should the claim not be submitted within this time, the claimant shall forfeit his/her right to compensation.

The claimant must pay for the medical expenses him/herself unless otherwise agreed and submit a claim to the Social Insurance Institution of Finland for compensation under the Health Insurance Act within six months of the date on which the expenses were paid.

If the insured is entitled to receive compensation for treatment expenses on the basis of legislation other than the Health Insurance Act, such as the Workers' Compensation Act, the Act on Farmers' Occupational Accident Insurance, the Motor Liability Insurance Act, the Basic Education Act or the Patient Injuries Act, compensation must first be claimed on the basis of the relevant legislation. The insurance company must be provided with a claim decision or other corresponding report covering the expenses that were not subject to compensation on the basis of legislation.

If the right to compensation under the Health Insurance Act or other legislation has been forfeited due to negligence of the aforementioned deadlines or for any other reason, the proportion of the compensation that would have been payable under the legislation will be deducted.

9 Medical treatment expenses cover

9.1 Indemnification regulations for Medical treatment expenses cover

Medical treatment expenses cover provides compensation for expenses arising from examinations and treatments that are conducted or ordered by a specialist physician and that are considered necessary in view of generally accepted medical practice to examine or treat an illness, accident or other injury caused by an insured event that is subject to compensation.

Preconditions for compensation of medical treatment expenses are that the cover was valid when the insured's illness began or when the accident or other insured event occurred and that the cover was valid for the entire period spanning the occurrence of the insured event and the incurrence of expenses.

Medical treatment expenses are subject to compensation on the basis of the original invoice or receipt insofar as they are not covered on the basis of any legislation.

Treatment expenses must be reasonable. If the expenses are clearly above the general national price level, compensation will only be paid in an amount corresponding to the general national price level. Compensation is only paid for expenses arising from treatments and examinations that were carried out in Finland.

Compensation is only paid for medical treatment expenses if the insured is covered by the Finnish social security system when the medical treatment expenses were incurred and if the insured has a valid Kela card (a personal health insurance card) to demonstrate this.

Compensation for medical treatment expenses related to the same illness, accident or other insured event subject to compensation will be paid up to the maximum insured amount stated in the insurance policy that was valid when the insured event took place. The deductible stated in the insurance policy will be deducted from the compensation that is payable for medical treatment expenses.

9.2 Compensation under Medical treatment expenses cover

With the limitations set out below, the following medical treatment expenses qualify for compensation:

- Expenses for treatment provided by a specialist physician (excluding specialists in general practice and specialists in occupational health care). For specialist consultation expenses to be covered, the insured needs to have a doctor's referral from the occupational health care unit.
- Expenses for treatment provided by a general practitioner or health care professional in the event of an acute illness, disease, accident or some other covered insured event that requires medical treatment, when the occupational health care services are not available. The costs of any possible further treatment and follow-up are eligible for cover only as instructed by LocalTapiola.
- Expenses for surgical procedures performed on the insured by a specialist physician in a public or private hospital or on the service provider's premises.
- Outpatient clinic charges levied by public hospitals and health centre visit charges.
- Daily hospital charges on the ward of a public or a private hospital or health centre.
- Reasonable expenses arising from medical documents that are requested by LocalTapiola and are necessary with regard to the insurance or claim.
- Expenses for necessary physiotherapy ordered by a specialist physician following surgical treatment or casting for one course of treatment up to a maximum of 15 treatment sessions for each insured event.
- Expenses for renting temporary medical equipment that is necessary for the insured's moving ability following surgical treatment or casting for up to two months from the surgical treatment or commencement of casting.
- Expenses for the cosmetic treatment of an injury resulting from an accident if the insurance company has approved the expenses in advance
- Costs of light treatment provided for skin diseases
- Medical treatment expenses for dental injuries resulting from accidents
- Expenses of the first orthopaedic bandage or support
- Expenses for surgical treatment for obesity if the surgical criteria for public health care treatment are fulfilled.

9.3 Exclusions to Medical treatment expenses cover

The following medical treatment expenses are not subject to compensation:

- Visits to general practitioners
- Medical examinations or treatments carried out outside Finland
- Sight tests, spectacles or contact lenses, or surgical treatment for refractive errors or cataracts
- Medical or periodic examinations, including preventive treatments or vaccinations
- Pharmaceutical preparations, non-medical creams, homeopathic or anthroposophic products or any pharmaceutical, vitamin, trace element or mineral preparations
- Nutrient preparations, such as preparations for special diets
- Trace element examinations or any equivalent examinations, even if they are ordered by a doctor
- Expenses arising from speech therapy, psychotherapy, occupational therapy or neuropsychological rehabilitation or other comparable therapy or rehabilitation
- Physiotherapy, physical treatment or other comparable treatment, unless specified as among treatment expenses subject to compensation
- Rehabilitation
- Expenses incurred on account of spending time at a rehabilitation centre, spa or natural remedy institution
- Bandages, medical aids, other aids or artificial limbs, unless specified as compensable treatment expenses

- Expenses incurred in purchasing or repairing spectacles, contact lenses, hearing aids, removable dentures and safety helmets, even if the object in question is broken or lost in conjunction with an accident, onset of illness or other insured event subject to compensation
- Examination or treatment of a dental illness, teeth or occlusion organs in order to treat an injury not caused by an accident, even in the event that the symptoms of such illness or injury have occurred in locations other than the teeth
- Cosmetic treatment or plastic surgery or complications resulting from these procedures, unless specified as among treatment expenses subject to compensation
- Expenses for pharmaceuticals or treatment primarily intended to improve quality of life, unless subject to compensation on the basis of the Health Insurance Act
- Examinations or treatments for erectile dysfunction
- Eyelid operations
- Breast reduction or enlargement
- Mole removal, unless concerning a malignant tumour or related precursor requiring medical treatment
- Obesity treatment, liposuction, gastric bypass or gastric restriction surgery or other surgical treatments for obesity or other examinations or treatments for obesity except surgical treatments for excessive obesity that fulfil the surgical criteria for public health care
- Treatment due to rapid weight loss, such as treatment of excessive skin
- Expenses related to examinations or treatments for contraception, pregnancy, childbirth, abortion, miscarriage or infertility or related complications
- Expenses for examinations or treatments for symptoms related to menopause
- Examinations or treatments for venous insufficiency in the legs
- Examinations or treatments for snoring that are not treatments for sleep apnoea confirmed by sleep registration
- Treatment related to variation in gender identity
- Treatment related to paraphilic disorder
- Examinations carried out to confirm or exclude the possibility of illnesses of which the insured did not experience symptoms before the examination began, such as genetic examinations
- Expenses for treatments for addiction caused by using narcotics, alcohol, medication, nicotine or other substances or other addiction
- Indirect expenses, such as travel and accommodation expenses, household management costs, loss of income, food and telephone expenses, clothing or supplies or travel and accommodation expenses of a companion
- Expenses that the insured would not have to pay him/herself for the treatment
- Any other treatment expenses not specified as treatment expenses covered by the policy

10 Pharmaceutical expenses cover

10.1 Indemnification regulations for Pharmaceutical expenses cover

"Pharmaceuticals" are preparations or substances that are intended to be used internally or externally to cure, relieve or prevent illnesses, injuries or associated symptoms in humans. Substances or combinations of substances are also considered "pharmaceuticals" if they are intended to be used internally or externally to restore, repair or change human organ functions by means of a pharmacological, immunological or metabolical action or to investigate the reason for a health-related factor, illness or injury.

"Medical preparations" are medications that are manufactured or imported subject to a permit issued by the authorities and that are intended for use as medicines and are packaged for sale.

Preconditions for compensation of pharmaceutical expenses are that the cover was valid when the insured's illness began or when the accident or other insured event occurred and that the cover was valid for the entire period spanning the occurrence of the insured event and the incurrence of expenses.

Pharmaceutical expenses are subject to compensation on the basis of the original invoice or receipt insofar as they are not covered on the basis of any legislation. Pharmaceutical expenses must be reasonable. If the expenses are clearly above the general national price level, compensation will only be paid in an amount corresponding to the general national price level. Compensation is only paid for pharmaceutical expenses related to medical preparations that are prescribed by physicians in Finland and purchased in Finland.

Compensation is only paid for pharmaceutical expenses if the insured is covered by the Finnish social security system when the pharmaceutical expenses were incurred and if the insured has a valid Kela card to demonstrate this.

Compensation for pharmaceutical expenses related to the same illness, accident or other insured event subject to compensation will be paid up to the maximum insured amount stated in the insurance policy that was valid when the insured event took place. The deductible stated in the insurance policy will be deducted from the compensation that is payable for pharmaceutical expenses.

10.2 Compensation under Pharmaceutical expenses cover

Pharmaceutical expenses cover provides compensation, subject to the exclusions set out below, for medical preparations that are prescribed by physicians, are sold in pharmacies on the basis of a permit issued by the authorities and are necessary in view of generally accepted medical practice to treat an illness, accident or other injury caused by an insured event that is subject to compensation.

10.3 Exclusions to Pharmaceutical expenses cover

The following pharmaceutical expenses are not subject to compensation:

- Medical preparations that are prescribed and purchased outside Finland

- Lotions, homeopathic or anthroposophic products or any pharmaceutical, vitamin, trace element or mineral preparations
- Nutrient preparations, such as preparations for special diets
- Bandages and medical aids
- Pharmaceutical treatment for obesity
- Pharmaceutical treatment for rapid weight loss
- Contraception or pharmaceutical treatments related to pregnancy
- Pharmaceutical treatment for infertility
- Expenses for pharmaceutical treatments for symptoms related to menopause
- Medications that are used to treat venous insufficiency (varicose veins) in the legs
- Medications that are used to reduce balding or the adverse effects of other physiological changes
- Preventive pharmaceutical treatment or vaccination
- Pharmaceutical treatment for cosmetic surgery or plastic surgery or complications resulting from these procedures
- Expenses for pharmaceutical treatment primarily intended to improve quality of life, unless subject to compensation on the basis of the Health Insurance Act
- Pharmaceutical treatment for erectile dysfunction
- Pharmaceutical treatment related to eyelid surgery
- Pharmaceutical treatment related to surgical reduction or enlargement of breasts
- Pharmaceutical treatment for snoring, except for sleep apnoea confirmed by sleep registration
- Expenses for pharmaceutical treatment for addiction caused by using narcotics, alcohol, medication, nicotine or other substances or other addiction
- Pharmaceutical treatment related to variation in gender identity
- Pharmaceutical treatment related to paraphilic disorder
- Indirect expenses, such as travel expenses to a pharmacy, expenses due to renewing prescriptions or equipment related to consuming medication, such as medication dispensers and tablet cutters
- Expenses that the insured would not have to pay him/herself for the treatment
- Any other pharmaceutical expenses not specified as treatment expenses covered by the policy

Claims for pharmaceutical expenses must be made to LocalTapiola within a year of incurrence.

11 Therapy cover

11.1 Indemnification regulations for Therapy cover

Therapy cover provides compensation for expenses arising from therapy that is provided or ordered by a specialist physician and that is considered necessary in view of generally accepted medical practice to treat an illness, a psychological illness or an injury or the psychological consequences of an illness, a psychological illness, an accident or an insured event that is subject to compensation.

As an exception, a referral to physiotherapy may also be issued by an occupational health care physician.

Preconditions for compensation of therapy expenses are that the cover was valid when the insured's illness began or when the accident or other insured event occurred and that the cover was valid for the entire period spanning the occurrence of the insured event and the incurrence of expenses.

Therapy expenses are subject to compensation on the basis of the original invoice or receipt insofar as they are not covered on the basis of any legislation. Therapy expenses must be reasonable. If the expenses are clearly above the general national price level, compensation will only be paid in an amount corresponding to the general national price level. Compensation is only paid for therapy expenses arising from treatment that was provided in Finland.

Compensation is only paid for therapy expenses if the insured was covered by the Finnish social security system when the therapy expenses were incurred and if the insured has a valid Kela card to demonstrate this.

Compensation can be paid under therapy expenses cover for a maximum of 25 treatment sessions per form of therapy per insured person for the period of validity of the insurance contract.

The deductible stated in the insurance policy will be deducted from the compensation that is payable for therapy expenses.

11.2 Compensation under Therapy cover

Subject to the exclusions set out below, compensation is paid for therapy expenses related to physiotherapy, psychotherapy, neuropsychological rehabilitation, occupational therapy and speech therapy due to an illness, accident or other insured event subject to compensation. Compensation is also paid for therapy expenses related to therapeutic treatment of alcohol addiction but not for related rehabilitation.

Expenses arising from psychotherapy are subject to compensation when psychotherapy is provided by a psychotherapist who is approved by the National Supervisory Authority for Welfare and Health (Valvira).

Expenses arising from neuropsychological rehabilitation are subject to compensation when they are related to the treatment of brain damage, such as serious brain injury, intracranial haemorrhage or stroke.

11.3 Exclusions to Therapy cover

The following therapy expenses are not subject to compensation:

- Therapeutic treatment carried out outside Finland
- Rehabilitation
- Neuropsychological rehabilitation, unless related to the treatment of brain damage, such as serious brain injury, intracranial haemorrhage or stroke
- Expenses incurred on account of spending time at a rehabilitation centre, spa or natural remedy institution
- Therapeutic treatment for behavioural disorders or developmental learning difficulties such as dyslexia, attention deficit disorder or visuo-spatial learning disabilities
- Therapeutic treatment for cosmetic surgery or plastic surgery or complications resulting from these procedures
- Therapeutic treatment related to variation in gender identity

- Therapeutic treatment related to paraphilic disorder
- Expenses for therapeutic treatment for addiction caused by using narcotics, alcohol, medication, nicotine or other substances or other addiction, except those stated as therapy expenses subject to compensation
- Indirect expenses such as travel and accommodation expenses
- Expenses that the insured would not have to pay him/herself for the treatment
- Any other expenses that are not specified as treatment expenses subject to compensation

General terms and conditions

The general terms and conditions of contract include the stipulations of the Insurance Contracts Act (543/94) as applicable.

The current Insurance Contracts Act shall apply to matters that are not addressed in these general terms and conditions. The following sets of conditions are applied to group insurance unless otherwise agreed in the group insurance contract or the terms and conditions relating to any particular matter.

In addition to these general terms and conditions of contract, the insurance contract is subject to the terms and conditions specified in the insurance policy and Finnish law. If the insurance policy and the terms and conditions of insurance contradict each other, the regulations in the insurance policy will apply.

Insurance companies are supervised by the Financial Supervisory Authority.

1 Some core terminology

The essential content of the **insurance contract** is determined in the insurance policy and the terms and conditions of insurance, which consist of the general terms and conditions of contract and any special clauses applicable to each insurance policy.

Personal insurance refers to insurance policies issued to insure natural persons.

The **policyholder** is the party who has entered into an insurance contract with the insurer.

The **insurer** is the insurance company that has entered into an insurance contract with the policyholder. In these terms and conditions, the insurer shall also be referred to as LocalTapiola.

The **insured** refers to the person to whom personal insurance applies.

An **exclusion clause** is a condition in the insurance contract specifying damage or loss that is not subject to compensation under the insurance or which otherwise restricts insurance cover.

The **insurance period** is the agreed period of validity of the insurance as stated in the policy document. The insurance contract continues for one (1) agreed insurance period at a time unless one of the contracting parties terminates the contract.

The **insurance premium period** is the period during which premium will be paid regularly as agreed.

An **insured event** refers to an event for which compensation is paid under the insurance.

Group insurance is an insurance under which the insured parties are members of a group specified in the insurance contract and for which the entire insurance premium is paid by the policyholder.

2 Provision of information prior to insurance contract

2.1 Insurance company's obligation to provide information

Before an insurance contract is concluded, the insurance company will provide the applicant with information on the types of insurance available, insurance premiums and insurance terms and conditions of such insurance policies as well as other information necessary for selecting an insurance policy that meets the insurance needs defined for the applicant. When such information is provided, attention shall also be directed to significant exclusions of the insurance cover.

2.1.1 Insurance company's failure to fulfil its obligation to provide information

If, when marketing the insurance, the insurance company or its representative fails to provide the policyholder with necessary information about the insurance or provides false or misleading information, the insurance company shall correct the false information without delay when the error has been detected. The insurance contract is considered to be in force in accordance with the rectified information from the moment when the policyholder has been informed about the rectification.

2.2 The policyholder's and insured's duty of disclosure

Before an insurance contract is issued, the policyholder, the insured or a representative thereof must give true and complete answers to the insurance company's questions, which may be of importance for assessing the insurance company's liability. Moreover, throughout the insurance period, the policyholder and the insured shall without undue delay rectify any errors or deficiencies that they may discover in the information given to the insurance company.

2.3 Failure of the policyholder or insured to fulfil their obligation to provide information

"Policyholder" also refers to the insured as well as a representative of the policyholder or the insured.

If the policyholder or the insured act fraudulently while fulfilling the aforementioned obligation, the insurance contract will not bind the insurance company. The insurance company is entitled to retain all premiums paid even if the insurance expires.

If the policyholder or the insured has, either wilfully or through negligence which cannot be considered slight, failed to fulfil its obligation to provide information and the insurance company would not have issued the insurance had true and complete answers been given, the insurance company is discharged from liability. If the insurance company would have granted the insurance only against a higher premium or otherwise with different terms and conditions than those agreed, the insurance company's liability

is limited to an amount corresponding to the agreed premium or to the terms and conditions with which the insurance would have been granted.

In the event that the aforementioned consequences of neglecting the obligation to provide information should lead to manifest unfairness towards the policyholder or a party entitled to compensation, they may be adjusted.

The insurance company is entitled to apply exclusions to the insurance cover for individual insured parties if the policyholder or the insured has given false or incomplete information about the state of health of the insured when the insured was added to the insurance policy.

3 Commencement of the insurance company's liability and validity of the insurance contract

3.1 Commencement of the insurance company's liability

Unless a different date has been individually agreed upon with the policyholder, the insurance company's liability commences when the insurance company or the policyholder sends or otherwise provides an approving reply to the offer made by the other party.

If the policyholder has delivered or dispatched a written application for insurance to the insurance company and it is evident that the insurance company would have accepted the application, the insurance company will also be liable for the occurrence of insured events that take place after the delivery or dispatch of the application.

An insurance application or an approving reply sent by the policyholder or otherwise submitted to the insurance company's representative will be deemed to have been submitted to the insurance company.

In the event that there is no evidence of what time of day the reply or application has been sent or otherwise provided, it shall be deemed to have taken place at 12 pm.

If the decision to grant insurance cover to an insured party is made on the basis of the state of health of the insured, the commencement of liability requires approval of a declaration of health. If the insurance company approves this, the liability towards the insured begins as of the date on which the signed declaration of health was received by the insurance company.

For group insurance, the liability towards individual insured parties begins when the insured becomes one of the group of insured parties as agreed upon by the policyholder and the insurance company, unless a different date is agreed upon in writing by the insurance company and the policyholder. Commencement of liability requires that the insured fulfils the requirements applying to insured parties as stated in the terms and conditions of the insurance policy.

3.2 Grounds for granting insurance

The insurance premium and other terms and conditions of contract are determined in accordance with the date of the insurance contract. If additional cover is added to the insurance contract, the insurance premium for this cover and the other terms and conditions of contract will be determined on the basis of the date on which the cover took effect.

The state of health of the insured is evaluated on the basis of the date on which a health declaration was provided or submitted.

The age of an insured party when the insurance takes effect or at the beginning of the insurance period is the difference between the current year and the year of birth of the insured.

The insurance company shall not prevent parties from being brought within the scope of the insurance cover on the grounds that the party has suffered an insured event or his/her health has deteriorated since the application documents were sent or otherwise submitted to the insurance company.

3.3 Validity of the insurance contract

Following the end of the first insurance premium period, the insurance contract will be valid for one agreed insurance premium period at a time, unless the policyholder or the insurance company terminates the contract. The insurance contract also may expire for other reasons, described below in items 4.3 and 12.

4 Premium

4.1 Determination of premium

The premium for each insurance period is determined using the technical bases effective at the beginning of the period. The insurance premium is affected by the age and sex of the insured as well as the policyholder's business sector. The insurance premium is tied to the human health activities sub-index of the producer price indices for services.

The insurance premium for group insurance also depends on the claims ratio. When the claims ratio is calculated, the claims paid by the insurance company in the 12-month period prior to the renewal period are taken into account in relation to the customer's insurance premiums.

If there is a change in a factor that is used to determine the insurance premium during the insurance period, the policyholder must supply the insurance company with the information that it requires to calculate the insurance premium for the insurance period. If the policyholder does not provide the requested information within one month, the insurance company is entitled to confirm a premium that it deems reasonable.

4.2 Payment of insurance premiums

The premium must be paid on the due date at the latest. However, the first payment need not be made prior to the commencement of the insurance company's liability, nor do later payments need be made before the commencement of the agreed insurance premium period or insurance period. If the insurance company's liability commences later in some respects, the premium relating to this part of the insurance need not be paid prior to the commencement of liability.

If the policyholder's payment is not enough to cover all of the insurance company's insurance premium receivables, the insurance company is entitled to determine which insurance receivables will be paid using the policyholder's payment.

4.3 Delayed payment of insurance premiums

If the policyholder fails to pay the insurance premium by the due date referred to in item 4.2, the insurance company will be entitled to terminate the insurance contract with 14 days' notice.

However, if the policyholder pays the insurance premium before the end of the notice period, the insurance contract will not expire at the end of the notice period. The insurance company shall mention this option in the notice of termination.

If the insurance premium is not paid within the period referred to in item 4.2 above, penalty interest shall be payable for the late payment in accordance with the Interest Act.

4.4 Entry into force of expired personal insurance

If the policyholder pays an overdue insurance premium after the insurance has expired, the insurance company's liability will commence on the day following the payment. In such an event, the insurance shall be valid until the end of the initially agreed insurance period, starting from the re-entry into force of the insurance.

However, if the insurance company does not wish to renew the expired insurance contract, it shall inform the policyholder within 14 days of the payment of the premium that it refuses to accept the payment.

4.5 Premium after expiry of the contract

If an insurance policy terminates earlier than agreed, the insurance company is only entitled to a premium for the period during which the cover was in force.

The insurance company will issue a prorated refund of the insurance premium to the policyholder corresponding to the premium for the rest of the insurance period. However, the premium shall not be refunded in the event of fraudulent action as referred to in item 2.2.

Overdue premiums that have not been paid and other overdue receivables may be deducted from the refund in accordance with general balancing conditions. However, if the total refundable amount is less than EUR 8, it is not refunded.

5 Provision of information during validity of the contract

5.1 Insurance company's obligation to provide information

Following the conclusion of the insurance contract, the insurance company provides the policyholder with the insurance policy and the terms and conditions of insurance, unless these were provided earlier or agreed otherwise.

During the validity of the contract, the insurance company shall inform the policyholder annually of the insured sum and other matters pertaining to the insurance that are of manifest importance to the policyholder.

If the insurance company or its representative provides incomplete, false or misleading information about the insurance while the insurance is valid, the insurance company shall correct the false information without delay when the error has been detected. The insurance contract is considered to be in force in accordance with the rectified information from the moment when the policyholder has been informed about the rectification.

Provision of information after the occurrence of an insured event is subject to the regulations in Section 9, Subsection 2 of the Insurance Contracts Act.

5.2 The insurance company's obligation to provide information to parties insured under group insurance

If the group insurance contract includes an agreement that the insurance company shall keep a list of the parties insured under group insurance, the insurance company shall provide the insured parties with information when the insurance enters into force, and at reasonable intervals thereafter, about the extent of the insurance cover, the key exclusions of the insurance cover, the obligations of insured parties on the basis of the insurance contract and the way in which the validity of the insurance depends on the insured belonging to the group stated in the group insurance contract. If no list is kept of insured parties, the aforementioned information shall be provided to insured parties in an appropriate manner with regard to the circumstances.

If the insurance company or its representative has failed to provide the insured with necessary information about the insurance or has provided false or misleading information, the insurance is deemed to be valid for the insured with the conditions that he/she had reason to believe would apply. However, this does not apply to information supplied by the insurance company or its representative concerning any future indemnity following an insured event.

5.3 Policyholder's obligation to provide information on increased risk

The policyholder and the insured must notify the insurance company of changes in factors that were declared when the insurance contract was concluded and that increase the risk of damage occurring and are thereby of significance to the insurance company from the point of view of evaluating its liabilities and that the insurance company cannot be deemed to have considered when the contract was concluded. Changes that lead to increased risk and must be declared include changes in the policyholder's business sector, a change in or termination of the occupational health care contract and termination of other insurance cover taken out by the insured. LocalTapiola need not be notified of a change in health.

Changes that lead to increased risk and must be declared under group insurance are changes in the policyholder's business sector, a change in or termination of the occupational health care contract and a change in the number of personnel in the insured group, along with changes to the gender and age distribution therein.

The policyholder must notify the insurance company of such changes no later than one month after the receipt of the annual report following the changes. If there is a significant change in the number of personnel, notification must be made within one month. The insurance company will remind the policyholder of this obligation in the annual report.

If the policyholder has wilfully or through negligence that cannot be considered slight failed to report the aforementioned increase of risk and the insurance company would not have upheld the validity of the insurance as a result of the change in circumstances, the insurance company shall be discharged from liability. If the insurance company would have upheld the insurance only against a higher premium, or otherwise with different terms and conditions, the insurance company's liability is limited to an amount corresponding to the premium, or to the terms and conditions under which the insurance would have been applied.

In the event that the aforementioned consequences of neglecting the obligation to provide information should lead to manifest unfairness towards the policyholder or another party entitled to compensation, they may be adjusted.

5.4 Provision of information about the termination of group insurance

If a group insurance policy is terminated as a result of action taken by the insurance company or the group insurance policyholder, the insurance company shall send notification of the termination of the insurance to the insured parties if the group insurance contract contains an agreement that the insurance company will keep a list of the insured parties under the group insurance policy. If no list is kept of insured parties, the aforementioned information shall be provided to insured parties in an appropriate manner with regard to the circumstances.

For insured parties, the insurance expires one month after the insurance company sends notice of termination of the insurance policy.

6 Causing an insured event

6.1 Insured event caused by the insured

The insurance company is free of any liability towards insured parties who wilfully cause insured events.

If the insured has caused an insured event through gross negligence, the insurance company's liability may be reduced as considered reasonable in the circumstances.

6.2 Insured event caused by a party entitled to compensation

If a person other than the insured who is entitled to compensation or benefit under the insurance wilfully causes an insured event, the insurance company is discharged from liability towards the person concerned.

If a person has caused an insured event through gross negligence or if he/she has been of such an age or in such a mental condition that he/she could not have been sentenced to punishment for a crime, the person may be entitled to full or partial compensation or benefit only if considered reasonable in view of the circumstances in which the insured event was caused.

7 Unaccountability and emergency

The insurance company will not invoke item 6 above in order to be released from liability either fully or partially if an insured event was caused by a person who was younger than 12 years of age or whose mental condition was such that he/she could not have been convicted of a crime.

The insurance company will not invoke items 5 and 6 above in order to be released from liability either fully or partially if increased risk or an insured event is caused by an insured party who was attempting to prevent damage to person or property in such circumstances that the negligence or action was justified.

8 Indemnification procedure

8.1 Liabilities of claimant

The claimant shall provide the insurance company with the documents and information that the insurance company needs to settle liabilities. These may include documentation that can be used to determine whether an insured event has taken place, how extensive the resulting damage is and to whom the compensation shall be paid. The claimant is liable to acquire the information that he or she has best access to while also taking into account the insurance company's possibilities to acquire the required information.

Crimes must be reported immediately to the local police.

The insurance company is not liable to pay compensation prior to receiving the aforementioned documentation.

Following an insured event, if the claimant acts with fraudulent intent in supplying the insurance company with false or misleading information that is of significance in relation to evaluating the insurance company's liability, compensation may be reduced or denied to the extent that is reasonable in light of the circumstances.

8.2 Expiration of right to compensation

A compensation claim must be submitted to the insurance company within one year of the claimant becoming aware of the validity of insurance, the insured event and the damaging consequences of the insured event. In any case, a compensation claim must be submitted within 10 years of the occurrence of the insured event or, if the insurance has been taken out to cover personal injury, within 10 years of the occurrence of the damaging consequences. Notification of an event of loss is comparable with the submittal of a claim. Should the claim not be submitted within this time, the claimant shall forfeit his/her right to compensation.

8.3 The insurance company's obligations

After the occurrence of an insured event, the insurance company shall provide the claimant with information about the content of the insurance and the compensation claim procedure. Any advance information provided about future compensation, the amount of compensation or the method of payment of compensation to the claimant shall have no effect on the obligation to pay under the insurance contract.

The insurance company shall pay the compensation or benefit due under an insurance contract on account of the occurrence of an insured event or notify the claimant that no compensation is to be paid without delay and no later than one month after receiving the documents and information necessary to assess its liability. If the amount of compensation is contested, the insurance company shall pay the undisputed portion of the compensation within the time period specified above.

The insurance company shall pay penalty interest on delayed compensation in accordance with the Interest Act. The insurance company shall not pay any other compensation due to delay.

8.4 Balancing

Overdue premiums that have not been paid and other overdue receivables of the insurance company may be deducted from the compensation in accordance with general balancing conditions.

9 Appealing an insurer's decision

The policyholder or the claimant have several ways of appealing against the insurance company's decision. He/she can contact the person handling the matter at LocalTapiola or submit an appeal against the decision to LocalTapiola's Customer Conciliation Office, ask for advice and guidance from the Finnish Financial Ombudsman Bureau or request a recommendation from the Finnish Financial Ombudsman Bureau. In addition, he/she has the right to initiate proceedings against LocalTapiola. Legal proceedings can be initiated even if the matter is being processed by the Finnish Financial Ombudsman Bureau. However, these appeal bodies will not handle matters that have already been or are being tried before a court.

9.1 Request for rectification and Customer Conciliation Office

If the policyholder or claimant suspects that there is an error in LocalTapiola's decision, he/she is entitled to receive further information about the grounds for the decision. If the decision is found to be incorrect, LocalTapiola will rectify it. If a customer is dissatisfied with the outcome of the request for rectification, he/she can contact the Customer Conciliation Office.

The Customer Conciliation Office is LocalTapiola's internal appeals body, handling matters relating to voluntary non-life insurance, life insurance and investment services.

The Customer Conciliation Office handles written appeals that are not pending in other appeal bodies. The appeal must be filed within three months of the customer receiving a written decision.

9.2 The Finnish Financial Ombudsman Bureau (FINE)

If the policyholder or the claimant is dissatisfied with the insurance company's decision, he/she may ask for advice and guidance from the Finnish Financial Ombudsman Bureau. The Finnish Financial Ombudsman Bureau is an independent body that provides advice to consumers, small entrepreneurs and related customers on matters relating to insurance and compensation. The Finnish Financial Ombudsman Bureau (FINE) and the Insurance Complaints Board also give recommendations in relation to disputes concerning interpretation and application of the law and the insurance terms and conditions under an insurance contract. The advisory services and recommendations are free of charge.

9.3 District court

If the policyholder or the claimant does not accept LocalTapiola's decision, he/she may institute legal proceedings against LocalTapiola. Legal action may be taken either in the district court of a claimant's Finnish domicile or the insurance company's domicile or in the district court of the location of the damage, subject to Finland's international conventions. Such legal action against a decision by LocalTapiola must be taken within three (3) years of receipt of LocalTapiola's decision and this deadline being received in writing by the party concerned. After the end of the above period, the right to institute proceedings will cease. The term for the right to take action does not run during Board proceedings.

10 The insurance company's right of recourse

The insured's entitlement to receive compensation for expenses due to illness or accident and loss of assets from a third party who is liable to pay compensation for the damage is transferred to the insurance company up to the amount that the insurance company has paid in compensation.

If a third party has caused the damage in the capacity of a private person, employee, official or other person referred to in Chapter 3, Section 1 of the Tort Liability Act, the insurance company has a subrogation right against the said person only if the person has caused the damage wilfully or through gross negligence, or under the law is liable to pay compensation regardless of his/her negligence.

11 Revision of the insurance contract

11.1 Alteration of terms and conditions of contract during the insurance period

The insurance company is entitled to change the premium payable and to amend any other terms or conditions of the insurance policy during the insurance period to meet the prevailing circumstances under the following conditions:

1. The policyholder or the insured – wilfully or through negligence that cannot be considered minor – has failed to fulfil his/her obligation to provide information referred to in item 2.2 and the insurance company, had it been provided with correct and complete information, would have granted the insurance only against a higher premium or otherwise with different terms and conditions than those agreed upon
2. The policyholder or the insured has acted fraudulently when responding to the obligation to provide information referred to in item 2.2 and irrespective of this, the insurance contract is binding upon the insurance company due to a change in the consequences of the neglect in accordance with item 2.3 or
3. The circumstances reported to the insurance company by the policyholder or the insured when concluding the insurance contract have changed in the meaning of item 5.3 during the insurance period, and the insurance company would have granted the insurance only against a higher premium or otherwise with different terms and conditions if the circumstance relating to the insured had already been in accordance with the change at the time of granting the insurance.

Upon becoming aware of any circumstances referred to above, the insurance company shall, without undue delay, send notification to the policyholder of changes to the insurance premium or terms and conditions. The notification shall contain a mention of the policyholder's right to terminate the insurance contract.

11.2 Amendment to terms and conditions of contract before the next insurance premium period

At the end of the insurance period, the insurance company has the right to amend the terms and conditions of insurance and the insurance premiums, as well as the other terms and conditions of contract. The effect of the index on the insurance contract is described under section 5 of the terms and conditions of insurance.

These changes shall apply as of the beginning of the fo≈llowing insurance premium period. The insurance company must inform the policyholder of substantial changes no later than one (1) month before the beginning of the new insurance period. The insurance policy shall continue in the amended form, unless the policyholder terminates the policy with a written notice before the beginning of a new insurance premium period.

12 Expiry of the insurance contract

12.1 Policyholder's right to terminate insurance

The policyholder may terminate a permanent insurance policy or individual cover with effect from the end of an insurance period. The written notice of termination must be sent to the insurance company no later than one month before the end of the insurance period.

If the policyholder does not accept a change to the terms and conditions of insurance or other terms and conditions of contract, the policyholder must terminate the insurance contract in writing within one month of receiving information about the change. When the insurance contract has been terminated, the insurance company's liability shall expire as of the day on which the change to the terms and conditions of insurance, the insurance premium or other terms and conditions would have taken effect.

If no such termination is provided in writing, the termination is not valid.

A fixed-term insurance contract expires on the agreed date without notice of termination.

12.2 The insurance company's right to terminate insurance during the insurance period

The insurance company is entitled to terminate an insurance contract during an insurance period under the following conditions:

1. The policyholder or the insured – wilfully or through negligence that cannot be considered minor – has failed to fulfil his/her obligation to provide information as referred to in item 2.2 and the insurance company would not have granted the insurance had correct and complete answers been provided
2. The policyholder or the insured has acted fraudulently when responding to the obligation to provide information referred to in item 2.2 and the insurance contract is binding upon the insurance company regardless of this on the basis of the said item
3. The circumstances reported by the policyholder or the insured to the insurance company when concluding the insurance contract have changed in the meaning of item 5.3 during the insurance period, and the insurance company would not have granted the insurance if the circumstances relating to the insured had been in accordance with the change at the time of granting the insurance
4. The insured has intentionally caused an insured event
5. After the occurrence of an insured event, the policyholder or insured has acted fraudulently in providing the insurance company with false or incomplete information that is of importance in assessing the insurance company's liability
6. The policyholder is declared bankrupt

After learning of a circumstance that justifies termination, the insurance company shall provide written notice of the termination of the insurance without undue delay. In its notice of termination, the insurer shall indicate the reason for termination. The insurance expires one month after the date the notice of termination was sent. The insurance company's right to terminate the insurance due to non-payment of the insurance premium shall be determined in accordance with item 4.3.

12.3 The insurance company's right to terminate insurance at the end of an insurance premium period

The insurance company is entitled to terminate an insurance policy with effect from the expiry of the insurance premium period. If the premium period is shorter than one year or it has not been separately agreed upon, the insurance company has the corresponding right to terminate the insurance effective from the end of the calendar year. The termination shall be carried out in writing no later than one month before the closing of the insurance premium period.

13 Processing of personal and loss-related data

LocalTapiola ensures the protection of our customers' privacy, and we process all personal data, in line with data protection legislation, insurance legislation, and good data management and data processing practice.

Personal data are processed in order to offer LocalTapiola's products and services and to take care of customer relationships. Data may also be used for purposes such as marketing to customers.

LocalTapiola utilises automated decision-making and profiling in tasks including the making of insurance decisions and claim settlement decisions and the targeting of marketing efforts. Every service making use of automated decision-making notifies of this in connection with that service.

Personal data are mainly obtained directly from customers, parties authorised by customers, public registers maintained by the authorities, and the credit register. Personal data are disclosed to third parties only with the customer's consent or under a legislative provision.

Into the insurance companies' common claims register, LocalTapiola registers data on the claims filed with us and in this connection checks what claims have been submitted to other insurance companies. The data in the claims register are used in claims handling to combat abuses targeting insurance companies. Into the insurance companies' common fraudulent claims register, LocalTapiola registers data on the criminal offences and the suspected criminal offences targeting the insurance activities in which LocalTapiola engages and checks the customer data available in the register. Data in the fraudulent claims register are used in claims handling and in the processing of insurance matters to combat crime targeting insurance companies.

Know Your Customer data and other personal data may be used in investigating, exposing and preventing money laundering and terrorist financing. In addition, data may be disclosed to the authorities to initiate investigations of money laundering and terrorist financing and of criminal offences committed to obtain any property or proceeds of crime subject to money laundering or terrorist financing.

LocalTapiola saves telephone calls and chat sessions with customers to verify that a call or a chat session has taken place and to ensure service quality.

Privacy statements have been compiled with respect to LocalTapiola's personal data files, providing information on the personal data processed in the data files, on the processing of these personal data, and on the data subject's rights. To read more about the privacy statements and how personal data are processed, visit LocalTapiola's website lahitapiola.fi/henkilotietojenkasittely. Privacy statements are also available upon request by mail or via an email to tietosuoja@lahitapiola.fi.

14 Other regulations

14.1 Partial invalidity of insurance contract

If an individual clause or part thereof in the insurance contract is declared invalid, the other terms and conditions of the contract will remain in force.

14.2 Embargo

The insurance is not valid insofar as an embargo set by a decision or declaration of the United Nations (UN), European Union (EU) or the United States, or based on Finnish legislation, limits insurance operations and the validity of an insurance policy.

The insurance company shall not pay any compensation if doing so would violate economic sanctions applicable to an embargo set by a decision or declaration of the United Nations (UN), European Union (EU) or the United States, or based on Finnish legislation.

In case of any dispute under these terms and conditions the original Finnish wording shall prevail.

Insurance is granted by the following mutual insurance companies in LocalTapiola Group (business ID):

LähiTapiola **Etelä** (0139557-7) | LähiTapiola **Etelä-Pohjanmaa** (0178281-7) | LokalTapiola **Sydkusten** - LähiTapiola **Etelärannikko** (0135987-5) | LähiTapiola **Itä** (2246442-0) | LähiTapiola **Kaakkois-Suomi** (0225907-5) | LähiTapiola **Kainuu-Koillismaa** (0210339-6) | LähiTapiola **Keski-Suomi** (0208463-1) | LähiTapiola **Lappi** (0277001-7) | LähiTapiola **Loimi-Häme** (0134859-4) | LähiTapiola **Länsi-Suomi** (0134099-8) | LähiTapiola **Pirkanmaa** (0205843-3) | LokalTapiola **Österbotten** - LähiTapiola **Pohjanmaa** (0180953-0) | LähiTapiola **Pohjoinen** (2235550-7) | LähiTapiola **Pääkaupunkiseutu** (2647339-1) | LähiTapiola **Savo** (1759597-9) | LähiTapiola **Savo-Karjala** (0218612-8) | LähiTapiola **Uusimaa** (0224469-0) | LähiTapiola **Varsinais-Suomi** (0204067-1) | LähiTapiola **Vellamo** (0282283-3) | LocalTapiola General Mutual Insurance Company (0211034-2)

The companies' contact details are available at www.lahitapiola.fi.

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