bliwa

SÄKRA

Säkra’s Group Insurance with Bliwa

INSURANCE CONDITIONS

APPLICABLE FROM 1 JANUARY 2026

A5-26:1

PURPOSE OF THE INSURANCE

Säkra's group insurance with Bliwa includes several different insurance products that provide financial protection for the insured in the event of sickness, accident and death. All of the insurance products are pure risk insurance, which have no value if they cease before an insurance event has occurred. An individual person may be covered by group insurance with Bliwa if a group agreement entitling them to such insurance has been concluded between Bliwa and a group to which they belong, i.e., Säkra.

INSURER

Bliwa Livförsäkring, ömsesidigt, corporate identity number 502006-6329 (referred to below as 'Bliwa') is the insurer for these insurance products. Bliwa is a mutual insurance company, which means that the company is owned by the policyholders. This means in its turn that the policyholders are entitled to a bonus from any surplus that may arise from Bliwa's operations; see Sub-clause 1.17.

Bliwa's insurance activities are subject to the supervision of the Swedish Financial Supervisory Authority (Finansinspektionen), postal address Box 7821, SE-103 97 Stockholm. Visiting address: Sveavägen 44, Stockholm. Email address: *finansinspektionen@fi.se.* Telephone number +46 (0)8-408 980 00. Website: *www.fi.se.* Bliwa's marketing is subject to the supervision of the Swedish Consumer Agency, postal address Box 48, SE-651 02 Karlstad. Visiting address: Tage Erlandergatan 8A. Email address: *konsumentverket@konsumentverket.se*. Telephone number +46 (0)771-42 33 00. Website: *www.ko.se*.

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

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

INFORMATION ABOUT THE CONDITIONS, ETC., GOVERNING THE INSURANCE

These insurance conditions apply from and including 1 January 2026. This means that the conditions apply to insurance products taken out or renewed from 1 January 2026 or later. The conditions also apply to an insurance event that occurs from 1 January 2026 or later. The insurance is also governed by the group agreement concluded and the insurance statement issued for the insurance. Furthermore, the Insurance Business Act (2010:2043), the Insurance Contracts Act (2005:104) and Swedish law in general apply. A provision specially agreed in a group agreement takes precedence over these conditions.

TAX RULES

The insurance products constitute capital insurance according to the Income Tax Act (1999:1229). As the insurance products constitute capital insurance, this means in tax respects, among other things, that compensation under the insurance products is exempted from tax.

COOLING-OFF PERIOD

If the policyholder is a consumer, they are entitled to withdraw from the insurance agreement ('cooling-off period') within 30 days from the date on which they received the insurance documents and were informed that the insurance agreement started to apply. The policyholder must notify Säkra if they wish to exercise their cooling-off right. A policyholder is also entitled to decline or give notice terminating the insurance at any time; see Sub-clause 1.8. The policyholder is always obligated to pay the premium for the period during which the insurance was in force.

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Definitions

APPLICATION DOCUMENTS

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

INCAPACITY TO WORK

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

BENEFIT PERIOD

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

FULLY CAPABLE OF WORKING

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

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

INCREASE IN PREMIUM

Bliwa may notify a higher cost that is to apply for a particular insurance if the risk of future ill health is so high that Bliwa considers that the insurance could not otherwise be granted.

BENEFICIARY

The person(s) entitled to receive a benefit under an insurance upon the death of the insured owing to a nomination of beneficiaries contained in these insurance conditions or through a separate nomination of beneficiaries.

INSURED

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

INSURANCE STATEMENT

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

INSURANCE EVENT

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

POLICYHOLDER

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

TERM OF INSURANCE

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

GROUP AGREEMENT

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

GROUP REPRESENTATIVE

The natural or legal person representing the group entitled to insurance in relation to Bliwa. This is Säkra for voluntary insurance. The respective company is the group representative for compulsory group insurance.

GROUP MEMBER

A person belonging to the group specified in the group agreement and who is thereby entitled to apply for and be covered by the insurance. In these

conditions, for voluntary insurance, these are natural persons who are either customers of Säkra or employees of a legal person that is a customer of Säkra.

The group entitled to compulsory insurance is shown in the group agreement.

QUALIFYING PERIOD

The time for which a sickness period should run before the insured may be entitled to benefits.

RESERVATION CLAUSE

A special exemption clause for a particular sickness or symptom, which Bliwa may have notified, is to apply for some insurance products if the risk of future ill health is so high that Bliwa considers that the insurance could not otherwise be granted. In such cases, the insured is notified of the reservation clause by a separate letter. This letter therefore constitutes part of the insured's insurance statement.

HUSBAND/WIFE

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

CO-INSURED

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

PRICE BASE AMOUNT

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

SICKNESS PERIOD

The period during which the insured is incapable of working owing to sickness or an accident.

MARRIAGE

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

1. Common provisions

1.1 INFORMATION ABOUT THE GROUP AGREEMENT AND VOLUNTARY AND COMPULSORY INSURANCE

THE GROUP AGREEMENT

Under the Insurance Contracts Act, a valid group agreement is a precondition for an individual group insurance agreement. The group agreement is concluded between Bliwa and the group representative. The group agreement determines whether the insurance is compulsory or voluntary and also the general scope of the insurance. The agreement also governs who belongs to the group entitled to insurance, the earliest date on which the insurance products can start to apply, how the insurance is to be administered, the term of validity of the group agreement, the right to give notice terminating the agreement, etc. If the group agreement relates to compulsory insurance, the premium for this is also specified in the group agreement. The group representative or Bliwa may give notice terminating the group agreement. If notice is given terminating the group agreement, this means that all of the insurance products issued on the basis of the group agreement cease to apply.

VOLUNTARY GROUP INSURANCE

Säkra's insurance is voluntary group insurance. This means that those covered by the group agreement are entitled to make their own decision about whether or not they want to have the insurance protection. The insurance agreement is then concluded between the group member, as the policyholder, and Bliwa. This is done by the group member applying for and being granted insurance. However, the company is the policyholder for the disability business interruption insurance included in the insurance agreement.

COMPULSORY GROUP INSURANCE

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

1.2 THE INSURANCE CONDITIONS AND THE INDIVIDUAL INSURANCE AGREEMENT

These insurance conditions apply to each individual group insurance concluded on the basis of the group agreement between the group representative and Bliwa. The application documents and health certificates applicable at any given time, Bliwa's pre-contract information and also the latest insurance statement issued also apply to each individual group insurance.

1.3 TERM OF VALIDITY OF THE INSURANCE

The insurance applies for no more than one year at a time unless otherwise specified in the group agreement. The first term of the insurance for new policies runs until the end of the year, i.e., up to and including 31 December of the year in which the insurance was taken out. The term of the insurance then runs for one year at a time, from 1 January to

31 December of each year. The insurance will be renewed annually provided notice has not been given terminating either the insurance or the group agreement at the end of the term of the insurance. Bliwa is then entitled to amend the insurance conditions; see Sub-clause 1.18. The insurance will be renewed for no longer than up to and including the date on which the insured attains the age at expiry for the insurance. The age at expiry is shown in the description of each product below.

1.4 WHO CAN APPLY FOR GROUP INSURANCE

The group agreement defines who are group members and who can thereby apply for or be covered by the insurance products. For Säkra's voluntary group insurance with Bliwa, it is natural persons who are either customers of Säkra or employees of a legal person that is a customer of Säkra. They can apply for voluntary insurance according to these conditions for themselves, their husband/wife or cohabitee and also children of their husband/wife or cohabitee.

For compulsory insurance, the group members are automatically covered by the insurance. The group entitled to compulsory insurance is shown in the group agreement.

The application documents also show whether Bliwa has imposed health requirements as a precondition for granting voluntary insurance.

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

1.5 WHEN THE INSURANCE ENTERS INTO FORCE

VOLUNTARY GROUP INSURANCE

Upon application

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

If the insurance can only be granted subject to a reservation clause and/or an increase in premium, the liability only enters into force when the applicant has been offered the insurance with the reservation clause/increase in premium and has accepted this offer.

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

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

COMPULSORY GROUP INSURANCE

Compulsory group insurance enters into force on the date specified in the group agreement and covers those who are group members on that date. For those who subsequently become group members, the insurance enters into force on the day after they join the group unless otherwise specified in the group agreement.

1.6 HEALTH REQUIREMENTS

1.6.1 VOLUNTARY INSURANCE

A group member or co-insured is normally required to be fully capable of working on the date on which the insurance enters into force in order to be covered by the voluntary group insurance. A higher health requirement applies for some insurance products. This means that those entitled to insurance should answer Bliwa's questions about health and that Bliwa will grant or reject the insurance application following a risk assessment. 'Reservation clauses' and an increase in premium may be applied to the insurance products if the insurance could not otherwise be granted.

Health requirements are usually also imposed when the sum insured is increased or the insurance protection is otherwise extended. The health requirements are shown in the application documents.

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

A person who is not fully capable of working and owing to this is denied an increase of their sum insured or other extension or improvement of the insurance protection may be granted the increase, extension or improvement requested when they are once again fully capable of working and have

certified this and also satisfy any other health requirements.

1.6.2 COMPULSORY INSURANCE

For compulsory insurance, the group members are covered by the insurance without health requirements. They are automatically affiliated to the insurance directly on the basis of the group agreement. However, in order for the group member to be entitled to insurance compensation in connection with an insurance event, requirements in respect of the group member's health may be imposed in certain agreements upon affiliation to the insurance. In such cases this will be shown in the insurance statement issued.

1.7 PREMIUM

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

1.7.1 PREMIUM PAYMENT

The premium for the insurance products must be paid by the person who is the policyholder. This means that the group member is the person responsible for paying for voluntary insurance. For disability business interruption insurance, however, the company, which is the policyholder, is responsible for paying the premium.

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

1.7.2 NOTICE OF TERMINATION OWING TO UNPAID PREMIUM

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

Notice of termination takes effect 14 days after the notice was sent from Säkra, unless the premium is paid within this time limit.

If it has not been possible to pay the premium for voluntary group insurance within the fourteen-day time limit because the group member was seriously ill, has been deprived of their liberty, has not received their pension or wages from their main employment or because another similar unexpected impediment occurred, the notice of termination takes effect one week after the impediment has ceased, though no later than three months after the fourteen-day time limit has expired.

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

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

1.7.3 REVIVAL OF INSURANCE

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

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

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

1.7.4 REPAYMENT OF PREMIUM

If a premium has been paid for a period after the term of the insurance for an insurance product has expired, the premium paid in error will be repaid, though no more than premiums for the past twelve months. This period is counted from the day on which Säkra received a request to repay premiums. If a premium has been paid in error owing to an oversight (for example, for child insurance despite the children having attained the age at expiry for the insurance or for a co-insured despite the group

member and the co-insured no longer being lawful spouses or cohabitees), a corresponding right to repayment of premiums applies, namely that no more than premiums for twelve months will be repaid.

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

1.8 WHEN THE INSURANCE CEASES TO APPLY

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

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

Child insurance ceases to apply at the end of the calendar year in which the child attains the age of 25 and when the group member's insurance ceases to apply because they are no longer a group member. Child insurance with a multiple-child premium that covers children of a group member's husband/wife or cohabitee also ceases to apply if the preconditions under Sub-clause 11.5.2 are no longer satisfied.

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

A person who is covered by compulsory insurance may decline the insurance at any time through a notification to Säkra.

1.9 EXTENDED COVER PROTECTION

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

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

'Extended cover protection' means that an insurance event that occurs during the extended cover protection period and before the insured attains the age at expiry for the insurance is regulated in accordance with the insurance conditions and at the sum insured applicable immediately preceding the extended cover protection period.

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

- Extended cover protection for life insurance ceases.
- Extended cover protection for personal accident insurance and accident and health insurance is limited to the scope applicable for accidents under Säkra's senior insurance.
- Extended cover protection for lump-sum benefit ceases.
- Extended cover protection for critical illness insurance ceases.
- Extended cover protection for health insurance ceases.
- Extended cover protection for disability business interruption insurance ceases.
- Extended cover protection for child insurance ceases.

1.10 CONTINUATION INSURANCE

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

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

For compulsory insurance, each insured is entitled to continuation insurance if Bliwa's liability ceases owing to the policyholder not having paid the premium.

A person, who has been insured under the respective insurance for less than six months or has chosen to give notice terminating the insurance but remains within the group, is not entitled to continuation insurance. This is also the case for a person who has been granted, or can obviously be granted, insurance protection of the same kind as before in some other way. A person may not take out continuation insurance if they have attained the age at expiry for the group insurance.

It is not possible to take out continuation insurance for disability business interruption insurance.

The continuation insurance has different insurance conditions, sums insured and premiums than the group insurance.

1.11 SENIOR INSURANCE

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

Säkra must have received the application for senior insurance no later than within three months from when the previous insurance ceased. The senior insurance has different insurance conditions, sums insured and premiums.

1.12 MEASURES REQUIRED FOR PAYOUT

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

The documents and other information that Bliwa considers are necessary to assess the insured's entitlement to insurance compensation must be submitted to Bliwa. Bliwa does not compensate any costs for arranging this. If required for Bliwa to be able to assess entitlement to insurance compensation, and if Bliwa so requests, the insured shall submit an authorisation so that Bliwa can obtain information from the policyholder, the insured, the employer or other group representative, physician, hospital, other care establishment, the Swedish Social Insurance Agency or another insurance establishment. If the insured does not submit such an authorisation, Bliwa may deny the right to insurance compensation. Clause 13 describes how Bliwa processes the information obtained.

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

If the insured does not assist in the manner described above, the benefit that would otherwise have been paid out will be reduced according to what is reasonable considering the circumstances. Compensations in the event of invalidity, scars and Critical illness compensation are paid out to the insured.

1.13 DATE OF PAYOUT

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

1.14 INTEREST ON LATE PAYOUT OF BENEFIT

Bliwa will pay interest under Section 6 of the Interest Act (1975:635) on a sum insured that has not been paid out on time according to these insurance conditions. The right to interest applies if the delay in payout was more than 30 days. Bliwa is not responsible for other losses that may arise if the investigation of the insurance event or payout of the insurance benefits is delayed. Interest for delay is not paid if the delay is due to an event in the nature of *force majeure*; see Sub-clause 12.7.

Irrespective of whether or not payout was delayed, Bliwa may pay interest on a death benefit or lump-sum benefit that has fallen due for payment but remains under Bliwa's administration. The right to interest then applies from and including one month from when the sum insured should have been paid out. The rate of interest that is then applied is the reference interest rate less two percentage points and, when applicable, reduced by the tax on returns that Bliwa must pay in respect of such amount. This interest is deducted from the interest for delay.

1.15 TIME LIMIT

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

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

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

1.16 ASSIGNMENT OF INSURANCE

Life insurance, lump sum benefit insurance and also critical illness insurance may be assigned to someone who may be a policyholder such as, for example, employer, partner/associate, husband/wife, and others.

In the event that the owner of the insurance is someone other than the insured, any insurance compensation will be paid out to the owner of the insurance. An assignment lapses upon a transfer to continuation insurance.

1.17 RULES FOR ALLOCATING SURPLUSES AND COVERING LOSSES

If a surplus should arise in Bliwa's insurance activities, the annual gain will be appropriated to a 'consolidation reserve'; see Sub-clause 1.17.1. However, it is not necessary for all surpluses to be appropriated for consolidation but they may instead be distributed to the policyholders through a bonus, in the first instance in the form of a reduction of future premiums. If a deficit should arise in the operation, an appropriation from Bliwa's consolidation reserve may be made to cover the loss.

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

1.17.1 HOW THE CONSOLIDATION RESERVE MAY BE USED

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

1.18 AMENDMENT OF THE INSURANCE CONDITIONS

Bliwa is entitled to amend these insurance conditions during an ongoing term of insurance if the amendment is needed owing to the nature of the insurance or owing to some other special circumstance such as, for instance, amended law, application of law or official regulation. An amendment that may need to be made owing to the nature of the insurance may, for example, be due to an amendment to a collective agreement forming the basis of the insurance. An amendment that is due to an amended law, application of law or official regulation, and trivial amendments, may start to apply immediately. Other amendments start to apply one month after Bliwa issued the amendment. Bliwa is also entitled to apply new insurance conditions in conjunction with renewal of the insurance.

1.19 REPRESENTATION SYSTEM

Bliwa Livförsäkring is a mutual insurance company. This means that the company is owned by its policyholders and that it is normally the policyholders that decide on the company's affairs.

Bliwa has a representation system whereby the powers to make decisions are exercised by special delegate members appointed at Bliwa's general meeting. According to Bliwa's Articles of Association, half of the delegate members are appointed through direct election by the policyholders of Bliwa together with a small number of named organisations entitled to each appoint one delegate member. The other half of the delegate members are appointed by those customers of Bliwa who have paid the highest premiums during the immediately preceding financial year.

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

2. Life insurance, including terminal illness, and also child protection

This insurance means that an amount is paid out to the insured's beneficiaries if the insured dies during the term of the insurance. 'Life insurance - death benefit' insurance includes 'death benefit - children'; see Sub-clause 2.4.

The sum insured is determined in the group agreement and shown in the application documents and insurance statement issued. The sum insured does not decrease with increasing age.

The date of the insurance event for the death benefit is the date on which the insured died. The date of the 'terminal illness' component is the date of the physician's assessment.

The insurance applies for at most up to and including the month in which the insured attains the age of 70.

2.1 OPTION ENTITLEMENT IN LIFE INSURANCE

Option entitlement is included in the life insurance. The following applies for an option entitlement:

An option entitlement for life insurance means that in the event of a particular family event and once (1) a year, upon certification of full capacity to work, the policyholder is entitled to increase the sum insured by one (1) level.

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

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

2.2 NOMINATION OF BENEFICIARIES FOR GROUP LIFE INSURANCE

The beneficiaries of the death benefit are, unless a written nomination has been presented to Bliwa:

- in the first instance, the insured's husband/wife or cohabitee
- in the second instance, all of the insured's children entitled to inherit
- in the third instance, the insured's heir(s).

Beneficiaries may waive their rights completely or in part. The persons next in line according to the nomination then become the beneficiaries instead. Any waiver should be made before the beneficiary may be considered to have taken possession of the benefit they acquired and before an estate inventory has been submitted to the Swedish Tax Agency.

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

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

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

The nomination of beneficiaries cannot be amended through a will.

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

2.3 TERMINAL ILLNESS

Compensation of half the sum insured for the life insurance may be paid out under the insurance as an advance payment if the insured contracts a sickness during the term of the insurance and that is assessed by a specialist physician during the term of the insurance to most likely result in the insured's

death within twelve months of the date of the assessment. The compensation is then paid out to the insured. After compensation for terminal illness has been paid out, half of the sum insured remains for the life insurance.

2.4 LIFE INSURANCE - DEATH BENEFIT - CHILDREN

'Life insurance - death benefit - children' insurance is included as part of the life insurance. Children, who are entitled to inherit from a person insured under the life insurance, are insured. Stillborn children who died after the end of the 22nd week of pregnancy is equated to a 'child entitled to inherit'.

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

Compensation is only paid once per child and agreement. The sum insured is one price base amount.

The insurance applies for at most up to and including the month in which the child attains the age of 20 (the age at expiry for the insurance). If the life insurance ceases to apply prior to this, the child's insurance also ceases to apply.

2.5 SPECIAL LIMITATION FOR INSURANCE TAKEN OUT SUBJECT TO FULL CAPACITY TO WORK

The following applies if the insured has had symptoms of or received care or medication for a sickness/injury/complaint at any time during the 12 months immediately before the insurance entered into force:

No compensation is paid out if the insured contracts a terminal illness (under Sub-clause 2.3) or dies within 36 months of the insurance entering into force if the reason for the terminal illness or death is caused by, or has a medical connection to, the sickness/injury/complaint that the insured had symptoms of or received care or medication for during the 12 months immediately before the insurance entered into force.

This limitation does not apply for 'life insurance - death benefit - children'.

3. Life insurance Extra – Cannot be taken out for new policies

This insurance means that an amount is paid out to the insured's beneficiaries if the insured dies during the term of the insurance.

The sum insured is determined in the group agreement and shown in the application documents and insurance statement issued. The sum insured does not decrease with increasing age.

The date of the insurance event is the date on which the insured died.

The insurance applies for at most up to and including the month in which the insured attains the age of 70.

3.1 NOMINATION OF BENEFICIARIES FOR GROUP LIFE INSURANCE

The beneficiaries of the death benefit are, unless a written nomination has been presented to Bliwa:

- in the first instance, the insured's husband/wife or cohabitee
- in the second instance, all of the insured's children entitled to inherit
- in the third instance, the insured's heir(s).

Beneficiaries may waive their rights completely or in part. The persons next in line according to the nomination then becomes the beneficiaries instead. Any waiver should be made before the beneficiary may be considered to have taken possession of the benefit they acquired and before an estate inventory has been submitted to the Swedish Tax Agency.

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

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

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

A nomination of beneficiaries cannot be amended through a will.

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

4. Lump-sum benefit

A lump-sum benefit is paid out as a lump sum if the insured suffers an incapacity to work as a

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

Entitlement to lump-sum benefit requires that the insured has been fully capable of working for the last three months before the insurance started to apply or that the insured was subsequently during the term of the insurance fully capable of working for at least three consecutive months. A lump-sum benefit is paid out upon a request from the insured.

The sum insured is determined in the group agreement and shown in the application documents and insurance statement issued. The sum insured decreases in pace with the insured's age in accordance with the following table.

Benefits will be paid out corresponding to 25, 50, 75 or 100 per cent incapacity to work. Benefits are based on the full sum insured for 100 per cent incapacity to work, half of the sum insured for 50 per cent incapacity to work, and so on. The amount of the benefit is calculated as a percentage of the insured's sum insured that applied for the month before the right to a lump-sum benefit arose considering the level of incapacity to work and also the age of the insured.

Benefit as a percentage of the sum insured considering the age of the insured

Age	For 100% incapacity to work	For 75% incapacity to work	For 50% incapacity to work	For 25% incapacity to work
-35	100	75	50	25
36	96	72	48	24
37	92	69	46	23
38	88	66	44	22
39	84	63	42	21
40	80	60	40	20
41	76	57	38	19
42	72	54	36	18
43	68	51	34	17
44	64	48	32	16
45	60	45	30	15
46	56	42	28	14
47	52	39	26	13
48	48	36	24	12
49	44	33	22	11
50	40	30	20	10
51	36	27	18	9
52	32	24	16	8
53	28	21	14	7
54	24	18	12	6
55	20	15	10	5
56	16	12	8	4
57	14	10.5	7	3.5
58	12	9	6	3
59	10	7.5	5	2.5
60-65	8	6	4	2

An insured previously entitled to a full lump-sum benefit (formerly advance benefit payment) from Bliwa at some time previously cannot receive another payout for a lump-sum benefit under the same group agreement or continuation insurance as a consequence of this group agreement.

An insured who previously received a partial lump-sum benefit/advance benefit payment may receive an additional lump-sum benefit if they subsequently become incapable of working to a higher extent during the term of the insurance and if the Swedish Social Insurance Agency therefore decides to grant the insured a higher level of sickness compensation or sickness benefit. For benefits based on a higher level of sickness benefit it is required that the insured has had the higher level of incapacity to work for a consecutive period of 11 of 12 months, after the date of the previous insurance event and within the term of the insurance, and was granted a corresponding level of sickness benefit by the Swedish Social Insurance Agency.

The amount of this additional lump-sum benefit is calculated as a percentage of the sum insured for

one (1) full lump-sum benefit applicable to the insured when entitlement to the new payout arises. Bliwa takes into account any lump-sum benefit and advance benefit payment previously paid out when paying out such extended lump-sum benefit. No more than one (1) full lump-sum benefit/advance benefit payment can be paid out in total.

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

The insurance applies for at most up to and including the month in which the insured attains the age of 65.

5. Health insurance

The health insurance may entitle the insured to a monthly benefit if the insurance event occurs during the term of the insurance. A payout under the health insurance is made upon a request from the insured.

The insured must have suffered a loss of income for benefits to be paid out under the health insurance. This loss of income shall be based on an incapacity to work owing to sickness or an accident that occurred during the period when the insurance was applicable (the term of the insurance).

The monthly benefit is paid out to the insured if they have suffered long-term incapacity to work as a consequence of sickness or an accident. A precondition for entitlement to benefits includes, among other things, the Swedish Social Insurance Agency having granted the insured sickness benefit, sickness compensation or activity compensation. The insurance applies with the sums insured shown in the insurance statement issued.

Benefits under the health insurance shall compensate the loss of income the insured suffers as a consequence of an incapacity to work owing to sickness or an accident. It is the insured personally who must apply for benefits under the insurance. This means that if the insured has died, the survivors cannot apply for benefits under the health insurance.

The date of the insurance event is the start of the sickness period.

The insurance applies for at most up to and including the month in which the insured attains the age of 67.

5.1 ASSESSMENT OF INCAPACITY TO WORK

Bliwa's decision to grant a monthly benefit under these insurance conditions is based primarily on the Swedish Social Insurance Agency's decision concerning the insured's incapacity to work.

However, Bliwa may decide to make its own assessment of the scope of the insured's incapacity to work and consequently make a different decision to the Swedish Social Insurance Agency if there are special reasons to do so. In such a case, the benefit will be based on the incapacity to work that Bliwa has assessed that the insured has suffered.

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

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

5.2 MONTHLY BENEFIT UNDER THE HEALTH INSURANCE

The insured must have suffered at least 25 per cent incapacity to work during the term of the insurance as a consequence of sickness or an accident in order to be entitled to a monthly benefit under the health insurance. In addition, it is required that the Swedish Social Insurance Agency has granted the insured sickness benefit (or corresponding benefits) as a consequence of the sickness or accident.

The insurance event is deemed to have occurred at the time of the start of the sickness period.

5.1.1 AMOUNT OF THE BENEFIT

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

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

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

5.1.2 QUALIFYING PERIOD

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

5.1.3 BENEFIT PERIOD

Benefits are paid out for as long as the sickness period lasts and the insured is receiving sickness benefit or similar compensation from the Swedish Social Insurance Agency, though at most for the period agreed in the group agreement (benefit period). If the insured attains the age at expiry for the insurance before benefits have been paid out for the entire benefit period, the payout and the insurance cease on the date on which the age at expiry is attained. The length of the benefit period is shown in the insurance statement. If the insured becomes capable of working after a shorter period than the maximum possible benefit period, the remaining benefit days may be used for a subsequent sickness period that occurs within 12 months, without a new qualifying period. This applies subject to the precondition that the insured is still covered by the insurance.

The insured is entitled to further benefits under the insurance in the event of a new sickness period if benefits have been paid out for the entire benefit period and the insured is subsequently fully capable of working for more than 12 months, provided the insured is still covered by the insurance.

Any new sickness period should then be regarded as a new insurance event. This means, among other things, that a new qualifying period applies before benefits can start to be paid out.

5.1.4 OVERINSURANCE

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

5.1.5 OPTION ENTITLEMENT UNDER HEALTH INSURANCE

Option entitlement is included in the health insurance. The following applies for an option entitlement:

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

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

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

b) when the new income started to apply.

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

6. Health insurance – payout period up to the age of 67 – cannot be taken out for new policies

The health insurance may entitle the insured to a monthly benefit if the insurance event occurs during the term of the insurance. The maximum benefit period under the health insurance is up to the month in which the insured attains the age of 67. A payout under the health insurance is made upon a request from the insured.

The insured must have suffered a loss of income for benefits to be paid out under the health insurance. This loss of income shall be based on an incapacity to work owing to sickness or an accident that occurred during the period when the insurance was applicable (the term of the insurance).

The monthly benefit is paid out to the insured if they have suffered long-term incapacity to work as a consequence of sickness or an accident. A precondition for entitlement to benefits includes, among other things, the Swedish Social Insurance Agency having granted the insured sickness benefit, sickness compensation or activity compensation. The insurance applies with the sums insured shown in the insurance statement issued.

Benefits under the health insurance shall compensate the loss of income the insured suffers as a consequence of an incapacity to work owing to

sickness or an accident. It is the insured personally who must apply for benefits under the insurance. This means that if the insured has died, the survivors cannot apply for benefits under the health insurance.

The date of the insurance event is the start of the sickness period.

The insurance applies for at most up to and including the month in which the insured attains the age of 67.

6.1 ASSESSMENT OF INCAPACITY TO WORK

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

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

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

6.2 MONTHLY BENEFIT UNDER THE HEALTH INSURANCE

The insured must have suffered at least 25 per cent incapacity to work during the term of the insurance as a consequence of sickness or an accident in order to be entitled to a monthly benefit under the health insurance. In addition, it is required that the Swedish Social Insurance Agency has granted the insured sickness benefit (or corresponding benefits) as a consequence of the sickness or accident.

The insurance event is deemed to have occurred at the time of the start of the sickness period.

6.2.1 AMOUNT OF THE BENEFIT

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

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

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

6.2.2 QUALIFYING PERIOD

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

6.2.3 BENEFIT PERIOD

Benefits are paid out for as long as the sickness period lasts and the insured is receiving sickness benefit or similar compensation from the Swedish Social Insurance Agency, though at most for the period agreed in the group agreement (benefit period). If the insured attains the age at expiry for the insurance before benefits have been paid out for the entire benefit period, the payout and the insurance cease on the date on which the age at expiry is attained. The length of the benefit period is shown in the insurance statement. If the insured becomes capable of working after a shorter period than the maximum possible benefit period, the remaining benefit days may be used for a subsequent sickness period that occurs within 12 months, without a new qualifying period. This applies subject to the precondition that the insured is still covered by the insurance.

The insured is entitled to a further benefit period under the insurance in the event of a new sickness period if a sickness period was interrupted before the benefit period expired and if the insured is subsequently fully capable of working for more than 12 months, provided the insured is still covered by the insurance.

Any new sickness period should then be regarded as a new insurance event. This means, among other things, that a new qualifying period applies before benefits can start to be paid out.

6.2.4 OVERINSURANCE

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

6.2.5 OPTION ENTITLEMENT IN HEALTH INSURANCE

Option entitlement is included in the health insurance. The following applies for an option entitlement:

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

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

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

b) when the new income started to apply.

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

6.2.6 INDEXATION OF MONTHLY BENEFITS UNDER HEALTH INSURANCE

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

7. Critical illness insurance

Benefits from Bliwa's critical illness insurance are paid out as a lump sum if the insured is diagnosed during the term of the insurance with any of the diagnoses or is affected by any of the events shown in Sub-clause 7.4. It is the insured personally who must apply for benefits under the insurance. This means that if the insured has died, the survivors cannot apply for benefits under the critical illness insurance.

The insurance applies for at most up to and including the month in which the insured attains the age of 70.

7.1 IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFIT

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

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

If the insured is undergoing examination for a certain diagnosis at the time of affiliation to the insurance, they are not entitled to benefits for such a diagnosis even if it is made after the insurance has entered into force.

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

Benefits are only paid for one diagnosis of the same kind. If the insured has already received benefits for a diagnosis, it is not possible to receive benefits for a new diagnosis under the same item. However, in the case of cancer, benefits are paid for a different kind of primary cancer that is not connected to the previous cancer diagnosis. The insurance pays benefits for no more than three different diagnoses during the term of the insurance. See also specific limitations under each diagnosis/event. Benefits are paid out under either item 15 or 16 (i.e., not under both of these items) in respect of kidney failure or kidney transplant.

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

Benefits are only paid for the diagnoses specified in Sub-clause 7.4.

7.2 BENEFITS

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

- the diagnosis was made (items 1 to 11 and 16 to 21 of 7.4)
- the operation was performed (items 12 to 15 of 7.4).

A precondition for payment of benefits is that a diagnosis has been made by a physician in Sweden, and also that any treatment of the sickness is medically justified according to Swedish medical expertise, complies with the guidelines and standards issued by the Swedish Medical Association and also otherwise complies with science and proven experience.

7.3 AMOUNT OF THE BENEFIT

Benefits under the insurance are paid out as a lump sum. The amount of the benefit is determined in the group agreement. It is also shown in the application documents and the last insurance statement issued.

7.4 DIAGNOSES AND EVENTS THAT AFFORD ENTITLEMENT TO BENEFITS

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

The following conditions are not covered by the insurance:

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

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

3. Stroke
A cerebrovascular (blood clot or haemorrhage) accident. The term 'cerebrovascular accident' includes thromboses, embolisms and ruptures of blood vessels in the brain. Exemptions from entitlement to benefits apply for Transient Ischaemic Attacks (TIA) and Reversible Ischaemic Neurologic Deficit (RIND). Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

4. Motor neurone disease
Progressive paralysis as a consequence of motor neurone disease – for example, amyotrophic lateral sclerosis (ALS).

5. Huntington's disease
The diagnosis must have been made according to diagnostic criteria applicable at any given time.

6. Alzheimer disease
The diagnosis must have been made according to diagnostic criteria applicable at any given time.

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

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

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

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

11. Tick-borne encephalitis (TBE)
Entitlement to benefits requires that the diagnosis has been made after TBE-specific antibodies have

been detected in the insured's cerebrospinal fluid or blood. Entitlement to benefits also requires that the insured has been admitted to hospital for inpatient care.

12. Coronary bypass operation

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

13. Operation for aortic stenosis or aneurysm

Surgical replacement of an aorta or a segment of an aorta

14. Replacement of heart valve

Replacement of one or more heart valves.

15. Organ transplant

Heart, liver, lungs, pancreas, kidney or bone marrow transplant received. The insurance does not cover the organ donor. Autologous bone marrow transplant does not afford entitlement to benefits. Benefits for kidney transplantation are not paid out if the insured has received benefits under item 16 for the same insurance event.

16. Kidney failure

The failure of the function of both kidneys. Use of peritoneal dialysis or haemodialysis or a kidney transplant is a medical necessity. The date on which such dialysis starts corresponds to the date on which the diagnosis was made. Benefits are not paid out if the insured has received benefits for a kidney transplant under item 15 for the same insurance event.

17. Deafness

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

18. Blindness

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

19. Loss of arm or leg

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

20. Loss of speech

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

21. Paralysis

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

7.5 CRISIS THERAPY

Compensation is paid for the costs of treatment by a psychologist, and also travelling costs in conjunction with such treatment, for an insured affected by a traumatic condition as a consequence of a loss occurrence that is indemnifiable under this insurance.

Bliwa only grants compensation subject to the precondition that the event occurred during the term of the insurance. The treatment is to be performed in Sweden, commence within one (1) year and be concluded within three (3) years of the loss occurrence. Bliwa must be contacted to grant approval of the treatment before it starts. Bliwa only approves treatment in Sweden. The insurance pays for no more than ten treatment sessions with a registered psychologist per insured and injury.

Costs of therapy and psychology services are only compensated in the first instance for treatment within the national healthcare service. However, Bliwa also grants the costs of therapy and psychology services within the private care sector if there are special reasons to do so.

The insured may be entitled to compensation for travelling costs in conjunction with treatment. Compensation is paid for the costs of the least expensive means of travel that the insured's health status allows. Compensation is not paid for travel using a private, official or company car and the like where no additional costs have arisen

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

8. Personal accident insurance

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

The insurance event is deemed to have occurred at the time of the accident.

The insurance applies for at most up to and including the month in which the insured attains the age of 70.

8.1 TERM OF VALIDITY

The insurance covers accidental injury that occurs during the term of the insurance. The insurance applies full-time, i.e., around the clock. Injuries that have occurred at work or on the way to or from work must be reported to the Swedish Social Insurance Agency. If the insured is covered by industrial injuries insurance (for example, work injury insurance for private employees (TFA), work injury insurance for employees of municipal, county and regional authorities, the Church of Sweden and certain municipally owned companies (TFA-KL) or compensation for Personal Injury Agreement work injury insurance for government employees (PSA)), the injury should also be reported to AFA Försäkring; see also Sub-clause 8.3.1.

8.2 DEFINITION OF THE TERM 'ACCIDENT'

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

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

8.2.1 INJURIES EQUATED TO AN ACCIDENTAL INJURY

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

Accidental injury also includes under this insurance the following sudden events if these arise at an identifiable time and place without a requirement regarding an external event.

Heart attack

For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: high blood pressure, high blood lipids, heart or vascular disease or diabetes mellitus.

Stroke – cerebral haemorrhage or cerebral thrombosis

For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: high blood pressure, high blood lipids, coagulation disorders, heart or vascular disease or diabetes mellitus.

Meningeal haemorrhage – Subarachnoid haemorrhage

Blood clot in the lung – Pulmonary embolism

For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: coagulation disorders or deep vein thrombosis.

Rupture of aorta – Rupture of aortic aneurysm

Sudden, unexplainable deafness – 'Sudden deafness'

Sudden retinal detachment

For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: eye disease, visual impairment by 8 dioptres or more.

8.2.2 INJURIES THAT ARE NEVER CONSIDERED TO BE AN ACCIDENTAL INJURY

Only injuries that satisfy the preconditions of Sub-clauses 8.2 and 8.2.1 are accidental injuries. Accidental injuries therefore do not include, for example, a bodily injury that has arisen through the insured intentionally having injured themselves or having demonstrated manifest indifference to the risk of getting injured. Nor do they include injuries that have arisen through, for example:

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

8.3 SCOPE OF THE INSURANCE BENEFITS

Benefits can be paid for the following items:

- medical costs – see Sub-clauses 8.3.1 and 8.4.1

- costs of dental injuries – see Sub-clauses 8.3.1 and 8.4.2
- travelling costs – see Sub-clauses 8.3.1 and 8.4.3
- additional costs – see Sub-clauses 8.3.1 and 8.4.4
- costs of rehabilitation and aids – see Sub-clauses 8.3.1 och 8.4.5
- costs of crisis therapy/psychology services – see Sub-clauses 8.3.1 and 8.4.6
- compensation in case of sick leave for at least 30 days – see Sub-clause 8.5
- compensation for scars and other appearance-related consequences of an injury – see Sub-clause 8.6
- invalidity – medical and financial invalidity – see Sub-clause 8.7, including sub-headings
- benefit in the event of death – see Sub-clause 8.8.

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

8.3.1 IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFIT

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

As regards compensation of costs, the insurance only compensates necessary and reasonable costs that the insured has incurred as a consequence of the accident. Bliwa does not compensate costs that should be compensated by another party according to law, statute, convention or collective agreement. Costs that have been compensated through other insurance are not compensated under this insurance. This applies irrespective of whether such compensation is paid according to a flat-rate model or against an original receipt. Nor does Bliwa compensate costs that are to be compensated under patient or healthcare insurance that has been taken out separately. If an accident occurred outside the insured's place of residence or abroad, the insurance does not compensate the costs compensated by separate travel insurance or a travel component of home insurance. This condition and other important limitations that apply to the entitlement to compensation in the case of an accident that occurred abroad are shown in Sub-clause 11.3.

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

Compensation is not paid for loss of income from work.

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

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

8.4 COMPENSATION OF COSTS

8.4.1 MEDICAL COSTS

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

Compensation is only paid for the costs of care or treatment abroad if the accident occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

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

8.4.2 COSTS OF DENTAL INJURIES

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

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

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

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

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

Compensation is only paid for any emergency treatment costs for persons who are entitled to free dental care owing to their age.

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

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

Compensation is only paid for the costs of treatment abroad if the accident occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

8.4.3 TRAVELLING COSTS

Compensation is paid for travelling costs between the permanent home and health and medical care establishment in conjunction with care and treatment prescribed by a physician to heal the injury.

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

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

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

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

8.4.4 ADDITIONAL COSTS

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

- Clothes normally worn and other personal belongings normally carried that were damaged in the course of the accident: spectacles/prescription lenses, wristwatches, plain wedding bands and helmets. Compensation is not paid for minor cosmetic damage to clothing. Personal protective equipment damaged at the time of the accident is compensated with at most SEK 3,000. The limitation to amounts does not apply for a damaged helmet. Compensation is only paid for the cost of repair if it is possible to repair the damaged object. Compensation may be paid for costs up to no more than 0.6 price base amounts in aggregate.
- Other unavoidable and reasonable additional costs that have arisen as a consequence of the accidental injury during the emergency treatment

and healing period for the injury. Compensation may be paid for costs up to no more than three price base amounts in aggregate.

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

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

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

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

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

8.4.5 COSTS OF REHABILITATION AND AIDS

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

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

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

Compensation is paid for costs up to no more than two price base amounts in aggregate for each insurance event. 'Price base amount' means the price base amount for the year in which the rehabilitation started.

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

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

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

8.4.6 COSTS OF CRISIS THERAPY/PSYCHOLOGY SERVICES

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

- an accidental injury for which there is an entitlement to benefits in accordance with these insurance conditions
- the death of a close relative ('close relative' means husband/wife, cohabitee, child and grandchild in these insurance conditions), including miscarriage
- robbery, threat or assault on the insured personally and that has been reported to the police
- rape or other sexual offences
- violence in the family
- involuntary unemployment for at least six months.

Bliwa only grants compensation subject to the precondition that the event occurred during the term of the insurance and the need for treatment arose within five years from when the event occurred. Bliwa must be contacted to grant approval of the

treatment before it starts. Bliwa only approves treatment in Sweden. The insurance pays for no more than ten treatment sessions with a registered psychologist per insured and injury.

Costs of therapy and psychology services are only compensated in the first instance for treatment within the national healthcare service. However, Bliwa also grants the costs of therapy and psychology services within the private care sector if there are special reasons to do so.

Compensation is not paid for the costs of treatment by a psychologist as a consequence of a traumatic condition that the insured suffers at work.

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 8.4.3.

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

8.5 COMPENSATION FOR PAIN AND SUFFERING

Bliwa pays compensation in case of sick leave for at least 30 days if the insured suffers an accidental injury that resulted in at least 25 per cent sick leave for 30 days or more during the normal emergency treatment and healing period for the injury. In order to be entitled to compensation it is required that the emergency treatment and healing period for the injury is at least 30 days. If Bliwa considers that the injury has been severe, compensation may also be paid for a sick leave period of less than 30 days. For assessment of what is considered to be a severe injury, guidance is taken from Trafikskadenämnden's examples of severe injury.

The amount of the compensation is determined by the type of damage and its extent, as well as time for treatment and healing. The compensation is calculated using the table below which is applied by Bliwa at the time of payment. At the time of payment, the compensation amount is rounded in accordance with the following rules. Amounts between SEK 1 and SEK 5,000 are rounded up to the nearest even 100s, amounts between SEK 5,000 and SEK 10,000 are rounded up to the nearest even 500s, amounts over SEK 10,000 are rounded up to the nearest even 1,000s.

Type of care and injury	Within one year of the injury	One year after the injury
Other care	110 SEK/day	74 SEK/day
Hospital care other injury	197 SEK/day	134 SEK/day
Hospital care sever injury	264 SEK/day	177 SEK/day

If compensation in case of sick leave for at least 30 days as a consequence of the accidental injury have already been compensated or should be compensated by another party as a consequence of law, statute, convention or collective agreement, Bliwa will not also pay compensation for the same period. The same applies if the insured has already received corresponding compensation from other insurance. If such compensation has been paid and the deductible has been deducted, Bliwa will not compensate for this deduction.

If compensation in case of sick leave for at least 30 days from another insurance has been adjusted due to the insured's negligence, Bliwa will not provide any compensation to cover the difference.

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

The insurance compensates scars and other appearance-related consequences of an injury as a result of accidental injury that occurred during the term of the insurance. Compensation is only paid after treatment has been completed and when the scar or appearance-related consequence of the injury is considered, by Bliwa, to be permanent for the future, though no earlier than one year after the accident happened.

'Scar' means a skin injury as a consequence of an accident. Other consequential injuries, such as for instance deformity or other bodily change where the skin is not damaged, are considered to be an appearance-related consequence of an injury.

The sum insured for scars and other appearance-related consequences of an injury corresponds to the chosen sum insured for medical invalidity. The sum insured is reduced by one percentage point for each year that the age of the insured exceeds 25. Compensation for multiple scars within the same group is a maximum of 25% of the sum insured for group 1, 10% for group 2, and 8% for group 3, regardless of the number of scars. Compensation of at most 25 per cent of the sum insured is paid for one and the same insurance event involving several scars from different groups.

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

Group 1 Face and Neck		Length < 0,5 cm	Length 0,5– 1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,05%	0,30%	0,60%	0,90%	1,50%	1,80%
Width 0,5–1,9 cm			0,60%	0,90%	1,20%	1,80%	2,40%
Width 2–5,9 cm				1,20%	1,80%	2,40%	3,60%
Width 6–9,9 cm					3,00%	4,00%	7,00%
Width 10–14,9 cm						8,00%	10,00%
Width ≥ 15 cm							25,00%
Appearance-related consequence of an injury ≥ 6 x 6 cm	5%						
Appearance-related consequence of an injury < 6 x 6 cm	0,5%						

Group 2 Forearms, lower legs/knee, hands and head		Length < 0,5 cm	Length 0,5– 1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,03%	0,15%	0,30%	0,45%	0,75%	0,90%
Width 0,5–1,9 cm			0,30%	0,45%	0,60%	0,90%	1,20%
Width 2–5,9 cm				0,60%	0,90%	1,50%	2,50%
Width 6–9,9 cm					1,20%	3,50%	6,00%
Width 10–14,9 cm						6,00%	8,00%
Width ≥ 15 cm							10,00%
Appearance-related consequence of an injury	0,2%						

Group 3 Upper arms, thighs, feet, elbows and trunk		Length < 0,5 cm	Length 0,5–1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,02%	0,15%	0,20%	0,30%	0,50%	0,60%
Width 0,5–1,9 cm			0,20%	0,30%	0,40%	0,60%	0,80%
Width 2–5,9 cm				0,40%	0,60%	0,80%	1,50%
Width 6–9,9 cm					0,80%	3,00%	4,00%
Width 10–14,9 cm						5,00%	6,00%
Width ≥ 15 cm							8,00%
Appearance-related consequence of an injury	0,1%						

8.7 BENEFITS IN THE EVENT OF INVALIDITY

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

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

A distinction is made between medical and financial invalidity when assessing invalidity.

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

'Financial invalidity' is a permanent impairment of the insured's capacity to work as a consequence of the accidental injury. Capacity to work is deemed to be permanently impaired when all opportunities for occupational rehabilitation have been exhausted and the Swedish Social Insurance Agency has granted at least 50 per cent sickness compensation under the Social Insurance Code. See further information below.

8.7.1 BENEFITS IN THE EVENT OF MEDICAL INVALIDITY

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

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

If the accidental injury has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent, Bliwa will nevertheless always pay no more than the sum insured for 100 per cent invalidity. If a lost body part can be replaced by a prosthesis, the level of invalidity will be determined considering the prosthesis and its importance to the bodily function of the insured.

The level of invalidity is determined with the guidance of the industry rating scale that applies at the time of payout.

8.7.2 BENEFITS IN THE EVENT OF FINANCIAL INVALIDITY

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

The accidental injury must have resulted in a measurable loss of the capacity to work within five years from the date of the accident for the insured to be entitled to benefits. Furthermore, it is required that the accidental injury resulted in medical invalidity before the financial invalidity arose and that this occurred within three years from the date of the accident.

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

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

The amount paid out as invalidity benefit is an equally large portion of the sum insured as the level of the sickness compensation granted by the Swedish Social Insurance Agency. Benefits are paid at 50 per cent of the sum insured in the case of half sickness compensation. Benefits are paid at 75 per cent of the sum insured in the case of three-quarters sickness compensation and at 100 per cent of the sum insured for full sickness compensation. Bliwa's decision concerning benefits under these insurance conditions is based primarily on the Swedish Social Insurance Agency's decision concerning the insured's incapacity to work. However, Bliwa may decide to make its own assessment of the insured's incapacity to work and consequently make a different decision to the Swedish Social Insurance Agency if there are special reasons to do so.

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

An insured who, as a consequence of an accident during the term of the insurance, suffers a permanent incapacity to work after they have attained the age of 60 may only receive financial invalidity benefit from Bliwa if the level of medical invalidity as a consequence of the accidental injury is at least 50 per cent.

8.7.3 AMOUNT OF THE INVALIDITY BENEFIT

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

If the insured had attained a certain age at the time of the injury, the sum insured for medical and/or financial invalidity may be reduced in accordance with what is agreed in the group agreement. From what age the reduction applies, and the size of the reduction is indicated by the insurance statement.

8.7.4 PAYOUT OF INVALIDITY BENEFIT

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

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

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

8.7.5 POSSIBILITY OF REVIEWING THE BENEFIT IF THE INVALIDITY INCREASES

The insured is entitled to have their level of invalidity reconsidered, following a written request to Bliwa, provided:

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

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

8.8 BENEFIT IN THE EVENT OF DEATH

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

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

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

A nomination of beneficiaries cannot be amended through a will.

9. Accident and health insurance

Accident and health insurance may provide the insured with financial compensation if they sustain a permanent bodily injury regardless of whether this arose through an accident or sickness.
The insurance comprises traditional personal accident insurance with a supplement that the insurance also affords entitlement to compensation for sicknesses that result in invalidity.

The insurance event is deemed to have occurred when the accident occurred or the sickness showed symptoms.

The insurance applies for at most up to and including the month in which the insured attains the age of 70.

9.1 TERM OF VALIDITY

This insurance product covers sickness or accidental injury that occurs during the term of the insurance and applies full-time, i.e., for both work and leisure time. Injuries that have occurred at work or on the way to or from work must be reported to the Swedish Social Insurance Agency. If the insured is covered by industrial injuries insurance (for example, work injury insurance for private employees (TFA), work injury insurance for employees of municipal, county and regional authorities, the Church of Sweden and certain municipally owned companies (TFA-KL) or compensation for Personal Injury Agreement work injury insurance for government employees (PSA)), the injury should also be reported to AFA Försäkring; see Sub-clause 9.6.

9.2 DEFINITION OF THE TERM 'SICKNESS'

'Sickness' means a deviation from normal health status that requires health and medical care and is not to be regarded as an accidental injury according to the definition of accidental injury below.

Sickness is considered to have occurred when the insured's physical or mental functional capacity has manifestly deteriorated owing to the sickness.

Sickness never means a bodily injury caused voluntarily.

9.3 LIMITATIONS AS REGARDS SICKNESS, ETC.

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

Nor does the insurance cover sicknesses caused by cosmetic procedures.

9.4 DEFINITION OF THE TERM 'ACCIDENT'

An accident that affords entitlement to benefits under this insurance must have comprised an external event. The accident must also have been caused by a sudden and unexpected event that

resulted in the insured involuntarily suffering a bodily injury. The person making the claim for benefits has to prove that an accidental injury has occurred.

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

9.4.1 INJURIES EQUATED TO AN ACCIDENTAL INJURY

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

Accidental injury also includes under this insurance the following sudden events if these arise at an identifiable time and place without a requirement regarding an external event.

Heart attack
For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: high blood pressure, high blood lipids, heart or vascular disease or diabetes mellitus.

Stroke – cerebral haemorrhage or cerebral thrombosis
For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: high blood pressure, high blood lipids, coagulation disorders, heart or vascular disease or diabetes mellitus.

Meningeal haemorrhage – Subarachnoid haemorrhage

Blood clot in the lung – Pulmonary embolism
For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: coagulation disorders or deep vein thrombosis.

Rupture of aorta – Rupture of aortic aneurysm

Sudden, unexplainable deafness – 'Sudden deafness'

Sudden retinal detachment
For the event to be regarded as an accidental injury, it is a requirement that the insured has not been previously diagnosed for any of the following sicknesses or symptoms: eye disease, visual impairment by 8 dioptres or more.

9.4.2 INJURIES THAT ARE NEVER CONSIDERED TO BE AN ACCIDENTAL INJURY

Only injuries that satisfy the preconditions of Sub-clauses 9.4 and 9.4.1 are accidental injuries. Accidental injuries therefore do not include, for example, a bodily injury that has arisen through the insured intentionally having injured themselves or having demonstrated manifest indifference to the risk of getting injured. Nor do they include injuries that have arisen through, for example:

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

9.5 SCOPE OF THE INSURANCE

In case of sickness

- Medical invalidity – see Sub-clause 9.11.1
- Compensation for scars and other appearance-related consequences of an injury – see Sub-clause 9.10

The insurance only pays benefits for medical invalidity as a consequence of sickness.

In the case of an accidental injury

Costs, etc.

- Medical costs – see Sub-clauses 9.6 and 9.7.1
- Costs of dental injuries – see Sub-clauses 9.6 and 9.7.2
- Travelling costs – see Sub-clauses 9.6 and 9.7.3
- Additional costs – see Sub-clauses 9.6 and 9.7.4
- Costs of rehabilitation and aids – see Sub-clauses 9.6 and 9.7.5
- Costs of crisis therapy/psychology services – see Sub-clauses 9.6 and 9.7.6
- Loss of income – see Sub-clause 9.8
- Compensation in case of sick leave for at least 30 days – see Sub-clause 9.9

Invalidity

- Scars and other appearance-related consequences of an injury – see Sub-clause 9.10

- Medical invalidity – see Sub-clause 9.11.1
- Financial invalidity – see Sub-clause 9.11.2

Death by accident

- Benefit in the event of death – see Sub-clause 9.14

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

9.6 IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFIT

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

As regards compensation of costs, the insurance only compensates necessary and reasonable costs that the insured has incurred as a consequence of the accident. Bliwa does not compensate costs that should be compensated by another party as a consequence of law, statute, convention or collective agreement. Costs that have been compensated through other insurance are not compensated under this insurance. This applies irrespective of whether such compensation is paid according to a flat-rate model or against an original receipt. Nor does Bliwa compensate costs that are to be compensated under patient or healthcare insurance that has been taken out separately. If an accident occurred outside the insured's place of residence or abroad, the insurance does not compensate the costs compensated by separate travel insurance or a travel component of home insurance; see Sub-clause 11.3.

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

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

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

9.7 COMPENSATION OF COSTS IN THE CASE OF AN ACCIDENT

9.7.1 MEDICAL COSTS

Compensation is paid for the costs of essential medical care, hospital care, treatment and aids prescribed by a physician for treatment of the injury. Compensation is paid for costs of care and treatment up to the level of the Swedish high-cost protection.

Compensation is only paid for the costs of care or treatment abroad if the accident occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

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

9.7.2 COSTS OF DENTAL INJURIES

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

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

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

Compensation is only paid for costs of dental treatment in Sweden if the treatment is covered by

the dental care insurance under the Social Insurance Code. Compensation is not paid for the costs of implant treatment that are not covered by the dental care insurance. Compensation is only paid for costs of treatment of damage to implants if the treatment is covered by dental care insurance.

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

Compensation is only paid for any emergency treatment costs for persons who are entitled to free dental care owing to their age.

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

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

Compensation is only paid for the costs of treatment abroad if the accident occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

9.7.3 TRAVELLING COSTS

Compensation is paid for travelling costs between the permanent home and the care provider in conjunction with care and treatment prescribed by a physician to heal the injury.

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

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

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

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

9.7.4 ADDITIONAL COSTS

Compensation is paid for the following items under general law of tort rules if the insured suffers a bodily injury as a consequence of an accident that required treatment within the health services:

- Clothes normally worn and other personal belongings normally carried that were damaged in the course of the accident: spectacles/prescription lenses, wristwatches, plain wedding bands and helmet. Compensation is not paid for minor cosmetic damage to clothing. Personal protective equipment damaged at the time of the accident is compensated with at most SEK 3,000. The limitation to amount does not apply for a damaged helmet. Compensation is only paid for the cost of repair if it is possible to repair the damaged object. Compensation is paid for costs up to no more than 0.6 price base amounts in aggregate unless otherwise indicated by a group agreement or insurance statement.
- Other unavoidable and reasonable additional costs that have arisen as a consequence of the accidental injury during the emergency treatment and healing period for the injury. Compensation is paid for costs up to no more than three price base amounts in aggregate unless otherwise indicated by a group agreement or insurance statement.

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

Age	0 to 1 year	1 to 2 years	2 to 3 years	3 to 4 years	4 years and older

Per cent	100	80	60	40	20

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

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

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

9.7.5 COSTS OF REHABILITATION AND AIDS

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

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

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

Compensation is paid for costs up to no more than two price base amounts in aggregate for each insurance event unless otherwise shown in a group agreement or insurance statement. 'Price base amount' means the price base amount for the year in which the rehabilitation started.

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

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

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

9.7.6 COSTS OF CRISIS THERAPY/PSYCHOLOGY SERVICES

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

- an accidental injury for which there is an entitlement to benefits in accordance with these insurance conditions
- the death of a close relative ('close relative' means husband/wife, cohabitee, child and grandchild in these insurance conditions), including miscarriage.
- robbery, threat or assault on the insured personally and that has been reported to the police.
- rape or other sexual offences
- violence in the family
- involuntary unemployment for at least six months.

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

Costs of therapy and psychology services are only compensated in the first instance for treatment within the national healthcare service. However, Bliwa also grants the costs of therapy and psychology services within the private care sector if there are special reasons to do so.

The insurance only covers therapy and psychology services that the insured needs as a consequence of trauma that the insured suffered as a private individual. Compensation is not paid for the costs of treatment by a psychologist as a consequence of a

traumatic condition that the insured suffered at work.

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 10.7.3.

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

9.8 LOSS OF INCOME

In the event of an accidental injury, compensation is paid for loss of income from work owing to incapacity to work up to 100 per cent of the components of annual pay, up to ten price base amounts. If the insured has received or receives benefits under another insurance or in some way as a consequence of incapacity to work, such benefits are deducted from the benefits that Bliwa pays. Benefits are provided from day 29 to day 90, though for no longer than the insured's incapacity to work is ongoing. Compensation is not paid for loss of income from work as a consequence of sickness.

9.9 COMPENSATION FOR PAIN AND SUFFERING

Bliwa pays compensation in case of sick leave for at least 30 days if the insured suffers an accidental injury that resulted in at least 25 per cent sick leave for 30 days or more during the normal emergency treatment and healing period for the injury. In order to be entitled to compensation it is required that the emergency treatment and healing period for the injury is at least 30 days. If Bliwa considers that the injury has been severe, compensation may also be paid for a sick leave period of less than 30 days. For assessment of what is considered to be a severe injury, guidance is taken from Trafikskadenämnden's examples of severe injury.

The amount of the compensation is determined by the type of damage and its extent, as well as time for treatment and healing. The compensation is calculated using the table below which is applied by Bliwa at the time of payment. At the time of payment, the compensation amount is rounded in accordance with the following rules. Amounts between SEK 1 and SEK 5,000 are rounded up to the nearest even 100s, amounts between SEK 5,000 and SEK 10,000 are rounded up to the nearest even 500s, amounts over SEK 10,000 are rounded up to the nearest even 1,000s.

Type of care and injury	Within one year of the injury	One year after the injury
Other care	110 SEK/day	74 SEK/day
Hospital care other injury	197 SEK/day	134 SEK/day
Hospital care sever injury	264 SEK/day	177 SEK/day

If compensation in case of sick leave for at least 30 days as a consequence of the accidental injury have already been compensated or should be compensated by another party as a consequence of law, statute, convention or collective agreement, Bliwa will not also pay compensation for the same period. The same applies if the insured has already received corresponding compensation from other insurance. If such compensation has been paid and the deductible has been deducted, Bliwa will not compensate for this deduction.

If compensation in case of sick leave for at least 30 days from another insurance has been adjusted due to the insured's negligence, Bliwa will not provide any compensation to cover the difference.

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

The insurance compensates scars and other appearance-related consequences of an injury as a result of an accidental injury or sickness that occurred during the term of the insurance. Compensation is only paid after treatment has been completed and when the scar or appearance-related consequence of the injury is considered, by Bliwa, to be permanent for the future, though no earlier than one year after the accident or sickness happened.

'Scar' means a skin injury as a consequence of an accident or sickness. Other consequential injuries, such as for instance deformity or other bodily change where the skin is not damaged, are considered to be an appearance-related consequence of an injury.

The sum insured for scars and other appearance-related consequences of an injury corresponds to the chosen sum insured for medical invalidity. The sum insured is reduced by one percentage point for each year that the age of the insured exceeds 25. Compensation for multiple scars within the same

group is a maximum of 25% of the sum insured for group 1, 10% for group 2, and 8% for group 3, regardless of the number of scars. Compensation of at most 25 per cent of the sum insured is paid for one and the same insurance event involving several scars from different groups.

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

Group 1 Face and Neck		Length < 0,5 cm	Length 0,5– 1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,05%	0,30%	0,60%	0,90%	1,50%	1,80%
Width 0,5–1,9 cm			0,60%	0,90%	1,20%	1,80%	2,40%
Width 2–5,9 cm				1,20%	1,80%	2,40%	3,60%
Width 6–9,9 cm					3,00%	4,00%	7,00%
Width 10–14,9 cm						8,00%	10,00%
Width ≥ 15 cm							25,00%
Appearance-related consequence of an injury ≥ 6 x 6 cm	5%						
Appearance-related consequence of an injury < 6 x 6 cm	0,5%						

Group 2 Forearms, lower legs/knee, hands and head		Length < 0,5 cm	Length 0,5– 1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,03%	0,15%	0,30%	0,45%	0,75%	0,90%
Width 0,5–1,9 cm			0,30%	0,45%	0,60%	0,90%	1,20%
Width 2–5,9 cm				0,60%	0,90%	1,50%	2,50%
Width 6–9,9 cm					1,20%	3,50%	6,00%
Width 10–14,9 cm						6,00%	8,00%
Width ≥ 15 cm							10,00%
Appearance-related consequence of an injury	0,2%						

Group 3 Upper arms, thighs, feet, elbows and trunk		Length < 0,5 cm	Length 0,5–1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,02%	0,15%	0,20%	0,30%	0,50%	0,60%
Width 0,5–1,9 cm			0,20%	0,30%	0,40%	0,60%	0,80%
Width 2–5,9 cm				0,40%	0,60%	0,80%	1,50%
Width 6–9,9 cm					0,80%	3,00%	4,00%
Width 10–14,9 cm						5,00%	6,00%
Width ≥ 15 cm							8,00%
Appearance-related consequence of an injury	0,1%						

9.11 BENEFITS IN THE EVENT OF INVALIDITY

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

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

A distinction is made between medical and financial invalidity when assessing invalidity.

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

'Financial invalidity' is a permanent impairment of the insured's capacity to work as a consequence of the accidental injury. Capacity to work is deemed to be permanently impaired when all opportunities for occupational rehabilitation have been exhausted and the Swedish Social Insurance Agency has granted at least 50 per cent sickness compensation under the Social Insurance Code. See further information below.

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

9.11.1 BENEFITS IN THE EVENT OF MEDICAL INVALIDITY

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

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

If the accidental injury or sickness has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity

exceeds 100 per cent, Bliwa will nevertheless always pay no more than the sum insured for 100 per cent invalidity. If a lost body part can be replaced by a prosthesis, the level of invalidity will be determined considering the prosthesis and its importance to the bodily function of the insured.

The level of invalidity is determined with the guidance of the industry rating scale that applies at the time of payout.

9.11.2 BENEFITS IN THE EVENT OF FINANCIAL INVALIDITY (ONLY IN THE CASE OF ACCIDENTAL INJURY)

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

The accidental injury must have resulted in a measurable loss of the capacity to work within five years from the date of the accident for the insured to be entitled to benefits. Furthermore, it is required that the accidental injury resulted in medical invalidity before the financial invalidity arose and that this occurred within three years from the date of the accident.

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

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

The amount paid out as invalidity benefit is an equally large portion of the sum insured as the level of the sickness compensation granted by the Swedish Social Insurance Agency. Benefits are paid at 50 per cent of the sum insured in the case of half sickness compensation. Benefits are paid at 75 per cent of the sum insured in the case of three-quarters sickness compensation and at 100 per cent of the sum insured is paid for full sickness compensation. Bliwa's decision concerning benefits under these insurance conditions is based primarily on the Swedish Social Insurance Agency's decision concerning the insured's incapacity to work. However, Bliwa may decide to make its own assessment of the insured's incapacity to work and consequently make a different decision to the Swedish Social Insurance Agency if there are special reasons to do so.

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

An insured who, as a consequence of an accident during the term of the insurance, suffers a permanent incapacity to work after they have attained the age of 60 may only receive financial invalidity benefit from Bliwa if the level of medical invalidity, as a consequence of the accidental injury is at least 50 per cent.

9.11.3 AMOUNT OF THE INVALIDITY BENEFIT

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

If the insured had attained a certain age at the time of the injury, the sum insured for medical and/or financial invalidity may be reduced in accordance with what is agreed in the group agreement. From what age the reduction applies, and the size of the reduction is indicated by the insurance statement.

Benefits are paid out in proportion to the level of invalidity and the sum insured. In the case of accidental injury that has resulted in financial invalidity, benefits paid out are calculated in accordance with the level of medical invalidity, if this results in a higher amount.

9.12 PAYOUT OF INVALIDITY BENEFIT

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

The loss will only be finally settled when the medical or, when applicable, the financial invalidity has been finally determined. However, an advance payment

of invalidity benefit may be paid out prior to this. This advance corresponds to the minimum level of invalidity expected. The advance, expressed in Swedish kronor, will subsequently be deducted from the benefit paid out when the level of invalidity has been finally determined.

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

9.13 POSSIBILITY OF REVIEWING THE BENEFIT IF THE INVALIDITY INCREASES

The insured is entitled to have their level of invalidity reconsidered, following a written request to Bliwa, provided:

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

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

9.14 BENEFIT IN THE EVENT OF DEATH

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

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

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

A nomination of beneficiaries cannot be amended through a will.

10. Child and pregnancy insurance

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

COMMON PROVISIONS

The insurance may apply with either a 'single-child premium' or 'multiple-child premium'. If the insurance applies with a 'single-child premium' (i.e., a premium is paid for each child insured), new insurance should be taken out in the event of a new pregnancy even if a group member already has a child insured under child insurance with Bliwa. If the insurance applies with a 'multiple-child premium', each pregnancy is insured through the existing child insurance if the other conditions are satisfied. What applies in the individual case is shown in the application documents and the insurance statement.

Child insurance may be taken out at two different levels: BASIC and PREMIUM. The difference between the different levels is shown in Sub-clause 10.6.1 below. The insurance may be taken out by a group member. Regardless of the level of the child insurance taken out, pregnancy insurance applies with the scope described below in Sub-clause 10.3 subject to the precondition that the insurance was taken out before the 36th week of pregnancy.

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

Pregnancy insurance applies for at most up to and including the date on which the child attained the age of six months. Child insurance enters into force when the child has been born and applies for at

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

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

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

10.1 DEFINITION OF THE TERM 'ACCIDENT'

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

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

10.1.1 INJURIES EQUATED TO AN ACCIDENTAL INJURY

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

10.1.2 INJURIES THAT ARE NEVER CONSIDERED TO BE AN ACCIDENTAL INJURY

Only injuries that satisfy the preconditions of Sub-clauses 10.1 and 10.1.1 are accidental injuries. Accidental injuries therefore do not include, for example, a bodily injury that has arisen through the insured intentionally having injured themselves or having demonstrated manifest indifference to the risk of getting injured. Nor do they include injuries that have arisen through, for example:

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

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

10.2 DEFINITION OF THE TERM 'SICKNESS'

'Sickness' means in these conditions a deviation from normal health status that requires health and medical care and is not to be regarded as an accidental injury in accordance with the above. Sickness is considered to have occurred when the insured's physical or mental functional capacity has manifestly deteriorated owing to the sickness. Sickness never means a bodily injury caused voluntarily.

10.3 PREGNANCY INSURANCE

10.3.1 TERM OF VALIDITY

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

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

10.3.2 INSURED

If the insurance applies with a single-child premium, new insurance should be taken out in the event of a new pregnancy even if a group member already has a child insured under child insurance with Bliwa. If the insurance applies with a 'multiple-child premium', each pregnancy is insured through the existing child insurance if the other conditions are satisfied. What applies in the individual case is

shown in the application documents and the insurance statement.

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

10.3.3 PRECONDITIONS FOR ENTITLEMENT TO BENEFITS

The accident or sickness must have occurred or manifested itself during the term of the insurance for there to be entitlement to benefits. The term of the pregnancy insurance is from when the insurance was taken out, though no earlier than from and including the 23rd week for the unborn child (see also Sub-clause 10.3.1). The term of the insurance ceases no later than the date on which the child attains the age of six months.

10.3.4 SCOPE OF THE INSURANCE

Compensation under the pregnancy insurance can be paid for the following if it was taken out before the 36th week of pregnancy:

- Medical costs for the child – see Sub-clause 10.4.1
- Travelling costs for the child – see Sub-clause 10.4.2
- Costs of crisis therapy/psychology services – see Sub-clause 10.4.3
- Hospital stay for mother and child – see Sub-clause 10.4.4
- Care expenses benefit – see Sub-clause 10.4.5
- Critical illness compensation – see Sub-clause 10.4.6
- Medical invalidity in the event the child has an accident – see Sub-clause 10.4.7
- Benefit in the event of death – see Sub-clause 10.4.8

10.4 COMPENSATION OF COSTS

10.4.1 MEDICAL COSTS FOR THE CHILD

Compensation is paid for the costs of essential medical care, hospital care, treatment and aids prescribed by a physician for treatment of the injury. Compensation is only paid for costs of care and treatment up to the level of the Swedish high-cost protection. Compensation is only paid for the costs of care or treatment abroad if the accident or sickness occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

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

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

10.4.2 TRAVELLING COSTS FOR THE CHILD

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

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

Compensation is paid at most for the cost of travel between permanent home and care establishment. Compensation is not paid for additional costs arising for travel to the care establishment if the insured is staying at a place that differs from their place of residence.

Compensation is paid for travelling costs made within five years from the date of the accident or the date when the sickness manifested itself.

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

10.4.3 COSTS OF CRISIS THERAPY/PSYCHOLOGY SERVICES

Compensation is paid for the costs of treatment by a psychologist and also travelling costs in conjunction with such treatment if the insured (the child's sibling, mother and/or father) has been affected by mental illness as a consequence of:

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

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

Costs of therapy and psychology services are only compensated in the first instance for treatment within the national healthcare service. However, Bliwa also grants the costs of therapy and psychology services within the private care sector if there are special reasons to do so.

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 10.4.2.

10.4.4 HOSPITAL STAY FOR MOTHER AND CHILD

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

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

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

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

No benefits are paid for outpatient care treatment.

10.4.5 CARE EXPENSES BENEFIT

A care expenses benefit may be paid out at most one price base amount per year. Entitlement to care expenses benefit arises from and including the first day when the mother or other custodian has been granted child carer’s allowance of at least 25 per cent for care and supervision or alternatively at least one eighth of the temporary parental benefit for care of a seriously ill child from the Swedish Social Insurance Agency for a child insured under the pregnancy insurance. The child's sickness that affords entitlement to child carer's allowance or temporary parental benefit for care of a seriously ill child shall have manifested itself during the term of the insurance and before the child is six months old. Entitlement to care expenses benefit lasts for as long as the above-mentioned benefits are paid out by the Swedish Social Insurance Agency, but for no more than one year from the first day of the child carer's allowance or alternatively temporary parental benefit for one and the same loss. If the insured child dies, the right to care expenses benefit ceases at the end of the calendar month in which the death occurred.

SPECIAL INFORMATION ABOUT BENEFITS WHEN CHILD CARER'S ALLOWANCE IS GRANTED

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

If the maximum child carer's allowance is paid out by the Swedish Social Insurance Agency, the benefit under Bliwa’s child insurance is one price base amount per year. If a reduced child carer's allowance is paid out by the Swedish Social Insurance Agency, the care expenses benefit from Bliwa’s child insurance is reduced to a corresponding extent. The amount of the child carer's allowance may be 25, 50, 75 or 100 per cent.

No benefits are paid for compensation for additional costs.

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

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

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

10.4.6 CRITICAL ILLNESS COMPENSATION FOR THE CHILD

Critical illness compensation is paid as a lump sum if the insured child has been diagnosed with any of the diagnoses indicated below, before the child has attained the age of six months. The accident or illness, which is the cause of the diagnosis, or event must have occurred or become apparent during the term of the insurance for there to be entitlement to compensation. Entitlement to compensation under the insurance arises no earlier than seven days after the diagnosis has been made. No critical illness compensation is paid if the insured dies within seven days of the diagnosis having been made.

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

Amount of the benefit

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

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

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

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

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

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

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

Congenital malformations of the great arteries (ICD Q25)

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

Blindness and low vision (ICD H54)

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

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

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

Haemophilia ICD D66-67

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

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

10.4.7 MEDICAL INVALIDITY IN THE EVENT THE CHILD HAS AN ACCIDENT

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

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

The accidental injury must have occurred during the term of the insurance and before the child had attained the age of six months for the insured to be entitled to benefits. The accidental injury must have resulted in a measurable invalidity within three years from the insurance event. Medical invalidity cannot normally be finally determined until one year has elapsed from the date of the accident. A final

assessment of entitlement to benefits shall only be made when the level of invalidity has been finally determined, which may be postponed for as long as there is a possibility of further medical rehabilitation.

If the accidental injury has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent, Bliwa will nevertheless always pay no more than the sum insured applicable for 100 per cent invalidity. If a lost body part can be replaced by a prosthesis, the level of invalidity will be determined considering the prosthesis and its importance to the bodily function of the insured.

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

10.4.8 BENEFIT IN THE EVENT OF DEATH

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

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

If the death relates to a stillborn child, the payout is made to the deceased's estate or to the group member.

10.5 CHILD INSURANCE - BASIC AND PREMIUM LEVELS

10.5.1 CHILD INSURANCE WITH SINGLE-CHILD PREMIUM

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

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

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

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

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

Compensations in the event of invalidity, scars and Critical illness compensation are paid out to the insured child. If the insured child is younger than 18 years old and the compensation at the time of payment is higher than one price base amount, the compensation is placed in an account with a guardian's hold.

PERSONAL ACCIDENT INSURANCE

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

HEALTH INSURANCE

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

10.5.2 CHILD INSURANCE WITH MULTIPLE-CHILD PREMIUM

Child insurance can only be taken out by a group member who is a policyholder. The insurance covers all of the group member's insured children who are entitled to inherit, subject to the precondition that they satisfy other requirements under this condition. In addition, children, who are entitled to inherit, of the group member's husband/wife or cohabitee are insured, subject to the precondition that they satisfy other requirements under this condition, and also that:

- the child is registered in the Swedish population register at the same address as the group member, or
- the child is registered in the Swedish population register at a different address, but the group

member's husband/wife/registered partner/cohabitee has custody. The insurance applies up until the age at expiry for the insurance subject to the precondition that custody has lasted/is ongoing up until the child's 18th birthday.

The group member pays a premium regardless of how many children are covered by the insurance ('multiple-child premium). The insurance applies full-time, i.e., around the clock.

If the pregnancy insurance was taken out during the pregnancy, the child insurance enters into force when the child is born.

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

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

If the insurance applies with a multiple-child premium, the insurance also ceases to apply for children, who are entitled to inherit, of a group member's husband/wife or cohabitee, if the child no longer satisfies the requirements contained in the item list above.

When the insurance has been taken out with one premium for all of the children, the policyholder must notify Bliwa when the youngest child has attained the age of 25 so that the insurance can be terminated.

PERSONAL ACCIDENT INSURANCE

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

HEALTH INSURANCE

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

10.6 COMMON PROVISIONS

10.6.1 SICKNESS THAT IS COMPLETELY OR PARTLY EXCLUDED FROM BENEFITS

CHILD INSURANCE - BASIC LEVEL

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

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

CHILD INSURANCE - PREMIUM LEVEL

Medical and financial invalidity benefits are calculated on the basis of an amount corresponding to ten per cent of the sum insured for the following sicknesses, intellectual disabilities or impairments - and for the consequences of such conditions:

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

10.6.1.1 Common limitations

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

The insurance does not cover sickness, impairment or bodily defect - nor the consequences of such conditions - if the symptoms manifested themselves before the insurance entered into force. This also applies if a diagnosis can only be made after the insurance entered into force. There is never entitlement to benefits for an invalidity that existed before the insurance entered into force.

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

Nor does child insurance cover sicknesses caused by treatments of a cosmetic nature.

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

If the child contracts a sickness, the child must have attained the age of six months before the sickness manifested itself for the first time for benefits to be paid out under the following components of the child insurance:

- Care expenses benefit
- Medical invalidity
- Financial invalidity.

It is a requirement that the need for hospital care arose for the first time after the child attained the age of six months in order to be able to pay out benefits under the *hospital stay* and *care at home* components. This limitation in respect of hospital care does not apply if the child was previously covered by pregnancy insurance.

10.7 SCOPE OF THE INSURANCE

Child insurance may be taken out at two different levels: BASIC and PREMIUM. The difference between the different levels is shown in Sub-clause 11.6.1 below.

The following compensation and benefits can be paid out from the insurance:

In the case of an accidental injury

- Medical costs – see Sub-clauses 10.8 and 10.9.1
- Costs of dental injuries – see Sub-clauses 10.8 and 10.9.2
- Travelling costs – see Sub-clauses 10.8 and 10.9.3
- Additional costs – see Sub-clauses 10.8 and 10.9.4
- Costs of rehabilitation and aids – see Sub-clauses 10.8 and 10.9.5
- Care expenses benefit – see Sub-clauses 10.8 and 10.9.6
- Costs of crisis therapy/psychology services – see Sub-clauses 10.8 and 10.9.7
- Benefit in connection with hospital care – see Sub-clauses 10.8 and 10.9.8
- Benefit in connection with care at home – see Sub-clauses 10.8 and 10.9.9
- Critical illness compensation – see Sub-clauses 10.8 and 10.9.10
- Compensation for scars and other appearance-related consequences of an injury – see Sub-clauses 10.8 and 10.9.11
- Invalidity – medical and/or financial invalidity – see Sub-clauses 10.8 and 10.9.12, including sub-headings
- Benefit in the event of death – see Sub-clauses 10.8 and 10.10

In the event of claims in respect of sickness

- Medical costs – see Sub-clauses 10.8 and 10.9.1
- Travelling costs – see Sub-clauses 11.8 and 10.9.3
- Costs of rehabilitation and aids – see Sub-clauses 10.8 and 10.9.5
- Care expenses benefit – see Sub-clauses 10.8 and 10.9.6
- Costs of crisis therapy/psychology services – see Sub-clauses 10.8 and 10.9.7
- Benefit in connection with hospital care – see Sub-clauses 10.8 and 10.9.8
- Benefit in connection with care at home – see Sub-clauses 10.8 and 10.9.9
- Critical illness compensation – see Sub-clauses 10.8 and 10.9.10
- Compensation for scars and other appearance-related consequences of an injury – see Sub-clauses 10.8 and 10.9.11
- Invalidity – medical or financial invalidity – see Sub-clauses 10.8 and 10.9.12, including sub-headings
- Benefit in the event of death – see Sub-clauses 10.8 and 10.10

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

10.8 IMPORTANT LIMITATIONS TO THE SCOPE OF THE BENEFIT

Depending on the level of the child insurance taken out, certain sicknesses are excluded or limited in accordance with the provisions of Sub-clause 10.6.1.

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

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

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

As regards compensation of costs, the insurance only compensates necessary and reasonable costs as a consequence of the accident or sickness. Bliwa does not compensate costs that should be

compensated by another party according to law, statute, convention or collective agreement. Costs that have been compensated through other insurance are not compensated under this insurance. This applies irrespective of whether such compensation is paid according to a flat-rate model or against an original receipt Nor does Bliwa compensate costs that are to be compensated under patient or healthcare insurance that has been taken out separately. If an accident or sickness occurred outside the insured's place of residence or abroad, the insurance does not compensate the costs compensated by separate travel insurance or a travel component of home insurance. This condition and other important limitations that apply to the entitlement to compensation in the case of an accident or sickness that occurred abroad are shown in Sub-clause 11.3.

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

Compensation is not paid for loss of income from work. Compensation is not paid for costs of dental care and additional costs as a consequence of sickness.

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

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

10.9 COMPENSATION OF COSTS

10.9.1 MEDICAL COSTS

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

Compensation is only paid for the costs of care or treatment abroad if the accident or sickness occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

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

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

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

10.9.2 COSTS OF DENTAL INJURIES AS A CONSEQUENCE OF AN ACCIDENT

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

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

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

Compensation is only paid for costs of dental treatment in Sweden if the treatment is covered by the dental care insurance under the Social Insurance Code. Compensation is not paid for the costs of implant treatment that are not covered by

the dental care insurance. Compensation is only paid for costs of treatment of damage to implants if the treatment is covered by dental care insurance.

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

Compensation is only paid for any emergency treatment costs for persons who are entitled to free dental care owing to their age.

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

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

Compensation is only paid for the costs of treatment abroad if the accident occurred abroad; see Sub-clause 11.3 regarding when compensation is paid for accidents abroad.

Compensation is not paid for costs as a consequence of sickness.

10.9.3 TRAVELLING COSTS

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

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

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

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

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

10.9.4 ADDITIONAL COSTS AS A CONSEQUENCE OF AN ACCIDENT

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

- Clothes normally worn and other personal belongings normally carried that were damaged in the course of the accident: spectacles/prescription lenses, wristwatches, plain wedding bands and helmets. Compensation is not paid for minor cosmetic damage to clothing. Personal protective equipment damaged at the time of the accident is compensated with at most SEK 3,000. The limitation to amounts does not apply for a damaged helmet. Compensation is only paid for the cost of repair if it is possible to repair the damaged object. Compensation may be paid for costs up to no more than 0.6 price base amounts in aggregate.
- Other unavoidable and reasonable additional costs that have arisen as a consequence of the accidental injury during the emergency treatment and healing period for the injury. Compensation may be paid for costs up to no more than three price base amounts in aggregate.

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

compensation as a percentage of the repurchase price.

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

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

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

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

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

10.9.5 COSTS OF REHABILITATION AND AIDS

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

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

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

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

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

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

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

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

10.9.6 CARE EXPENSES BENEFIT

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

For entitlement to benefits, the insurance event must have occurred during the term of the insurance and after the insured child has attained the age of six months. See also Sub-clause 11.6.1.2.

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

This means that the care expenses benefit from Bliwa's child insurance may not in any event exceed the sum insured shown in the application documents and the insurance statement.

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

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

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

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

SPECIAL INFORMATION ABOUT BENEFITS WHEN CHILD CARER'S ALLOWANCE IS GRANTED

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

If the maximum child carer's allowance is paid out by the Swedish Social Insurance Agency, the benefit under Bliwa's child insurance is one price base amount per year. If a reduced child carer's allowance is paid out by the Swedish Social Insurance Agency, the care expenses benefit from Bliwa's child insurance is reduced to a corresponding extent. The amount of the child carer's allowance may be 25, 50, 75 or 100 per cent.

No benefits are paid for compensation for additional costs.

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

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

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

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

10.9.7 COSTS OF CRISIS THERAPY/PSYCHOLOGY SERVICES

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

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

the death of a close relative (parent, sibling, grandparent, spouse, cohabitee, the insured's child), including miscarriage

- robbery, threat or assault on the insured personally and that has been reported to the police
- rape or other sexual offences
- violence in the family
- bullying

- the involuntary unemployment of an insured adult that has lasted for at least six months.

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

Costs of therapy and psychology services are only compensated in the first instance for treatment within the national healthcare service. However, Bliwa also grants the costs of therapy and psychology services within the private care sector if there are special reasons to do so.

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

The insured may be entitled to compensation for travelling costs in conjunction with treatment; see Sub-clause 10.9.3.

10.9.8 BENEFIT IN CONNECTION WITH HOSPITAL CARE

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

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

For sickness, the need for health and medical care must have arisen for the first time after the child attained the age of six months. This does not apply if the child was covered by pregnancy insurance.

No benefits are provided for outpatient care treatment.

10.9.9 CARE AT HOME

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

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

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

10.9.10 CRITICAL ILLNESS COMPENSATION

Critical illness compensation is paid out as a lump sum if the insured child is diagnosed during with any of the diagnoses or adversely affected by any of the events indicated below. The accident or illness, which is the cause of the diagnosis, or event must have occurred or become apparent during the term of the insurance for there to be entitlement to compensation. Entitlement to compensation under the insurance arises no earlier than seven days after the diagnosis has been made. No critical illness compensation is paid if the insured dies within seven days of the diagnosis having been made.

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

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

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

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

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

AMOUNT OF THE BENEFIT

The benefit will be paid out as a lump sum. The amount of the critical illness compensation is dependent on the scope of child insurance taken out. The sum insured is one price base amount if the Basic Level has been taken out and two price base amounts if Premium Level has been taken out. 'Price base amount' means the price base amount for the year in which the entitlement to the benefit arised.

DIAGNOSES AND EVENTS THAT AFFORD ENTITLEMENT TO BENEFITS

10.9.10.1 1. Cancer

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

The following conditions are not covered by the insurance:

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

10.9.10.2 2. Residual disablement from meningitis

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

10.9.10.3 3. Tick-borne encephalitis (TBE)

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

10.9.10.4 4. Neuroborreliosis

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

10.9.10.5 5. Kidney failure

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

10.9.10.6 6. Organ transplant

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

10.9.10.7 7. Deafness

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

10.9.10.8 8. Blindness

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

10.9.10.9 9. Loss of arm or leg

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

10.9.10.1010. Loss of speech

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

10.9.10.1111. Paralysis

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

10.9.10.1212. Stroke

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

10.9.10.1313. Multiple sclerosis (MS)

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

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

The insurance compensates scars and other appearance-related consequences of an injury as a result of an accidental injury or sickness that occurred during the term of the insurance. The change must have occurred after the child has been born and when the child insurance is in force. Compensation is only paid after treatment has been completed and when the scar or appearance-related consequence of the injury is considered, by Bliwa, to be permanent for the future, though no earlier than one year after the accident or sickness happened.

'Scar' means a skin injury as a consequence of an accident or sickness. Other consequential injuries, such as for instance deformity or other bodily change where the skin is not damaged, are considered to be an appearance-related consequence of an injury.

The sum insured for scars and other appearance-related consequences of an injury corresponds to the chosen sum insured for medical invalidity. Ersättning för flera ärr inom samma grupp är högst 25% av försäkringsbeloppet för grupp 1, 10% för grupp 2, och 8% för grupp 3, oavsett antal ärr. Compensation of at most 25 per cent of the sum insured is paid for one and the same insurance event involving several scars from different groups.

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

Group 1 Face and Neck		Length < 0,5 cm	Length 0,5– 1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,05%	0,30%	0,60%	0,90%	1,50%	1,80%
Width 0,5–1,9 cm			0,60%	0,90%	1,20%	1,80%	2,40%
Width 2–5,9 cm				1,20%	1,80%	2,40%	3,60%
Width 6–9,9 cm					3,00%	4,00%	7,00%
Width 10–14,9 cm						8,00%	10,00%
Width ≥ 15 cm							25,00%
Appearance-related consequence of an injury ≥ 6 x 6 cm	5%						
Appearance-related consequence of an injury < 6 x 6 cm	0,5%						

Group 2 Forearms, lower legs/knee, hands and head		Length < 0,5 cm	Length 0,5– 1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,03%	0,15%	0,30%	0,45%	0,75%	0,90%
Width 0,5–1,9 cm			0,30%	0,45%	0,60%	0,90%	1,20%
Width 2–5,9 cm				0,60%	0,90%	1,50%	2,50%
Width 6–9,9 cm					1,20%	3,50%	6,00%
Width 10–14,9 cm						6,00%	8,00%
Width ≥ 15 cm							10,00%
Appearance-related consequence of an injury	0,2%						

Group 3 Upper arms, thighs, feet, elbows and trunk		Length < 0,5 cm	Length 0,5–1,9 cm	Length 2–5,9 cm	Length 6–9,9 cm	Length 10–14,9 cm	Length ≥ 15 cm
Width < 0,5 cm		0,02%	0,15%	0,20%	0,30%	0,50%	0,60%
Width 0,5–1,9 cm			0,20%	0,30%	0,40%	0,60%	0,80%
Width 2–5,9 cm				0,40%	0,60%	0,80%	1,50%
Width 6–9,9 cm					0,80%	3,00%	4,00%
Width 10–14,9 cm						5,00%	6,00%
Width ≥ 15 cm							8,00%
Appearance-related consequence of an injury	0,1%						

10.9.12 BENEFITS IN THE EVENT OF INVALIDITY

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

The following limitations apply for entitlement to benefits in the event of invalidity as a consequence of sickness: the sickness or manifest symptom of sickness shall have manifested itself for the first time during the term of the insurance and after the insured child has attained the age of six months. See also Sub-clause 10.6.1.2.

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

'Financial invalidity' is an impairment of the insured's future capacity to work as a consequence of the accidental injury or sickness. For Bliwa to pay benefits, it is required that the Swedish Social Insurance Agency, as a consequence of the

accidental injury or sickness, has granted at least 50 per cent activity compensation or sickness compensation for at least five years and/or at least 75 per cent child carer's allowance for the insured from and including the age of ten for at least five years. Entitlement to benefits for financial invalidity requires that the accidental injury or sickness has resulted in permanent medical invalidity.

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

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

If the accidental injury or sickness has resulted in the insured having suffered injuries to several parts of the body so that the total level of invalidity exceeds 100 per cent, Bliwa will nevertheless always pay no more than the sum insured applicable for 100 per cent invalidity. If a lost body part can be replaced by a prosthesis, the level of invalidity will be determined considering the prosthesis and its importance to the bodily function of the insured.

The level of invalidity is determined with the guidance of the industry rating scale that applies at the time of payout.

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

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

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

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

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

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

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

If the insured was entitled to sickness compensation, activity compensation or other corresponding benefits under the Social Insurance Code at the time of the injury owing to a permanent incapacity to work, the financial invalidity benefit

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

10.9.12.1 Additional benefits

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

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

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

10.9.12.2 Payout of invalidity benefit

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

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

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

10.9.12.3 Possibility of reviewing the benefit if the invalidity increases

The insured is entitled to have their level of invalidity reconsidered, following a written request to Bliwa, provided:

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

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

10.10 BENEFIT IN THE EVENT OF DEATH

As a result of an accident

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

If the insured commits suicide, this is treated as an accidental injury under this insurance.

10.10.1.1 As a result of sickness

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

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

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

www.sakra.se/sv/sakra-personskydd or from *www.bliwa.se/sakra.* A nomination of beneficiaries cannot be amended through a will.

11. Limitations to Bliwa's liability

11.1 DUTY OF DISCLOSURE

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

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

11.2 CONSEQUENCE OF INCORRECT INFORMATION

If the policyholder has acted fraudulently or in bad faith when performing their duty of disclosure under Sub-clause 11.1, the insurance agreement may be invalid and Bliwa released from its liability for an insurance event that subsequently occurs. Bliwa may in such case retain the premium paid in respect of the preceding periods.

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

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

11.3 VALIDITY OF THE INSURANCE PRODUCTS IN THE EVENT OF STAYS ABROAD

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

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

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

The insured shall also be covered by Swedish social insurance during the stay abroad.

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

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

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

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

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

11.4 VALIDITY OF THE INSURANCE PRODUCTS IN THE EVENT OF STATE OF WAR AND POLITICAL UNREST

IN THE EVENT OF A STATE OF WAR IN SWEDEN

A 'state of war in Sweden' means a war or situation for which special legislation applies (Act (1999:890) on insurance activities during war or risk of war, etc.).

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

Lump-sum benefit, health insurance and disability business interruption insurance
These insurance products do not cover an insurance event suffered by the insured while a state of war prevails in Sweden if the incapacity to work may be considered to be due to the state of war. The same rule applies if the insured suffers an incapacity to work within one year after the state of war has ceased. However, the insurance products do cover invalidity that occurs as a consequence of an act of war during the period when a situation of war prevails in Sweden.

Critical illness insurance, personal accident insurance, accident and health insurance and child insurance
These insurance products do not cover an insurance event that occurs while a state of war prevails in Sweden and that may be considered to be due to the state of war. However, the insurance products do cover invalidity and death that occur as a consequence of an act of war during the period when a situation of war prevails in Sweden.

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

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

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

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

Life insurance – death benefit, lump-sum benefit, health insurance, disability business interruption insurance, critical illness insurance, personal accident insurance, accident and health insurance and also child insurance
The following applies if the insured is staying outside Sweden in an area where war or warlike political unrest prevails – but is not personally participating:

If the insurance was taken out in conjunction with the outward journey to, or during the stay in, the area and the war or unrest was already underway or there was a manifest risk of war, this insurance does not cover death, work incapacity, sickness or an

accident that occurs during the stay in the area. Nor does the insurance cover an insurance event that occurs within one year after the end of the stay and that may be considered to be due to the war or unrest.

11.5 LOSSES CAUSED BY A NUCLEAR REACTION AND ALSO BIOLOGICAL, CHEMICAL AND NUCLEAR SUBSTANCES

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

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

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

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

Critical illness insurance, personal accident insurance, accident and health insurance and also child insurance

In the event of an accidental injury, compensation will be reduced or denied completely if:

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

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

11.7 FORCE MAJEURE

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

11.8 LEGAL REPRESENTATIVE

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

11.9 JOINT CLAIMS REPORT REGISTER

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

12. Processing of personal data

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

13. Information about insurance distribution

Bliwa's insurance products may be distributed by Bliwa or another distributor engaged by Bliwa to deal with the distribution. The party distributing the insurance must provide the customer with information about the distribution. Säkra distributes the insurance products in accordance with these conditions and shall provide the customer with information about the distribution.

14. If we do not agree

RECONSIDERATION BY BLIWA

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

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

THE SWEDISH CONSUMERS' INSURANCE BUREAU

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

MUNICIPAL CONSUMER ADVICE OFFICER

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

THE BOARD FOR INSURANCE OF PERSONS

The Board for Insurance of Persons only considers matters that involve insurance-medical issues and where the Board therefore needs the support of a consultant physician.

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

THE NATIONAL BOARD FOR CONSUMER COMPLAINTS (ARN)

ARN is a government authority that considers disputes between private individuals and business operators. The Board applies limits in respect of values that may mean that disputes involving low values are not considered. Nor does the Board conduct any medical assessments. Address: Allmänna reklamationsnämnden, Box 174, SE-101 23 Stockholm, Sweden. Telephone number: +46 (0)8-508 860 00.

JUDICIAL REVIEW

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

bliwa

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