OP

Insurance terms and conditions 1 January 2018 • L1801

Sports Cover

Contents

Sports Cover

1 Insured person and beneficiary

The insured is the person to whom the policy was bought. Medical expenses indemnity and handicap benefit is paid to the insured person.

Death Cover beneficiaries are the insured person's next of kin unless the policyholder has notified the insurance company of another beneficiary.

Such a beneficiary clause and relevant alterations to or cancellations of it must be submitted to the insurance company in writing.

2 Validity

The policy is valid in matches, competitions, training or travel immediately related to them concerning a sport specified in the sports licence insurance, the insurance policy or insurance contract according to the chosen sports licence option or to the extent specified in the insurance policy or insurance contract. The policy may also be valid in the subgroups referred to in the product description in matches, competitions and training related to other sports, and travel immediately related to them.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act or under some other legislation.

The insurance cover is valid in the period stated in the sports licence insurance, the insurance policy or insurance contract.

The insurance is valid everywhere in the world.

3 Sudden event and restrictions to it

3.1 A sudden event refers to one that causes bodily injury

3.2 We do not compensate the following bodily injuries caused by a sudden event

- stress pain and injuries or illnesses, such as shin splints, tendinitis or inflammation of tendons' attachment sites
- gradually arising pains, injuries or illnesses
- illnesses, such as bone or cartilage diseases, arthrosis or arthritis or heart attacks or other attacks of illness
- herniation of intervertebral disk
- abdominal, umbilical or groin hernia

Contrary to the above, stress fracture or its initial stage is compensated.

4 Types of compensation

4.1 Medical expenses indemnity

The right to compensation arises when the insured person incurs examination and treatment expenses as a result of a sudden event causing bodily injury. The insurance must be valid at the time of the injury. Compensation will only be paid for expenses incurred within three years of the injury, but no more than the maximum amount referred to in the product description. There is no maximum compensation period for dental injuries.

The deductible will be subtracted once per insurance event causing injury.

Expenses are covered provided that the examination or treatment of the injury is prescribed by a physician. In addition, the examination or treatment procedures must be in accordance with generally accepted medical practice and necessary for the treatment of the injury in question. Of such expenses, we compensate reasonable

- fees for examination and treatment procedures carried out by physicians or healthcare professionals
- costs for medicinal products and wound dressings sold in pharmacies
- daily hospital charges
- costs of dental injury examinations and treatments
- costs for orthopaedic braces or bandages for the treatment of a coverable injury
- costs for physiotherapy required to recover from a fracture or a surgical procedure. Physiotherapy is also covered in knee and shoulder injuries in which the physiotherapy is applied instead of surgery. However, physiotherapy is only covered for a maximum of 10 sessions per sudden event.
- rental costs of crutches
- cost for clothes and accessories that have been cut open in connection with a coverable procedure
- reasonable travel expenses to the nearest hospital or clinic. Costs incurred by the insured person using his/her own car are covered as reasonable or necessary expenses to the maximum amount of motor vehicle travel costs specified under the decree issued by the Ministry of Social Affairs and Health on the basis of the Health Insurance Act.

The insurance company can choose the medical centre, hospital or nursing institution in which examinations and treatment measures shall be undertaken, unless this is unreasonably inconvenient for the insured.

The insurance does not cover

- costs for examination or treatment provided by a physiotherapist, with the exception of physiotherapy required for recovery as described above or physiotherapy compensated instead of surgery.
- costs of examination or treatment of the following or equivalent: foot therapist, occupational therapist, speech therapist, nutritional therapist, psychologist, neuropsychologist , optician, chiropractor, osteopath, naprapath or massage therapist
- costs of psychotherapy or equivalent treatment
- costs of medical aids, other aids and supplies or artificial limbs, except as described above concerning orthopaedic braces or bandages or rental costs of forearm or underarm crutches
- indirect costs such as accommodation and meal costs.

4.1.1 Filing a claim

The claimant shall submit to the insurance company documentation of the injury, examination and treatment. This must be done by filling in the insurance company's loss report available on the website. If requested, you

must also provide additional information in order to settle the claim. Fees charged by doctors for medical statements are not compensated as loss inquiry costs. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

The claimant must pay the treatment expenses him/herself and claim reimbursement of the expenses under the Health Insurance Act. Claimants must upon request submit the original receipts to the insurance company.

4.2 Handicap benefit

The right to handicap benefit arises if the insured person suffers permanent handicap caused by a bodily injury incurred from a sudden event that occurred during the validity of the handicap benefit cover and the permanent handicap has continued for three months.

Permanent handicap refers to a medically assessed general handicap which the insured has incurred through an injury and which, according to medical prognosis, is unlikely to be healed. In determining the handicap, only the nature of the injury is taken into account. The individual circumstances of the injured person, such as their profession or leisure-time pursuits, do not affect the determination of the handicap.

The degree of handicap is determined in accordance with the handicap classification decision based on the Workers' Compensation Act and valid when the accident occurred. Injuries are divided into handicap classes 1–20, with class 20 corresponding to full handicap and class 1 to the smallest coverable handicap.

The benefit for full, permanent handicap according to class 20 is paid as a lump sum equal to the sum insured valid at the time the sudden event occurred. For partial, permanent handicap, the benefit is paid as a lump sum equal to as many twentieths of the sum insured as indicated by the handicap class.

A handicap is considered permanent once it has been medically diagnosed as such, and this can be done no sooner than three months and no later than three years after the event. If the degree of handicap changes by at least two handicap classes before three years have elapsed since the event, the amount of benefit must be revised correspondingly. However, no benefit already paid will be recovered.

4.2.1 Filing a claim

The claimant must notify the insurance company in writing of the bodily injury caused by a sudden event by filling in the insurance company's loss report accompanied by any other relevant documentation. In order for the handicap benefit to be processed, the claimant must send upon request an E Doctor's statement to the insurance company, describing the handicap. The fee for a doctor's statement is compensated only if the insurance company has specifically requested for one.

4.3 Death benefit

The right to death benefit arises if the insured dies owing to bodily injury caused by a sudden event that occurred during the validity of the death benefit cover.

The compensation is the sum insured valid when the sudden event took place. No benefit will be paid if the insured dies three years after the sudden event occurred.

4.3.1 Filing a claim

The claimant must notify the insurance company in writing of the bodily injury caused by a sudden event For the processing of death benefit, the claimant must provide the insurance company with a death certificate for the insured and official extracts from the population register, or equivalent, on beneficiaries. The insurance company must also be sent, upon request, further documentation by the authorities on the cause of death. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

General terms of contract

The General Terms of Contract contain the relevant provisions of the Insurance Contracts Act (543/94). The symbol § in brackets refers to the relevant sections of the Insurance Contracts Act in which the matters in question are dealt with. The insurance contract is also subject to certain provisions of the Insurance Contracts Act not appearing from these General Terms of Contract. The clauses below apply to group insurance unless otherwise agreed in respect of a matter stipulated in the group insurance contract or the terms and conditions.

1 Key concepts (§§2 and 6)

The policyholder is the party who has concluded an insurance contract with the insurer.

The insurer is OP Insurance Ltd. In these terms and conditions, the insurer is referred to as 'the insurance company'.

The insured person is a person who is covered by the insurance.

The **insurance period** is the agreed period during which the insurance is valid.

An insurance event is an event for which compensation is paid under the insurance.

Group insurance (§2) is insurance under which those insured are members of a group as defined in the insurance contract and the premium is paid in full by its policyholder.

2 Disclosure of information prior to concluding an insurance contract

2.1 Obligation of the policyholder and the insured person to disclose information (§§22 and 24)

Prior to the insurance being granted, the policyholder and the insured person must provide full and correct answers to all questions presented by the insurance company which may affect the assessment of the insurance company's liability. During the validity of the insurance period, the policyholder and the insured person must also correct without undue delay any information provided to the insurance company by them which they have found to be incorrect or insufficient.

If the policyholder or the insured person has acted fraudulently with regard to the abovementioned obligation, the insurance contract is not binding on the insurance company. The insurance company has the right to withhold all premiums paid, even if the insurance is annulled.

2.2 Failure to disclose information

If the policyholder or the insured has wilfully or through negligence which cannot be deemed minor failed in his/her obligation to disclose information, and the insurance company would have refused to grant the insurance altogether had the full and correct information been provided, the insurance company is free from liability. If the insurance company had granted the insurance only against a higher premium or otherwise on terms other than those agreed, the insurance company's liability is restricted to what corresponds to the agreed premium or the terms on which the insurance would have been granted.

If the above-mentioned consequences of failure to disclose information would lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

3 Beginning of insurance company's liability and validity of insurance contract

3.1 Beginning of Insurance Company's liability

Payment of the premium for the insurance period is a precondition for commencement of the insurance company's liability.

3.2 Validity of the insurance contract

The insurance contract is made for a fixed term.

A fixed-term insurance contract is valid for the agreed insurance period. The insurance can, however, be terminated during the insurance period on grounds specified below in sections 13.1 and 13.2.

4 Insurance premium

4.1 Returning of premium at the termination of a contract (§45)

If the insurance terminates before the date agreed, the Insurance Company is entitled only to the premium for the period during which it was liable. The rest of the premium paid is returned to the policyholder.

When determining the amount of returnable premium, the validity is calculated in days according to the insurance period to which the premium pertains.

The insurance company will charge a minimum premium for each insurance period. This will not be returned even if the insurance was terminated in the middle of the insurance period.

However, the premium is not returnable in cases stated below in this clause or if the policyholder or the insured person has acted fraudulently in the circumstances referred to in clause 2.1 above. Yet no refund will be made if the sum to be returned is less than the sum in euros in the Insurance Contracts Act.

4.2 Setoff against premiums to be refunded

The Insurance Company may deduct any outstanding premiums overdue and other overdue receivables from the premium to be returned.

5 Policyholder's obligation to disclose information about any increase in risk (§27)

The policyholder must notify the insurance company of any changes in factors increasing risk that were reported when the insurance contract was concluded and that are relevant in terms of assessment of the insurance company's liability, such as changes in profession/occupation, leisure time activities or place of residence, or the termination of any other insurance cover. A change resulting in increased risk may be, for instance, residence abroad of the insured person for over a year on a continuous basis. The insurance company must be notified of any such changes no later than one month of receipt of the annual bulletin following such a change. Changes in the person's state of health do not have to be reported. The insurance company reminds policyholders in the annual bulletin of their disclosure obligation.

If a policyholder has wilfully or through negligence which cannot be deemed minor failed to notify the insurance company of increased risk as mentioned above, and the insurance company would not, as a result of the changed circumstances, have kept the insurance in force, the insurance company is released from liability. If, however, the insurance company would have continued the insurance but only for a higher premium or on other terms, the insurance company's liability is limited to that which corresponds to the insurance premium or the terms on which the insurance would have been continued.

If the above-mentioned consequences of failure to disclose information lead to a result that is clearly unreasonable from the point of view of the policyholder or another party entitled to compensation, they may be adjusted.

6 Causing an insurance event

6.1 Causing an insurance event (§28)

The insurance company is released from liability to any insured person who has wilfully caused a loss event.

If the insured has caused the insurance event through gross negligence, the insurance company's liability may be reduced, depending on what is deemed reasonable in the circumstances.

6.2 Insurance event caused by a person entitled to compensation (§29)

If a person entitled to compensation or benefit other than the insured person has wilfully caused the insurance event, the insurance company is released from liability to such party. If such a person has caused the insurance event through gross negligence or they were at an age or in a state of mind which meant that they could not be sentenced for a crime, the compensation or part of the compensation may be paid to them, but only when this is deemed reasonable considering the circumstances in which the insurance event was caused. If the insured has died, the other parties entitled to compensation are paid that part of the compensation which is not paid to the person or persons who caused the insurance event.

7 Irresponsibility and emergency (§36)

The insurance company will not invoke clause 6 above to release itself from or restrict its liability if the insured person was under 12 years of age at the time he/she caused the insurance event or was in such a state of mind that he/she could not have been sentenced for a crime. The insurance company will not invoke clauses 5 and 6 above to release itself from or restrict its liability if the insured person was seeking to prevent injury to a person or damage to property in circumstances in which his/her negligence or action was justifiable at the time he/she increased the risk or caused the insurance event.

8 Beneficiary clause

8.1 Beneficiary (§47) (Does not apply to group insurance, see clause 8.3)

The policyholder has the right to name a person (beneficiary) who is entitled to compensation instead of the policyholder or the insured person. The policyholder may change or cancel the beneficiary clause if the insurance event to which the clause is intended to be applied has not occurred.

If the beneficiary clause is valid, the benefit payable due to the death of the insured person is not part of the insured persons estate. The benefit is part of the insured person's estate when there is no beneficiary clause and the benefit is not in the terms and conditions of the insurance set out to be payable to the policyholder.

8.2 Form of the beneficiary clause (§48)

A beneficiary clause, its cancellation or amendment is null and void unless it has been submitted to the insurance company in writing.

8.3 Beneficiary clause and its form in group insurance

The insurance company and the policyholder agree on the beneficiary clause in the group insurance contract.

The policyholder may change the beneficiary if the right to do this has been agreed in the group insurance contract.

If the beneficiary clause is valid, the benefit payable due to the death of the insured person is not part of the insured persons estate. The benefit is part of the insured persons estate if there is no beneficiary clause and if the benefit is not payable to the policyholder under the insurance terms and conditions.

9 Claims settlement procedure

9.1 Duties of claimant (§§69 and 72)

The claimant must provide the insurance company with documents and information necessary for the assessment of the insurance company's liability.

These include documents and information which confirm whether an insurance event occurred, the extent of the loss or damage and who is to be indemnified. The claimant is required to obtain the documentation which he/she is best able to obtain, though taking into account that the insurance company may also acquire such documentation.

The insurance company is not required to pay compensation before it has received the above documentation.

If the claimant has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability, his/her compensation may be reduced or disallowed, depending on what is reasonable in the circumstances. Insurance companies share a non-life insurance information system which can be used in processing claims to check claims submitted to different companies.

9.2 Limitation on right to obtain compensation (§73)

A claim for compensation must be presented to the insurance company within 12 months of the date when the claimant became aware of the insurance and was informed of the insurance event and the damaging consequences of that event. A claim for compensation must in any case be presented within 10 years of the date when the insurance event occurred or the damaging consequences were caused. Reporting an insurance event is comparable to presenting a claim. If the claim is not presented within the said period, the claimant loses his/her right to obtain compensation.

9.3 Setoff against compensation

Any one of the insurance companies may, on behalf of all of the insurance companies that may be acting as insurers in the agreement, deduct any outstanding premiums overdue and other outstanding overdue amounts from compensation.

10 Lodging an appeal against decision taken by insurance company (§§8 and 74)

10.1 Right to correct

If a policyholder or claimant suspects that the insurance company has made a mistake in its claim settlement decision, he/she has the right to obtain more information about matters which have led to the decision. The insurance company will revise the decision if the new investigations give cause to do so.

10.2 FINE and the Consumer Disputes Board

The Finnish Financial Ombudsman Bureau (www.fine.fi) offers free and independent advice and assistance. The Finnish Financial Ombudsman Bureau and the Finnish Insurance Complaints Board also give settlement recommendations in civil action cases. FINE does not handle a dispute pending in the Consumer Disputes Board or a court of justice or processed by the Consumer Disputes Board or a court of justice.

A decision made by an insurance company may also be submitted to the Consumer Disputes Board (www.kuluttajariita.fi). Before submitting a matter to the Consumer Disputes Board, consumers should first consult the

Local Register Office's Consumer Advice services (www.kuluttajaneuvonta.fi). The Consumer Disputes Board will not process any disputes that are pending or already processed at the Finnish Insurance Complaints Board or a court of law.

10.3 District court

If the policyholder or claimant is dissatisfied with the insurance company's decision, he/she may bring action against the insurance company.

Action against the insurance company's decision must be brought within three years of the policyholder or claimant being informed in writing about the insurance company's decision and the time limit. The right to bring action ceases once the time limit has expired.

Handling of a case by a board will interrupt the limitation period for the right to bring action.

11 The insurance company's right of recovery (§75)

The insured persons right to claim compensation from a liable third party for expenses arising from an illness or injury and for loss of property transfers to the insurance company up to the amount of compensation paid by the insurance company.

If the loss or damage was caused by a third party as a private person or as an employee, a civil servant or any other person comparable to these as referred to in chapter 3 of the Tort Liability Act, the right of recovery will be transferred to the insurance company only if the person in question caused the insurance event wilfully or through gross negligence or is held liable regardless of the nature of his/her negligence.

12 Altering an insurance contract

The insurance company has the right to alter the insurance premiums or other terms of contract during the insurance period to correspond with the changed circumstances if

1 the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed to observe his/her obligation to disclose information as referred to in clause 2.1 above, and if the insurance company, had it been given the correct and full information, had granted the insurance only against a higher premium or otherwise on terms other than those agreed; or
2 the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.1 above and, regardless of this, the insurance is binding on the insurance company on the basis of this clause due to the adjustment of the consequences of the failure to disclose information; or
3 during the insurance period, a change as referred to in clause 5 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would have granted the insurance only against a higher premium or on otherwise other terms in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance.

After being informed of the said change, the insurance company will notify the policyholder, in writing and without undue delay, of any change in the premium or other terms. The notification shall state that the policyholder has the right to cancel the insurance.

13 Termination of insurance contract

13.1 Policyholder's right to terminate the insurance

The policyholder has the right, at any time, to terminate the insurance contract during the insurance period. Notice of termination must be given in writing. Notice of termination given in any other manner shall be null and void. If the policyholder has not specified a later termination date, the insurance will terminate on the date the notice was submitted or sent to the insurance company.

13.2 Insurance company's right to terminate insurance during insurance period (§27)

During the insurance period, the insurance company has the right to terminate the insurance (or to terminate the cover for an individual insured person) if

1 the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor neglected his/her obligation to disclose information as referred to in clause 2.1 above, and the insurance company, had it been given correct and complete information, had refused to grant the insurance altogether;
2 the policyholder or the insured person has acted fraudulently in observing his/her obligation to disclose information as referred to in clause 2.1 above and, regardless of this, the insurance contract is binding on the insurance company on the basis of that clause;
3 during the insurance period, a change as referred to in clause 5 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would not have granted the insurance in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance;
4 the insured person has wilfully caused the insurance event; or
5 the insured person has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability.

Having been informed of the grounds for permitting termination, the insurance company will give written notice of termination without undue delay. For an individual insured person, the insurance contract or insurance cover will terminate in one months time of the date on which the notice was sent.

14 Applicable law and calculation bases

Finnish law and the calculation bases required by the Insurance Companies Act shall apply to all insurance contracts.

15 Other matters dealt with in the Insurance Contracts Act

The Insurance Contracts Act also covers the following matters:
Scope of application (§1)
Peremptory nature of provisions (§3)
Insurance company's obligation to disclose information (§§5–7 and 9)
Information on reason for rejection (§6a)
Insurance company's obligations (§§7–9, 67–68 and 70)
Insignificance of misrepresentation or increase in underlying risk (§35)
Payment to wrong person (§71)
Subrogation (§75)
The Insurance Contracts Act is available at http://finlex.fi/fi/laki/kaannokset/1994/19940543.

OP Insurance Ltd, Gebhardinaukio 1, 00013 OP, domicile: Helsinki, main line of business: insurance operations
The company is registered in the Trade Register, Business ID 1458359-3