Critical Illnesses Insurance Terms and Conditions

TCI-EE-20251



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Critical Illnesses Insurance Terms and Conditions

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Unofficial translation. In case of differences in interpretation of following conditions, the Estonian text will be regarded as the original.

You are presented with the "Critical Illnesses Insurance Terms and Conditions." These insurance terms are used together with the "General Terms and Conditions of Personal Insurance." This means that both sets of terms apply jointly and are not mutually exclusive.

Critical illnesses insurance is part of health insurance or accident insurance coverage and cannot be used as a standalone product. However, the terms of health insurance or accident insurance do not apply to critical illnesses insurance.

Please take the time to read through the insurance terms and conditions. If anything remains unclear, call If's insurance helpline or send us an email. We will be happy to answer your questions.

1. Definitions

1.1. **Insured Person** – the person named on the policy or otherwise designated in the insurance contract.

1.2. **Beneficiary** – the Insured Person, their heirs, or a third party indicated on the policy, provided that the beneficiary has been designated by a document signed by an adult Insured Person. The document signed by the Insured Person to designate the beneficiary is valid for both the current Insurance Period and subsequent Insurance Periods, unless the Insured Person has specified otherwise. For minor Insured Persons, a third party cannot be designated as a beneficiary.

1.3. **Type of Insurance Indemnity** – the method of payment of the critical illnesses indemnity chosen by the policyholder:
- lump-sum payment of the insurance indemnity;
- payment of the insurance indemnity in instalments according to the percentages specified in the insurance contract.

1.4. **Critical Illnesses** – unexpected illnesses or functional disorders described in Clause 3 of these terms and conditions, confirmed with a Final Diagnosis.

1.5. **Final Diagnosis** – a diagnosis confirmed by a specialist physician authorized to practice medicine or by a medical board, supported by relevant laboratory and/or instrumental health examinations, and recorded in the Insured Person's medical record.

1.6. **Initial Diagnosis** – a preliminary diagnosis based on the identification of early signs of a Critical Illness as recorded in the Insured Person's medical record, determined on the basis of characteristic symptoms and medical history.

1.7. **Waiting Period** – a 90-day period starting from the day following the beginning of the Insurance Period. During the waiting period, insurance coverage does not apply.

1.8. **ICD-10** refers to the International Statistical Classification of Diseases and Related Health Problems.

2. Insurance Object and Validity Conditions

2.1. The insurance object is the life and physical condition of the Insured Person.

2.2. The insurance is valid worldwide, unless otherwise specified in the insurance policy.

2.3. Insurance coverage is valid 24/7, unless otherwise specified in the insurance policy.

2.4. The waiting period does not apply in the following cases:
2.4.1. for the following Critical Illnesses: stroke, myocardial infarction, blindness, deafness, loss of speech, paralysis, or loss of limbs;
2.4.2. for business clients with 10 or more employees insured under Critical Illnesses insurance;
2.4.3. for a subsequent insurance contract, if the previous insurance contract included Critical Illnesses coverage and the subsequent contract is concluded between the Insurer and the same Policyholder, provided that the interval between the contracts does not exceed 2 months.

3. Insurance Event

3.1. An Insurance Event is the recording of a Final Diagnosis in medical documentation confirming that the Insured Person has been diagnosed with a Critical Illness described in Clause 3 of these terms and conditions, provided that:
- the Final Diagnosis was made after the end of the Waiting Period but no later than 60 days after the end of the Insurance Period, and
- the Initial Diagnosis was made after the end of the Waiting Period but before the end of the Insurance Period.

3.2. Insurance events are the same for both types of insurance indemnity and are as follows:

3.2.1. Myocardial Infarction
Irreversible damage to the heart muscle caused by impaired circulation of the cardiac muscle (ICD-10 code I21), confirmed by a cardiologist's conclusion and supported by at least two of the following indicators of myocardial infarction:
- characteristic coronary symptoms;
- typical changes in the electrocardiogram (ECG);

- elevated biochemical markers of myocardial damage.

3.2.2. Stroke (Brain Infarction)
Sudden cerebrovascular disorders (ICD-10 codes I60–I64) resulting in neurological damage lasting more than 24 hours. The damage must be permanent and persist for at least three consecutive months after the stroke. The stroke must be confirmed by a neurologist. The diagnosis must be based on typical clinical symptoms and findings from brain computed tomography (CT) or magnetic resonance imaging (MRI).

3.2.3. Malignant Tumour (Cancer)
The occurrence and spread of malignant cells into healthy tissues (ICD-10 codes C00–C97), confirmed by an oncologist's conclusion and verified by a corresponding histological analysis.

The following tumours are **not** considered an Insurance Event:
- pre-invasive tumours and tumours in situ;
- benign and pre-cancerous tumours;
- cervical dysplasia;
- cervical cancer (CIN1–CIN3);
- stage 1 prostate cancer (T1a, T1b, T1c);
- skin melanoma with Breslow thickness less than 1.5 mm or Clark level below III.

Diagnosis of a malignant tumour is **not** considered an Insurance Event in the following cases:
- the person has been diagnosed with HIV infection or AIDS (Acquired Immunodeficiency Syndrome);
- before the beginning of the Insurance Period, the person has been under medical observation related to ICD-10 codes C00–C97;
- the malignant tumour has developed due to metastases of a previously diagnosed and treated cancer, even if it is of a different type or has spread to other organs.

3.2.4. Cardiac valve replacement or restoration of function
Damage, insufficiency, or a combination of both affecting a heart valve, requiring replacement of one or more valves with a prosthesis or surgical repair of function, including minimally invasive and catheter-based procedures.
Additional condition: the surgery must be prescribed during the Insurance Period and performed within the same period or no later than 120 days after the end of the Insurance Period.

3.2.5. Chronic Kidney Failure
Chronic and irreversible kidney damage resulting in renal failure requiring substitution therapy. Substitution therapy must be prescribed permanently, and its initiation must occur during the Insurance Period.
Clause 7.7.3 of these terms does not apply in the case of chronic renal failure.

3.2.6. Multiple Sclerosis (Sclerosis Multiplex)
An autoimmune disease of the central nervous system affecting the brain and spinal cord (ICD-10 code G35). The disease must be diagnosed in accordance with established diagnostic criteria for multiple sclerosis and confirmed by a neurologist, based on MRI examinations.

3.2.7. Transplantation of Internal Organs
Irreversible damage to the heart, lungs, liver, pancreas, or bone marrow requiring organ transplantation surgery. The Insured Person must be placed on the relevant transplant waiting list no later than 30 days after the end of the Insurance Period.
Organ transplantation is not considered an Insurance Event if it is associated with a previously diagnosed Critical Illness.

3.2.8. Blindness
Irreversible and total bilateral loss of vision, caused by a disease (not classified as a Critical Illness) or by an injury occurring during the Insurance Period. The diagnosis must be confirmed by an ophthalmologist.
Additional condition: the loss of vision must persist for at least six consecutive months after the final diagnosis, during which appropriate treatment must have been carried out without success.

3.2.9. Deafness
Irreversible and complete bilateral loss of hearing, caused by a disease (not classified as a Critical Illness) or by an injury occurring during the Insurance Period. The diagnosis must be confirmed by an otorhinolaryngologist (ENT specialist). The hearing loss must persist for at least six consecutive months after the final diagnosis, during which appropriate treatment must have been carried out without success.

3.2.10. Loss of Speech
Irreversible and total loss of speech, caused by a disease (not classified as a Critical Illness) or by an injury occurring during the Insurance Period. The loss of speech must be confirmed by an audiometric examination and an otorhinolaryngologist's conclusion.
The loss must persist for at least six consecutive months after the final diagnosis, during which appropriate treatment must have been carried out without success.
Loss of speech due to mental or psychiatric disorders is not considered an Insurance Event.

3.2.11. Loss of Limbs or Limb Function
Loss of one or more limbs (above the knee or elbow joint) or complete and irreversible loss of function due to paralysis. The cause must be a disease (not classified as a Critical Illness) or an injury occurring during the Insurance Period.
The loss must be confirmed by a neurologist or traumatologist and must persist for at least six consecutive months after the final diagnosis, during which appropriate treatment must have been carried out without success.

Loss of limbs or limb function related to a previously diagnosed Critical Illness is not considered an Insurance Event.

3.2.12. Benign Cerebral Tumour
A benign brain tumour requiring surgical intervention or being medically inoperable and causing permanent and progressive neurological impairment. The tumour must be confirmed by a neurosurgeon and/or neurologist.

Treatment of an operable tumour must include at least one of the following methods:
- complete or partial surgical removal;
- stereotactic radiosurgery;
- radiotherapy.

The following formations are not considered Insurance Events: cysts, granulomas, vascular malformations of the brain, and pituitary tumours.

3.2.13. Third-Degree Burns and Higher
Burns covering at least 20% of body surface area (1% equating to the surface of the patient's palm), provided that the injury occurred during the Insurance Period.

3.2.14. Primary Type 1 Diabetes
An autoimmune disease characterized by insulin deficiency due to the destruction of insulin-producing beta cells in the pancreas (ICD-10 code E10). The diagnosis must be confirmed by an endocrinologist, and treatment must require continuous insulin injections.

Insulin deficiency caused by acute or chronic pancreatitis, dysfunction of other organ systems, alcohol or drug use, or any other type of diabetes is not considered an Insurance Event.

3.2.15. Aplastic Anaemia
A chronic and irreversible disorder of blood formation in the bone marrow, causing anaemia, neutropenia, and thrombocytopenia. The diagnosis must be confirmed by a haematologist.

The Insured Person must undergo a blood transfusion during the Insurance Period or within 120 days thereafter and must additionally use at least one of the following treatment methods:
- bone marrow stimulating agents;
- immunosuppressants;
- bone marrow transplantation.

Cases where the Insured Person has previously been diagnosed with a malignant tumour and subsequently develops aplastic anaemia as a secondary diagnosis are not considered an Insurance Event.

3.2.16. Amyotrophic Lateral Sclerosis (ALS)
A rapidly progressing neurological disease affecting nerve cells in the brain and spinal cord, causing loss of muscle control. The diagnosis must be based on modern diagnostic criteria for ALS and confirmed by a neurologist's opinion, supported by clinical, electrophysiological (EMG), and MRI findings.

3.2.17. Aortic Aneurysm Requiring Surgery
Pathological enlargement of the aortic wall requiring surgical intervention, confirmed by the opinion of a cardiologist or cardiovascular surgeon based on examination results. The surgery must be performed during the Insurance Period or within 120 days thereafter. An aortic injury caused by trauma or other diseases (e.g., connective tissue disorders) is not considered an Insurance Event.

3.2.18. Coronary Artery Disease Requiring Surgery
Narrowing of the coronary arteries requiring surgical intervention to correct the narrowing or blockage of two or more coronary arteries. The diagnosis must be confirmed by a cardiologist or cardiovascular surgeon based on coronary angiography. The surgery must be performed during the Insurance Period or within 120 days thereafter.

3.2.19. Cerebral Aneurysm Requiring Surgery
Congenital or acquired localized enlargement of a cerebral blood vessel wall, compressing surrounding tissues and causing symptoms. The diagnosis must be confirmed by CT, MRI, or angiography. The surgery must be performed during the Insurance Period or within 120 days thereafter. Asymptomatic cerebral aneurysms detected incidentally or during routine examinations are not considered Insurance Events.

3.2.20. Parkinson's Disease Before Age 65
A progressive neurodegenerative disease of the central nervous system characterized by movement disorders (ICD-10 code G20).

The Insured Person must be under the age of 65. The diagnosis must be confirmed by a neurologist and based on at least two of the following symptoms:
- muscle rigidity;
- tremors;
- bradykinesia.

Secondary parkinsonism (including drug- or toxin-induced), essential tremor, or parkinsonism associated with other neurodegenerative diseases is not considered an Insurance Event.

3.2.21. Alzheimer's Disease Before Age 65
A progressive degenerative disease of the central nervous system (ICD-10 code G30.0), diagnosed in accordance with established diagnostic criteria for Alzheimer's disease and confirmed by a neurologist's conclusion, where the Insured Person is under 65 years of age.

4. Sum Insured

4.1. The Sum Insured is the maximum monetary amount stated in the Insurance Policy that the Insurer shall pay to the Insured in the Insurance Event, according to the selected method of indemnity payment.

4.2. When an indemnity is paid out, the Sum Insured shall be reduced by the amount of the indemnity already paid.

5. Procedure for Payment of Indemnity

5.1. In the case of an Insurance Event, the Insurer shall pay indemnity to the Beneficiary, taking into account the terms and exclusions provided in these insurance conditions.

5.2. If the selected type of Critical Illnesses indemnity is payment of indemnity as a lump sum, then in the case of an Insurance Event, the indemnity shall be paid out as a lump sum up to the Sum Insured stated in the Insurance Policy.

5.3. If the selected type of Critical Illnesses indemnity is payment of indemnity in instalments, then in the case of an Insurance Event:
5.3.1. the initial indemnity shall be 10% of the Sum Insured,
5.3.2. if, within 1 year from the date of establishing the Final Diagnosis, the Insured suffers functional impairments as a result of the Critical Illness or dies, then additional indemnity shall be determined according to the following table, based on the health condition of a healthy person of the same age, without taking into account the Insured's other illnesses, individual characteristics, lifestyle, employment, or hobbies:

Severity of functional impairment according to medical assessment	Additional indemnity as % of Sum Insured	Description
Grade 1	15% of the sum insured together with initial indemnity: 25%	The person has mild functional impairments. Daily self-care activities (eating, dressing, washing, moving inside or outside the home) can be performed independently, but significantly slower, with greater effort, or at lower quality compared to the normal standards of the same age group. Impairments may include speech defects, fine motor difficulties, balance issues when standing or walking, etc.
Grade 2	40% of the sum insured together with initial indemnity: 50%	The person has severe functional impairments. The person can perform only light and short-term activities independently, with significantly reduced capacity. Therefore, the person depends to a considerable extent on assistance from another person in performing daily activities (eating, washing, clothing, moving at home or outside etc).
Grade 3	90% of the sum insured together with initial indemnity: 100%	The person has extremely severe functional impairments. Assistance or supervision by another person is indispensable for carrying out daily self-care activities (eating, washing, clothing, moving at home or outside etc).
Death	90% of the sum insured together with initial indemnity: 100%	The Insured dies as a result of the Insurance Event.

5.3.3. A continued deterioration of the Insured's health or physical functions, or death, shall not be considered an Insurance Case if the deterioration or death occurs more than one year after the date of the Final Diagnosis.
5.3.4. If the Insured is affected by multiple Insurance Cases (several Critical Illnesses are diagnosed) during the Insurance Period, the initial indemnity (first part) shall be paid separately for each Insurance Case. For the determination of the amount of the additional indemnity (second part), the combined effect of all Insurance Cases shall be considered, and this shall be paid out as one payment. The health condition shall be assessed one year after the date of the first diagnosis.

Example:

- The Sum Insured is €50,000.
- For the first Critical Illness, the initial indemnity of 10% (€5,000) is paid.
- For the second Critical Illness, another initial indemnity of 10% (€5,000) is paid.
- After one year, the Insured's health condition corresponds to Grade 2 according to the above table, considering the effect of both illnesses.
- Since €10,000 (20% of the Sum Insured) has already been paid as initial indemnity for the two Critical Illnesses, the basic indemnity paid is €15,000 (30%) instead of 40%. In total, 50% is paid out.

6. What To Do in the Case of an Insurance Event and Required Documents

6.1. In the case of an Insurance Event, the following must be done as soon as possible:

6.1.1. consult a doctor and follow the doctor's instructions;

6.1.2. notify the Insurer of the occurrence of the Insurance Event and follow the instructions provided by the Insurer (if such instructions are given);

6.1.3. after the Final Diagnosis has been established, submit the following documents to the Insurer in order to:

- receive indemnity in the full amount of the Sum Insured (in case of lump-sum indemnity), or
- receive the initial indemnity (the first part of instalment-based indemnity).
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Type of document	Description
Indemnity application	Application for indemnity
Medical documents	Documents confirming and proving that the Insured has been diagnosed with a Critical Illness for the first time in their life. Extract from the Insured's medical record and a written conclusion by a licensed physician or medical board stating the exact diagnosis and date of the Final Diagnosis.
In the event of the Insured's death	1. Copy of the Insured's death certificate. 2. Document confirming that the cause of death was a Critical Illness. 3. Document confirming the Beneficiary's right to receive indemnity, such as a copy of the certificate of succession.
Muud dokumendid:	Any additional documents or information required by the Insurer.
Additional documents to be submitted if the Insurance Policy specifies that indemnity shall be paid in instalments	
Indemnity application	Repeated indemnity application, if functional impairment or death occurred as a result of the Critical Illness.
Medical documents	Documents confirming and proving that the Insured has developed functional impairments due to the Critical Illness, e.g. medical extracts, conclusions, test results, X-rays, etc., issued by a specialist or attending physician licensed to practice medicine.
In the event of the Insured's death	1. Copy of the Insured's death certificate. 2. Document confirming that the cause of death was a Critical Illness. 3. Document confirming the Beneficiary's right to receive indemnity, such as a copy of the certificate of succession.
Other documents	Any additional documents or information required by the Insurer.

6.2. If the Policyholder, Insured, and/or Beneficiary has submitted a copy of a document to the Insurer, they are obliged, at the request of the Insurer, to present the original document.

6.3. The Insurer is not obliged to pay indemnity if the Policyholder, Insured, and/or Beneficiary has not provided the Insurer with all documents required to assess the circumstances of the Insurance Case, or fails to provide the original copies of the above documents when requested.

6.4. The Insurer has the right to verify the accuracy of the information provided, the occurrence of the Insurance Event, and the justification of the indemnity payment by reviewing the Insured's health data held by healthcare institutions and medical staff. If necessary, the Insurer may require the Insured to participate in a consultation with an independent expert physician to assess their health condition.

7. Exclusions

7.1. The following exclusions apply to all Insurance Events. In the occurrence of the circumstances listed below, the event shall not be deemed an Insurance Event.

7.2. In addition to the exclusions specified in these conditions, the exclusions in the "General Terms and Conditions of Personal Insurance" also apply.

Natural disasters, state of emergency, epidemic

7.3. The Insurer shall not pay indemnity, and an Insurance Event shall not be deemed to have occurred, in the case of illness, death, or functional impairments caused by, or contributed to by, an epidemic, pandemic, quarantine, large-scale regional natural disaster, or other circumstances under which a competent authority has declared a state of emergency or crisis.

Military service, imprisonment

7.4. The Insurer shall not pay indemnity, and an Insurance Event shall not be deemed to have occurred in respect of a Critical Illness, death, or functional impairments if the Insured:
7.4.1. is in the military, defence forces reserve service, active service, or conscript service in any part of the armed forces or peacekeeping forces;
7.4.2. is in prison, arrested, legally detained, or serving a sentence in a correctional facility.

Intentional acts or endangerment of self

7.5. The Insurer shall not pay indemnity, and an Insurance Event shall not be deemed to have occurred in respect of a Critical Illness, death, or functional impairments arising from suicide, attempted suicide, self-inflicted injury, or the Insured's deliberate endangerment of life or health (e.g. a fight initiated by the Insured, reckless driving), or where such acts have contributed to the event. This exclusion does not apply in cases of self-defence or necessity permitted by law.

Intoxication

7.6. The Insurer shall not pay indemnity, and an Insurance Event shall not be deemed to have occurred in respect of a Critical Illness, death, or functional impairments resulting from the use of alcohol, narcotics, psychotropic, toxic, or other intoxicating substances.

Medical procedures, pre-existing conditions

7.7. The Insurer shall not pay indemnity, and an Insurance Event shall not be deemed to have occurred in respect of a Critical Illness, death, or functional impairments if:
7.7.1. the Insured has previously in their lifetime been diagnosed with a Critical Illness, or prior to the commencement of insurance cover was aware of any circumstance indicating that they had contracted a Critical Illness;
7.7.2. medical examinations or investigations, including biopsies, had been initiated prior to the beginning of the Insurance Period, even if the Critical Illness was first diagnosed during the Insurance Period and after the waiting period;
7.7.3. the Critical Illness, functional impairment, or death occurred as a result of decompensation or complication of another illness;
7.7.4. the Critical Illness, functional impairment, or death resulted from experimental or unconventional treatment;
7.7.5. the Critical Illness, functional impairment, or death was caused by the improper use of medicines or similar preparations, or due to the Insured's participation in a clinical drug trial, or if the Insured used doping substances listed in the Annex to the Council of Europe Anti-Doping Convention No 135;
7.7.6. the Critical Illness, functional impairment, or death occurred because the Insured failed to follow medical instructions;
7.7.7. the Critical Illness, functional impairment, or death occurred or was contributed to by HIV, AIDS, and/or other immune deficiency disorders.