# 313 Health insurance

**INSURANCE TERMS AND CONDITIONS**

**This is a translation of the authoritative Icelandic text. Should there be any discrepancy between the translation of these terms and the Icelandic version, the original Icelandic terms apply.**

## 1. Basis of the insurance contract and definitions

1.1 Other than as stipulated in these terms and conditions, on the insurance certificate, in the application or in any other documentation on which the insurance contract is based, Act No 30/2004 on insurance contracts ('the Insurance Contracts Act') shall apply.

1.2 In these terms and conditions, the following terms shall mean as follows:

a. **the Company**: TM líftryggingar hf.;
b. **the policyholder**: the person entering into a health-insurance policy with the Company;
c. **the insured person**: the person whose health is covered by the health-insurance policy;
d. **insurance event**: an event that the insurance policy states may result in the payment of compensation;
e. **the sum insured**: the amount paid out in the event of an insurance event.

## 2. Insurance coverage period and start and end of the Company's liability

2.1 Unless a request is made for the insurance policy to take effect at a later date, the Company's liability shall begin when it receives a written application for an insurance policy, provided that the application is not refused on the basis of information regarding risk (a risk assessment). The Company's liability shall not cover damages caused by incidents occurring before said application is received and of which the Company is aware at the time of the risk assessment resulting in insurance being denied.

2.2 The insurance policy shall be renewed yearly, until the insured person reaches the age of 70 years, and ultimately lapses on the maturity date indicated on the insurance certificate, unless it lapses at an earlier juncture in accordance with the law or these terms and conditions.

## 3. The policyholder's right of termination

3.1 The policyholder may terminate the insurance policy at any time during its period of validity. Such termination shall be communicated to the Company in writing.

3.2 The policyholder shall pay premiums for the period in which the insurance policy was in effect. The premium shall be calculated *pro rata*.

## 4. Geographical scope

4.1 The insurance policy shall be valid anywhere in the world.

## 5. What the insurance policy covers

5.1 The diseases, surgeries and other incidents covered by the insurance policy fall under the following five compensation categories (cf. also Article 7):

**Compensation category 1 – Cancer and benign tumours in the brain and in the spinal cord**
**Compensation category 2 – Cardiovascular diseases**
**Compensation category 3 – Neurological and neurodegenerative diseases**
**Compensation category 4 – Total loss of vision, hearing, speech and other serious deseases and accidents**
**Compensation category 5 – Other serious diseases and accidents**

5.2 The Company shall pay the insured person compensation if an insurance event is confirmed to have occurred while the insurance policy is in effect. An insurance event shall be deemed to have occurred only if the insured person is diagnosed with any of the diseases, undergoes any of the surgeries or suffers any of the incidents listed and defined in Article 7. After the insurance policy has lapsed, no liability for

compensation shall exist, even if it may be deemed likely that the disease had been present while the insurance policy was in effect.

5.3 Liability for compensation shall be dependent on a medical specialist in the relevant field confirming the diagnosis, surgery or other incident covered by the insurance policy. Further provisions may be made in this regard in Article 7. The Company may have a medical specialist review the available medical records and/or examine the insured person to confirm the diagnosis, surgery or other incident covered by the insurance policy. The Company will pay for the necessary certificates and opinions.

5.4 Compensation shall be paid only once under each of the compensation categories set out in Article 7. If compensation has been paid out under one compensation category, the Company's liability for compensation under another compensation category shall be dependent on more than 6 months having passed between the first and second insurance events. When the Company has paid compensation in respect of insurance events from all five compensation categories of the insurance policy, the insurance policy shall lapse.

## 6. What the insurance policy does not cover

6.1 Diseases, surgeries and incidents other than those listed as eligible for compensation in Article 7 are not covered by this insurance policy.

6.2 The company shall not pay compensation if the insured person dies within 30 days of a disease or other insurance event listed and defined in Article 7 being confirmed or occurring.

## 7. Diseases and incidents covered by the insurance policy – Compensation categories

### Compensation category 1 – Cancer and benign tumours in the brain and in the spinal cord

**1.a. Cancer**

The diagnosis of a malignant tumour characterised by uncontrolled invasive growth and spread, verified by histopathological report, and classified as malignant cancer. Such cancer includes malignant lymphoma and malignant bone marrow disorders including leukaemia.

The following are excluded:

a. cancer diagnosed within the first 3 months following the purchase of the renewal of the insurance policy. This restriction shall not apply, however, if the insured person was covered the same type of insurance from another company up until the time at which this insurance policy comes into effect;
b. carcinoma in situ (CIS), tumour in situ (TIS), pre-invasive cancer, dysplasia, benign tumours, cysts and all pre-malignant conditions,
c. thyroid tumours staged less than T2N0M0 under the TNM Staging System,
d. basal cell and squamous cell carcinomas of the skin, sarcomas, dermatofibrosarcoma and melanoma at stage 1A (T1aN0M0) under the TNM Staging system,
e. prostate tumours classified with a Gleason score less than 7 or staged less than T2bN0M0 under the TNM Staging System,
f. urothelial tumours staged less than T1bN0M0 under the TNM Staging System,
g. gastrointestinal stromal tumours (GIST) and neuroendocrine tumours with a lower WHO grade than 2, unless the tumour has spread to the lymph nodes or metastasised,
h. cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence.

**1.b. Benign brain tumours**

A non-malignant neoplastic tumour originating from the brain, cranial nerves or meninges.

The diagnosis must be confirmed by a specialist doctor in neurology.

The following are excluded:

a. cysts,
b. granulomas,
c. pituitary gland tumours,
d. abscesses,

e. haematomas,
f. angiomas,
g. cholesteatomas,
h. traumatic neuromas,
i. tumours originating in bone tissue.

**1.c. Benign spinal-cord tumours**

A non-malignant neoplastic tumour originating from the spinal cord.
The diagnosis must be confirmed by a specialist doctor in neurology.
The following are excluded:

a. cysts,
b. granulomas,
c. abscesses,
d. haematomas,
e. angiomas,
f. cholesteatomas,
g. traumatic neuromas,
h. tumours originating in bone tissue.

**1.d. Bone-marrow transplant**

The insured person undergoes surgery as a recipient of bone marrow from another human donor.

**Compensation category 2 – Cardiovascular diseases:**

**2.a. Heart attack / coronary thrombosis**

A definite diagnosis of myocardial infarction with death of heart muscle confirmed by the characteristic rise and/or fall of a cardiac biomarker blood test (Troponin I, Troponin T or CK-MB) to the level considered diagnostic of acute myocardial infarction, plus at least two of the following evidence:

a. acute cardiac symptoms and signs consistent with a heart attack;
b. new ECG changes characteristic of an acute myocardial infarction;
c. imaging evidence of new loss of viable myocardium or regional wall motion abnormality.

The diagnosis must be confirmed by a cardiologist.
The following are excluded:

a. Angina Pectoris without myocardial infarction;
b. other acute coronary syndromes;
c. myocardial injuries, such as myocarditis and pericarditis.

**2.b. Coronary artery bypass surgery**

Upon the advice of a cardiologist, the insured person undergoes open-heart surgery, in which an artery graft is inserted to bypass blockages in one or more coronary arteries.
The following are excluded:

a. other procedures such as coronary angioplasty;
b. laser surgery.

**2.c. Open-heart surgery**

Open-heart surgery, upon the advice of a cardiologist, in which an artificial valve is inserted in the place of one or more heart valves, or an atypical valve is repaired.

**2.d. Aortic surgery**

Upon the advice of a cardiologist, the insured person undergoes a surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft.
The term aorta includes the thoracic and abdominal aorta but not its branches.
The following are excluded:

a. any other surgical procedure, for example the insertion of stents or endovascular repair,
b. surgery following traumatic injury to the aorta.

**2.e. Stroke**

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in all of the following:

a. abrupt onset of new neurological symptoms consistent with a stroke;

b. new objective neurological deficits on clinical examination persisting continuously for at least 60 days following the diagnosis of the stroke;
c. new findings on CT scan or MRI, if done, consistent with the clinical diagnosis.

The diagnosis must be confirmed by a specialist doctor in neurology.
The following are excluded:

a. transient ischemic attack (TIA);
traumatic injury to brain tissue or blood vessels;
b. death of tissue of the optic nerve or retina/eye stroke;
c. secondary haemorrhage into a pre-existing cerebral lesion;
d. an abnormality seen on brain or other scans without clearly related clinical symptoms and neurological signs.

**2.f. Major organ transplants – Heart, lungs, kidney and pancreas**

The insured person undergoes surgery as the recipient of a heart, lungs, pancreas or kidney from another human donor.

**2.g. Kidney failure**

Final stage of kidney failure characterised by chronic and permanent failure of the function of both kidneys and resulting in either regular haemodialysis or peritoneal dialysis.
Excluded from payment under the insurance policy is acute, reversible renal failure requiring temporary renal dialysis.

**Compensation category 3 – Neurological and degenerative diseases:**

**3.a. Multiple sclerosis**

A definite and unequivocal diagnosis of Multiple Sclerosis confirmed by a neurologist in accordance with the 2017 McDonald MS Diagnostic Criteria.
There must be current objective motor deficits on clinical examination persisting for at least 6 months.
The following are excluded:

a. possible MS and isolated neurological syndromes suggestive but not diagnostic of MS.

**3.b. Motor neurone disease (MND)**

A definite and unequivocal diagnosis of one of the following motor neurone diseases confirmed by a specialist doctor in neurology:

a. amyotrophic lateral sclerosis (ALS),
b. primary lateral sclerosis (PLS),
c. progressive muscular atrophy (PMA),
d. progressive bulbar palsy (PBP),
e. spinal muscular atrophy (SMA).

**3.c. Alzheimer's disease**

Unambiguous diagnosis of Alzheimer's disease confirmed by a geriatrician and/or neurologist before the insured person's sixtieth birthday, by means of appropriate testing, examinations and symptom assessment. The disease must result in the insured person needing constant supervision and assistance with activities of daily life.

**3.d. Parkinson's disease**

Unambiguous diagnosis of Parkinson's disease with unknown cause, carried out by a neurologist, before the sixtieth birthday of the Insured. The Insurance covers only Parkinson's disease with unknown cause (idiopathic).
All other kinds of Parkinson's disease are exempt.

**3.e. Paralysis caused by brain or spinal-cord disease**

Total and irreversible loss of muscle function of two or more limbs due to a disease of the spinal cord or brain.The diagnosis must be confirmed by a specialist doctor in neurology and classified as diplegia, hemiplegia, tetraplegia or quadriplegia.
The following are excluded:

a. cancer,
b. benign tumours of the brain and/or spinal cord,
c. a stroke.

# 313 Health insurance

**INSURANCE TERMS AND CONDITIONS**

**Compensation category 4 – Total loss of vision, hearing, speech and other serious deseases and accidents:**

**4.a. Blindness**

Total, permanent and irreversible loss of sight in both eyes, which cannot be improved by a laser procedure, medication or surgery, as confirmed by an ophthalmologist.

**4.b. Deafness**

Permanent and irreversible loss of hearing to such an extent that the loss of hearing is more than 80 decibels in all frequency ranges in the ear with better hearing, using an audiogram from a pure-tone audiometric test. It must also not be possible to cure the loss of hearing by means of a medical procedure. The diagnosis must be confirmed by an ear, nose and throat specialist.

**4.c. Loss of speech**

Total permanent and irreversible loss of the ability to speak as a result of a physical injury or disease. The diagnosis must be confirmed by a specialist doctor in otolaryngology or neurology, and the loss of speech must not be able to be corrected by medical procedure.

**4.d. Meningitis caused by bacterial infection**

Inflammation in the meninges or the spinal cord resulting in significant and permanent reduction in nerve activity, as confirmed by a neurologist. The presence of bacterial infection in cerebrospinal fluid must confirmed by means of a lumbar puncture.

**4.e. Major head trauma**

An unequivocal and definitive diagnosis of impaired brain function, death of brain tissue, following a serious head injury caused by an accident resulting in the insured person being permanently unable to perform three or more of the following activities of daily living (ADL) unaided, provided that the condition has lasted for at least 3 months:

a. bathing,
b. dressing and undressing,
c. moving between rooms,
d. moving between a bed and a chair,
e. eating,
f. having control over bowel and bladder functions.

A neurologist must confirm the diagnosis, which must be supported by the results of imaging studies, for example, MRI and/or CT scans.

If the head injury is due to self-inflicted injury, the Company shall not liable (cf. Article 89(1) of the Insurance Contracts Act).

**4.f. Paralysis caused by an accident**

Total and irreversible loss of muscle function of two or more limbs due to physical injury.

The diagnosis must be confirmed by a specialist doctor in neurology and classified as diplegia, hemiplegia, tetraplegia or quadriplegia.

**Compensation category 5 – Other serious diseases and accidents:**

**5.a. Loss of limbs**

Permanent loss of two or more limbs above the wrist or ankle, caused by an accident or disease.

If the loss of limb is due to self-inflicted injury, the Company shall not liable (cf. Article 89(1) of the Insurance Contracts Act).

**5.b. Serious burns**

Third-degree burns covering at least 20% of the body surface area of the insured person, as confirmed by a dermatologist or plastic surgeon.

If the burns are due to self-inflicted injury, the Company shall not liable (cf. Article 89(1) of the Insurance Contracts Act).

**5.c. HIV infection**

The insured person contracts HIV or is diagnosed with AIDS, and the cause can be traced to any of the following:

a. a blood transfusion as part of medical treatment;
b. a physical assault suffered by the insured person;
c. an incident suffered by the insured person in the course of their professional duties as a healthcare worker, firefighter, paramedic or police officer.

The incident causing the infection must have occurred within the insurance period of the policy and in Iceland. In all cases, the incident must have been reported to the relevant authorities and investigated by recognised means.

In cases under points (b) and (c), a negative HIV antibody test performed within 5 days from when the incident occurred must also be submitted. Another HIV antibody test must be conducted within 12 months, confirming that the HIV has appeared or that HIV antibodies are present.

Excluded from payment under the insurance policy are HIV infections resulting from other causes, including sexual activity or drug and alcohol use.

**5.d. Major organ transplants – Liver**

The insured person undergoes surgery as the recipient of a liver from another human donor.

**8. Child health insurance**

8.1 The Company shall pay the insured person compensation in respect of an insurance event suffered by a child of theirs, aged between 3 months and 18 years, while the insurance policy is in effect. The Company shall also pay compensation according to the same definition for foster children and stepchildren of the insured person who share legal residence and live together with the insured person. An insurance event shall be deemed to have occurred only if a child is diagnosed with any of the diseases, undergoes any of the surgeries or suffers any of the incidents listed and defined in Article 7.

8.2 Compensation paid under child health insurance shall be 50% of the sum insured of the insured person, up to a maximum of ISK 16 000 000 for each child. Compensation for the same child may never be exceed that amount, even if there is than one health-insurance policy in place with the Company under which the insurance event may fall. Compensation shall then be paid to the insured person as a percentage of the abovementioned maximum compensation, based on the sums insured under the health-insurance policies held with the Company.

8.3 Payments of compensation under the insurance policy for children, foster children and stepchildren of the insured person shall have no effect on either the sum insured or the validity of the health-insurance policy.

8.4 Compensation shall not be paid for:

a. children, foster children or and stepchildren of the insured person, unless a disease liable for compensation is diagnosed while the insurance policy is in effect. If a disease is diagnosed after the insurance policy has lapsed, no liability for compensation shall exist, even if it may be deemed likely that the disease had been present while the insurance policy was in effect;
b. diseases or surgeries that can be demonstrably attributed, directly or indirectly, to the child's condition before the age limit indicated in Article 8.1 or before the insurance policy was taken out;
c. adopted children, if the causes of a disease or surgery can be traced to the condition of the child before they were adopted. The same shall apply to foster children and stepchildren.

8.5 The Company shall not pay compensation if the child dies within 30 days of a disease or insurance event listed and defined in Article 7 being confirmed or occurring.

8.6 For further information on the payment of compensation, the scope of compensation and the limitation to liability for compensation, see Articles 5, 6, and 7, as applicable.

**9. Payment of premiums**

9.1 The first premium shall be payable at the time it is charged, and subsequent premiums shall be payable the due dates specified at that time. The Company shall send the policyholder notifications of upcoming premium payments. Such notifications shall specifically state the payment deadline, which shall be at least 1 month from the date on which the notification is sent.

9.2 If the premium is not paid by the deadline set under Article 9.1, the Company may send a special warning demanding payment within 14 days, after which the insurance policy shall be terminated if the premium is still unpaid.

9.3 If the policyholder has not specifically negotiated payment of the premium with the Company before the deadline under Article 9.2 expires, the premium shall be deemed unpaid if not paid in full by the deadline.

9.4 Unless the policyholder agrees with the Company on another payment method, requests for premium payments are sent to the policyholder's online bank.

9.5 If the insurance policy is terminated pursuant to Article 9.2, the policyholder shall nevertheless pay premiums for the period in which the insurance policy was in effect. The premium shall be calculated *pro rata*.

9.6 When collecting premiums, the Company may charge a special fee – further details of which shall be set out in the premium tariff – to cover the costs of collecting premiums. This shall also be specifically indicated in notifications of upcoming premium payments.

## 10. Changes to the sum insured and to premiums

10.1 The sum insured shall initially be indicated on the insurance certificate, and subsequently on the renewal certificate in effect at any given time. The certificate shall also stipulate whether the amount of the sum insured changes with the age of the insured person.

10.2 If the sum insured does change with age, the certificate shall also indicate the age of the insured person at which the change comes into effect, with the amount of the sum insured decreasing annually from that age, at the start of the first day of each insurance year. The aim of this decrease is to keep the premium unchanged in real terms from year to year. Up until that point, however, the insurance premium shall be dependent on the age of the insured person and changes annually upon renewal, in line with the insured person's increasing age.

10.3 If the insured sum does not change with age, insurance premiums shall be dependent on the age of the insured person and change annually upon renewal, in line with the insured person's increasing age.

10.4 Upon renewal at the start of each insurance year, the sum insured and the premium shall change in proportion to the change in the consumer price index for indexation from the basic health-insurance index quoted on the insurance certificate to the index for the month preceding the renewal. Any decrease in the index shall not reduce either the premium or the sum insured.

## 11. Obligation of the policyholder, the insured person or the compensation claimant to provide information and consequences of failing to do so

11.1 When establishing or amending an insurance policy, the Company may request information that may be significant for its risk assessment. The policyholder or, as appropriate, the insured person shall provide accurate and exhaustive replies to the Company's queries. The policyholder or, as appropriate, the insured person shall also, unprompted, provide any information about particular incidents that they know or could know to be of real significance for the risk assessment performed by the Company when establishing or amending the insurance policy (cf. Article 82 of the Insurance Contracts Act).

11.2 If the Company learns that the obligation to provide information pursuant to Article 11.1 has been breached and if said breach on the part of the policyholder or insured person's is not deemed insignificant, it may then terminate the insurance policy with 14 days' notice (cf. Article 84 of the Insurance Contracts Act). If, however, the failure to provide information pursuant to Article 11.1 is fraudulent in nature, the Company may terminate the insurance policy, as well as any other insurance policies of the policyholder during the insurance period, without notice.

11.3 If an insurance event occurs and the obligation to provide information pursuant to Article 11.1 is breached in a fraudulent manner, the Company shall bear no liability. If the policyholder or insured person has otherwise breached their obligation to provide information pursuant to Article 11.1 in a manner that is not deemed insignificant, the Company may void liability in whole or in part (cf. Article 83 of the Insurance Contracts Act).

11.4 As part of the procedure for settling claims, the insured person shall provide the Company with the information and documentation they have in their possession and that the Company needs to assess its liability and pay compensation.

11.5 If the insured person provides incorrect information that they know or could know will result in the payment of compensation to which they are not entitled, their right to compensation shall be rendered void, and the Company may terminate all insurance policies with the claimant in question, as set out in greater detail in Article 120 of the Insurance Contracts Act.

11.6 If the insurance policy is terminated in accordance with this provision, the premium shall be paid for the period during which the insurance policy was in effect. The premium shall be calculated *pro rata*.

## 12. Declaring insurance events – Deadline for declaring damages

12.1 If an insurance event has occurred, the person deeming themselves entitled to a payment under the insurance policy shall report the event to the Company without undue delay.

12.2 If this reporting obligation is breached intentionally or through gross negligence, resulting in the Company being unable to researching the cause of an insurance event, the Company may reduce of void its liability.

12.3 The insured person shall lose their entitlement to compensation if they do not report their claim within 1 year of knowing of the incident on which it is based.

## 13. Payment of compensation – Offsetting debts – Expiry of claims

13.1 Compensation may be claimed 14 days after the Company was able to obtain the documentation necessary to assess its liability.

13.2 Full compensation shall equal the sum insured indicated on the insurance or renewal certification in effect on the day on which the insurance event occurs. In accordance with Article 123 of the Insurance Contracts Act, the insured person shall be entitled to interest on their claim.

13.3 In accordance with Article 122 of the Insurance Contracts Act, the Company may offset unpaid premiums against any insurance compensation payable.

13.4 Claims for compensation under the insurance police shall expire according to the rules laid down in Article 125 of the Insurance Contracts Act.

## 14. Right to increase the sum insured without a health declaration

14.1 The insured person may submit a written request for an increase of the sum insured during the insurance period of the policy, without further information about their health, within 6 months from the time when they:

a. have a child;
b. adopt a child under the age of 18 years;
c. buy a residential property.

14.2 The entitlement referred to in Article 14.1 shall not exist if:

a. a risk assessment determines a health-insurance premium with a surcharge;
b. a claim for compensation is filed pursuant to Article 5 or if the insured person is diagnosed with any of the diseases, undergoes any of the surgeries or suffers any of the incidents defined in Article 7;
c. if the insured person is awaiting surgery of a type defined in Article 7 or has suffered a serious injury during the policy period;
d. the insured person is entitled to a premium waiver under Article 15;
e. the insured person is 45 years or older when the Company receives the request referred to in Article 14.1.

14.3 The sum insured may increase by no more than ISK 4 000 000 at event of the type referred to in Article 14.1. It may not, however, exceed ISK 25 000 000.

14.4 The insurance premium shall increase in line with the increase in the sum insured, according to the Company's premium tariff. The increase shall take effect when the Company sends the policyholder a certificate confirming the increase and a premium payment request.

## 15. Waiver of premium

15.1 If the insured person loses at least half of their ability to work while the insurance policy is in effect, as the result of an accident or disease, they shall be entitled to a proportional reduction of premiums while the situation in questions lasts, for up to a maximum of 7 years, but no longer than age 65.

15.2 The insured person shall not be entitled to a premium waiver:

a. before 3 months have elapsed from the time at which their ability to work is assessed to have fallen by at least a half;
b. if the loss of ability to work is caused by a disease or incident covered by Article 5 of these terms and conditions;
c. for any longer than a period of 1 year before the Company receives their request for a premium waver;
d. in respect of diseases that were present or had displayed symptoms before the insurance policy came into effect, nor for consequences of an accident occurring before the insurance policy came into effect;
e. if the loss of ability to work is caused by war, military action, riots, uprisings or similar events;
f. if the loss of ability to work is caused by alcohol, drug, pharmaceutical or toxin abuse or by participation in criminal acts.

15.3 Requests for a premium waiver shall be made in writing on the form provided by the Company. The Company shall base its assessment of loss of working capacity on the insured person's ability to perform their normal job and their options for performing other jobs. To that end, the Company may ask for necessary documentation – such as medical certificates, information on employment income and existing disability assessments – to be obtained from public insurance institutions, pension funds or insurance companies, free of charge to the Company. The Company shall notify the insured person, in a verifiable manner, of its premium-waiver decision and, if granted, what the reduction is and for how long it will be given.

15.4 If a premium waiver has been granted, the insured person must inform the Company as soon as they regain full or partial ability to work. While a premium waiver is in effect, the Company may at any time request necessary documentation of the type referred to in Article 15.3, at the Company's expense. The provisions laid down in Article 11 regarding false information shall also apply to premium waivers, as applicable.

## 16. Changes to the premium base

16.1 The Company reserves the right to change premiums in line with a new premium tariff, if there is a general increase in risk or if the general premisses of the insurance policy prove to be different than originally supposed.

## 17. Dispute resolution – Venue

17.1 Disputes regarding the Company's liability for compensation and other disputes concerning the provisions of the Insurance Contracts Act may be referred to the Insurance Arbitration Committee, in accordance with the Committee's statues as in force at any given time. Further information regarding the Committee and referrals can be found at www.nefndir.is and with the Company.

17.2 Notwithstanding the remedy referred to in Article 17.1, the parties may submit disputes to the courts, which shall rule thereon in accordance with Icelandic law, unless otherwise provided by international commitments to which Iceland is bound.

17.3 The Company's domicile and venue are in Reykjavik. Disputes arising from this insurance policy shall be brought before the District Court of Reykjavik. The Company may, however, bring disputes arising from the insurance policy before the jurisdiction at the policyholder's domicile.

These terms and conditions shall take effect on 15 April 2026.