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CRITICAL DISEASE INSURANCE REGULATION NO. KS06-2021

CRITICAL DISEASE INSURANCE REGULATION NO. KS06-2021 is applied in conjunction with Health Insurance Regulation No. VA 06-2021, **if the Critical Disease Insurance is provided for in the Insurance Agreement (policy)**. Issues not stipulated hereby shall be resolved by applying Health Insurance Regulation No. VA 06-2021. Terms used and not defined in these terms and conditions correspond to the terms defined in Health Insurance Terms and Conditions No. VA 06-2021.

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1. Terms used in the Regulation

Insurer – 'ERGO Life Insurance' European company (SE) (registered in the Register of Legal Entities of the Republic of Lithuania under Registration No. 110707135, legal address: Geležinio Vilko 6A, LT-03507, Vilnius, Lithuania), which is represented in the Republic of Latvia by **ERGO Life Insurance SE Latvian Branch** (registered in the Republic of Latvia's Commercial Register under unified registration No. 40103336441, legal address: Skanstes iela 50, Riga, LV-1013).
Insured Person – a private individual specified in the Insurance Policy who has an insurable interest and who is agreed to be paid Insurance Indemnity should an Insurance Event occur, unless otherwise specified in the insurance agreement.
Insurance Object – the health and physical condition of the Insured Person.
Insurance Risk – an event independent from the will of the Insured Person (Insured Person has fallen ill with a critical disease during the Insurance period).
Insurance Event – an event with a causal relationship to the Insured Risk upon which during the effective period of the Insurance Agreement an Insurance Indemnity is to be paid under the Insurance Agreement.
Insurance Coverage Amount – the maximum amount determined in the Insurance Agreement, which, when an Insurance Event enters into force, is paid by the Insurer in the events and according to the procedure prescribed in the Insurance Agreement.
Insurance Premium – payment by the Insurant for the Insurance Policy.
Treatment – professional and individual prevention, diagnostics and treatment of illnesses, medical rehabilitation and patient care;
Medical treatment service – a service which the Insured Person has received in the Medical Institution from a medical specialist, who in accordance with the procedure prescribed in the laws and regulations of the Republic of Latvia may provide services in a specific speciality and apply the medical technology – a method used for treatment and approved by the procedure established by the Cabinet, and a medicinal device or medicinal products conforming to the requirements and released in the market according to the requirements established in respect of the laws and regulations of the Republic of Latvia
Waiting period – a period of 60 (sixty) days from the Insurance Agreement taking effect for the specific natural person whose Insurance protection against the risk of Critical Disease is not valid. If a critical disease is diagnosed during the period in which the Insurance Agreement has taken effect but before the end of the waiting period, the Insured Person has no valid claim to receive any Insurance Indemnity amount. The waiting period is not considered to be valid when the Insurance Agreement is extended without interruption into the next insurance period.
Critical Disease – those diseases listed in Paragraph 3 which are confirmed by the Final Diagnosis and/or surgery.
Final Diagnosis – a diagnosis which is approved by a report that is issued by a certified doctor or a council of doctors, which is confirmed by a relevant laboratory and/or instrumental medical examinations, and is registered in the Insured Person's medical record.
Survival Period – a period of thirty (30) days after any occurrence of an Insurance Event during which the Insurance Indemnity is not paid out if the Insured Person does not survive.

2. Critical disease insurance protection and types of indemnity payments

In the event of critical disease insurance, the Insurance Indemnity is paid by one of the Insurance Indemnity payment methods and according to the method mentioned in the Insurance Policy.

2.1. The Insurance Indemnity amount paid shall be equal to the insurance coverage amount.

2.1.1. The insurance protection is in force for 24 (twenty four) hours a day throughout the world.
2.1.2. Upon the occurrence of an Insurance Event, within the Insurance Period , after the end of the Waiting Period, the Insurance Indemnity is paid to the Insured Person to the full Amount of the Insurance cover.
2.1.3. During the Insurance Period only one (1) Insurance Indemnity is paid. Following the payment of the Insurance Indemnity, the Insurance protection is terminated in regard to the risk of Critical Disease.
2.1.4. If no Insurance Event occurs before the Insurance Agreement expires, the Insurance Indemnity shall not be paid.
2.1.5. The Insurance Indemnity shall not be paid if the Insured Person should die within the duration of the Insurance Agreement.

2.2. Payment of Insurance Indemnity According to the Compensation Principle

2.2.1. **Insurance Location and Time – twenty-four (24) hours a day within the borders of the Republic of Latvia, the Republic of Lithuania, and the Republic of Estonia.**
2.2.2. Payment of the Insurance Indemnity is made according to the principle of compensation – the Insurer covers the expenses of the Insured Person, incurred as a result of a critical illness treatment.
2.2.3. If, during the Insurance Agreement's period of validity, following the expiry of the Waiting Period, any Critical Disease specified herein is diagnosed for the Insured Person, the Insurer shall indemnify any medical expenses which occur when receiving Medical Services for the Treatment of Critical Diseases, by not exceeding the Insurance Amount set forth in the Insurance Agreement.
2.2.4. If, within the Insurance Period, the Insured Person should die after the Insurance Event enters into force and the Insurance Indemnity payment has been made, then the Insured Person's Insurance Protection expires and the Insurance Premium that is paid out for the Insured Person is not indemnified.

3. Payment and Amount of Insurance Indemnity (Critical disease)

3.1. If the Insurance Event enters into force and it is not indicated otherwise in the Insurance Agreement, the Insurance Indemnity is paid in one of the insurance indemnity payment ways referred to in Paragraph 2 of this Regulation, if, within the Insurance Period the Insured Person falls ill with one of the following Critical Diseases:
3.1.1. myocardial infarction – the Insured Person suffers a coronary obstruction. Diagnosis of a myocardial infarction is determined following an abrupt, strong pain (the clinical symptoms of ischaemia), new changes in ECG (pathological Q waves and/or ST elevation or depression) and the dynamics of myocardial injury biochemical markers (troponins or CK-MB);
3.1.2. coronary artery bypass graft surgery (bypass surgery) – surgery due to the vasoconstriction or blockage of a minimum of two coronary heart vessels (which involves opening up of the rib cage), the need for which has been established by means of angiography. The Insurance Indemnity shall not be paid in the event of coronary angioplasty or other intraarterial treatment methods (which do not involve opening up the rib cage);
3.1.3. apoplectic attack (ischaemic or haemorrhagic stroke) – the Insured Person suffers cerebral artery stenosis, or cerebral ischaemic damage has developed as a result of occlusion, or a spontaneous rupture of a blood vessel in the brain substance or above it, a haemorrhagic stroke and sudden neurological damage symptoms remain for longer than 3 hours after the apoplectic attack, confirmed by a physician-neurologist;
3.1.4. cancer (malignant tumour) – the Insured Person has one or more malignant tumours, including leukaemia and lymphoma. The diagnosis of a malignant tumour has been confirmed histologically.
The Insurance Indemnity shall not be paid out for the following forms of cancer: chronic lymphocytic leukaemia, first stage lymphogranulomatosis, first stage prostate cancer, undetermined localisation (carcinoma in situ) and all tumours for persons who are HIV positive;
3.1.5. terminal renal insufficiency – the Insured Person has life-threatening renal insufficiency, uraemia, which is manifested as chronic, irreversible function disorders of both kidneys and which is treated by regular haemodialysis or kidney transplantation. The right of payment of the Insurance Indemnity arises with referral to dialysis that is confirmed by a doctor or following kidney surgery;
3.1.6. loss of extremities/loss of the function of extremities – full and permanent loss of two or more extremities or their function as a result of disease or trauma. Loss of extremities is defined as a loss of an extremity above the knee or elbow joints. Loss of the function of extremities (including paralysis) is confirmed by the decision of the Health and Work Ability Expertise State Doctors' Commission (VDEĀK) (or by a document issued by an authorised institution of another country, if the Insured Person is a foreigner, and in accordance with the legislation in force in the Republic of Latvia VDEĀK does not take decisions regarding him/her), where the loss of work capacity is indicated as a rate and falls between 24% – 100%;
3.1.7. loss of vision (blindness) – full and irreversible loss of vision in both eyes as a result of disease or trauma, which must be confirmed by an ophthalmologist with the help of clinical and instrumental examination methods;
3.1.8. multiple sclerosis (disseminated sclerosis) – disorders related to sensory and locomotor functions which last for longer than three (3) months from the disease being diagnosed. The right to have the Insurance Indemnity amount paid out arises with a diagnosis that is made by a neurologist and which is confirmed by clinical and instrumental examinations (magnetic resonance examination);
3.1.9. internal organ transplantation surgery – heart, lungs, kidneys, pancreas, small intestine, or bone marrow transplantation surgery for the Insured Person, with that person being the recipient of such organs;
3.1.10. heart valve replacement (prosthetics) – the replacement of one or several heart valves (aortic, mitral, tricuspid, pulmonary) with artificial valves due to stenosis and/or insufficiency. The Insurance Indemnity amount shall not be paid out for valve correction or cutting surgery;
3.1.11. aortic valve replacement surgery – liquidation of a part of the abdominal or thoracic aorta, which has been damaged as a result of disease, and the replacement of it by means of a transplant. The Insurance Indemnity amount shall not be paid out in the event of surgery on the aorta branches or bypass surgery or when surgery is required due to traumatic damage being suffered by the aorta;
3.1.12. Alzheimer's Disease (determined for anyone below the age of 65) – irreversibly lost cognitive functions:
- language, memory, thinking, reasoning ability, dependence upon a carer;
- characteristic clinical symptoms and the results of instrumental examinations.

In the event of a disease being suffered, continuous (24 h) supervision is required. The diagnosis and the necessity of supervision must be confirmed by a consultant neurologist;
3.1.13. benign brain tumour – a benign brain tumour diagnosis is confirmed, which is defined as a benign tumour growing in the cranial vault that only affects the brain, the brain's soft casings, or the cranial nerves. At least one of the following methods is used for treating the tumour:
- surgery (full or partial resection of the tumour);
- radiotherapy (radioactive exposure);
- chemical therapy;
- stereotactic radiosurgery.

If, due to medical indications, none of these treatments can be used, the tumour will inevitably result in permanent neurological disorders, which must be documented for a minimum three (3) months after the date on which the diagnosis is determined. The diagnosis must be approved by a neurologist or a neurosurgeon and confirmed by imaging studies.
The Insurance Indemnity amount shall not be paid in the following cases:
- malformations of cyst, granuloma, hamartoma, or cerebral arteries or veins;
- tumours of the pituitary gland;

3.1.14. loss of hearing (deafness) – permanent and irreversible loss of hearing as a result of ear-related disease or trauma. The diagnosis must be confirmed by a consultant – an otorhinolaryngologist (ENT) – and instrumental examinations (audiogram);
3.1.15. loss of speech – full and irreversible loss of speech as a result of physical trauma or a disease of the vocal ligaments. The disorder must be continuous for a minimum of 6 months. The diagnosis must be confirmed by a consultant – an ENT.
The Insurance Indemnity amount shall not be paid out for any loss of speech as a result of mental disorders;
3.1.16. third and fourth degree burns – burns which cause skin damage down as far as the subdermal tissue and/or muscles and which affect a minimum of 20% of the body surface area. Insurance Indemnity shall not be paid for:
- burns which have occurred as a result of an action that the Insured Person has committed against itself.
- first or second degree burns;

3.1.17. idiopathic Parkinson's Disease (suffered by someone who is below the age of 65) – slowly progressing brain disease.
The determined diagnosis of the primary idiopathic Parkinson's Disease, which is confirmed by a minimum of two of the clinical implications provided below:
- muscle rigidity;
- tremors;
- bradykinesia (pathologically slow movement, and slow physical and mental response reactions).

An inability to independently perform a minimum of 3 out of 6 daily activities continuously for a period of at least 3 months:
- washing – the ability to wash oneself in a bath or shower (which includes getting into a bath or shower and out of it again) or to wash oneself in an appropriate way by using other equipment;
- putting clothes on and taking them off – the ability to put on, take off, fasten, and unfasten all parts of one's clothing and, if required, also handle fastenings, artificial extremities, or other medical auxiliary devices;
- eating – the ability to eat when a meal is cooked and served;
- personal hygiene – the ability to maintain a satisfactory level of personal hygiene by going to the toilet or otherwise controlling the process of gastric emptying and urination;
- moving between premises – the ability to be able to move oneself from one premises to another on an even floor surface;
- getting into bed and out of it – the ability to get out of bed and sit on a chair placed nearby or in a wheelchair and be able to get back into bed.

The diagnosis must be confirmed by a neurologist.
The Insurance Indemnity amount shall not be paid out for secondary parkinsonism (including parkinsonism caused by medicaments or toxins);
3.1.18. bacterial meningitis – severe brain and/or spinal cord inflammation caused by a bacterial infection, which results in serious, irreversible, and permanent neurological disorders.
The diagnosis is justified by:
- bacterial infection seen in a lumbar puncture;
- a diagnosis made by a neurologist and/or a neurosurgeon with neurological symptoms lasting for a minimum of 2 (two) months;

3.1.19. aplastic anaemia – chronically persistent bone marrow disorders, as a result of which blood cells (RBC, WBC, platelets) are not produced in a sufficient amount. These disorders cause anaemia, neutropenia and thrombocytopenia, the elimination of which requires at least one of the following therapies:
- blood product transfusion;
- allogeneic bone marrow transplantation;
- immunosuppressive therapy;
- the use of stimulating agents;

Diagnosis is justified by:
- laboratory examinations;
- a haematologist;

Exceptions:
- haemorrhagic anaemia;
- haemolytic anaemia;
- iron deficiency anaemia;
- Vitamin B12 anaemia;

3.1.20. active tuberculosis – an infectious disease which mostly affects the lungs – lung tuberculosis, and also the spine, bones, kidneys, reproductive organs, brain, lymphatic gland, etc – beyond the original lung tuberculosis diagnosis.
The diagnosis is justified by:
- laboratory and instrumental examinations;
- pneumologist;

3.1.21. Crohn's disease – a chronic and often progressive disease in the digestive tract.
The diagnosis is justified by:
- a gastroenterologist, in accordance with the clinical data;
- instrumental examinations;

3.1.22. hepatic failure – liver necrosis or liver cell damage causing hepatic function disorders. hepatic encephalopathy (consciousness disorders) and coagulopathy (blood coagulation disorders) Most commonly, it is caused by viral hepatitis, toxins (medication, toadstools) or specific auto-immune, metabolic illnesses.
The diagnosis is justified by:
- clinical and objective findings (ASAT, ALAT increase, hepatic encephalopathy, reduced hepatic synthesis function, INR>1.5);
- a hepatologist and/or the treating doctor.

Exceptions:

- liver failure developed as a result of unreasonable use of medicines;

3.1.23. HIV infection – chronic infection disease, which is caused by the Human Immunodeficiency Virus (HIV) and which is obtained by a transfusion of infected blood/blood preparations or as a result of an accident at work or physical violence.
HIV must be primarily diagnosed and confirmed by an infectiology centre in the relevant country during the Insurance Validity period.
The contraction of the illness is justified by:
- a stationary card report on blood transfusion
- a document on an accident in the work place or physical violence, which has been reported according to the procedure determined by the regulatory enactments of the Republic of Latvia;

3.1.24. Hepatitis C – acute or chronic infection disease, which is caused by the Hepatitis C virus (HIV) and which is obtained by the transfusion of infected blood/blood preparations or as a result of an accident at work. Hepatitis C must be primarily diagnosed and confirmed by an infectologist's and/or hepatologist's report.
The contraction of the illness is justified by:
- a stationary patient medical card report on blood transfusion;
- a document on an accident in the work place or physical violence, which has been reported according to the procedure determined by the regulatory enactments of the Republic of Latvia;

3.1.25. tick-borne encephalitis – a disease caused by the bite of an infected tick. The Insurance Indemnity amount shall be paid out if the disease is diagnosed in cases in which a full vaccination course against tick-borne encephalitis has been received (which should be confirmed by the individual concerned presenting their vaccination passport) and treatment in a hospital for at least ten (10) days;

3.1.26. Lyme's disease – a disease caused by the bite of an infected tick as a result of which a minimum of two bodily systems are damaged (skin, neurological, joints).
The diagnosis is justified by:
- the results of analyses confirming the presence of the infection *(Borrelia burgdorferi)* in blood or cerebrospinal fluid;
- a neurologist/infectologist and/or the treating doctor;

3.1.27. **Primary type 1 sugar diabetes** – an auto-immune pancreatic disease with insulin production disorders, as a result of which because of the lack of insulin the level of glucose in the blood is elevated and permanent treatment with insulin injections is required.
The diagnosis is justified by:
- an endocrinologist in accordance with the laboratory testing results.

Exceptions:
- other types of diabetes, including type 2 sugar diabetes, secondary sugar diabetes, gestational (pregnancy) diabetes;
- latent auto-immune diabetes of adults.

4. Rights and obligations of the parties

4.1. The obligations of the Insured Person when establishing the possible occurrence of an Insurance Event are:
4.1.1. to apply for medical assistance without delay, as soon as possible, and to observe any instructions that are issued by the doctor;
4.1.2 after the confirmation of the Final Diagnosis, requesting the Insurance Indemnity, the Insured Person shall submit the following documents to the Insurer:

a) insurance indemnity application writing;
b) medical documentation or its copies, confirming the contraction of a critical illness, where the Final Diagnosis, the Date of establishing the Final Diagnosis, the results of the instrumental and laboratory testing and operation reports are indicated,
c) other documents and information as requested by the Insurer.

5. Decision on Payment of insurance Indemnity

5.1. The Insurer reaches a decision regarding the payment of the Insurance Indemnity within a period of thirty (30) days of the day upon which all documents that are required for the decision-making process have been received.
5.2. The Insurance Indemnity amount shall be paid out in accordance with the Insurance Indemnity payment type prescribed in the provisions of Paragraph 2 of the Insurance Policy.

6. Exceptions

By signing the Insurance Agreement, the parties agree that the following will not qualify as an Insurance Event and that no Insurance Indemnity will be paid, in the event of:
6.1. Deliberate deterioration of the state of health by the Insured Person (including by directly self-caused bodily injuries) or through a suicide attempt;
6.2. Participation in a war or similar activities, in the operations of any military formation, or in any terrorism event or period of public unrest;
6.3. Participation in operations that have been organised by the country's National Armed Forces, including peace support missions;
6.4. If the Critical Disease has been contracted, when the Insured Person has been performing illegal activities, serving a sentence in a penal institution, committing a violation of rights, or committing a crime (or participating in it), when this is acknowledged by a court or other competent institution;
6.5. The Critical Disease has been incurred due to radioactive contamination, radioactive pollution, natural disasters;
6.6. The Critical Disease has been incurred due to the use of alcohol, narcotics, or any toxic or other intoxicating substances, or the malevolent use of medicaments, or self-treatment, experimental treatment or non-traditional treatment;
6.7. The Insured Person is found to have HIV infection or AIDS (when receiving a positive AIDS test result), except for in the cases stipulated by Paragraph 3.1.23;
6.8 When the Insured Person is found to have a Critical Disease due to a failure to observe the doctor's instructions;

6.9. The Insured Person has received a medical consultation and/or treatment regarding any of the critical diseases prior to the start of the Insurance Period;
6.10. The Insured Person has already had a Critical Disease diagnosed earlier in their life or the Insured Person has been aware of any circumstances that have revealed the potential presence of a Critical Disease prior to the insurance cover taking effect.