Working capacity insurance

Group insurance Applies to policies starting on or after 1 June 2017

Contents

LOCALTAPIOLA

1 General description

Working capacity insurance is a group insurance that supplements your occupational health services. In order for a contract of insurance to take effect and to remain in force, the policyholder must have valid statutory workers' compensation insurance cover with LocalTapiola and the content of the policyholder's occupational health agreement must have LocalTapiola's approval.

For your working capacity insurance policy, you can select the basic cover to consist of either:

1. GP Medical Expenses Cover, or
2. Specialist Medical Expenses Cover,
3. combined into GP and Specialist Medical Expenses Cover,
4. Surgical Expenses Cover.

If you select the above combination or only Specialist Medical Expenses Cover for your policy, you can supplement your insurance with one or several of the following covers:

- Pharmaceutical Expenses Cover,
- Physio Cover,
- Therapy Cover.

The chosen covers will be stated in your policy schedule.

2 Insureds and the recipient of compensation

2.1 Insureds

The insureds are the policyholder's employees, aged between 15 and 80, who belong to the group of persons stated in the policy schedule and who are entitled to occupational healthcare on the basis of an occupational health agreement.

The cover provided by this insurance can also apply to any persons living permanently in Finland whose residence, as determined by current legislation, is in Finland and who are covered by the Finnish Health Insurance Act.

2.2 Recipient of compensation

Any compensation that is provided will be payable to the insured, unless otherwise agreed in your contract of insurance. The policyholder may later by written notification change the recipient of compensation. The policyholder may authorise the insured to appoint the recipient of compensation for the insured's own insurance.

3 Validity of the insurance

3.1 Entry into force

Commencement of LocalTapiola's liability and the validity of contracts of insurance are discussed in section 3 of the General terms and conditions of contract.

Those belonging to the group stated in the policy schedule will be insured from the time when their entitlement to occupational health services starts under an occupational health agreement.

3.2 Territorial limits and the period of cover

Cover applies round the clock both in the course of work and in leisure time worldwide.

3.3 Validity in sport activities

With the exception of professional sport, cover applies in all sport activities.

Professional sport is when an athlete practises an individual or team sport as a professional activity for which he or she is paid a wage, a salary or another consideration or benefit that is more than the sum laid down in the Act on Athletes' Accident and Pension Cover, or when the athlete is required to take out the insurance laid down in the Act on Athletes' Accident and Pension Cover.

3.4 Nuclear damage, war and criminal activity

This insurance does not cover any claim, loss, damage or injury arising out of:

- war, rebellion, riot, armed conflict or similar, or service in a peacekeeping operation or other military action organised by the United Nations, the European Union or some other entity. If the insured has started their international journey before the armed action commences and does not participate in it personally, this section will apply only after 14 days after the commencement of the armed action. If the insured personally takes part in the armed action, or where there is a major war, this exclusion will apply immediately. Major war means any war between two or more permanent members of the United Nations Security Council;
- impact of any weapon or device based on a nuclear reaction injuring masses of people;
- nuclear damage as described in the Nuclear Liability Act, or arising out of damage caused by any material, device or weapon based on a nuclear reaction, regardless of where the damage occurs;
- the insured's criminal activity.

3.5 Insurer's right to select the place of treatment

To be covered by working capacity insurance, your examination and treatment must be provided by the agreed service provider or another medical institution expressly approved by LocalTapiola.

3.6 Termination of cover

In respect of an individual insured, cover will terminate:

- at 24.00 on the day on which the insured's employment with the policyholder ends;
- at the end of the period of insurance during which the insured turns 80;
- when the validity of the contract of insurance ends after the policyholder or LocalTapiola has cancelled the contract;
- upon declaration that the policyholder is in liquidation; or
- at the insured's death.

At the termination of Medical Expenses Cover, any optional covers included in your contract of insurance will also terminate.

Termination of contracts of insurance is discussed in further detail in section 12 of the General terms and conditions of contract.

4 Sum insured

The covers selected for your policy share a common sum insured such that the maximum compensation payable from the different covers on the basis of any one illness, disease or accident is limited to €10,000, unless otherwise stated in the policy schedule.

5 Indexation of the insurance

With regard to the premiums, the insurance is tied to an index, unless otherwise stated in the policy schedule. The index is called sub-index 86 'Human health activities' of the Producer price index for services. The premium will be index-adjusted annually at the beginning of the period of insurance. The basic index is the index number for the first quarter of the year preceding the insurance inception year. The adjustment index is the index number for the first quarter of the year preceding the period of insurance stated in the policy schedule. The adjustment is effected on the start date of the period of insurance.

6 Insured events

6.1 Illness as an insured event

Illness means any condition requiring medical care which, on the basis of the material supplied to LocalTapiola, has started independently of the insured's will and not accidentally.

6.2 Accident as an insured event

Accident means any sudden and unexpected event caused by an external factor that causes a bodily injury to the insured against his or her will.

The following are also considered accidents:

- the insured's involuntary drowning, sunstroke, heatstroke, frostbite, gas poisoning, and poisoning caused by a substance which the insured ingests accidentally;
- injury caused by significant pressure variation;
- muscle or tendon strains resulting from a sudden motion or exertion when the insured's illness, disease or physical defect is not the principal cause of the strain.

6.3 Excluded events

Where factors unrelated to a covered insured event essentially contribute to the occurrence of an injury or illness or prolong its healing, cover will apply only insofar as the treatment need can, on the basis of medical knowledge, be deemed to result from the covered insured event.

There will be no cover if an insured event is caused by:

- poisoning by an ingested substance not intended for food purposes;
- the insured's attempted suicide;
- in the course of any measure or procedure carried out to treat an illness, disease or physical defect, unless carried out to treat an insured event that is covered by this insurance;
- the insured's consumption of any narcotic drug, alcohol, medicinal substance, nicotine or another intoxicating agent, except those stated in the covered Therapy Cover expenses.

There will be no cover for:

- injury caused from biting to a tooth, the temporomandibular joints or dentures, not even when an external factor contributes to the injury;
- examination or treatment of any dental disease, the teeth or the masticatory system, not even when a dental or a masticatory disease or injury causes symptoms elsewhere than in the dentition.

7 Indemnification regulations

7.1 Accident

For expenses to be covered by this insurance, your examinations and treatments must be carried out by a doctor or another healthcare professional and provided in Finland at a LocalTapiola contractual partner or at a medical institution expressly approved by LocalTapiola. The examinations may also be provided using remote services, where medically possible. In addition, for expenses to be covered, cover must be in force when the expenses are incurred.

For medical expenses to be covered, the examination, treatment, procedures and medicinal products must be doctor ordered and, according to generally accepted medical practice, necessary and essential for examining or treating the illness, disease or accident and commonly employed in healthcare in Finland.

Expenses will be covered on the basis of original invoice or receipt insofar as they are not covered on the basis of statutory preventive occupational healthcare (section 12 of the Occupational Health Care Act) or by any law.

A condition for covering expenses is also that the insured must, at the time when the expenses are incurred, be covered by the Finnish social security system and must have a valid Kela (health insurance) card as an indication of this.

For any one illness, disease or accident, the maximum covered expenses are limited to the sum insured, stated in the policy schedule, that is valid at the time of occurrence of the insured event. The deductible, if any, will be shown in the policy schedule.

8 Limitations of cover

Under the General terms and conditions of contract, cover can be reduced if the insured or others entitled to insurance compensation through gross negligence contribute to the injury or event. Cover can be refused if the insured or others entitled to insurance compensation cause the insured event intentionally.

9 How to make a claim

A claim must be filed with LocalTapiola within one year of the day on which the claimant becomes aware of the validity of the insurance, of the insured event and of the loss, damage or injury that results from it. In any case a claim for compensation must be presented within 10 years of the occurrence of loss, damage or injury. If no compensation claim is presented within this time period, the claimant will forfeit their entitlement to compensation.

Unless otherwise agreed, the claimant is required to pay their medical expenses out of pocket, and in respect of them claim from the Social Insurance Institution of Finland (Kela) the reimbursement set out in the Health Insurance Act within six months of the date of payment of the expenses.

If the insured is entitled to reimbursement of medical expenses under an act other than the Health Insurance Act, such as the Workers' Compensation Act, the Workers' Compensation Act for Self-employed Farmers, the Motor Liability Insurance Act, the Basic Education Act or the Patient Insurance Act, reimbursement must first be claimed under that act. Regarding expenses for which no reimbursement was paid by operation of law, LocalTapiola must be supplied with a claim settlement decision or an equivalent document.

If entitlement to the reimbursement set out in the Health Insurance Act or another relevant act has been extinguished on account of failure to comply with the above time limits or for some other reason, cover will be reduced by the portion that would have been paid under these acts.

10 GP Medical Expenses Cover

10.1 What is included in GP Medical Expenses Cover?

Subject to the exclusions described below, covered medical expenses include:

- expenses for treatment and examination provided or prescribed to the insured by a general practitioner, a specialist in general practice, a specialist in occupational healthcare or a healthcare professional. For these expenses to be covered, treatment must be sought as instructed by LocalTapiola.
- expenses for one-off on-call treatment provided by a general practitioner or a healthcare professional in the event of an acute illness, disease or accident that requires medical treatment. Costs of any possible follow-up treatment and monitoring will be covered only as instructed by LocalTapiola;
- public hospital outpatient clinic fees and health centre consultation fees, which include medical treatment and surgery;
- daily hospital charges of public hospitals and health centre inpatient wards
- reasonable costs for any medical materials and documents LocalTapiola requests that are necessary for settling the insurance case or claim;
- rental costs of the temporary post-surgery or post-casting medical aids that are essential for movement, for a maximum of two months from surgery or from the start of casting;
- costs of treating accidental dental injuries;
- costs of any essential first orthopaedic dressing, bandage or support, per insured event.

10.2 Exclusions to GP Medical Expenses Cover

GP Medical Expenses Cover does not cover:

- expenses incurred from any examination or treatment carried out on or prescribed to the insured by a specialist;
- examination carried out or treatment provided outside Finland;
- ultrasonic cardiography;
- MRI scanning;
- computed tomographic scanning (computed tomography);
- contrast-enhanced imaging studies;
- eye tests, acquisition of spectacles or contact lenses, or surgery for refractive errors or cataract;
- medical or periodic inspections, including preventive treatments and vaccinations;
- pharmaceutical preparations, emollient creams, and homeopathic, anthroposophic, herbal medicinal, vitamin, trace element and mineral products, not even when they are prescribed by a doctor;
- nutrient preparations, including dietetic products;
- trace element examinations or other comparable examinations, not even when they are prescribed by a doctor;
- costs of speech therapy, psychotherapy, occupational therapy or neuropsychological rehabilitation, or costs of any comparable therapy, treatment or rehabilitation;
- physiotherapy, physical treatment or other comparable treatment;
- rehabilitation;
- expenses of stay at any rehabilitation centre, spa or natural therapy facility;
- dressings, medical aids, other assistive devices or prostheses, except those stated under the covered medical expenses;
- acquisition or repair costs of spectacles, contact lenses, hearing aids, dentures and hard hats, not even when the item in question gets broken or goes missing in an accident or another covered insured event or during a bout of illness;
- treatment or examination of dental diseases, the teeth or the masticatory system, not even when a dental or a masticatory disease causes symptoms elsewhere than in the dentition;
- cosmetic treatment or any complications of these procedures;
- costs of any treatment which primarily improves the quality of life, unless covered as healthcare costs under the Health Insurance Act;
- examinations or treatment of erectile dysfunctions;
- mole removal, except in the case of a malignant tumour that requires medical treatment or in the case of a related premalignant condition;
- examination and treatment of obesity;
- costs of contraception, pregnancy, childbirth, abortion, miscarriage, or infertility examination and treatment, or costs of related complications;
- costs of examinations or treatment of menopausal problems;
- examinations or treatment of the venous insufficiency of the legs (varicose veins);
- examinations or treatment of snoring, except for treating polysomnography-confirmed sleep apnea;
- treatment related to gender identity variance;
- treatment related to disorder of sexual preference;
- examinations carried out to identify or exclude an illness for which the insured had no symptoms before the examination was started, such as gene testing;

- costs of treating addiction caused by the consumption of any narcotic drug, alcohol, medicinal substance, nicotine or another substance, or costs of treating some other addiction;
- indirect costs, such as travel and overnight accommodation expenses, home care costs, loss of earnings, meal and telephone expenses, clothing, equipment, or an escorting person's expenses of travel or accommodation;
- expenses that the insured themselves would not be liable to pay for their treatment;
- any other expenses not stated under the covered medical expenses.

11 Specialist Medical Expenses Cover

11.1 What is included in Specialist Medical Expenses Cover?

Subject to the exclusions described below, covered medical expenses include:

- expenses for treatment and examination provided by a specialist (excluding specialists in general practice and specialists in occupational healthcare). For expenses to be covered, the insured needs to have a doctor's referral from occupational healthcare;
- expenses of surgery carried out by a specialist;
- expenses for treatment provided by a general practitioner and a healthcare professional in the event of an acute illness, disease or accident that requires medical treatment, when the occupational healthcare services are not available. Costs of any possible follow-up treatment and monitoring will be covered only as instructed by LocalTapiola;
- public hospital outpatient clinic fees and health centre consultation fees, which include medical treatment and surgery;
- daily hospital charges of public and private hospitals and health centre inpatient wards;
- costs of essential post-surgery or post-casting specialist-ordered physiotherapy for a maximum of one care episode consisting of up to 15 treatment sessions, per insured event;
- rental costs of the temporary post-surgery or post-casting medical aids that are essential for movement, for a maximum of two months from surgery or from the start of casting;
- costs of cosmetic treatment for treating an accidental injury, when the costs are approved by LocalTapiola in advance;
- costs of phototherapy administered to treat a skin disease;
- costs of treating accidental dental injuries;
- costs of any essential first orthopaedic dressing, bandage or support, per insured event;
- expenses of obesity surgery fulfilling the criteria for surgery in public healthcare;
- reasonable costs for any medical materials and documents LocalTapiola requests that are necessary for settling the insurance case or claim.

11.2 Exclusions to Specialist Medical Expenses Cover

Specialist Medical Expenses Cover does not cover:

- general practitioner appointments, except those stated under the covered medical expenses;
- examination carried out or treatment provided outside Finland;
- eye tests, acquisition of spectacles or contact lenses, or surgery for refractive errors or cataract;
- medical or periodic inspections, including preventive treatments and vaccinations;
- pharmaceutical preparations, emollient creams, and homeopathic, anthroposophic, herbal medicinal, vitamin, trace element and mineral products, not even when they are prescribed by a doctor;
- nutrient preparations, including dietetic products;
- trace element examinations or other comparable examinations, not even when they are prescribed by a doctor;
- costs of speech therapy, psychotherapy, occupational therapy or neuropsychological rehabilitation, or costs of any comparable therapy, treatment or rehabilitation;
- physiotherapy, physical treatment or other comparable treatment, except those stated under the covered medical expenses;
- rehabilitation;
- expenses of stay at any rehabilitation centre, spa or natural therapy facility;
- dressings, medical aids, other assistive devices or prostheses, except those stated under the covered medical expenses;
- acquisition or repair costs of spectacles, contact lenses, hearing aids, dentures and hard hats, not even when the item in question gets broken or goes missing in an accident or during a bout of illness;
- treatment or examination of dental diseases, the teeth or the masticatory system, not even when a dental or a masticatory disease causes symptoms elsewhere than in the dentition;
- cosmetic treatment or any complications of these procedures, except those stated under the covered medical expenses;
- costs of any treatment which primarily improves the quality of life, unless covered as healthcare costs under the Health Insurance Act;
- examinations or treatment of erectile dysfunctions;
- eyelid surgery;
- reduction mammaplasty or augmentation mammaplasty;
- mole removal, except in the case of a malignant tumour that requires medical treatment or in the case of a related premalignant condition;
- obesity treatment, liposuction, gastric bypass or gastric sleeve surgery, or other obesity surgery or other obesity examination or treatment, except in the case of obesity surgery that fulfils the criteria for surgery in public healthcare;
- treatment for which the need arises as a result of severe weight loss, such as the treatment of excess skin;
- costs of contraception, pregnancy, childbirth, abortion, miscarriage, or infertility examination and treatment, or costs of related complications;
- costs of examinations or treatment of menopausal problems;
- examinations or treatment of the venous insufficiency of the legs (varicose veins);
- examinations or treatment of snoring, except for treating polysomnography-confirmed sleep apnea;

- treatment related to gender identity variance;
- treatment related to disorder of sexual preference;
- examinations carried out to identify or exclude an illness for which the insured had no symptoms before the examination was started, such as gene testing;
- costs of treating addiction caused by the consumption of any narcotic drug, alcohol, medicinal substance, nicotine or another substance, or costs of treating some other addiction;
- indirect costs, such as travel and overnight accommodation expenses, home care costs, loss of earnings, meal and telephone expenses, clothing, equipment, or an escorting person's expenses of travel or accommodation;
- expenses that the insured themselves would not be liable to pay for their treatment;
- any other expenses not stated under the covered medical expenses.

12 Pharmaceutical Expenses Cover

12.1 What is included in Pharmaceutical Expenses Cover?

Subject to the exclusions described below, Pharmaceutical Expenses Cover covers:

- doctor-prescribed pharmaceutical preparations that are sold by pharmacies under licence granted by a public authority and that, according to generally accepted medical practice, are necessary and essential for treating an injury caused by illness, disease or accident.

12.2 Exclusions to Pharmaceutical Expenses Cover

Pharmaceutical Expenses Cover does not cover:

- pharmaceutical preparations prescribed and obtained outside Finland;
- emollient creams, and homeopathic, anthroposophic, herbal medicinal, vitamin, trace element and mineral products;
- nutrient preparations, including dietetic products;
- dressings, and medical aids;
- pharmaceutical treatment of obesity;
- pharmaceutical treatment of severe weight loss;
- contraception, or pregnancy-related pharmaceutical treatments;
- pharmaceutical treatment of infertility;
- costs of pharmaceutical treatment of menopausal problems;
- pharmaceutical treatment of the venous insufficiency of the legs (varicose veins);
- medicinal products used for alleviating the adverse effects of balding or other physiological changes;
- preventive pharmaceutical treatment, or vaccinations;
- pharmaceutical treatment related to cosmetic or plastic surgery treatment or to any complications of these procedures;
- costs of any pharmaceutical treatment which primarily improves the quality of life, unless covered as healthcare costs under the Health Insurance Act;
- pharmaceutical treatment of erectile dysfunctions;
- pharmaceutical treatment related to eyelid surgery;
- pharmaceutical treatment related to reduction mammaplasty or augmentation mammaplasty;
- pharmaceutical treatment of snoring, except pharmaceutical treatment of polysomnography-confirmed sleep apnea;
- costs of pharmaceutical treatment of addiction caused by the consumption of any narcotic drug, alcohol, medicinal substance, nicotine or another substance, or costs of pharmaceutical treatment of some other addiction;
- pharmaceutical treatment related to gender identity variance;
- pharmaceutical treatment related to disorder of sexual preference;
- indirect expenses, including travel expenses to a pharmacy, expenses of renewing prescriptions or assistive devices related to the consumption of medicinal products, including dosette boxes and pill splitters;
- expenses that the insured themselves would not be liable to pay for their treatment;
- any other expenses not stated under the covered medical expenses.

Claimants are required to claim pharmaceutical expenses from LocalTapiola within one year of the day on which they are incurred.

13 Physio Cover

13.1 What is included in Physio Cover?

This Cover covers expenses arising from doctor-ordered physiotherapy, naprapathy and chiropractic provided by a physiotherapist, naprapath or chiropractor approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira). Expenses will be covered for up to a maximum of 10 treatment sessions, per insured, during the period of insurance.

The treatment must, according to generally accepted medical practice, be necessary and essential for treating an illness, disease or accident determined in this policy wording.

13.2 Exclusions to Physio Cover

Physio Cover does not cover:

- treatment provided outside Finland;
- rehabilitation;
- expenses of stay at any rehabilitation centre, spa or natural therapy facility;
- indirect expenses, including travel and overnight accommodation expenses;
- expenses that the insured themselves would not be liable to pay for their treatment;
- any other expenses not stated under the covered expenses.

14 Therapy Cover

14.1 What is included in Therapy Cover?

Subject to the limitations described below, covered therapy expenses include expenses for specialist-ordered psychotherapy, neuropsychological rehabilitation, functional therapy and speech therapy (excluding specialists in general practice and specialists in occupational healthcare).

Covered therapy expenses also include therapeutic treatment of alcohol addiction, drug addiction or pharmaceutical addiction, but related rehabilitation is excluded from cover.

Expenses of psychotherapy will be covered when the psychotherapy is provided by a psychotherapist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira).

Expenses of neuropsychological rehabilitation will be covered when it concerns treatment of brain damage, such as cerebral haemorrhage, a brain tumour, cerebrovascular accident or severe brain injury.

For any one insured, therapy expenses will be covered for up to a maximum of 25 treatment sessions per form of therapy, during the entire term of the contract of insurance.

14.2 Exclusions to Therapy Cover

Therapy Cover does not cover any:

- therapeutic treatment provided outside Finland;
- rehabilitation;
- neuropsychological rehabilitation, except for treating any brain damage stated in the covered expenses, such as cerebral haemorrhage, a brain tumour, cerebrovascular accident or severe brain injury;
- expenses of stay at any rehabilitation centre, spa or natural therapy facility;
- therapeutic treatment of behavioural problems or developmental learning disorders, including dyslexia, attention deficit disorder or visual perception disorder;
- therapeutic treatment related to cosmetic or plastic surgery treatment or to any complications of these procedures;
- therapeutic treatment related to gender identity variance;
- therapeutic treatment related to disorder of sexual preference;
- indirect expenses, including travel and overnight accommodation expenses;
- expenses that the insured themselves would not be liable to pay for their treatment;
- any other expenses not stated under the covered expenses.

15 Surgical Expenses Cover

15.1 What is included in Surgical Expenses Cover?

Covered surgical expenses include:

- expenses for the insured's surgery carried out by a specialist. For expenses to be covered, the insured needs to have a doctor's referral from occupational healthcare;
- costs of cosmetic surgery for an accidental injury when LocalTapiola approves the costs in advance;
- expenses of hospitalisation immediately in the context of the surgery;
- surgery-related daily hospital charges;
- expenses of one preoperative consultation, and of one postoperative care follow-up consultation, with a specialist necessitated by the surgery;
- costs of specialist-ordered postoperative physiotherapy treatment after surgery, for a maximum of one care episode consisting of up to 15 treatment sessions;
- rental costs of temporary post-surgery medical aids that are essential for movement, for a maximum of two months from surgery or from the start of casting;
- costs of any essential first orthopaedic dressing, bandage or support after surgery, per insured event;
- expenses of obesity surgery that fulfils the criteria for surgery in public healthcare;
- reasonable costs for any medical materials and documents LocalTapiola requests that are necessary for settling the claim.

15.2 Exclusions to Surgical Expenses Cover

Surgical Expenses Cover does not cover:

- treatment provided outside Finland;
- surgery carried out without a specialist referral;
- presurgery examinations and treatments, not even when they are necessary and essential to perform the surgery, except those stated under the covered surgical expenses;
- imaging, including X-ray and ultrasound examinations and MRI scans;
- pharmaceutical preparations;
- mole removal, except in the case of a malignant tumour that requires medical treatment or in the case of a related premalignant condition;
- costs of the insured's contraception, pregnancy, childbirth, abortion, miscarriage, or infertility examination and treatment, or costs of related complications;
- infertility treatment;
- medical treatment of the teeth or the masticatory system to treat a non-accidental injury, not even when a dental or a masticatory disease causes symptoms elsewhere than in the dentition;
- surgery for refractive errors or cataract;
- costs of speech therapy, psychotherapy, occupational therapy or neuropsychological rehabilitation, or costs of any comparable therapy or treatment;
- physiotherapy, physical treatment or other comparable treatment, except those stated under the covered surgical expenses;
- rehabilitation;
- expenses of stay at any rehabilitation centre, spa or natural therapy facility;
- dressings, medical aids, other assistive devices or prostheses, except those stated under the covered surgical expenses;
- aesthetic surgery or any complications of these procedures;
- costs of surgery which primarily improves the quality of life;
- eyelid surgery;
- reduction mammaplasty or augmentation mammaplasty;
- liposuction, gastric bypass or gastric sleeve surgery, or other obesity surgery, except in the case of obesity surgery that fulfils the criteria for surgery in public healthcare;

- treatment for which the need arises as a result of severe weight loss, such as surgery for excess skin;
- surgery for erectile dysfunctions;
- surgery for the venous insufficiency of the legs (varicose veins);
- surgery for snoring, except in the case of surgery for polysomnography-confirmed sleep apnea;
- surgery related to gender identity variance;
- surgery related to disorder of sexual preference;
- indirect costs, such as travel and overnight accommodation expenses, home care costs, loss of earnings, accommodation, meal and telephone expenses, clothing, equipment, or an escorting person's expenses of travel or accommodation;
- expenses that the insured themselves would not be liable to pay for their treatment;
- any other expenses not stated under the covered surgical expenses.

General terms and conditions of contract

The General terms and conditions of contract contain, in essence, regulations laid down in the Insurance Contracts Act (543/1994).

The Insurance Contracts Act in force from time to time will be applied insofar as these General terms and conditions of contract do not include a corresponding provision. For the purposes of group insurance, the below sections of the terms and conditions will apply unless, with respect to some matter, otherwise agreed in the group insurance contract or the terms and conditions.

In addition to these General terms and conditions of contract, contracts of insurance are subject to the policy wordings and the other terms and conditions of insurance stated in the policy schedule, as well as being governed by the law of Finland. Where there is a conflict between the policy schedule and the policy wording, the regulations of the policy schedule will prevail.

The Financial Supervisory Authority is the competent authority that regulates insurance undertakings.

1 Some key concepts

Contract of insurance: the key content of a contract of insurance is determined in the policy schedule and the relevant policy wordings, which include the General terms and conditions of contract and the wordings of the special conditions applying to each insurance.

Personal insurance means any insurance providing cover for a natural person.

Policyholder means the party that has concluded a contract (policy) of insurance with the insurer.

Insurer means the insurance undertaking that has concluded a contract (policy) of insurance with the policyholder. In this wording, the insurer is also called LocalTapiola.

Insured is whoever to whom personal insurance cover applies.

Exclusion means any term contained in the contract of insurance which determines perils that the insurance will not cover or which otherwise reduces cover.

Period of insurance means the agreed length of time stated in the policy schedule for which the insurance is in force. A contract of insurance continues from one agreed period of insurance to another, unless terminated by either party.

Premium period means any period of time over which the premium is agreed to be paid at regular intervals.

Insured event means any event on the basis of which the insurance will pay indemnity.

Group insurance is a type of insurance in which cover applies to the members of the group stated in the contract of insurance and for which the full premium is paid by the policyholder.

2 Provision of information before concluding a contract of insurance

2.1 Insurer's duty to provide information

Before concluding a contract of insurance, the insurer will inform the insurance applicant about the kinds of insurance it provides and about the premiums and the terms of these insurances, as well as providing the other information necessary for selecting an insurance that suits the insurance need determined for the applicant. When supplying this information, attention will also be paid to the material exclusions restricting the cover.

2.2 Failure to comply with the insurer's duty to provide information

If, when marketing the insurance, the insurer or its representative fails to give to the policyholder any necessary details about the insurance or gives to the policyholder any details about it that are incorrect or misleading, the insurer will rectify the incorrect details immediately after the error is detected. The contract of insurance is deemed to be in force in accordance with the rectified details from the time when the policyholder is informed about the rectification.

2.3 Policyholder's and insured's duty to provide information

Before granting the insurance, the policyholder, the insured or their representative is required to give true and complete answers to any questions the insurer puts that may be relevant for assessing the liability of the insurer.

In addition, throughout the period of insurance, the policyholder and the insured are required to rectify without undue delay any information they have given to the insurer that they discover to be incorrect or incomplete.

The insurer has the right to add an exclusion to the insurance cover of an individual insured if the policyholder or the insured has given any incorrect or incomplete information about the insured's health when the insured was added to the policy.

2.4 Failure to fulfil the policyholder's and the insured's duty to provide information

For the purposes herein, policyholder also means the insured and the policyholder's or the insured's representative.

If, when fulfilling the above obligation imposed on it, the policyholder or the insured acts in bad faith, the insurer will not be bound by the contract of insurance.

The insurer has a right to keep any paid premiums, even if the insurance were to lapse.

Where the policyholder or the insured intentionally or through negligence which cannot be considered slight fails to fulfil their duty to provide information for the purposes of the insurance, and if the insurer had not granted the insurance at all had true and complete answers been given, the insurer will be discharged from liability. Had the insurer granted the insurance only against a higher premium or otherwise on different terms than what was agreed, the liability of the insurer will be limited to that which reflects the agreed premium or the terms on which the insurance would have been granted.

Were the above consequences of failure to comply with the duty to provide information to cause the policyholder or a party entitled to insurance compensation clear disproportionate hardship, they can be reconciled.

The insurer has the right to add an exclusion to the insurance cover of an individual insured if the policyholder or the insured have given any incorrect or incomplete information about the insured's health when the insured was added to the policy.

3 Commencement of the insurer's liability, and validity of the contract of insurance

3.1 Commencement of the insurer's liability

Unless another time is individually agreed with the policyholder, the liability of the insurer will commence when the insurer or the policyholder gives or sends an acceptance of the offer which the other party has made.

Where the policyholder has given or sent a written insurance application to the insurer and if it is obvious that the insurer would have accepted the application, the insurer will also be liable for any insured event that occurs after the application was given or sent.

Any insurance application or acceptance that the policyholder gives or sends to a representative of the insurer is deemed as having been submitted or given to the insurer.

In the absence of any indication of the time of day when the acceptance or application was given or sent, this is deemed to have taken place at 24.00.

If the decision on whether to grant insurance cover to the insured is based on the insured's health, a condition for the commencement of liability is that the relevant health declaration must be approved. If the insurer approves it, liability in respect of the insured will commence from the time when the signed health declaration was delivered to the insurer.

For the purposes of group insurance, liability in respect of the insured will commence from the time when the insured is introduced into the scope of the insured group which the policyholder and the insurer have agreed, unless another time is agreed in writing between the insurer and the policyholder. A condition for the commencement of liability is that the insured must fulfil the requirements set for the insured that are stated in the policy wording.

The insured's health will be assessed with reference to the time when the health declaration was given or submitted.

The insurer will not refuse admission into the policy on the grounds that the person has suffered an insured event or his or her health has deteriorated after the application documents were given or sent to the insurer.

3.2 Determination of the contractual terms

The premium and the other contractual terms are determined according to the anniversary of the contract of insurance. If a new cover is added to the contract of insurance, for this cover the premium and the other contractual terms will be determined according to the time of commencement of the cover.

The insured's age at the time of commencement of cover or at the start of the period of insurance is the difference between the current year and the insured's year of birth.

3.3 Validity of the contract of insurance

After the expiry of the first premium period, the contract of insurance will be in force one agreed premium period at a time, unless the policyholder or the insurer cancels the contract. The contract of insurance can also terminate for the other reasons set out in sections 4.3 and 12 below.

4 Premium

4.1 Determination of the premium

For each period of insurance, the premium will be determined in accordance with the actuarial principles valid at the beginning of the period. The amount of the premium is affected by the insured persons' age and sex as well as the sector in which the policyholder operates. The premium is tied to the sub-index 'Human health activities' of the Producer price index for services.

The amount of the group insurance premium is also affected by the number of insured persons and by the claims ratio. When calculating the claims ratio, account will be taken of the ratio of the customer's premiums to the claims that the insurer has paid during the period of insurance that precedes the period of renewal.

In the event that a factor affecting determination of the premium changes during the period of insurance, the policyholder is required to supply to the insurer the information necessary for calculating the premium for the following period of insurance. If the policyholder fails to give the requested information within one month, the insurer will have the right to confirm the premium to be an amount which it considers reasonable.

4.2 Payment of the premium

The premium must be paid on the due date or sooner. However, the first premium need not be paid before the liability of the insurer commences, and any subsequent premiums do not need to be paid before commencement of the agreed premium period or period of insurance. If the liability of the insurer to some extent commences later, the premium in respect of this extent does not need to be paid before the commencement of the liability.

Where a payment made by the policyholder is insufficient to cover the insurer's all premium receivables, the insurer is entitled to order what premium receivables the policyholder's payments are to pay off.

4.3 Delayed premium

Where the policyholder fails to pay the premium within the time limit defined in section 4.2 above, the insurer has the right to cancel the contract of insurance to terminate 14 days after the day on which notice of cancellation is sent.

If the policyholder pays the premium before the expiry of the period of notice, the contract of insurance will nevertheless not terminate at the expiry of the period of notice. The insurer will make a mention of this opportunity in the cancellation notice.

Where the premium is not paid within the time period defined in section 4.2 above, interest for late payment is to be paid for the period of delay as specified in the Interest Act.

4.4 Bringing terminated personal insurance cover into force

Where the policyholder pays a neglected premium after cover has terminated, the liability of the insurer will recommence from the date that follows the date of payment. Cover will then be in force from the time when cover was reinstated until the end of the originally agreed period of insurance.

However, if the insurer does not wish to reinstate cover that has terminated, it will notify the policyholder within 14 days of payment of the premium that it refuses to accept the payment.

4.5 Premium at termination of the contract

Where cover terminates earlier than the agreed time, the insurer will be entitled to a premium only in respect of the time period for which its liability has been in force.

The insurer will return to the policyholder that portion of the paid premium which reflects the remainder of the period of insurance. However, no premium will be returned in the event that there has been bad faith conduct in any of the situations defined in section 2.2.

Unpaid overdue premiums and other overdue receivables can be deducted from the repayment in accordance with the general conditions laid down for offsetting. If the repayable amount is smaller than €8, it will not be returned separately.

5 Provision of information during the contract term

5.1 Insurer's duty to provide information

After conclusion of the contract of insurance, the insurer will provide the policyholder with a policy schedule and the policy wording, unless provided earlier or otherwise agreed.

During the period of cover, the insurer will notify the policyholder annually of the sum insured and the other factors which bear obvious relevance to the policyholder.

If, during the period of cover, the insurer or its representative provides any incomplete, incorrect or misleading information about the insurance, the insurer will rectify the incorrect information immediately after the error is detected. The contract of insurance is deemed to be in force in accordance with the rectified details from the time when the policyholder is informed about the rectification.

The provision laid down in section 9, subsection 2 of the Insurance Contracts Act applies to the provision of information after occurrence of an insured event.

5.2 Insurer's duty to provide information to those insured by group insurance

If the group insurance policy specifies that the insurer will maintain a list of the group insurance insureds, the insurer will, once cover has started and after that at reasonable intervals, inform the insureds about the scope of cover, the essential exclusions to cover, the insured's obligations that are based on the contract of insurance, and about the manner in which the validity of cover depends on the insured belonging to the group stated in the group insurance policy. If no list is maintained of the insureds, the above information is to be provided to the insureds in a manner suitable in the circumstances.

If the insurer or its representative fails to give to the insured any necessary information about the insurance or gives to the insured incorrect or misleading information, cover is considered to be in force for the benefit of the insured in the form the insured had reason to understand. However, this does not apply to information that the insurer or its representative, following the occurrence of an insured event, gives about any future indemnification.

5.3 Policyholder's duty to provide information about increased risk

The policyholder and the insured are required to notify the insurer of any change in the aspects increasing the risk of damage that were notified when concluding the contract of insurance and that are relevant for assessing the liability of the insurer if the insurer cannot be regarded as having taken the change into account when concluding the contract. The risk-increasing changes that need to be notified include any change in the policyholder's line of business, a changed or terminated occupational health agreement or termination of the insured's other insurance cover. The onset of or developments in a health condition do not need to be notified.

Under a group insurance policy, the risk-increasing changes that need to be notified include any change in the policyholder's line of business, a changed or terminated occupational health agreement and changes in the number of persons included in the insured group together with an indication of their distribution by age and sex.

The policyholder is required to notify such changes to the insurer no later than one month after receipt of the annual announcement that postdates the change. Any significant change in the number of persons must be notified no later than within one month of the change. The insurer will remind the policyholder of this duty in the annual announcement.

Where the policyholder intentionally or through negligence which cannot be considered slight fails to notify of increased risk as specified above and had the insurer, owing to the changed circumstance, not kept cover in force any longer, the insurer will be discharged from liability. If the insurer had continued the cover but only against a higher premium or otherwise on different terms, the liability of the insurer will be limited to that which reflects the premium or the terms on which the cover would have been continued.

Were the above consequences of failure to comply with the duty to provide information to cause the policyholder or another party entitled to insurance compensation clear disproportionate hardship, they can be reconciled.

5.4 Informing about the termination of group insurance

If the group insurance policy terminates due to any measures taken by the insurer or the holder of the group insurance policy, the insurer will notify the insureds of the termination of the insurance if the group insurance contract specifies that the insurer will maintain a list of the group insurance insureds. If no list is maintained of the insureds, the above information is to be provided to the insureds in a manner suitable in the circumstances.

In respect of the insured, cover will terminate one month after the insurer notifies of the termination of the insurance.

6 Causing an insured event

6.1 Insured events caused by the insured

The insurer is discharged from liability towards any insured who intentionally causes an insured event.

Where the insured causes an insured event through gross negligence, the liability of the insurer can be reduced according to what is reasonable having regard to the circumstances.

6.2 Insured events caused by others entitled to insurance compensation

Where someone else entitled to insurance compensation than the insured intentionally causes an insured event, the insurer is discharged from liability towards that person.

Anyone who causes an insured event through gross negligence, or who because of their age or mental state cannot be convicted of an offence, can claim insurance compensation or a part of it only if this is considered reasonable in view of the circumstances under which the insured event was caused.

7 Insanity and necessity

The insurer will not invoke section 6 above to avoid or limit liability if the insured, when causing an insured event, is younger than twelve years old or in such a mental state that the insured cannot be convicted of an offence.

The insurer will not invoke sections 5 and 6 to avoid or limit liability if the insured, when causing any increased risk or insured event, is acting to prevent bodily injury or property damage under circumstances where the failure or the measure is defensible.

8 Indemnification procedure

8.1 Claimant's obligations

The claimant is required to give to the insurer all documents and information that are necessary for determining the liability of the insurer. These include documents and information necessary for determining whether an insured event has occurred, how extensive the resulting damage is and to whom compensation is payable. The claimant is liable to obtain the materials which are readily available to the claimant, while also taking account of the insurer's opportunities to obtain material.

Criminal offences must be reported to the police authority of the locality of the offence.

The insurer will not be liable to pay any indemnity before it has been provided with the foregoing materials.

If, after the insured event, the claimant in bad faith gives to the insurer any incorrect or incomplete information that is relevant for assessing the liability of the insurer, the indemnity can be reduced or it may be refused according to what is reasonable having regard to the circumstances.

8.2 Limitation of the claim for damages

An insurance claim must be filed with the insurer within one year of the day on which the claimant becomes aware of the validity of the insurance, of the insured event and of the loss, damage or injury that results from it. In any case a claim for compensation must be presented within 10 years of the insured event or, if the insurance was taken out against bodily injury, of the occurrence of the resulting loss, damage or injury. Filing a report about the insured event is considered equivalent to presenting a compensation claim. If no compensation claim is presented within this time period, the claimant will forfeit their entitlement to compensation.

8.3 Insurer's obligations

After an insured event has occurred, the insurer will inform the claimant about the content of cover and the procedure for obtaining compensation. Any preliminary information given to the claimant about the compensation payable, or about the compensation amount or the manner in which compensation will be made, has no impact on the liability for making payment under the contract of insurance.

Expeditiously and not later than one month after receipt of the documents and information necessary for establishing its liability, the insurer will pay the compensation specified in the contract of insurance that is due for the insured event or will notify that no compensation is payable. If the amount of compensation is contested, the insurer will nevertheless pay within the time period shown above the uncontested portion of the compensation.

On any delayed compensation, the insurer will pay interest for late payment as provided for in the Interest Act (633/1982). The insurer will not pay any other types of compensation due to delay.

8.4 Offsetting

Unpaid overdue premiums and other overdue receivables that are due to the insurer can be deducted from the compensation in accordance with the general conditions laid down for offsetting.

9 Appealing the insurer's decision

The policyholder or the claimant has various means at their disposal to seek remedy against the insurer's decisions. They may contact the person responsible for examining their matter at LocalTapiola, or seek remedy with the LocalTapiola Customer Conciliation Office, ask for advice and assistance from the Finnish Financial Ombudsman Bureau FINE or request a dispute settlement recommendation from FINE. In addition, they have the right to bring legal action against LocalTapiola. Examination of the matter at FINE does not preclude bringing an action. However, these bodies of appeal will not examine any cases already tried by or pending at the courts.

9.1 Application for revision and the Customer Conciliation Office

Where the policyholder or the claimant has reason to suspect that the insurer's decision contains an error, they have the right to be informed in more detail of the factors underlying the decision. The insurer will rectify the decision if it proves to be incorrect.

If the issue remains unresolved despite applying for revision, the customer can approach the Customer Conciliation Office. The Customer Conciliation Office is LocalTapiola's own channel for redress that examines issues related to voluntary non-life insurance, life insurance, and investment services. The Customer Conciliation Office examines the written appeals addressed to it not pending at other bodies of appeal. An appeal must be lodged within three months of the customer receiving a written decision.

9.2 FINE – The Finnish Financial Ombudsman Bureau

If the policyholder or the claimant is not satisfied with the insurer's decision, they can seek advice and assistance from FINE – The Finnish Financial Ombudsman Bureau. FINE is a neutral body tasked with providing advice to consumers, small entrepreneurs and comparable customers about insurance and claims. Furthermore, FINE and the Insurance Complaints Board also issue dispute settlement recommendations in disputes that concern the interpretation and application of the law and the terms and conditions of insurance in an insurance relationship.

These advisory services and dispute settlement recommendations are free of charge.

9.3 District court (section 74 of the Insurance Contracts Act)

If the policyholder or the claimant is not satisfied with the insurer's decision, they can bring legal action against the insurer. An action can be brought either at the district court of the domicile in Finland of the party concerned, at the district court of the insurer's domicile or at the district court of the locality where the damage occurred, subject to the international conventions binding on Finland.

An action for a decision that the insurer has made must be brought within three years of the day on which the party concerned is informed in writing of the insurer's decision and this deadline. After the expiry of the time limit, the right to bring an action is extinguished. Board examinations will interrupt the lapsing of the time limit for the right to bring an action.

10 Insurer's right of subrogation

The insured's right to be compensated by the third party person liable for the damage for expenses and loss of assets arising from illness or accident will transfer to the insurer up to the compensation amount it pays.

If damage is caused by a third party person in the capacity of private individual, worker, public official or another person comparable to them under chapter 3, section 1 of the Tort Liability Act, this will afford the insurer a right of subrogation against that person only if he or she has caused the damage intentionally or through gross negligence or if that person is liable to provide compensation regardless of negligence.

11 Changing the contract of insurance

11.1 Changing the contractual terms during the period of insurance

The insurer has the right during the period of insurance to change the premium and the other contractual terms to reflect the true or changed circumstances if:

1. the policyholder or the insured intentionally or through negligence which cannot be considered slight fails to fulfil their duty to provide information as set out in section 2.2 and if the insurer, had true and complete information been given, had granted the insurance only against a higher premium or otherwise on different terms than what was agreed;
2. the policyholder or the insured has acted in bad faith in fulfilling their duty to provide information as set out in section 2.2 and the insurance, regardless of this and owing to reconciliation of the consequences of the failure, according to section 2.3 binds the insurer; or
3. during the period of insurance, any change referred to in section 5.3 has taken place in the factors that the policyholder or the insured notified to the insurer when concluding the contract and the insurer had granted the insurance only against a higher premium or otherwise on different terms had the insured-related factor corresponded to the change already when the insurance was granted.

Having become aware of any factor referred to above, the insurer will without undue delay send to the policyholder a notice concerning the changing of the premium or the terms. This notice will make a mention that the policyholder has the right to cancel the insurance.

11.2 Changing the contractual terms upon a new premium period

Upon starting a new premium period, the insurer has the right to change the terms of the policy, the premium and the other terms and conditions of contract. Section 5 of the policy wording describes how indexation impacts contracts of insurance.

The changes will apply from the start of the following premium period. The insurer is required to notify of any changes no later than one month before the start of a new premium period. The insurance will continue in the changed form unless cancelled by the policyholder in writing before the start of the new premium period.

12 Termination of the contract of insurance

12.1 Policyholder's right to cancel the insurance

The policyholder has the right to cancel a continuous policy or an individual cover to terminate at the end of the period of insurance. Written notice of the cancellation must be sent to the insurer no later than one month before the end of the period of insurance.

If the policyholder does not accept a change made to the policy terms, the premium or the other terms and conditions of contract, the policyholder is required to cancel the contract of insurance in writing within one month of receiving notice of the change. Once the contract of insurance has been cancelled, the liability of the insurer will terminate from the day on which the changed policy terms, premium or other terms and conditions of contract would have taken effect.

If cancellation is not made in writing, the cancellation will be void.

A fixed-term policy will terminate on the agreed termination date without cancellation.

12.2 Insurer's right to cancel the insurance during the period of insurance

The insurer has the right to cancel the insurance to end during the period of insurance if:

1. the policyholder or the insured intentionally or through negligence which cannot be considered slight fails to fulfil their duty to provide information as set out in section 2.2 and if the insurer, had true and complete answers been given, had not granted the insurance at all;
2. the policyholder or the insured has acted in bad faith in fulfilling their duty to provide information as set out in section 2.2 and the contract of insurance, regardless of this, according to that section binds the insurer;
3. during the period of insurance, any change referred to in section 5.3 has taken place in the factors that the policyholder or the insured notified to the insurer when concluding the contract and the insurer had not granted the insurance had the insured-related factor corresponded to the change already when the insurance was granted;
4. the insured causes an insured event intentionally;
5. after an insured event, the insured in bad faith gives to the insurer any incorrect or incomplete information that is relevant for assessing the liability of the insurer; or
6. the policyholder is declared bankrupt.

The insurer will cancel the insurance in writing without undue delay after becoming aware of a reason justifying cancellation. The notice of cancellation will set out the reason for cancellation. The insurance will terminate one month after the day on which notice of cancellation is sent. The insurer's right to cancel the insurance due to failure to pay the premium is determined in accordance with section 4.3.

12.3 Insurer's right to cancel the insurance at the end of the premium period

The insurer has the right to cancel the insurance to terminate at the end of the premium period.

If the premium period is shorter than one year in duration or if it has not been agreed, the insurer will correspondingly have the right to cancel the insurance to terminate at the end of the calendar year. Cancellation will be made in writing no later than one month before the end of the premium period.

13 Processing of personal and claim data

LocalTapiola ensures the appropriate protection of the privacy of our customers, and we process all personal data, in line with data protection legislation, insurance legislation, the other applicable provisions, and good data management and data processing practice.

Personal data are processed for the purpose of providing LocalTapiola's products and services and following up customer relations. Data may also be used for purposes such as marketing to customers.

LocalTapiola utilises automated decision-making and profiling in tasks including the making of insurance decisions and claim settlement decisions and the targeting of marketing efforts. Customers are made aware of automated decision-making in the context of every service that utilises it.

Personal data are mainly obtained directly from the customer, from parties authorised by the customer, from public registers maintained by the authorities and from the credit register. Personal data will be disclosed to third parties only with the customer's consent or under a legislative provision.

In the claims register maintained jointly by insurers, LocalTapiola registers data about the claims reported to it, and in this connection checks what claims have been reported to other insurers. The data in the claims register are used in claims handling to combat abuses against insurers. In the fraudulent claims register maintained jointly by insurers, LocalTapiola registers data about the criminal offences and suspected criminal offences committed against the insurance activity it carries on, and will check the data about the customer that have been entered in the register. Data in the fraudulent claims register are used in claims handling and in the insurance process to combat crime against insurers.

The customer's due diligence data and other personal data may be used for investigating, exposing and preventing money laundering and terrorist financing. In addition, data may be disclosed to public authorities for initiating investigations of money laundering and terrorist financing and of criminal offences committed to obtain property or proceeds of crime that are subject to money laundering or terrorist financing.

LocalTapiola saves telephone calls and chat sessions conducted with customers in order to verify the content of transactions and to ensure service quality.

For LocalTapiola's personal data files, we have prepared privacy notices, which describe the personal data processed in the data files and discuss the processing of these data and the data subject's rights. For the privacy notices and to read more about how personal data are processed, please visit the LocalTapiola website at lahitapiola.fi/henkilotietojenkasittely. Privacy notices can also be requested by post, or by email to tietosuoja@lahitapiola.fi.

14 Other provisions

14.1 Partial invalidity of the contract of insurance

If an individual section or subsection of the terms of the contract of insurance is determined to be invalid, the other terms of the contract will remain in force.

14.2 Embargo

Cover is not in force insofar as any embargo or economic blockade imposed under a declaration or a decision by the United Nations (UN), the European Union (EU) or the United States or pursuant to the laws of Finland limits insurance or the validity of cover.

The insurer will not pay any insurance compensation if the payment of compensation were in violation of sanctions of any embargo or economic blockade imposed under a declaration or a decision by the United Nations (UN), the European Union (EU) or the United States or pursuant to the laws of Finland.

In case of any dispute under these terms and conditions the original Finnish wording shall prevail.

Insurance is granted by the following mutual insurance companies in LocalTapiola Group (business ID):

LähiTapiola **Etelä** (0139557-7) | LähiTapiola **Etelä-Pohjanmaa** (0178281-7) | LokalTapiola **Sydkusten** - LähiTapiola **Etelärannikko** (0135987-5) | LähiTapiola **Itä** (2246442-0) | LähiTapiola **Kaakkois-Suomi** (0225907-5) | LähiTapiola **Kainuu-Koillismaa** (0210339-6) | LähiTapiola **Keski-Suomi** (0208463-1) | LähiTapiola **Lappi** (0277001-7) | LähiTapiola **Loimi-Häme** (0134859-4) | LähiTapiola **Länsi-Suomi** (0134099-8) | LähiTapiola **Pirkanmaa** (0205843-3) | LokalTapiola **Österbotten** - LähiTapiola **Pohjanmaa** (0180953-0) | LähiTapiola **Pohjoinen** (2235550-7) | LähiTapiola **Pääkaupunkiseutu** (2647339-1) | LähiTapiola **Savo** (1759597-9) | LähiTapiola **Savo-Karjala** (0218612-8) | LähiTapiola **Uusimaa** (0224469-0) | LähiTapiola **Varsinais-Suomi** (0204067-1) | LähiTapiola **Vellamo** (0282283-3) | LocalTapiola General Mutual Insurance Company (0211034-2)

The companies' contact details are available at www.lahitapiola.fi.

V-EH-02624-en, 0125 Edita

LOCALTAPIOLA