Policy Conditions
General Policy Conditions

Policy Conditions valid from 1 January 2025
Replaces Policy Conditions of 1 January 2024

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This document is a translation of the Norwegian original. In the event of any discrepancies between the translation and the original, or doubt about the interpretation, please refer to the original.

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1. Provisions in connection with establishment of the insurance contract

1.1 Regulation of the insurance relationship – relationship to the legislation

The insurance relationship is regulated by the insurance contract to the extent there is no conflict with mandatory (invariable) legislation. In the case that the insurance contract does not regulate a particular circumstance, the current legislation applicable to the area shall be applied.

The contract of insurance consists of the insurance certificate and the policy conditions. The text of the insurance contract and the insurance certificate takes precedence over the policy conditions. The special policy conditions take precedence over DNB Liv's general policy conditions (Personnel Insurance) in the event of conflict.

1.1.1 Choice of law

The insurance contract is governed by Norwegian law to the extent it does not conflict with the Act of 27 November 1992 on choice of law in insurance, or where other agreement is made.

1.2 Definitions

1.2.1 Policyholder

The party to the insurance contract with DNB Livsforsikring AS.

1.2.2 Insurance Company

The insurance company is the entity into an insurance contract with the policyholder. In this case the entity is DNB Livsforsikring AS, hereafter referred to as the company or DNB Liv.

1.2.3 The Insured

The person covered by the insurance.

1.2.4 Co-insured

Co-insured means the insured's spouse or cohabitant in accordance with the definitions in subsections 1.2.6 (spouse) and 1.2.7 (cohabitant) of the general policy conditions.

1.2.5 Entitled Party

The person who is entitled to compensation or the sum insured.

1.2.6 Provider

This is a person who either has

- a spouse/cohabitant, or
- a child/children under the age of 21 that he/she supports.

The definition of children is set out in section 1.2.9. (children) of the insurance terms and conditions.

1.2.7 Spouse

A person with whom the Insured has contracted a legal marriage.

A person is no longer considered a spouse when judgement or an administrative order has been given for separation or divorce. This applies even if the decision is not legally enforceable or final.

1.2.8 Cohabitant

A cohabitant is understood to be:

1. A person with whom the Insured lives in a relationship similar to marriage, if the National Population Register shows that the two have shared the same residence for the last two years.
2. A person who has children of the relationship, regardless of the children's age, and a common residence with the Insured.

A person is nevertheless not deemed to be a cohabitant if at the date of the occurrence of the insured event there were circumstances constituting an impediment to lawful marriage. Cohabitation is deemed to cease at the expiry of the day the above-mentioned requirements are no longer fulfilled.

1.2.9 Children

Children mean:

1. The Insured's own (biological) children and adopted children under the age of 21.
2. Children of the insured's spouse/cohabitant from a previous relationship who are registered in the national register as living at the same address as the insured. For this to apply, the definition of cohabitant in section 1.2.8. herein must be met.

1.2.10 Sole provider

A person who has sole parental responsibility for the child or children, because the other parent is deceased.

1.2.11 Insurance contract

The contract between the policyholder and the Company containing mutual rights and obligations as provided for under the established insurance.

1.2.12 Insurance certificate

Confirmation of the insurance contract formed by the parties, which specifies in more detail the cover under the insurance contract and any exclusions from the insurance cover.

1.2.13 Period of insurance

The period of insurance is the period of time that the policyholder is covered under the agreed Personnel Insurance.

1.2.14 Sum insured

This is the amount agreed for the chosen insurance cover, which forms the basis for calculation of compensation. The sum insured is shown in the insurance certificate.

1.2.15 Settlement date

The settlement date is the date on which all the conditions for payment have been fulfilled.

1.2.16 Insured event

An insured event is the circumstance that gives rise to entitlement to claim the sum insured or compensation. When an insured event is deemed to have taken place is regulated in more detail by special policy conditions for the individual types of cover included in the insurance contract.

1.2.17 Beneficiary

The policyholder/Insured may appoint one or more persons and/or legal persons who as beneficiaries will be entitled to receive all or part of the sum insured, when it becomes payable.

1.2.18 Basic amount (G) under the national insurance scheme

The basic amount (G) for calculation of pensions under the Norwegian national insurance scheme. The basic amount is determined annually by Stortinget (Norwegian parliament) pursuant to Section 1–4, second paragraph of the National Insurance Act.

1.2.19 Medical disability

Medical disability or disability by medical standards is understood to mean a permanent and significant injury/disease/defect of a medical nature.

1.2.20 Compensation for permanent injury

Compensation for permanent injury is paid of permanent medical disability.

1.2.21 Disability/incapacity for work
Disability is understood to mean a permanent reduction in the Insured's capacity to engage in gainful employment in general.

1.2.22 Fitness for work
Fitness for work means the capacity of the Insured to be gainfully employed in a full-time position equivalent to 100 %. The Insured's fitness for work must be confirmed through a statement of fitness for work from the employer. The requirement for fitness for work as a condition for admission to the insurance scheme is described in further detail in the special policy conditions for the insurance in question.

1.2.23 Medical history statement
A personal statement of medical history to be completed by the Insured. The statement forms the basis for the Company's assessment of the health of the Insured.

1.2.24 Self-administered scheme
A type of insurance scheme based on an agreement which does not involve the company keeping a list of members.

1.3 Scope of the insurance
The content of the insurance is specified in the insurance certificate and the insurance contract. The insurance certificate states in further detail who is covered, as well as the age limits for admission to and cessation of the insurance.

1.4 Payment of insurance premium
The insurance premium is payable in advance by the policyholder for all the insured jointly. This applies unless otherwise agreed upon.

The premium falls due when claimed in accordance with the insurance contract. The due date shall be not less than one month from the day when the Company sent the claim for the premium to the policyholder; see Section 14-1 of the Insurance Contracts Act (Forsikringsavtaleloven, "FAL").

1.4.1 Consequences of default on payment
If the insurance premium has not been paid by the expiry of the time limit for payment, the insurance will terminate 14 days after dispatch of the statutory notification; see FAL Section 14-2.
The Company reserves the right to charge a reminder fee and claim interest; see the Debt Collection Act (Inkassoloven) and the Act relating to Interest on Overdue Payments etc. (Lov om renter ved forsinket betaling).

1.4.2 Calculation of premium
The insurance premium is determined upon the establishment of the insurance contract, and thereafter once annually, when the insurance is renewed. See however Section 2 concerning amendment/variation.

1.4.3 Reimbursement
If the policyholder has paid too much premium, the overpayment will be offset when the next payment falls due.

1.5 When the insurance enters into force
Unless otherwise agreed upon, the insurance enters into force when the insurance contract has been formed. The Company is not liable in respect of insured events which occur before the insurance contract is in force.

Fitness for work
Where the Company requires full (100 %) fitness for work as a condition for entry into force of the insurance, any employee who is not 100 % fit for work at the date of admittance to the scheme can be insured from the date the employee is fully fit for work once more.

Medical history statement
Where the Company requires a full medical history statement, an approved medical history statement will be a condition for the insurance to enter into force for the individual member. If the date on which the insurance contract enters into force does not correspond with the date on which it enters into force for the individual member, the Company will be liable in respect of insured events that occur in this period, provided there are no circumstances relating to the health of the member at the time that the insurance contract entered into force which would have been revealed during the Company's investigations and would have led to refusal.

Admission of new members
Upon admission of new members, the insurance enters into force according to the same rules as in Section 1.5 regarding full fitness for work and medical history statement.

Co-insured
Where there is a co-insured spouse/cohabitant, the insurance enters into force from the same date as for the employee.

Increase in sum insured or extension of cover
In the event the contract is amended, for example if the sum insured is increased or the cover is extended, the rules described under Section 1.5 concerning full fitness for work and medical history statement apply similarly.

1.5.1 Right to opt out of the scheme
Unless otherwise agreed and stated in the insurance certificate, membership of the insurance scheme is compulsory for those covered by the Personnel Insurance.

Any employee who had the right to opt out as mentioned above may be admitted to the schemes at a later date, provided that a satisfactory statement of fitness for work and/or medical history statement is provided; see Section 1.5.

1.6 Duty of the policyholder and the Insured to provide information about risk
The policyholder and the Insured shall give complete and accurate answers to the questions from the Company. They shall also upon their own initiative give details of specific matters which they must understand to be of material significance to the Company in their evaluation of the risk; see FAL Section 13-1.

In connection with its evaluation of risk, the Company is entitled to obtain information from doctors, hospitals, social security offices, and others if applicable. If the Company so requests, the Insured has a duty to permit himself/herself to be examined by a doctor.

1.6.1 Consequences of failure to disclose information in connection with establishment of the insurance contract
If during the period of cover the Company becomes aware that the duty to give information has been neglected, and the blame attached to the policyholder or the Insured is not merely slight, it may terminate the insurance with 14 days' notice. If the policyholder has acted fraudulently the Company may nevertheless terminate this and any other insurance contracts it may have with the policyholder with immediate effect; see FAL Section 13-3, first paragraph.

2 Provisions in connection with amendment and/or renewal of the insurance contract

2.1 Change in risk

The insurance premium is determined on the basis of the risks that the group represents collectively in relation to the type of business or industry to which the enterprise belongs and the type of work done by the Insured. In the event any of these circumstances changes, the Company shall be notified. The Company shall also be notified if the Insured travels to or stays in any area where there are acts of war or political disturbances resembling war. The Company will then determine whether the risk can be covered and at what premium, if relevant.

Self-administered scheme (Insurance without list of members)

Where the insured company is required to send yearly membership data, changes of 10 % or more during the period of insurance must be reported immediately such that the insurance may be amended accordingly.

This does not apply if otherwise agreed upon and stated in the insurance contract.

Contracts that DNB Liv manages (Insurance with list of members)

The policyholder must notify DNB Liv on an ongoing basis when an employee leaves or a new employee begins in the enterprise, as well as in the case of a change in work/occupation or group affiliation.

2.2 Change in premium schedule

The Company may amend the premium schedule at the annual renewal of the insurance contract.

2.3 Renewal of the insurance contract

The insurance contract is renewed automatically for one year at the end of the insurance period, unless the policyholder or the Company gives notice that the insurance shall not be renewed pursuant to the regulations in FAL Sections 12-8 and 12-9.

2.4 Reservation of right to vary the insurance contract

The Company may change policy conditions, premiums, and other terms, cf. FAL Section 19-8, correspondingly Section 9-7 for the statutory Workers' Compensation Insurance. If the variation will be to the detriment of the policyholder and/or the Insured, the Company shall notify them in writing. Such changes will enter into force one month after notice of the variation is sent. The same applies if the policyholder is made aware of the changes in some other appropriate manner.

For the parties to the contract, variation in connection with renewal will comply with the rules for establishment of insurance contracts.

3 Withdrawal, cessation and notice

3.1 Withdrawal

The policyholder is not entitled to withdraw the Insured from the group scheme as long as the Insured belongs to the group or groups of employees covered by the scheme. This applies unless otherwise agreed upon and stated in the insurance contract.

If the Insured withdraws from the group because he/she leaves the policyholder's employment or for some other reason, it is the policyholder's duty to withdraw the Insured from the scheme.

3.1.1 Temporary absence due to sickness or accident

Temporary absence due to incapacity for work as a result of sickness or accident is not considered to be grounds for withdrawal (disenrollment).

3.1.2 Temporary absence due to leave of absence

Unless otherwise agreed between the policyholder and the Insured, the Personnel Insurance will remain in force for the Insured during statutory leave. This applies to both paid and unpaid leave. For non-statutory leave, the Insured may be covered by the insurance for a maximum of 12 months or for an agreed shorter period.

3.1.3 Temporary lay-offs

Unless otherwise agreed between the policyholder and the Insured, the Personnel Insurance will also remain in force for the Insured if they are temporarily laid off as a result of curtailment of operations etc.

3.1.4 Strike/lockout

A strike/lockout is not considered a reason for withdrawal from the insurance scheme.

For all cases under Sections 3.1–3.1.4, it is assumed that the premium will be paid for as long as the Insured is to be covered by the insurance scheme.

For non-statutory leaves of absence, the policyholder is obliged to cancel the Insured's membership of the insurance scheme with effect from the first day after 12 months have passed from the date the leave started. If it has been agreed that the Insured will be covered by the scheme for a shorter period, the Insured will be withdrawn with effect from the first day after the end of this period.

If it has been agreed that the Insured is not to be a member of the insurance scheme in the event of a temporary lay-off, the Insured must be withdrawn from the insurance scheme from the time it has been agreed that the insurance is to expire.

In cases where the policyholder is required to send information about continuation insurance, this must be done no later than the same date.

3.2 Cessation

When a member of a group insurance scheme in which DNB Liv maintains the list of members (a scheme managed by DNB Liv) withdraws from the group included under the insurance, the insurance for the member (the Insured) concerned shall cease at the earliest 14 days after a written reminder has been sent by the Company or the policyholder.

In an insurance scheme in which DNB Liv does not maintain a list of the members (self-administered scheme), or where reminder as mentioned above is not sent, the insurance shall cease at the earliest two months after the Insured withdrew from the group. If a reminder is sent as specified above, liability will cease after 14 days at the earliest, nevertheless not in such a way that the liability exceeds two months from the time the member in question left the group. In insured events for which the Company is liable under the first and second paragraph, the Company may make a deduction from the compensation to the extent that the member concerned has in the meantime been included under a corresponding insurance scheme and receives compensation from that scheme. Other full or partial termination for a member follows the same rules as mentioned above.

If the policyholder or DNB Liv terminates the insurance relationship, or if DNB Liv's liability ceases to apply owing to failure by the policyholder to pay the premium, written notification shall be sent to the members, or they shall be notified in some other appropriate manner. In such case, the insurance for individual members (Insured) terminates at the earliest one month after notification has been given or the member has otherwise become aware of the situation.
The second paragraph, third sentence, shall apply accordingly. This follows from the rules in FAL Section 19-6.

If the insurance is terminated owing to the policyholder's failure to pay the premium, the policyholder will be charged for the period the insurance was in force.

3.3 Right of continuation

When the Group Life, Other Sickness or Sickness Assessment insurance schemes cease pursuant to the provision in FAL Section 19-6, each of its members (each Insured) is entitled to continue the insurance contract with individual calculation of the premium without providing new details of health; see FAL 19-7.

The member (Insured) must be informed either by written notification or some other appropriate manner of the right to take out continuation of the cover. The member must have exercised this right within six months after the liability of the Company has ceased. If upon transfer or renewal the sum insured and/or cover is less than the insurance had originally, the right of continuation only comprises the reduction in the sum insured and the cover.

3.4 Calculation of premium when the insurance terminates during the insurance period

If the insurance terminates during the insurance period, the policyholder is credited with the premium for the remaining insurance period.

If the insurance terminates as a result of failure to pay the premium, a price will be calculated for the period the insurance has been in force.

3.5 Termination

Unless otherwise agreed in the insurance contract, the policyholder is entitled to cancel or terminate the contract with at least one month's notice if the insurance is no longer required or if there are other special reasons or if the insurance is transferred to another company. In the case of transfer, the notification shall provide information about the company to which the insurance is to be transferred and about the transfer date; see FAL Section 12-3.

Unless otherwise agreed, the Company is entitled to cancel or terminate the contract with at least two months' notice; see FAL Section 12-4. The termination must be effected without undue delay after DNB Liv becoming aware of the circumstance entailing its entitlement to terminate the insurance. Notice of the termination must be given in writing, with grounds stated. In the notice DNB Liv shall provide information about the possibility of requesting the Appeals Board to consider the termination under Section 22-2, or about other alternatives for testing the legality of the termination.

4 Settlement – General

4.1 Duty to report claims – time limit for reporting claims – period of limitation

If an insured event has occurred, the person who believes he/she has a claim against the Company in that connection must report this to the Company without undue delay; see FAL Section 13-11 first paragraph.

If the duty to report a claim has been neglected willfully or grossly, the Company's liability may be reduced or cease to exist; see FAL Section 13-11, second paragraph.

Anybody who is entitled to compensation under an accidental injury or sickness policy will forfeit the right unless the claim has been filed with the Company within one year after the Entitled Party became aware of the circumstances on which the claim is founded; see FAL Section 18-5.

A claim for the sum insured in an endowment assurance under life insurance will be statute-barred by limitation after 10 years, and other claims for compensation or a sum insured after three years. The term commences at the end of the calendar year in which the Insured acquired the necessary knowledge of the circumstances upon which the claim is founded. The claim will nevertheless be statute-barred at the latest 20 years or 10 years, respectively, after the end of the insurance year during which the insured event occurred. When in an accidental injury or sickness insurance policy DNB Liv has sent notification as mentioned in FAL Section 18-5 second paragraph, limitation occurs at the earliest upon expiry of the term stipulated; see FAL Section 18-6 first paragraph.

A claim that is reported to the Company before the limitation period has expired will become statute-barred no earlier than six months after the Insured or his/her survivors have received separate written notification that the Company will invoke the statute of limitations; see FAL Section 18-6 third paragraph.

Please refer to the special policy conditions for further details of the insurances mentioned here.

4.2 Duty of disclosure in reporting injury, sickness or death

Whoever wants to advance a claim against DNB Liv must furnish the Company with the information and documents available to him or her which are required by the Company in order to make a decision on the claim and payment of the sum insured; see FAL Section 18-1, first paragraph.

Anybody who in a claims settlement gives incorrect or incomplete details which he or she knows or must understand may result in compensation being paid to which he or she is not entitled, forfeits any and all claims for compensation against the Company under all insurance contracts in connection with the same event. If the matter is only slightly blameworthy, merely relates to a small part of the claim, or if there are special reasons in other respects, the party concerned may nevertheless receive partial compensation. FAL Section 13-3 applies correspondingly; see FAL Section 18-1, second paragraph.

In instances such as those mentioned in the above paragraph, DNB Liv may terminate any and all insurance contracts it has with the party concerned with one week's notice. FAL Section 12-4 third paragraph, first, second and fourth sentences apply correspondingly; see FAL Section 18-1, third paragraph.

With the consent of the Insured, the Company has the right to obtain statements from doctors or medical specialists. The specialist statement must be written by an independent specialist in the relevant field. If the Insured and the Company do not agree on the choice of specialist, a specialist in the field who is employed by a Norwegian public hospital is to be chosen.

In the event of the death of the Insured, a claim shall be submitted to the Company accompanied by the death certificate stating the cause of death, a certificate of probate or certificate of undivided possession of the estate by the surviving spouse, and a birth certificate for any surviving children.

4.3 Full or partial limitation of the Company's liability

4.3.1 Consequences of fraudulent misrepresentation

If the policyholder or the Insured has been fraudulently negligent of the duty of disclosure under FAL Section 13-1 , and an insured event has occurred, the Company is without liability; see FAL Section 13-2, first paragraph.

If the policyholder or the Insured have otherwise been negligent of the duty of disclosure, and the consequent blame attached to them is not merely slight, the Company's liability may be reduced or cease to exist; see FAL Section 13-2 second paragraph.

If during the period of cover DNB Liv becomes aware that the duty of disclosure has been neglected, and the blame attached to the policyholder or the Insured is not merely slight, DNB Liv may terminate the insurance with 14 days' notice. The provisions in FAL Section 12-4 third paragraph apply correspondingly. If the policyholder has acted fraudulently DNB Liv may nevertheless terminate any insurance contract it has with the policyholder with immediate effect; see FAL Section 13-3 first paragraph.

4.3.2 Consequences of contributory negligence

If the Insured has intentionally brought about the insured event, the Company is not liable.

The Company is, nevertheless, liable if owing to age or mental state the Insured was incapable of understanding the implications of his or her actions; see FAL Section 13-8 first paragraph.

If the Insured by being grossly negligent has brought about the insured event or increased the extent of the loss, the liability of the Company may be reduced or cease to exist; see FAL Section 13-9 first paragraph and the Act relating to workers' compensation insurance of 16 June1989 No 65 (Lov om yrkesskadeforsikring, available in Norwegian only), Section 14.

DNB Liv cannot invoke the rules of the paragraph above if, for reasons of age or mental state, the Insured was incapable of understanding the implications of his or her actions; see FAL Section 13-9 second paragraph.

4.4 Limitation of liability in acts of terrorism

An act of terrorism is understood to be an unlawful, harmful act directed at the public, including acts of violence or dangerous spread of biological or chemical substances, and which appears to be carried out for the purpose of influencing political, religious or other ideological bodies or to cause fear.

The Company's total liability in damages in respect of all customers is limited to NOK 1 billion per loss event, that is to say all losses within a period of 48 hours. The coverage is furthermore limited to NOK 1 billion in total for all customers per calendar year. If the set limit per loss per annum is exceeded, the compensation will be reduced proportionately.

The Company is not liable for losses resulting from the spread or use of chemical substances, nuclear weapons or weapons of mass destruction unless specifically noted in the insurance agreement.

This limitation of liability does not apply in the event of bodily injury that falls under the Act relating to workers' compensation insurance (Lov om yrkesskadeforsikring)

4.5 Principles for establishing permanent medical disability

The degree of permanent medical disability is determined on the basis of the disability tables drawn up in the current Regulations of 21 April 1997, parts II and III. In addition, the associated guidance for use of the disability tables applies.

The degree of medical disability is determined on an objective basis without taking into account the Insured's occupation, reduced ability to engage in income-generating work (degree of disability) and the like.

In cases of medical disability which is not included in the tables, the degree of disability will be determined discretionally. The percentage rates provided in the tables will in that case serve as guidance.

In the event of partial loss of body part(s) or partial loss of function, a correspondingly lower percentage rate will be determined. If the functional ability of the injured body part was already reduced prior to the occurrence of the injury, this will be deducted when the degree of medical disability is established.

The total degree of permanent medical disability caused by one or more injury or sickness can never exceed 100 per cent. If an injury or sickness results in more injury or sickness for the same person, the degree of permanent medical disability is determined on the basis of an overall assessment (called the reduction method).

4.6 Interest

In respect of the Company's duty to pay interest on claims under Occupational Injury/Occupational Disease, the provisions of the Regulation on standardized compensation provided pursuant to Section 13 of the Act relating to workers' compensation insurance (Lov om yrkesskadeforsikring) apply. In respect of the Company's duty to pay interest otherwise, the Insurance Contracts Act (FAL), Section 18-4 applies.

Interest may not be claimed for time lost as a result of the claimant(s) failing to furnish the Company with information necessary to decide the claim for compensation. The same applies if the claimant(s) unlawfully reject full or partial settlement; see FAL, Section 18-4. Otherwise the Act relating to Interest on Overdue Payments, etc. (Lov om renter ved forsinket betaling m.m.) of 17 December 1976, No. 100 applies to the extent appropriate.

4.6.1 Currency

Premiums and compensation following from the contract are calculated in Norwegian kroner (NOK) unless otherwise agreed.

4.7 Right of recourse

The Company has a right of recourse ("regress") against the person causing the loss or against a third party for compensation paid; see the Act relating to compensation in certain circumstances, Section 3-7 and the Act relating to workers' compensation insurance (Lov om yrkesskadeforsikring), Section 8.

4.8 Coordination of compensation

With social security benefits:
When paying compensation for extra expenses incurred and when calculating compensation for future extra expenses, loss of income and compensation to others than spouse/cohabitant or children, deduction will be made on a krone for krone basis for the social security benefits under the Norwegian national insurance scheme to which the Insured is entitled as a result of the injury or sickness. If the Insured was not a member of the national insurance scheme, deduction will be made from the compensation for the benefits the person concerned would have been entitled to.

With the Automobile Liability Act:
Compensation which can be claimed under the Automobile Liability Act (Bilansvarsloven) will be deducted on a krone for krone basis from the settlement of claim.

With other compensation:
Compensation which can be claimed under other laws relating to compensation will be deducted from the settlement of claim.

4.9 Reopening

Case reopening takes place in accordance with Section 36 of the Act relating to the Conclusion of Agreements, etc. (Avtaleloven) and with judicial precedent in effect. In cases where the legislator has decided that the right to reopen a case shall be extended in relation to the above-mentioned provision, this will be stated in the separate policy conditions.

5 Other provisions regulating the insurance contract

5.1 Assignment, pledge and beneficiaries

As long as the Insured's claim against the insurance company has not become payable, the Insured is not entitled to assign his or her right; see FAL, Section 19-13; the equivalent also applies to pledging such right as collateral. Unless otherwise agreed and stated in the insurance contract, the Insured may appoint one or more persons who as beneficiaries will be entitled to receive the sum insured, or part of it, when it becomes payable; see FAL Section 15-2.

5.2 Cancellation rights

This product does not include any cancellation rights.

5.3 Disputes and appeals

Contact one of our customer advisers at our customer service centre on (+47) 915 04800 or send a written complaint to DNB Livsforsikring. You can find information about DNB Livsforsikring's handling of complaints on DNB's joint website for complaints on dnb.no. Here you can also submit a written complaint by logging in to DNB's online bank. In the event of a dispute between the parties in an insurance relationship, either party may, under Section 22-2 of the Insurance Contracts Act, bring the case before the Norwegian Financial Services Complaints Board. This can be done by submitting a complaint on www.finkn.no, or by contacting Finansklagenemda (the Norwegian Financial Services Complaints Board) using the following address: Postboks 53 Skøyen, 0212 Oslo, or phone number: (+47) 23 13 19 60.

You also have the opportunity to complain to other supervisory authorities under section 22-3 of the Insurance Contracts Act, such as the Norwegian Consumer Authority and the Norwegian Data Protection Authority.

5.3.1 Legal venue in the case of disputes

Disputes arising from the insurance contract will be decided by the Norwegian courts, unless this conflicts with mandatory rules in the relevant legislation, or other agreement is made.

The ordinary venue for a Norwegian court of law is determined in accordance with the provisions of the Dispute Act (Tvisteloven) in Section 4-4.

5.4 Central register of losses/claims (FOSS)

All losses that are reported to an insurance company are registered in the insurance companies' central register of losses/claims (Forsikringsselskapenes sentrale skaderegister, FOSS).

When an insurance company reports a claim or loss to the register, the company automatically receives a list of all claims that have previously been reported for the same customer, including claims in other insurance companies. The information is not available to parties other than the insurance companies and can be retrieved only in connection with the registration of a claim or loss.

Registered claims are deleted after 10 years. As the Insured, you have the right to access to the personal data that has been registered about you. You can gain access to your personal data in FOSS by contacting Finance Norway's insurance committee (Finans Norge Forsikringsdrift, FNF). Sensitive personal data and national identity numbers must never be sent by unsecured email. Therefor, the FNF only handles cases concerning right of access by letter or via the digital mailbox Digipost.

Send a request for access to:
Finans Norge Forsikringsdrift
PO Box 2473 Solli
0202 Oslo

5.5 Communication

DNB Liv will use electronic communication in the portal or send documents by post/email to the company. DNB Liv will also communicate electronically with the individual company employee, unless the recipient opts out of receiving electronic communication. A prerequisite for this is that the employee establishes or has established a user agreement on dnb.no. The employee can opt out of receiving electronic communication by contacting us. All letters and other communication that have been adapted for email will be sent to the employee's mailbox on dnb.no. By logging in to dnb.no, the employee accepts that messages are considered to have reached the recipient when they are made available in the mailbox on dnb.no. The customer is responsible for ensuring that DNB Liv always has access to the customer's current email address/telephone number. If the employee opts out of electronic communication, this will have the following effects:

- For employees who have chosen this option, documents will be sent by post.
- Messages to and from DNB Liv are considered to have reached the recipient in accordance with the Insurance Contracts Act and associated contractual rules.

The customer is obliged to familiarize himself/herself with the terms of the insurance and the information received from DNB Liv. If, without reasonable cause, the customer fails to comply with our request to familiarize himself/herself with the information that he or she receives, DNB Liv is not responsible for the customer's lack of knowledge about something he or she would have had knowledge of if the request had been followed.

5.6 Conflicts of interest

In DNB Liv, we are required by the Group's guidelines and legal requirements to identify conflicts of interest and organize our business operations in such way that the risk of conflicts of interest between us and our customers, or between our customers, is reduced to a minimum, and that there is little risk of us providing customers service that is in breach of the requirements for good business practice.

5.7 Data protection in DNB Livsforsikring AS

If you want to know how and why we process your personal data and what rights you have in this area, you can read DNB's privacy protection statement https://www.dnb.no/en/about-us/protection-of-personal-privacy.html.