Conditions – occupational

Family360

Healthcare advice and health navigation in case of serious illness

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Contact Dansk Sundhedssikring

You can reach us by phone at +45 70 20 61 11 or via your personal page Mit DSS on our website: ds-sundhed.dk.

1. Contractual basis

These insurance conditions are valid from 1 January 2026.

The insurance has been taken out with Forsikringsselskabet Dansk Sundhedssikring A/S, CVR no. 34739307 – in the following referred to as "Dansk Sundhedssikring".

The overall insurance contract with Dansk Sundhedssikring A/S comprises the insurance contract (the policy), any supplements to the insurance contract and the insurance conditions attached to the insurance contract. The insurance is also subject to Danish legislation, including the Danish Insurance Contracts Act, the Danish Insurance Business Act and the Danish Financial Business Act.

The insurance contract applies between Forsikringsselskabet Dansk Sundhedssikring A/S and the company, association or organisation listed as the policyholder in the policy.

The insurance conditions supplement the contract. Special provisions and any deviations from these insurance conditions must be stated in the insurance contract.

The policyholder is obliged to inform its employees/members about what the policy covers, which is stated in the insurance contract with any supplements.

ESG (Environmental, Social and Governance)
Dansk Sundhedssikring takes significant responsibility to ensure that we comply with the requirements set out in the UN Global Compact and uphold our social responsibility in relation to the environment and climate, social matters and corporate conduct (read more about this on our website).

Definitions used in the insurance conditions:

Insurance company
Forsikringsselskabet Dansk Sundhedssikring A/S, referred to as "Dansk Sundhedssikring", "we" or "us" in the conditions.

Period of insurance
The period of insurance is the period from when the insurance takes effect until it ends, for whatever reason.

Policyholder
The person or company with whom we have entered into the insurance contract.

Insured
The person who is covered by the insurance, in the following often referred to as "you" or "your".

Dementia
Dementia is an umbrella term for a range of conditions characterised by persistent impairment of mental functions, such as Alzheimer's.

Serious accident
In these conditions, a serious accident is defined as a sudden event that causes personal injury. The event must be sudden, unexpected and accidental.

1.1 When does the insurance apply?

The insurance applies in the period of insurance. The insurance takes effect at the time agreed between the policyholder and Dansk Sundhedssikring.

The waiting period begins when the insurance comes into force, cf. section 2.2 "Waiting period provisions".

1.2 What does the insurance cover?

The insurance covers healthcare advice and health navigation in relation to serious or critical illness and accident, as described in these conditions, and where the patient has been referred for examination and treatment at a public Danish hospital.

The insurance only covers the diseases/disorders defined in more detail in the conditions in section 5.2.

2. Who is covered by the insurance?

The insurance can be taken out by companies registered with a CVR no. in Denmark, and the companies must be located in Denmark.

The insurance covers the employees who are enrolled and named in the insurance contract, and their families who are registered on the policy.

The insurance can be taken out for employees or a group of employees as a mandatory or voluntary scheme. There is no upper age limit for employees.

The policy covers the following persons:

- You
- Your spouse/partner
- Your/your spouse's/partner's biological children, adopted children or children for whom you or your spouse/partner is the legal parent, regardless of whether they are officially registered at your address or not.

If purchased, your biological parents, adoptive parents, stepparents or legal parents, regardless of age, and your spouse's/partner's biological parents, adoptive parents, stepparents or legal parents, regardless of age, are also covered. A maximum of four parent persons can be registered at a time.

The insured persons must be registered on the policy to be covered. The insured persons can be registered via the personal page on our website.

The insurance ends when it is cancelled by either party or upon the death of the policyholder.

The insured and any co-insured persons must have a permanent registered address in Denmark (excluding Greenland and the Faroe Islands), have a Danish health card and be entitled to receive Danish public healthcare services in hospitals.

Employees posted abroad and any co-insured persons who are posted together with the insured are only covered if examination and treatment are carried out at a public hospital in Denmark.

Transport costs to and from Denmark are not covered.

2.1 Enrolling and disenrolling employees

The company must always keep us informed of which employees should be enrolled in or disenrolled from the insurance plan.

Enrolment and disenrollment can only take place during the current annual period and a maximum of three months back in time. Adjustment in connection with the annual renewal, which triggers a new invoice, may be subject to an administration fee.

The company pays for claims payments that Dansk Sundhedssikring has made for employees who have been disenrolled back in time.

2.2 Waiting period provisions

There is a six-month waiting period for existing diseases, injuries and disorders. This means that you must have been covered by this insurance for six months before the insurance can cover a disease/disorder that occurred and/or was diagnosed before the insurance took effect. Therefore, it is important that the insureds are registered on the policy. Diseases/disorders that occur after the insurance has entered into force is covered based on the applicable insurance conditions.

3. Where does the insurance cover?

The insurance covers healthcare advice and health navigation (described in more detail in section 5) concerning serious accident and the 20 diseases/disorders mentioned in the insurance conditions, and where assessment, examination and treatment take place in a public hospital in Denmark, or where, as part of the assessment and treatment, the public hospital has referred or re-referred to a hospital with which the region has an agreement.

Examinations and treatment carried out in Greenland or the Faroe Islands are never covered. This also applies if you have an officially registered address in Denmark but are staying in Greenland or the Faroe Islands.

4. Use of the insurance

The full conditions apply, but more detailed rules and exceptions are described in the following sections, which is why we recommend that you read the full conditions before using the insurance.

The insurance covers healthcare advice and health navigation for up to 24 months per disease/disorder mentioned in section 5.2. Only these diseases/disorders are covered by this insurance.

Sequelae arising in relation to the disease/disorder covered, or in relation to its treatment, are covered within the same period. The period of cover is reckoned from the day we have received and approved your claim.

The insurance does not cover relapses of the same disorder/disease or sequelae thereof outside the cover period of 24 months.

4.1 Referral to a public hospital

To use the insurance, you must have been referred to a public hospital in Denmark for assessment, examination or treatment or to a public treatment package for one of the diseases/disorders covered by the insurance. We need a copy of your doctor's referral before the insurance assistance can begin.

4.2 Claims must be approved

We must always approve your claim before the insurance assistance can begin. To assess this, we need a copy of the referral. If your claim fulfils the conditions, you will be contacted in order to establish an initial interview with you and possibly your relatives. During the interview, we will together identify your need for help.

4.3 Ongoing and planned examination/treatment

If you file a claim at a time when you have started a course of treatment or already have an ongoing course of treatment in a public hospital for one of the covered diseases/disorders, the period of cover of up to 24 months will start when we have received and approved your claim. We may ask you to send us medical records and other documents from your hospital treatment so that we can help you in the best possible way.

4.4 Assistance in case of emergency hospitalisation and emergency treatment

The insurance covers healthcare advice and health navigation during our opening hours on weekdays.

If you are acutely hospitalised during your period of cover and need healthcare advice, you or your relatives can contact us on the next working day. Alternatively, you can write to us via your claim and we will call you on the next working day.

If you need urgent assistance or emergency treatment, you or your relatives should contact your GP, the emergency medical service, the emergency hotline, the accident and emergency unit or 112.

4.5 Healthcare advice and health navigation while abroad

The insurance only covers healthcare advice, health navigation and medical advice regarding your public hospital treatment in Denmark. The insurance does not cover healthcare advice, health navigation or medical advice if you are abroad during your course of treatment or are undergoing treatment and/or recreation abroad, to which the Danish healthcare system has referred you.

4.6 Extension of the period of cover in case of no-show and cancellation of hospital appointments

If you choose not to attend an examination or treatment and this contributes to prolonging your overall hospital treatment, the period of cover will not be extended accordingly.

If the hospital cancels your treatment without a medical/health professional reason and this contributes to significantly prolonging your referral process at the hospital, a reasonable extension of the period of cover is possible via the insurance.

If the hospital cancels or postpones your examination or treatment for medical/health professional reasons, and this causes your referral process to be significantly extended, we will assess whether this should give rise to a reasonable extension of the period of cover via the insurance.

The period of cover can be extended by a maximum of four months. The assessment of an extension will be based on a medical assessment of what is deemed to be expected in relation to the disease/disorder. The extension must be assessed and approved by us.

4.7 Experimental treatment or treatment performed as part of a research project

The insurance does not cover advice on experimental examination and treatment, examination/treatment that has not been finally approved by the Danish health authorities, or examination/treatment performed as part of a research project.

4.8 Reporting a claim

Claims must always be reported during the period of insurance and as soon as possible. The claim can be reported by telephone on weekdays. Claims can also be reported online via our website.

Reported claims are processed quickly and in most cases overnight.

5. What does the insurance cover?

The insurance covers healthcare advice and health navigation. Our counselling team consists of experienced nurses, doctors, physiotherapists, social workers, psychologists and other healthcare professionals. All have many years of experience from different specialities and offer professional advice and navigation in the Danish healthcare system.

5.1 Your contact nurse

Once your claim has been approved, you will be assigned a healthcare advisor, a primary contact nurse, who will be with you and your family throughout your public hospital treatment.

Every effort will be made to ensure that your contact nurse is the same throughout the process. In case of temporary or permanent absence (e.g. illness or maternity leave), we ensure a handover to a new contact nurse.

Your contact nurse will support you and your family by, for example:

- Helping you liaise with the hospital regarding follow-up when you are called in, including ensuring compliance with applicable assessment/treatment guarantees.
- Preparing you for your meeting with the hospital, examinations and further treatment.
- Participating in medical consultations via digital platforms or by phone and act as your professionally competent and independent counsellor.
- Helping you review your medical records and examination results from the hospital.
- Providing medical advice from the insurance's own medical consultants, including whether the planned examinations are adequate, relevant and expected in relation to your disease or condition.
- Providing clinical advice, including medication counselling.
- Booking appointments for treatment or examination, to the extent permitted by the public hospital system.
- Helping you book transport or other assistance if you need it.
- Making care calls for you.
- Helping you liaise with your pension company, accident insurance company and the like.
- Contacting local authorities if needed.
- Assisting you in the transition between hospitalisation and discharge.
- Providing social counselling.
- Providing psychological counselling for serious illness, grief/crisis.
- Providing end-of-life counselling.

Your process begins with a consultation where we together identify your need for help. You will also need to give us your permission to contact the relevant authorities on your behalf so that we can assist you during your hospital treatment.

We will be in regular contact with you – and also your relatives, if you wish.

We always end your hospital treatment with a consultation with you and your relatives, where you are helped and guided in the right direction.

5.2 Diseases/disorders covered by the insurance

The insurance covers the following 20 diseases/disorders:

- Cancer diseases that fall under the public healthcare system's "treatment packages" – the cancer treatment packages ensure uniform assessment and treatment, specially organised for selected types of cancer.
- Alzheimer's/dementia – progressive brain disease that affects memory and the ability to function.
- Cerebral haemorrhage – bleeding in the brain.
- Blood clot.
- Aneurysm – a bulge in an artery.
- Heart failure.
- Coronary artery narrowing requiring bypass or PCI (percutaneous coronary intervention).
- AMI (acute myocardial infarction) – blood clot in the heart.
- Sclerosis – neurological disorder that attacks the brain and spinal cord.
- Heart rhythm disorder requiring an implantable cardioverter-defibrillator (ICD).
- Renal failure – condition in which the kidney function is significantly reduced or has ceased.
- Muscular dystrophy – incurable muscle disease where muscle tissue is gradually replaced by connective tissue.
- HIV/AIDS – virus that breaks down the immune system.
- ALS – incurable disease that affects the brain and spinal cord.
- Pulmonary embolism – blood clot in the lungs.
- Parkinson's disease – disease that gradually destroys nerve cells in the brain.
- Total blindness/deafness – loss of sight/hearing.
- Type 1 diabetes – type 1, insulin-dependent diabetes.
- Post-concussion syndrome – long-term sequelae of more than 24 months' duration after a concussion.
- Whiplash syndrome – chronic whiplash.

Serious accident
The insurance also includes healthcare advice, health navigation and a contact nurse for the family in the event of a serious accident.

5.3 Sequelae, side effects and relapses

Sequelae arising in relation to the basic disease/disorder eligible for cover, or in relation to its treatment, are covered within the same period of cover of 24 months from the approval of the basic disease/disorder and cover includes healthcare advice and health navigation. The period of cover is reckoned from the day we receive and approve your claim.

There is no cover for relapses of the same disorder/disease or sequelae thereof outside the cover period of up to 24 months per disease/disorder.

5.4 Membership of a patient association

If you have been or are diagnosed with one of the 20 conditions covered by the insurance, the insurance will cover the cost of membership of a relevant patient organisation for up to 12 months. However, there is a maximum of a certain reasonable amount determined and continuously regulated by Dansk Sundhedssikring based on the current rates for patient organisations in Denmark and the general price development for these. The amount will appear from the payment guarantee we issue. Your 12-month membership of a patient organisation has no influence on your course of treatment via the insurance.

5.5 Counselling on the possibility of a second opinion

We will advise and guide you on the possibility of being recommended for a second opinion in a public hospital if there is a medical reason for this.

We may also offer you the possibility of having our doctors review all relevant medical records and examination descriptions to advise you on whether the examination that has been carried out is deemed sufficient, relevant and expected in relation to your disease or disorder.

5.6 DementiaNavigator – early detection and screening for dementia (additional cover)

The additional cover is subject to the full insurance conditions, but also to the more detailed rules and exclusions stated in the supplement.

Based on a professional assessment, the supplement covers access to rapid tests and screening, monitoring, prevention, healthcare advice and health navigation if you are at risk of developing dementia and have self-perceived symptoms of dementia.

The supplement does not provide access to rapid tests and screening if your GP has referred you for dementia assessment in the public healthcare system. Here we offer healthcare advice and health navigation based on the provisions in section 5.1 “Health navigator and healthcare advice”.

The insurance does not cover in cases where a diagnosis of dementia has been made.

The detailed provisions for the “DementiaNavigator” are stated in supplement 1 “DementiaNavigator – early detection and screening for dementia”, which you can find on our website.

6. Communication between you and your contact nurse

Communication with your contact nurse will primarily be by telephone and email correspondence via your profile on our website.

For medical consultations that take place at the hospital, your contact nurse can participate via digital platforms or on speakerphone. It is also possible for you and your family to talk to your contact nurse before the medical consultation so that you are as prepared as possible for the consultation with the doctor.

On a case-by-case basis, you and your contact nurse will arrange when the next contact takes place. You can always write to your contact nurse, who will get back to you as soon as possible.

You can also call our healthcare team during opening hours on weekdays or request a call by writing to the healthcare team.

It is important that we have the right contact details about you and the relatives you want to be informed about your programme.

6.1 Consent and power of attorney

In order to assist you in the best possible way during your hospital treatment, we may need to ask you to complete a consent form so that we have your permission to provide your relatives, or other persons named by you, with information about your hospital treatment and your insurance assistance. Consent must always be authorised by you.

You may also need to give us a power of attorney to contact the hospital on your behalf if we need to coordinate examinations, attend medical consultations or contact local authorities, patient associations or similar. We will inform you if there is a need for this.

A power of attorney must always be signed by you before it is valid.

7. What the insurance does not cover

In addition to what is mentioned in the insurance conditions, including the provisions of the individual covers, the insurance does not cover expenses for:

- Diseases/disorders not mentioned in section 5.2. If a diagnosis is made of a condition that is not covered by this insurance, a final counselling session will be offered to determine whether the claim should be reported to another insurance or whether advice should be given about another authority or treatment intervention.
- Pre-existing conditions that occurred before the insurance came into force. These will not be eligible for cover until six months after the insurance has been taken out.
- Examination, treatment, transport, aids, home help, rehabilitation, prescriptions and medication and what we consider to be equivalent to these.
- Examination and treatment at a private hospital or a specialist medical clinic outside the public hospital system, whether the clinic is public or private.
- Assessment and treatment that takes place abroad or is carried out by doctors abroad.
- Advice and guidance in relation to treatment that is not medically authorised, experimental treatment, examination and treatment carried out as part of research or a research project or examination and treatment that is not organised by the public hospital system and as part of your hospital treatment.
- Medical interference in the assessment and treatment plan planned by the hospital. We help you review your assessment/treatment plan and assist you in clarifying questions related to it.
- Complications, sequelae, side effects or similar as a result of assessment and treatment in the public healthcare system beyond the 24 months from approval of the claim, cf. section 5.3.
- Recurrence of the same disease/disorder and/or relapse elsewhere in the body of the same disease/disorder beyond the 24 months from the approval of the claim.
- Navigation and healthcare advice in relation to preventive examination/treatment and screenings.
- Injuries/diseases resulting from war or warlike acts and conditions, including civil war, civil unrest, rebellion, revolution, terrorism, bacteriological and chemical attacks, nuclear reactions, atomic energy, radioactive forces, radiation from radioactive fuel and waste and the like.
- Injuries/diseases resulting from general strikes, natural disasters, lack of electricity supply or network connections, epidemics, pandemics, viral infections and related vaccines.
- Injuries/diseases or sequelae from medication or vaccines and their side effects/long-term consequences.

8. General provisions

Communication
We send letters and documents digitally. We use digital platforms such as e-Boks, the insurance company's user portal and mit.dk when we communicate with you about your insurance. We send invoices, notifications, premium increases and similar documents about your insurance via digital platforms. When you receive digital letters and documents, they have the same legal effects as when you receive regular mail. This means that you must open and check what we send to you digitally. If you are exempt from digital mail, e.g. for having e-Boks, you must notify us. We will then send your letters and documents by email or regular mail.

Communication with you in connection with your reported claims takes place either by phone or via the claims function on the insurance company's user portal.

8.1 Duration of the insurance

The duration of the insurance is stated in the insurance contract. The insurance is automatically renewed on the annual renewal date, unless otherwise stated in the insurance contract.

8.2 Payment of the insurance

The insurance is paid for the first time when it comes into effect. Subsequent payments follow the contract. We will send an invoice to the email address provided or via electronic payment collection. In other cases, we will send an invoice to the payment address provided. If the payment address is changed, we must be notified immediately.

Monthly payment
To be able to pay the insurance monthly, it is a requirement that the payment is registered for PBS or other automatic collection.

Timely payment date
The amount is charged with information about the last timely payment date.

Late payment
If the amount in the first invoice is not paid on time, we have the right to terminate the insurance without further notice. If the amount in the subsequent invoices is not paid on time, we will send the first reminder letter. If the amount is not paid within the deadline stated in the reminder letter, the policyholder loses the right to compensation. If the amount in the second reminder letter is not paid on time, we will cancel the insurance.

We charge a fee for each reminder letter we send. The fee can be found on our website.

We also have the right to charge interest on the amount due in accordance with the Danish Interest Act and the right to assign the amount for legal debt recovery.

Fees for services
We have the right to increase existing fees or introduce new fees to fully or partially cover our costs, e.g. in connection with:

- Sending invoices.
- Serving customers and performing other services in connection with policy and claims handling.
- Cancelling the insurance before the expiry of a period of insurance.
- Communicating via a non-digital channel.

We increase an existing fee with one month's notice to the first of a month. We introduce new fees with three months' notice to the first of a month. We notify increases and new fees on our website.

8.3 Premium adjustment and changes to insurance conditions

The price is adjusted once a year, unless otherwise agreed.An annual statement is prepared of the actual number of insureds versus the number paid for. Any difference is credited or debited to the policyholder.

The premium is set once a year on the annual renewal date. Premium adjustments are based on the previous year's claims account as well as the wage index for the private sector published by Statistics Denmark, unless otherwise stated in the contract. If this index ceases to exist or if the basis for its calculation changes, we are entitled to use a similar index from Statistics Denmark.

Premium adjustments may occur in addition to indexation and statutory changes.

If the premium is adjusted, you can choose to cancel the contract in writing by giving one month's notice to the expiry of the period, after you have received the notification of the renewal premium.

If the price is based on assumptions that no longer exist, we may adjust the price at the next annual renewal date. If risk accounts are prepared for the insurance, the price will be adjusted according to special rules.

In addition to the index adjustment, we can change the conditions and/or price for already established schemes with one month's notice to the end of a month. The price will be adjusted by a percentage set by Dansk Sundhedssikring.

If you cannot accept the changes, you must terminate the contract in writing within 14 days of receiving the notification of the notified changes. The insurance will then be cancelled on the date of the change. If the contract is not cancelled in writing, the insurance will continue with the changed insurance conditions and/or price.

We regularly assess whether there is a need to amend the insurance conditions. Such amendments may be due to various factors, e.g. changes in legislation, tax and duty regulations, market conditions, product changes, and financial circumstances such as increasing supplier costs (beyond index) or rising claims expenses.

Changes to the insurance conditions that are solely of a clarifying nature and that do not impair the insurance cover, such as linguistic updates and improvements, are not notified.

Price changes as a result of indexation and taxes, etc. imposed by public authorities are not considered changes to the insurance conditions or the price and will not be notified.

8.4 Termination and cessation of the insurance

Insurance policies taken out for one year at a time are automatically renewed from the annual renewal date. Unless otherwise agreed, an annual policy is taken out with an annual statement of debit or credit.

The insurance can be cancelled in writing by the policyholder or Dansk Sundhedssikring with one month's notice to the expiry of the period. If the insurance is not cancelled, it will be renewed for one year at a time. In the event of signs of fraud or attempted fraud, we can cancel the insurance without notice.

The insurance ceases at the end of the month in which your employment ends, if you leave the scheme, if you pass away, or in the event of non-payment of the premium.

The insurance ceases at the end of a month if you no longer have a registered address in Denmark.

In any case, the insurance ceases at the time when the overall agreement between the company and Dansk Sundhedssikring ceases.

In the event of non-payment of the insurance premium, the rules under section 8.2 "Payment of the insurance" will be followed.

Cover on termination of the insurance

When the insurance ends, you lose the right to cover, and no new claims can be filed. Claims that have been reported and authorised during the period of insurance are covered for up to three months after termination of the insurance. Cover requires that we have received all necessary information.

Disease/disorder occurring after the expiry of the insurance or referrals to the hospital dated after the expiry of the insurance are not covered by the insurance and are not covered.

Co-insured

For co-insured family members of a principal insured who are covered under a company scheme, the insurance will continue to the date for which cover has been paid, in cases where the principal insured leaves the scheme, or upon the death of the principal insured.

Continuation of the insurance
If you are no longer covered by the company scheme, you can under our rules apply to continue your insurance on our individual conditions and at our individual price for private individuals. Your request for continuation must be made before or in direct connection with the withdrawal from the previous insurance contract. The insurance will then be continued without a waiting period for existing disorders. If you do not request continuation without delay, there will be a six-month waiting period for existing conditions. Co-insured persons also have the option of applying for continuation of the insurance on our individual conditions and at our individual price for private individuals.

Reimbursement of expenses
Bills for approved membership of a patient organisation must always be submitted no later than three months after the date of payment for you to be eligible for reimbursement.

8.5 Duty of disclosure

You are obliged to provide us with/send us the information we deem necessary to process the case so that we can assess the extent to which the insurance covers. If you move, we must always be notified.

We have the right to ask about your health, and you are obliged to provide us with all relevant information, including permission for us to obtain necessary information from doctors, hospitals and other professionals who have relevant knowledge of your health.

We may obtain the information we deem necessary, including obtaining medical records or other written material about your health. We will only ever collect information with your consent. The information relates to both the period before and after the insurance takes effect.

Membership of Sygeforsikringen "danmark" must always be stated in connection with the filing of a claim, as we are entitled to this subsidy.

When you resign from your position
When reporting a disease/injury or if you request treatment, you are obliged to inform us if you have resigned or are leaving the company.

The insurance covers authorised claims reported during the period of insurance for up to three months from the date you leave the company. Referrals to the hospital must always be dated during the period of insurance.

We may demand reimbursement of patient organisation expenses if you have not stated that you have left the company and have received a payment guarantee to cover one year's membership of a patient organisation.

Double insurance
If there are changes in the risk conditions of the insurance, including double insurance, we must be notified immediately, as we may otherwise limit the cover or refuse to cover the claim altogether.

If you have reported the claim to another insurance company, you must always inform us of this when you report the claim to us. If another insurance company covers the claim, the cover from this insurance will be subsidiary and the other cover must therefore be used first. We will not pay expenses for claims for which full cover has been received from another company.

8.6 Processing of personal data

We treat your personal data confidentially and in accordance with applicable legislation. When you take out an insurance policy with us, we collect a range of information in connection with the registration, reporting of claims and use of our digital platforms, e.g. civil reg. no., telephone number, email address, membership of Sygeforsikringen "danmark", industry, employment, marital status and any health information. This information is used to create and administer the insurance policy for use when filing claims and in the ongoing case processing to ensure the best possible service and as part of sales management, product development, quality assurance, counselling and determination of general user behaviour.

We store the collected data for as long as necessary and in accordance with applicable legislation.

You can always contact us if you want to know what personal data we have registered about you. You have the right to have incorrect information changed.

On our website you can read more about data security and how we process your personal data.

In certain cases, we may disclose your personal data to suppliers with whom we co-operate.

8.7 Processing of health information

There is no requirement to provide health information when you take out insurance with us. However, if you wish to join the scheme after having previously provided a waiver, we may require you to provide necessary health information. By reporting a disease/injury, you accept that we may obtain information about health conditions if we deem it relevant in connection with the reported disease/injury. We can obtain this information from the healthcare system and public authorities, including municipalities, Labour Market Insurance, insurance companies, pension companies and sundhed.dk. The information is always obtained with your written or verbal consent.

Health information is only used in connection with the processing of a reported disease/injury and is always processed in accordance with the Danish Health Act's requirement for confidentiality (section 40 of the Health Act: "A patient is entitled to expect healthcare professionals to observe secrecy about what they learn or suspect about health conditions and other confidential information during the exercise of their profession").

Disclosure of health information is only made in connection with the examination/treatment of the reported disorder/injury in accordance with section 41 of the Health Act on disclosure of health information, etc. in connection with the treatment of patients.

When reporting a claim, the insured or the holder of parental custody for insured persons under the age of 18 accepts that we may obtain information about health conditions if it is relevant in connection with the reported disease/injury.

8.8 Incorrect information

The insurance requires correct information. If you provide incorrect information or withhold information when the insurance is taken out or at a later date, the cover may be cancelled in whole or in part.

8.9 Time limitation

The agreement follows the normal rules of limitation according to the applicable Danish Limitation Act.

8.10 Avenues of complaint

If you disagree with or are dissatisfied with our decision, you should contact the department that handled the case. If you are still not satisfied after contacting the department, you can write to our complaints officer to have your case reviewed.

Your complaint will be handled by a complaints officer as soon as possible and within seven working days at the latest. You can submit your complaint via the complaints portal on our website.

The complaint must include your name and address and a brief explanation of why you disagree or are dissatisfied with our decision. The complaint must be sent as soon as possible and no later than six months after the case was decided.

If you then wish to appeal the decision made by the complaints officer, you can appeal to the Insurance Appeals Board. The appeal can be submitted online at ankeforsikring.dk. Complaints to the Appeals Board involve a fee.

Governing law

The insurance is governed by Danish law, including the Danish Insurance Contracts Act and the Danish Insurance Business Act. Disputes about the insurance contract are settled according to Danish law by the Danish courts and according to the rules on venue in the Danish Administration of Justice Act.

We are not liable for the result of examinations, treatments and assessments, including lack of effect of the treatment or if the treatment results in errors. Any claim for compensation must be brought against the hospital or clinic that was responsible for the treatment.

In cases where a foreign-language insurance contract or foreign-language insurance conditions were used, any discrepancies resulting from the translation will mean that the Danish text will always apply.

8.11 If you want to know more

If you want to know more about your insurance, you can contact Dansk Sundhedssikring by phone or by email.

You can find more information on our website, where you can also report your claim online.