Rules in English [UNOFFICIAL]

GENERAL PROVISIONS

1 §

The name of the insurance fund is Luotea Sickness Fund.

The registered office of the fund is in Helsinki.

2 §

The purpose of the fund is to grant benefits according to the Health Insurance Act and additional benefits according to these rules. The fund operates as an occupational fund referred to in the Health Insurance Act (1224/2004).

In addition to these rules, the operations of the fund are governed by the Act on Pension Foundations and Pension Funds (946/2021) and the Insurance Funds Act (948/2021).

The overall supervision of the fund's operations is carried out by the Financial Supervisory Authority. The activities of the fund under the Health Insurance Act are monitored by the Social Insurance Institution (Kela).

3 §

The fund must have a minimum of 300 insured individuals.

OPERATIONAL SCOPE AND INSURANCE RELATIONSHIP

4 §

The operational scope of Luotea Sickness Fund includes individuals employed by the following companies and organizations:

Luotea Oyj	(Business ID: 1680140-0)
L&T Siivous Oy	(Business ID: 3155982-7)
L&T Kiinteistöhuolto Oy	(Business ID: 3155934-1)
L&T Kiinteistötekniikka Oy	(Business ID: 3155933-3)
Luotea Sickness Fund	(Business ID: 2153218-8)

These companies are referred to as "shareholders" in these rules. Inclusion in the operational scope requires that an individual primarily derives their livelihood from a shareholder or the fund.
An individual cannot be included in the operational scope if they are insured in another sicness fund. However, individuals whose employment is intended to be temporary and last no longer than 6 months are not included in the fund's operational scope.

All individuals within the operational scope of the fund are insured, and the insurance relationship is mandatory.

The insurance relationship begins 6 months after the start of the employment, once the conditions are met.

The fund's general meeting may, through a separate decision with a 3-month deadline, allow the insurance relationship for individuals employed by a shareholder who have not previously joined as insured.

The insurance relationship is voluntary for those individuals employed by a shareholder who were not previously within the operational scope of the fund and who are in employment at the time these rules come into effect. They must join as insured within 3 months of the rules coming into effect.

Upon the commencement of the insurance relationship, the insured individual will be sent a copy of the fund's rules to their email address.

Insured individuals will be informed of the statutory provisions and any changes on the fund's website.

WITHDRAWAL FROM THE FUND AND TERMINATION

5 §

An insured individual is considered to have withdrawn from the fund, and the insurance relationship automatically terminates when the insured individual ceases to belong to the fund's operational scope.

An insured individual cannot be dismissed from the fund.

6 §

A shareholder is considered to have withdrawn from the fund when the shareholder ceases to belong to its operational scope. A shareholder can also withdraw from the fund by submitting a written notice of withdrawal to the fund at least 6 months before the withdrawal date.

A shareholder may be expelled from the fund if they fail to pay the insurance premium or fail to remit the collected insurance premiums from the insured individuals for a period of 2 months, despite receiving a payment reminder.

7 §

A shareholder who withdraws from or is dismissed from the fund, or an insured individual who is considered to have withdrawn from the fund, has no right to the fund's assets.

INSURANCE PREMIUMS

8 §

The insurance premium for an insured individual is 0.54 percent of the gross salary subject to withholding tax, received by the insured individual from the shareholder, but not less than 11,70 euros and not more than 28,16 euros per month. No insurance premium is deducted from the holiday compensation and holiday allowance payable upon the termination of employment.

The minimum and maximum amounts of the insurance premium for an insured individual are tied to the wage coefficient referred to in Sections 96, 97, and 100 of the Employees Pensions Act (395/2006), in such a way that the euro amounts in this section correspond to a wage coefficient of 1.673. No insurance premium is deducted for unpaid sick leave or parental leave.

Upon application, the fund's board can exempt an insured individual from the obligation to pay the insurance premium during a long-term foreign assignment. During the period of exemption, the insured individual is not entitled to benefits under Sections 14-14 a of these rules.

The insurance premium for a shareholder is equal to the total insurance premiums paid by the employed insured individuals of the fund.

9 §

The shareholder deducts the insurance premium from the insured individual's salary during the payment of wages. The insurance premiums are remitted to the fund at least once a month.

The insurance premium for a shareholder is remitted to the fund at the same time as the corresponding installment of insurance premiums for the insured individuals.

10 §

If the financial situation of the fund so requires, the fund's board may reduce or increase the insurance premiums of the shareholders and adjust the minimum and maximum amounts of the insured individuals' insurance premiums by the wage coefficient by up to 30 percent. The consent of the shareholder must be obtained before implementing any changes to the premiums. However, a change in premiums lasting more than six months must be implemented through an amendment to the rules.

OPERATIONS ACCORDING TO THE HEALTH INSURANCE ACT

11 §

An insured individual is entitled, as provided in the Health Insurance Act and the regulations issued thereunder, to:

1) reimbursement of necessary medical care expenses due to illness;
2) sickness allowance due to incapacity for work resulting from illness;
3) reimbursement of necessary expenses related to pregnancy and childbirth;
4 a) maternity, paternity, and parental allowances, as well as special maternity allowance;
4 b) pregnancy allowance, special pregnancy allowance, parental allowance;

12 §

The benefits, their amounts and limitations, the commencement and termination of insurance, the application and payment of benefits, appeals, and other tasks related to operations according to the Health Insurance Act are determined in accordance with the Health Insurance Act and the regulations and provisions issued under it.

13 §

The fund is entitled to receive funds from the National Health Insurance Fund for the payment of benefits under the Health Insurance Act and reimbursement of administrative expenses in accordance with the provisions of the Health Insurance Act and the Government Decree on the Implementation of the Health Insurance Act (1335/2004).

ADDITIONAL BENEFITS

14 §

The fund reimburses the costs arising from necessary treatment for the insured individual who, due to illness, pregnancy, or childbirth, needs to seek treatment from a physician, dentist, or other appropriately trained professional. Assisted fertilization is not considered such treatment. Compensation is paid to the extent that the treatment would have been necessary to avoid unnecessary costs.

Before the payment of the additional benefit, the compensation provided under the Health Insurance Act is deducted. Similarly, if the insured individual is entitled to compensation under the legislation of a country other than Finland, the fund may, at the discretion of the board, take that compensation into account either in full or in part when determining the fund's compensation.

Covered costs:

14.1. Public Healthcare

The additional benefit compensation is paid up to the maximum limit set by the Decree on Customer Fees in Social and Health Care (912/1992).

The following fees in the public sector are reimbursed:

- Health center fees
- Physiotherapy fees
- Serial treatment fees
- Outpatient clinic fees
- Day surgery fees
- Hospitalization daily fees
- Temporary home care and home hospital fees

Once the maximum limit has been reached, hospitalization daily fees are reimbursed up to the maximum amount set by the Decree on Customer Fees in Social and Health Care. Compensation is provided for a maximum of 60 days.

Reimbursement of rehabilitation facility daily fees up to the aforementioned maximum limits if the board deems it reasonable to approve it on a case-by-case basis.

14.2. Medications

Compensation is provided for medications, clinical nutritional products, equivalent products, and basic ointments prescribed by a physician, dentist, or healthcare professional with limited prescribing rights when reimbursement is also received under the Health Insurance Act. Compensation is calculated based on the reference price. The portion exceeding the reference price is the responsibility of the insured individual if they refuse the substitution of the product.

14.3. Doctors` Fees:

1. 80% of the specialist doctor's consultation fee, up to a maximum of four visits per calendar year;
2. 80% of endoscopic procedures and associated facility fees according to the list approved by the board.

Compensation for the specialist doctor consultation fee is contingent on receiving reimbursement under the Health Insurance Act.

14.4. Private Healthcare Examinations and Treatment:

1. Laboratory tests prescribed by a doctor according to the list approved by the board, including pathology-related tests. The list of examinations is approved every six months or as needed;
2. Ultrasound and X-ray examinations prescribed by a doctor according to the list approved by the board. The list of examinations is approved every six months or as needed;
3. Magnetic resonance imaging (MRI) and computed tomography (CT) scans prescribed by a doctor;

4. 80% coverage for physiotherapy prescribed by a doctor, or reimbursed under the Health Insurance Act, up to a maximum of 10 treatment sessions per calendar year;
5. 80% coverage for massage, naprapathy, osteopathy, or chiropractic treatments prescribed by a doctor up to a maximum of 5 treatment sessions per calendar year;

14.5. Travel Expenses

Travel expenses are reimbursed in accordance with the current travel guidelines issued by the board.

14.6. Assistive Devices

Assistive devices prescribed by a doctor, dentist, or physiotherapist.
Assistive devices include:

- Support stockings, support vests, and orthotic insoles
- Joint supports
- Dental splints
- Bandages
- Prosthetic limbs

Compensation is up to 100 euros per calendar year/device. The right to compensation is determined based on the date of purchase.

The acquisition of prescribed treatment supplies, equipment, and meters, either partially or entirely, may be approved by the board on a case-by-case basis if deemed reasonable.

14.7. Eyeglasses

After an insurance relationship at least one year the maximum reimbursement for eyeglasses prescribed by a doctor or optometrist, purchased on the same occasion, is 400 euros, or alternatively, up to 400 euros per reimbursement for costs incurred from refractive eye surgery. The reimbursement is subject to the condition that the lenses of the eyeglasses are optically corrected for visual acuity. The right to eyeglass reimbursement is granted every third calendar year. The entitlement to reimbursement is determined based on the date of purchase.

14.8. Dental Care

The right to compensation for dental treatment begins after an insurance relationship that has lasted at least one year.

a) 100% of the fees and charges in accordance with Decree 912/1992 on social and health care customer fees collected from dental care provided in a public health care unit;

b) 80% of the fee or fee charged by a dentist, special dental technician and dental hygienist prescribed by a dentist in a private health care unit. Dental examination, orthodontic treatment, prosthetic procedures and dental technician work are also considered nursing work.

Reimbursement for dental treatment is a maximum of 500 euros of the costs incurred for the treatment given in each calendar year.

The condition for compensation for private dental care is that compensation has also been received under the Health Insurance Act. 80% of the fee charged for care provided by a dental hygienist can be reimbursed without a doctor's prescription, if the compensation is also paid under the Health Insurance Act. No health insurance reimbursement is required for prosthetic procedures, dental technical work and the deductible portion of the service voucher.

14 a §

The costs incurred from operation performed to prevent the insured individual's disability and improve their work and earning capacity can be fully or partially reimbursed if deemed reasonable by the board or, with authorization from the board, by the fund's medical expert together with the CEO, on a case-by-case basis and if they are not otherwise reimbursable according to §14. Additionally, reimbursement is subject to the presentation of a B medical certificate obtained from occupational health services or other equivalent documentation demonstrating the necessity of the operation.

15 §

The prerequisite for the payment of compensation according to these rules is that:

1. The examination has been performed or the treatment has been provided by a doctor or another appropriately trained individual registered in the central register of professional practitioners maintained by the National Supervisory Authority for Welfare and Health (Valvira); or
2. The examination or treatment conducted in private healthcare has taken place in a private healthcare unit as referred to in the Act on Healthcare Supervision (741/2023).

Necessary treatment and examinations are considered to be medically accepted disease management practices in accordance with good medical practice. A doctor's prescription must be obtained prior to the reimbursable event. The prescription entitles the individual to compensation for a period of one year from the date of issuance. A maximum of 15 examination or treatment sessions is covered by a single prescription if the examination or treatment has been conducted within one year of the prescription's issuance.
Treatment provided abroad is reimbursed up to the amount that would have been payable if the treatment had been provided in Finland. Travel expenses to foreign countries are not reimbursed.

16 §

The fund provides the benefits defined in Sections 14-14 a only to the extent that they exceed the corresponding benefits obtainable under the Health Insurance Act. If a member of the fund is entitled to receive compensation under any other Finnish law besides the

Health Insurance Act, compensation is only paid to the extent that it exceeds the compensation payable under the other law. Similarly, if a member is entitled to receive compensation under legislation other than Finnish, the relevant compensation may be taken into account wholly or partially at the discretion of the board when determining the fund's compensation.

17 §

The fund's liability regarding additional benefits begins from the commencement of the insurance relationship and ends upon the termination of the insurance relationship. The fund only reimburses costs incurred during the insurance relationship. The reimbursement of hospital daily fees ceases upon the expiration of the maximum period specified in Section 14, subsection 14.1, or, if the insured transitions to old-age pension prior to that, upon the commencement of the old-age pension, provided that the hospital treatment has commenced before the termination of the insurance relationship.

Costs are deemed to be incurred when the treatment is provided and the examination is conducted. When considering the annual maximum amounts of compensation, the basis for reimbursement is determined based on the time of treatment, regardless of when the costs were paid.

RESTRICTIONS ON ADDITIONAL BENEFITS

18 §

If the insured is absent from work without pay due to a work stoppage, lack of work-related reasons, or any other reason other than illness or parental leave, the additional benefits under Sections 14-14a of these rules will not be paid for the relevant period.

19 §

If the insured, after the occurrence of the insured event, fraudulently provides the fund with false or incomplete information that is relevant to the receipt or amount of an additional benefit, the entitlement to the benefit may be denied or reduced to a reasonable extent based on the circumstances.

The fund is not liable for additional benefits to an insured person who intentionally caused the insured event.

If the insured person has caused the insured event due to gross negligence, the entitlement to the additional benefit may be denied, reduced, or the payment of the granted benefit may be suspended to a reasonable extent based on the circumstances.

The same applies if the insured person has intentionally impeded their recovery or, without a justifiable reason, has refused to undergo an examination or treatment prescribed by the fund's appointed doctor, except for procedures posing a serious health risk.

Before denying or reducing the benefit or suspending the payment of the granted benefit, the insured person must be heard, and their conduct in the matter and the amount of the benefit already paid must be taken into consideration.

20 §

The board has the right to determine which service provider is to be used when it comes to treatment eligible for additional compensation under these rules.

The insured person is obliged, at the expense of the fund, to visit the doctor appointed by the board or a healthcare or research facility designated by the board for the purpose of investigating the compensation matter.

If the insured person does not comply with the provisions of the first or second paragraph, the compensation may be denied, either in whole or in part.

APPLYING FOR ADDITIONAL BENEFITS

21 §

Additional benefits according to these rules must be applied for in writing. The application must be accompanied by any necessary documentation deemed necessary.

Compensation must be applied for within six months from the date the payment for which compensation is sought has been made. Despite the delay, the benefit may be granted, either in whole or in part, if the denial is considered unreasonable.

Benefit applications must be processed urgently. The provisions of Section 8 of Chapter 6 of the Insurance Fund Act regarding delays in benefits apply.

22 §

Compensation according to Section 14 of these rules may be paid in full if the receipt of compensation under the Health Insurance Act or other legislation is delayed due to reasons beyond the insured person's control, and if the insured person agrees to repay the fund an amount equivalent to the compensation paid by the fund.

23 §

If the insured person has received more additional benefits under these rules than they were entitled to, any unjustified benefits paid must be recovered. The recovery of unjustified additional benefits must adhere to good debt collection practices.

The recovery may be waived, either in whole or in part, if it is deemed reasonable and the payment of the benefit was not due to the actions of the insured person or another beneficiary, or if the amount unjustifiably paid is negligible.

The recoverable amount may be offset against future additional benefits paid by the fund if the insured person or another beneficiary agrees to it.

The board of the fund must establish procedural guidelines for these situations to ensure consistent treatment of the insured persons.

APPEALING AN ADDITIONAL BENEFIT DECISION

24 §

A person dissatisfied with the fund's decision regarding additional benefits may request a recommendation for resolution from the Insurance and Financial Advisory Service. The request for a recommendation for resolution must be submitted to their own fund or the Insurance and Financial Advisory Service within 30 days of the insured person receiving notice of the decision. The insured person is considered to have received notice of the decision on the seventh day following the mailing date of the decision.

A person dissatisfied with the additional benefit decision may also bring the matter to court for resolution. The lawsuit must be filed within three years from the date the person dissatisfied with the benefit decision received written notice of the fund's decision and the three-year time limit. The court of first instance is the general district court of the fund's domicile, which is the Helsinki District Court. The lawsuit can also be considered in the district court within whose jurisdiction the claimant has their domicile or permanent residence.

EQUITY FUNDS

25 §

The insurance fund has two types of reserves: the contingency reserve and the operating reserve.

The contingency reserve must be increased annually by at least 20 percent of the surplus indicated in the financial statements, after deducting any deficit from previous fiscal years. When the contingency reserve is equal to or greater than the average premium income for the current fiscal year and the two preceding fiscal years, it is no longer mandatory to transfer funds to the contingency reserve.

The contingency reserve may only be reduced according to a decision made by the insurance fund's assembly, and only for the purpose of covering a confirmed deficit indicated in the balance sheet.

Notwithstanding what is stated in the fourth paragraph, the Financial Supervisory Authority may, upon application and for special reasons, grant permission to the insurance fund to

reduce the amount of its contingency reserve, generally not below the full amount of the contingency reserve.

26 §

The operating reserve must receive the portion of the surplus that has not been transferred to the contingency reserve.
The operating reserve may be used for:

1. Primarily covering the deficit indicated in the financial statements.
2. Increasing the benefits mentioned in the insurance fund's rules, according to a plan approved by the assembly for a maximum period of one year at a time.
3. Paying the benefits mentioned in the insurance fund's rules for a specified period during unpaid absences, according to a plan made at the discretion of the assembly.

If the operating reserve becomes so large that it exceeds 40 percent of the full amount of the contingency reserve, the insurance fund must take action to either increase the additional benefits according to these rules or reduce the premiums.

LIABILITY PROVISION

27 §

The liability provision of the insurance fund consists of the compensation liability, which corresponds to the unpaid amounts of additional benefits and other amounts to be paid due to the occurred insurance events.

The compensation liability is calculated for the financial statements in accordance with the regulations of the Financial Supervisory Authority.

FINANCIAL STATEMENTS

28 §

The financial year of the insurance fund is the calendar year.

For each financial year, a financial statement must be prepared in accordance with the decree of the Ministry of Social Affairs and Health (1196/2021) and the regulations issued by the Financial Supervisory Authority. The financial statement includes the income statement and the balance sheet with accompanying notes. The financial statement must be accompanied by a management report. The financial statement and the management report must be submitted for audit to the auditors at least one month before general meeting.

29 §

If the operating reserve is insufficient to cover the deficit of the insurance fund, the contingency reserve is used for this purpose.

The insurance fund is not subject to the additional contribution obligation referred to in Section 12 of the Insurance Funds Act.

AUDIT

30 §

The insurance fund must have one auditor appointed for a calendar year at a time. The auditor may be a natural person or an approved auditing firm.

For a natural person appointed as an auditor, a deputy auditor must also be appointed. However, no deputy auditor is appointed for an approved auditing firm. The auditor and their deputy auditor must be authorized auditors as defined in the Auditing Act (1141/2015).

GENERAL MEETING

31 §

The general meeting exercises the highest power of decision-making in matters concerning the fund. Each insured person and shareholder has the right to participate and speak in the meeting.
The meeting must be held at the domicile of the insurance fund. By the decision of the board, the assembly may be conducted through remote communication.

32 §

Each insured person has one vote in the meeting. The insured person exercises their right to vote personally or through a proxy. Only another insured person can act as a proxy, and they have the right to represent a maximum of 1 insured person.

Shareholders represent a number of votes in the assembly equal to the total number of votes of the insured persons present at the meeting. The number of votes is distributed among the shareholders in proportion to the insurance premiums paid in the previous financial year.

The proxy holder for an insured person or shareholder must present a dated and specific power of attorney.

33 §

The insurance fund holds one regular general meeting each year, which must take place no later than April.

In the regular general meeting:

1. The financial statements and the auditor's report are presented.
2. A decision is made regarding the approval of the previous year's financial statements.
3. A decision is made regarding the use of surplus or covering a deficit.
4. A decision is made discharging the members of the board and the managing director from liability.
5. Decisions are made on other measures that may be necessary based on the previous year’s operations and financial statements

6. The remuneration for the chairman, other board members, and auditors is determined.
7. Necessary members and alternate members are elected to replace outgoing members of the board and alternate members.
8. An auditor and, if necessary, a deputy auditor are appointed.
9. Other matters mentioned in the meeting invitation are discussed.

34 §

An extraordinary meeting must be held when the board deems it necessary.
An extraordinary meeting must also be held if eligible voters in the meeting, with at least one-tenth of the total voting rights, or the Financial Supervisory Authority, or the auditor of the insurance fund, request it in writing for the purpose of addressing a stated matter.

35 §

An insured person or shareholder has the right to have their desired matter considered in the regular general meeting. If an insured person or shareholder wishes to have a matter considered in the regular general meeting, the proposal must be submitted in writing to the managing director of the insurance fund by the end of February, who will bring the matter to the attention of the board.

36 §

An invitation for a meeting must be delivered no earlier than four weeks and no later than one week before the meeting. If the decision-making on a matter to be discussed at the meeting is postponed to a subsequent meeting, a separate invitation must be given if the meeting takes place more than four weeks later.

An invitation for a meeting and other communications from the insurance fund are made known through a notice published on the insurance fund's website. The invitation for a meeting is also posted on the notice board for the shareholders.

The invitation for an extraordinary meeting must be delivered within two weeks from the submission of the request as referred to in Section 34, Paragraph 2 of the regulations.

37 §

The invitation for a meeting must specify the date, time, and location of the meeting, as well as the matters to be discussed during the meeting.

When the meeting addresses the financial statements, the documents related to the financial statements or their copies must be made available for eligible voters to review at the insurance fund's office or on the website for at least one week before the meeting. The documents must also be available for viewing during the assembly. If the meeting discusses a matter concerning an amendment to the regulations, the availability of the documents must be indicated in the invitation and on the insurance fund's website.

38 §

General meetings are chaired by a person elected by the meeting for this purpose.
The decision of the meeting shall be determined, unless otherwise provided by law or these regulations, by the opinion supported by more than half of the votes cast, or in case of a tie, by the opinion with which the chairperson agrees. In elections, the candidate who receives the most votes is considered elected. In case of a tie, the outcome is determined by drawing lots.

A decision regarding an amendment to the regulations is valid only if it is supported by eligible voters with at least two-thirds of the total voting rights represented in the meeting. The same requirement applies to the placement of the insurance fund into liquidation and its termination in cases other than those required by law, as well as the approval of an agreement regarding the merger of the insurance fund.

If an amendment to the regulations directly affects the rights or obligations of a shareholder, the amendment's confirmation additionally requires the acceptance of the shareholder. If there are multiple shareholders, the confirmation of the amendment requires that at least two-thirds of all shareholders have accepted it. Furthermore, the accepted votes of the shareholders must represent at least two-thirds of the total voting rights that would exist if all shareholders were represented at the meeting.

39 §

A decision concerning a matter in which the procedural rules of the Pension Funds and Pension Funds Act or the provisions regarding the invitation for the meeting in these regulations have not been followed can only be made if the insured individuals and shareholders affected by the omission give their consent. If an issue must be addressed at the meeting according to the law or these regulations, the meeting may make the decision on it even if the matter was not mentioned in the invitation for the meeting. The meeting may also decide to convene an extraordinary meeting to discuss a specific matter.

40 §

Minutes are kept at the meeting, recording the eligible voters present, their voting rights, the decisions made during the meeting, and the voting results when a vote has been taken. The minutes must be reviewed and signed by the chairperson and at least one eligible voter

chosen for that purpose at the meeting. The minutes must be made available for shareholders and insured individuals to review at the insurance fund's office no later than two weeks after the meeting. Shareholders and insured individuals have the right to obtain a copy of the minutes and their appendices.

BOARD

41 §

The insurance fund's board consists of 6 regular members, each of whom must have a personal alternate member.

The general meeting elects the board. The insured individuals elect 3 regular members of the board with their alternate members, while the shareholders elect 3 regular members with their alternate members.

The term of office for a board member is 2 years. The term begins after the general meeting that decides on the election of a new member.

No meeting fees are paid to Board members.

42 §

The board represents the insurance fund and is responsible for the administration of the fund and ensuring the proper organization of its activities.
The tasks of the board include, in particular:

1. selecting and dismissing the CEO and the medical specialit, as well as determining the conditions of their service;
2. providing the CEO with the necessary instructions and directives for the day-to-day management and other opertions
3. ensuring proper supervision of the fund's accounting and asset management;
4. making decisions regarding the investment of the fund's assets and the taking of loans;
5. deciding on the granting of benefits, unless the board has delegated decision-making authority to the CEO or fund personnel;
6. convening the general meeting and preparing the matters to be discussed at the meeting, as well as making proposals in the annual report regarding measures concerning the surplus or deficit indicated in the financial statements; and
7. granting the authority to sign on behalf of the fund.

43 §

The board elects a chairperson and a vice-chairperson from among its members annually. The CEO cannot serve as the chairperson of the board.

The board meets at the invitation of the chairperson or, in their absence, the vice-chairperson. The chairperson must convene the board if requested by a board member or the CEO.

The board is quorate when the chairperson or vice-chairperson and at least 3 other members are present.

A proposal is considered adopted by the board if it is supported by more than half of the members present. In the event of a tie, the chairperson has the deciding vote.

A board member or the CEO may not participate in the consideration of matters concerning their relationship with the fund or otherwise their private interest.

44 §

Minutes must be kept for board meetings and signed by the chairperson and the author of the minute The minutes must be reviewed by at least one board member chosen specifically for that purpose at each meeting.

A board member and the CEO have the right to have their dissenting opinions recorded in the minutes. The minutes must be numbered consecutively and kept securely.
The minutes must include:

1. the date, start and end times, and location of the meeting;
2. the board members present and other individuals in attendance;
3. the matters discussed, decisions made, votes taken, and dissenting opinions; and
4. any conflicts of interest or other matters deemed necessary

CEO

45 §

The CEO is responsible for the day-to-day administration of the fund in accordance with the instructions and directives of the board. The CEO must ensure that the fund's accounting complies with the law and that financial management is conducted reliably.

The CEO has the authority to represent the fund in matters assigned to them by Section 13 of Chapter 4 of the Pension Funds and Pension Funds Act.

MEDICAL SPECIALIST

46 §

The fund must have a medical specialist whose task is to serve as the fund's medical expert.

SIGNING AUTHORITY OF THE FUND

47 §

The fund's documents are signed jointly by a board member, the CEO, or a fund employee authorized by the board, with at least two signatures required.

INVESTMENT OF ASSETS AND BORROWING

48 §

The fund must invest its assets securely and profitably while considering the fund's liquidity. The fund's assets may not be used for purposes clearly unrelated to the fund's operations. The fund must manage its operations in such a way that it is possible to operate without borrowing. However, the fund may temporarily take short-term loans to maintain liquidity. The fund may not provide guarantees.

AMENDMENT OF SHAREHOLDER'S OBLIGATIONS

49 §

If a shareholder wishes to amend the obligations concerning the shareholder in these regulations, written notice must be given to the fund at least 6 months before the amendment takes effect.

If a shareholder revokes their consent regarding mandatory membership as referred to in Section 3 of Chapter 2 of the Pension Funds and Pension Funds Act, the consent remains valid for a further six months after the notification of revocation has been received by the fund.

MERGER AND DIVISION

50 §

The fund may merge or divide. The merger and division and the measures required for them must be carried out in accordance with the provisions of Chapter 7 of the Insurance Funds Act.

STATUTORY LIQUIDATION AND DISSOLUTION

51 §

Regarding the liquidation and dissolution of the pension fund and the measures required in such cases, the provisions of Chapter 9 of the Pension Funds and Pension Funds Act must be followed.

The fund must be placed in liquidation and dissolved:

1. if the number of insured individuals has not reached the minimum specified in these regulations by the end of the last two calendar years, and it cannot be considered likely that the number will exceed the aforementioned threshold within the next four months;
2. if the fund's financial statements show a deficit, and the deficit has not been covered within the following two accounting periods;
3. if the fund does not meet the requirements for liability calculation or the provisions regarding liability coverage and segregation of assets;
4. if all the shareholders cease their operations, within which the insured individuals operate;
5. if specified separately in the regulations; and
6. if the Financial Supervisory Authority has ordered the dissolution of the fund.

52 §

Upon the dissolution of the fund, the remaining assets are distributed to those who were insured individuals of the fund at the commencement of the liquidation. The distribution is made in proportion to the insurance premiums paid by the insured individuals during the immediately preceding 60 months. If the distributable amount is insignificant, the fund's meeting may, with a two-thirds majority of votes, decide to allocate the assets to another purpose equivalent to the fund's activities or for a charitable purpose.