Mortgage Life Insurance

Details of arrangements under the master plan

terms and conditions booklet

This product is provided by Irish Life Assurance plc.

This is the Terms and Conditions booklet for the proposer's **Mortgage Life Insurance** arrangement in relation to you, as outlined in the certificate of membership. You should read the document carefully as it contains detailed and important information. Please keep it safe in your welcome pack as you will need to refer to it in the future.

Introduction

We have granted this master plan to, and it has been accepted by, the proposer on the basis of the declaration the proposer made on the master application and each application form signed by you, the lives assured.

This plan is designed to repay a mortgage if the life assured dies during the term of the plan as long as:

- the mortgage repayments are kept up to date; and
- the mortgage interest rate is no more than the interest rate we have assumed as shown on the certificate of membership.

The proposer's benefits under the master plan will reduce each month. If the mortgage interest rate is, on average, higher than the interest rate we have assumed, the cover will not be enough to repay the mortgage in full. If benefits are altered under section 5 the cover may not be enough to repay the mortgage in full.

The plan consists of the certificate of membership, the table of protection benefits, this master plan Terms and Conditions Booklet, the application form and each application form signed by the lives assured. It also includes any related information, and any extra rules which our head office staff may add in writing.

We have given cover under this master plan on the understanding that the information you gave in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare all cover for you void. If this happens:

- the proposer will lose all your rights in relation to you under the master plan;
- we will not pay any claim; and
- we will not return any payments.

If we do decide to refund any payments made we may deduct any associated medical evidence, administration or sales costs we have incurred under the plan. If a cover is voided on one life on a joint life cover plan all cover will end under that plan for both lives.

Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the payment or level of benefits or when deciding whether to provide cover at all.

This plan is a protection plan only. The proposer cannot cash it in at any time. Even if you have not made a claim by the time the period of cover ends, we will not return your payments. All cover under the plan will end on the 'expiry date of your protection benefits' shown in the certificate of membership, unless some or all of it has ended before that for any of the reasons explained in these terms and conditions.

The benefits provided under this plan are stated in the certificate of membership. If a benefit is not mentioned in the certificate of membership, we do not provide that benefit. The amount of each

benefit will reduce on a monthly basis over the full term of your plan. The table of protection benefits in the certificate of membership shows this reduction on a monthly basis for the first year only. Although this reduction continues monthly, the table only indicates the amount of cover which applies at the start of each remaining year as long as benefits have not been altered under section 5.

If the proposer is making a claim under this master plan, they should contact us at:

Irish Life Assurance plc.

Irish Life Centre

Lower Abbey Street

Dublin 1.

As long as the proposer makes the payments shown in the certificate of membership on the dates given, we will pay them the benefits shown in the certificate of membership. The proposer will need to send us evidence of the claim including the age of the lives assured.

We will pay claims only from the assets we hold to make payments due to customers. We will normally pay all benefits under this plan in the currency of Ireland.

In legal disputes Irish law will apply.

In the event of extraordinary circumstances beyond our control including, without limitation, act of civil or military authority; sabotage; crime; terrorist attack; war or other government action; civil disturbance or riot; strike or other industrial dispute; an act of god; national emergency; epidemic; flood, earthquake, fire or other catastrophe, we may be directly or indirectly prevented from fulfilling our obligations under or pursuant to this plan or from doing so in a timely manner. If this happens, we are not liable for any loss, damage or inconvenience caused.

More detailed information on all these matters is in the relevant sections of this Terms and Conditions booklet.

How does the master plan work?

You choose the type of cover you need. The proposer is responsible for making sure the payments are made to us as set out in the certificate of membership. We describe the benefits in greater detail later on in this terms and conditions booklet.

The proposer named in the certificate of membership (usually a financial institution such as a bank or building society) is the legal owner of the plan. We will pay all plan benefits to the proposer. Note the exceptions in relation to partial payments on specified illness cover (see section 4.7), children's life cover and children's specified illness cover (see section 7.5).

Writing to us

If you need to write to us about this plan, please write to:

Irish Life Assurance plc.
Irish Life Centre
Lower Abbey Street
Dublin 1.

Complaints

We will do our best to sort out complaints fairly and quickly through our internal complaints procedure. If you are not satisfied after complaining to us, you can take your complaint to the Financial Services Ombudsman of Ireland. You can get more information from:

Financial Services Ombudsman
3rd Floor
Lincoln House
Lincoln Place
Dublin 2
Lo-call: 1890 88 20 90
Fax: 01 6620890
Email: enquiries@financialombudsman.ie
Website: www.financialombudsman.ie

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Full Payment Specified Illness conditions

If a Life Assured has selected specified illness cover (if selected it will be shown on your certificate of membership) then they are covered, on a full payment basis, for the illnesses listed below and defined in full in section 4.6.

1. Alzheimer's disease – resulting in permanent symptoms
2. Aorta graft surgery – for disease or traumatic injury
3. Aplastic anaemia - of specified severity
4. Bacterial Meningitis – resulting in permanent symptoms
5. Benign brain tumour – resulting in permanent symptoms or requiring surgery
6. Benign spinal cord tumour – resulting in permanent symptoms or requiring surgery
7. Blindness – permanent and irreversible
8. Brain injury due to anoxia or hypoxia – resulting in permanent symptoms
9. Cancer – excluding less advanced cases
10. Cardiac arrest – with insertion of a defibrillator
11. Cardiomyopathy - resulting in a marked loss of ability to do physical activity
12. Chronic Pancreatitis – of specified severity
13. Coma –resulting in permanent symptoms
14. Coronary artery by-pass grafts
15. Creutzfeldt-Jakob Disease – resulting in permanent symptoms
16. Crohn's disease – of specified severity
17. Deafness – total, permanent and irreversible
18. Dementia – resulting in permanent symptoms
19. Encephalitis – resulting in permanent symptoms
20. Heart attack – of specified severity
21. Heart valve replacement or repair
22. Heart structural repair
23. HIV infection – caught in the European Union, Norway, Switzerland North America, Canada, Australia and New Zealand, from a blood transfusion, a physical assault or at work in the course of performing normal duties of employment.
24. Intensive Care - requiring mechanical ventilation for 10 consecutive days
25. Kidney failure – requiring ongoing dialysis
26. Liver Failure – irreversible and end stage
27. Loss of Independence – permanent and irreversible
28. Loss of limb – permanent physical severance
29. Loss of speech – permanent and irreversible
30. Major organ transplant – specified organs
31. Motor neurone disease – resulting in permanent symptoms
32. Multiple sclerosis or Neuromyelitis optica (Devic's Disease) – with persisting symptoms
33. Paralysis of One limb - total and irreversible
34. Parkinson's disease (idiopathic)– resulting in permanent symptoms
35. Parkinson Plus Syndromes - resulting in permanent symptoms
36. Peripheral Vascular Disease – with bypass surgery
37. Pneumonectomy – the removal of a complete lung
38. Pulmonary Arterial Hypertension (idiopathic) – of specified severity
39. Pulmonary Artery Surgery – with surgery to divide the breast bone
40. Respiratory Failure of specified severity

41. Severe Burns/3rd Degree
42. Stroke – resulting in permanent symptoms
43. Systemic lupus erythematosus – of specified severity
44. Traumatic head injury – resulting in permanent symptoms

Partial Payment Specified Illness Cover

If a Life Assured has selected specified illness cover (if selected it will be shown on your certificate of membership) then they are covered, on a partial payment basis, for the illnesses listed below and defined in full in section 4.7.

a) Brain abscess drained via craniotomy
b) Carcinoma in Situ – Oesophagus, treated by specific surgery
c) Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty
d) Cerebral aneurysm – with surgery or radiotherapy
e) Cerebral arteriovenous malformation – treated by craniotomy, stereotactic radiosurgery or endovascular repair
f) Coronary Artery Angioplasty – of specified severity
g) Crohn's disease – treated with surgical intestinal resection
h) Ductal Carcinoma in Situ – Breast, treated by surgery
i) Early stage urinary bladder cancer – of specified advancement
j) Implantable Cardioverter Defibrillator (ICD) for primary prevention of sudden cardiac death
k) Liver resection
l) Low Level Prostate Cancer with Gleason score between 2 and 6 – and with specific treatment
m) Peripheral vascular disease - treated by Angioplasty
n) Pituitary tumour – resulting in permanent symptoms or surgery
o) Serious Accident Cover – resulting in at least 28 consecutive days in hospital
p) Severe Burns/3rd Degree Burns covering at least 5% of the body's surface
q) Significant visual impairment – permanent and irreversible
r) Single Lobectomy – the removal of a complete lobe of a lung
s) Surgical removal of one eye
t) Syringomelia or Syringobulbia - treated by surgery
u) Ulcerative Colitis – treated with total colectomy

Definitions

Section 1

This section defines some of the important words used in this master plan.

Benefit (or benefits)

The benefit shown in the certificate of membership under the heading 'your protection benefits'. If, at any stage during the term of your plan, the proposer chooses to reduce the benefit amounts, the benefit amount will be lower than that shown on your certificate of membership, allowing for normal benefit reductions under the plan. We will send you a revised certificate of membership showing the new benefit amounts at that time.

Certificate of membership

This is part of the contract. It sets out the specific details of the plan such as:

- the start date;
- the expiry date (of the life and specified illness cover benefits);
- the life or lives covered;
- the benefits; and
- any special conditions that have been agreed with us.

Child

Someone who is under 21 and who:

- is shown by birth certificate to be the son or daughter of a life assured; or
- has been legally adopted by a life assured.

Day

A period of 24 hours in a row.

Expiry date of the life cover benefit

The plan expiry date – this is shown in the certificate of membership. The life cover will end on this date unless it has ended earlier.

Expiry date of the specified illness cover benefit

The plan expiry date or expiry date of the specified illness cover benefit – whichever is shown in the certificate of membership. The specified illness cover will end on this date unless it has ended earlier.

Irreversible

An illness or condition is irreversible if after having appropriate treatment, including surgery, there is no reasonable hope of a recovery according to medical knowledge at that time.

Life assured or lives assured

The person or people named in the certificate of membership as the life or lives covered. The benefits of the plan depend on the lives of those people.

Major hospital

An institution in one of the accepted countries (see section 6.4), which has facilities for diagnosis, treatment and major surgery and has accommodation for in-patients. It does not include a long-term nursing unit, a geriatric or pre-convalescent ward, or an extended-care facility for convalescence, rehabilitation or other similar function. We reserve the right to insist that a major hospital is a hospital in Ireland or the United Kingdom.

Medical specialist

A registered medical practitioner (see below) who has specialist qualifications in an appropriate branch of medicine and who is practising at a major hospital (see above).

Month

A calendar month.

Payment

This is:

- 'your total payment' as shown in the certificate of membership under the heading 'your payment details';
- the amount we tell the proposer when we reinstate cover under section 3.4; or
- a different amount (which we will tell you) if we or the proposer make any amendment to the plan details.

Proposer

The person or company (usually a financial institution such as a bank or building society) named as proposer in the certificate of membership and who is responsible for making sure payments are made and is legally entitled to the plan benefits.

Registered medical practitioner

A person who meets the legal requirements for carrying on a medical practice in an accepted country (see section 6.4) and who actually practices medicine in that country. We reserve the right to insist that a registered medical practitioner practices in Ireland or the United Kingdom.

Start date

The start date shown in the certificate of membership which relates to each life assured under the master plan. The is the date on which cover will start for each life assured.

We, us

Irish Life Assurance plc.

You

The person (or people) named in the certificate of membership as the life or lives assured, who the proposer has asked us to cover and who we have accepted for life cover or specified illness cover. In the text describing each illness covered under the heading 'in simpler terms' in sections 4.6 and 4.7, we have assumed that 'you' is the life assured. This may not always be the case. If it is not, we are referring to the life assured when we talk about an illness and the symptoms suffered.

Basis of cover

Section 2

This section explains the legal basis on which cover is given.

2.1 We have agreed to provide cover to the proposer on your life under the master plan on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare cover in relation to you under the master plan void. If this happens the proposer will lose all rights under the master plan in relation to you, we will not pay any claim and we will not return any payments. Information is 'relevant' if it might influence the judgment of a reputable insurer when fixing the payment or level of benefits or when deciding whether to provide cover at all.

If we do decide to refund any payments made we may deduct any associated medical evidence, administration or sales costs we have incurred under the plan. If cover is voided on one life on a joint life cover plan all cover will end under that plan for both lives.

2.2 If the proposer's cover in relation to you ends but is reinstated under section 3.4, we will reinstate it on the understanding that the information given in the evidence of health form and any related document is true and complete and that all relevant information has been provided.

If this is not the case, we will be entitled to declare cover in relation to you under the master plan void. If this happens, the proposer will lose all rights in relation to you under the master plan, we will not pay any claim and we will not return any payments. If we refund payments, we are entitled to deduct appropriate costs incurred as a result of the setting up and administration of this plan. Information is 'relevant' if it might influence the judgment of a reputable insurer when fixing the level of payments or benefits; when deciding whether to reinstate cover at all; or when deciding whether to attach conditions.

Making payments

Section 3

This section explains the proposer's responsibility in making payments and explains what happens if payments fall behind.

3.1 Although each payment is due on the payment dates shown in the certificate of membership, we give the proposer 30 days to make the payment unless the proposer make payments monthly, in which case we will we give them 10 days to make the payment. (The time allowed is known as a 'period of grace'.) If we are due to pay a benefit during a period of grace, we will take from your benefit any payment which the proposer has not yet made.

3.2 If the proposer has not made a payment by the end of the period of grace, all cover in relation to you under the master plan will end immediately. A payment is not made until we have received it. It is up to the proposer or you to make sure that we receive the payment. We are entitled to pass on to the proposer or you any charge which we have to pay because all or part of the payment (for example, a direct debit) is dishonoured.

3.3 If cover under the master plan ends as described in section 3.2, the proposer can restore the cover within 90 days from the date the first missed payment became due. The proposer must make all the payments which would have been due if your cover had not ended. The proposer will not be entitled to benefits for anything that happens between the end of the period of grace and the date we receive all missed payments.

3.4 If, after 90 days and before 180 days of the first missed payment being due, the proposer asks us for cover to be restored, you must fill in an evidence of health form and all the payments, which would have been paid if cover had not ended, must be made. If the information on the evidence of health form shows that your health is now different to that declared on the application form, we may refuse to restore cover or restore the cover:

- without any change;
- with an increased payment; or
- with new conditions (for example, you might lose cover for certain specified illnesses)

If we decide to restore cover, we will ask the proposer to start making payments again. The proposer will not be entitled to benefits for anything that happens between:

- the end of the period of grace; and
- the date, following our agreement to restore cover, on which we receive all missed payments.

If we accept a payment (or part payment) which is no longer due, this does not mean that we are providing cover. We will return the amount we receive as soon as we discover the mistake.

Your cover

Section 4

This section explains the benefits which we provide.

4.1 The benefits provided for the proposer in relation to you under this master plan are shown in the certificate of membership. If a benefit is not mentioned on the certificate of membership, we do not provide that benefit. We will pay a claim when a 'benefit event' happens. The certificate of membership also shows the amount of cover. If, at any stage during the term of your plan, the proposer requests to change the benefit amounts and we allow this, the cover amount will be different than that shown in the certificate of membership, allowing for the normal benefit reductions on the plan. We will send a revised certificate of membership showing the new cover amounts. Benefit amounts cannot increase again once the proposer has chosen to reduce them.

The following benefits are available.

- Life cover,
- Life cover and specified illness cover (with the specified illness benefit amount being **equal to** the life cover benefit amount).
- Life cover and specified illness cover (with the specified illness benefit amount being **less than** the life cover benefit amount).

The plan may also have guaranteed cover again (see section 5.2). Check the certificate of membership to see which benefits apply for the proposer in relation to you.

Accidental Death Benefit

This is an automatic additional benefit. We will pay the death benefit (to a maximum of €150,000) on accidental death between the time the application is received by Irish Life (together with a completed direct debit) and the earlier of the following:

- the day of the final underwriting decision if terms are being offered
- the day of the underwriting decision if we are declining or postponing cover
- 30 days from the date we receive the application.

For this benefit "Accidental Death" means death caused solely and directly as a result of an accident caused by violent, visible and external means and independently of any other cause.

There are the following restrictions:

- The benefit payable is subject to the lesser of the life sum assured or €150,000
- The benefit is subject to a maximum entry age of 55
- Exclusions apply around the nature of the death e.g. suicide or intentional self-inflicted injury causing death are excluded. For full details of exclusions see section 6.

We will only pay once under Accidental Death Benefit in respect of any life, regardless of the number of plans or applications a person has with Irish Life.

In the case of joint life applications the benefit is only paid once, on the death of the first life to die.

4.2 If we accept a claim for a benefit event, we will pay the proposer

- the amount of benefit set out in the certificate of membership, less
- the amount (if any) by which it has been reduced by an optional reduction, less
- the amount by which it has been reduced under the normal benefit reductions under the plan.

There are two possible benefit events.

(a) A life cover benefit event

If the certificate of membership shows life cover under the heading 'your protection benefits', a benefit event will happen:

- If there is only one life assured (single life), when the life assured dies or is diagnosed as having a terminal illness; or
- if there are two lives assured (joint life), when the first of the lives assured dies, or is diagnosed as having a terminal illness. If both lives assured die at the same time, or if it is impossible to say who died first, we will assume the oldest life assured died first.

(b) An accelerated specified illness cover benefit event

If the certificate of membership shows both life cover and accelerated specified illness cover under the heading 'your protection benefits', a benefit event will happen:

- If there is only one life assured (single life), when the life assured is diagnosed as having a specified illness as defined in section 4.6; or
- if there are two lives assured (joint life), when the first of the lives assured is diagnosed as having a specified illness as defined in section 4.6.

We then reduce the amount of life cover by the amount of any benefit we have paid for accelerated specified illness cover.

Check the certificate of membership (and any subsequent letters we send) to see which benefits apply.

4.3 (a) If a life assured is diagnosed as having a terminal illness (as in section 4.5) we will pay the amount of life cover. No further payment will be made when the life assured dies. Also see part (e) of this section.

A terminal illness benefit will only be paid once per plan.

(b) If a life assured has accelerated specified illness cover, in certain circumstances we will reduce the amount of specified illness cover we will pay for a life assured by the amount of any benefit we have paid under section 4.7 (Partial Payment Specified Illness Cover) and section 4.8 (Prepayment of Surgery). If we have reduced the amount of specified illness cover to nothing for a life assured, all specified illness cover ends.

(c) If we pay a claim for an accelerated specified illness cover benefit event under section 4.6, all specified illness cover ends (including cover for those conditions listed in section 4.7). For example, this means that you cannot claim for a heart attack and then claim for cancer.

(d) The life cover we will pay for a life assured will be reduced by the amount of any benefit we have paid under accelerated specified illness cover under section 4.6. If the amount of life cover is reduced to nil, all cover ends. If the amount of accelerated specified illness cover is the same as the amount of life cover, all

cover will end when an accelerated specified illness cover benefit event happens.

(e) If a life assured who has accelerated specified illness cover is diagnosed as having a specified illness and we previously paid a benefit for that life assured being diagnosed as having a terminal illness, we will not pay any further benefit as all benefits end on the payment for a terminal illness.

(f) If the amount of accelerated specified illness is the same as the amount of life cover, all cover will end when the accelerated specified illness cover benefit event happens.

4.4 All life or specified illness cover under this plan will end:

- at the end of a period of grace, if all or part of a payment has still not been made;
- on the expiry date, as shown in the certificate of membership; or
- when a life cover benefit event happens; or

  when a specified illness cover benefit event happens (if the amount of the specified illness cover is the same as the amount of the life cover);

whichever is earliest.

4.5 A life assured is 'diagnosed as having a terminal illness' if the attending consultant gives a definite diagnosis that, our Chief Medical Officer agrees, satisfies both of the following:

- The illness has either no known cure or has progressed to the point where it cannot be cured; and
- In the opinion of the attending consultant that the illness is expected to lead to death within 12 months.

4.6 Full Payment Specified Illness Conditions

We will make a full payment for specified illness cover if the life assured is diagnosed as having a specified illness.

You are 'diagnosed as having a specified illness' if on a date after the start date and before the expiry date of the specified illness cover benefit, you have:

- had any surgery defined in a plan definition below; or
- been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition below.

The accelerated specified illness benefit payable will be that applicable on the date you are 'diagnosed as having a specified illness' as per the plan definition above.

Explanatory notes

The explanatory notes in the sections headed 'In simpler terms' are intended to provide a less technical explanation of the illness definitions, and some of the medical terms used within that definition. They are not intended as an alternative definition of the illness and will not be used to assess claims. In the event of any dispute, the illness 'definition' overrules the 'In simpler terms' explanation.

1. Alzheimer's disease – resulting in permanent symptoms

Plan definition:

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Other types of dementia.

In simpler terms:

Alzheimer's disease occurs when the nerve cells in the brain deteriorate over time and the brain shrinks. There are various ways in which this can affect someone, for example, severe loss of memory and concentration and mental ability gradually failing.

A claim can be made if the life covered has been diagnosed by a consultant neurologist or consultant geriatrician as having Alzheimer's disease and his/her judgement, understanding and rational thought process have been seriously affected.

2. Aorta graft surgery – for disease or traumatic injury

Plan definition:

The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft.

The term aorta includes the thoracic and abdominal aorta but not the branches.

For the above definition, the following are not covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair.

We also cover surgery for traumatic injury to the aorta needing excision and surgical replacement of a portion of the aorta with a graft.

In simpler terms:

The aorta is the main artery of the body. It supplies blood containing oxygen to other arteries. The aorta can become narrow (often because of a build-up of fatty acids on its walls) or it may become weakened because of a split (dissection) in the internal wall. The aorta may also weaken because of an 'aneurysm' which means that the artery wall becomes thin and expands. A graft might be necessary to bypass the narrowed or weakened part of the artery.

You can claim if you have had surgery to remove and replace a part of the thoracic or abdominal aorta, to correct narrowing or weakening, with a graft.

Surgery to the branches of the aorta are not covered as this surgery is generally less critical.

3. Aplastic anaemia - of specified severity

Plan definition:

A definite diagnosis by a Consultant Haematologist of permanent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood transfusion
- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplant

For the above definition, the following are not covered:

- All other types of anaemia

In simpler terms:

Aplastic anaemia is a failure of the bone marrow to produce sufficient blood cells for the circulation. When this function of the marrow declines, the main blood constituents (red cells, white cells, platelets) decline or cease production and the individual becomes progressively more dependent on blood transfusions.

You can claim if a Consultant Haematologist diagnoses permanent bone marrow failure which is treated by blood transfusion, agents to stimulate the bone marrow, immunosuppressive agents or a bone marrow transplant.

4. Bacterial Meningitis – resulting in permanent symptoms

Plan definition:

A definite diagnosis of Bacterial Meningitis causing inflammation of the membranes of the brain or spinal cord *resulting in permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

• All other forms of meningitis including viral meningitis.

(Adult and Child cover)

*"permanent neurological deficit with persisting clinical symptoms" is defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

Bacterial meningitis is a life-threatening illness that results from bacterial infection of the meninges (the three layers of membrane that surround the brain and spinal cord). In many cases, it is possible to recover fully from bacterial meningitis with no lasting ill-effects. However, if there were lasting effects as outlined above, we would pay a claim.

You can make a claim if a consultant neurologist diagnoses bacterial meningitis which results in permanent brain/nerve damage. Examples of such damage include paralysis of the left- or right-hand side of the body or disturbed speech or hearing. All other forms of meningitis including viral are excluded.

5. Benign brain tumour – resulting in permanent symptoms or requiring surgery

Plan definition:

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, *resulting in permanent neurological deficit with persisting clinical symptoms*.* The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

The requirement for permanent neurological deficit will be waived if the benign brain tumour is treated by stereotactic radiosurgery or by surgical removal (full or partial).

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms

- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

A benign brain tumour is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of the brain.

These growths can be life-threatening and may have to be treated by surgery. We will exclude other conditions that are not usually life-threatening.

The pituitary is a small gland at the base of the brain. An angioma is a benign lesion made up of a collection of small blood vessels.

You can claim if you are diagnosed as having a benign tumour of the brain and you have had either radiotherapy or surgery to treat it, or are suffering from permanent neurological deficit (nerve damage) as a result of the tumour. Examples of tumours covered include gliomas, acoustic neuromas and meningiomas. Neurological symptoms must be permanent and as defined within the definition.

6. Benign spinal cord tumour – resulting in permanent symptoms or requiring surgery

Plan definition:

A non-malignant tumour of the spinal canal or spinal cord, causing pressure and/or interfering with the function of the spinal cord which requires surgery or results in *permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Angiomas.

The requirement for permanent neurological deficit will be waived if the benign spinal cord tumour is removed by invasive surgery or treated by stereotatic radiosurgery.

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms

- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

A benign tumour of the spinal canal or spinal cord is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of spinal cord or spinal canal.

You can claim if you are diagnosed as having a benign spinal cord tumour and have had surgery to have it removed or are suffering from permanent neurological deficit as a result of the tumour. Neurological symptoms must be permanent. We do not cover angiomas of the spinal cord or spinal canal.

7. Blindness – permanent and irreversible

Plan definition:

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart.

In simpler terms:

You can claim only if you have irreversible loss of sight in both eyes to the extent that even using eye glasses or other visual aids, the sight in your better eye is confirmed by an Ophthalmologist or Consultant Physician as 3/60 or worse using the recognised sight test known as the Snellen eye chart. A Snellen chart is the test an optician uses, where you are asked to read rows of letters. 3/60 is the measure when you can only see at three feet away what someone with perfect sight could see at 60 feet away.

It is possible to be 'registered blind' (as certified by an eye specialist) even though the loss of sight may only be partial. Even if you are 'registered blind', your claim will only be met if the loss of sight meets the criteria outlined in our definition and cannot be corrected.

8. Brain injury due to anoxia or hypoxia – resulting in permanent symptoms

Plan definition:

Death of brain tissue due to reduced oxygen supply resulting in *permanent neurological deficit with persisting clinical symptoms*.*

For the above definition the following are not covered:

- children under the age of 90 days

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking,

lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

Anoxia (no oxygen) or hypoxia (a poor oxygen supply) can result in permanent brain damage leaving the individual with lifelong problems. There are many causes including carbon-monoxide poisoning, near drowning, poisoning by anaesthesia and others.

9. Cancer – excluding less advanced cases

Plan definition:

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
    - pre-malignant;
    - non-invasive;
    - cancer in situ;
    - having either borderline malignancy; or having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (ie Gleason score 7 or above only) or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer (including cutaneous lymphoma), other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) ie >=Clarks level 2.

- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are non-malignant and are excluded from this cover.
- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0.

In simpler terms:

The term 'cancer' is used to refer to all types of malignant tumours (tumours which can spread to distant sites) as opposed to benign tumours (which do not spread elsewhere in the body). A tumour is caused when the process of creating and repairing body tissue goes out of control, leading to an abnormal mass of tissue being formed.

A malignant tumour:

- *may grow quickly;*
- *often invades nearby tissue as it expands;*
- *often spreads through the blood or the lymph vessels to other parts of the body; and*
- *usually continues to grow and is life-threatening unless it is destroyed or removed.*

You can claim if you are diagnosed as suffering from a malignant tumour which has invaded surrounding tissue, unless the type of cancer or tumour is specifically excluded. The claim must be supported by a microscopic examination of a sample of the tumour cells – this is known as 'histology'. The histology examination is performed on tissue removed during surgery or by biopsy (a procedure to remove a sample of the tumour for examination).

Cancers 'in situ' (cancers in a very early stage that have not spread in any way to neighbouring tissue) as well as pre-malignant and non-invasive tumours are not covered under this definition. (They may be covered on a partial payment basis, see section 4.7.) These are well-recognised conditions. Cancers detected at this stage are not likely to be life-threatening and are usually easily treated. An example of this would be carcinoma (cancer) in situ of the cervix (neck of the womb).

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. We will not pay a claim for prostate cancer under this cancer definition unless the tumour has a Gleason score (a method of measuring differentiation in cells) of greater than 6 (in other words, a Gleason score of 7 or above) or it has progressed to at least clinical classification of T2N0M0. A partial payment benefit may be available (see section 4.7).

The 'Gleason score' and the 'TNM classification' are ways of measuring and describing how serious the cancer is and whether it has spread beyond the prostate gland based on its appearance under a microscope.

Leukaemia (cancer of the white blood cells) and Hodgkin's disease (a type of lymphoma) are both covered. However, chronic lymphocytic leukaemia must have progressed to Binet Stage A for us to consider a claim.

Most forms of skin cancer are relatively easy to treat and are rarely life-threatening. This is because they do not spread out of control to other parts of the body. The only form of skin cancer that we cover is malignant melanoma which has been classified as being a 'Clark level 2' or greater. Clark's system is an internationally recognised method of classifying skin melanomas and uses a scale of 1 to 5. A Clark level 1 reflects a very early melanoma which carries a favourable long-term outlook.

Many forms of bladder cancer have a slow course over many years and are managed by surgery or diathermy (generating heat locally in body tissues by using high-frequency electromagnetic currents). The prognosis for patients with these superficial bladder cancers is very good. The TNM classification system is internationally recognised and used as a method of staging or measuring a tumour. The 'T' element relates to the primary tumour and is graded on a scale of 1 to 4. 1 represents a small tumour restricted to the organ. We will not pay a claim for a T1 bladder cancer unless lymph nodes or metastases (the cancer spreading) are involved as measured by the 'N' and 'M' elements of TNM.

10. Cardiac arrest – with insertion of a defibrillator

Plan definition:

Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- Implantable Cardioverter-Defibrillator (ICD); or
- Cardiac Resynchronization Therapy with Defibrillator (CRT-D).

For the above definition the following are not covered:

- Insertion of a pacemaker
- Insertion of a defibrillator without cardiac arrest
- Cardiac arrest secondary to illegal drug abuse.

In simpler terms:

Cardiac arrest happens when the heart suddenly stops beating, sometimes because of an abnormal heart rhythm (arrhythmia) or coronary heart disease. This can stop the heart from pumping blood which prevents oxygen being delivered to the body. Lack of oxygen to the brain causes loss of consciousness which in turn means that you stop breathing. A brain injury or death can occur if the arrest goes untreated.

A device known as an Implantable Cardioverter Defibrillator (ICD or CRT-D) can be implanted inside your body which will monitor the rhythm in your heart. If the rhythm becomes abnormal, the

device will deliver an electric pulse or shock which will restore the rhythm back to normal and prevent a cardiac arrest.

You can claim if you have had a cardiac arrest followed by the permanent insertion of an ICD or CRT-D. A cardiac arrest not accompanied by the insertion of an ICD or CRT-D is not covered under this condition. A cardiac arrest secondary to illegal drug abuse is not covered under this condition.

11. Cardiomyopathy - resulting in a marked loss of ability to do physical activity

Plan definition:

A definite diagnosis of cardiomyopathy by a Consultant Cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity*. The diagnosis should be supported by a current echocardiogram or cardiac MRI showing abnormalities consistent with the diagnosis of cardiomyopathy.

* New York Heart Association Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

For the above definition, the following are not covered:

- Cardiomyopathy secondary to alcohol or drug abuse
- All other forms of heart disease, heart enlargement and myocarditis.

In simpler terms:

Cardiomyopathy is a disorder affecting the muscle of the heart, the cause of which is unknown. It may result in enlargement of the heart, heart failure, abnormal rhythms of the heart (arrhythmias) or an embolism (blockage of a blood vessel).

You can claim if you suffer cardiomyopathy which is permanent and causing symptoms which significantly hinder your normal everyday activities. To qualify for payment your physical ability must be measurable and limited to a specific degree (New York Heart Association Class 3). The NYHA Function Classification is a measure used to classify the extent of heart failure.

12. Chronic Pancreatitis – of specified severity

Plan definition:

A definite diagnosis of Chronic Pancreatitis by a consultant gastroenterologist. The diagnosis must be evidenced by the following:

- calcification of the pancreas
- malabsorption due to failure of secretion of pancreatic enzymes
- chronic inflammation of the pancreas as shown by Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholepancreatography (MRCP).
- pancreatic duct dilatation, beading and stricture

For the above definition the following is not covered

- Chronic pancreatitis secondary to alcohol or drug abuse
- Acute pancreatitis

In simpler terms:

Pancreatitis is an inflammation of the pancreas, an organ that is important in both the digestive and endocrine systems of the body. Chronic pancreatitis is an ongoing, inflammatory process with continued and permanent injury to the pancreas.

Acute pancreatitis is a sudden inflammation of the pancreas. It can be serious with severe complications. However, it usually settles and the patient can make a full recovery.

ERCP (endoscopic retrograde cholangiopancreatography) is a procedure that uses and endoscope (a thin, flexible telescope) to look at the bile duct and pancreatic duct. A dye can be injected into the bile duct and pancreatic duct so that these can be seen clearly on an X-ray.

MRCP (magnetic retrograde cholangiopancreatography) is a medical imaging technique that uses magnetic resonance imaging to visualise the biliary and pancreatic ducts.

13. Coma –resulting in permanent symptoms

Plan definition:

A state of unconsciousness with no reaction to external stimuli or internal physiological needs which:

- Requires life supporting systems
- Results in permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following is not covered:

- Coma secondary to alcohol where there is a history of alcohol abuse
- Coma secondary to illegal drug abuse.

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia

(difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

A coma is a state where a person is unconscious and cannot be brought round. Someone in a coma will have little or no response to any form of physical stimulation and will not have control of their bodily functions. Comas are caused by brain damage, most commonly arising from a head injury, a stroke or lack of oxygen.

14. Coronary artery by-pass grafts

Plan definition:

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts via a thoracotomy, a thorascope or mini thoracotomy.

For the above definition, the following are not covered:

- balloon angioplasty, atherectomy, insertion of stents and laser treatment or any other procedures.

In simpler terms:

Coronary artery surgery may be necessary if one or more coronary arteries (the arteries which supply blood to the heart) are narrowed or blocked. The surgery is done to relieve the pain of angina or if the blocked artery is life-threatening.

Coronary artery bypass surgery is carried out by taking a heathly blood vessel and using it to direct blood past the diseased or blocked artery.

You are not covered under this definition for any other intervention techniques to treat coronary artery disease such as angioplasty or laser relief.

15. Creutzfeldt-Jakob Disease – resulting in permanent symptoms

Plan definition:

Confirmation by a Consultant Neurologist of a definite diagnosis of Creutzfeldt-Jakob disease resulting in *permanent neurological deficit with persisting clinical symptoms*.*

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

CJD is a degenerative condition of the brain. As the disease progresses muscular coordination diminishes, the intellect and personality deteriorate and blindness may develop.

You can claim if your Consultant Neurologist confirms the diagnosis of CJD which has resulted in permanent neurological deficit.

16. Crohn's disease – of specified severity

Plan definition:

A definite diagnosis by a consultant gastroenterologist of Crohn's disease with fistula formation and intestinal strictures.

There must have been two or more resections of the small or large intestine on separate occasions.

There must also be evidence of continued inflammation with on-going symptoms, despite optimal therapy with diet restriction, medication use and surgical interventions.

In simpler terms:

Crohn's disease is a chronic condition that causes inflammation of the digestive tract. While there is no known cure for Crohn's disease, therapies can reduce symptoms and bring about remission.
The condition must be as severe as is described in the definition.

17. Deafness – total, permanent and irreversible

Plan definition:

Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

In simpler terms:

You can claim if you have a severe form of deafness (to the degree described in our definition) as measured by a pure tone audiogram. A pure tone audiogram is a key hearing test used to identify hearing threshold levels in an individual. The test establishes the quietest sounds you are able to hear at different frequencies or pitches. A decibel is a measure of the volume of a sound.

You cannot claim if you have reduced hearing in one or both ears which does not meet this definition. You cannot claim if the deafness can be improved by the use of medical aids.

18. Dementia – resulting in permanent symptoms

Plan definition:

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of ability to do all of the following:

- Remember;
- Reason; and
- Perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

- Dementia secondary to alcohol or illegal drug abuse.

In simpler terms:

Dementia is a term used to describe a number of signs and symptoms characterised by the loss of cognitive functioning and intellect, and behavioural changes. Areas of cognition affected may be memory, concentration, language and problem solving.

A claim can be made if the life covered has been diagnosed by a consultant neurologist or consultant geriatrician or psychiatrist, as having Dementia and his/her judgement, understanding and rational thought process have been seriously affected. These symptoms must be permanent.

19. Encephalitis – resulting in permanent symptoms

Plan definition:

A definite diagnosis of Encephalitis by a Consultant Neurologist resulting in *permanent neurological deficit with persisting clinical symptoms*.*

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria

(difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

Encephalitis is an acute inflammation of the brain. The illness can vary from mild to life-threatening. Most people with a mild case can recover fully. More severe cases of Encephalitis may recover but there may be damage to the nervous system. This damage can be permanent.

You can claim if you have a diagnosis of Encephalitis confirmed by a Consultant Neurologist and where there are neurological symptoms which the Neurologist deems to be permanent.

20. Heart attack – of specified severity

Plan definition:

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- New characteristic electrocardiographic (ECG) changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
  Troponin T >1.0ng/ml
  Troponin I >= 0.5ng/ml

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:-

- Other acute coronary syndromes including but not limited to angina.

In simpler terms:

A heart attack (myocardial infarction) happens when an area of heart muscle dies because it does not get enough blood containing oxygen. It is usually caused by a blocked artery and causes permanent damage to the part of the heart muscle affected. The blockage is usually caused by a clot (thrombosis) where the artery has already grown narrow.

To confirm the diagnosis, your doctor will usually test your heart using a machine called an electrocardiograph (ECG). This tells the doctor if there have been any changes in the heart's function and if it is likely that you have had a heart attack.

Your doctor will also take a blood sample. This can show that markers are present in the blood (in the form of enzymes or troponins) at a much higher level than is normally expected.

You can claim if you are diagnosed as having suffered death of heart muscle. Your claim must be supported by an increase in cardiac enzymes or troponins that are typical of a heart attack (released into the bloodstream from the damaged heart muscle) and new ECG changes typical of a heart attack.

21. Heart valve replacement or repair

Plan definition:

The actual undergoing of a surgical procedure (including balloon valvuloplasty) to replace or repair one or more heart valves on the advice of a Consultant Cardiologist.

In simpler terms:

Heart valves regulate and control the flow of blood to and from the heart. The valves may become narrow or leak, and if one of the four heart valves is not working properly, an operation may be necessary to repair or replace the valve.

You will be able to claim if you undergo surgery to replace or repair a heart valve on the advice of a Consultant Cardiologist.

22. Heart structural repair

Plan definition:

The undergoing of heart surgery requiring thoracotomy on the advice of a consultant cardiologist, to correct any structural abnormality of the heart.

In simpler terms:

Structural abnormalities include openings in the wall separating the left and right chambers of the heart.

You will be able to claim if you have surgery where the surgeon cuts into the chest wall to correct a structural abnormality of the heart.

23. HIV infection – caught in the European Union, Norway, Switzerland North America, Canada, Australia and New Zealand, from a blood transfusion, a physical assault or at work in the course of performing normal duties of employment.

Plan definition:

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment;
- a physical assault;
- an accident occurring during the course of performing normal duties of employment;

after the start of the policy and satisfying all of the following:

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.
- The incident causing infection must have occurred in the European Union, Norway, Switzerland, North America, Australia, Canada or New Zealand.

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or illegal drug abuse.

In simpler terms:

Human immunodeficiency virus (HIV) is generally recognised as the virus that causes acquired immune deficiency syndrome (AIDS). The virus can be passed on in several ways including through contaminated blood, bloodstained bodily fluids and infected needles. This benefit is designed to cover people who get HIV through their work or who have become infected as a result of a physical assault or a blood transfusion in the European Union, Norway, Switzerland, North America, Canada, Australia and New Zealand. The infection must happen after the start date of the plan and must be reported and investigated in line with established procedures.

24. Intensive Care - requiring mechanical ventilation for 10 consecutive days

Plan definition:

Any sickness or injury resulting in the Life assured requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an intensive care unit in an acute care hospital.

For the above definition the following are not covered:

- sickness or injury as a result of drug or alcohol misuse or other self-inflicted means;
- children under the age of 90 days.

In simpler terms:

Mechanical ventilation involves using a machine to take over breathing for a patient. Tracheal intubation means placing a tube into the trachea (windpipe) to keep the airway open in patients if they cannot breathe on their own.

You can claim if there has been continuous tracheal intubation for 10 days or more.

25. Kidney failure – requiring ongoing dialysis or transplant

Plan definition:

Chronic and end stage failure of both kidneys to function, as a result of which long term regular dialysis is necessary and ongoing or a kidney transplant is necessary.

In simpler terms:

The kidneys act as filters which remove waste materials from the blood. When the kidneys do not work properly, waste materials build up in the blood. This may lead to life-threatening problems. The body can function with only one kidney, but if both kidneys fail completely, dialysis (kidney machine treatment) or a kidney transplant will be necessary. In some circumstances it is possible for the kidneys to fail temporarily and recover following a period of dialysis.

You will be able to claim if both your kidneys fail completely and the condition is chronic and you need regular long-term dialysis or a kidney transplant.

26. Liver Failure – irreversible and end stage

Plan definition:

A definite diagnosis, by a Consultant Physician, of irreversible end stage liver failure due to cirrhosis resulting in all of the following:

- Permanent jaundice
- Ascites, and
- Encephalopathy

For the above definition, the following is not covered:

- Liver failure secondary to alcohol or illegal drug misuse.

In simpler terms:

Liver failure is the inability of the liver to perform its normal synthetic and metabolic function. Liver failure occurs when a large portion of the liver is damaged.

You can claim if you are diagnosed by a Consultant Physician as having incurable liver failure caused by cirrhosis and showing particular symptoms. Jaundice is a yellow discoloration of the skin and eye whites due to abnormally high levels of bilirubin (bile pigment) in the blood stream. This jaundice must be a permanent feature. Ascites is a fluid build-up in the abdomen caused by fluid leaks from the surface of the liver and intestines. It can occur if the blood or lymphatic flow through the liver is blocked.
Encephalopathy caused by liver failure is the deterioration of brain function due to toxic substances building up in the blood which are normally removed by the liver.

You cannot claim if the liver failure occurs as a direct or indirect result of excess alcohol consumption of illegal drug use.

27. Loss of Independence – permanent and irreversible

Plan definition:

The permanent and irreversible loss of the ability to function independently which is defined as follows:

1. Permanent confinement to a wheelchair, or
2. being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or
3. being permanently unable to fulfill at least three of the following activities unassisted by another person:
    - The ability to walk 100 metres unaided
    - The ability to get into and out of a vehicle unaided.
    - The ability to put on, take off, secure and unfasten all necessary garments and any braces, artificial limbs or other surgical appliances.
    - The ability to feed oneself once food and drink has been prepared and made available.
    - The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained
    - The ability to climb stairs without the assistance of special aids
    - The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.
4. or suffer from severe and permanent intellectual impairment which must,
    a. result from organic disease or trauma, and
    b. be measured by the use of recognized standardized tests and
    c. have deteriorated to the extent that requires the need for continual supervision and assistance of another person

The diagnosis must be confirmed to the satisfaction of the professional opinion of Irish Life's Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.

In all of the above permanent means that, even with the best treatment available, the life assured is not expected to recover. The condition must continue for at least six months following diagnosis before the benefit can be claimed.

In simpler terms:

This benefit is intended to make your total cover more wide-ranging and will be particularly valuable as you get older. By focusing on the disability rather than the specific illness, extra cover is provided for a variety of events which may radically change your life.

28. Loss of Limb – permanent physical severance

Plan definition:

Permanent physical severance of 1 or more hands or feet at or above the wrist or ankle joints.

If a life assured loses a limb as a result of their own deliberate act, or a penalty imposed by a court of law, we will not pay you any benefit under the plan.

In simpler terms:

You will be able to claim if you have lost a limb above the wrist or ankle joint either by injury or because they have had to be removed. This loss must be permanent.

We will not make a payment for loss of any individual fingers or toes or combination of fingers and toes.

If you lose a limb as a result of your own deliberate act, or a penalty imposed by a court of law, we will not pay you any benefit under the plan.

29. Loss of speech – permanent and irreversible

Plan definition:

Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.

In simpler terms:

You will be able to claim only if you suffer from total and permanent loss of speech as a result of physical damage or disease.

30. Major organ transplant – specified organs

Plan definition:

The undergoing as a recipient of a transplant of bone marrow or a complete heart, kidney, liver, lung, or pancreas, or a lobe of liver, or a lobe of lung, or inclusion onto the official programme waiting list of a major Irish or UK hospital for such a procedure

For the above definition, the following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

In simpler terms:

Serious disease or injury can severely damage the heart, lungs, kidneys, liver or pancreas. The only form of treatment available may be to replace the damaged organ with a healthy organ from a donor. This is a major operation and the tissues of the donor and patient must be matched accurately. For this reason a patient

could be on a waiting list for a long period waiting for a suitable organ. We will also cover a bone-marrow transplant, or transplant of a lobe of the liver or a lobe of the lung.

You can claim if you have had a transplant of any of the organs listed or are on an official Irish or UK programme waiting list for a transplant.

31. Motor neurone disease – resulting in permanent symptoms

Plan definition:

A definite diagnosis of motor neurone disease by a Consultant Neurologist.

There must be permanent clinical impairment of motor function.

In simpler terms:

Motor neurone disease is a disease which affects the central nervous system that controls movement. As the nerves deteriorate the muscles weaken. There is currently no known cure and the cause of the disease is also unknown.

You can claim if there is a definite diagnosis by a consultant neurologist that you are suffering from motor neurone disease.

32. Multiple sclerosis or Neuromyelitis optica (Devic's Disease) – with persisting symptoms

Plan definition:

A definite diagnosis of Multiple sclerosis or Neuromyelitis Optica (Devic's Disease) by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 3 months.

In simpler terms:

Multiple sclerosis is a disease of the central nervous system which destroys the protective covering (myelin) of the nerve fibres in the brain and spinal cord. The symptoms depend on which areas of the brain or spinal cord have been affected. They include temporary blindness, double vision, loss of balance and lack of co-ordination.

Devic's disease or neuromyelitis optica, (NMO) is a disease that is very similar to multiple sclerosis in terms of symptoms. However, it is recognised as a separate condition.

You can claim if you are diagnosed by a consultant neurologist as suffering from multiple sclerosis or Devic's disease and you have ongoing symptoms of the disease which have been present continuously for at least three months.

33. Paralysis of One limb - total and irreversible

Plan definition:

Total and irreversible loss of muscle function to the whole of any one limb.

In simpler terms:

The brain controls the movement of muscles in the body by sending messages through the spinal cord and nerves. Paralysis is normally caused by an injury to the spinal cord.

You will be able to claim if you suffer complete and permanent loss of the use of an entire limb.

34. Parkinson's disease (idiopathic) – resulting in permanent symptoms

Plan definition:

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must also be permanent clinical impairment that includes bradykinesia (slowness of movement) and at least one of the following:

- Tremor; or
- muscle rigidity; or
- postural instability

For the above definition, the following are not covered:

- Parkinsonian syndromes including but not limited to those caused by alcohol or drugs

In simpler terms:

Parkinson's disease is a disease of the central nervous system which affects voluntary movement. It happens when certain nerve cells (neurons) die or become impaired. Normally, these cells produce a vital chemical known as dopamine which allows smooth, co-ordinated function of the body's muscles and movement.The term 'idiopathic' means that the cause of the disease is not known, so any form of Parkinsonian syndrome brought on by a known cause such as drugs, toxic chemicals or alcohol is not covered.

35. Parkinson Plus Syndromes - resulting in permanent symptoms

Plan definition:

A definite diagnosis by a Consultant Neurologist of one of the following Parkinson Plus syndromes:

- Multiple system atrophy
- Progressive supranuclear palsy
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Corticobasal ganglionic degeneration
- Diffuse Lewy body disease

There must be also permanent clinical impairment of at least one of the following:

- motor function; or
- eye movement disorder; or
- postural instability; or
- dementia

In simpler terms:
Parkinsonian-plus syndromes are a group of neurodegenerative disorders which share the features of idiopathic Parkinson's disease but with other unique characteristics specific to the condition diagnosed.

You can claim if you are diagnosed with one of the named Parkinsonian-plus syndromes and you have permanent symptoms as defined.

36. Peripheral Vascular Disease – with bypass surgery

Plan definition:

A definite diagnosis of peripheral vascular disease, due to atherosclerosis or Buerger's disease, with objective evidence from an ultrasound of obstruction in the arteries which results in by-pass graft surgery to an artery.

For this definition, the following is not covered:

- Angioplasty

In simpler terms:

Peripheral vascular disease happens when there is significant narrowing of arteries. Symptoms vary from feeling pain in your calf when exercising (intermittent claudication) to pain when resting (critical limb ischaemia), skin ulceration, and gangrene.

Atherosclerosis is caused when fatty deposits build up along the inner walls of an artery.

Buerger's disease (thromoangiitis obliterans) is caused by inflammation of the blood vessels (vasculitis). The blood vessels tighten and can become totally blocked.

Bypass surgery is carried out by taking a healthy blood vessel and using it to direct blood past the narrowed or blocked artery.

You are not covered under this definition for any other intervention techniques such as angioplasty.

37. Pneumonectomy – the removal of a complete lung

Plan definition:

The undergoing of surgery to remove a complete lung for disease or physical injury.

For the above definition, the following are not covered:

- Removal of a lobe of the lungs (lobectomy)
- Lung resection or incision.

In simpler terms:
The lungs are in the chest and transport oxygen from the air into the blood and remove carbon dioxide from the blood. Serious disease or injury can severely damage the lungs. In some cases, the only form of treatment available may be to remove a damaged lung.

You can claim if you have a complete lung removed due to illness or injury.

38. Pulmonary Arterial Hypertension (idiopathic) – of specified severity

Plan definition:

Pulmonary arterial hypertension of unknown cause that has resulted in all of the following:

- Elevated pulmonary arterial pressure
- Right ventricular dysfunction
- Shortness of breath.

For the above definition, the following are not covered:

- Pulmonary hypertension due to established cause
- Other types of hypertension.

In simpler terms:

Pulmonary arterial hypertension is a disease which happens when blood pressure in the pulmonary artery or the major blood vessel connecting the right heart ventricle and the lungs is higher than normal. There is no apparent cause (idiopathic). A higher pulmonary artery blood pressure means the heart has to work harder to pump enough blood into the lungs. Over time, the condition progresses and often results in heart failure.

39. Pulmonary Artery Surgery – with surgery to divide the breast bone

Plan definition:

The actual undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

In simpler terms:

Pulmonary Artery surgery may be carried out for some disorders to the pulmonary artery, including pulmonary atresia (atresia means "no opening") and aneurysm. A claim can be made if the life assured undergoes open heart surgery involving the surgical division of the breastbone to replace the diseased pulmonary artery with a graft.

40. Respiratory Failure of specified severity

Plan definition:

Confirmation by a Consultant Physician of chronic lung disease resulting in:

- The need for daily oxygen therapy on a permanent basis;
- Evidence that the oxygen therapy has been required for a minimum period of six months;
- FEV1 being less than 40% of normal; and
- Vital Capacity less than 50% of normal

In simpler terms:

Respiratory Failure is a condition where the level of oxygen in the blood becomes too low or the level of carbon dioxide in the blood becomes too high.

You can claim if you have severe and chronic respiratory failure, evidenced by lung function tests showing forced expiratory volume less than 40% of normal and a vital capacity less than 50% of normal and you require daily oxygen therapy. FEV and VC are ways of measuring lung function.

41. Severe Burns/3rd Degree Burns

Plan definition:

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or at least 25% surface area of the face which for the purpose of this definition includes the forehead and the ears.

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You will be able to claim if you have suffered third-degree burns covering 20% or more of the surface area of your body or 25% or more of the surface area of the face.

First- and second-degree burns are not covered under this definition.

42. Stroke – resulting in permanent symptoms

Plan definition:

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in *permanent neurological deficit with persisting clinical symptoms**. A diagnosis of Subarachnoid Haemorrhage resulting in *permanent neurological deficit with persisting clinical symptoms**, supported by CT or MRI evidence, is covered under this definition.

For the above definition, the following are not covered:

- Transient ischaemic attack.
- Traumatic injury to brain tissue or blood vessels.

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:-

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms

- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

The brain controls all the functions of the body, so damage to the brain can have serious effects. A stroke happens when there is severe damage to the brain caused by internal bleeding (haemorrhage) or when the flow of blood in an artery has been blocked by a piece of tissue or a blood clot (a thrombus or embolus) resulting in the brain being starved of oxygen.

This benefit does not cover 'transient ischaemic attacks' (also known as ministrokes) where there is a short-term interruption of the blood supply to part of the brain, the main symptoms tend to be dizziness and temporary weakness or loss of sensation in part of the body or face.

43. Systemic lupus erythematosus – of specified severity

Plan definition:

A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following:

- *Permanent neurological deficit with persisting clinical symptoms**, or
- Permanent impairment of kidney function tests as follows:
    - Glomerular Filtration Rate (GFR) below 30ml/min

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma. For the purpose of this definition - lethargy will not be accepted as evidence of permanent neurological deficit.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease. The immune system attacks the body's cells and tissue resulting in inflammation and tissue damage. The course of the disease is unpredictable with periods of illness alternating with remission. SLE is a multi-system disease because it can affect many different organs and tissues in the body. Systemic

lupus erythematosus can be a mild condition treated by medication or there can be life-threatening complications. The condition can be present for many years without progressing to brain and kidney involvement.

You can claim if you are diagnosed with systemic lupus erythematosus by a Consultant Rheumatologist which is complicated by brain involvement resulting in permanent neurological deficit with persisting clinical symptoms or kidney involvement with a GFR below 30ml/min.

44. Traumatic head injury – resulting in permanent symptoms

Plan definition:

Death of brain tissue due to traumatic injury resulting in *permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be supported by an opinion of a Consultant Neurologist and agreed by our Chief Medical Officer.

For the above definition, the following is not covered:

- Injury secondary to alcohol where there is a history of alcohol abuse
- Injury secondary to illegal drug abuse.

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

A head injury caused by trauma can leave an individual with permanent brain/nerve damage.

You can claim if a Consultant Neurologist confirms that you have permanent neurological deficit with persisting clinical symptoms as a direct result of a head injury.

4.7 Partial Payment Specified Illness Cover

This is an automatic additional benefit that only applies to a life assured if the certificate of membership shows that the life assured has accelerated specified illness cover.

You are 'diagnosed as having a specified illness' if on a date after the start date and before the expiry date of the specified illness cover benefit, you have:

- had any surgery defined in a plan definition below; or
- been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition below.

(a) We will make a partial payment for specified illness cover if a life assured is diagnosed as having one of the specified illnesses below, on a date after the start date and before the expiry date of the specified illness cover benefit.

The total amount we will pay through partial payments is limited to the amount of the accelerated specified illness in respect of you as shown on the certificate of membership. You are only allowed to claim once for each of the illnesses defined below.

For the illness Coronary Artery Angioplasty – of specified severity, the amount we will pay on single vessel coronary artery angioplasty is:

- €10,000; or
- 18.75% of the amount of specified illness cover the life assured has;

whichever is lower.

When the life assured goes on to have a second coronary angioplasty to another artery, we will pay:

- €30,000; or
- 56.25% of the amount of specified illness cover the life assured has;

whichever is lower.

Where the life assured undergoes a coronary angioplasty in 2 or more coronary arteries, where no previous claim has been made under this benefit, we will pay:

- €40,000; or
- 75% of the amount of specified illness cover the life assured has;

whichever is lower.

For the other illnesses defined below the amount we will pay is:

- €15,000; or
- Half the amount of specified illness cover the life assured has;

whichever is lower.

The accelerated specified illness cover benefit will be that applicable on the date you are 'diagnosed as having a specified illness'.

For children, the partial payment is the lesser of €7,500 or half of the specified illness benefit amount. We will only make a partial payment once for each child.

(b) We will only make one payment per life on the plan for each of the illnesses defined below under (a) above. This payment is independent of the main specified illness cover benefit amount. The total amount we will pay through partial payments is limited to the amount of the accelerated specified illness in respect of you as shown on the certificate of membership.

(c) We will not pay any benefit under this section if a life assured dies within 14 days of a diagnosis as described in (a).

(d) If there is a claim paid under a partial payment definition, you cannot claim the full sum insured under a related full payment specified illness cover definition which occurs or is diagnosed within 30 days of the occurrence or diagnosis of the partial payment specified illness cover event. If an admissible claim arises within 30 days for a related condition, the full payment specified illness cover benefit will be paid less the amount previously paid under the partial payment definition. Once 30 days has elapsed since the occurrence or diagnosis of the partial payment specified illness, any admissible claim for a related condition under the full payment specified illness cover benefit will be assessed and paid independently.

In respect of a partial payment for serious accident cover, once 30 days have elapsed, in the event of a related claim for full payment specified illness cover the full payment specified illness cover benefit will be paid less the amount previously paid under the partial payment definition.

Conditions where this 30 day rule may occur are as follows:

- Angiopasty to correct Carotid Stenosis - Stroke/Heart Attack
- Carcinoma in Situ, Oesophagus - invasive cancer Oesophagus
- Cerebral aneurysm- Stroke
- Coronary Angioplasty - Heart attack
- Crohns Disease partial payment- Crohns Disease full payment
- Ductal Carcinoma in Situ, Breast - invasive breast cancer
- Early stage urinary bladder cancer- Invasive cancer of the bladder
- Liver resection- Cancer of liver and major organ transplant
- Low Level Prostate Cancer - >=T2 Prostate Cancer
- Peripheral Vascular Disease, treated with angioplasty – Peripheral Vascular Disease, treated with bypass & heart attack & stroke.
- Pituitary tumour- Invasive cancer
- Severe Burns 10% body - Severe Burns 20% body /25% face
- Significant Visual impairment – blindness
- Surgical Removal of one eye – Blindness
- Treatment for Cerebral AVM - Stroke

Once a full payment specified illness cover benefit is paid, the Partial Payment Benefit ends immediately.

(e) All the normal plan terms and conditions including but not limited to sections 6.3, 6.4 and 7.2 apply to these limited payments.

Explanatory notes

The explanatory notes in the sections headed 'In simpler terms' are intended to provide a less technical explanation of the illness definitions, and some of the medical terms used within that definition. They are not intended as an alternative definition of the illness and will not be used to assess claims. In the event of any dispute, the illness 'definition' over rules the 'In simpler terms' explanation.

A Brain abscess drained via craniotomy

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes the surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

In simpler terms:

A brain abscess results from an infection in the brain. Swelling and inflammation develop in response to the infection. Infected brain cells, white blood cells and organisms collect in an area of the brain, a membrane forms and creates the abscess. While this immune response can protect the brain from the infection, an abscess may put pressure on delicate brain tissue.

A craniotomy is a surgical operation in which part of the skull is removed in order to access the brain.

You can claim if you are diagnosed with an intracerebral abscess which is treated by surgical drainage by craniotomy by a Consultant Neurosurgeon. A craniotomy is a surgical operation in which part of the skull is removed in order to access the brain.

B Carcinoma in Situ – Oesophagus, treated by specific surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a carcinoma in situ of the oesophagus, which has been treated surgically by removal of a portion or all of the oesophagus. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

For the above definition, the following are not covered:

- Treatment by any other method is specifically excluded.

In simpler terms:

The oesophagus is a muscular, membranous tube approximately 25 cm long which connects the mouth to the stomach. Carcinoma in situ is an early form of carcinoma that involves only the cells in which it began and has not spread to other tissues.

You can claim if you have been diagnosed with a carcinoma in situ of the oesophagus and you have been treated surgically by removal of part or all of the oesophagus.

This benefit does not cover any other disease or disorder of the oesophagus.

C Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty

Plan definition:

We will make a limited payment under specified illness cover if a life assured undergoes endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

In simpler terms:

Endarterectomy is a surgical procedure to remove atheromatous plaques (fatty tissue) or a blockage in the lining of an artery. It is carried out by separating the plaque from the arterial wall. An angioplasty is a procedure which uses a temporarily inflated balloon on a catheter (tube) to widen a narrowed or blocked blood vessel by compressing plaque against the artery wall. A stent is a device inserted into an artery to help keep it open.

You can claim if you have had a 70% narrowing or blockage of the carotid artery treated by either endarterectomy or angioplasty. We will require a copy of the angiogram report showing 70% stenosis in the carotid artery.

You cannot claim under this benefit for any other treatment of the carotid artery or vascular system.

D Cerebral aneurysm – with surgery or radiotherapy

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes treatment of a cerebral aneurysm via craniotomy, or stereotatic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral aneurysm.

For the above definition, the following is not covered:

- Cerebral arteriovenous malformation.

In simpler terms:

A cerebral aneurysm is a weakness in the wall of a cerebral artery or vein resulting in a swelling of the blood vessel. A cerebral aneurysm can rupture, bleeding into surrounding tissue. Some cerebral aneurysms, particularly those that are very small, do not bleed or cause any problems.

You can claim if you have a craniotomy, stereotactic radiosurgery, or endovascular treatment using coils under the care of a consultant neurologist or radiologist, as appropriate, to treat a cerebral aneurysm.

A craniotomy is a surgical operation in which part of the skull is removed to access the brain. Stereotactic radiosurgery is a form of radiation therapy that focuses on a small area of the body. Endovascular treatment uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.

E Cerebral arteriovenous malformation – treated by craniotomy, stereotactic radiosurgery or endovascular repair

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes treatment of a cerebral arteriovenous fistula or malformation via craniotomy or stereotactic radiosurgery or undergoes endovascular treatment by a consultant neurosurgeon or radiologist using coils to cause thrombosis (embolization).

For the above definition, the following is not covered:

- Intracranial aneurysm.

In simpler terms:

A cerebral arteriovenous malformation (AVM) is an abnormal connection between arteries and veins in the brain that interrupts normal blood flow between them. An AVM is characterised by tangles of abnormal and enlarged blood vessels. In serious cases, the blood vessels rupture.

An arteriovenous fistula is an abnormal passageway between an artery and a vein. Normally blood flows from arteries into capillaries and back to your heart in veins. When an arteriovenous fistula is present, blood flows directly from an artery into a vein, bypassing the capillaries. If the volume of blood flow diverted is large, tissues downstream receive less blood supply. Also, there is a risk of heart failure due to the increased volume of blood returned to the heart.

You can claim if you have a craniotomy, stereotactic radiosurgery, or endovascular treatment using coils under the care of a consultant neurologist or radiologist, as appropriate, to treat a cerebral AVM or AV fistula.

A craniotomy is a surgical operation in which part of the skull is removed to access the brain. Stereotactic radiosurgery is a form of radiation therapy that focuses on a small area of the body. Endovascular treatment uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.

F Coronary Artery Angioplasty – of specified severity

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes coronary artery angioplasty, atherectomy, laser treatment or stent insertion on the advice of a consultant cardiologist to correct:

- narrowing or blockages of at least 70%, confirmed by angiographic evidence, or
- narrowing or blockages where there is a fractional flow reserve ratio of <0.8.

Provided the above requirements are met, we will make the following payments:

- €10,000 (subject to limits above) on completion of coronary artery angioplasty, atherectomy, rotablation, laser treatment and/or insertion of stent(s) in one coronary artery.

- An additional €30,000 (subject to limits above) will be paid if the life assured undergoes a further coronary artery angioplasty, atherectomy, laser treatment or stent insertion provided it is not performed on the same coronary artery or its branches.

- €40,000 (subject to limits above) will be paid if the life assured undergoes coronary artery angioplasty, atherectomy, laser treatment or stent insertion in 2 or more coronary arteries, where no previous claim has been made under this benefit.

In simpler terms:

Arteries can become blocked with fatty deposits, like the 'furring up' of a kettle. If the blockages are in the coronary arteries close to the heart, this causes extra strain on the heart, which then may lead to more serious heart disease. We will need a copy of the angiogram reports showing at least 70% stenosis (narrowing) in the coronary arteries.

The fractional flow reserve (FFR) is defined as the pressure after a narrowing in an artery compared to the pressure before the narrowing. FFR is a procedure that accurately measures blood pressure and flow through a specific part of the coronary artery. FFR is carried out at the same time as the angiogram.

Balloon angioplasty involves a surgeon passing a fine balloon catheter (a flexible plastic tube) down one of the arteries to the heart (a coronary artery). When the balloon reaches the place where the artery has narrowed, it is inflated to force the walls of the artery apart.

Atherectomy and laser treatment are also techniques which involve passing a catheter into the blocked artery.

G Crohn's disease – treated with surgical intestinal resection

Plan definition:

We will make a limited payment if a life assured is diagnosed with Crohn's disease and has undergone surgery to remove part of the small or large intestine.

A definite diagnosis of Crohn's disease must be confirmed by a consultant gastroenterologist or by histological confirmation.

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Intestinal biopsy

In simpler terms:

Crohn's disease is a chronic condition that causes inflammation of the digestive tract. While there is no known cure for Crohn's disease, therapies can reduce symptoms and bring about remission.

You can claim if you have had an operation to surgically remove part of the small or large intestine (bowel) as a result of Crohn's disease.

We will not consider a claim for a diagnosis of Crohn's disease unless it has resulted in surgery as shown in the definition.

H Ductal Carcinoma in Situ – Breast, treated by surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a ductal carcinoma in situ of the breast, which has been removed surgically by mastectomy, partial mastectomy, segmentectomy or lumpectomy. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

In simpler terms:

Carcinoma in situ is an early form of carcinoma that involves only the cells in which it began and has not spread to other tissues. The term 'ductal' refers to the ducts in the milk glands in the breast.

You can claim if you are diagnosed as having a ductal carcinoma in situ of the breast which is removed surgically.

No benefit is payable under this benefit for any other breast disorder.

I Early stage urinary bladder cancer – of specified advancement

Plan definition:

We will make a limited payment for specified illness cover if a life assured is diagnosed by histological confirmation of having urinary bladder cancer that has progressed to either:

- stage Tis - Carcinoma in situ – diffuse 'flat' non-papillary tumour; or
- stage T1 - Carcinoma which has invaded the sub-epithelial connective tissue

For the above definition, the following is not covered:

- Any urinary bladder tumour which has been histologically classified as stage Ta (non-invasive papillary carcinoma).

In simpler terms:

Bladder cancer is often detected at an early stage because usually it shows signs and symptoms that are very noticeable before it becomes advanced.

'TNM classification' is a worldwide measure of how serious cancer is, and whether it has spread beyond the original site, in this case the bladder. The letter T is followed by numbers or letters (or both) to describe how far the main tumour has grown through the bladder wall and whether it has grown into nearby tissues. Higher T numbers mean more extensive growth. Tis and T1 tumours of the bladder are covered under this definition. We do not cover Ta

tumours as they generally have a better prognosis and are easily treatable.

J Implantable Cardioverter Defibrillator (ICD) for primary prevention of sudden cardiac death

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes the insertion of an Implantable Cardioverter-Defibrillator (ICD) on the advice of a Consultant Cardiologist for primary prevention of sudden cardiac death.

For the above definition, the following is not covered:

- Insertion of a pacemaker

In simpler terms:

An implantable cardiovertor defibrillator (ICD) is a small electrical device implanted in patients who are at risk of sudden death due to life-threatening, irregular heart rhythms. The ICD monitors the rhythm of the patient's heartbeat. When the ICD records arrhythmia (abnormal electrical activity in the heart), it acts to restore rhythm.

We do not cover inserting a pacemaker as this is a different device and is used to treat conditions that are generally less serious.

K Liver resection

Plan definition:

We will make a limited payment under specified illness cover if a life assured undergoes a partial hepatectomy (liver resection) on the advice of a specialist surgeon in gastroenterology and hepatology.

For this definition the following are not covered:

- Surgery relating to liver disease resulting from alcohol or drug abuse
- Surgery for liver donation (as a donor)
- Liver Biopsy

In simpler terms:
A liver resection is surgery to remove part of the liver. There are many reasons for removing part of the liver, including benign tumours, cysts, or traumatic injury.

L Low Level Prostate Cancer with Gleason score between 2 and 6 – and with specific treatment

Plan definition:

We will make a limited payment for specified illness cover if a life assured is diagnosed with a prostate cancer which has been histologically classified as having a Gleason score between 2 and 6 provided:

- The tumour has progressed to at least clinical TNM classification T1N0M0; and
- The client has undergone treatment by prostatectomy, external beam or interstitial implant radiotherapy

For the above definition, the following are not covered:

- Treatment with cryotherapy, transurethral resection of the prostate, 'experimental' treatments or hormone therapy.

In simpler terms:

With increased and improved screening, prostate cancer is being detected at an earlier stage. If prostate cancer is caught early, when it is still classified as 'low-grade', there is a good chance that treatment will be successful and the long-term outlook is good. The 'Gleason score' and the 'TNM classification' are ways of measuring and describing how serious the cancer is, and whether it has spread beyond the prostate gland based on its microscopic appearance. Cancers with a Gleason score less than or equal to 6 are less aggressive and have a better prognosis.

M Peripheral vascular disease - treated by Angioplasty

Plan definition:

We will make a limited payment under specified illness cover if a life assured undergoes a balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a cardiologist or vascular surgeon to correct at least 70% narrowing or blockage to an artery of the legs. Angiographic evidence will be required.

In simpler terms:

Peripheral vascular disease happens when there is significant narrowing of arteries. Symptoms vary from calf pain on exercise (intermittent claudication) to rest pain (critical limb ischaemia), skin ulceration, and gangrene.
Balloon angioplasty involves a surgeon passing a fine balloon catheter (a flexible plastic tube) into the narrowed artery. When the balloon reaches the place where the artery has narrowed, it is inflated to force the walls of the artery apart.

Atherectomy and laser treatment are also techniques which involve passing a catheter into the blocked artery.

If you have balloon angioplasty, atherectomy or laser treatment, you can claim if the treatment is to correct a 70% narrowing of an artery of the legs.

Under this definition, we do not cover peripheral vascular disease treated by any other method, including changing your lifestyle and medication.

N Pituitary tumour – resulting in permanent symptoms or surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a non-malignant tumour in the pituitary gland resulting in either of the following:

- *Permanent neurological deficit with persisting clinical symptoms**; or
- Treatment of the tumour by surgery or stereotactic radiosurgery

For the above definition, the following are not covered:

- Where symptoms of pituitary tumour are absent with on-going medical treatment
- Tumours in the brain

*"permanent neurological deficit with persisting clinical symptoms" is clearly defined as:

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

The pituitary gland makes hormones that control many other glands in the body. A pituitary tumour is a growth of abnormal cells in the pituitary gland. Most tumours of the pituitary gland are benign and slow-growing. However, they can cause a variety of symptoms including headache, loss of vision, and infertility. Treatment may include surgery, radiation therapy and drug therapy.

We do not cover pituitary tumours where symptoms are controlled by ongoing medication only.

O Serious Accident Cover – resulting in at least 28 consecutive days in hospital

Plan definition:

We will make a limited payment if a life assured suffers a serious accident resulting in severe physical injury where the life assured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

Severe physical injury means injury resulting solely and directly from unforeseen, external, violent and visible means and independent of any other causes.

We will also cover treatment in an inpatient rehabilitation centre, if the client is transferred directly from hospital to the rehabilitation centre for continuous treatment.

Only one partial payment or full payment will be paid resulting from the same accident.

For the above definition the following are not covered:

- Stays in hospital of less than 28 consecutive days
- Serious accident secondary to alcohol where there is a history of alcohol abuse
- Serious accident secondary to illegal drug abuse.

In simpler terms:

You can claim if you have a serious accident and are hospitalised for at least 28 consecutive days to receive medical treatment for your injuries. The 28 consecutive days can include time spent in a rehabilitation centre if you are transferred there directly from the hospital to continue your treatment. You can only make one claim for partial payment resulting from the same accident.

P Severe Burns/3rd Degree Burns covering at least 5% of the body's surface

Plan definition:

We will make a limited payment for specified illness cover if a life assured suffers burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% and less than 20% of the body's surface area.

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You will be able to claim if you have suffered third- degree burns covering at least 5% and less than 20% of the surface area of your body.

Q Significant visual impairment – permanent and irreversible

Plan definition:

We will make a limited payment for specified illness cover if a life assured suffers the permanent and irreversible reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/18 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lenses.

In simpler terms:

You can only claim if you have irreversible loss of sight in both eyes to the extent that even using eye glasses or other visual aids, the sight in your better eye is confirmed by an Opthalmologist or Consultant Physician and to the satisfaction of our Chief Medical Officer, as 6/18 or worse using the recognised sight test known as the Snellen eye chart. A Snellen chart is the test the Optician uses when you are asked read rows of letters. 6/18 is the measure when you can only see at six metres what someone with perfect sight would see at 18 metres away.

It is possible to be "registered blind" (as certified by an eye specialist) even though the loss of sight may be only partial. Even if you are "registered blind", your claim will only be met if the loss of sight meets the criteria outlined in our definition and cannot be corrected.

R Single Lobectomy – the removal of a complete lobe of a lung

Plan definition:

The undergoing of medically essential surgery to remove a complete lobe of a lung for disease or traumatic injury.

For the above definition, the following are not covered:

- Partial removal of a lobe of the lungs (segmental or wedge resection)
- Any other form of lung surgery.

In simpler terms:

The right lung is divided into three lobes and the left lung into two. The lobes of the lungs are further divided into segments. A lobectomy is an operation to remove one or more of the lobes from a lung.

You can claim if you have an operation to remove an entire lobe from the lung because it is diseased or because of a wound or an injury. You will not be able to claim if a segment of the lobe is removed, or for any other type of lung surgery. The operation to remove the entire lobe must be deemed medically essential by our Chief Medical Officer.

S Surgical removal of one eye

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes surgical removal of a complete eyeball for disease or trauma. To qualify for payment, the removal of the eyeball must happen on a date after the start date and before cover ends.

In simpler terms:

You can claim if you have to have an eyeball removed as a result of disease or injury.

No benefit is payable for loss of sight in one eye unless it was medically necessary to proceed and remove the eyeball.

T Syringomelia or Syringobulbia - treated by surgery

Plan definition:

We will make a limited payment if a life assured is diagnosed with a definite diagnosis of Syringomelia or Syringobulbia by a Consultant Neurologist, which has been surgically treated. This includes surgical insertion of a permanent drainage shunt.

In simpler terms:

Syringomyelia is a disorder in which a cyst or cavity forms within the spinal cord. The cyst can increase over time, destroying the centre of the spinal cord. If not treated surgically, syringomyelia can lead to progressive weakness, pain and loss of sensation in the arms and legs.

***Syringobulbia** is the same as syringomyelia, **but** the cyst or abnormal cavity exists within the brainstem.*

U Ulcerative Colitis – treated with total colectomy

Plan definition:

We will make a limited payment if a life assured is diagnosed with ulcerative colitis which is treated by removal of the entire colon (large bowel).
A definite diagnosis of ulcerative colitis must be confirmed by a consultant gastroenterologist.
For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Partial removal of the colon

In simpler terms:
Ulcerative colitis is a chronic inflammatory bowel disease that affects the large intestine (colon) and the rectum. There is inflammation and ulceration of the innermost lining of the intestine. Common symptoms include diarrhoea, an urgent need to go to the toilet, rectal bleeding and abdominal pain.

If ulcerative colitis does not respond to medical treatment, surgery may be needed. Surgery involves permanently removing the colon (colectomy).

You can claim if you have had a colectomy to treat ulcerative colitis.

We will not consider a diagnosis of ulcerative colitis treated by medication unless it has resulted in removing the entire colon.

4.8 Prepayment of surgery

This section only applies to a life assured if the certificate of membership shows that the life assured has accelerated specified illness cover.

(a) If a life assured's specified illness cover has not ended, we will make an advance payment for specified illness cover if a life assured has to have coronary artery bypass surgery, heart valve replacement or repair, heart structural repair, or aorta graft surgery. You must provide proof (as set out below) of the need for the surgery before we will pay any benefit. We will not make a payment if the type of surgery is not included in a life assured's cover. The amount we will pay is:

- €30,000; or
- the amount of specified illness cover the life assured has;

whichever is lower.

For children, the advance payment is €7,500.

Proof needed for coronary artery surgery

If a life assured needs coronary artery surgery, you must provide the following proof:

- Certification from a cardiologist or cardiac surgeon of a major hospital that the life assured is on a waiting list or scheduled for a coronary artery bypass graft. This need must be confirmed by our chief medical officer.
- A report on the symptoms which make the surgery necessary.
- The result of a recent angiogram showing the extent of the coronary artery disease.

Proof needed for heart valve replacement or repair and heart structural repair.

If a life assured needs heart valve replacement or repair or heart surgery to correct a structural abnormality, you must provide the following proof.

- Certification from a cardiologist or cardiac surgeon of a major hospital that the life assured is on a waiting list or scheduled for heart surgery he or she definitely needs within one year in order to repair or replace one or more heart valves or to correct structural abnormalities. This need must be confirmed by our Chief Medical Officer.
- A report on the symptoms which make the surgery necessary.
- The result of a recent echocardiogram and angiogram showing significant heart valve disease or a significant structural defect of the heart.

Proof needed for aorta graft surgery

If the life assured needs aorta graft surgery, you must provide the following proof.

- Certification from a cardiologist or vascular surgeon of a major hospital that the life assured is on a waiting list or scheduled for surgery he or she definitely needs in order to correct any narrowing or weakening of the thoracic or abdominal aorta by surgical replacement of a portion of the aorta with a graft. This need must be confirmed by our chief medical officer.
- A report on the nature of the disease or trauma and the symptoms.

(b) We will only make one payment for a life assured under this section.

(c) We will not make a payment under this section unless the life assured is alive when the claim is made.

(d) If accelerated specified illness cover applies to a life assured:

i. we will permanently reduce the level of specified illness cover and life cover the life assured has by the amount of any benefit we pay under this section;

ii. if we pay a benefit under this section and this reduces the amount of specified illness cover to nothing, all specified illness cover for the life assured will end;

iii. if we pay a benefit under this section and this reduces the life cover to nothing, all cover for the life assured will end; and

iv. we will pay any specified illness cover which is left after the life assured has the surgery.

4.9 Children's Life Cover

If cover has not ended, we will pay €6,000 for the funeral expenses of the child of a life assured (see definitions) if the child dies at least six months after the start date. However, the six-month restriction will not apply if the child dies as a result of an accident that happened after the start date. For each child we will only pay a total of €6,000.

We will not pay this benefit from more than one plan, even if both of the child's parents are lives assured and even if the life (or lives) assured is covered by more than one plan which provides similar benefits.

4.10 Children's Specified Illness Cover

If your cover includes specified illness cover and this cover has not ended, any child (see definitions section) above the age of 30 days is covered for children's specified illness cover except for the following specified illnesses (as defined in section 4.6)

- Brain injury due to anoxia or hypoxia; or
- Intensive Care requiring medical ventilation;

where cover is provided for children above the age of 90 days.

We will only pay children's specified illness cover benefit once for each child. This is so even if both parents are lives covered with specified illness cover, or even if the life assured is covered under more than one plan which provides similar benefits. The amount of children's specified illness cover benefit is the lower of €25,000 or half of your specified illness benefit amount. If there are two people named on the certificate of membership as the lives

covered (joint life), the amount of children's specified illness cover benefit is the lower of €25,000 or half of the first life's specified illness benefit amount.

We will pay the benefit for a child above the age of 30 days (subject to the exceptions above) who survives for more than 14 days after being diagnosed as having a specified illness (see section 4.6), we will pay a benefit for a child suffering one of the conditions listed under the specified illness cover partial payment benefits (see section 4.7) of €7,500 or half of the specified illness benefit amount for a single life, whichever is lower. If there are two people named on the certificate of membership as the lives covered (joint life), the partial payment for children is the lesser of €7,500 or half of the first life's specified illness benefit amount. We only make a partial payment once for each child.

We will not pay children's specified illness cover benefit in the following circumstances.

- If, in the professional opinion of our chief medical officer, a claim arises from any illness or condition (whether referred to in section 4.6 and/or 4.7 or not) which was known to exist or significant symptoms were present before the start date of the plan, before the child was 30 days or before the child was adopted by the life assured.
- If the child is not alive on the date the claim is made.

All these terms and conditions apply to this cover as they apply to specified illness cover on the life assured including, but not limited to section 7.4.

In summary the cover start age for the children's benefits in sections 4.9 and 4.10 above.

Type of Children's Cover	Cover start age
Children's Life Cover	**Birth** Plan must be in force for 6 months unless death is as a result of an accident.
Children's Specified Illness Cover	**30 days(*)**

*see section 4.10 for the exceptions for Children's Specified Illness Cover where the cover start age may be 90 days.

Changing the Level of Cover

Section 5

This section explains how the benefits reduce over the term of the plan, how you can take out some additional cover and have the right to alter your cover.

5.1 The amount of each benefit will reduce on a monthly basis over the full term of your plan. The table of protection benefits in the certificate of membership shows this reduction on a monthly basis for the first year only. Although this reduction continues monthly, the table only indicates the amount of cover which applies at the start of each remaining year.

5.2 Guaranteed Cover Again

If the certificate of membership shows that Guaranteed Cover Again applies, the proposer can convert this plan into another plan without you having to provide evidence of health. The proposer must change the plan before the benefits that you wish to convert end. The proposer may only do this once.

The following conditions apply.

- You must be under age 60 at the outset of the plan to select this option.
- The plan or Cover must not have already ended as a result of missed payments or a benefit event happening.
- You will be offered a decreasing cover plan with a guaranteed payment and fixed term, assuming we have such a product available at that time.
- You cannot take out a guaranteed payment whole of life or level or increasing plan using this option.
- The initial level of Cover under the new plan for a life assured cannot be greater than the level of Cover under this plan on the date you convert the plan.
- Guaranteed Cover Again applies to a maximum life cover sum insured of €5,000,000 and a maximum specified illness Cover sum insured of €1,000,000. These limits apply to the total benefit amounts converted across all policies where the life assured has Cover.
- The term of your new plan plus your age when exercising cannot pass the current maximum expiry age limits. These are currently 75 for specified illness Cover and 80 for life Cover, but these may change in the future.
- The cost of the new decreasing term assurance plan will be based on the terms which apply at that time.
- We will issue the new plan under our normal terms which apply at the time this plan is converted.
- Any special conditions which attach to this plan will apply to the new plan. This option may not be available if certain special conditions apply to your plan. You can ask us whether any special conditions on your plan prevent you from taking up this option.
- If a life assured is classified as a smoker on this plan they will be classified as a smoker on the new plan.
- You must apply in writing before the expiry date of the benefit.
- You cannot get Guaranteed Cover Again under the new plan.

- When you convert this plan, all cover under it will end.
- If we no longer offer specified illness cover, you may only convert any life cover benefit you have on the plan.
- The new plan will not provide cover for any illness or condition that is not insured under section 4 of this plan.
- If we have stopped giving cover for any of the illnesses or conditions in section 4 (if the life assured has this cover), these will not be insured under the new plan.
- If you have reduced your benefit amounts, the option will apply to the lesser of your current and original benefits.
- If there are differences between the illness or condition definitions given in this plan and the new plan, the definitions in the new plan will apply.

5.3 Guaranteed insurability option

This is an automatic additional benefit. If cover has not ended, the proposer can ask us to set up a new decreasing term assurance plan for the lesser of:

- 50% of initial life cover and / or specified illness cover benefit (or the new benefit amount if the proposer has reduced the level of cover in relation to you); or
- €125,000 life cover and / or specified illness cover.

And, you do not have to provide evidence of health. This applies within three months of:

- Being granted a new mortgage or an increase in an existing mortgage (the increase in cover cannot be higher than the mortgage or increase in mortgage), where the new or increased mortgage arises from a move to a new house or significant improvements to the existing house. The mortgage must be drawn down; or
- getting married or entering into a registered civil partnership; or
- having or adopting a child; or
- an increase in the life assured's salary, as a result of a change in job or getting a promotion. In this instance, the percentage increase in the sum assured is limited to the percentage increase in salary. Your employment status must be employee / employed. This is not available where your employment status is self-employed, company director or partner.

You must be aged 55 or under in order to exercise this option. If the basis of cover is Joint Life, the older life must be aged 55 or under.

You will need to provide independent proof of the mortgage, marriage, registered civil partnership, birth, adoption or salary increase before we can set up a new plan. You must ask for a new plan under this option within three months of the marriage, the registering of the civil partnership, birth, adoption or salary increase, or the date of the mortgage drawdown.

If you want to take out additional specified illness cover, you must take out the plan before the specified illness cover benefit comes to an end.

The following conditions apply.

- You can only take advantage of this option twice.
- The plan or cover must not have already ended as a result of missed payments or a benefit event happening.
- You will be offered a decreasing term assurance plan with a guaranteed payment and fixed term, assuming we have such a product available at that time.
- The cost of the new decreasing term assurance plan will be based on the terms which apply at that time.
- We will issue the new plan under our normal terms which apply at the time this option is exercised.
- Any special conditions which attach to this plan will apply to the new plan, in particular, if you are classed as a smoker on your existing plan you will be classed as a smoker on the new plan.
- You must apply in writing before the expiry date of the benefit being applied for.
- This option will not apply to the new plan.
- If we no longer offer specified illness cover, you may only take out a new plan with life cover.
- The new plan will not provide cover for any illness or condition that is not covered under section 4 of this plan.
- If we have stopped giving cover for any of the illnesses or conditions in section 4 (if the life assured has this cover), these will not be covered under the new plan.
- If there are differences between the illness or condition definitions given in this plan and the new plan, the definitions in the new plan will apply.

5.4 Optional Flexibility

If the plan has not ended, subject to certain rules, the proposer may ask us to:

- Reduce the cover or remove a benefit altogether.
- Reduce the term of the plan
- Increase the existing benefits
- Increase the term of the plan

The following conditions apply:

- The proposer can only alter the benefits or the term of the plan during the first five years of the plan.
- To increase the benefits or the term of the plan you must be aged 49 or younger.
- The original term of the plan must be greater than ten years for the proposer to be allowed to increase or reduce the term remaining on the plan.
- If the proposer wishes to increase the benefits or extend the term the current life cover amount cannot exceed €500,000 per life, while the current specified illness cover amount cannot exceed €300,000 per life.
- The maximum benefit increase allowed is 20% of the current benefit amount.
- The maximum term extension allowed is 5 years
- The proposer cannot increase benefits or alter the term on plans that were rated or had exclusions at inception, nor is it permitted on cases that have submitted a claim prior to requesting the plan be altered.
- Where a benefit is being increased and / or a term is being extended, a declaration of health is required. You must pass this in order for the alteration to be accepted.
- A benefit can only increase or have its term extended once.
- Any accelerated serious illness cover amount cannot be greater than the life cover amount.
- If the proposer chooses to alter the plan we will review the payments. Payments must be at least €13 a month (or another amount we may specify at the time).
- For the plan to continue, the life assured must always have life cover of at least €1,000.
- If you or the proposer has chosen the guaranteed cover again option, it cannot be removed.

Exclusions

Section 6

This section explains the circumstances in which we will not pay benefits.

6.1 If a life assured dies within a year of the start date, or within a year of increasing the life cover, as a result of their own deliberate act, or a penalty imposed by a court of law, we will not pay the proposer any benefit under the plan. But if the plan has been assigned as a condition of the granting of a loan, and the assignee can prove entitlement to all or part of the benefits under the plan, we will pay the lesser of the outstanding loan amount or the amount that would otherwise be payable under the plan, before the act which caused the death or for which the penalty was imposed.

6.2 If, within a year of the start date, or within a year of increasing the life or specified illness cover, a life assured is diagnosed as having a terminal illness as a result of their own deliberate act, we will not pay any benefit under the plan. But if the plan has been assigned as a condition of the granting of a loan, and the assignee can prove entitlement to all or part of the benefits under the plan, we will pay the lesser of the outstanding loan amount or the amount that would otherwise be payable under the plan, before the act which caused the terminal illness.

6.3 We will not pay accidental death cover benefit or specified illness cover benefit for coma, loss of limb, loss of independence, brain injury due to anoxia or hypoxia and intensive care requiring mechanical ventilation for 10 consecutive days, paralysis of a limb, severe burns/3rd degree burns or traumatic head injury, and will not pay limited payments for severe burns/3rd degree burns covering at least 5% of the body surface or surgical removal of one eye or the serious accident cover partial payment benefit, in any of the following circumstances.

- If the condition or accidental death is caused directly or indirectly by war, revolution or taking part in a riot or civil commotion.
- If the condition or accidental death is caused, directly or indirectly by taking part in a criminal act.
- If the condition or accidental death is self-inflicted or caused directly or indirectly by the life assured taking alcohol or taking illegal drugs.
- If the life assured failed to follow reasonable medical advice or failed to follow medically recommended therapies, treatment or surgery.
- If the condition or accidental death is caused by the life assured taking part in hazardous pursuits, including but not limited to the following.
  - Abseiling
  - Bobsleighing
  - Boxing

- Flying, taking part in any flying activity, other than as a passenger in a commercially licenced aircraft
- Hang gliding
- Horse racing
- Motor car or motorcycle racing or sports
- Mountaineering
- Parachuting
- Pot-holing or caving
- Power boat racing
- Rock climbing
- Scuba diving.

6.4 We will only pay specified illness cover benefit, or life cover benefit for a life assured who has been diagnosed as having a terminal illness, if the life assured lives in one of the accepted countries. These are any Member State of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland and the USA. We reserve the right to refuse to accept medical evidence produced from any country, in respect of specified illness cover benefit, other than from a recognised hospital in Ireland or the UK or health professional resident in Ireland or the UK.

6.5 A life assured must write and tell us immediately if they start living in a country that is not an accepted country. We will then decide whether cover will continue and on what basis.

Claims

Section 7

This section explains how to make a claim and how we will assess the proposer's claim.

7.1 We have worked out the benefits provided under the master plan on the basis that the date of birth of the life assured is as shown on the application form. When you make a claim, we will ask you or the proposer to provide proof of the date of birth. If the date of birth on the application form is not correct, we will recalculate the benefits in line with the correct date of birth.

7.2 We will not consider any claim until we have received the following:

- A properly filled-in claim form.
- Proof of entitlement to claim the benefits. This could include proof that these terms and conditions and any special conditions contained in the certificate of membership have been followed.
- Proof (in the form of a birth certificate) of the age of the life assured.
- The original plan documents outlining the details of the arrangements under the master plan. If they are not available, whoever makes the claim must accept legal responsibility if it turns out that someone else is entitled to the benefit.

7.3 If a claim is being made for the death of a life assured or the funeral expenses of a child, we are entitled to ask for proof of death in the form of a death certificate, and any other proof we reasonably need.

7.4 If the proposer is claiming life cover benefit for a terminal illness, or specified illness cover benefit or children's specified illness cover benefit you must tell us, in writing, about the surgery or diagnosis within six months of the day on which it occurred. If you do not, we may refuse to pay the benefit. You must provide and pay for any certificates, tests, information or evidence, which we reasonably need to prove the proposer's claim.

You or the child must agree to any medical examinations and tests which are necessary to prove the proposer's claim, and if you or the child dies we may ask for a post mortem examination. If you fail or the child fails to meet these requirements within a reasonable time, or if you or the child fails to follow the advice of a registered medical practitioner, we will not pay the benefits claimed. We may also adjust the life cover benefits for the death of the life assured or child, or end the master plan altogether.

7.5 If a claim is admitted for children's life cover or children's specified illness cover, we will pay the benefits directly to the life (or lives) assured. We will pay these directly to the life (or lives assured), rather than to the proposer, as these do not effect any lender's security under the plan.

If any of the information we have been given is not correct, true or complete, we will not pay the benefits claimed and may also alter the other benefits for the life assured or the child under the master plan, or the benefits under the master plan may end altogether.

Tax

Section 8

This section explains what will happen if there is any change in tax law.

8.1 Under current law, tax does not have to be taken from life cover or specified illness cover benefits. A government levy is charged on payments that the proposer makes under this plan (as at December 2012).

8.2 Any taxes or levies imposed by the government will be deducted by Irish Life. We will deal with this plan in line with the requirements of the Revenue Commissioners. If tax laws or any other relevant laws change after the start date, we will change the terms and conditions of the plan if we need to do this to keep the plan in line with those changes. We will write and tell you about any changes in the terms and conditions.

We recommend that you seek independent tax advice in respect of your own specific circumstances.

Other information

Section 9

This section provides other information you need to know.

9.1 Under the conditions of the master plan there is no cash-in value.

9.2 The master plan is governed by the law of Ireland, and the Irish courts are the only courts which are entitled to hear any dispute.

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Contact us

Phone: 01 704 20 00
Fax: 01 704 19 00
e-mail: customerservice@irishlife.ie
Website: www.irishlife.ie
Write to: Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1.