Term 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 **Term Life Insurance** plan 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 it in the future.

Introduction

We have granted this master plan to you, 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 pay benefits if you die or suffer any of the conditions covered during the term of the plan. With **Term Life Insurance** you can choose life cover or specified illness cover on their own or a combination of life cover and specified illness cover. When you decide which combination best suits your needs, you can then add accident cash cover or hospital cash cover as valuable extras. You must have chosen a minimum of €25,000 life cover in order to have life cover additional payments or to add either hospital cash cover or accident cash cover.

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

We have issued this master plan to the proposer on the understanding that the information given in your application in response to our questions and any related document is true and complete and that we have been given all information as required by those questions.

Your application includes your application form (a copy of which has been sent to you) and any other medical or other questionnaires you have provided.

You must answer all of the questions in your application honestly and with reasonable care. We have relied on the information you have given us when deciding to insure you and when setting the terms and premium. Where we ask you to answer a specific question, the subject matter of the question is material to the risk we are undertaking or the calculation of the premium or both.

This could include questions about your health, family history, lifestyle habits (such as smoking, drinking alcohol or taking illegal drugs), occupation, income, age, other financial details, hobbies or pastimes.

If any of the answers to the questions are not answered honestly and with reasonable care, we may be entitled (depending on the breach) to declare the plan void, refuse your claim, treat your insurance as if it was entered on different terms, or reduce your claim.

In any future application(s) for changes to your cover after the start date of your plan if any of the questions are not answered honestly and with reasonable care, we may be entitled (depending on the breach) to declare the plan void, refuse your claim, treat your insurance as if it was entered on different terms, or reduce your claim.

We may refuse to pay a claim even if there is no direct medical connection between the illness that caused the claim and the medical condition which was not revealed to us on the application for cover. To do this we must be able to show that the facts you did not tell us about at the time the application was completed would have affected our original decision to provide the cover. If cover is voided on one life on a dual cover plan all cover will cease under that plan for both lives.

We will rely on what you have told us and you must not assume that we have automatically confirmed with your own GP or any doctor any information you have provided.

This plan is a protection plan only – the proposer cannot cash it in. Even if a claim has not been made 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' shown in the certificate of membership, unless 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.

If the proposer is making a claim under this master plan, please contact our head office at:

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

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 want, and the proposer is responsible for making sure payments are made as set out in the certificate of membership. If a benefit event occurs we will pay the proposer the appropriate benefit (the benefits are described 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 life cover additional payments, the additional payments on specified illness cover, payment of children's cover, hospital cash cover and accident cash cover, (see section 7.2). Once your mortgage is repaid, the proposer may tell us that we can pay future benefits to you.

This plan cannot be assigned (transferred) to anyone else, including other financial institutions.

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 and Pensions Ombudsman of Ireland. You can get more information from:

Financial Services and Pensions Ombudsman

Lincoln House

Lincoln Place

Dublin 2

D02 VH29

Tel: (01) 567 7000
Email: info@fspo.ie
Website: www.fspo.ie

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Life Cover Additional Payments

If a Life Assured has at least €25,000 Life Cover at the point of claim then they are automatically covered for the life cover additional payments listed below and defined in full in section 4.6.

a) Disseminated Intravascular Coagulation (DIC)
b) Ectopic Pregnancy
c) Hydatidiform Mole
d) Placental Abruption
e) Eclampsia

Full Payment Specified Illness conditions

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

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 or cyst – resulting in permanent symptoms, surgery or radiosurgery
6. Benign spinal cord tumour or cyst– 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 –with associated 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 – definite diagnosis
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 permanent dialysis or transplant
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 from another donor
31. Motor neurone disease – resulting in permanent symptoms
32. Multiple sclerosis or Neuromyelitis optica (Devic's Disease) – with past or present symptoms
33. Necrotising Fasciitis
34. Paralysis of One limb - total and irreversible
35. Parkinson's disease (idiopathic)– resulting in permanent symptoms
36. Parkinson Plus Syndromes - resulting in permanent symptoms
37. Peripheral Vascular Disease – with bypass surgery
38. Pneumonectomy – the removal of a complete lung
39. Primary Sclerosing Cholangitis – of specified severity
40. Pulmonary Arterial Hypertension (idiopathic) – of specified severity
41. Pulmonary Artery Graft Surgery
42. Respiratory Failure of specified severity
43. Short Bowel Syndrome - requiring permanent parenteral nutrition
44. Spinal Stroke – resulting in permanent symptoms
45. Stroke – of specified severity
46. Systemic lupus erythematosus – of specified severity
47. Third Degree Burns of specified surface area
48. Traumatic brain injury – resulting in permanent symptoms

Additional Payment Specified Illness Cover

If a Life Assured has selected specified illness cover (if selected it will be shown on the certificate of membership) then they are covered, on an additional payment basis, for the illnesses listed below and defined in full in section 4.8.

1. Aortic Aneurysm with endovascular repair
2. Brain Abscess drained via craniotomy
3. Cancer in situ of the anus - treated by surgery
4. Cancer in situ of the Cervix - with specified surgery
5. Cancer in situ of the colon or rectum - resulting in intestinal resection
6. Cancer in situ of the larynx – with specified treatment
7. Cancer in situ of the lung and bronchus - treated by specified surgery
8. Cancer in situ of the oesophagus, treated by specified surgery
9. Cancer in situ of the oral cavity or oropharynx – treated by surgery
10. Cancer in situ of the renal pelvis and ureter - of specified severity

11. Cancer in situ of the testicle – requiring surgery to remove at least one testicle
12. Cancer in situ of the urinary bladder
13. Cancer in situ of the uterus – with specified surgery
14. Cancer in situ of the vagina – with surgery
15. Cancer in situ of the vulva – with surgery
16. Ductal Carcinoma in situ Breast, treated by surgery
17. Cancer in situ – other (sites not already mentioned) – with surgery
18. Carotid Artery Stenosis treated by endarterectomy or angioplasty
19. Central retinal artery or vein occlusion (eye stroke) resulting in permanent visual loss
20. Cerebral or spinal aneurysm with surgery, radiotherapy or endovascular repair
21. Cerebral or spinal arteriovenous malformation with surgery, stereotactic radiosurgery or endovascular repair
22. Coronary Artery Angioplasty - of specified severity
23. Crohn's disease treated with surgical intestinal resection
24. Cystectomy – removal of the complete bladder
25. Gastrointestinal Stromal Tumour (GIST) – with surgery
26. Implantable cardiovertor defibrillator (ICD) for primary prevention of sudden cardiac death
27. Liver resection
28. Low Level Prostate Cancer with Gleason score between 2 and 6 and with specified treatment
29. Neuroendocrine Tumour (NET) of low malignant potential - with surgery
30. Ovarian Tumour of Borderline Malignancy / Low Malignant Potential – with surgical removal of an ovary
31. Peripheral vascular disease treated by angioplasty
32. Permanent Pacemaker Insertion for heartbeat abnormalities
33. Pituitary tumour resulting in permanent symptoms or surgery
34. Serious Accident Cover resulting in at least 28 consecutive days in hospital
35. Severe Burns/3rd degree burns covering at least 5% of the body's surface
36. Significant visual impairment - permanent and irreversible
37. Single lobectomy - the removal of a complete lobe of a lung
38. Surgical removal of one eye
39. Syringomyelia or Syringobulbia - treated by surgery
40. Thyroid Cancer – early stage with surgery

41. Total colectomy, including colectomy for ulcerative colitis.

Definitions

Section 1

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

Application form

This is the application form that you complete for this plan. Where you are exercising your guaranteed cover again option or conversion option, this also includes the original application form for your existing 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 the certificate of membership. We will send 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 assured;
- the benefits; and
- any special conditions that we have agreed to.

Child

Someone who is under 25 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.

Deferred period

This is the interval between the date each period of incapacity (as a result of an accident) begins and the beginning of the period for which we will pay the accident cash cover benefit. This interval is two weeks for accident cash cover (see section 4.10).

Earnings

If you are an employed person, your salary or wage for PAYE assessment purposes. This includes overtime and regular bonuses for the 12 months up to and ending at the start of the deferred period.

If you are self-employed, the average profit earned each year after deductions (that is, yearly net profit) for your business

occupation for three years (or less if not in business for at least three years). This period ends on the most recent accounting date before the start of the deferred period. The profit we use to work out earnings is the profit before any adjustments necessary for tax purposes. If accounts are prepared for a period of more or less than one year, we will take account of this. If there are items included in the accounts which do not relate to your occupation, we will take account of these as well.

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.

Incapacity as a result of an accident

This means that the life assured is totally unable to carry out the main duties of their normal occupation and is also not following any other occupation. The incapacity must arise as a direct result of an injury suffered in an accident that happens after the start date of cover. This means that the injury must be caused by external, violent and accidental means which leaves a visible bruise or wound. Injuries to muscles, intravertrebral discs, ligaments or any other soft tissues will not be covered unless caused by being hit by an object. The incapacity must be independent of all other causes and confirmed by our Chief Medical Officer. Main duties are those normally needed to do a job and which cannot reasonably be left out or altered.

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 functions. 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 practicing 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 protection benefits '; or
- the amount we tell you when we reinstate cover under section 3.4.

or

- a different amount (which we will tell you) if we or you make any amendment to your plan details.

Proposer

The proposer or company (usually a financial institutions such as a bank or building society) named as the proposer in the certificate of membership, who is responsible of making the payments and is legally entitled to the plan benefits. If the proposer tells us in writing that the mortgage has been repaid, all the obligations, rights and entitlements of the proposer will pass to you, the life or lives assured shown in the certificate of membership.

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. Cover will start on this date.

Supplementary benefits

The supplementary benefits under this plan are hospital cash cover and accident cash cover.

We, us

Irish Life Assurance Plc.

You

The person (or people) named in the certificate of membership as the life or lives assured. The benefits of the plan depend on the lives of those people. If different benefits applies to each of the lives assured (where two people are named on the certificate of membership), we will use the term 'life assured' rather than 'you' to make the meaning clearer. In the text

describing each illness covered under the heading ‘in simpler terms’ in sections 4.6, 4.7 and 4.8 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 issued this master plan on the understanding that the information given in your application in response to our questions and any related document is true and complete and that we have been given all information as required by those questions.
If this is not the case we will be entitled to take the actions described below, depending on the nature of your breach.

Your application includes your application form, any medical questionnaires, or any other information provided in response to questions before entering this plan.

You must answer all of the questions in your application honestly and with reasonable care. We have relied on the information you have given us when deciding to insure you and when setting the terms and premium. Where we ask you to answer a specific question, the subject matter of the question is material to the risk we are undertaking or the calculation of the premium or both.

If you have answered our questions honestly and with reasonable care, but if your answer includes a negligent misrepresentation (that is, not innocent or fraudulent), we are entitled to take the following actions:

(a) If, being aware of the full facts, we would not have entered the plan on any terms, this plan will be treated as void from the start of cover and we will refuse all claims, but return your premium;
(b) If, being aware of the full facts, we would have entered the plan on different terms, the plan will be treated as if it had been entered into on those different terms;
(c) If, being aware of the full facts, we would have charged a higher premium for the plan, we can reduce your claim proportionately.

If your answers to our questions are false or misleading in any material respect, and you know that they are false or misleading or consciously disregard if they are false or misleading (a "fraudulent misrepresentation") or any of your conduct involved fraud, this plan will be treated as void from the start of your policy. If this happens, you will lose all your rights under the plan, we will not pay any claim and we will not return any payments.

If cover is voided on one life on a dual cover plan all cover may cease under that plan for both lives, and we will tell you if this is the case.

2.2 If the proposer's cover 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 in response to our questions and any related document is true and complete and that all information has been provided as required by those questions.

If this is not the case, we will be entitled to take the actions described below, depending on the nature of your breach.

You must answer all of the questions in your evidence of health form honestly and with reasonable care. We will rely on the information you provide when deciding to reinstate your cover and when setting the terms and premium. Where we ask you to answer a specific question, the subject matter of the question is material to the risk we are undertaking or the calculation of the premium or both.

If you have answered our questions honestly and with reasonable care, but if your answer includes a negligent misrepresentation (that is, not innocent or fraudulent), we are entitled to take the following actions:
(a) If, being aware of the full facts, we would not have entered the plan on any terms, this plan will be treated as void from the start of cover and we will refuse all claims, but return your premium;
(b) If, being aware of the full facts, we would have entered the plan on different terms, the plan will be treated as if it had been entered into on those different terms;
(c) If, being aware of the full facts, we would have charged a higher premium for the plan, we can reduce your claim proportionately.

If your answers to our questions are false or misleading in any material respect, and you know that they are false or misleading or consciously disregard if they are false or misleading (a "fraudulent misrepresentation") or any of your conduct involved

fraud, this plan will be treated as void from the start of your policy. If this happens, you will no longer be covered, we will not pay any claim and we will not return any payments.

If cover is voided on one life on a dual cover plan all cover may cease under that plan for both lives, and we will tell you if this is the case.

Making payments

Section 3

This section explains the obligations 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 makes payments monthly, in which case we will give you 10 days to make the payment. (The time allowed is known as a 'period of grace'.) If you become entitled to a benefit during a period of grace, we will take from it any payment that the proposer has not made.

3.2 If the payment has not been made by the end of the period of grace, all cover 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 your 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 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, we receive a request for cover to be restored, then you must fill in an evidence of health form and the proposer must make all the payments which would have been made if cover had not ended must be made. If the information on the evidence of health form shows that the health of the life assured 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 you can choose under the plan.

4.1 The benefits provided to the proposer in relation to you under this master plan are shown in the certificate of membership. If a benefit is not mentioned in the certificate of membership, we do not provide that benefit. The certificate of membership also shows the amount of cover the proposer has in relation to you. 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 on the certificate of membership. We will send a revised certificate of membership showing new cover amounts. You cannot increase your benefit amount once you have chosen to reduce it.

The following benefits are available.

- Life cover
- Accelerated specified illness cover or
- Independent specified illness cover
- Hospital cash cover
- Accident cash cover

Your plan may also have guaranteed cover again (see section 5.1). Check your certificate of membership to see which benefits apply to this master plan.

A minimum of €25,000 life cover is required in order to have life cover additional payments or to select either hospital cash cover or accident cash cover.

All normal conditions for the plan (and any specific details in the sections explaining the benefits) apply to each benefit.

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 6.3.

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.

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.

There are three possible benefit events.

(a) A life cover benefit event

A life cover benefit event will happen when a life assured dies.

(b) An accelerated specified illness cover benefit event

An accelerated specified illness cover benefit event will happen when a life assured is diagnosed as having a specified illness as defined in section 4.7. The amount of life cover for that life assured is then reduced by the amount of any benefit we have paid for accelerated specified illness cover.

(c) An independent specified illness cover benefit event

An independent specified illness cover benefit event will happen 14 days after a life assured is diagnosed as having a specified illness as defined in section 4.7. The life assured must still be alive 14 days after the diagnosis. This 14-day period is on top of any time period we have mentioned in the definition of a particular illness or condition. We will not pay the benefit under

independent specified illness cover if the life assured dies within these periods.

Check the certificate of membership (and any subsequent revised certificate of memberships 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 the 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 for each policyholder.

If a life assured has independent specified illness cover but no life cover and is diagnosed as having a Terminal Illness (see section 4.5) we will pay the lesser of:

- 50% of the amount of specified illness cover; or
- €15,000;

(b) If a life assured has accelerated or independent specified illness cover, 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 sections 4.11 and in certain circumstances 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 or independent specified illness cover benefit event under section 4.7, all specified illness cover ends (including cover for those conditions listed in section 4.8 Additional Payment Specified Illness Cover). 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 sections 4.7 and 4.11. If the amount of life cover is reduced to nil for a life assured, all cover for that life assured ends. If the amount of accelerated specified illness cover is the same as the amount of life cover, all cover for a life assured 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.

(f) If a life assured has independent specified illness cover and no life cover and is diagnosed as having a terminal illness and this illness is covered as one of the listed specified illnesses (see section 4.7), there will only be one payout under the plan. The specified illness cover benefit will be paid out and there will be no payout under the terminal illness element of the plan. All specified illness cover for that life ends when the specified illness cover benefit is paid out. If a life assured has independent specified illness cover and no life cover and is diagnosed as having a terminal illness which is not listed as one of the listed specified illnesses (see section 4.7), we will pay the terminal illness cover amount. If the life assured is subsequently diagnosed with one of the listed specified illnesses, we will not pay any further benefit.

(g) If the amount of accelerated specified illness is the same as the amount of life cover, all cover for a life assured will end

when the accelerated specified illness cover benefit event happens.

4.4 All cover, including any supplementary benefits, will end for a life assured under the master plan:

- 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;
- when the life assured dies; or
- when an accelerated specified illness cover benefit event happens (if the amount of accelerated specified illness cover is the same as the amount of life cover);

whichever is earliest.

If you have life cover and specified illness cover, the expiry date of the specified illness cover may be earlier than the expiry date of the life cover benefit, because we limit specified illness cover to a maximum age of 75.

The hospital cash cover benefit and the accident cash cover benefit will end at the earlier of the policy anniversary before the life assured's 60th birthday and the expiry of the life cover benefit.

If there is only one life assured named on the certificate of membership as the life assured (single life) the plan ends when all cover in relation to you ends (as set out above).

If there are two lives assured named on the certificate of membership (dual life), when cover has ended for one life (as set out above) the other life's cover continues unless cover has ended because of missed payments or on the expiry dates. When cover in relation to both of you has ended, the master plan ends.

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 Life Cover Additional Payments

A life cover additional payments benefit of €5,000 will be paid if a life assured is diagnosed as having one of the five pregnancy life cover additional payment illnesses as defined below and a minimum of €25,000 life cover is chosen.

This is an automatic additional benefit attaching to life cover. This cover attaches to all lives assured under age 45 at point of claim who take out life cover. If life cover applies to a particular life assured it will be shown on the certificate of membership.

We will not pay this benefit during the first year after the commencement of the plan. We will pay a maximum of one life cover additional payment during any one pregnancy and a maximum of three life Cover additional payments under any one plan. If the life cover amount at the time of claim for the life assured who wishes to claim a Life Cover Additional Payment, is

less than €25,000 then life cover additional payments are not available.

The five pregnancy life cover additional payments covered by this benefit are set out below.

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. **Disseminated Intravascular Coagulation (DIC**)

Plan definition:

We will make a limited payment of €5000, if the life assured has a definite diagnosis by a Consultant Obstetrician of Disseminated Intravascular Coagulation (DIC) secondary to complications of pregnancy.

In simpler terms:

Disseminated Intravascular Coagulation (DIC) is a complex systemic thrombohaemorrhagic (clotting and bleeding) disorder involving an over-activation of clotting factors and fibrinolytic enzymes, resulting in thrombosis (clotting), tissue necrosis (death of tissue) and haemorrhaging (bleeding) from multiple sites.

We cannot consider a claim for Disseminated Intravascular Coagulation unless it has been directly caused by complications of pregnancy.

2. **Ectopic Pregnancy**

Plan definition:
We will make a limited payment of €5000, if the life assured has a definite diagnosis by a Consultant Obstetrician of ectopic pregnancy which requires emergency surgery.

In simpler terms:

An ectopic pregnancy occurs when a fertilised egg has implanted outside the uterus.

You can claim if you require immediate surgery for ectopic pregnancy.

3. **Hydatidiform Mole**

Plan definition:
We will make a limited payment of €5000, if the life assured has a definite diagnosis by a Consultant Obstetrician of hydatidiform mole.

In simpler terms:

Hydatidiform Mole is a benign neoplasm (growth) that forms around a fertilized egg inside the uterus during pregnancy. Tissue that normally would have developed into the placenta instead develops as an abnormal cluster of cells. (This is also called a molar pregnancy.)

4. **Placental Abruption.**

Plan definition:
We will make a limited payment of €5000, if the life assured has a definite diagnosis by a Consultant Obstetrician of placental abruption which requires medical intervention.

In simpler terms:

The placenta is a temporary vascular organ that joins the mother and the foetus. It transfers oxygen and nutrients from the mother to the baby and releases carbon dioxide and waste products from the foetus.

Placental abruption is the premature separation of the placental lining from the wall of the uterus before the birth of the baby.

5. **Eclampsia**

Plan definition:
We will make a limited payment of €5000, if the life assured has a definite diagnosis by a Consultant Obstetrician of eclampsia that has resulted in all of the following:

- Tonic-clonic seizure(s); and
- Pregnancy related hypertension; and
- Proteinuira

For the above condition, the following is not covered:
- Pre-eclampsia.

In simpler terms:

Eclampsia is a severe complication of pregnancy, where the mother has raised blood pressure, protein in her urine and suffers convulsions or coma.

A diagnosis of Eclampsia must be made by a Consultant obstetrician

4.7 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.

A life assured is '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, the life assured has:

- undergone 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 or independent 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 or cyst – resulting in permanent symptoms, surgery or radiosurgery

Plan definition:

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in any of the following:

- *Permanent neurological deficit with persisting clinical symptoms*;* or
- Surgical removal of the tumour; or
- Stereotactic radiosurgery to destroy tumour cells.

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Tumours originating from bone tissue
- Angioma and cholesteatoma .

*"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. A cholesteatoma is an uncommon abnormal collection of skin cells inside your ear.

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 or cyst– resulting in permanent symptoms or requiring surgery

Plan definition:

A non-malignant tumour of the spinal canal, meninges or spinal cord, causing pressure and/or interfering with the function of the spinal cord resulting in any of the following:

-surgery

-stereotactic radiosurgery

- 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.

*"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 or cyst 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 or cyst and have had surgery to have it removed, stereotactic radiosurgery to destroy tumour cells, 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 (with glasses or lenses), vision is measured by an ophthalmologist to be either of the following:

Visual activity of 3/60 or worse in the better eye using a Snellen eye chart, or

Visual field is reduced to 20 degrees or less of an arc.

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– or

Your visual field is reduced to 20 degrees or less of an arc. The visual field is the area of your surroundings that you can see at any one time and a visual field test will measure your entire scope of vision.

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 of malignant cells and invasion of tissue.

The term malignant tumour includes:

- leukaemia
- sarcoma
- lymphoma (except cutaneous lymphoma - lymphoma confined to the skin).

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 7 or above, or having progressed to at least TNM classification T2bN0M0.
- 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) i.e. >=Clarks level 2.
- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are specifically excluded from this cover.
- Any thyroid 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 an additional payment basis, see section 4.8.) 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 TNM classification of T2bN0M0. An additional payment benefit may be available (see section 4.8).

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.

Early stage thyroid cancer is very treatable, and the prognosis for patients with these early stage thyroid 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 thyroid cancer under this definition 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 –with associated permanent symptoms

Plan definition:

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

- requires the use of life support systems and
- results in associated permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following is not covered:

- Medically induced coma
- 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 resulting in all of the following:

- surgical resection to remove part of the small intestine or bowel on at least two separate occasions, and
- there must also be evidence of continued inflammation with on-going symptoms, despite optimal therapy with diet restriction, medication use and surgical interventions.

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.
The condition must be as severe as is described in the definition. In order to claim you must have had at least two separate surgeries and have continued inflammation and symptoms despite optimal therapy or surgery.

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 – definite diagnosis

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 or other positive changes on diagnostic imaging tests; and
- The characteristic rise of cardiac enzymes or Troponins

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes
- Angina without myocardial infarction

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. You may also undergo diagnostic imaging tests (e.g Cardiac CT or MRI scan)

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 (or other positive changes on diagnostic imaging tests).

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, Canada, Australia 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 permanent dialysis or transplant

Plan definition:

Chronic and end stage failure of both kidneys to function, as a result of which permanent 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 permanent regular 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 fulfil 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 from another donor

Plan definition:

The undergoing as a recipient of a transplant from another donor of bone marrow or a complete heart, kidney, liver, lung, or pancreas, or a lobe of liver, or a lobe of lung, or inclusion on an official Irish or UK waiting list 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 one of the following motor neurone diseases by a Consultant Neurologist.

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)

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 past or present symptoms

Plan definition:

A definite diagnosis of Multiple sclerosis or Neuromyelitis Optica (Devic's Disease) by a Consultant Neurologist. There must be a history of, or continuing clinical impairment of motor or sensory function caused by multiple sclerosis or neuromyelitis optica.

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 a history of or ongoing symptoms of the disease.

33. Necrotising Fasciitis

Plan definition:

A definite diagnosis of life threatening necrotising fasciitis or gas gangrene by a Consultant Physician, requiring immediate surgery to remove necrotic tissue and intravenous antibiotic treatment to prevent imminent death.

For the above definition, the following is not covered:

- All other forms of gangrene or cellulitis.

In simpler terms:

Necrotising fasciitis is a bacterial infection which spreads quickly in the body. It is caused by bacteria entering a wound.

Treatment is the cutting away (surgical removal) of dead body tissue. Medicines that kill bacteria (antibiotics) are given directly into a vein or veins (intravenous) to treat this condition.

In order to claim a hospital consultant doctor must require you to have both surgical and intravenous treatment.

34. 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.

35. 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.

36. 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.

37. 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.

38. 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.

39. Primary Sclerosing Cholangitis – of specified severity

Plan definition:

A definite diagnosis of primary sclerosing cholangitis as evidenced by imaging confirmation of typical multifocal formation of strictures and dilatation of intrahepatic and/or extrahepatic bile ducts.

The following are not covered:

• All other causes of bile duct stricture formation and dilation.

In simpler terms:

Primary Sclerosing Cholangitis is a chronic liver disease in which the bile ducts inside the liver (intrahepatic) and outside the liver (extrahepatic) become inflamed. This causes scars to form in the ducts blocking the movement of bile. Bile builds up inside the liver and damages the liver cells, which causes hardening of the tissue affecting the liver's ability to work.

A stricture is an abnormal narrowing and dilatation refers to the widening or stretching beyond normal of the bile duct.

40. 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.

41. Pulmonary Artery Graft Surgery

Plan definition:

The undergoing of surgery 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 heart surgery to replace the diseased pulmonary artery with a graft.

42. 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.

43. Short Bowel Syndrome - requiring permanent parenteral nutrition

Plan definition:

A definite diagnosis by a Consultant Gastroenterologist, of short bowel syndrome, resulting from massive loss of the small intestine, and requiring parenteral nutrition on a permanent basis.

In simpler terms:

Short bowel syndrome is a condition in which the body cannot absorb enough nutrients from food eaten because there is not enough working small intestine. The small intestine is where the majority of the nutrients are absorbed during digestion.

Parenteral Nutrition, also known as intravenous nutrition feeding, is a method of getting nutrition into the body through the veins.

44.Spinal stroke – resulting in permanent symptoms

Plan definition:

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column 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

The spinal cord depends on a supply of blood to function properly. A disruption in the blood supply causes tissue damage and can block messages (nerve impulses) travelling along the spinal cord. A spinal stroke happens when the blood flow to the spinal cord has been blocked by internal bleeding (haemorrhage) or by a piece of tissue or a blood clot (a thrombus or embolus)

45. Stroke – of specified severity

Plan definition:

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in all of the following evidence of stroke:

Neurological deficit with persisting clinical symptoms lasting at least 24 hours*, and

Definite evidence of death of tissue or haemorrhage on a brain scan.

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

Symptoms of dysfunction in the nervous system that are present on clinical examination and last for at least 24 hours. 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 above definition, the following are not covered:

- Transient ischaemic attack.
- Traumatic injury to brain tissue or blood vessels.
- Death of tissue of the optic nerve or retina/eye stroke
- 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 include '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.

46. 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.

47. Third Degree Burns of specified surface area

Plan definition:

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least the following:

- 20% of the body's surface area, or
- 20% surface area of the face which for the purpose of this definition includes the forehead and the ears, or
- 50% of both hands, requiring surgical debridement and/or grafting

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, 20% or more of the surface area of the face, or 50% of both hands requiring surgical removal of the burnt tissue and/or skin grafting.

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

48. Traumatic brain injury – resulting in permanent symptoms

Plan definition:

Death of brain tissue due to traumatic injury resulting in *permanent neurological deficit with persisting clinical symptoms**.

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.

4.8 Additional 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 proposer has accelerated specified illness cover or independent specified illness cover in relation to you.

A life assured is '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, the life assured has:

- 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 an additional 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. If independent specified illness cover applies to a life assured, we will only make this payment if the life assured is still alive 14 days after the diagnosis.

The total amount we will pay through additional payments is limited to the amount of your accelerated or independent specified illness as shown on your 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 client 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 or independent specified illness cover benefit will be that applicable on the date you are 'diagnosed as having a specified illness' (see Section 4.7).

For children, the additional payment is the lesser of €7,500 or half of the specified illness benefit amount for a single life. If there are two lives assured named on the certificate of membership (dual life), the additional payment for children is the lesser of €7,500 or half of the highest specified illness benefit amount. We will only make an additional 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 additional payments is limited to the amount of the accelerated or independent 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 an additional payment definition, the proposer 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 additional 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 additional payment definition. Once 30 days has elapsed since the occurrence or diagnosis of the additional 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 an additional 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 additional payment definition.

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

- Angioplasty to correct Carotid Stenosis - Stroke/Heart Attack
- Cancer in situ (all definitions) - invasive cancer of the same site
- Cerebral aneurysm- Stroke
- Coronary Angioplasty - Heart attack
- Crohn's Disease additional payment- Crohn's Disease full payment
- Ductal Carcinoma in Situ, Breast - invasive breast cancer
- Thyroid cancer, early stage - >= T2 thyroid cancer
- 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 pituitary cancer
- Severe Burns 5% body - Severe Burns 20% body /20% face/50% hands
- 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 additional Payment Benefit ceases 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.

1. Aortic aneurysm - with endovascular repair

Plan definition:
We will make a limited payment for specified illness cover if a life assured undergoes endovascular repair of an aneurysm of the thoracic or abdominal aorta with a graft.
For the above definition the following are not covered:
• Procedures to any branches of the thoracic and abdominal aorta.

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 stent graft might be necessary to bypass the narrowed or weakened part of the artery.

Endovascular repair involves a surgeon passing a catheter (a flexible plastic tube) through small incisions in a distal artery, through the blood vessels to the site of the aneurysm. The catheter delivers a stent graft (a fabric tube held in place by metal wire stents) to the site of the aneurysm where it is put in position in the affected segment of the aorta. The stent graft acts like a sleeve against the walls of the aorta to reinforce the weakened area allowing blood to pass through it without pushing on the aneurysm.

2.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.

3.Cancer in situ of the anus - 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 cancer in situ of the anus with surgery to remove the tumour.
For the above definition, the following are not covered:
▪ Anal Intraepithelial carcinoma (AIN) grade 1 or 2 is not covered.

In simpler terms:
The anus is the opening where the gastrointestinal tract exits the body. Cancer in situ is an early form of cancer 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 cancer in situ of the anus and you have been treated by an operation to cut out the tumour.

Anal intraepithelial neoplasia (AIN) means there are abnormal cells in the lining of the anus. It is not cancer but the cells might develop into cancer in the future.

4.Cancer in situ of the cervix - with specified surgery

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the cervix uteri resulting in trachelectomy (removal of the cervix) or hysterectomy.
For the above definition, the following are not covered:
• Loop excision, laser surgery, conisation and cryosurgery; and
• Cervical intraepithelial neoplasia (CIN) grade 1 or 2.

In simpler terms:
The cervix (or neck of the uterus) is the lower, narrow part of the uterus (womb) that joins to the top of the vagina. Cancer in situ is an early form of cancer 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 cancer in situ of the cervix and you are treated by removal of the cervix (trachelectomy) or removal of the uterus (hysterectomy).

The following less invasive treatments are not covered under this definition. Loop excision (removing the abnormal cells and tissue using a thin wire loop that's heated with an electric current), laser surgery (pinpointing and destroying abnormal cells on your cervix with a laser); conisation (cutting out a cone-shaped piece of tissue containing the abnormal cells).

Cervical intraepithelial neoplasia (CIN) means there are abnormal cells in the lining of the cervix. It is not cancer but the cells might develop into cancer in the future. CIN 1 and CIN 2 refer to mildly and moderately abnormal cells in the cervix and are not covered by this definition.

5.Cancer in situ of the colon or rectum - resulting in intestinal resection

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the colon or rectum resulting in intestinal resection.
For the above definition, the following are not covered:
- Local excision and polypectomy are not covered.

In simpler terms:
The colon is part of the digestive system. Its function is to reabsorb fluids and process waste products for elimination from the body. The rectum connects the lower colon to the anus. The rectum receives waste from the colon and stores it until it passes out of the body through the anus. Cancer in situ is an early form of cancer that involves only the cells in which it began and has not spread to other tissues.

You can claim under this definition if you have been diagnosed with a cancer in situ of the colon or rectum and you are treated by surgery to remove a portion of your large bowel (large intestine).
This benefit does not cover surgery which removes only the tumor and the area of normal tissue surrounding it (local excision). The removal of a polyp, or polyps, from the inside of the colon is also excluded from this definition. A polyp is an abnormal collection of tissue.

6. Cancer in situ of the larynx – with specified treatment

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a cancer in situ of the larynx which is treated with surgery, laser or radiotherapy.

In simpler terms:
The larynx is part of the respiratory system. The main function of the larynx is to prevent food entering the airways and it also produces vocal sounds. Cancer in situ is an early form of cancer 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 cancer in situ of the larynx and you are treated by: an operation (surgery), pinpointing and destroying abnormal cells with a laser (laser therapy), or the use of radiation to kill abnormal cells (radiotherapy).

7. Cancer in situ of the lung and bronchus - treated by specified surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a cancer situ of the lung or bronchus resulting in wedge resection or lobectomy.
Only one limited payment will be made resulting from the same condition. You will not be able to claim under cancer in situ of the lung and bronchus and single lobectomy for the same surgery.

In simpler terms:
The lungs and bronchus are parts of the respiratory system. Air enters your lungs when you breathe in and oxygen from the air moves from your lungs into your body. The lungs also remove waste gases from the body when you breathe out. A bronchus is a large air passage that begins at the end of the windpipe and branches into the lungs. Cancer in situ is an early form of cancer 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 cancer in situ of the lung or bronchus and you are treated by an operation to remove the tumour, along with a triangular-shaped section of normal lung tissue around the tumour (wedge resection). You can also claim if you have been diagnosed with a cancer in situ of the lung or bronchus and you are treated by an operation to remove a complete lobe of the lung (a lobectomy). 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.

This contract also covers lobectomy for other causes under the heading of single lobectomy. We will not pay out for cancer in situ of the lung and bronchus under both the cancer in situ and the single lobectomy definitions.

8. Cancer in situ of the oesophagus treated by specified surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a cancer in situ of the oesophagus, which has been treated surgically by removal of a portion or all of the oesophagus. A cancer 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. Cancer in situ is an early form of cancer 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 cancer 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.

9. Cancer in situ of the oral cavity or oropharynx – treated by surgery

Plan definition:

We will make a limited payment under specified illness cover If a life assured is diagnosed with cancer in situ of the oral cavity or oropharynx with surgery to remove the tumour. Oropharynx includes lip, inside of cheek, floor of mouth, tongue, gums, hard palate, soft palate and tonsils.

For the above definition, the following is not covered:

- Treatment for Leukoplakia

In simpler terms

Cancer in situ is an early form of cancer that only involves the cells in which it began and has not spread to other tissues. You can claim if you have been diagnosed with a cancer in situ of the oral cavity or oropharynx (which includes the lip, inside of cheek, floor of mouth, tongue, gums, hard palate, soft palate and tonsils), which has been removed surgically.

Leukoplakia i*s a white patch that develops in the mouth. It is usually painless but is closely linked to an increased risk of mouth cancer.*

10.Cancer in situ of the renal pelvis and ureter - of specified severity

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the renal pelvis or ureter.
For the above definition the following are not covered:

- Non-invasive papillary carcinoma
- Tumours of TNM classification stage Ta.

In simpler terms:
The renal pelvis is the area at the centre of the kidney where urine collects and then funnels into the ureter. The ureter is the tube that connects the kidney to the bladder. Cancer in situ is an early form of cancer 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 cancer in situ of the renal pelvis or ureter.

You cannot claim for a cancer of the renal pelvis or ureter which is described as either non-invasive papillary carcinoma or stage Ta. This is an early cancer that is only found on the surface of the inner lining of the renal pelvis or ureter. It has not invaded (spread deeper into) the renal pelvis or ureter wall.

11.Cancer in situ of the testicle – requiring surgery to remove at least one testicle

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU), histologically confirmed by biopsy, and as a result is treated by orchidectomy (complete surgical removal of the testicle)
For the above definition, the following are excluded -
▪ Treatment by any other method is specifically excluded.

In simpler terms:
The testicles form part of the male reproductive system. The testicles produces sperm and secrete testosterone.
Intratubular germ cell neoplasia unclassified is an uncontrolled, abnormal growth of cells which may develop into a testicular cancer.

You can claim if you have been diagnosed with a cancer in situ of one of the testicles (also known as intratubular germ cell neoplasia unclassified or ITGCNU) and you have been treated by an operation to remove an entire testicle (orchidectomy).

12. Cancer in situ of the urinary bladder

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 stage Tis - Cancer in situ - diffuse flat non-papillary tumour.
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:
The urinary bladder is where urine is stored temporarily before emptying through the urethra. Cancer in situ is an early form of cancer that involves only the cells in which it began and has not spread to other tissues.

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

You cannot claim for a cancer of the urinary bladder which is described as either non-invasive papillary carcinoma or stage Ta. This is an early cancer that is only found on the surface of the inner lining of the urinary bladder. It has not invaded (spread deeper into) the bladder wall.

13. Cancer in situ of the uterus – with specified surgery

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the lining of the uterus (endometrium) resulting in hysterectomy.

In simpler terms:
The uterus, or womb, is part of the female reproductive system. The implantation and nourishment of the fertilized egg takes place in the uterus. Cancer in situ is an early form of cancer 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 cancer in situ of the uterus and you are treated by a surgical operation to remove the uterus (hysterectomy).

14. Cancer in situ of the vagina – with surgery

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the vagina resulting in surgery to remove the tumour.

For the above definition, the following are not covered:
• Laser surgery and diathermy; and
• Vaginal intraepithelial neoplasia (VAIN) grade 1 or 2.

In simpler terms:
The vagina is part of the female reproductive system. It is the muscular passageway from the outside of the body to the uterus (womb). Cancer in situ is an early form of cancer 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 cancer in situ of the vagina and you have been treated by an operation to cut out the tumour.

The following treatments are not covered under this definition, laser surgery (a beam of high-energy light is used to vaporize the abnormal tissue); and diathermy (removal of abnormal cells using a heated probe).

Vaginal intraepithelial neoplasia (VAIN) are abnormal cells in the lining of the vagina (the passage leading from the vulva to the uterus). It is not cancer but the cells might develop into cancer in the future.

15. Cancer in situ of the vulva – with surgery

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of cancer in situ of the vulva resulting in surgery to remove the tumour.
For the above definition, the following are not covered:
• Laser surgery and diathermy; and
• Vulval intraepithelial neoplasia (VIN) grade 1 or 2.

In simpler terms:
The vulva is the external part of the female reproductive system. The vulva is the area of skin that surrounds the urethra and vagina, including the clitoris and labia. Cancer in situ is an early form of cancer 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 cancer in situ of the vulva and you have been treated by an operation to cut away the tumour.

The following treatments are not covered under this definition, laser surgery (a beam of high-energy light is used to vaporize the abnormal tissue); and diathermy (removal of abnormal cells using a heated probe).

Vulval intraepithelial neoplasia (VIN) are abnormal cells in the lining of the vulva. It is not cancer but the cells might develop into cancer in the future.

16. 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.

17. Cancer in situ – other (sites not already mentioned) – with surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a cancer in situ diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of an organ and that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

• Any skin cancer (including melanoma); and

• Tumours treated with radiotherapy, laser therapy, cryotherapy, cone biopsy, LLETZ (large loop excision of the transformation zone), diathermy treatment or topical therapy.

This definition includes but is not limited to, cancer in situ of the bile duct, gall bladder, liver, pancreas, stomach and thymus.

For this definition you can claim more than once as long as the in situ cancer is of a separate site to one previously claimed for and also is not covered under any of the cancer in situ definitions of named sites.

In simpler terms:

Cancer in situ is an early form of cancer that involves only the cells in which it began and has not spread to other tissues.

The epithelial lining is the tissue that covers the outer surfaces of organs and blood vessels throughout the body, as well as the inner surfaces of cavities in many internal organs.

You can claim under this definition if you have been diagnosed with a cancer in situ of an organ, not covered under its own specific heading in this contract, and you have been treated by an operation to cut out the tumour.

This benefit does not cover any form of skin cancer. 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. Malignant Melanoma which has been classified as being a 'Clark level 2' or greater is covered under our "Cancer – excluding less advanced cases" definition.

Treatment by any other method than cutting away the tumour is specifically excluded.

18. 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.

19. Central retinal artery or vein occlusion (eye stroke) resulting in permanent visual loss

Plan definition:

We will make a limited payment for specified illness cover if a life assured is diagnosed with death of the optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in permanent visual impairment of the affected eye

For the above definition, the following are not covered:

- Branch retinal artery or vein occlusion, or haemorrhage, and

- Traumatic injury to tissue of the optic nerve or retina

In simpler terms:

The eye depends on a supply of blood to function properly. An eye stroke happens when there is disruption in the blood supply to the optic nerve or central retinal artery or vein caused by internal bleeding (haemorrhage) or blockage resulting in permanent loss of vision in the affected eye.

20. Cerebral or spinal aneurysm – with surgery, 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 or spinal aneurysm via surgery, stereotatic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral or spinal aneurysm.

For the above definition, the following is not covered:

- Cerebral arteriovenous malformation.

In simpler terms:

A cerebral or spinal aneurysm is a weakness in the wall of a cerebral or spinal artery or vein resulting in a swelling of the blood vessel. A cerebral or spinal 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 surgery, stereotactic radiosurgery, or endovascular treatment using coils under the care of a consultant neurologist or radiologist, as appropriate, to treat a cerebral or spinal aneurysm.

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.

21. Cerebral or spinal arteriovenous malformation – with surgery, 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 or spinal arteriovenous fistula or malformation via surgery 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 or spinal aneurysm.

In simpler terms:

A cerebral arteriovenous malformation (AVM) is an abnormal connection between arteries and veins in the brain or spine 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 surgery, 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.

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.

22. 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.

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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.

23. 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.

24. Cystectomy – removal of the complete bladder

Plan definition:
We will make a limited payment for specified illness cover if a life assured undergoes complete surgical removal of the urinary bladder.
For the above definition the following are not covered:
• Urinary bladder biopsy;

• Removal of a portion of the urinary bladder.

In simpler terms:
The urinary bladder is where urine is stored temporarily before emptying through the urethra. Cystectomy is the medical term for the surgical operation which removes the entire urinary bladder.

We will not consider a claim for a procedure in which small pieces of tissue are removed from the bladder to be tested under a microscope (urinary bladder biopsy); or for a surgical operation which removes a section but not all of the urinary bladder.

25.Gastrointestinal Stromal Tumour (GIST) – with surgery

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of Gastrointestinal stromal tumour (GIST) of low malignant potential diagnosed by histological confirmation and that has been treated by surgery to remove the tumour.
For the above definition, the following is not covered:
• Tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment.

In simpler terms:
Gastrointestinal stromal tumour (GIST) are soft tissue tumours that develop in the digestive system. Their most common sites are the stomach and small intestine.

Tumours of low malignant potential can be considered as 'in-between' tumours. They have some but not all the features to be classified as benign and they also have some features but not all to be classified as malignant.

You can claim if you have been diagnosed with a Gastrointestinal stromal tumour (GIST) and you are treated by an operation to cut away the tumour.

The following treatments are not covered under this definition: the use of radiation to kill abnormal cells (radiotherapy), pinpointing and destroying abnormal cells with a laser (laser therapy), treatment using extreme cold to freeze the abnormal cells to kill them (cryotherapy), or removal of abnormal cells using a heated probe (diathermy).

26. 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 under this definition as this is a different device.

27. 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.

28. Low Level Prostate Cancer with Gleason score between 2 and 6 – and with specified 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.

29. Neuroendocrine Tumour (NET) of low malignant potential - with surgery

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of neuroendocrine tumours of low malignant potential, including Merkel cell cancer of the skin, diagnosed by histological confirmation and that has been treated by surgery to remove the tumour.
The following are not covered:
• Tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment

In simpler terms:
Neuroendocrine Tumours (NETs) form from cells that release hormones into the blood in response to signals from the nervous system.
Tumours of low malignant potential can be considered as 'in-between' tumours. They have some but not all the features to be classified as benign and they also have some features but not all to be classified as malignant.

You can claim if you have been diagnosed with a Neuroendocrine Tumour (NET) of low malignant potential and you are treated by an operation to cut away the tumour.

Merkel cell carcinoma is a type of skin cancer that forms when Merkel cells grow out of control.

The following treatments are not covered under this definition: the use of radiation to kill abnormal cells (radiotherapy), pinpointing and destroying abnormal cells with a laser (laser therapy), treatment using extreme cold to freeze the abnormal cells to kill them (cryotherapy), or removal of abnormal cells using a heated probe (diathermy).

30. Ovarian Tumour of Borderline Malignancy / Low Malignant Potential – with surgical removal of an ovary

Plan definition:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of ovarian tumour of borderline malignancy/low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.
For the above definition, the following is not covered:
• Removal of an ovary due to cyst.

In simpler terms:
The ovary is part of the female reproductive system. It produces and releases eggs.
Tumours of low malignant potential can be considered as 'in-between' tumours. They have some but not all the features to be classified as benign and they also have some features but not all to be classified as malignant.

You can claim if you have been diagnosed with an ovarian tumour of borderline malignancy/low malignant potential and

you are treated by an operation to remove the affected ovary (oophrectomy).

You cannot claim under this definition if you have an ovary removed due to the growth of a benign fluid filled sac (cyst).

31. 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.

32. Permanent Pacemaker Insertion for heartbeat abnormalities

Plan definitions:
We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of an abnormal rhythm of heartbeat by a consultant cardiologist resulting in the insertion of an artificial pacemaker on a permanent basis.

In simpler terms:
A pacemaker is a small, battery-operated device, fitted in the chest or abdomen. This device senses when your heart is beating irregularly or too slowly, or missing beats. It sends an electrical signal to your heart that makes your heart beat at the correct pace.

33. 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.

34. 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 additional 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 additional payment resulting from the same accident.

35. 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.

36. 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 (with glasses or lenses), vision is measured by an ophthalmologist to be either of the following:

- Vision is measure at 6/18 or worse in the better eye using a Snellen eye chart, or
- Visual field is reduced to 50 degrees or less of an arc.

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.

Or

Your visual field is reduced to 50 degrees or less of an arc. The visual field is the area of your surroundings that you can see at any one time. A visual field test will measure your entire scope of vision.

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.

37. 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.
- Only one limited payment will be made resulting from the same condition. You will not be able to claim under single lobectomy and cancer in situ of the lung and bronchus for the same 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.

38. 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.

39. Syringomyelia or Syringobulbia - treated by surgery

Plan definition:

We will make a limited payment if a life assured is diagnosed with a definite diagnosis of Syringomyelia or Syringobulbia by a Consultant Neurologist, which has been surgically treated.

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.*

40. Thyroid Cancer – early stage with surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of thyroid cancer that has been histologically classified as having progressed to at least TNM classification T1N0M0 and where surgery has been performed to remove the tumour.

In simpler terms:

The thyroid is a gland in the neck which releases hormones to control how the body uses energy from food, a process called metabolism. Thyroid hormones regulate breathing, heart rate and temperature among other vital body functions.

'TNM classification' is a worldwide measure of how serious cancer is, and whether it has spread beyond the original site, in this case the thyroid. The letter T is followed by numbers or letters (or both) to describe how far the main tumour has grown within and beyond the thyroid gland and whether it has grown into nearby tissues. Higher T numbers mean more extensive growth.

You can claim under this definition if you have been diagnosed with a T1 tumour of the thyroid and you have been treated by an operation to cut away the tumour.

41. Total colectomy, including colectomy for ulcerative colitis

Plan definition:

We will make a limited payment if a life suffers a condition which is treated by the removal of the entire colon (large bowel)

The need for surgery to remove the entire colon must be confirmed by a consultant surgeon.

For the above definition, the following are not covered:

- Total colectomy as a result of Crohn's 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.

You can also claim if you have had your entire colon surgically removed due to another medical condition, but Crohn's disease is specifically excluded.

4.9 Hospital cash cover

This benefit only applies to a life assured if hospital cash cover is shown in the certificate of membership as a benefit type for that life assured under the heading 'Your benefits' and a minimum of €25,000 life cover is chosen

i. If a life assured has hospital cash cover, we will pay this benefit when the life assured has been in hospital as an inpatient for more than 72 hours in a row. After the 72 hours, we will pay the benefit amount shown on the certificate of membership for each day the life assured is in hospital (including the first three days). We will pay the benefit for up to 365 days during the lifetime of the plan. We will not pay any benefit if the life assured is in the hospital for less than 72 hours.

ii. We will only pay the benefit for hospital stays starting after the start date and before the cover ends.

iii. A 'hospital' is an institution, in one of the accepted countries, that has facilities for diagnosis, treatment and major surgery and has accommodation for inpatients. 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.

iv. If the life assured goes back into hospital within seven days of a hospital stay we paid a benefit for, we will start paying benefit again immediately. That is, we will not wait until the life assured has been in hospital for 72 hours.

v. We normally pay the total benefit in one lump sum after the life assured has left hospital. If you ask, we will make part payments when the hospital stay is likely to last longer than 21 days.

vi. All the normal plan terms and conditions apply to hospital cash cover.

vii. We will not pay hospital cash cover benefit if the life assured goes into hospital in the following circumstances.

1. For treatment of mental illness, a psychiatric disorder, stress, anxiety or alcoholism.
2. For any cosmetic surgery, unnecessary surgery, or surgery which the life assured chooses to have even though it is not essential.
3. If the hospital stay is within two years of hospital cash cover starting and is due to any disability, accident, illness or condition which the life assured knew about or should have known about before the cover started.
4. If the hospital stay is within 9 months of hospital cash cover starting and is for or related to a pregnancy or childbirth, or complications from these.

viii. The exclusions contained in sections 6.3 and 6.4 apply to this benefit.

ix. Hospital cash cover for a life assured ends:

- when the life assured reaches the policy anniversary before their 60th birthday;
- when the life assured no longer has any life cover; or
- if 365 days' payments have been made during the lifetime of the plan;

whichever is earlier.

4.10 Accident Cash Cover

This benefit only applies to a life assured if accident cash cover is shown in the certificate of membership as a benefit type for that life assured under the heading 'Your benefits' and a minimum of €25,000 life cover is chosen.

i If we accept a claim for incapacity as a result of an accident (see the definitions section), we will pay you the accident cash cover benefit amount set out in the certificate of membership. We will do this for any continuous period of incapacity as a result of an accident lasting longer than the deferred period (which is two weeks). In other words, we will not pay accident cash cover benefit for the first two weeks of any period of continuous incapacity. We will only pay accident cash cover benefit for up to 52 weeks in total through the lifetime of the plan. Any limits set in paragraphs (ii) and (iii) will apply to the amount we pay.

ii The accident cash cover benefit amount set out in the certificate of membership is the most we will pay if you make a claim. The actual amount you will receive cannot be more than 40% of the life assured's yearly earnings (see the definitions section) less:

- the amount of any salary, earnings, profit, reward or other earned income which the life assured continues to receive from any source;
- the amount of any income the life assured receives from a pension fund; and
- the amount of any regular benefit the life assured is receiving from any other insurance plan for incapacity or disability.

We will carry out this calculation from time to time during any claim. We have designed the calculation to make sure that the life assured has enough financial incentive to return to work while we are paying accident cash cover benefit. We will not refund any payments if, as a result of this, we pay less than the accident cash cover benefit amount shown in the certificate of membership .

iii If the you make a claim and you were unemployed at the start of the deferred period, the amount we will pay under accident cash cover will be reduced to:

- 50% of the accident cash cover benefit amount set out in the certificate of membership; or
- €100 a week;

whichever is lower.

If you are unemployed at the start of the deferred period, we will use your occupation as shown on the application form when assessing if you meet the definition of incapacity as a result of an accident.

We have included this rule to make sure that the life assured has enough financial incentive to return to work while we are paying accident cash cover benefit. We will not refund any payments if, as a result of this, we pay less than the accident cash cover benefit amount shown in the certificate of membership. All normal plan conditions, including but not limited to ii above and v below apply to this rule.

iv If you suffer one of the qualifying injuries listed below as a result of an accident before the earlier of:

- the policy anniversary before your 60th birthday; and
- the expiry of the life cover benefit;

we will pay immediately the number of weeks benefit listed for that injury. This will be in place of a weekly benefit from week three of any period of incapacity as a result of an accident. The amount of benefit payable per week will be subject to the limitations under paragraphs ii and iii above. If at the end of the listed period of weeks, you still meet the definition of incapacity as a result of an accident, we will pay regular benefits from then in line with all normal plan conditions.

Qualifying injury	Number of weeks benefit
Fracture of the upper leg	12
Fracture of the lower leg or ankle	10
Fracture of the arm	10
Fracture of the wrist	6
Fracture of the vertebrae, shoulder blade or sternum	4
Fracture of the jaw or cheekbone	4
Fracture of the foot	6
Fracture of the ribs or collarbone	4
Open fracture of the skull	12
Closed fracture of the skull	4
Dislocation of the hip	4
Dislocation of the ankle	4
Dislocation of the elbow	4
Dislocation of the shoulder	4

These fractures and dislocations are defined as follows.

- Fracture of the upper leg means breaking the femur or hip.

- Fracture of the lower leg or ankle means breaking the tibia, fibula, patella or tarsus (ankle bone).
- Fracture of the arm means breaking the humerus or upper two-thirds of the radius or ulna.
- Fracture of the wrist means breaking any of the carpal bones or lower one third of the radius or ulna.
- Fracture of the vertebrae, shoulder blade or sternum means breaking any of the vertebrae, scapula or sternum.
- Fracture of the jaw or cheekbone means breaking the mandible, maxilla or cheekbone (the nasal bones are not included).
- Fracture of the foot means breaking the oscalcis, talus, the tarsal bones or metatarsal bones (the toes (phalanges) are not included).
- Fracture of the ribs or collarbone means breaking any of the ribs or clavicle.
- Open fracture of the skull means a compound fracture where the bone ends have pierced the overlying skin with significant damage to surrounding tissues (the nasal bones are not included).
- Closed fracture of the skull means a simple fracture (includes hairline fracture) with little damage to surrounding tissues and no break in the overlying skin (the nasal bones are not included).
- Dislocation of the hip means displacing the femur from the acetabulum.
- Dislocation of the ankle means displacing the talus bone from the socket formed by the lower end of the tibia and fibula.
- Dislocation of the elbow means displacing the ulna or radius bone in relation to the lower end of the humerus.
- Dislocation of the shoulder means displacing the head of the humerus from the glenoid fossa.

We will pay a benefit only if the qualifying injury happens after the start date and before cover ends. If a claim involves more than one qualifying injury arising from a single accident, we will pay only once under the qualifying injury with the higher number of weeks benefit. The qualifying injury must be caused by external, violent and accidental means which leaves a visible bruise or wound. The 52-week limit for all accident cash cover claims over the lifetime of the plan applies to payments for qualifying injuries. Any benefit paid under this rule is included when counting the total weeks of benefit paid. If the qualifying injury is a dislocated shoulder, only one claim will be paid in any two year period for that shoulder. If the same shoulder is dislocated again within 2 years of a previous claim for a dislocation of the same shoulder joint, this second claim (and any subsequent claims) will not be paid. All normal plan conditions apply to this rule.

v If we do pay a claim, accident cash cover benefit will end:

- when we have paid 52 weeks of accident cash cover benefit in total for a life assured (including all claims over the lifetime of the plan);

- when the life assured reaches the policy anniversary before their 60th birthday;
- when the life assured dies;
- when the life assured returns to work;
- if our Chief Medical Officer decides that incapacity as a result of an accident has ended; or
- if the life assured goes back to their normal occupation or takes up another occupation and fails to tell us immediately about this;

whichever is earliest.

vi We will not pay accident cash cover benefit in any of the following circumstances.

- If the claim is caused as a result of an accident involving a motorcycle where the life assured is driving the motorcycle.
- If the claim is caused directly or indirectly by any mental or functional nervous disorder, including but not limited to stress (including posttraumatic stress disorder), physical symptoms of a psychiatric illness, anxiety, depression, psychoneurotic, psychotic, personality, emotional or behavioural disorders, or disorders related to substance abuse and dependency which includes alcohol, drug or chemical abuse. The definition of incapacity as a result of an accident makes it clear that the incapacity must arise as a result of an injury suffered in an accident and be independent of all other causes.
- If a claim arises within six months of the Accident Cash Cover benefit starting, unless you suffer one of the qualifying injuries as outlined in section 4.9 (iv).

vii If, after a period of incapacity as a result of an accident for which we have paid accident cash cover benefit, you go back to your normal occupation in a limited capacity or take up another occupation at reduced earnings, we may pay part of the benefit. However:

- the life assured must remain totally unable to carry out the main duties of their normal occupation in the opinion of our Chief Medical Officer; and
- we agree beforehand.

In these circumstances we will reduce the accident cash cover benefit by any earnings the life assured receives from their new occupation. All normal plan conditions (including but not limited to v) apply to this provision.

viii If, after a period of incapacity as a result of an accident for which we have paid accident cash cover benefit, a life assured goes back to their normal occupation but is then incapacitated from the same cause within the following month, we will treat the further period of incapacity as a continuation of the original period. We will then begin to pay accident cash cover benefit again immediately. All normal plan conditions (including but not limited to v) apply to this rule.

ix While we are paying accident cash cover benefit, you must continue to make payments.

x The exclusions in sections 6.3 and 6.4 as well as all the normal plan conditions (including but not limited to section 7.3) apply to accident cash cover benefit.

4.11 Prepayment of surgery

This section only applies to you if the certificate of membership shows that the proposer has accelerated specified illness cover or independent specified illness cover in relation to you.

(a) If the specified illness cover under the master plan in relation to you has not ended, we will make an advance payment for specified illness cover if you have to have coronary artery bypass surgery, heart valve replacement or repair, heart structural repair with surgery to divide the breast bone, or aorta graft surgery. Please note this does not cover the additional payment - 'Aortic aneurysm - with endovascular repair. 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 proposer'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 you need 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 you need 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 you need 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.

Prepayment of surgery does not cover the additional payment - 'Aortic aneurysm - with endovascular repair.

(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 you are alive when the claim is made.

(d) If accelerated specified illness cover applies to you:

i. we will permanently reduce the level of specified illness cover and life cover the proposer has in relation to you 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.

(e) If independent specified illness cover applies to you:

i. we will permanently reduce the level of specified illness cover a 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; and

iii. we will pay any specified illness cover which is left 14 days after the life assured has the surgery as long as the life assured is still alive.

4.12 Children's Life Cover

If cover has not ended, we will pay €7,000 for the funeral expenses of a 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 which happened after the start date. For each child we will only pay a total of €7,000. 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 that provides similar benefits.

4.13 Children's Specified Illness Cover

If your cover includes specified illness cover and this cover has not ended, any child (see definitions section) is covered from birth for children's specified illness cover except for the following specified illnesses (as defined in section 4.7)

- 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 lives assured named on the certificate of membership (dual life), the amount of children's specified illness cover benefit is the lower of €25,000 or half of the highest specified illness benefit amount.

We will pay the benefit for a child (subject to the exceptions above) who survives for more than 14 days after being diagnosed as having a specified illness (see section 4.7), we will pay a benefit for a child suffering one of the conditions listed under the specified illness cover additional payment benefits (see section 4.8) of €7,500 or half of the specified illness benefit amount for a single life, whichever is lower. If there are two lives assured are named on the certificate of membership (dual life), the additional payment for children is the lesser of €7,500 or half of the highest specified illness benefit amount. We only make an additional 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, symptoms first arose, the underlying condition was first suspected, the underlying condition was diagnosed or either parent received counselling or medical advice in relation to the condition before

- the commencement date
- your legal adoption of the child, or

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 7.2.

4.14 Children's Hospital Cash Cover

If a life assured's cover includes hospital cash cover and cover has not ended, we will pay a hospital cash benefit for any child of the life assured above the age of one who is in hospital for more than 72 hours in a row. The amount we will pay for each day in hospital is 25% of the life assured's hospital cash cover amount. Where both of the child's parents are lives covered under the plan, we will pay 25% of each life assured's hospital cash cover benefit amount. We will not pay children's hospital cash cover if the child goes into hospital as a result of any illness or condition they have had since birth or which was known to exist before the start date, before the child was one or before the child was adopted by the life assured. If a child of a life assured is in hospital for more than 14 days in a row, we will double the amount of hospital cash benefit payable from the 15th day in hospital.

All these terms and conditions apply to this cover as they apply to hospital cash cover on the life assured (including but not limited to sections 4.9, 6.3, 6.4 and 7).

In summary the cover start age for the children's benefits in sections 4.12, 4.13 and 4.14 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	**Birth (*)**
Children's Hospital Cash Cover	**1 year**

*see section 4.13 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 you have the right to renew your cover or can alter your cover.

5.1 Guaranteed Cover Again

If the certificate of membership shows that guaranteed cover again applies, the proposer can convert this master 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 come to an end. The following conditions apply.

- You must be under age 65 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.
- When you are offered a new plan, you will have the choice of two types of protection plan, as described below in Option A and Option B.
- The 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 assured of €5,000,000 and a maximum specified illness cover sum assured of €1,000,000. These limits apply to the total benefit amounts converted across all policies where the life assured has cover.
- The cost of the new 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 may have the option of moving to non-smoker rates at the time of conversion, subject to process, sum assured, age criteria or other rules, that are then in place in relation to changes of smoker status.
- You must apply in writing before the expiry date of the benefit.
- When you convert this plan, all cover under it will end.
- The indexation option is not available on the new plan.
- The new plan will not provide cover for any illness or condition that is not covered under section 4 of this plan.
- If you have reduced your benefit amounts, the option will apply to the lesser of your current and original benefits.
- You cannot convert either the hospital cash cover benefit or the accident cash cover benefit.

Option A – Take out another fixed term protection plan which will provide cover for a specified term, after which cover will cease

- If you have chosen the guaranteed cover again option on this plan then you have the option to get guaranteed cover again under the new plan.
- If we no longer offer specified illness cover, you may only convert any life cover benefit you have on this plan.
- The new plan will not provide cover for any illness or condition that is not covered under section 4 of this 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.
- 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 85 for life cover, but these may change in the future.

Option B – Take out a whole of life protection plan with Irish Life which will provide life cover for the remainder of your life, as long as you continue to pay premiums.

- To avail of this option you must apply in writing before the expiry date of the life cover benefit, subject to the plan conditions and benefits we offer at that time.
- Specified Illness Cover isn't available on a whole of life plan.

5.2 Guaranteed insurability option

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

- 50% of your initial life cover and / or specified illness cover benefit (or your new benefit amount if you have reduced your level of cover); 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.
- getting married; 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 Dual Life, you may exercise this option in respect of each Life assured separately.

You will need to provide independent proof of the mortgage, marriage, 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, 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 plan with a guaranteed payment and fixed term, assuming we have such a product available at that time.
- The cost of the new 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 may have the option of moving to non-smoker rates at the time of conversion, subject to process, sum assured, age criteria or other rules, that are then in place in relation to changes of smoker status
- 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.
- This option does not apply to the hospital cash cover benefit or the accident cash cover benefit.

5.3 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 alter the term of your plan during the first five years of the plan.
- To increase your benefits or the term of the plan you must be aged 49 or younger.
- The original term of your 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 (excluding claims for Hospital Cash Cover or Accident Cash Cover) 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 be able to sign this in order for the alteration to be accepted.
- A benefit can only increase once.
- The term of the plan can only be extended once.
- For accident cash cover or hospital cash cover to continue, the proposer must have life cover of at least €25,000.
- It is not possible to increase the hospital cash cover or accident cash cover benefits.
- Any accelerated specified illness cover amount cannot be greater than the life cover amount.
- If the proposer chooses to alter the plan we will review your payments. Payments must be at least €15 a month (or another amount we may specify at the time).
- For the plan to continue, the life assured must always have life cover or specified illness cover of at least €1,000.
- If you or the proposer have 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 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 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, third degree burns or traumatic head injury, and will not pay limited payments for third-degree burns covering at least 5% of the body surface or surgical removal of one eye or the serious accident cover additional payment benefit or the hospital cash cover or accident cash cover benefit, in any of the following circumstances:

i. If the condition or accidental death is caused directly or indirectly by war, revolution or taking part in a riot or civil commotion.

ii. If the condition or accidental death is caused directly or indirectly by taking part in a criminal act.

iii. If the condition or accidental death is self-inflicted or caused directly or indirectly by the life assured taking alcohol, where there is a history of alcohol abuse, or taking illegal drugs.

iv. If the life assured failed to follow reasonable medical advice or failed to follow medically recommended therapies, treatment or surgery.

v. 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 licensed aircraft passenger on a regular public airline
- Hang gliding
- Horse racing (but not general equestrian activities)
- Motor car or motorcycle racing or sports
- Mountaineering
– Mixed Martial Arts
- Parachuting
- Pot-holing or caving
- Power boat racing
- Rock climbing
- Scuba diving

6.4 We will pay:

- The specified illness cover benefit;
- The life cover benefit for a life assured who has been diagnosed as having a terminal illness;
- The hospital cash cover benefit; or
- The accident cash cover benefit:

only if the life assured lives in one of the accepted countries. These are any Member State of the European Union,United Kingdom, 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 life cover or specified illness cover benefit, hospital cash cover benefit and accident cash cover benefit, other than from a recognised hospital in Ireland or the United Kingdom or health professional resident in Ireland or the United Kingdom. The 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 can continue or not and on what basis. If Irish Life is not advised immediately in writing, or if cover for these benefits cannot continue and must be cancelled due to residence, then we will let you know and we may refund a proportion of your most recent monthly payment

Claims

Section 7

This section explains how to make a claim and how we will assess a 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 a claim is made, we will ask for 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.
• If someone else makes a claim on your behalf, we will ask the person making the claim for a power of attorney
• If the life assured has died, we may ask for a grant of probate or letters of administration.
• Proof (in the form of a birth certificate) of the age of the life assured.
• The original plan documents outlining the details of the arrangement under the master plan, including any plan documents provided as a result of changes made to the 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.

If a claim is admitted for children's life cover, children's specified illness cover, hospital cash cover, children's hospital cash cover or accident cash cover we will pay the benefits directly to the life (or lives assured). We will pay these to the life (or lives assured), rather than the proposer.

If the proposer is claiming:

- life cover benefit for a terminal illness;
- specified illness cover benefit;
- Life Cover Additional Payments;
- children's specified illness cover benefit; or
- hospital cash cover benefit

you must tell us, in writing, about the surgery, diagnosis or admission to hospital within six months of the day on which it occurred. If you do not, we may refuse to pay the benefit if we have been prejudiced by the delay. You must provide and pay for any certificates, tests, information or evidence which we reasonably need to prove your claim. The life assured or child must agree to any medical examinations and tests that are necessary to prove your claim. If you fail or the life assured or the child fails to meet these requirements within a reasonable time, or if the life assured or child fails to follow the advice of a registered medical practitioner, we will not pay the benefits until you, or the life assured, correct this failure. If this failure cannot be corrected, then we may refuse the claim. We may also adjust the life cover benefits for the death of the life assured or child, or end the plan altogether. If any of the information we have been given is not correct, true or complete, we may not pay the benefits claimed and may also alter the other benefits under the master plan, or end the master plan altogether, in accordance with Section 2

7.2.1 In respect of Life, Specified Illness or Terminal Illness, hospital cash and accident cash covers, Irish Life reserves the right to refuse to accept medical or other required claim evidence produced in any country other than Ireland or the United Kingdom.
Any claim forms, medical reports or other claim related evidence should be submitted in the English language. If this is not possible certified English language translations (by a professional translation service) and the original documents must be provided by the claimant. Any associated costs incurred by Irish Life in relation to the translation or the verification of claim related documents provided by the claimant or third parties including doctors will be deducted from any claim benefits payable

7.3 (i) If you want to make a claim in relation to accident cash cover benefit, you must notify us within two weeks of your accident.

In order to fairly assess a claim it is important that we have the opportunity to investigate the injury sustained, therefore filled-in claim forms must be returned to us within four weeks of the accident.

If we do not receive filled-in claim forms within four weeks:

- we can refuse to pay a claim for accident cash cover benefit; or
- we can decide to only pay the accident cash cover benefit from the date we received the filled-in claim forms.

It is your responsibility to ensure the filled-in claim form is completed by your doctor or specialist and you will have to pay any costs involved.

(ii) If a claim in relation to accident cash cover benefit is made, we will not start to consider any claim until we have received the following:

- A properly filled-in claim form together with a claim form filled in by the life assured's own doctor.
- Proof of entitlement to claim the benefit.

Where a claim in relation to accident cash cover benefit is made we will need:

- Confirmation from the life assured's employer of the absence from work.
- Proof of earnings where the life assured is an employed person, in the form of a copy of the life assured's P60 for the year immediately before the start of the deferred period together with a note from the life assured's employer confirming earnings in the 12 months before the start of the deferred period.
- Proof of earnings, where the life assured is self-employed, in the form of copies of accounts, tax computations and income tax assessment for the three years immediately before the start of the deferred period.

(iii) Any certificates, tests, information or evidence which we reasonably need to prove your claim must be provided at your

expense. You must agree (as often as necessary) to any medical examinations and tests which are necessary to prove the claim. If you fail to meet these requirements within a reasonable time, or if you fail to follow the advice of a registered medical practitioner, we will not pay the benefits. We may also change the benefits the proposer has in relation to you or the benefits under the plan may end altogether.

We may also arrange for someone to visit the life assured in their own home before or while we are paying accident cash cover benefit. We may not tell you or the life assured before some of these visits. We may also contact the life assured by phone.

(iv) We will only accept a claim if we are satisfied that the life assured is entitled to the benefit and, in particular, that they meet the definition of incapacity as a result of an accident for accident cash cover benefit. This means that there will be a delay between the date on which the claim is made and the date on which we might accept it. We will try to keep the delay as short as possible. We assess all claims individually to make sure they are valid. When assessing the claim, we will consider the effect of the life assured's injury on their fitness for their normal occupation (in the case of accident cash cover benefit). The availability or lack of actual employment opportunities will not affect our assessment.

(v) In the event of an ongoing accident cash benefit claim, the life assured must notify us every three weeks of his/her ongoing incapacity and must provide satisfactory medical confirmation of the continuing disability. If such confirmation is not submitted every three weeks, we reserve the right not to pay the claim.

(v) If any of the information we have been given is not correct, true or complete, we will not pay the benefits and may also change the other benefits under the plan, or end the plan altogether.

(vi) You must let us know immediately if you go back to your normal occupation or take up another occupation while receiving accident cash cover benefit. If you do not do this, we will stop paying benefit and all cover under the plan will end.

Tax

Section 8

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

8.1 Under current Irish 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 August 2021).

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 Irish 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 master plan in line with those changes. We will let the proposer and 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 This master plan does not have any cash-in value.

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

9.3 If any court or any other relevant authority deem any provision (or part of a provision) of these conditions invalid, illegal or unenforceable then this provision will not form part of this contract. The other provisions of the contract will not be affected by this decision.

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