

Your Guide to Irish Life's

# Group Specified Illness Cover

The Company of Choice for Specified Illness Cover



Irish Life Corporate Business

Irish Life



# Irish Life Corporate Business

First Class Providers of  
Illness Cover Protection

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# introduction

## What is specified illness cover?

Specified illness cover (sic) is an optional benefit which pays a lump sum if you suffer from one of the 25 common conditions we cover, such as malignant cancer, heart attack and stroke.

## Why do I need specified illness cover?

Serious illness can strike at any age. The effects can be catastrophic. Not only could you face increased medical bills on top of your regular bills, you could also face them when your income is reduced because you can't work.

The statistics are frightening:

- You are four times more likely to suffer one of the conditions specified in this booklet before age 65, than to die.
- The average age of our customers who claim for specified illness cover is 51 for males, and 48 for females.
- 1 in 5 claims are for people under age 40.
- The most common illnesses are malignant cancer, heart related illnesses (diagnosed) and stroke (permanent symptoms).

*Reference: Irish Life Claims Department*

The good news is that with continual medical advances it's more likely than ever that you will survive a serious illness. Still, for many of those who survive, life may never be the same again. Some become disabled and have to change their home and car, while others need ongoing medical care. It is up to you to protect yourself and your family against the financial impact of a serious illness.

## The Group SIC Plan

The Group Specified Illness Cover Plan will help you control your and your family's financial future if you were to become seriously ill.

All staff/union members who are over 18 and under age 60 can join the plan. Spouses/partners\* of these members over age 18 and under age 60, can also join the plan.

*\*Partner is defined as a person living in a spousal type relationship with the member for 12 or more months at the time the application for cover is made.*



It is important that you read this booklet carefully as it explains what you are covered for under the plan, when you can claim and what exactly each illness is defined as.

## Which illnesses are covered?

We have identified 25 conditions that could change your life so much that you would need financial help.

Listed overleaf are the 25 conditions we cover for full payment. You will find detailed descriptions of these from page 10.

②

specified  
illness cover

## 2a Details of the plan

The benefit provided is usually a fixed lump sum, typically between €30,000 and €50,000.

There can also be options included, where the members choose from predetermined levels of cover that would best suit them.

For example, €30,000, €40,000 or €50,000

This cost will be deducted from your salary. It is your responsibility to ensure that your deductions have been set up and continue to be deducted from your pay. Your cover will commence the day the first deduction is taken from your salary.

The cost of the plan is reviewed every three years. If large numbers of people leave the plan or if there is a high number of people claiming then Irish Life reserves the right to increase the cost of cover or go off risk. Of course, the costs can also be reviewed downwards in the future.

Specified Illness Cover is paid if you suffer any of the following illnesses and survive (assuming you have not suffered from that illness or a related illness previously).

Alzheimer's disease	Heart attack	Multiple sclerosis
Aorta graft surgery	Heart valve replacement or repair	Paralysis of limbs
Benign brain tumour	Heart valve structural repair with surgery to divide the breastbone	Parkinson's disease
Blindness	HIV Infection	Respiratory failure of specified injury
Cancer	Kidney Failure	Severe burns or third degree burns
Coma	Loss of Limbs	Stroke
Coronary Angioplasty	Loss of Speech	
Coronary artery by-pass graft	Major organ transplant	
Creutzfeld-Jakob disease (CJD)	Motor neurone disease	
Deafness		

*(Please note: no cancer claims will be paid where the condition presents within 6 months of the date of commencement of cover under the group plan). A full definition of each illness is given in Section 2 B. of this booklet.*



We do not cover any other conditions. Once you claim for specified illness cover, your specified illness cover ends and you cannot make any further specified illness claims.

## Is there a survival period?

Yes. If you suffer a specified illness and wish to claim under the plan, you must survive for a minimum period after the date on which the illness was diagnosed or surgery took place, before a payment can be made. In the event of death within this period no benefit is payable.

The relevant periods are:

- (a) 14 days for heart attack, coronary artery surgery, angioplasty (two arteries), cancer, coma, emphysema, stroke, kidney failure, heart valve surgery, aorta graft surgery, major organ transplant, benign brain tumour, multiple sclerosis, motor neurone disease, severe burns, CJD, HIV infection, paralysis of two or more limbs and severance of two or more limbs.
- (b) six months for Parkinson's Disease, Alzheimer's Disease and loss of sight.
- (c) twelve months for loss of hearing and loss of speech.
- (d) 14 days after surgery in cases where there has been pre-payment of part of the benefit. The balance of the benefit would be paid upon survival after this period.

## When am I covered until?

You shall cease to be covered once you:

- cease to be a staff/union member of the sponsoring Company/Union
- reach age 65
- are paid a claim under the plan
- die **or**
- cease to make contributions.

Your spouse/partner (where applicable) is no longer covered once:

- they reach age 65
- a claim has been paid under the Plan in their respect
- they die
- you cease to make contributions **or**
- you cease to be a staff/union member of the sponsoring Company/Union

If you claim then your spouse/partner can still be covered and vice versa once satisfactory arrangements are made to continue making contributions.

Each of your children (over age 1) is no longer covered once:

- they reach age 21
- a claim has been paid under the Plan in their respect
- they die **or**
- you leave the plan

If you have more than one child then please note that if one child claims the others are still covered. In addition, if one or more child claims you and your spouse/partner remain covered.

# Do I have to provide Medical Information?

Members can apply for this Specified Illness cover without providing any medical information if they join the plan at the first available opportunity.

## Pre-existing conditions

However due to this concession, pre-existing conditions apply on the following basis (these conditions will also apply to your spouse/partner, where applicable).

1. Where you have previously suffered, at any time prior to the commencement date of cover from one of the specified illnesses covered you will never be covered for that illness and cannot therefore claim for that illness. For example, if you contracted cancer in 2000 you can never claim under cancer. You are however covered for the remaining illnesses.

In addition, because of the links between heart attack, stroke, coronary artery surgery, angioplasty and heart transplant if you have suffered or undergone one of the above prior to the commencement date of cover you can never claim under any of these five illnesses.

For example, if you underwent coronary artery surgery in 2002 you will never be covered for and cannot claim in respect of heart attack, stroke, coronary artery surgery, angioplasty or heart transplant. You are covered for the remaining illnesses.

2. In the event of one of the specified illnesses covered occurring within two

years of the commencement date of cover you will not be paid a claim for a particular illness and cover for that illness will cease, if prior to the commencement date of cover you suffered from one of a number of related conditions which are set out under each illness in Section 3 of this booklet.

For example, a claim would not be paid and cover for heart attack will cease in the event of a heart attack occurring in the first two years of cover, if prior to the commencement date of cover you had suffered from diabetes.

Being a diabetic before the commencement date of cover means that if you suffer a stroke or a heart attack or undergo coronary artery surgery, angioplasty or major organ transplant in the first two years of cover, a claim will not be paid and cover for that specified illness will cease.

It should be noted that the second set of provisions only arises if the event occurs within the first 2 years of cover. Thus a diabetic who first suffers a heart attack three years after the commencement date of cover will be eligible to claim.

3. No cancer claims will be paid where the condition presents within the first six months of you joining the plan. In such circumstances cover in respect of cancer ceases.



Please note that where you increase your cover (in schemes that have various levels of cover), the two year related conditions rule and the six month moratorium in relation to cancer claims recommence for the amount of the increase.

## 2b

# Explanation of each specified illness and its pre-existing conditions

We have defined the 25 conditions that you are protected for on the following pages.



The notes in the sections headed 'In simpler terms' are meant to provide a less technical explanation of the illness definitions, and some of the medical terms used in that definition. They are not an alternative definition of the illness and will not be used to assess claims. If there is 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 their judgement, understanding and rational thought process have been seriously affected.

### Pre-existing conditions:

If you have been diagnosed with Alzheimer's disease prior to the commencement date of cover, you can never claim for Alzheimer's disease under the Specified Illness Cover plan. If you have a history of arteriosclerotic dementia, amnesia or memory loss prior to the commencement date of cover and you are found to have Alzheimer's disease within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for Alzheimer's disease.

### Survival Period:

Six months

## 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'. This means that the artery wall becomes thin and expands. You might need a graft 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 is not covered as this surgery is generally less critical.

### Pre-existing conditions:

If you have had aorta graft surgery prior to the commencement date of cover, you can never claim for aorta graft surgery under the Specified Illness Cover plan.

If you have a history of aortitis, Marfan's syndrome, Ehlers-Danlos syndrome or peripheral artery disease prior to the commencement date of cover and you require aorta graft surgery within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for aorta graft surgery.

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

### Plan definition:

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

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

The requirement for permanent neurological deficit will be waived if the benign brain tumour is surgically removed or treated by stereotactic radiosurgery.

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

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

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

The following are not covered:-

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

#### 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 removed by surgery. We do not cover other conditions that are not usually life-threatening. The pituitary is a small gland at the base of the brain, and an angioma is a benign growth made up of small blood vessels.

You can claim if you are diagnosed as having a benign brain tumour of the brain and have

had surgery to have it removed or are suffering from permanent neurological deficit as a result of the tumour. Examples of tumours covered include gliomas, acoustic neuromas and meningiomas. Neurological symptoms must be permanent. We do not cover tumours or lesions in the pituitary gland.

#### Pre-existing conditions

If you have been diagnosed with a benign brain tumour prior to the commencement date of cover, you can never claim for Benign brain tumour under the Specified Illness Cover plan.

If you have a history of epilepsy, unilateral neural deafness, fits or blackouts, double vision, Von Recklinghausen's disease or tuberous sclerosis prior to the commencement date of cover and you are found to have a benign brain tumour within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for benign brain tumour

## 4. Blindness – permanent and irreversible

#### Plan definition:

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

To qualify for payment, blindness must happen on a date after the start date of the plan and before cover ends.

### In simpler terms:

You can claim only if you have permanent loss of sight with no possibility of improvement in both eyes and even if, using glasses or other visual aids, your 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. An optician uses a Snellen chart (made up of rows of letters) to test your eyesight. 3/60 is the measure when you can only see at three feet away what someone with perfect sight could see at 60 feet away. It is possible to be 'registered blind' (as confirmed by an eye specialist) even though the loss of sight may only be partial. Even if you are 'registered blind', we will only pay your claim if the loss of sight meets the definition above and cannot be corrected.

### Pre-existing conditions

If you are diagnosed with loss of sight as described above prior to the commencement date of cover, you can never claim for blindness under the Specified Illness Cover plan.

If you have a history of diabetes mellitus, glaucoma, severe myopia, congenital nystagmus, retrobulbar or optic neuritis, retinitis pigmentosa, multiple sclerosis or hysteria prior to the commencement date of cover and you become blind within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for blindness.

### Survival Period:

Six months.

## 5. Cancer – excluding less advanced cases

### Plan definition:

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

The term malignant tumour includes leukaemia, lymphoma and sarcoma

- For the above definition, the following are not covered:
  - pre-malignant;
  - non-invasive;
  - cancer in situ;
  - having either borderline malignancy; or having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (ie Gleason score 7 or above only) or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) i.e.  $\geq$ Clarks level 2.
- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are non-malignant and are excluded from this cover.
- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0

- If you are HIV (human immunodeficiency virus) positive, you will not be covered for lymphoma or Kaposi's sarcoma as these tumours are directly related to the virus.

No cancer claims will be paid where the condition presents within the first six months of a member joining the plan. In such circumstances cover in respect of cancer ceases.

### 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 we specifically do not cover the type of cancer or tumour. 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 carried out on tissue removed during surgery or by biopsy

(a procedure to remove a sample of the tumour for examination).

We do not cover cancers 'in situ' (cancers in a very early stage that have not spread in any way to neighbouring tissue) or premalignant and non-invasive tumours. These are well-recognised conditions, and 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) which is easy to treat and cure.

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. It is not possible to provide full specified illness cover against these early prostate cancers. We will not pay a claim for prostate cancer under this definition of cancer unless the tumour has a Gleason score (a method of measuring differentiation in cells) of greater than 6 (in other words, a Gleason score of 7 or above) or it has progressed to at least clinical classification of T2N0M0. 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 what it looks like under a microscope.

We will cover leukaemia (cancer of the white blood cells) and Hodgkin's disease (a type of lymphoma). However, for us to cover a claim for chronic lymphocytic leukaemia, it must have progressed to Binet Stage A. (Binet Stage A is where there is no anaemia, no thrombocytopaenia and fewer than three areas of enlarged nodes.)

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 and do not produce growths in 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 longterm outlook.

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

### Pre-existing conditions

If you have been diagnosed with cancer or ductal carcinoma in situ of the breast prior to the commencement date of cover, you can never claim for Cancer under the Specified Illness Cover plan.

If you have a history of carcinoma in situ, Bowens disease, familial polyposis of the colon, Hodgkin's disease, leukoplakia, Barrett's oesophagus, ulcerative colitis, Crohn's disease or a history of raised PSA (prostate specific antigen) above 4.0ng/ml prior to the commencement date of cover and you are found to have cancer within the

first two years, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for cancer.

## 6. Coma – of specific duration and resulting in permanent symptoms

### Plan definition:

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

- Continues for a period of at least 96 hours
- Requires life supporting systems including assisted ventilation throughout the period of unconsciousness
- Results in permanent neurological deficit with persisting clinical symptoms\*.

For the above definition, the following is not covered:

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

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

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

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

The following are not covered:-

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

### 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.

### Pre-existing conditions

If you have had a coma prior to the commencement date of cover, you can never claim for coma under the Specified Illness Cover Plan.

If you have a history of head injury or concussion, epilepsy, diabetes mellitus, brain tumour, brain haemorrhage, cerebral aneurysm, hepatic encephalopathy, asthma or cancer prior to the commencement date of cover and you suffer a coma within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for coma.

## 7. Coronary Angioplasty - to 2 or more coronary arteries

### Plan definition

We will make a limited payment for specified illness cover if a life assured undergoes a balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of two or more coronary arteries. Angiographic evidence will be required.

- Insertion of 2 stents in different arteries at different times (e.g. on different days several years apart) does qualify for payment, after the second artery has been stented.
- 2 stents to one artery, or branches of the same artery, does not qualify.

### 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.

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.

If you have balloon angioplasty, atherectomy or laser treatment, you can claim if the treatment is to correct a 70% narrowing of at least two coronary arteries. We do not cover this treatment if only one artery is involved. We will need a copy of the angiogram reports showing at least 70% stenosis in the coronary arteries.

We will pay benefit for treatment by balloon angioplasty, atherectomy or laser treatment, in two different arteries on two separate occasions, to treat narrowing or blockages of at least 70%, after you have had the second procedure.

## 8. Coronary artery by-pass grafts

### Plan definition:

The undergoing of surgery on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of one or more coronary arteries with by-pass grafts via a thoracotomy, a thoracoscope 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:

You may need coronary artery surgery 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 vein, normally from the thigh, and using it to direct blood past the diseased or blocked artery.

You will be able to claim if you have coronary artery bypass surgery for ischaemic heart disease of at least 70% in one artery. You are not covered under this definition for any other techniques used, such as angioplasty or laser relief.

Ischaemic heart disease happens if there is inadequate blood flow through the coronary arteries to the heart due to a build up of fatty materials (such as cholesterol) in the artery walls.

### Pre-existing conditions

If you have ever suffered from a heart attack, stroke or carotid artery stenosis or undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of cover you can never claim under any one of these six illnesses.

If you have a history of coronary artery disease, aneurysm, atrial fibrillation, cardiomyopathy diabetes mellitus, peripheral vascular disease, hypertension, hypercholesterolaemia, tachycardia or valvular heart disease, prior to the commencement date of cover and you require coronary artery bypass grafts within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for coronary artery bypass grafts.

## 9. Creutzfeldt-Jakob Disease – resulting in permanent symptoms

### Plan definition:

Confirmation by a Consultant Neurologist of a definite diagnosis of Creutzfeldt-Jakob disease (CJD) 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

### In simpler terms:

CJD is a degenerative condition of the brain. As the disease gets worse, your muscular co-ordination reduces, and your intellect and

personality are affected. You may also go blind. You can claim if your consultant neurologist confirms the diagnosis of CJD which has resulted in permanent neurological deficit.

### Pre-existing conditions

If you have been diagnosed with Creutzfeldt-Jakob disease (CJD) prior to the commencement date of cover, you can never claim for CJD under the Specified Illness Cover plan.

If you have a history of dementia, involuntary movements or were treated with human growth hormone treatment (prior to 1985), prior to the commencement date of cover and you are found to have CJD within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for CJD.

## 10. 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.

To qualify for payment, deafness must happen on a date after the start date of the plan and before cover ends.

### In simpler terms:

You can claim if you have a severe form of deafness (as described above) as measured

by a pure tone audiogram. A pure tone audiogram is a hearing test used to identify hearing levels. The test will check the quietest sounds you can 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 using medical aids.

### Pre-existing conditions

If you have been diagnosed with loss of hearing as described above prior to the commencement date of cover, you can never claim for deafness under the Specified Illness Cover plan.

If you have a history of any disorder or disease of the inner or middle ear or the acoustic nerve including Meniere's disease, labyrinthitis or tinnitus prior to the commencement date of cover and you become deaf within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for deafness.

**Survival period:** Twelve months

## 11. Heart attack – of specified severity

### Plan definition:

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

- New characteristic electrocardiographic (ECG) changes.

- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;

Troponin T > 1.0 ng/ml

AccuTnI > 0.5 ng/ml or equivalent

threshold with other Troponin 1 methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

### In simpler terms:

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

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

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

You can claim if you are diagnosed as having suffered death of heart muscle. Your claim must be supported by an increase in cardiac enzymes or troponins that are typical of a

heart attack (released into the bloodstream from the damaged heart muscle) and new ECG changes typical of a heart attack.

### Pre-existing conditions

If you have ever suffered from a heart attack, stroke or carotid artery stenosis or undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of cover you can never claim under any one of these six illnesses.

If you have a history of aneurysm, atrial fibrillation, cardiomyopathy, coronary artery disease, diabetes mellitus, peripheral vascular disease, hypertension, hypercholesterolaemia, tachycardia or valvular heart disease prior to the commencement date of cover and you suffer a heart attack within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for heart attack.

## 12. 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, you may need an operation to repair or replace the

valve. You will be able to claim if you have surgery to replace or repair a heart valve on the advice of a consultant cardiologist.

### Pre-existing conditions

If you have had heart valve replacement or repair prior to the commencement date of cover you cannot make a claim under the Specified Illness Cover Plan.

If you have a history of any disorder of the aortic, mitral, pulmonary or tricuspid valves, rheumatic fever, endocarditis, Fallots tetralogy, Ebsteins anomaly or any congenital or acquired structural cardiac abnormality prior to the commencement date of cover and you require heart valve or structural surgery within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for heart valve replacement or repair.

## 13. Heart structural repair with surgery to divide the breastbone

### Plan definition:

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) 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, on the advice of a consultant cardiologist, you have open heart surgery (including surgery to divide the breastbone) to correct a structural abnormality of the heart.

### Pre-existing conditions

If you have had structural heart repair prior to the commencement date of cover, you can never claim for heart structural repair under the Specified Illness Cover plan.

If you have a history of heart valve disease, cardiomyopathy, congenital heart disease, ventricular aneurysm, constrictive pericarditis, fallots tetralogy or transposition of great vessels prior to the commencement date of cover and you require structural heart repair within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for structural heart repair.

## 14. HIV infection

### 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 [from the eligible occupations listed below]; 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 or transfusion causing infection must have occurred in the European Union, North America, Australia or New Zealand.

### Occupations Covered:

- Ambulance workers
- Dental nurses
- Dental surgeons
- District nurses
- Dublin Bus employees
- Fire brigade and firefighters
- General practitioners and nurses employed by them
- Hospital caterers
- Hospital cleaners
- Hospital Doctors/surgeons/consultants
- Hospital laboratory workers
- Hospital laundry workers
- Hospital nurses
- Hospital porters
- Members of the Armed Forces
- Members of the Gardai
- Midwives

- Paramedics
- Prison officers
- Refuse Collectors
- Social Workers
- Taxi drivers

#### In simpler terms:

Human immunodeficiency virus 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 are in special danger of getting HIV or AIDS through their work or who have become infected as a result of a physical assault or a blood transfusion in the European Union, North America, Australia and New Zealand.

The infection must happen after the start date of the plan and must be appropriately reported and investigated as described in the definition above.

#### Pre-existing conditions

If you have been diagnosed with HIV infection prior to the commencement date of cover, you can never claim for HIV infection under the Specified Illness Cover plan.

## 15. Kidney failure – requiring ongoing dialysis

#### Plan definition:

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

#### 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 (a machine providing artificial replacement for lost kidney function) or a kidney transplant will be necessary. In some circumstances it is possible for the kidneys to fail temporarily and recover after a period of dialysis.

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

#### Pre-existing conditions

If you have ever been diagnosed with kidney failure prior to the commencement date of cover, you can never claim for kidney failure under the Specified Illness Cover plan.

If you have a history of diabetes mellitus, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, hypertension, paraplegia or pre-existing renal impairment with raised serum creatinine prior to the commencement date of cover and you suffer kidney failure within the first two years of

cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for kidney failure.

## 16. Loss of limbs – permanent and irreversible

### Plan definition:

Permanent physical severance of any combination of two or more hands or feet at or above the wrist or ankle joints.

To qualify for payment, the loss of two or more limbs must happen after the start date of the plan and before cover ends.

### In simpler terms:

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

### Pre-existing conditions

If you have previously suffered the loss of one or more limbs prior to the commencement date of cover, you can never claim for Loss of limbs under the Specified Illness Cover plan.

If you have a history of peripheral vascular disease or diabetes mellitus prior to the commencement date of cover and you suffer the loss of two or more limbs within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for loss of limbs.

## 17. Loss of speech – permanent and irreversible

### Plan definition:

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

To qualify for payment, loss of speech must happen on a date after the start date of the plan and before cover ends.

### 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.

### Pre-existing conditions

If you have been diagnosed with loss of speech prior to the commencement date of cover, you can never claim for loss of speech under the Specified Illness Cover plan.

If you have a history of multiple sclerosis, cancer, stroke, transient ischaemic attack, motor neurone disease or chronic laryngitis prior to the commencement date of cover and you suffer from loss of speech within the first two years of cover no benefit will be payable under the Specified Illness Cover Plan and you will cease to be covered for loss of speech.

### Survival period:

Twelve months

## 18. Major organ transplant – specified organs

### Plan definition:

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

For the above definition, the following is not covered:

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

### In simpler terms:

Serious disease or injury can severely damage the heart, lungs, 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 you could be on a waiting list for a long period waiting for a suitable organ. We also cover bone-marrow transplants.

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.

### Pre-existing conditions

If you have ever suffered from a heart attack, stroke or carotid artery stenosis or undergone coronary artery surgery, angioplasty, heart transplant or any other major organ transplant prior to the commencement date of cover you can never

claim under any one of these seven illnesses.

If you have a history of the following:

- Heart conditions - congestive cardiac failure, cardiomyopathy, coronary artery disease, left ventricular failure, hypertensive heart disease, any congenital or acquired structural cardiac abnormalities, ischaemic heart disease
- Lung conditions - cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic), pulmonary fibrosis, emphysema, chronic bronchitis, chronic asthma
- Liver conditions – liver failure, any type cirrhosis, hepatitis B or C, liver tumours, alcohol abuse, sclerosing cholangitis, Budd-Chiara syndrome
- Blood disorders - leukaemia, aplastic anaemia, thalassaemia major, immune deficiency disease, sickle cell anaemia, myeloproliferative disease (polycythaemia vera, thrombocythaemia), neutropenia
- Inflammatory disorders - systemic lupus erythematosus, sarcoidosis, pancreatitis
- Metabolic disorders - diabetes mellitus, haemochromatosis, Wilson's disease prior to the commencement date of cover and you are placed on an official waiting list for or require major organ transplant within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for major organ transplant.

## 19. Motor neurone disease – resulting in permanent symptoms

### Plan definition:

A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

### In simpler terms:

Motor neurone disease is a disease which affects the central nervous system that controls movement. As the nerves deteriorate, the muscles weaken. There is currently no known cure and the cause of the disease is also not known.

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

### Pre-existing conditions

If you have been diagnosed with motor neurone disease prior to the commencement date of cover, you can never claim for motor neurone disease under the Specified Illness Cover plan.

If you have a Family History of motor neurone disease in a first degree relative (i.e. father, mother, brother or sister) or a history of muscle weakness in any limb prior to the commencement date of cover and you are found to have motor neurone disease within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for motor neurone disease.

## 20. Multiple sclerosis

### Plan definition:

A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

### In simpler terms:

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

You can claim if you are diagnosed by a consultant neurologist as suffering from multiple sclerosis and you have ongoing well-defined symptoms of the disease continuously for at least six months.

### Pre-existing conditions

If you have been diagnosed with multiple sclerosis prior to the commencement date of cover, you can never claim for multiple sclerosis under the Specified Illness Cover plan.

If you have a history of retrobulbar or optic neuritis, diplopia (double vision), paraesthesia, numbness, tingling or unilateral weakness of upper or lower limbs, trigeminal neuralgia, Bell's palsy or in-coordination of movement or speech prior to the

commencement date of cover and you are found to have multiple sclerosis within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for multiple sclerosis.

## 21. Paralysis of limbs – total and irreversible

### Plan definition:

Total and irreversible loss of muscle function to the whole of any 2 limbs. Permanent Paraplegia or Quadriplegia are covered under this definition.

To qualify for payment, the total and irreversible paralysis of two or more limbs must happen on a date after the start date of the plan and before cover ends

### 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 two or more limbs.

### Pre-existing conditions

If you have been diagnosed with total and irreversible paralysis of two or more limbs prior to the commencement date of cover, you can never claim for paralysis of limbs under the Specified Illness Cover plan.

If you have a history of multiple sclerosis, motor neurone disease, stroke, transient

ischaemic attack, a spinal cord tumour or severe head injury prior to the commencement date of cover and you became paralysed within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for paralysis of two or more limbs.

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

### Plan definition:

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability. For the above definition, the following is not covered

- Parkinson's disease secondary to chronic alcohol abuse or illegal drug abuse.

### In simpler terms:

Parkinson's disease is a disease of the central nervous system which affects voluntary movement. It is characterised by muscle stiffness or rigidity, slow movements, shaking limbs and head and loss of balance. It normally takes hold gradually. The term 'idiopathic' means that the cause of the disease is not known, so we will not cover any form of Parkinson's disease brought on by a known cause such as drugs, poisonous chemicals or alcohol.

### Pre-existing conditions

If you have been diagnosed with Parkinson's disease prior to the commencement date of cover, you can never claim for Parkinson's disease under the Specified Illness Cover plan.

If you have a history of encephalitis, encephalomyelitis or tremor prior to the commencement date of cover and you are found to have Parkinson's disease within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for Parkinson's disease.

### Survival Period:

Six months

## 23. Respiratory Failure of specified injury

### 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 long-term respiratory failure, as shown by lung-function tests showing forced expiratory volume (FEV1) less than 40% of normal and a vital capacity (VC) less than 50% of normal and you need daily oxygen therapy. Forced expiratory volume is the maximum volume of air that can be forcibly blown out in the first second. It is measured in litres. Vital capacity (VC) is the volume of air that can forcibly be blown out after a full breath in, measured in litres.

### Pre-existing conditions

If you have been diagnosed with respiratory failure prior to the commencement date of cover, you can never claim for respiratory failure under the Specified Illness Cover plan.

If you have a history of cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic), pulmonary fibrosis, emphysema, chronic bronchitis, chronic asthma, other systemic disorders that produce pulmonary fibrosis such as sarcoid or pulmonary fibrosis as a result of exposure to extrinsic organic or inorganic agents prior to the commencement date of cover and you are found to have respiratory failure within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for respiratory failure.

## 24. Severe Burns/3rd Degree Burns

### Plan definition:

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

To qualify for payment, severe or 3rd degree burns covering at least 20% of the body's surface must happen on a date after the start date of the plan and before cover ends

### 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.

### Pre-existing conditions

None.

## 25. Stroke

### Plan definition:

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

For the above definition, the following are not covered:

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

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

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

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

- Neurological signs occurring without symptomatic abnormality, e.g.. brisk reflexes without other symptoms

and you suffer a stroke within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for stroke.

### In simpler terms:

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

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

### Pre-existing conditions:

If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplast, heart transplant or carotid artery stenosis prior to the commencement date of cover you can never claim under any of these six illnesses.

If you have a history of intracranial aneurysm, atrial fibrillation, coronary artery disease, diabetes mellitus, peripheral vascular disease, hypercholesterolaemia, transient cerebral ischaemia, hypertension, arteriovenous malformation, thrombotic disorders eg, primary phospholipid syndrome, hyperviscosity states (polycythaemia), heart valve disease and carotid atherosclerosis prior to the commencement date of cover

## 2c

# Children's Specified Illness Cover



*Each of your dependent children (as proven by your name on their birth cert if there is a claim) between the ages of 1 and 21 are automatically covered.*

### Plan definition

Under the specified illness cover full payment benefits, each of your dependent children (as proven by your name on their birth cert if there is a claim) between the ages of 1 and 21 are automatically covered.

As we do not ask for medical details on your children prior to including them in the plan they are not covered if a claim arises as a result of:

- a condition they have had since birth or
- a condition known to exist or with symptoms present prior to attaining age 1
- a condition known to exist prior to the commencement date of the plan

Therefore, if a child is known to be suffering from a heart valve defect prior to commencement date of the plan or prior to attaining age 1, we would not pay a claim for heart valve surgery. However if that child develops an unrelated ailment such as cancer or benign brain tumour, we would pay such a claim.

Only one claim can be made per child and your child must survive for the same periods mentioned on page 8 following diagnosis or surgery in order for the benefit to be payable.

The benefit payable shall only be payable once in respect of any child regardless of whether or not both the child's parents are insured persons under this group policy. This cover remains in force for as long as there is specified illness cover in force on you under the plan.

If you have more than one child then please note that if a claim is paid in respect of one of your children the others are still covered.

3

additional  
information

# 3a

## Additional Benefit-Part prepayment on need for surgery

### Your policy definition

Where coronary artery surgery, heart valve surgery and aorta graft surgery are specifically covered under your plan, Irish Life will, in the event of the life assured satisfying the following conditions, pay immediately:

€15,000 (€7,500 for children).

### Conditions

1. One claim can only be made under this provision.
2. The level of specified illness cover applying in respect of a life assured immediately before payment will be permanently reduced by the amount of any sum paid in respect of that life assured under this extension to specified illness cover.
3. The life assured in respect of whom the claim is being made, must be alive on the date of the claim under part payment
4. The standard 'pre-existing' conditions clauses apply to 'Part Prepayment on need for surgery' benefit
5. Certification in accordance with the provisions of (A), (B) or (C) below:

#### (A) Coronary artery surgery

- (i) Certification to the satisfaction of the Chief Medical Officer of Irish Life

from a cardiologist or cardiac surgeon in Ireland or the UK that the life assured is on a waiting list or scheduled for a coronary artery bypass graft together with (a) a report on the symptoms necessitating the surgery and (b) the result of a recent angiogram which shows the extent of the coronary artery disease.

- (ii) Certification to the satisfaction of the Medical Officer of Irish Life from a cardiologist in Ireland or the UK that the life assured is on a waiting list or scheduled for angioplasty, atherectomy or laser treatment to treat a 70% narrowing of two or more coronary arteries together with (a) a report on the symptoms necessitating the surgery and (b) the result of a recent angiogram which shows at least a 70% narrowing of two or more coronary arteries.

#### (B) Heart valve surgery

Certification to the satisfaction of the Chief Medical Officer of Irish Life from a cardiologist in Ireland or the UK that the life assured definitely requires a heart valve replacement within one year and is on a waiting list or scheduled for same together with (a) a report on the symptoms necessitating the surgery and (b) the results of a recent echocardiogram and/or angiogram showing significant heart valve disease.

### (C) Aorta graft surgery

Certification to the satisfaction of the Chief Medical Officer of Irish Life from a cardiologist or vascular surgeon in Ireland or the UK that the life assured definitely requires removal and replacement of the aorta or a segment of the aorta within one year and is on a waiting list or scheduled for same together with a report on the nature of the disease and symptoms.

### Which Means

If you are covered for and are diagnosed as requiring either coronary artery surgery, heart valve surgery or aorta graft surgery as defined in the above paragraphs and you have obtained the specified certification then provided that the other conditions above are complied with, Irish Life will pay €15,000 (€7,500 for children).

The benefit is provided automatically with specified illness cover. It means that you will have a cash lump sum which can be used to influence when and where you have your surgery performed. The amount paid out will be deducted from your specified illness cover. The remaining amount of the specified illness cover will of course be paid once the surgery has been carried out and on survival 14 days after the surgery.

## 3b A note on Specified Illness Cover Claims

In the event of a claim only the definitions in the master policy document will be used to determine the validity of the claim. The contents of this booklet and the explanations given do not affect the interpretation of the policy rules.

### Complaints

If for any reason you feel that this plan is not right for you, or if you have any questions, you should contact CODE, Irish Life Corporate Business, Lower Abbey Street, Dublin 1 who will deal with your enquiry. Corporate Business operate an internal complaints procedure and any complaints you may have will, in the first instance, be fully reviewed by them.

If you feel we have not dealt fairly with your complaint, you should contact the office of the Financial Services Ombudsman, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2. Telephone: 01 6620899. Email: [enquires@financialombudsman.ie](mailto:enquires@financialombudsman.ie)

## 3c Rules of the Plan

The Plan is governed by a master Policy Document issued by Irish Life Assurance plc. Members of the Plan may examine the policy at any reasonable time at the Head Office of Irish Life. This booklet provides a brief summary of the main policy conditions only and confers no legal rights.



## Additional information in relation to this plan and the supplier (Irish Life Assurance plc)

Identity and main business of supplier	Irish Life Assurance plc ("Irish Life") A Life assurance undertaking providing policies of life assurance
Geographical address of business	Irish Life Centre, Lower Abbey Street, Dublin 1
Registered Number	Irish Life is registered in Ireland under number 152576
Supervisory Authority	Irish Life Assurance plc is regulated by the Central Bank of Ireland
VAT registration number	The Irish Life's VAT registration number is 9F55923G
What are the main characteristics of this plan?	The plan provides a lump sum benefit in the event of a member suffering from certain specified illnesses. The information about the plan is in the booklet.
Are there other taxes or costs that are neither paid nor imposed by Irish Life?	Currently, there is no tax liability on the benefit payable under this plan
For what period is the information Irish Life valid?	The information in the booklet is valid at the date of issue. Usually, we review our plans every 3 years.
What arrangement for payment and performance apply under the policy?	This information is in the booklet
Do I have the right to cancel my membership?	If, after joining this plan, you feel that it is not suitable, you may cancel it by writing to us. If you do this within 30 days from the date of completing the application we will return any payments you have made. You will then be treated as having not joined the plan and no benefit will be payable to you under the plan. We recommend that you talk to your financial adviser before you cancel your membership
How do I cancel my membership?	You can cancel your membership at any time by writing to your broker, or contacting us directly at CB Voluntary Risk, Irish Life Assurance plc, Lower Abbey Street, Dublin 1
What rights does Irish Life have to cease cover under this policy?	Irish Life can cancel the policy at the end of the review period. Also, see booklet for details about when your cover ceases
What Jurisdiction and laws apply Irish to this policy?	Irish Life's policies are governed by the laws of the Republic of Ireland, and the courts and law will be used to determine any matters which may become subject to a legal dispute
What language is used in the policy and other communication?	The terms and conditions of this policy will be provided in the English language. Irish Life Assurance plc will communicate with you in the English language at all times
Is there an out of court complaint and redress process?	If you make a complaint and after we process your complaint you remain dissatisfied with the outcome, you may request a signing-off letter to enable you to refer your complaints to: The office of the Financial Services Ombudsman, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2 Tel: 01 6620899. Email: enquires@financialombudsman.ie





## Contact us

phone: 01 704 1338

fax: 01 704 1905

e-mail: [cbvoluntaryrisk@irishlife.ie](mailto:cbvoluntaryrisk@irishlife.ie)

website: [www.irishlife.ie](http://www.irishlife.ie)

write to: CB Voluntary Risk, 4th Floor, Irish Life Assurance plc,  
Lower Abbey Street, Dublin 1.

Irish Life Assurance plc is regulated by the Central Bank of Ireland. In the interest of customer service we may record and monitor calls. Irish Life Assurance plc, Registered in Ireland number 152576, Vat number 9F55923G.