PENSIONS
INVESTMENTS
LIFE INSURANCE

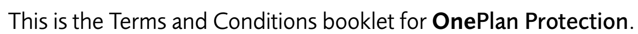
Irish Life

ONEPLAN PROTECTION

TERMS AND CONDITIONS BOOKLET

This product is provided by Irish Life Assurance plc.

This is the Terms and Conditions booklet for **OnePlan Protection**.



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

This plan offers a range of benefits to cover your different protection needs. OnePlan Protection has the benefits listed below which can be available on their own or as a combination of benefits:

1. A lump sum life cover payout if the life (lives) assured dies during the term of the benefit. This lump sum life cover amount decreases annually in line with your replacement income needs as identified with your adviser. This lump sum is paid out once per life assured. This benefit is called decreasing life cover.

2. A monthly payout to help pay the mortgage or rent and essential household bills while the life (lives) assured is unable to work due to illness or injury. This benefit is called bill cover.

3. A lump sum payout in the event of suffering certain specified illnesses or conditions during the term of the benefit to help the life assured recover without additional financial worries. This benefit is called specified illness cover.

4. Life cover to provide family protection if the life (lives) assured dies. This benefit is available as level life cover and / or whole of life cover.

5. Life cover to help with the cost of funeral and other related expenses. This benefit is called funeral cover.

This plan is provided by us (Irish Life Assurance plc) to you (the proposer or proposers named in the plan schedule).

The plan consists of the plan schedule, this terms and conditions booklet, the application form, any related information, and any extra rules which our head office staff may add in writing.

We have issued this plan to you on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. This is called 'disclosure of material facts'.

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

If you do not disclose all material facts in your initial application for cover, or if any of the answers to the questions are not true and complete, we will be entitled to declare the plan void (including any subsequent changes to your cover), you will lose all your rights under the plan, any claim will not be paid and we will not return any payments.

If you do not disclose all material facts in any future application(s) for changes to your cover after the start date of your plan, or if any of the answers to the questions are not true and complete, we will be entitled to declare the plan void or to void the changes(s) made to your cover after the start date of your plan.

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 we do decide to refund any payments made we may deduct any associated medical evidence, administration or sales costs we have incurred under the plan. If cover is voided on one life on a dual cover plan all cover will cease under that plan for both lives. Relevant information (material facts) includes anything that might influence the judgment of a reputable insurer when fixing the level of payments or benefits, or when deciding whether to provide cover at all.

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 – you cannot cash it in. Even if you have not made a claim by the time the period of cover ends, we will not return your payments. The benefits under this plan will end at the end of the term of each benefit as shown in the plan schedule. The plan may end before that for any of the reasons explained in these terms and conditions.

The benefits provided under this plan are stated in the plan schedule. If a benefit is not mentioned in the plan schedule, you have not availed of this benefit.

If you are making a claim under this 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 plan work?

You choose the type of cover you want, and make the payments to us as set out in the schedule. If an event for which the life assured is covered occurs we will pay you the appropriate benefit (the benefits are described in greater detail later on in this terms and conditions booklet).

Who receives the money we pay out?

We will normally pay any benefit due under the plan to you. If you die, we will pay the person who deals with your estate.

If you assign the plan to someone else (for example, you pass it to a building society to be placed with your title deeds as security for your mortgage), we will pay that person. Where a plan is assigned to someone else as security for a mortgage we will not pay an extra amount to cover any interest on that mortgage between the date you submit a claim and the date that claim is paid. If the plan is written under trust, we will pay the trustee.

If there are two proposers, we will pay you jointly. If one of you has died, we will pay the other.

Please note that if assigning the plan, all benefits under the plan will be assigned, therefore any subsequent claims will require authorisation from the assignee.

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.

Cooling-off period

If, after taking out this plan, you feel it is not suitable, you may cancel it by writing to us at the address shown above. If you do this within 30 days from the date we send you your plan documents (or a copy), we will return any payments you have made. We strongly recommend that you consult with your Financial Adviser before you cancel your plan.

Complaints

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

Financial Services Ombudsman
3rd Floor
Lincoln House
Lincoln Place
Dublin 2

Lo-call: 1890 88 20 90
Fax: 01 662 0890
Email: enquiries@financialombudsman.ie
Website: www.financialombudsman.ie

CONTENTS

Definitions
Section 1

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

Basis of cover
Section 2

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

Making payments
Section 3

This section explains your obligations in making payments and explains what happens if payments fall behind.

Your cover
Section 4

This section explains the benefits you can choose under the plan.

Changing the Level of Cover
Section 5

This section explains how you can change the benefits on your plan.

Exclusions
Section 6

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

Claims
Section 7

This section explains how to make a claim and how we will assess your claim.

Tax
Section 8

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

Other information
Section 9

This section provides other information you need to know.

Index of full payment Specified Illness Conditions and Additional Payment Specified Illness Conditions

Full Payment Specified Illness conditions

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

1. Alzheimer's disease – resulting in permanent symptoms
2. Aorta graft surgery – for disease or traumatic injury
3. Aplastic anaemia - of specified severity
4. Bacterial Meningitis – resulting in permanent symptoms
5. Benign brain tumour – resulting in permanent symptoms, 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. Paralysis of One limb - total and irreversible
34. Parkinson's disease (idiopathic)– resulting in permanent symptoms
35. Parkinson Plus Syndromes - resulting in permanent symptoms
36. Peripheral Vascular Disease – with bypass surgery

37. Pneumonectomy – the removal of a complete lung
38. Pulmonary Arterial Hypertension (idiopathic) – of specified severity
39. Pulmonary Artery Graft Surgery
40. Respiratory Failure of specified severity
41. Spinal Stroke – resulting in permanent symptoms
42. Stroke – of specified severity
43. Systemic lupus erythematosus – of specified severity
44. Third Degree Burns of specified surface area
45. 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 your plan schedule) then they are covered for the conditions listed below and defined in full in section 4.7 on an additional payment basis.

a) Brain abscess drained via craniotomy

b) Carcinoma in Situ – Oesophagus, treated by specific surgery

c) Carcinoma in Situ – Oral cavity or oropharynx treated by surgery

d) Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty

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

f) Cerebral or spinal aneurysm – with surgery, stereotactic radiosurgery or endovascular repair

g) Cerebral or spinal arteriovenous malformation –with surgery, stereotactic radiosurgery or endovascular repair

h) Coronary Artery Angioplasty – of specified severity

i) Crohn's disease – treated with surgical intestinal resection

j) Ductal Carcinoma in Situ – Breast, treated by surgery

k) Early stage urinary bladder cancer – of specified advancement

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

m) Liver resection

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

o) Peripheral vascular disease - treated by Angioplasty

p) Pituitary tumour – resulting in permanent symptoms or surgery

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

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

s) Significant visual impairment – permanent and irreversible

t) Single Lobectomy – the removal of a complete lobe of a lung

u) Surgical removal of one eye

v) Syringomelia or Syringobulbia - treated by surgery

w) Total colectomy, including colectomy for ulcerative colitis

DEFINITIONS

Section 1

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

Benefit (or benefits)

The benefit shown in the plan schedule under the heading 'your protection benefits'. If, at any stage during the term of your plan, you choose to change your benefit, your benefits will be different to that shown on your schedule. We will send you a revised plan schedule showing your new benefit amounts at that time.

Claim Payment Term

The bill cover benefit has a claim payment term of either 2 years, 5 years or for the full term of the bill cover benefit. The claim payment term starts at the end of the deferred period. The claim payment term is shown on your plan schedule if you have chosen the bill cover benefit.

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

There is an interval between the date each period of inability to work begins and the beginning of the period for which we will pay the bill cover benefit. This interval is called the deferred period and is either 8, 13, 26 or 52 weeks in a row (see your schedule).

Bill cover benefit

If the life assured is medically totally unable to carry out the main duties of their normal occupation the life assured may be entitled to the bill cover benefit. The life assured must also not be following any other occupation. This inability to work must arise as a result of illness or injury and this must be 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. The maximum monthly bill cover benefit provided is limited to 40% of the life assured's monthly income at outset net of tax. In the event of a claim for bill cover, Irish Life reserves the right to seek evidence to check the life assured's employment status and that the net income threshold was not breached at outset. The maximum bill cover amount is €2,000 a month for a single life or €4,000 a month for both lives assured.

Irreversible

An illness or condition is irreversible if after having all 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 plan schedule 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 next page) who has specialist qualifications in an appropriate branch of medicine and who is

practising at a major hospital (see above).

Month

A calendar month.

Payment

This is:

- 'your total payment' as shown in the plan schedule 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.

or

- a different amount (which we will tell you) if you change your level of cover or benefits. The cost of your benefits may increase to reflect your new cover levels, your age, or your health status. There is no charge for requesting a change to your level of cover and benefits or for cancelling a benefit.

Plan schedule

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

- the start date;
- the benefit terms;
- the life or lives covered;
- the benefits;
- the deferred period;
- the bill cover claim payment term; and
- any special conditions that have been agreed with us.

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 plan schedule. Cover will start on this date.

We, us

Irish Life Assurance Plc.

You

The person (or people) named as the proposer in the plan schedule, who is responsible for making the payments and is legally entitled to the plan benefits as long as they have not been assigned (passed) to someone else. In the text describing each illness covered under the heading 'in simpler terms' in sections 4.6 and 4.7 we have assumed that the person who owns the plan (you) is also the person who is protected (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 plan to you on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the plan void. 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. Information is 'relevant' if it might influence the judgment of a reputable insurer when fixing the level of payments or benefits or when deciding whether to provide cover at all.

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

2.2 If your 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 and any related document is true and complete and that all relevant information has been provided.

If this is not the case, we will be entitled to declare the plan void. 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 we refund payments, we are entitled to deduct appropriate costs incurred as a result of the setting up or administration of this plan. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of payments or benefits;

when deciding whether to reinstate cover at all; or when deciding whether to attach conditions. If cover is voided on one life on a dual cover plan all cover will cease under that plan for both lives.

MAKING PAYMENTS

Section 3

This section explains your 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 plan schedule, we 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 your benefit any payment that you have not made.

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

3.3 If your cover under the plan ends as described in section 3.2, you can restore your cover within 90 days from the date the first missed payment became due. You must make all the payments which would have been due if your cover had not ended. You 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, you ask for cover to be restored, the life assured must fill in an evidence of health form and 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 you to start making payments again. You 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.

3.5 While a bill cover benefit is being claimed, we will make the payments for this benefit only. If we stop paying the bill cover claim, you must start making payments again to keep this benefit. We will not make payment for any other benefits available on the plan during the bill cover claim.

YOUR COVER

Section 4

This section explains the benefits you can choose under the plan.

4.1 The benefits provided for a life assured under this plan are shown in the plan schedule. If a benefit is not mentioned in the plan schedule, you have not availed of that benefit. The plan schedule also shows the amount of cover. If, during the term of your plan, you request to change your benefit amounts and we allow this, your cover amount will be different than that shown on your original schedule. We will send you a revised plan schedule showing your new cover.

The following benefits are available. Check your plan schedule to see which benefits apply in your case.

Benefit	
Decreasing Life Cover	A lump sum life cover payout. This lump sum is paid out once on the death of the life (lives) assured(s)and decreases annually in line with the replacement income needs as identified with your adviser.
Bill Cover	A monthly payout to help pay the mortgage or rent and essential household bills while the life (lives) assured is unable to work due to illness or injury.
Specified Illness Cover	A lump sum payout in the event of the life (lives) assured suffering certain specified illnesses to help them recover without additional financial worries.
Level Life Cover	Life cover to provide family protection if the life (lives) assured dies during the benefit term
Whole of Life Cover	Whole of life cover to provide family protection if the life (lives) assured dies.
Funeral Cover	Life cover to help provide for funeral expenses if the life (lives) assured dies.

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

Decreasing Life Cover

The benefit is designed to pay out a lump sum on death. This lump sum reduces each year over the term of the cover.

Bill Cover

This benefit will pay out a specified monthly benefit if we accept a claim. We will do this for any continuous period of being unable to work lasting longer than the deferred period (8, 13, 26 or 52 weeks as shown in the schedule). You must be working at the time of the illness or injury for a bill cover claim to be valid.

If we do pay a claim, the payment will end:

- at the end of the bill cover claim payment term (2 years, 5 years or the full term of the benefit);
- at the end of the benefit term as set out in the schedule;
- when the life assured dies;
- when the life assured returns to work;
- if our chief medical officer decides the bill cover benefit has ended because the life assured is fit to return to work; or
- if the life assured goes back to their normal occupation;

whichever is earliest.

Specified Illness Cover

This benefit is designed to pay if the life (lives) assured suffers any of the specified illness conditions covered by the policy during the term of the benefit.

Level Life Cover

This benefit is designed to pay if the life (lives) assured dies during the term of the benefit.

Whole of Life Cover

This benefit is designed to pay if the life (lives) assured dies

Funeral Cover

This benefit is designed to pay if the life (lives) assured dies.

4.2 If we accept a claim for a benefit event, we will pay you the amount of benefit set out in the most recent plan schedule. This may differ from any previous plan schedules you received.

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) A bill cover benefit event

A bill cover benefit event will happen when a life assured is unable to work due to illness or injury. The life assured must be working at the time of the illness or injury for a bill cover claim to be valid.

(c) A specified illness cover benefit event

The specified illness cover benefit event will happen 14 days after a life assured is diagnosed as having a specified illness or condition as defined in section 4.6. 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 specified illness cover if the life assured dies within these periods.

Check your plan schedule (and any subsequent revised schedules we send you) to see which benefits apply and any special conditions which attach to this plan.

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

4.3 (a) If a life assured is diagnosed as having a terminal illness during the term of the plan (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.

A terminal illness benefit will only be paid once for each life assured.

(b) If a life assured has specified illness cover but no life cover and is diagnosed as having a terminal illness during the term of the plan (see section 4.5) we will pay the lesser of:

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

The specified illness cover benefit will be reduced by the amount of the terminal illness benefit paid. If the life assured is subsequently diagnosed with one of the listed specified illnesses, we will pay the balance of any further specified illness benefit. All specified illness cover for that life ends when the specified illness cover benefit is paid out.

4.4 All cover under this plan will end:

- at the end of a period of grace, if all or part of a payment has still not been made;
- at the end of the latest benefit term as shown in the plan schedule; or
- when the life assured dies;

whichever is earliest.

If you have life cover, specified illness cover and/or bill cover, the term of these benefits may end at different times.

If there is only one person named on the plan schedule as the life assured (single life) the plan ends when all cover for that person ends (as set out above).

If there are two people named on the plan schedule as the lives assured (dual life), when cover has ended for one person (as set out above) the other person's cover continues unless cover has ended because of missed payments until the latest benefit term on the plan. When cover for both lives assured has ended, the plan ends.

4.5 A life assured is 'diagnosed as having a terminal illness' if the attending consultant gives a definite diagnosis which, 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 the illness is expected to lead to death within 12 months.

4.6 Full Payment Specified Illness Conditions

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

A life assured is 'diagnosed as having a specified illness' if on a date after the start date and before the end of the term 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 specified illness benefit payable will be that applicable on the date you are 'diagnosed as having a specified illness' as per the plan definition 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. 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 judgment, understanding and rational thought process have been seriously affected.

2. Aorta graft surgery – for disease or traumatic injury

Plan definition:

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

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

For the above definition, the following are not covered:

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

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

In simpler terms:

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

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

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

3. Aplastic anaemia - of specified severity

Plan definition:

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

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

For the above definition, the following are not covered:

- All other types of anaemia

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

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

4. **Bacterial Meningitis – resulting in permanent symptoms**

Plan definition:

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

For the above definition, the following are not covered:

- All other forms of meningitis including viral meningitis.
  (Adult and Child cover)

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

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

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

The following are not covered:-

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

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

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

5. **Benign brain tumour – resulting in permanent symptoms, 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
- Surgery; 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:-

- AnAn 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:
  - o pre-malignant;
  - o non-invasive;
  - o cancer in situ;
  - o having either borderline malignancy;
  - o 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 bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0.

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

A malignant tumour:

- *may grow quickly;*
- *often invades nearby tissue as it expands;*

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

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

Cancers 'in situ' (cancers in a very early stage that have not spread in any way to neighbouring tissue) as well as pre-malignant and non-invasive tumours are not covered under this definition. (They may be covered on 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.

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

10. Cardiac arrest – with the 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 Cholangiopancreatography (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 an endoscope (a thin, flexible telescope) to look at the bile duct and pancreatic duct. A dye can be injected into the bile duct so that these can be seen clearly on X-ray.

MRCP (magnetic resonance cholangiopancreatography) is a medical imaging technique that uses magnetic resonance imaging to visualize 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 healthy 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.

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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 judgment, 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, or
4. 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 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. Paralysis of One limb - total and irreversible

Plan definition:

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

In simpler terms:

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

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

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

Plan definition:

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must also be

permanent clinical impairment that includes bradykinesia (slowness of movement) and at least one of the following:

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

For the above definition, the following are not covered:

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

In simpler terms:

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

35. Parkinson Plus Syndromes - resulting in permanent symptoms

Plan definition:

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

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

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

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

In simpler terms:

Parkinson-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 Parkinson-plus syndromes and you have permanent symptoms as defined.

36. Peripheral Vascular Disease – with bypass surgery

Plan definition:

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

For this definition, the following is not covered:

- Angioplasty

In simpler terms:

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

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

Buerger's disease (thromboangiitis obliterans) is caused by inflammation of the

blood vessels (vasculitis). The blood vessels tighten and can become totally blocked.

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

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

37. Pneumonectomy – the removal of a complete lung

Plan definition:

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

For the above definition, the following are not covered:

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

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

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

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

Plan definition:

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

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

For the above definition, the following are not covered:

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

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

39. Pulmonary Artery 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.

40. Respiratory Failure of specified severity

Plan definition:

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

- The need for daily oxygen therapy on a permanent basis;

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

In simpler terms:

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

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

41. 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)

42. 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.

43. Systemic lupus erythematosus – of specified severity

Plan definition:

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

- Permanent neurological deficit with persisting clinical symptoms*, or
- Permanent impairment of kidney function tests as follows:
    - o 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.

The following are not covered:

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

In simpler terms:

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease. The immune system attacks the body's cells and tissue resulting in inflammation and tissue damage. The course of the disease is unpredictable with periods of illness alternating with remission. SLE is a multi-system disease because it can affect many different organs and tissues in the body. Systemic lupus erythematosus can be a mild condition treated by medication or there can be life-threatening complications. The condition can be present

for many years without progressing to brain and kidney involvement.

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

44. 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.

45. 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.

4.7 Additional Payment Specified Illness Cover

This is an automatic additional benefit that only applies to a life assured if the plan schedule shows that the life assured has specified illness cover.

A life assured is 'diagnosed as having a specified illness' if on a date after the start date and before the end of the term 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, on a date after the start date and before the end of the term of the specified illness cover benefit. If 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 specified illness as shown on your schedule. You are only allowed to claim once for each of the illnesses defined below.

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

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

whichever is lower.

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

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

whichever is lower.

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

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

whichever is lower.

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

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

whichever is lower.

The specified illness cover benefit will be that applicable on the date you are 'diagnosed as having a specified illness' (see Section 4.6).

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 people named on the plan schedule as the lives covered (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 your specified illness as shown on your schedule.

(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, you cannot claim the full sum insured under a related full payment specified illness cover definition which occurs or is diagnosed within 30 days of the occurrence or diagnosis of the 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:

- Angiopasty to correct Carotid Stenosis - Stroke/Heart Attack
- Carcinoma in Situ, Oesophagus - invasive cancer Oesophagus
- Cerebral aneurysm- Stroke
- Coronary Angioplasty - Heart attack
- Crohns Disease additional payment- Crohns Disease full payment
- Ductal Carcinoma in Situ, Breast - invasive breast cancer
- Early stage urinary bladder cancer- Invasive cancer of the bladder
- Liver resection- Cancer of liver and major organ transplant
- Low Level Prostate Cancer - >=T2 Prostate Cancer
- Peripheral Vascular Disease, treated with angioplasty – Peripheral Vascular Disease, treated with bypass & heart attack & stroke.
- Pituitary tumour- Invasive cancer
- Severe burns covering at least 5% of the body's surface – Severe burns/3rd Degree Burns of specified body surface area.
- 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.

A **Brain abscess drained via craniotomy**

Plan definition:

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

In simpler terms:

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

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

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

B **Carcinoma in situ – oesophagus, treated by specific surgery.**

Plan definition:

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

For the above definition, the following are not covered:

Treatment by any other method is specifically excluded.

In simpler terms:

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

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

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

C **Carcinoma in situ – 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:

Carcinoma in situ is an early form of carcinoma 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 carcinoma 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 is a white patch that develops in the mouth. It is usually painless but is closely linked to an increased risk of mouth cancer.

D 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.

E 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.

F 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, stereotactic 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.

G 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.

H Coronary Artery Angioplasty – of specified severity

Plan definition:

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

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

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

- €10,000 (subject to limits above) on completion of coronary artery

angioplasty, atherectomy, rotablation, laser treatment and/or insertion of stent(s) in one coronary artery.

- An additional €30,000 (subject to limits above) will be paid if the life assured undergoes a further coronary artery angioplasty, atherectomy, laser treatment or stent insertion provided it is not performed on the same coronary artery or its branches.
- €40,000 (subject to limits above) will be paid if the life assured undergoes coronary artery angioplasty, atherectomy, laser treatment or stent insertion in 2 or more coronary arteries, where no previous claim has been made under this benefit.

In simpler terms:

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

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

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

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

I 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.

J 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

K Early stage urinary bladder cancer – of specified advancement

Plan definition:

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

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

For the above definition, the following is not covered:

Any urinary bladder tumour which has been

- histologically classified as stage Ta (non-invasive papillary carcinoma).

In simpler terms:

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

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

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

Plan definition:

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

For the above definition, the following is not covered:

- Insertion of a pacemaker

In simpler terms:

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

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

M 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.

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

Plan definition:

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

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

For the above definition, the following are not covered:

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

In simpler terms:

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

O **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.

P 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.

Q 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.

R 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.

S 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.

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

Plan definition:

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

For the above definition, the following are not covered:

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

In simpler terms:

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

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

U 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.

V Syringomelia or Syringobulbia - treated by surgery

Plan definition:

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

In simpler terms:

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

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

W Total colectomy, including colectomy for ulcerative colitis

Plan definition:

We will make a limited payment if a life assured 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.

4.8 Prepayment of surgery

This section only applies to a life assured if the plan schedule shows that the life assured has specified illness cover.

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

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

whichever is lower.

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

Proof needed for coronary artery surgery

If a life assured needs coronary artery surgery, the following proof must be provided:

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

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

If a life assured needs heart valve replacement or repair or heart surgery to correct a structural abnormality, the following proof must be provided:

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

Proof needed for aorta graft surgery

If the life assured needs aorta graft surgery, the following proof must be provided:

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

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

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

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

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.

4.9 Children's Life Cover

If a Life Assured has any of the life cover benefits below:

- Decreasing Life Cover
- Level Life Cover

we will pay €7,000 for the funeral expenses of any 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.

Children's life cover will only be paid out once for each claim regardless of the number of benefits a person has with Irish Life. For example, if you have decreasing life cover and level life cover at the point of claim, you will only receive one payment for children's life cover.

4.10 Children's Specified Illness Cover

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

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

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

We will only pay children's specified illness cover benefit once for each child. This is so even if both parents are lives covered with specified illness cover, or even if the life assured is covered under more than one plan which provides similar benefits. The amount of children's specified illness cover benefit is the lower of €25,000 or half of your specified illness benefit amount. If there are two people named on the plan schedule as the lives covered (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 above the age of 30 days (subject to the exceptions above) who survives for more than 14 days after being diagnosed as having a specified illness (see section 4.6). We will pay a benefit for a child suffering one of the conditions listed under the specified illness cover additional payment benefits (see section 4.7) of €7,500 or half of the specified illness benefit amount for a single life, whichever is lower. If there are two people named on the plan schedule as the lives covered (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 or 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

- 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.

4.11 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. 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, benefits or applications a person has with Irish Life.

CHANGING THE LEVEL OF COVER

Section 5

This section explains how you can change the benefits on your plan.

5.1 Changing your benefits in the future

If your plan has not ended, subject to certain rules, you may ask us to change your benefits as identified with your adviser.

You may be able to change the benefits, cover level and term, subject to underwriting. The cost of the benefits may increase to reflect your new cover levels, your ages or your health status. If we allow this, we will send you a revised plan schedule showing your new cover levels, benefit and term.

Once a benefit(s) has been changed, the cost of the benefit(s) will change. You can request a subsequent change(s) to return your plan benefits to their level before the alteration took place, however the cost of the benefits may be different to the cost of the benefit before the change was made. The benefit cost that will apply to your plan will be calculated at the time of your subsequent change.

There is no charge for requesting a change to your level of cover and benefits, the term of your cover or for cancelling a benefit.

We will allow changes to existing or new benefits which are available at the time you request to change your cover level. For example, if you request to add a whole of life cover benefit in the future and we do not offer this, you cannot add this to your plan.

It is important that you disclose all relevant information (material facts) to Irish Life when you are requesting a change to your plan.

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

Failure to tell us all relevant information or if the information provided is not true and complete, we may treat the plan as 'void', if this happens there will be no cover under the plan, or we may void the changes(s) made to your cover after the start date of your plan.

Relevant information (material facts) includes anything that might influence the judgment of a reputable insurer when fixing the level of payments or benefits, or when deciding whether to provide cover at all.

We will rely on what you tell us and you must not assume that we will automatically confirm with your own GP or any doctor any information you provide to us when you request a change to your benefits.

If you are not sure something is relevant, you should tell us anyway.

5.2 Guaranteed Cover Again

5.2.1 Benefits with Guaranteed Cover Again

Guaranteed cover again is available as an option to select on the following benefits:

- Decreasing Life Cover
- Level Life Cover
- Specified Illness Cover

You must be under age 65 at the outset of the benefit to select this option.

Your plan schedule will show if you have this option on the above benefits.

Guaranteed cover again is not available on any other benefit on your plan.

5.2.2 Guaranteed Cover Again

If the plan schedule shows that guaranteed cover again applies to your benefits, you can change your existing benefit in the future without having to provide evidence of health. You must do this before the benefit that you wish to change has ended. You may only do this once per benefit.

The following conditions apply.

- Your new benefit after exercising this option cannot be any higher than the benefit amount immediately prior to exercising this option.
- The benefit must not have already ended as a result of missed payments or a benefit event happening.
- The cost of the new benefit will be based on the terms which apply at that time.
- We will issue the new benefit under our normal terms which apply at the time this benefit is converted.
- Any special conditions which attach to this benefit will apply to the new benefit. This option may not be available if certain special conditions apply to your benefit. 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 benefit they will be classified as a smoker on the new benefit. 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 end of the term of the benefit to avail of guaranteed cover again.
- You cannot get guaranteed cover again under the new benefit.
- When you convert this benefit, all cover under the existing benefit will end.
- Guaranteed cover again applies to a maximum life cover sum insured of €5,000,000. This limit applies to the total benefit amount converted across all policies where the life assured has life cover.

5.2.3 Guaranteed Cover Again – Additional Conditions for Level Life Cover

- Your age when exercising this option cannot pass the current maximum age limits. This is currently 83 for life cover, but this may change in the future.
- The cost of the new benefit (level life cover or whole of life cover) will be based on the terms which apply at that time and the benefits we have available at that time. For example, you cannot exercise your conversion option into a whole of life cover benefit if we do not offer this at that time.
- The term of your new level life cover benefit plus your age when exercising cannot pass age 85 for level life cover, but this may change in the future.

5.2.4 Guaranteed Cover Again – Additional Conditions for Decreasing Life Cover

- This option applies to the current benefit amount at the time you exercise your option.
- If the plan schedule shows that guaranteed cover again applies on decreasing life cover you will be offered a decreasing term cover benefit with a guaranteed payment and fixed term, assuming we have such a benefit available at that time.
- You cannot take out a guaranteed payment whole of life or level or increasing benefit using this option.

- Your age when exercising this option cannot pass the maximum age limits, currently age 80 for decreasing life cover, but this may change in the future.
- The term of your new benefit plus your age when exercising cannot pass age 85 for decreasing life cover, but this may change in the future.
- The term of the new converted benefit cannot exceed the term of the existing benefit.

5.2.5 Guaranteed Cover Again – Additional Conditions for Specified Illness Cover

- You cannot take out a guaranteed payment whole of life benefit using this option.
- Guaranteed cover again applies to 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 specified illness cover.
- Your age when exercising this option cannot pass the current maximum age limits of 65 for specified illness cover, but this age limit may change in the future.
- The term of your new benefit plus your age when exercising cannot pass the current maximum age limits. This is currently age 75 for specified illness cover, but this may change in the future.
- Any special conditions which attach to this benefit will apply to the new benefit. This option may not be available if certain special conditions apply to your benefit. You can ask us whether any special conditions on your benefit prevent you from taking up this option.
- The new benefit 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 benefit.
- If there are differences between the illness or condition definitions given in this benefit and the new benefit, the definitions for the new benefit will apply.

5.3 Guaranteed insurability option

This is an automatic additional benefit. If cover has not ended, you can ask us to increase your existing benefits (level life cover, specified illness cover or decreasing life cover) to 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 increase the benefits on the plan. You must ask for 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 do so 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 the increased benefit, assuming we have such a benefit available at that time.
- The cost of the increase in benefit will be based on the terms which apply at that time.
- We will issue the increased benefit under our normal terms which apply at the time this option is exercised.
- Any special conditions which attach to this benefit will apply to the new benefit, in particular, if you are classed as a smoker on your existing benefit you will be classed as a smoker on the new benefit. 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.
- The new benefit 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 benefit.
- This option does not apply to the bill cover benefit.
- If there are differences between the illness or condition definitions given in this benefit and the new benefit, the definitions for the new benefit will apply.

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 amending the benefits under the plan (for example increasing the term of your cover or adding a new benefit), 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. But if your 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 your plan, we will pay the lesser of the outstanding loan amount or the amount that would otherwise be payable under your 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 amending the benefits under the plan (for example increasing the term of your cover or adding a new benefit), a life assured is diagnosed as having a terminal illness as a result of their own deliberate act, we will not pay you any benefit under the plan. But if your 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 your plan, we will pay the lesser of the outstanding loan amount or the amount that would otherwise be payable under your plan, before the act which caused the terminal illness.

6.3 We will not pay the 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 of a specified surface area or traumatic brain injury, and will not pay limited payments for severe burns/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 bill cover benefit, in any of the following circumstances:

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

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

iii. If the condition 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 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 on a regular public airline)
- Hang gliding
- Horse racing (but not general equestrian activities)
- Motor car or motorcycle racing or sports
- Mountaineering
- Parachuting

- Pot-holing or caving
- Power boat racing
- Rock climbing
- Scuba diving

vi. If the condition results directly or indirectly from the claimants own deliberate act or a penalty imposed by a court of law.

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 bill cover benefit (see section 7 for restrictions that apply)

only if the life assured lives in one of the accepted countries. These are any Member State of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland and the USA.

In respect of specified illness cover and terminal illness cover Irish Life must be advised immediately in writing if a life assured starts living in a country that is not an accepted country for these benefits. 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 due to residence no refund of premiums paid will apply in these circumstances.

Irish Life will pay bill cover claims if the life assured is living in Ireland when a claim is made. However, if at the time of making a bill cover claim the life assured is living in any Member State of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland or the USA, Irish Life will pay a bill cover claim for a maximum period of 13 weeks. Irish Life may then insist that the life assured returns to Ireland if payment of the bill cover claims is to continue and if the life assured fails to return to Ireland the claim will cease.

If at the time of making a claim for the bill cover benefit the life assured is living in a country other than any Member State of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland or the USA the claim for the bill cover benefit will not be paid.

We reserve the right to refuse to accept medical evidence produced from any country in respect of life cover, specified illness cover or bill cover benefit other than from a recognised hospital in Ireland or the UK or health professional resident in Ireland or the UK.

Bill cover & Unemployment

6.5 We will not pay the bill cover benefit if the life assured leaves employment. If the life assured becomes unemployed or ceases to be self-employed, the life assured can submit a claim during the first month of unemployment. After this one month period, a claim under the bill cover benefit will not be paid. If you wish to cancel your bill cover benefit at this point, you may do so. You will be able to start cover again within 6 months of the life assured becoming unemployed, without having to provide any extra medical or health details provided the life assured returns to employment or to self-employment. If the life assured is unable to work due to illness or injury, is going through the deferred period, and becomes unemployed or ceases to be self-employed unexpectedly and involuntarily, Irish Life will pay a valid claim for the bill cover benefit.

CLAIMS

Section 7

This section explains how to make a claim and how we will assess your claim.

7.1 Your benefits have been calculated on the basis that the date of birth of the life assured is as shown on the application form. When you make a claim, we will ask you to provide proof of the date of birth. If the date of birth on the application form is not correct, we will recalculate the benefits in line with the correct date of birth.

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

- A properly filled-in claim form.
- 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 plan schedule, 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 you are claiming for the death of a life assured or the funeral expenses of a child, we are entitled to ask for proof of death in the form of a death certificate, and any other proof we reasonably need.

If you are claiming:

- life cover benefit for a terminal illness;
- specified illness cover benefit; or
- children's specified illness 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. 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 claimed. 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 will not pay the benefits claimed and may also alter the other benefits under the plan, or end the plan altogether.

7.2.1 In respect of life, specified illness, terminal illness or bill cover claims, 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 will be deducted from any claim benefits payable.

7.3 Bill cover claims

7.3.1 If you think you qualify for the bill cover benefit, you should notify us at a minimum of 3 weeks before the end of the deferred period, if the deferred period is 8 weeks (at least 5 weeks before the end of the deferred period if the deferred period is 13 weeks, at least 10 weeks before the end of the deferred period if it is 26 weeks or 22 weeks before the end of the deferred period if it is 52 weeks). We will ask you to fill in a claim form and to have a separate claim form filled in by your own doctor or specialist. You have to pay any costs involved in having this form completed. These forms must be sent to us within two weeks of us posting them to you.

If we do not receive filled-in claim forms within six months of the end of the deferred period, we can refuse to pay a claim for the bill cover benefit altogether. If forms are sent to us within six months of the end of the deferred period, we can decide to only pay bill cover benefit from the date we receive the filled-in claim forms.

7.3.2 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 (in the form of a birth certificate) of the age of the life assured.
- You or the life assured must provide and pay for any certificates, tests, information or evidence which we reasonably need to prove your claim. The life assured must agree, as often as necessary, to attend any medical examinations, psychiatric assessment, assessment by an occupational therapist or functional capacity evaluator, or any other medical or tests, to include the taking and testing of blood, urine or other samples, which are necessary to prove the claim. If you, or the life assured, fail to meet these requirements within a reasonable time as specified by Irish Life, or if the life assured fails to follow the advice of a registered medical practitioner, we will not pay the benefits. We may also change the benefits for the life assured or end the plan altogether.

We may also arrange to have the life assured visited in their own home before or while we are paying bill 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.

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. This could include information about your health, occupation, financial details, hobbies or pastimes. The maximum monthly bill cover benefit provided is limited to 40% of the life assured's monthly income net of tax at outset or subsequent applications to change the Bill Cover benefit net of tax. In the event of a claim for bill cover, Irish Life reserves the right to seek evidence to check the life assured's employment status and that the net income threshold was not breached at outset or subsequent changes to the bill cover benefit.

If the occupation provided at the outset or subsequent changes to the bill cover benefit was incorrect, inaccurate or incomplete this may result in the bill cover claim not being paid or the benefit amount being reduced.

We may require the life assured, either before any decision is made to admit their claim or while their claim is in payment, to undergo medical rehabilitation, or while their claim is in payment, we may ask the life assured to partake in a career change programme to rehabilitate them back into the workforce. If they refuse to comply

with such a request within 3 months without reasonable cause, we reserve the right to end payments on their claim.

We will only accept a claim if we are satisfied that the life assured is entitled to the bill 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 illness or injury on how fit they are for their normal occupation. The availability, location or lack of actual employment opportunities will not affect our assessment.

You must let us know immediately if the life assured goes back to their normal occupation or takes up another occupation while receiving the bill cover benefit. If you or the life assured do not do this, we will stop paying the bill cover benefit.

7.3.3 If we are paying the bill cover benefit and the life assured goes back to their normal occupation but is then incapacitated from the **same cause** within the following six months, we will treat the further period of being unable to work as a continuation of the original claim. We will then begin to pay the bill cover benefit again immediately if the claim payment term on the previous claim(s) has not exceeded the maximum bill cover claim payment term as shown on your plan schedule.

7.3.4 If we are paying the bill cover benefit and the life assured goes back to their normal occupation for a continuous period of six months, we will treat any further period of incapacity from the **same cause** as a new claim. If this new claim qualifies we will then pay the bill cover benefit at the end of the new deferred period (after returning to work for six months) to the maximum bill cover claim payment term as shown on your plan schedule.

7.3.5 If we are paying the bill cover benefit and the life assured goes back to their normal occupation but is then incapacitated from a **different cause** even within the following six months, we will treat this as a new claim. A new deferred period will apply to this claim.

7.3.6 We have worked out your bill cover benefit on the basis that the life assured's date of birth is as shown on the application form. When you make a claim, we will ask for proof of the date of birth. If the date of birth on the application form is not correct, and the life assured is older than shown, we will reduce the bill cover benefit in line with the correct date of birth.

7.3.7 We will not pay the bill cover benefit if the life assured leaves employment or ceases to be self-employed. But if the life assured becomes unemployed or ceases to be self-employed the life assured can still submit a bill cover claim during the 1st month of unemployment. After this one month period, you will not be eligible to claim the bill cover benefit.

If you become unemployed or cease to be self-employed (unexpectedly and involuntarily) during the deferred period of a bill cover claim, we will pay a claim.

The claim will be paid at the end of the deferred period. The assessment will be against your occupation immediately prior to becoming unemployed. If unemployed, the deferred period will start on the date the life assured first attended a doctor for the condition.

TAX

Section 8

This section gives a summary of current Irish tax law and explains what will happen if there is any change in Irish tax law.

8.1 Under current Irish law, generally tax does not have to be taken from life cover, specified illness benefits cover or bill cover benefits. However, in some circumstances tax may have to be paid on life cover. For example, if you die within the term of the plan and your life cover is paid to your estate, your beneficiaries may have to pay inheritance tax on the proceeds from the plan. A government levy is charged on payments that you make under this plan (as at June 2017).

8.2 Any taxes or levies imposed by the government will be deducted by Irish Life. We will deal with this plan in line with the requirements of the Revenue Commissioners. If tax laws or any other relevant laws change after the start date, we will change the terms and conditions of the plan if we need to do this to keep the plan in line with those changes. We will write and tell you about any changes in the terms and conditions. However, 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 plan does not have any cash-in value.

9.2 This 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 you assign (transfer) the plan to someone else, the person you assign it to must write and tell us at:

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

PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

CONTACT US

PHONE: **01 704 2000**
8am to 8pm Monday to Thursday
10am to 6pm on Fridays
9am to 1pm on Saturdays

FAX: 01 704 1900

EMAIL: customerservice@irishlife.ie

WEBSITE: www.irishlife.ie

WRITE TO: Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1.

In the interest of customer service we will record and monitor calls.

Irish Life Assurance plc, Registered in Ireland number 152576, VAT number 9F55923G.
Irish Life Assurance plc is regulated by the Central Bank of Ireland.

PEFC
From sustainably managed forests – For more info: www.pefc.org

TC 1842 (REV 07-17)