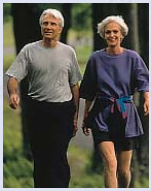
Halligan
INSURANCES

What Does Your Future Hold?








Explantory Booklet for

Your **AGSI** Group Specified Illness Cover Plan

ARRANGED BY: Halligan Insurances

Unity Building, 16/17 Lower O'Connell Street, Dublin 1.
Telephone: 01 – 8731033 or email: info@halligan.ie
www.halligan.ie

Contents **Page**

1. Introduction

Serious illness can strike at any age. The specified illness cover claims paid by Irish Life show the average age of specified illness cover claimants is just 37 and 82% of all claims paid are to people under age 49.

The AGSI Group Specified Illness Cover Plan, helps you control your and your families' financial future if you were to become seriously ill.

All members of AGSI who are under age 57 can join the plan. Spouses of these members under age 57, can also join the plan.

It is important that you read this booklet carefully as it explains what you are covered for under the plan, when you can claim and, in the case of Specified Illness Cover, what exactly each illness is defined as. There is also a copy of this booklet on www.halligan.ie

2. Specified Illness Cover - Details of the Plan

The Benefit

Member and spouse up to age 50 **€ 26,000 Specified Illness Cover**

Member and spouse age 50 to 65 **€ 11,900 Specified Illness Cover**

Hopitalisation expenses after 7 consecutive days/max 182 days €35 per day

Plus FREE Benefit For all who Join

Each of your children (aged between 1 and 21), are **automatically** covered for **€20,000 Specified Illness Cover and €10,000 Life Cover** (aged between 1 and 21)

The Cost: - € 5.66 per week

This cost will be deducted from your salary. It is your responsibility to ensure that your deductions have been set up and continue to be deducted from your pay. Your cover will commence the day the first deduction is taken from your salary. When you retire it is your responsibility to ensure that your contributions are paid directly to Halligan Insurances by Direct Debit. You must set up this direct debit within one month of retirement. The cost of the plan is reviewed every three years. If large numbers of people leave the plan or if there is a high number of people claiming then Irish Life Assurance reserves the right to review the cost of cover.

The next review will take place in October 2017

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

Alzheimer's disease
Angioplasty (two or more arteries)
Aorta graft surgery
Benign brain tumour
Cancer
Coma
Coronary artery surgery
Creutzfeld-Jakob disease (CJD)
Emphysema
Heart attack
Heart valve and structural surgery
HIV/AIDS from blood transfusion
HIV/AIDS from needlestick injury
HIV/AIDS as result of physical assault
Kidney Failure
Loss of Hearing
Loss of Sight
Loss of Speech
Major organ transplant
Motor neurone disease
Multiple sclerosis
Paralysis of two or more limbs
Parkinson's Disease
Severance of two or more limbs
Severe Burns
Stroke
Bacterial Menigitis for Children

(Please note: no cancer claims will be paid where the condition presents within 6 months of the date of commencement of cover under the group plan).A full definition of each illness is given in Section 3 of this booklet.

Is there a survival period?

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

The relevant periods are:

(a) 14 days for heart attack, coronary artery surgery, angioplasty (two arteries), cancer, coma, emphysema, stroke, kidney failure, heart valve surgery, aorta graft surgery, major organ transplant, benign brain tumour, multiple sclerosis, motor neurone disease, severe burns, CJD, HIV/AIDS from needlestick injury, HIV/AIDS from physical assault, HIV/AIDS from blood transfusion, paralysis of two or more limbs and severance of two or more limbs.

(b) six months for Parkinson's Disease, Alzheimer's Disease and loss of sight.

(c) six months for bacterial meningitis in respect of children's cover and

(d) twelve months for loss of hearing and loss of speech.

(e) 14 days after surgery in cases where there has been pre-payment of part of the benefit. The balance of the benefit would be paid upon survival after this period.

When am I covered until?

You shall cease to be covered once you:

- cease to be a member of AGSI before normal retirement date (except when promoted to a higher grade)
- reach age 65
- are paid a claim under the plan
- die
  or
- cease to make contributions

Spouses (where applicable) are no longer covered once:

- they reach age 65
- they are paid a claim under the Plan
- they die
- you cease to make contributions
- you cease to be a member of AGSI
  or

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

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

- reach age 21
- are paid a claim under the Specified Illness plan
- die
  or
- you leave the plan

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

Do I have to provide Medical Information?

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

However due to this concession, you will not be covered for pre-existing conditions under the Specified Illness Cover portion of the plan on the following basis (these conditions will also apply to your spouse/partner, where applicable).

1. Where you have previously suffered, at any time prior to the commencement date of cover from one of the specified illnesses covered you will never be covered for that illness and cannot therefore claim for that illness. For example, if you contracted cancer in 1990 you can never claim under cancer. You are however covered for the remaining illnesses.

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

   For example, if you underwent coronary artery surgery in 1992 you will never be covered for and cannot claim in respect of heart attack, stroke, coronary artery surgery, angioplasty or heart transplant. You are covered for the remaining illnesses.

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

   For example, a claim would not be paid and cover for heart attack will cease in the event of a heart attack occurring in the first two years of cover, if prior to joining the scheme, you suffered with a condition that could lead to a specified illness, then you must be in the scheme a minimum of two years before qualifying for cover for illness. Being a diabetic before the commencement date of cover means that if you suffer a stroke or a heart attack or undergo coronary artery surgery, angioplasty or major organ transplant in the first two years of cover, a claim will not be paid and cover for that specified illness will cease.

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

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

3. Explanation of each specified illness and its pre-existing conditions

This section outlines the policy definition of the specified illnesses that are covered under the plan, a brief simple explanation of each illness, and information on the related conditions that preclude cover in the event of insured illnesses occurring within the first two years of cover. These should be read in conjunction with paragraph 1 and 2 of Pre-Existing Conditions on page 6.

Alzheimer's disease

Policy definition

A global failure of brain function resulting in significant reduction in mental and social functioning to the extent that the continuous supervision and assistance of another person is required. The diagnosis must be confirmed by a consultant neurologist or consultant geriatrician of a major Irish or UK hospital who is satisfied that there is no other discernible cause and, if Irish Life so requires, this confirmation must be supported by one or more consultant neurologists or consultant geriatricians nominated by Irish Life. The condition must be present for a continuous period of at least six months. The condition must be irreversible with no reasonable prospect of there ever being any improvement.

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.

You can claim if you have been diagnosed by a consultant neurologist or consultant geriatrician as having Alzheimer's disease and you need to be continuously supervised and assisted because your judgement, understanding and rational thought processes have been seriously affected and you cannot perform daily tasks such as preparing food, dressing yourself and washing yourself. You must have the condition for 6 months following diagnosis before you can claim this benefit. According to current medical knowledge there must be no reasonable expectation of improvement in your condition.

Pre-existing conditions

If you have a history of arteriosclerotic dementia, amnesia or memory loss prior to the commencement date of cover and you are found to have Alzheimer's Disease within the first two years of cover no benefit will be payable under the specified Illness Cover plan and you will cease to be covered for Alzheimer's Disease.

Angioplasty (two or more arteries)

Policy definition
The undergoing, on the advice of a consultant cardiologist of a major Irish or UK hospital, of balloon angioplasty, atherectomy or laser treatment to treat a 70% narrowing of two or more coronary arteries. Irish Life shall be entitled to require that angiograms be produced. Such a procedure to one artery only is not covered.

In simpler terms
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. Unlike bypass surgery, these procedures do not involve open heart surgery.

If you have balloon angioplasty, atherectomy or laser treatment, you can claim if the treatment is to correct a 70% narrowing of at least two coronary arteries. We do not cover such treatment where only one artery is involved. Investigations (such as angiograms) into blocked arteries are also not covered.

We may need to see 'angiograms' to confirm that your claim qualifies. Angiograms are carried out by passing a catheter into the artery, injecting a liquid into the area and taking rapid x-ray pictures. An angiogram is the only real way of seeing how badly an artery is narrowed or blocked. It will always be done before a bypass or balloon angioplasty is carried out.

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

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

Aorta graft surgery

Policy Definition
The undergoing of surgery to correct any narrowing, dissection or aneurysm of the thoracic or abdominal aorta.

In simpler terms
The aorta is the main artery of the body and the source of all others. It supplies blood containing oxygen to other arteries. The aorta can narrow (often due to 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 weakened or narrowed part of the artery.

You can claim if you have had surgery to the aorta to correct narrowing or weakening. Only the parts of the aorta in the chest and abdomen (thoracic and abdominal aorta) are covered because these are the parts which are closest to the heart and so are where any blockage or weakness is more serious. The branches of the aorta are less critical and damage to these is not usually life threatening.

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

Benign brain tumour

Policy definition
A non-malignant tumour in the brain that has required surgical removal or has resulted in permanent neurological deficit. Tumours or lesions in the pituitary gland are not covered.

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

These growths can be life-threatening and may have to be removed by surgery.

You can claim if you are diagnosed as having a benign tumour of the brain and have had surgery to have it removed or are suffering from permanent neurological problems as a result of the tumour. Examples of tumours covered include gliomas, acoustic neuromas and meningiomas. We do not cover tumours or lesions in the pituitary gland. By neurological problems we mean definite symptoms of damage to the central nervous system. Examples of these symptoms include numbness, paraesthesia (an abnormal tingling sensation), paralysis, localised weakness, dysarthria (difficulty speaking), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty walking, problems with co-ordination, tremor, seizures (fits), dementia, delirium (for example, hallucinations) or coma. These neurological problems must be permanent.

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

Cancer

Policy definition

Any malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term cancer includes leukaemia and Hodgkin's disease but the following are excluded.

- *All tumours which are histologically described as pre-malignant, as non-invasive or as cancer in situ.*
- *All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least TNM classification T2N0M0.*
- *All forms of lymphoma in the presence of any human immunodeficiency virus.*
- *Kaposi's sarcoma in the presence of any human immunodeficiency virus*
- *Any skin cancer other than malignant melanomas which have been histologically classified as having progressed to a Clark's level 2 or higher ie. have invaded beyond the epidermis.*

In simpler terms

The term 'cancer' is used to refer to all types of malignant tumours (tumours which can be spread) as opposed to benign tumours (which do not spread). A tumour results when the process of creating and repairing body tissue goes out of control leading to an abnormal mass of tissue being formed. The tumour may grow faster than, and not be linked to, the adjoining normal tissues.

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).

Leukaemia (cancer of the white blood cells) and Hodgkin's disease (a type of lymphoma) are both covered.

Cancer continued…

We do not cover 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. These are well-recognised conditions and cancers detected at this stage are not likely to be life-threatening and are usually easily treated. An example of this would be carcinoma (cancer) in situ of the cervix (neck of the womb) which is easy to threat and cure.

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. It is not possible to provide cover against these early prostate cancers. The TNM classification system is internationally recognised and used as a method of measuring a tumour. The 'T' element relates to the primary tumour and it 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 prostate cancer unless the tumour has a Gleason score (a method of measuring the differences in cells) of greater than 5 or lymph nodes or metastases (the cancer spreading) are involved as measured by the 'N' and 'M' elements of TNM.

Most forms of skin cancer are relatively easy to treat and are rarely life-threatening. This is because they do not spread out of control and do not produce growths in other parts of the body. The only form of skin cancer that is covered 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 carried a favourable long-term outlook.

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

Pre-existing conditions

If you have a history of Bowens disease, familial polyposis of the colon, Hodgkin's disease, leukoplakia or ulcerative colitis prior to the commencement date of cover and you are found to have cancer within the first two years, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for cancer.

Coma

Policy definition

Unrousable unconsiousness arising as a result of illness or injury continuing for at least 96 hours and resulting in permanent neurological deficit. Life supporting systems including assisted ventilation must be required throughout the period of unconsciousness.

In simpler terms

A coma is a state where a person is unconscious and cannot be brought around. 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.

You can claim if:

- You are unconscious (as a result of injury or illness) for at least 96 hours;
- You need a life-support machine for that 96-hour period; and
- You suffer permanent neurological deficit as a result.

By neurological problems we mean definite symptoms of damage to the central nervous system. Examples of these symptoms include numbness, paraesthesia (an abnormal tingling sensation), paralysis, localised weakness, dysarthria (difficulty speaking), aphasia (inability to speak), dysphagia (difficult swallowing), visual impairment, difficulty walking, problems with co-ordination, tremor, seizures (fits), dementia, delirium (for example, hallucinations) or coma. These neurological problems must be permanent.

Pre-existing conditions

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

Coronary artery surgery

Policy Definition
The undergoing on the advice of a consultant cardiologist of a major Irish or UK hospital of open heart surgery to correct narrowing or blockage of ONE or more coronary arteries with bypass grafts but excluding balloon angioplasty, laser relief 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 by-pass surgery is carried out by taking a vein, normally from the thigh, and using it to direct blood past the diseased or blocked artery. This is a major operation, involving the actual opening of the chest wall to reach the heart and using a heart-lung machine (cardiopulmonary bypass) during the surgery. Open heart surgery does not include heart surgery performed without a cardiopulmonary bypass.

You will be able to claim if you have open heart surgery for the purpose of coronary artery bypass surgery for arterial disease. You are not covered under this definition for any other techniques such as angioplasty or laser relief.

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

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

Creutzfeld-Jakob Disease (CJD)

Policy Definition
An unequivocal diagnosis of Creutzfeldt-Jakob Disease (CJD) made by a Consultant Neurologist.

In simpler terms
CJD is a degenerative condition of the brain thought to be due to a viral infection. As the disease progresses muscular co-ordination diminishes, the intellect and personality deteriorate and blindness may develop.

Pre-existing conditions
None.

Emphysema

Policy Definition
Diagnosis of severe restrictive lung disease by a respiratory specialist who has been appointed as a consultant physician where there is shortness of breath at rest with markedly abnormal pulmonary function tests, the diagnosis being evidenced by all the following:
(a) vital capacity being less than 50% of normal;
(b) FEV1 (forced expiratory volume at one second) being less than 50% of normal; and
(c) The need for continuous daily oxygen therapy.

In simpler terms
Emphysema is a condition of the lungs characterised by abnormal enlargement of the airspaces. It is usually associated with chronic bronchitis and obstructive airways disease (COAD). The disease is progressive and eventually clinical features develop such as chronic productive cough, progressive exertional shortness of breath and wheezing. No curative therapy is available for emphysema. Antiobiotics, bronchodilators, corticosteroids and inhalation therapy are used to relieve symptoms and control potentially fatal complications. Severity of the condition must meet the definition in order for a claim to be paid.

Pre-existing conditions
If you have a history of chronic obstructive airways disease, chronic bronchitis or chronic asthma prior to the commencement date of cover and you suffer emphysema within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for emphysema.

Heart Attack

Policy definition

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

- *Typical chest pain*
- *New characteristic electrocardiographic changes;*
- *The characteristic rise of cardiac enzymes, troponins or other biochemical markers*

where all of the above shows a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina are not covered under this definition.

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. You can claim if you are diagnosed as having suffered death of heart muscle.

Your claim must be supported by:

- new ECG changes that are typical of a heart attack (ECG stands for electrocardiogram which is a record of the electrical impulses that make the heart beat); and
- an increase in cardiac enzymes, troponins or other biochemical markers that are typical of a heart attack (which are released into the bloodstream from the damaged heart muscle);and
- chest pains which are typical of a heart attack.

The ECG would confirm that you suffered a heart attack. Increased levels of cardiac enzymes, troponins or other biochemical markers found in blood tests will support this diagnosis and confirm that the heart attack was recent.

This benefit does not cover angina or other acute coronary syndromes if there are no changes in the ECG together with blood tests that support the diagnosis of heart attack.

Pre-existing conditions

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

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

Heart valve and structural surgery

Policy definition
The undergoing of open heart surgery to repair or replace one or more heart valves or to correct structural abnormalities.

In simpler terms
If one of the four heart valves is not working properly, an operation may be necessary to repair or replace the valve. 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 open heart surgery:

- to repair or replace a heart valve; or
- to correct a structural abnormality of the heart.

Open heart surgery is a major operation which involves opening the chest wall to reach the heart and using a heart-lung machine (cardiopulmonary bypass) during the surgery. Open heart surgery does not include surgery performed without cardiopulmonary bypass.

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

HIV/AIDS as a result of a blood transfusion

Policy Definition

Infection by any human immunodeficiency virus (HIV) acquired from a transfusion of blood given as part of medical treatment administered in any member state of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland or the United States of America by registered medical practitioners after the start date of specified illness cover under this policy. There must be clear evidence satisfactory to Irish Life's Chief Medical Officer that the infection was acquired in this way. Such infection shall be deemed to have occurred where tests, including blood, urine or other tests, indicate in the professional opinion of Irish Life's Chief Medical Officer either the presence of any human immunodeficiency virus or antibodies to such a virus.

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.

You can claim if you are infected with HIV or get AIDS from a blood transfusion which is medically necessary and which is carried out in any member state of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland or the United States of America. The transfusion must have taken place after specified illness cover starts under the policy. There must be proof that the transfusion was the source of the infection.

Pre-existing conditions

If you have a history of Haemophilia prior to the commencement date of cover and you become HIV positive within the first two years of cover no benefit will be paid under the Specified Illness Cover Plan and you will cease to be covered for HIV/AIDS from blood transfusion.

HIV/AIDS from Needlestick Injury

Policy Definition
Infection by any human immunodeficiency virus acquired by a life assured where Irish Life's Chief Medical Officer is satisfied that the infection was caused by an accidental injury by a sharp instrument or by exposure to blood or blood stained body fluid which occurred in Ireland or the UK during the twelve months preceding diagnosis but after the date of the commencement of serious illness cover under this plan and that it occurred while the life assured was following the normal duties of their occupation. In addition to the general condition above, it shall be a particular condition of the validity of a cliam that the following sequence of events took place:

1. *The accident was reported in accordance with the established occupational procedures for such an accident*
2. *Within seven days of the accident the relevant life assured underwent a blood test and this blood test indicated the absence of any HIV or antibodies to such a virus*
3. *Within fourteen days of the accident, the circumstances of the accident were reported in full to Irish Life Assurance at its head office and it was reported that the blood test, referred to in (2) above, had been undergone*
4. *The accident was followed up in accordance with the established occupational procedures*
5. *A further blood test, within 12 months of the accident, indicated the presence of HIV or of antibodies to such a virus, which supports the diagnosis of HIV infection.*

Such infection shall be deemed to have occurred where tests including blood, urine or other tests indicate in the opinion of Irish Life's Chief Medical Officer either the presence of any human immunodeficiency virus or antibodies to such a virus.

In simpler terms
Human Immunodeficiency Virus (HIV) is generally recognised as the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The virus can be transmitted in a number of ways including contaminated blood, blood stained bodily fluids and infected needles used by intravenous drug users. The benefit is designed to cover those people who are in special danger of contracting HIV/AIDS through their work.

You can claim if you contract HIV/AIDS as a result of accidental injury which occurred whilst working and after the commencement of the serious illness cover under this plan. In order to qualify for payment the procedures set out above must be followed. The purpose of these procedures is to ensure that the HIV infection is definitely as a result of the relevant incident.

Pre-existing conditions
None

HIV infection or AIDS as a result of physical assault

Policy Definition

Infection by any human immunodeficiency virus (HIV) acquired by a life assured where such infection was caused by a physical assault on the life assured in the Republic of Ireland. The assault must have occurred at least 26 weeks after the start date of specified illness cover under this policy. There must be evidence that the infection occurred as a result of the assault on the life assured and the assault must have been reported to the Garda Síochana within 24 hours of its occurrence. The life assured must have undergone a blood test within seven days of the assault which caused the infection indicating the absence of HIV or antibodies to such a virus and a further blood test within twelve months of the assault indicating the presence of HIV or antibodies to such a virus. Such infection shall be deemed to have occurred where tests, including blood, urine or other tests, indicate in the professional opinion of Irish Life's Chief Medical Officer either the presence of any human immunodeficiency virus, or antibodies to such a virus. All blood tests must be processed by a recognised hospital laboratory in the Republic of Ireland.

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, blood-stained bodily fluids and infected needles. In some circumstances, there is a risk of becoming infected as a result of a physical assault. For this reason, you can claim if you are infected with HIV or get AIDS as a result of a physical assault in the Republic of Ireland. The assault giving rise to the infection must occur at least 26 weeks after the specified illness cover starts under your policy and have been reported to the Garda Síochana. Separate tests carried out within 7 days and then 12 months of the assault must establish that the physical assault was the source of the infection.

Pre-existing conditions

None.

Kidney failure

Policy definition
End stage renal failure due to chronic irreversible failure of both kidneys to function. This must be evidenced by the life assured undergoing regular peritoneal dialysis or haemodialysis or having had renal transplantation.

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 permanently and you need regular long-term dialysis or a kidney transplant.

Pre-existing conditions
If you have a history of diabetes mellitus, glomerulonephritis, nephrotic syndrome, paraplegia, polycystic renal disease, hypertension or pre-existing renal impairment with raised serum creatinine prior to the commencement date of cover and you suffer kidney failure within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for kidney failure.

Loss of hearing

Policy definition

Total and irreversible loss of hearing in both ears before the 65th birthday of the life assured. Irish Life can require confirmation that the loss of hearing is total and irreversible from an appropriate consultant physician of a major Irish or UK hospital and, if Irish Life so requires, this confirmation must be supported by one or more consultant physicians nominated by Irish Life. The condition must be present for a continuous period of at least twelve months.

In simpler terms

You can claim if before reaching age 65 you have total and irreversible loss of hearing in both ears. Although it is possible to be partially deaf, we will not pay unless the loss of hearing is complete and permanent in both ears. The condition must continue for 12 months following diagnosis before you can claim benefit.

Pre-existing conditions

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

Loss of sight

Policy definition
Total, permanent and irreversible loss of sight in both eyes. The Irish Life can require confirmation that the loss of sight is total and irreversible from an appropriate consultant physician of a major Irish or UK hospital and if Irish Life so requires this, confirmation must be supported by one or more consultant physicians nominated by the Irish Life. The condition must be present for a continuous period of at least six months.

In simpler terms
You will be able to claim only if you have total and irreversible loss of sight in both eyes. You should know that it is possible to be 'registered blind' (a procedure usually undertaken by an eye specialist) though the loss of sight may only be partial. Even if you are registered blind, the claim will only be met if the loss of the sight is complete and cannot be corrected.

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

For further information on Loss of Sight contact: The National Council for the Blind, P.V. Doyle House, Whitworth Road, Drumcondra, Dublin 9. Telephone: (01) 830 7033, 1850 334353.

Loss of speech

Policy definition
Total and irreversible loss of the ability to speak because of physical damage to or disease of the vocal cords. Irish Life can require confirmation that the loss of speech is total and irreversible from an appropriate consultant physician of a major Irish or UK hospital, and, if Irish Life so requires, this confirmation must be supported by one or more consultant physicians nominated by Irish Life. The condition must be present for a continuous period of at least 12 months.

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 to or disease of the vocal cords.

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

Major organ transplant

Policy definition
The actual undergoing in a major hospital of, or confirmation of acceptance onto the official programme waiting list of a major hospital for, a necessary transplantation as a recipient of a heart, lung, liver, pancreas or bone marrow.

In simpler terms
Serious disease or injury can severely damage the heart, lungs, liver or pancreas. The only form of treatment available may be to replace the damaged organ with a healthy organ from a donor. This is a major operation and the tissues of the donor and patient must be matched accurately. For this reason a patient could be on a waiting list for a long period waiting for a suitable organ.

You can claim if:

- your condition is life threatening; and
- you have had a transplant of any of the above or are on an official Irish or UK programme waiting list for a transplant.

Pre-existing conditions
If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of cover you can never claim under any of these five illnesses.

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

Motor neurone disease

Policy Definition
Unequivocal diagnosis of motor neurone disease by a consultant neurologist of a major hospital where there are obvious neurological signs. If Irish Life so requires, the diagnosis must be supported by one or more consultant physicians nominated by Irish Life.

In simpler terms
Motor neurone disease is a rare disease which affects the central nervous system that controls movement. As the nerves deteriorate the muscles weaken. The cause is not known.

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

Pre-existing conditions
If you have a history of muscle weakness in any limb prior to the commencement date of cover and you are found to have motor neurone disease within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for motor neurone disease.

Multiple sclerosis

Policy Definition

A definite diagnosis by a consultant neurologist of multiple sclerosis which satisfies all of the following criteria.

- There must be current impairment of motor or sensory function, which must have persisted for a continuous period of at least six months.
- The diagnosis must be continued by diagnostic techniques current at the time of the claim.

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 cause is not known and at present there is no cure but the search for one continues. 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.

It can be difficult to diagnose multiple sclerosis but a neurologist can carry out various tests such as:

- CT scanning (computerised tomography which is a computer and x-ray technique which produces images of the body from different angles);
- Lumbar puncture (a process which tests the spinal fluid); and
- MRI (magnetic resonance imaging which forms images by putting the patient in a strong magnetic field).

You can claim if:

- you are diagnosed by a consultant neurologist as suffering from multiple sclerosis;
- there is supporting evidence from diagnostic tests which apply at the time of your claim; and
- you have ongoing, well-defined symptoms of the disease which have been present for at least six months.

Pre-existing conditions

If you have a history of retrobulbar or optic neuritis, facial paraesthesia, numbness or tingling of upper or lower limbs, trigeminal neuralgia, diplopia, unilateral weakness of a lower limb or incoordination of movement or speech prior to the commencement date of cover and you are found to have multiple sclerosis within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for multiple sclerosis.

Paralysis of two or more limbs

Policy Definition
The total and irreversible loss of the use of two or more limbs. Irish Life has the right to require confirmation of the total and irreversible nature of the paralysis from an appropriate consultant physician of a major Irish or UK Hospital and can require that such confirmation be supported by one or more appropriate consultant physicians nominated by Irish Life.

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

You will be able to claim if you suffer complete and permanent loss of the use of two or more limbs.

Pre-existing conditions
If you have a history of multiple sclerosis, motor neurone disease, stroke or transient ischaemic attack prior to the commencement date of cover and you became paralysed within the first two years of cover no benefit will be payable under the Serious Illness Cover plan and you will cease to be covered for paralysis of two or more limbs.

Parkinson's Disease

Policy definition
The unequivocal diagnosis by a consultant neurologist of a major Irish or UK hospital of idiopathic Parkinson's disease resulting in the need for permanent supervision and assistance. If Irish Life so requires, this diagnosis must be supported by one or more consultant neurologists nominated by Irish Life. The condition must be present for a continuous period of at least six months.

In simpler terms
Parkinson's disease is a disease of the central nervous system which affects voluntary movement. It is characterised by uncontrollable shuffling, slow movements and shaking of the limbs and head. It normally takes hold gradually and at present there is no known cure.

You can claim if you have 'idiopathic' Parkinson's disease to a degree where you need permanent supervision and help to carry out daily tasks such as dressing and eating. 'Idiopathic' means that the cause of the disease is not known, so any form of Parkinson's disease brought on by a known cause such as certain drugs, toxic chemicals or alcohol is not covered. The condition must continue for six months following diagnosis before you can claim benefit.

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

Severance of two or more limbs

Policy Definition
The irreversible severance of two or more limbs from above the wrist or ankle joint.

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

Pre-existing conditions
If you have a history of peripheral vascular disease or you have suffered a previous accident which has led to partial or total severance of two or more limbs, no benefit will be payable under the Specified Illness Cover Plan and you will cease to be covered for severance of two or more limbs.

Severe burns

Policy definition
Burns affecting no less than 20% of the body surface area to a depth of full thickness (i.e. third degree).

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 (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin. You will be able to claim if you have suffered third-degree burns covering 20% or more of the surface area of your body.

Pre-existing conditions
None.

Stroke

Policy definition

Any cerebrovascular incident resulting in infarction of brain tissue, haemorrhage or embolisation from an extracranial source. There must be evidence of permanent neurological deficit. Transient ischaemic attacks are specifically excluded.

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).

You will only be able to claim if you suffer a stroke that results in permanent neurological problems. By neurological problems we mean definite symptoms of damage to the central nervous system. Examples of these symptoms include numbness, paraesthesia (an abnormal tingling sensation), paralysis, localised weakness, dysarthria (difficulty speaking), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty walking, problems with co-ordination, tremor, seizures (fits), dementia, delerium (for example, hallucinations) or coma. These neurological problems must be permanent.

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

Pre-existing conditions

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

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

4. Children's Specified Illness Cover

Each of your dependent children (as proven by your name on their birth cert if there is a claim) between the ages of 1 and 21 are automatically covered for €20,000.

As we do not ask for medical details on your children prior to including them in the plan they are not covered if a claim arises as a result of a condition they have had since birth or a condition known to exist prior to attaining age 1 or the commencement date of specified illness cover under the plan. Therefore, if a child is known to be suffering from a heart valve defect prior to commencement date of the plan or prior to attaining age 1, we would not pay a claim for heart valve surgery. However if that child is unfortunate enough to develop an unrelated ailment such as cancer or benign brain tumour, we would pay such a claim.

The cover provided is limited to the illnesses listed on page 3. In addition children will be covered for:

Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit. The diagnosis must be confirmed by a Consultant Neurologist. The neurological deficit must be present for a continuous period of at least six months. All other forms of meningitis, including viral, are not covered.

Only one claim can be made per child and your child must survive for the same periods mentioned on page 5 following diagnosis or surgery in order for the benefit to be payable. In addition, the benefit is payable only once for any child irrespective of how many policies there are on that child. This cover remains in force for as long as there is specified illness cover in force on you under the plan.

If you have more than one child then please note that if one child claims the others are still covered.

5. Additional Benefit-Part prepayment on need for surgery

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

(i) 50% of the specified illness cover (if any) applying in respect of that life assured on that date

or

(ii) €15,000 (€10,000 for children).

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

(A) Coronary artery surgery

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

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

(B) Heart valve surgery

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

(C) Aorta graft surgery

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

Which Means

If you are covered for and are diagnosed as requiring either coronary artery surgery, heart valve surgery or aorta graft surgery as defined in the above paragraphs and you have obtained the specified certification then provided that the above conditions are complied with, 50% of your specified illness cover may be paid out up to a maximum of €15,000 (€10,000 for children).

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

6. A note on Specified Illness Cover

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

7. Hospitalisation Expenses

We will pay your hospitalisation expenses if you are in hospital as an in-patient for more than seven consecutive days. The benefit will be payable at the rate of €35 per day for each complete day (24 hours) of in-patient stay starting with the 8th day. No benefit is payable for the first 7 days. This is subject to the following conditions.

(a) Hospitalisation benefit ends:

- When you are discharged from hospital;
- After the 183rd day of of cumulative benefit payment;
- On the expiry date set out in the policy;
- Whichever is the earliest.

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

(c) A "Hospital" is an institution, in one of the accepted countries, that has facilities for diagnosis, treatment and major surgery and has accommodation for inpatients. It does not include a long-term nursing unit, a geriatric or pre-convalescent ward or an extended care facility for convalescence, rehabilitation or other similar function.

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

(e) We will not pay hospitalisation benefit if the life assured goes into hospital in the following circumstances:

- For treatment of mental illness, a psychiatric disorder or alcoholism
- For any cosmetic surgery or surgery which the life assured chooses to have even though it is not essential.

Rules of the Plan

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

ARRANGED BY:

HALLIGAN INSURANCES
Unity Building, 16/17 Lower O'Connell Street, Dublin 1.
Telephone: 01 – 8731033 Fax: 01- 873 1978 email: info@halligan.ie