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Irish Life

AGSI
GROUP SPECIFIED ILLNESS COVER PLAN

EXPLANATORY BOOKLET - GROUP POLICY NO. 22067

DECEMBER 2021

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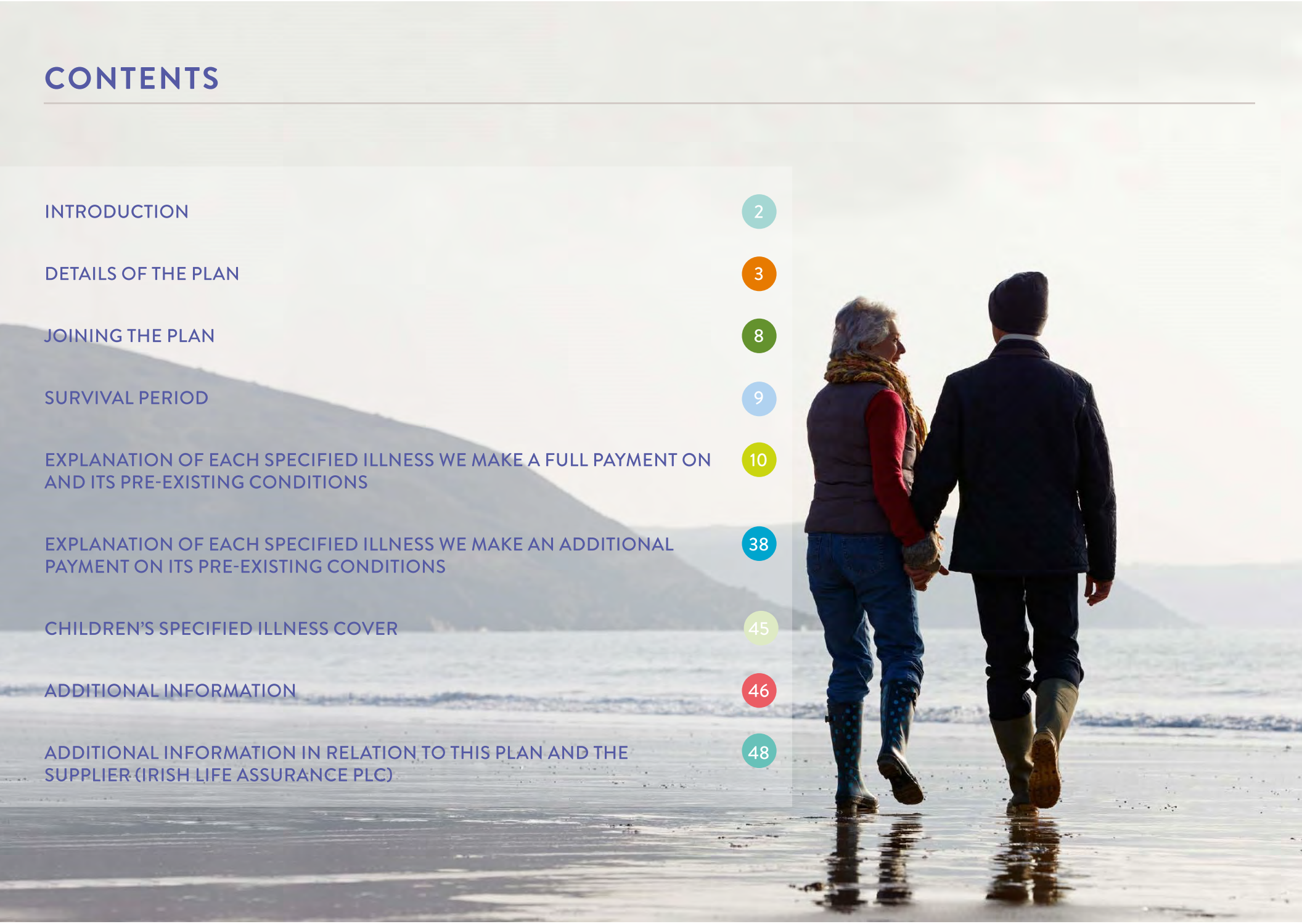

SECTION 1

INTRODUCTION

This booklet will explain the details of your Specified Illness Cover Plan in short and simple terms.

WHAT IS SPECIFIED ILLNESS COVER?

Specified Illness Cover (SIC) is a benefit which pays a lump sum if you suffer from one of the 36 common conditions we cover, such as malignant cancer, heart attack and stroke. Details of the illnesses covered are set out in detail in Section 5 of this booklet.

WHY DO I NEED SPECIFIED ILLNESS COVER?

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

- You are four times more likely to suffer one of the conditions specified in this booklet before age 65, than to die.
- The most common illnesses are malignant cancer, heart related illnesses (diagnosed) and stroke (permanent symptoms).

Source: Irish Life Claims Department.

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

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

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

SECTION 2

DETAILS OF THIS PLAN

PLAN NAME

The name of the plan is AGSI Specified Illness Cover Plan.

POLICYHOLDER

The policyholder is AGSI.

WHO IS THE BROKER?

The Broker and distributor of the plan is Halligan Insurance. William Norton House, 575 North Circular Road, Dublin 1. For any queries, contact Halligan Insurance on 01 8797100 or info@halligan.ie.

WHO IS THE PROVIDER?

The underwriter for this plan is: Irish Life Assurance plc, Irish Life Centre, Lower Abbey Street, Dublin 1.Tel: 01 704 1776.

WHO CAN JOIN?

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

Where Partner is mentioned in this booklet, it should be understood to mean spouse, civil partner, partner. Partner is defined as a person living in a spousal type relationship with the member for 12 months at the time the application for cover is made.

If your partner is now different to the person you named on your original form, and you wish to include them for cover under the Plan, a new application form must be completed .

BENEFIT AMOUNT AND COST

The benefits and costs under this plan are as follows:

AGE OF MEMBER & PARTNER	BENEFIT	COST
Up to age 50 years	€30,000 SIC	€5,66 per week(Member & Partner)
Age 50 to age 65 years	€10,000 SIC	€5,66 per week(Member & Partner)
Children's SIC benefit Age 30 days to 25 years	€20,000	Included
Children's Death benefit Age 1 to 21 years	€10,000	Included
Hospitisation expenses after 7 consecutive days/182 days	€35 per day	Included

Member's contribution is €5.66 per week and automatically includes the member's parter and children at no additional cost. See below and overleaf for more details

Warning: The current premium amount may increase after the next rate review date 01/01/2024.

JOINING THE PLAN?

All members of AGSI who are under age 57 can join the plan. Partners of these members under age 57 can also join the plan. On joining the plan you will be covered for one of either €30,000 or €10,000 depending on your age.

This cost will be collected by direct debit or by salary deduction for eligible members. It is your responsibility to ensure that your deductions have been set up and continue to be deducted from your bank account or from your salary. Your cover will commence the day the first deduction is taken from your bank account or from your salary.

CAN I INCREASE MY COVER UNDER THE PLAN?

You have the opportunity to change partner future 'open periods'. Open periods are typically once per year.

CHILDREN'S BENEFIT

If you are covered under the plan, all your children (aged from age 30 days to 25) are covered for the amount indicated above free of charge.

ADDITONAL BENEFIT PART-PREPAYMENT OF BENEFIT AMOUNT

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 conditions set out in Section 8, pay immediately 50% of your benefit (50% of benefit for children also).

REVIEWING THE PLAN

The cost of the plan is reviewed every few years, typically every two or three years. If large numbers of people leave the plan or if there are a high number of people claiming, then Irish Life reserves the right to increase the cost of cover or go off risk.

Of course, the costs can also be reviewed downwards in the future. The term of this Group Policy is to the next review date. The premium amount will not change prior to the next review date. The next review of the plan will take place on 01/01/2024.

WHICH ILLNESSES ARE COVERED?

We have identified 36 conditions that could change your life so much that you would need financial help.

We have also identified a further 10 conditions that we will make one additional payment on.

FULL PAYMENT

Listed here are these 36 conditions we cover for full payment. You will find detailed descriptions of these in Section 5 of this booklet.

A full Specified Illness Cover payment 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).

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

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

ILLNESSES WE COVER FOR FULL PAYMENT (36)

1 Aorta graft surgery – for disease or traumatic injury

2 Aplastic anaemia - of specified severity*

3 Bacterial Meningitis – resulting in permanent symptoms

4 Benign brain tumour or cyst – resulting in permanent symptoms, surgery or radiosurgery*

5 Benign spinal cord tumour or cyst – resulting in permanent symptoms or requiring surgery

6 Blindness – permanent and irreversible

7 Cancer – excluding less advanced cases

8 Cardiac arrest – with insertion of a defibrillator*

91 Cardiomyopathy – resulting in a marked loss of ability to do physical activity

10 Coma –with associated permanent symptoms

11 Coronary artery by-pass grafts

12 Creutzfeldt-Jakob Disease – resulting in permanent symptoms

13 Deafness – total, permanent and irreversible

14 Dementia including Alzheimer's disease – resulting in permanent symptoms

15 Encephalitis – resulting in permanent symptoms

16 Heart attack – definite diagnosis

17 Heart valve replacement or repair

18 Heart structural repair

19 HIV infection

20 Kidney Failure - requiring permanent dialysis or transplant

21 Liver Failure – irreversible and end stage*

22 Loss of Limb – permanent physical severance

23 Loss of speech – permanent and irreversible

24 Major organ transplant – specified organs from another donor

25 Motor neurone disease – resulting in permanent symptoms

ILLNESSES WE COVER FOR FULL PAYMENT CONTINED (36)

26 Multiple sclerosis or Neuromyelitis optica (Devic's Disease) – with past or present symptoms

27 Paralysis of One limb - total and irreversible

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

29 Parkinson Plus Syndromes - resulting in permanent symptoms

30 Pulmonary Arterial Hypertension (idiopathic) – of specified severity*

31 Pulmonary Artery Graft Surgery*

32 Respiratory Failure of specified severity

33 Stroke – of specified severity

34 Systemic lupus erythematosus – of specified severity*

35 Third Degree Burns of specified surface area

36 Traumatic brain injury – resulting in permanent symptoms*

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 5 of this booklet.

*New illnesses introduced with effect from 01/10/2020.

ADDITIONAL PAYMENTS

At the time of suffering an illness we know that the last thing you want to worry about is your finances. Based on our recent claims experience we have identified a further 10 conditions that we will make a separate additional payment on.

Listed below are the 10 conditions we cover for additional payment. You will find detailed descriptions of these in Section 6 of this booklet.

This additional payment amount is €10,000. The additional payment on these illnesses is totally separate from your main Specified Illness Cover benefit. That means it does not affect the amount you could receive if you need to make a specified illness claim for one of the 36 conditions we cover on a full payment basis at a later date.

ILLNESSES WE COVER FOR ADDITIONAL PAYMENT

1 Brain abscess drained via craniotomy

2 Carcinoma in situ – oesophagus, treated by specific surgery

3 Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty

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

5 Coronary Artery Angioplasty – of specified severity

6 Ductal Carcinoma in Situ – Breast, treated by surgery

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

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

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

10 Surgical removal of one eye

*New illnesses introduced with effect from 01/10/2020.

We will only make one additional payment per person under any Specified Illness Cover plan.

A person can become a member of the AGSI SIC Plan either as an AGSI member or the partner of an AGSI member, but not both ie only one amount of Benefit will ever be paid to, or in respect of any given person under the AGSI SIC Plan, even if that person is both a member of AGSI and also the partner of another AGSI member.

For members who joined the Scheme before 1 October 2020.

If you joined the Scheme prior to 1 October 2020 and had any of the Specified Illnesses marked* prior to 1 October 2020 you are not covered for that illness. If you are diagnosed with any of the new specified illnesses after 1 October 2020 the waiting period as set out in Section 3 applies from 1 October 2020.

WHEN DOES MY POLICY CEASE?

Your policy will cease once you:

- you cease to be a member of AGSI
- reach age 65
- are paid a claim under the plan
- die or
- cease to pay premiums.

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

- they reach 65
- a claim has been paid under the Plan in respect of them
- they die
- they cease to be your partner
- you cease to pay premiums or
- you cease to be a member of AGSI

Each of your children from 30 days are no longer covered once:

- they reach age 25 for Serious Illness Cover (cover is from age 30 days to age 25)
- they reach age 21 for Death Cover (cover is from age 1 to age 21)
- a claim has been paid under the Plan in their respect
- they die or
- you leave the plan
- you cease to pay premiums
- you cease to be a member of AGSI

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

SECTION 3

JOINING THE PLAN

DO I HAVE TO PROVIDE MEDICAL INFORMATION?

Members can apply for this Specified Illness Cover without providing any medical information.

PRE-EXISTING CONDITIONS

However, due to this concession, if you have a pre-existing condition, cover can only be provided on the following basis (these conditions will also apply to your partner, if they are covered under the Plan).

1. Where you have previously suffered, at any time prior to the commencement date of cover or prior to the date the illness was first introduced 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 2008 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 2012 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 or 2 years from when the the illness was first introduced you will not be paid a claim for the particular illness and cover for that illness will cease, if prior to the commencement date of cover or 2 years from when the the illness was first introduced you suffered from one of a number of related conditions which are set out under each illness in Section 5 of this booklet.

   For example, a claim would not be paid and cover for heart attack will cease in the event of a heart attack occurring in the first two years of cover, if prior to the commencement date of cover or 2 years from when the the illness was first introduced you had suffered from diabetes. Being a diabetic before the commencement date of cover means that if you suffer a stroke or a heart attack or undergo coronary artery surgery, angioplasty or major organ transplant in the first two years of cover, a claim will not be paid and cover for that specified illness will cease.

   It should be noted that the second set of provisions only arises if the event occurs within the first 2 years of cover. Thus a diabetic who first suffers a heart attack three years after the commencement date of cover or 2 years from when the the illness was first introduced 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.

SECTION 4

SURVIVAL PERIOD

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 Aorta graft surgery, Aplastic anaemia, Bacterial Meningitis, Benign brain tumour or cyst, Cardiac arrest, Cardiomyopathy, Coma, Coronary artery by-pass grafts, CJD, Encephalitis, Heart attack, Heart valve replacement or repair, Heart structural repair, HIV infection, Kidney failure, Liver failure, Loss of limbs, Major organ transplant, Motor neuron disease, MS or Neuromyelitis optica, paralysis of one limb, Pulmonary Arterial Hypertension, Pulmonary Artery graft surgery, Respiratory Failure, Stroke, Systematic lupus erythematosus, Third degree burns and Traumatic brain injury.

(b) 6 months for Parkinson's Disease, Dementia and Blindness.

(c) 12 months for Deafness and Loss of Speech.

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

It should be noted that the second set of provisions , referred to in section 2 under the heading 'Pre -Existing Conditions', 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.

SECTION 5

EXPLANATION OF EACH SPECIFIED ILLNESS WE MAKE A FULL PAYMENT ON AND ITS PRE-EXISTING CONDITIONS

We have defined the 36 conditions that you are protected for on the following pages.

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

1. AORTA GRAFT SURGERY – FOR DISEASE OR TRAUMATIC INJURY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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 is not covered as this surgery is generally less critical.	If you have had aorta graft surgery or history of an aortic aneurysm prior to the commencement date of cover, you can never claim for aorta graft surgery under the Specified Illness Cover plan. If you have a history of aortitis, Marfan's syndrome, Ehlers-Danlos syndrome or peripheral artery disease prior to the commencement date of cover and you require aorta graft surgery within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for aorta graft surgery.

2. APLASTIC ANAEMIA - OF SPECIFIED SEVERITY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with aplastic anaemia prior to the commencement date of cover, you can never claim for aplastic anaemia under the Specified Illness Cover plan. If you have a previous family history of Fanconi's anaemia or variants of this condition, or a history of autoimmune or inflammatory disease, or have been exposed to toxic chemicals and/or non-theraputic radiation prior to the commencement date of cover and you are found to have aplastic anaemia 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 aplastic anaemia.

3. BACTERIAL MENINGITIS – RESULTING IN PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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*. • All other forms of meningitis including viral meningitis. (Adult and Child cover). *'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.	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.	If you have been diagnosed with bacterial meningitis prior to the commencement date of cover, you can never claim for bacterial meningitis under the Specified Illness Cover plan. If you have previously had shunts inserted for hydrocephalus prior to the commencement date of cover, no benefit will be payable under the Specified Illness Cover plan and you will not to be covered for Bacterial Meningitis.

4. BENIGN BRAIN TUMOUR OR CYST LIKE SPINAL TUMOUR – RESULTING IN PERMANENT SYMPTOMS, SURGERY OR RADIOSURGERY

ILLNESS 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:

- 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.

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.

PRE-EXISTING CONDITIONS

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

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

5. BENIGN SPINAL CORD TUMOUR OR CYST – RESULTING IN PERMANENT SYMPTOSM OR REQUIRING SURGERYS

ILLNESS 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.

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.

PRE-EXISTING CONDITIONS

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

If you have a history of Neurofibromatosis, Spina bifida or tumour of peripheral nerves prior to the commencement date of cover, and are found to have a benign spinal cord 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 spinal cord tumour.

6. BLINDNESS – PERMANENT AND IRREVERSIBLE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you are diagnosed with loss of sight as described above prior to the commencement date of cover, you can never claim for blindness under the Specified Illness Cover plan. If you have a history of stroke, transient ischaemic attack (TIA),diabetes mellitus, glaucoma, severe myopia, congenital nystagmus, retrobulbar or optic neuritis, retinitis pigmentosa, multiple sclerosis or hysteria prior to the commencement date of cover and you become blind within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for blindness. **Survival Period** Six months.

7. CANCER – EXCLUDING LESS ADVANCED CASES

ILLNESS DEFINITION

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

The term malignant tumour includes:

- Leukaemia
- Sarcoma
- Lymphoma (except cutaneous lymphoma - lymphoma confined to the skin).

The following are not covered:

- All cancers which are histologically classified as any of the following:
  - Pre-malignant;
  - Non-invasive;
  - Cancer in situ;
  - Having either borderline malignancy; or having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score 7 or above, or having progressed to at least TNM classification T2bN0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer (including cutaneous lymphoma), other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) i.e. >=Clarks level 2.
- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are specifically excluded from this cover.
- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0.

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.

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 premalignant and non-invasive tumours are not covered under this definition. (They may be covered on an additional payment basis, see section 6.) 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 6).

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.

See pre-existing conditions overleaf.

7. CANCER – EXCLUDING LESS ADVANCED CASES CONTINUED

PRE-EXISTING CONDITIONS

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

If you have a history of carcinoma in situ, Bowens disease, familial polyposis of the colon, leukoplakia, Barrett's oesophagus, ulcerative colitis, Crohn's disease or a history of raised PSA

(prostate specific antigen) above 4.0ng/ml prior to the commencement date of cover and you are found to have cancer within the first two years, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for cancer.

8. CARDIAC ARREST – WITH INSERTION OF A DEFIBRILLATOR

ILLNESS 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 Resynchronisation Therapy with Defibrillator (CRT-D).

For the definition above the following are not covered

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

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.

PRE-EXISTING CONDITIONS

If you have been diagnosed with heart attack, stroke, coronary artery disease, valvular heart disease, cardiomyopathy, long QT syndrome, heart attack, congenital heart disease, ventricular arrhythmia or you have a family history in a first degree relative of known cardiac electrical abnormality, prior to the commencement date of cover, you can never claim for Cardiac arrest - with insertion of a defibrillator under the Serious Illness Cover plan.

If you have a history of hypertension, diabetes or raised cholesterol, prior to the commencement date of cover and you are found to have a cardiac arrest requiring implantation of a defibrillator 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 cardiac arrest – with insertion of a defibrillator.

9. CARDIOMYOPATHY – RESULTING IN A MARKED LOSS OF ABILITY TO DO PHYSICAL ACTIVITY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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. • Cardiomyopathy secondary to alcohol or drug abuse. • All other forms of heart disease, heart enlargement and myocarditis.	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.	If you have been diagnosed with cardiomyopathy prior to the commencement date of cover, you can never claim for cardiomyopathy under the Specified Illness Cover plan. If you have a history of heart failure, myocardial infarction, cardiac enlargement or ventricular arrhythmias prior to the commencement date of cover and you are found to have cardiomyopathy 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 Cardiomyopathy.

10. COMA –WITH ASSOCIATED PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have had a coma prior to the commencement date of cover, you can never claim for coma under the Specified Illness Cover Plan. If you have a history of head injury or concussion, epilepsy, diabetes mellitus, brain tumour, brain haemorrhage, cerebral aneurysm, hepatic encephalopathy, asthma, or cancer prior to the commencement date of cover and you suffer a coma within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for coma.

11. CORONARY ARTERY BY-PASS GRAFTS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have ever undergone coronary artery surgery or suffered from a heart attack, stroke, coronary artery disease, carotid artery stenosis peripheral vascular disease or angioplasty prior to the commencement date of cover you can never claim under coronary artery bypass graft. If you have a history of, aneurysm, atrial fibrillation, cardiomyopathy, diabetes mellitus, hypertension, hypercholesterolaemia, tachycardia or valvular heart disease, prior to the commencement date of cover and you require coronary artery bypass grafts within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for coronary artery bypass grafts.

12. CREUTZFELDT-JAKOB DISEASE – RESULTING IN PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with Creutzfeldt-Jakob disease (CJD) prior to the commencement date of cover, you can never claim for CJD under the Specified Illness Cover plan. If you have a history of dementia, involuntary movements or were treated with human growth hormone treatment (prior to 1985), prior to the commencement date of cover and you are found to have CJD within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for CJD.

13. DEAFNESS – TOTAL, PERMANENT AND IRREVERSIBLE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with loss of hearing as described above prior to the commencement date of cover, you can never claim for deafness under the Specified Illness Cover plan. If you have a history of any disorder or disease of the inner or middle ear or the acoustic nerve including Meniere's disease, labyrinthitis or tinnitus or any history of cholesteatoma prior to the commencement date of cover and you become deaf within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for deafness. **Survival Period** Twelve months.

14. DEMENTIA INCLUDING ALZHEIMER'S DISEASE – RESULTING IN PERMANENT SYMPTOMS ILLNESS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
A definite diagnosis of Dementia or 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: • Dementia secondary to alcohol or illegal drug abuse.	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. 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 Dementia or Alzheimer's disease and his/her judgment, understanding and rational thought process have been seriously affected.	If you have been diagnosed with Dementia or Alzheimer's disease prior to the commencement date of cover, you can never claim for Dementia or Alzheimer's disease under the Specified Illness Cover plan. If you have a history of amnesia or memory loss, Lewy body disease secondary to Parkinson's disease, frontotemporal dementia, Pick's disease, CJD or memory loss with or without associated behavioural and emotional changes within the first two years of the cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for dementia including Alzheimer's Disease. **Survival Period** Six months.

15. ENCEPHALITIS – RESULTING IN PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with encephalitis prior to the commencement date of cover, you can never claim for encephalitis under the Specified Illness Cover plan. If you have a history of bacterial meningitis, HIV or Lyme disease prior to the commencement date of cover and you are diagnosed with encephalitis 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 encephalitis.

16. HEART ATTACK – DEFINITE DIAGNOSIS

ILLNESS 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.

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).

PRE-EXISTING CONDITIONS

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

If you have a history of aneurysm, atrial fibrillation, cardiomyopathy, se, diabetes mellitus, 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.

17. HEART VALVE REPLACEMENT OR REPAIR

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have had heart valve replacement or repair, or a history of any disorder of the aortic, mitral, pulmonary or tricuspid valves, fallots tetralogy, Ebsteins anomaly, Marfan's syndrome, Ehlers Danlos syndrome or any congenital or acquired structural cardiac abnormality prior to the commencement date of cover you cannot make a claim under the Specified Illness Cover Plan. If you have a history of, rheumatic fever or endocarditis prior to the commencement date of cover and you require heart valve or structural surgery within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for heart valve replacement or repair.

18. HEART STRUCTURAL REPAIR

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
The undergoing of heart surgery requiring thoracotomy on the advice of a consultant cardiologist, to correct any structural abnormality of the heart.	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.	If you have had structural heart repair prior to the commencement date of cover, you can never claim for heart structural repair under the Specified Illness Cover plan. If you have a history of heart valve disease, cardiomyopathy, congenital heart disease, ventricular aneurysm, constrictive pericarditis, fallots tetralogy or transposition of great vessels prior to the commencement date of cover and you require structural heart repair within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for structural heart repair.

19. 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.

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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. • 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 are not covered: • IV infection resulting from any other means, including sexual activity or illegal drug abuse.	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. 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.	If you have been diagnosed with HIV infection prior to the commencement date of cover, you can never claim for HIV infection under the Specified Illness Cover plan.

20. KIDNEY FAILURE – REQUIRING PERMANENT DIALYSIS OR TRANSPLANT

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have ever been diagnosed with kidney failure prior to the commencement date of cover, you can never claim for kidney failure under the Specified Illness Cover plan. If you have a history of diabetes mellitus, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, hypertension, paraplegia or pre-existing renal impairment with raised serum creatinine prior to the commencement date of cover and you suffer kidney failure within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for kidney failure.

21. LIVER FAILURE – IRREVERSIBLE AND END STAGE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have ever been diagnosed with liver failure, cirrhosis or sclerosing cholangitis prior to the commencement date of cover, you can never claim for liver failure under the Specified Illness Cover plan. If you have a history of, alcohol abuse, hepatitis B or C infection, liver tumours/cancer, Budd-Chiari syndrome, haemochromatosis, sarcoidosis, portal hypertension or a metabolic disorder affecting the liver prior to the commencement date of cover and you are found to have liver 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 liver failure.

22. LOSS OF LIMB – PERMANENT PHYSICAL SEVERANCE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
Permanent physical severance of one 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.	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.	If you have previously suffered the loss of one or more limbs prior to the commencement date of cover, you can never claim for Loss of limbs under the Specified Illness Cover plan. If you have a history of peripheral vascular disease, bone or soft tissue cancer or diabetes mellitus prior to the commencement date of cover and you suffer the loss of a limb 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 limb.

23. LOSS OF SPEECH – PERMANENT AND IRREVERSIBLE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.	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.	If you have been diagnosed with loss of speech prior to the commencement date of cover, you can never claim for loss of speech under the Specified Illness Cover plan. If you have a history of multiple sclerosis, cancer, stroke, transient ischaemic attack, motor neurone disease or chronic laryngitis prior to the commencement date of cover and you suffer from loss of speech within the first two years of cover no benefit will be payable under the Specified Illness Cover Plan and you will cease to be covered for loss of speech. **Survival Period** Twelve months.

24. MAJOR ORGAN TRANSPLANT – SPECIFIED ORGANS FROM ANOTHER DONOR

ILLNESS 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.

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.

PRE-EXISTING CONDITIONS

You cannot 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. If you have ever suffered from a heart attack, stroke or carotid artery stenosis or undergone coronary artery surgery, angioplasty, heart transplant or any other major organ transplant prior to the commencement date of cover you can never claim under any one of these seven illnesses.

If you have a history of the following:

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

25. MAJOR ORGAN TRANSPLANT – SPECIFIED ORGANS FROM ANOTHER DONOR

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with motor neurone disease prior to the commencement date of cover, you can never claim for motor neurone disease under the Specified Illness Cover plan. If you have a Family History of motor neurone disease in a first degree relative (i.e. father, mother, brother or sister) or a history of muscle weakness in any limb prior to the commencement date of cover and you are found to have motor neurone disease within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for motor neurone disease.

26. MULTIPLE SCLEROSIS OR NEUROMYELITIS OPTICA (DEVIC'S DISEASE) – WITH PAST OR PRESENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with multiple sclerosis or neuromyelitis optica (Devic's disease) prior to the commencement date of cover, you can never claim for multiple sclerosis or neuromyelitis optica under the Specified Illness Cover plan. If you have a history of retrobulbar or optic neuritis, diplopia (double vision), paraesthesia, numbness, tingling or unilateral weakness of upper or lower limbs, trigeminal neuralgia, Bell's palsy or in-coordination of movement or speech of have been noted to have an associated lesion on brain or spinal MRI prior to the commencement date of cover and you are found to have multiple sclerosis or neuromyelitis optica 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.

27. PARALYSIS OF ONE LIMB - TOTAL AND IRREVERSIBLE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
Total and irreversible loss of muscle function to the whole of any one limb.	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.	If you have been diagnosed with total and irreversible paralysis of one or more limbs prior to the commencement date of cover, you can never claim for paralysis of limbs under the Specified Illness Cover plan. If you have a history of multiple sclerosis, motor neurone disease, stroke, transient ischaemic attack, a spinal cord tumour or severe head injury prior to the commencement date of cover and you became paralysed within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for paralysis of a limb.

28. PARKINSON'S DISEASE (IDIOPATHIC) – RESULTING IN PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with Parkinson's disease prior to the commencement date of cover, you can never claim for Parkinson's disease under the Specified Illness Cover plan. If you have a history of encephalitis, encephalomyelitis, tremor, or rigidity of limbs 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.

29. PARKINSON PLUS SYNDROMES - RESULTING IN PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with a Parkinson Plus Syndrome, Parkinson's disease, dementia or motor neurone disease prior to the commencement date of cover, you can never claim for a Parkinson Plus Syndrome under the Specified Illness Cover plan If you have a history of severe cerebral trauma, stroke, impairment of eye movement, postural hypotension or instability, auditory or visual hallucinations and you are found to have a Parkinson Plus syndrome 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 Plus syndromes.

30. PULMONARY ARTERIAL HYPERTENSION (IDIOPATHIC) – OF SPECIFIED SEVERITY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have a history of pulmonary arterial hypertension, congenital cyanotic heart disease, pulmonary fibrosis or chronic respiratory failure prior to the commencement date of cover you can never claim under the Specified Illness Cover Plan.

31. PULMONARY ARTERY GRAFT SURGERY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have a history of congenital heart disease requiring pulmonary artery surgery or have had pulmonary artery surgery prior to the commencement date of cover you cannot make a claim under the Specified Illness Cover Plan.

32. RESPIRATORY FAILURE OF SPECIFIED SEVERITY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with respiratory failure prior to the commencement date of cover, you can never claim for respiratory failure under the Specified Illness Cover plan. If you have a history of cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic), pulmonary fibrosis, emphysema, chronic bronchitis, chronic asthma, other systemic disorders that produce pulmonary fibrosis such as sarcoid or pulmonary fibrosis as a result of exposure to extrinsic organic or inorganic agents prior to the commencement date of cover and you are found to have respiratory failure within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for respiratory failure.

33. STROKE – OF SPECIFIED SEVERITY

ILLNESS 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.

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.

PRE-EXISTING CONDITIONS

If you have ever suffered from a heart attack, stroke, transient cerebral ischaemia, intracranial aneurysm, arteriovenous malformation, coronary artery disease, carotid atherosclerosis, peripheral vascular disease, transient ischaemic attack or have undergone a heart transplant prior to the commencement date of cover you can never claim under stroke.

If you have a history, atrial fibrillation, diabetes mellitus, hypercholesterolaemia, hypertension, thrombotic disorders eg hyperviscosity states (polycythaemia), heart valve disease and carotid atherosclerosis 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.

34. SYSTEMIC LUPUS ERYTHEMATOSUS – OF SPECIFIED SEVERITY

ILLNESS DEFINITION

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

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

Glomerular Filtration Rate (GFR) below 30ml/min

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

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

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

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.

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.

PRE-EXISTING CONDITIONS

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

If you have a history of inflammatory disease of the joints, including Rheumatoid Arthritis and related disorders, Sjogren's disease, connective tissue disorder or anti-phospholipid syndrome prior to the commencement date of cover and you are found to have systemic lupus erythematosus 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 systemic lupus erythematosus.

35. THIRD DEGREE BURNS OF SPECIFIED SURFACE AREA

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	None.

36. TRAUMATIC BRAIN INJURY – RESULTING IN PERMANENT SYMPTOMS

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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. • njury 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. Pulmonary artery surgery may be carried out for some disorders to the pulmonary artery, including pulmonary atresia (atresia means 'no opening') and aneurysm. You can claim if you have open heart surgery involving surgically dividing the breastbone to replace the diseased pulmonary artery with a graft.	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.	If you have suffered a traumatic head injury prior to the commencement date of cover, you can never claim for traumatic head injury under Specified Illness Cover plan. If you have a history of alcohol or drug abuse, or psychosis (requiring inpatient treatment) prior to the commencement date of cover and you suffer a traumatic brain injury 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 traumatic brain injury.

SECTION 6

EXPLANATION OF EACH SPECIFIED ILLNESS WE MAKE AN ADDITIONAL PAYMENT ON AND ITS PRE-EXISTING CONDITIONS

The 36 illnesses we cover for Specified Illness Cover are defined in the previous section. There are an extra 10 conditions that you can receive additional payment under.

We will pay an additional payment of €10,000 (€5,000 for Children) for the 10 conditions shown on the following pages. We will only make one additional payment per person under any Specified Illness Cover plan.

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

1. BRAIN ABSCESS DRAINED VIA CRANIOTOMY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with a brain abscess prior to the commencement date of cover, you can never claim for brain abscess under the Specified Illness Cover plan. If you have a history of chronic middle ear infection prior to the commencement date of cover and you are found to have a brain abscess within the first two years, no benefit will be payable under the Specified Illness Additional Cover plan and you will cease to be covered for brain abscess.

2. CARCINOMA IN SITU – OESOPHAGUS, TREATED BY SPECIFIC SURGERY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with cancer of the oesophagus or carcinoma in situ of the oesophagus prior to the commencement date of cover, you can never claim for carcinoma in situ of the oesophagus under the Specified Illness Cover plan. If you have a history of Barrett's oesophagus and/or symptomatic reflux requiring chronic or recurrent treatment prior to the commencement date of cover and you are found to have carcinoma in situ within the first two years, no benefit will be payable under the Specified Illness Additional Cover plan and you will cease to be covered for carcinoma in situ.

3. CAROTID ARTERY STENOSIS - TREATED BY ENDARTERECTOMY OR ANGIOPLASTY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have ever suffered from carotid artery stenosis, a heart attack, stroke, coronary artery disease, peripheral vascular disease, transient ischaemic attack, or you have undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of cover, you can never claim under carotid artery stenosis. If you have a history of diabetes mellitus, hypertension or hypercholesterolaemia prior to the commencement date of cover and you are found to have carotid artery stenosis 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 carotid artery stenosis.

4. CEREBRAL OR SPINAL ARTERIOVENOUS MALFORMATION – WITH SURGERY, STEREOTACTIC RADIOSURGERY OR ENDOVASCULAR REPAIR

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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..	If you have ever suffered from or been found to have a cerebral or spinal arteriovenous malformation prior to the commencement date of cover, you can never claim under cerebral or spinal arteriovenous malformation. If you have a history of loss of consciousness, fits or seizures, petit mal absence attacks, loss of power or sensation, visual disturbance, dysarthria or postural instability prior to the commencement date of cover and you are found to have a cerebral or spinal arteriovenous malformation 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 cerebral or spinal arteriovenous malformation.

5. CORONARY ARTERY ANGIOPLASTY – OF SPECIFIED SEVERITY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplasty, coronary artery disease, peripheral vascular disease or heart transplant prior to the commencement date of cover, you can never claim under angioplasty. If you have a history of aneurysm, atrial fibrillation, cardiomyopathy, diabetes mellitus, hypertension, hypercholesterolaemia, tachycardia or valvular heart disease prior to the commencement date of cover and you suffer a coronary angioplasty within the first two years of cover, no benefit will be payable under this plan and you will cease to be covered for coronary angioplasty.

6. DUCTAL CARCINOMA IN SITU – BREAST, TREATED BY SURGERY

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with breast cancer or carcinoma in situ of the breast prior to the commencement date of cover, you can never claim for ductal carcinoma in situ under the Specified Illness Cover plan. If you have a history of interstitial mastitis, fibrocystic disease or atypical cells of the breast prior to the commencement date of cover and you are found to have a ductal carcinoma in situ within the first two years, no benefit will be payable under the Specified Illness Additional Cover plan and you will cease to be covered for ductal carcinoma in situ.

7. IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD) FOR PRIMARY PREVENTION OF SUDDEN CARDIAC DEATH

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with heart attack, stroke, coronary artery disease, valvular heart disease, cardiomyopathy, long QT syndrome, heart attack, congenital heart disease or ventricular arrhythmia or you have a family history in a first degree relative of known cardiac electrical abnormality, prior to the commencement date of cover, you can never claim for Implantable cardioverter defibrillator (ICD) for primary prevention of sudden cardiac death under the Serious Illness Cover plan. If you have a history of hypertension, diabetes or raised cholesterol, prior to the commencement date of cover and you are found to have a cardiac arrest requiring implantation of a defibrillator 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 cardiac arrest – with insertion of a defibrillator.

8. LOW LEVEL PROSTATE CANCER WITH GLEASON SCORE BETWEEN 2 AND 6 – AND WITH SPECIFIC TREATMENT

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have been diagnosed with prostate cancer prior to the commencement date of cover, you can never claim for low level Prostate cancer under the Specified Illness Cover plan. If you have a history of raised PSA (prostate specific antigen) above 4.0 ng/ml prior to the commencement date of cover and you are found to have low level prostate cancer, no benefit will be payable under the Specified Illness Additional Cover plan and you will cease to be covered for low level prostate cancer.

9. SEVERE BURNS/3RD DEGREE BURNS COVERING AT LEAST 5% OF THE BODY'S SURFACE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	None.

10. SURGICAL REMOVAL OF ONE EYE

ILLNESS DEFINITION	SIMPLER TERMS	PRE-EXISTING CONDITIONS
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.	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.	If you have had an eyeball removed prior to the commencement date of cover, you can never claim for surgical removal of one eye under the Specified Illness Cover plan. If you have a history of eye trauma or eye disease, including uveitis or retrobulbar carcinoma prior to the commencement date of cover and you have an eye surgically two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for surgical removal of one eye.

SECTION 7

CHILDREN'S SPECIFIED ILLNESS COVER PLAN

PLAN DEFINITION

Each of your dependent children (as proven by your name on their birth cert or on their adoption papers if there is a claim) from age 30 days to age 25 years.

Under the Specified Illness cover full payment benefits, each of your dependent children (as proven by your name on their birth cert or on their adoption papers if there is a claim) from age 30 days to age 25 years are automatically covered.

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

- A condition they have had since birth or
- A condition known to exist or with symptoms present prior at birth
- A condition known to exist prior to the commencement date of the plan.

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

Only one claim can be made per child and your child must survive for the same periods (as mentioned in Section 4) following diagnosis or surgery in order for the benefit to be payable.

The benefit payable shall only be payable once in respect of any child regardless of whether or not both the child's parents are insured persons under this group policy.

This cover remains in force for as long as there is Specified Illness Cover in force on you under the plan.

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

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 €20,000.

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 5). We will pay a benefit for a child suffering one of the conditions listed under the specified illness cover additional payment benefits (see section 6) of €5,000 or half of the specified illness benefit amount for a single life, whichever is lower.

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 prior to the commencement date of the plan.
- Before the commencement date of your legal adoption of the child.

All these terms and conditions apply to this cover as they apply to specified illness cover on the life assured.

Under the Serious Illness Cover plan, you are also covered for €10,000 children's death benefit at no additional cost

Children's benefit (either Life Cover or Serious Illness Cover) is only payable once per child per policy.

SECTION 8

ADDITIONAL INFORMATION

ADDITIONAL BENEFIT PART-PREPAYMENT ON NEED FOR SURGERY

YOUR BENEFIT 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 amount specified in Section 2 of this booklet.

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:

The cover provided is limited to the illnesses listed in Section 2, Section 5 and Section 6. In addition children will be covered for:

A. CORONARY ARTERY SURGERY

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

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

B. HEART VALVE SURGERY

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

C. AORTA GRAFT SURGERY

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

WHICH MEANS

If you are covered for and are diagnosed as requiring either coronary artery surgery, heart valve surgery or aorta graft surgery as defined in the above paragraphs and you have obtained the specified certification then provided that the other conditions above are complied with, Irish Life will pay the amounts of benefit for which you are covered as set out in Section 2.

The benefit is provided automatically with 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.

A NOTE ON SPECIFIED ILLNESS COVER CLAIMS

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

CONTACT INFORMATION FOR COMPLAINTS

If for any reason you feel that this plan is not right for you, or if you have any questions, you should contact:

CODE,
Irish Life Corporate Business,
Lower Abbey Street, Dublin 1.

Who will deal with your enquiry? Corporate Business operate an internal complaints procedure and any complaints you may have will, in the first instance, be fully reviewed by them.

If you feel we have not dealt fairly with your complaint, you should contact:

Financial Services and Pensions Ombudsman,
Lincoln House, Lincoln Place,
Dublin 2, D02 VH29.

Phone: 01 567 7000
Email: info@fspo.ie
Website: www.fspo.ie

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.

SECTION 9

ADDITIONAL INFORMATION - IN RELATION TO THIS PLAN AND THE SUPPLIER (IRISH LIFE ASSURANCE PLC)

IDENTITY AND MAIN BUSINESS OF SUPPLIER

Irish Life Assurance plc ('Irish Life') A Life Assurance undertaking providing policies of life assurance.

GEOGRAPHICAL ADDRESS OF BUSINESS

Irish Life Centre, Lower Abbey Street, Dublin 1.

REGISTERED NUMBER

Irish Life is registered in Ireland under number 152576.

SUPERVISORY AUTHORITY

Irish Life Assurance plc is regulated by the Central Bank of Ireland.

VAT REGISTRATION NUMBER

The Irish Life's VAT registration number is 9F55923G.

WHAT ARE THE MAIN CHARACTERISTICS OF THIS PLAN?

The Plan provides a lump sum benefit in the event of an insured person suffering from certain specified illnesses. The information about the plan is in the booklet.

ARE THERE OTHER TAXES OR COSTS THAT ARE NEITHER PAID NOR IMPOSED BY IRISH LIFE?

Currently, there is no tax liability on the benefit payable under this plan.

FOR WHAT PERIOD IS THIS INFORMATION FROM IRISH LIFE VALID?

The information in the booklet is valid at the date of issue up to the next review date (detailed in Section 2 of this booklet under the heading 'Reviewing the Plan').

DO I HAVE THE RIGHT TO CANCEL MY MEMBERSHIP?

If, after joining this plan, you feel that it is not suitable, you may cancel it by writing to us. If you do this within 30 days from the date of completing the application we will return any payments you have made. You will then be treated as having not joined the plan and no benefit will be payable to you under the plan. We recommend that you talk to your financial adviser before you cancel your membership.

HOW DO I CANCEL MY MEMBERSHIP?

You can cancel your membership at any time by contacting us directly at Corporate Business Voluntary Risk, Irish Life Assurance plc, Lower Abbey Street, Dublin 1.

If you cancel your plan membership you will not be entitled to any refund of premiums paid prior to your cancellation except if you do so within 30 days of the commencement of your cover under the plan.

CAN MY EMPLOYER CANCEL COVER UNDER THE PLAN?

Your employer can cancel the policy with Irish Life and your cover under the plan would cease.

WHAT RIGHTS DOES IRISH LIFE HAVE TO CEASE COVER UNDER THIS POLICY?

Irish Life can cancel the policy at the end of the review period. Also, see booklet for details about when your cover ceases.

WHAT JURISDICTION AND LAWS APPLY TO THIS POLICY?

Irish Life's policies are governed by the laws of the Republic of Ireland, and the courts and law will be used to determine any matters which may become subject to a legal dispute.

WHAT LANGUAGE IS USED IN THE POLICY AND OTHER COMMUNICATION?

The terms and conditions of this policy will be provided in the English language. Irish Life Assurance plc will communicate with you in the English language at all times.

IS THERE AN OUT OF COURT COMPLAINT AND REDRESS PROCESS?

If you make a complaint and after we process your complaint you remain dissatisfied with the outcome, you may request a signing-off letter to enable you to refer your complaints to:

Financial Services and Pensions Ombudsman,
Lincoln House, Lincoln Place,
Dublin 2, D02 VH29.

Phone: 01 567 7000
Email: info@fspo.ie
Website: www.fspo.ie

ABOUT IRISH LIFE

Established in Ireland in 1939, Irish Life is now part of the Great-West Lifeco group of companies, one of the world's leading life assurance organisations.

Great-West Lifeco and its subsidiaries, including The Great-West Life Assurance Company, have a record for financial strength, earnings stability and consistently high ratings from the independent rating agencies.

The Great-West Life Assurance Company has an AA rating for insurer financial strength from Standard & Poor's.

Information correct as of January 2021. For the latest information, please see **www.irishlifecorporatebusiness.ie.**

SOLVENCY AND FINANCIAL CONDITION REPORT

Irish Life's current Solvency and Financial Condition Report is available on our website at http://www.irishlifecorporatebusiness.ie/about-us

PENSIONS
INVESTMENTS
LIFE INSURANCE

Irish Life

CONTACT US

PHONE: 01 704 1776
FAX: 01 704 1905
EMAIL: cbvoluntaryrisk@irishlife.ie
WEBSITE: www.irishlifecorporatebusiness.ie
WRITE TO: CB Voluntary Risk, 4th Floor, Irish Life Assurance plc, Lower Abbey Street, Dublin 1.

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

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