

LIFE MORTGAGE COVER

Form: LH14SAA/LH14FAA/LH15SAA/LH15FAA

TC 1001 (REV 05-11)

Terms & Conditions booklet

This is the Terms and Conditions booklet for your Life Mortgage Cover plan. You should read the document carefully as it contains detailed and important information. Please keep it safe in your welcome pack as you will need to refer to it in the future.

Introduction

This plan is designed to repay a mortgage if the life assured dies during the term of the plan as long as:

- the mortgage repayments are kept up to date; and
- the mortgage interest rate is no more than the interest rate we have assumed as shown on the plan schedule.

The benefits will reduce each month. If the mortgage interest rate is higher, on average than the interest rate we have assumed, the cover will not be enough to repay the mortgage in full. If benefits are altered under section 5 the cover may not be enough to repay the mortgage in full.

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

The plan consists of the plan schedule, the table of protection benefits, this Terms and Conditions Booklet, the application form, any related information, and any extra rules which our head office staff may add in writing.

We have issued this plan to you on the understanding that the information you gave in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to make the plan void. If this happens:

- you will lose all your rights under the plan;
- we will not pay any claim; and
- we will not return any payments.

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

Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the payment or level of benefits or when deciding whether to provide cover at all.

This plan is a protection plan only. You cannot cash it in at any time. Even if you have not made a claim by the time the period of cover ends, we will not return your payments. All cover under the plan will end on the 'expiry date of your protection benefits' shown in the plan schedule, unless some or all of it has ended before that for any of the reasons explained in these terms and conditions.

The benefits provided under this plan are stated in the plan schedule. If a benefit is not mentioned in the schedule, we do not provide that benefit. The amount of each benefit will reduce on a monthly basis over the full term of your plan. The table of protection benefits in the schedule shows this reduction on a monthly basis for the first year only. Although this reduction continues monthly, the table only indicates the amount of cover which applies at the start of each remaining year as long as benefits have not been altered under section 5..

We will pay claims only from the assets we hold to make payments due to customers. We will normally pay all benefits under this plan in the currency of Ireland.

In legal disputes Irish law will apply.

In the event of extraordinary circumstances beyond our control including, without limitation, act of civil or military authority; sabotage; crime; terrorist attack; war or other government action; civil disturbance or riot; strike or other industrial dispute; an act of god; national emergency; epidemic; flood, earthquake, fire or other catastrophe, we may be prevented from fulfilling our obligations to you or from doing so in a timely manner. If this happens, we are not liable for any loss, damage

or inconvenience caused.

More detailed information on all these matters is in the relevant sections of this Terms and Conditions Booklet.

How does the plan work?

You choose the type of cover you want, and make the payments to us as set out in the schedule. We describe the benefits in greater detail later on in this terms and conditions booklet.

Who receives the money we pay out?

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

If you assign the plan to someone else (for example, you pass it to a building society to be placed with your title deeds as security for your mortgage), we will pay that person. Note the exceptions in relation to partial payments on specified illness cover (see section 4.7) children's life cover and children's specified illness cover (see section 7.5). Where a plan is assigned to someone else as security for a mortgage we will not pay an extra amount to cover any interest on that mortgage between the date you submit a claim and the date that claim is paid. If the plan is written under trust, we will pay the trustee.

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

Writing to us

If you need to write to us about this plan, please write to:

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

Cooling-off period

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

Complaints

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

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

Lo-call: 1890 88 20 90

Fax: 01 6620890

Email: enquiries@financialombudsman.ie

Website: www.financialombudsman.ie

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Definitions

Section 1

Benefit (or benefits)

The benefit shown in the plan schedule under the heading 'your protection benefits'. If, at any stage during the term of your plan, you choose to reduce your benefit amounts, your benefit amount will be lower than that shown on your schedule, allowing for normal benefit reductions under the plan. We will send you a revised plan schedule showing your new benefit amounts at that time.

Child

Someone who is under 21 and who:

- is shown by birth certificate to be the son or daughter of a life assured; or
- has been legally adopted by a life assured.

Day

A period of 24 hours in a row.

Expiry date of the life cover benefit

The plan expiry date – this is shown in the plan schedule. The life cover will end on this date unless it has ended earlier.

Expiry date of the specified illness cover benefit

The plan expiry date or expiry date of the specified illness cover benefit – whichever is shown in the plan schedule. The specified illness cover will end on this date unless it has ended earlier.

Irreversible

An illness or condition is irreversible if after having appropriate treatment, including surgery, there is no reasonable hope of a recovery according to medical knowledge at that time.

Life assured or lives assured

The person or people named in the plan schedule as the life or lives covered. The benefits of the plan depend on the lives of those people.

Major hospital

An institution in one of the accepted countries (see section 6.4), which has facilities for diagnosis, treatment and major surgery and has accommodation for in-patients. It does not include a long-term nursing unit, a geriatric or pre-convalescent ward, or an extended-care facility for convalescence, rehabilitation or other similar function. We reserve the right to insist that a major hospital is a hospital in Ireland or the United Kingdom.

Medical specialist

A registered medical practitioner (see below) who has specialist qualifications in an appropriate branch of medicine and who is practising at a major hospital (see above).

Month

A calendar month.

Payment

This is:

- 'your total payment' as shown in the plan schedule under the heading 'your payment details';
- the amount we tell you when we reinstate cover under section 3.4; or
- a different amount (which we will tell you) if we or you make any amendment to your plan details.

Plan schedule

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

- the start date;
- the expiry date (of the life and specified illness cover benefits);

- the life or lives covered;
- the benefits; and
- any special conditions that have been agreed with us.

Registered medical practitioner

A person who meets the legal requirements for carrying on a medical practice in an accepted country (see section 6.4) and who actually practices medicine in that country. We reserve the right to insist that a registered medical practitioner practices in Ireland or the United Kingdom.

Start date

The start date shown in the plan schedule. Cover will start on this date.

We, us

Irish Life Assurance plc.

You

The person (or people) named as the proposer in the schedule, who is responsible for making the payments and is legally entitled to the plan benefits as long as they have not been assigned (passed) to someone else. In the text describing each illness covered under the heading 'in simpler terms' in section 4.6, we have assumed that the person who owns the plan (you) is also the person who is protected (the life assured). This may not always be the case. If it is not, we are referring to the life assured when we talk about an illness and the symptoms suffered.

Basis of cover

Section 2

2.1 We have issued this plan to you on the understanding that the information given in the application form and any related document is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the plan void. If this happens you will lose all your rights under the plan, we will not pay any claim and we will not return any payments. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the payment or level of benefits or when deciding whether to provide cover at all.

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

2.2 If your cover ends but is reinstated under section 3.4, we will reinstate it on the understanding that the information given in the evidence of health form and any related document is true and complete and that all relevant information has been provided.

If this is not the case, we will be entitled to declare the plan void. If this happens, you will lose all your rights under the plan, we will not pay any claim and we will not return any payments. If we refund payments, we are entitled to deduct appropriate costs incurred as a result of the setting up and administration of this plan. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of payments or benefits; when deciding whether to reinstate cover at all; or when deciding whether to attach conditions.

Making payments

Section 3

- 3.1 Although each payment is due on the payment dates shown in the plan schedule, we give you 30 days to make the payment unless you make payments monthly, in which case we will give you 10 days to make the payment. (The time allowed is known as a 'period of grace'.) If you become entitled to a benefit during a period of grace, we will take from your benefit any payment that you have not made.
- 3.2 If you have not made a payment by the end of the period of grace, your cover under the plan will end immediately. A payment is not made until we have received it. It is up to you to make sure that we receive your payment. We are entitled to pass on to you any charge which we have to pay because all or part of your payment (for example, a direct debit) is dishonoured.
- 3.3 If your cover under the plan ends as described in section 3.2, you can restore your cover within 90 days from the date the first missed payment became due. You must make all the payments which would have been due if your cover had not ended. You will not be entitled to benefits for anything that happens between the end of the period of grace and the date we receive all missed payments.
- 3.4 If, after 90 days and before 180 days of the first missed payment being due, you ask for cover to be restored, the life assured must fill in an evidence of health form and all the payments, which would have been paid if cover had not ended, must be made. If the

information on the evidence of health form shows that the health of the life assured is now different to that declared on the application form, we may refuse to restore cover or restore the cover:

- without any change;
- with an increased payment; or
- with new conditions (for example, you might lose cover for certain specified illnesses).

If we decide to restore cover, we will ask you to start making payments again. You will not be entitled to benefits for anything that happens between:

- the end of the period of grace; and
- the date, following our agreement to restore cover, on which we receive all missed payments.

If we accept a payment (or part payment) which is no longer due, this does not mean that we are providing cover. We will return the amount we receive as soon as we discover the mistake.

Your cover

Section 4

- 4.1 The benefits provided for a life assured under this plan are shown in the plan schedule. If a benefit is not mentioned on the schedule, we do not provide that benefit. We will pay a claim when a 'benefit event' happens. The plan schedule also shows the amount of cover. If, at any stage during the term of your plan, you request to change your benefit amounts and we allow this, your cover amount will be different than that shown on your schedule, allowing for the normal benefit reductions on the plan. We will send you a revised plan schedule showing your new cover. You cannot increase your benefit amount once you have chosen to reduce it.

The following benefits are available.

- Life cover,
- Life cover and specified illness cover (with the specified illness benefit amount being **equal to** the life cover benefit amount).
- Life cover and specified illness cover (with the specified illness benefit amount being **less than** the life cover benefit amount).

Accidental Death Benefit

This is an automatic additional benefit. We will pay the death benefit (to a maximum of €150,000) on accidental death between the time the application is received by Irish Life (together with a completed direct debit) and the earlier of the following:

- the day of the final underwriting decision if terms are being offered
- the day of the underwriting decision if we

- are declining or postponing cover
- 30 days from the date we receive the application.

For this benefit "Accidental Death" means death caused solely and directly as a result of an accident caused by violent, visible and external means and independently of any other cause.

There are the following restrictions:

- The benefit payable is subject to the lesser of the life sum assured or €150,000
- The benefit is subject to a maximum entry age of 55
- Exclusions apply around the nature of the death e.g. suicide or intentional self-inflicted injury causing death are excluded. For full details of exclusions see section 6.

We will only pay once under Accidental Death Benefit in respect of any life, regardless of the number of plans or applications a person has with Irish Life.

In the case of joint life applications the benefit is only paid once, on the death of the first life to die.

4.2 If we accept a claim for a benefit event, we will pay you.

- the amount of benefit set out in the plan schedule, less
- the amount (if any) by which it has been reduced by an optional reduction, less
- the amount by which it has been reduced under the normal benefit reductions under the plan.

There are two possible benefit events.

(a) A life cover benefit event

- If there is only one life assured (single life), when the life assured dies or is diagnosed as having a terminal illness; or
- if there are two lives assured (joint life), when the first of the lives assured dies, or is diagnosed as having a terminal illness. If both lives assured die at the same time, or if it is impossible to say who died first, we will assume the oldest life assured died first.

(b) An accelerated specified illness cover benefit event

- If there is only one life assured (single life), when the life assured is diagnosed as having a specified illness as defined in section 4.6; or
- if there are two lives assured (joint life), when the first of the lives assured is diagnosed as having a specified illness as defined in section 4.6.

We then reduce the amount of life cover by the amount of any benefit we have paid for accelerated specified illness cover.

Check your plan schedule (and any subsequent letters we send you) to see which benefits apply.

4.3 (a) If a life assured is diagnosed as having a terminal illness (as in section 4.5) we will pay the amount of life cover. No further payment will be made when the life assured dies. Also see part (e) of this section.

A terminal illness benefit will only be paid once per plan.

(b) If a life assured has accelerated specified illness cover, in certain circumstances we will reduce the amount of specified illness cover we will pay for a life assured by the amount of any benefit we have paid under section 4.7 (Partial Payment Specified Illness Cover) and section 4.8 (Prepayment of Surgery). If we have reduced the amount of specified illness cover to nothing for a life assured, all specified illness cover ends.

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

(d) The life cover we will pay for a life assured will be reduced by the amount of any benefit we have paid under accelerated specified illness cover under section 4.6. If the amount of life cover is reduced to nil, all cover ends.

If the amount of accelerated specified illness cover is the same as the amount of life cover, all cover will end when an accelerated specified illness cover benefit event happens.

(e) If a life assured who has accelerated specified illness cover is diagnosed as having a specified illness and we previously paid a benefit for that life assured being diagnosed as having a terminal illness, we will not pay any further benefit as all benefits cease on the payment for a terminal illness.

(f) If the amount of accelerated specified illness is the same as the amount of life cover, all cover will end when the accelerated specified illness cover benefit event happens.

4.4 All life or specified illness cover under this plan will end:

- at the end of a period of grace, if all or part of a payment has still not been made;
- on the expiry date, as shown in the plan schedule; or
- when a life cover benefit event happens; or
- when a specified illness cover benefit event happens (if the amount of the specified illness cover is the same as the amount of the life cover);

whichever is earliest.

4.5 A life assured is 'diagnosed as having a terminal illness' if the attending consultant gives a definite diagnosis that, our Chief Medical Officer agrees, satisfies both of the following:

- The illness has either no known cure or has progressed to the point where it cannot be cured; and
- In the opinion of the attending consultant that the illness is expected to lead to death within 12 months.

4.6 Full Payment Specified Illness Conditions

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

A life assured is 'diagnosed as having a specified illness' if on a date after the start date and before the expiry date of the specified illness cover benefit, the life assured has:

- had any surgery defined in a plan definition below; or
- been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition below.

The accelerated specified illness benefit payable will be that applicable on the date you are 'diagnosed as having a specified illness' as per the plan definition above.

Explanatory notes

The explanatory notes in the sections headed 'In simpler terms' are intended to provide a less technical explanation of the illness definitions, and some of the medical terms used within that definition. They are **not** intended as an alternative definition of the illness and will **not** be used to assess claims. In the event of any dispute, the illness 'definition' overrules the 'In simpler terms' explanation.

1. Alzheimer's disease – resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember;
- reason; and

- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:

- Other types of dementia.

In simpler terms:

Alzheimer's disease occurs when the nerve cells in the brain deteriorate over time and the brain shrinks. There are various ways in which this can affect someone, for example, severe loss of memory and concentration and mental ability gradually failing.

A claim can be made if the life covered has been diagnosed by a consultant neurologist or consultant geriatrician as having Alzheimer's disease and his/her judgement, understanding and rational thought process have been seriously affected.

2. Aorta graft surgery – for disease or traumatic injury

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

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

For the above definition, the following are not covered:

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

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

In simpler terms:

The aorta is the main artery of the body. It supplies blood containing oxygen to other arteries. The aorta can become narrow (often because of a build-up of fatty acids on its walls) or it may become weakened because of a split (dissection) in the internal wall.

The aorta may also weaken because of an 'aneurysm' which means that the artery wall becomes thin and expands. A graft might be necessary to bypass the narrowed or weakened part of the artery.

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

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

3. Aplastic anaemia - of specified severity

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

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

For the above definition, the following are not covered:

- All other types of anaemia

In simpler terms:

Aplastic anaemia is a failure of the bone marrow to produce sufficient blood cells for the circulation. When this function of the marrow

declines, the main blood constituents (red cells, white cells, platelets) decline or cease production and the individual becomes progressively more dependent on blood transfusions.

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

4. Bacterial Meningitis – resulting in permanent symptoms

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

For the above definition, the following are not covered:

- All other forms of meningitis including viral meningitis.

(Adult and Child cover)

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

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

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia

(inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

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

In simpler terms:

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

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

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

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms. The*

diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

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

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

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

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

The following are not covered:-

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

- Symptoms of psychological or psychiatric origin.

In simpler terms:

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

These growths can be life-threatening and may have to be removed by surgery. Other conditions that are not usually life-threatening are specifically excluded. The pituitary is a small gland at the base of the brain, and an angioma is a benign growth made up of small blood vessels.

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

6. Benign spinal cord tumour – resulting in permanent symptoms or requiring surgery

A non-malignant tumour of the spinal canal or spinal cord, causing pressure and/or interfering with the function of the spinal cord which requires surgery or results in *permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Angiomas.

The requirement for permanent neurological deficit will be waived if the benign spinal cord tumour is removed by invasive surgery or treated by stereotactic radiosurgery.

"permanent neurological deficit with persisting clinical symptoms" is clearly defined as: Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

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

The following are not covered:-

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

In simpler terms:

A benign tumour 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 and have had surgery to have it removed or are suffering from permanent neurological deficit as a result of the tumour. Neurological symptoms must be permanent. We do not cover angiomas of the spinal cord or spinal canal.

7. Blindness – permanent and irreversible

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

In simpler terms:

You can claim only if you have irreversible loss of sight in both eyes to the extent that even using eye glasses or other visual aids, the sight in your better eye is confirmed by an Ophthalmologist or Consultant Physician as 3/60 or worse using the recognised sight test known as the Snellen eye chart. A Snellen chart is the test an optician uses, where you are asked to read rows of letters. 3/60 is the measure when you can only see at three feet away what someone with perfect sight could see at 60 feet away.

It is possible to be 'registered blind' (as certified by an eye specialist) even though the loss of sight may only be partial. Even if you are 'registered blind', your claim will only be met if the loss of sight meets the criteria outlined in our definition and cannot be corrected.

8. Cancer – excluding less advanced cases

Any malignant tumour positively diagnosed with histological confirmation and characterised by

the uncontrolled growth and spread of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, 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 greater than 6 (ie Gleason score 7 or above only) or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer (including cutaneous lymphoma), other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) ie \geq Clarks level 2.
- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are non-malignant and are excluded from this cover.
- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0.
- Kaposi's sarcoma in the presence of any human immunodeficiency virus.

In simpler terms:

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

A malignant tumour:

- *May grow quickly;*
- *Often invades nearby tissue as it expands;*
- *Often spreads through the blood or the lymph vessels to other parts of the body; and*
- *Usually continues to grow and is life-threatening unless it is destroyed or removed.*

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

Cancers 'in situ' (cancers in a very early stage that have not spread in any way to neighbouring tissue) as well as pre-malignant and non-invasive tumours are not covered under this definition (they may be covered on a partial payment basis, see section 4.7). These are well-recognised conditions and cancers detected at this stage are not likely to

be life-threatening and are usually easily treated. An example of this would be carcinoma (cancer) in situ of the cervix (neck of the womb) which is easy to treat and cure.

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. It is not possible to provide full specified illness cover against these early prostate cancers. We will not pay a claim for prostate cancer under this cancer definition unless the tumour has a Gleason score (a method of measuring differentiation in cells) of greater than 6 (ie a Gleason score of 7 or above) or it has progressed to at least clinical classification of T2NOMO. A partial payment benefit may be available where a life assured does not meet this definition (see section 4.7). 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.

Leukaemia (cancer of the white blood cells) and Hodgkin's disease (a type of lymphoma) are both covered. However, please note there is a requirement for Chronic lymphocytic leukaemia to have progressed to Binet Stage A in order for a claim to be considered.

Most forms of skin cancer are relatively easy to treat and are rarely life threatening. This is because they do not spread out of control and do not produce growths in other parts of the body. The only form of skin cancer that we cover is malignant melanoma which has been classified as being a 'Clark level 2' or greater.

Clark's system is an internationally recognised method of classifying skin melanomas and uses a scale of 1 to 5. A Clark level 1 reflects a very early melanoma which carries a favourable long-term outlook.

Many forms of bladder cancer have a slow course over many years and are managed by surgery or diathermy (the generation of local heat in body tissues by high frequency electromagnetic currents). The prognosis for patients with these superficial bladder cancers is very good. The TNM classification system is internationally recognized 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.

If you are HIV (Human Immunodeficiency Virus) positive, you will not be covered for Kaposi's sarcoma as these tumours are directly related to the virus.

9. Cardiac arrest – with insertion of a defibrillator

Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- Implantable Cardioverter-Defibrillator (ICD); or
- Cardiac Resynchronization Therapy with Defibrillator (CRT-D).

For the above definition the following are not covered:

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

In simpler terms:

Cardiac arrest happens when the heart suddenly stops beating, sometimes because of an abnormal heart rhythm (arrhythmia) or coronary heart disease. This can stop the heart from pumping blood which prevents oxygen being delivered to the body. Lack of oxygen to the brain causes loss of consciousness which in turn means that you stop breathing. A brain injury or death can occur if the arrest goes untreated.

A device known as an Implantable Cardioverter Defibrillator (ICD or CRT-D) can be implanted inside your body which will monitor the rhythm in your heart. If the rhythm becomes abnormal, the device will deliver an electric pulse or shock which will restore the rhythm back to normal and prevent a cardiac arrest.

You can claim if you have had a cardiac arrest followed by the permanent insertion of an ICD or CRT-D. A cardiac arrest not accompanied by the insertion of an ICD or CRT-D is not covered under this condition. A cardiac arrest secondary to illegal drug abuse is not covered under this condition.

10. Cardiomyopathy - resulting in a marked loss of ability to do physical activity

A definite diagnosis of cardiomyopathy by a Consultant Cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity*. The diagnosis should be supported by a current echocardiogram or cardiac MRI showing abnormalities consistent with the diagnosis of cardiomyopathy.

* New York Heart Association Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

For the above definition, the following are not covered:

- Cardiomyopathy secondary to alcohol or drug abuse
- All other forms of heart disease, heart enlargement and myocarditis.

In simpler terms:

Cardiomyopathy is a disorder affecting the muscle of the heart, the cause of which is unknown. It may result in enlargement of the heart, heart failure, abnormal rhythms of the heart (arrhythmias) or an embolism (blockage of a blood vessel).

You can claim if you suffer cardiomyopathy which is permanent and causing symptoms which significantly hinder your normal everyday activities. To qualify for payment your physical ability must be measurable and

limited to a specific degree (New York Heart Association Class 3). The NYHA Function Classification is a measure used to classify the extent of heart failure.

11. Coma – of specific duration and resulting in permanent symptoms

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

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

For the above definition, the following is not covered:

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

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

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

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

The following are not covered:-

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

In Simpler terms:

A coma is a state where a person is unconscious and cannot be brought round. Someone in a coma will have little or no response to any form of physical stimulation and will not have control of their bodily functions. Comas are caused by brain damage, most commonly arising from a head injury, a stroke or lack of oxygen.

12. Coronary artery by-pass grafts

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

For the above definition, the following are not covered:

- balloon angioplasty, atherectomy, insertion of stents and laser treatment or any other procedures.

In simpler terms:

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 vein, normally from the thigh, and using it to direct blood past the diseased or blocked artery.

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

13. Creutzfeldt-Jakob Disease – resulting in permanent symptoms

Confirmation by a Consultant Neurologist of a definite diagnosis of Creutzfeldt-Jakob disease resulting in *permanent neurological deficit with persisting clinical symptoms**.

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

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

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

The following are not covered:-

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

- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

In simpler terms:

CJD is a degenerative condition of the brain. As the disease progresses muscular co-ordination 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.

14. Deafness – total, permanent and irreversible

Permanent and irreversible loss of hearing to the extent that the loss is greater than 95 decibels across all frequencies in the better ear using a pure tone audiogram.

In simpler terms:

You can claim if you have a severe form of deafness (to the degree described in our definition) as measured by a pure tone audiogram. A pure tone audiogram is a key hearing test used to identify hearing threshold levels in an individual. The test establishes the quietest sounds you are able to hear at different frequencies or pitches. A decibel is a measure of the volume of a sound.

You cannot claim if you have reduced hearing in one or both ears which does not meet this definition. You cannot claim if the deafness can be improved by the use of medical aids.

15. Dementia – resulting in permanent symptoms

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of ability to do all of the following:

- Remember;
- Reason; and
- Perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered

- Dementia secondary to alcohol or illegal drug abuse.

In simpler terms:

Dementia is a term used to describe a number of signs and symptoms characterised by the loss of cognitive functioning and intellect, and behavioural changes. Areas of cognition affected may be memory, concentration, language and problem solving.

A claim can be made if the life covered has been diagnosed by a consultant neurologist or consultant geriatrician or psychiatrist, as having Dementia and his/her judgement, understanding and rational thought process have been seriously affected. These symptoms must be permanent.

16. Encephalitis – resulting in permanent symptoms

A definite diagnosis of Encephalitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

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

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

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

The following are not covered:-

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

In simpler terms:

Encephalitis is an acute inflammation of the brain. The illness can vary from mild to life-threatening. Most people with a mild case can recover fully. More severe cases of Encephalitis may recover but there may be damage to the nervous system. This damage can be permanent.

You can claim if you have a diagnosis of Encephalitis confirmed by a Consultant Neurologist and where there are neurological symptoms which the Neurologist deems to be permanent.

17. Heart attack – of specified severity

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

- Typical clinical symptoms (for example characteristic chest pain)
- New characteristic electrocardiographic (ECG) changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
Troponin T > 1.0 ng/ml
AccuTnl > 0.5 ng/ml or equivalent threshold with other Troponin 1 methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:-

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

In simpler terms:

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

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

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 blood stream from the damaged heart muscle) and new ECG changes typical of a heart attack.

18. Heart valve replacement or repair

The actual undergoing of a surgical procedure (including balloon valvuloplasty) to replace or repair one or more heart valves on the advice of a Consultant Cardiologist.

In simpler terms:

Heart valves regulate and control the flow of blood to and from the heart. The valves may become narrow or leak, and if one of the four heart valves is not working properly, an operation may be necessary to repair or replace the valve.

You will be able to claim if you undergo surgery to replace or repair a heart valve on the advice of a Consultant Cardiologist.

19. Heart structural repair with surgery to divide the breastbone

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist, to correct any structural abnormality of the heart.

In Simpler terms:

Structural abnormalities include openings in the wall separating the left and right chambers of the heart.

You will be able to claim if on the advice of a Consultant Cardiologist, you have open heart surgery (including surgery to divide the breast bone) to correct a structural abnormality of the heart.

20. HIV infection – caught in the European Union, North America, Australia and New Zealand, from a blood transfusion, a physical assault or at work in an eligible occupation

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment;
- a physical assault;
- an accident occurring during the course of performing normal duties of employment [from the eligible occupations listed below]*;

after the start of the policy and satisfying all of the following:

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.

- The incident causing infection must have occurred in the European Union, North America, Australia or New Zealand.

For the above definition, the following is not covered:

- HIV infection resulting from any other means, including sexual activity or illegal drug abuse.

*Occupations Covered:

- Ambulance workers
- Dental nurses
- Dental surgeons
- District nurses
- Dublin Bus employees
- Fire brigade and firefighters
- General practitioners and nurses employed by them
- Hospital caterers
- Hospital cleaners
- Hospital doctors/surgeons/consultants
- Hospital laboratory workers
- Hospital laundry workers
- Hospital nurses
- Hospital porters
- Members of the Gardai
- Midwives
- Paramedics
- Prison officers
- Refuse collectors
- Social workers
- Taxi drivers

In simpler terms:

Human immunodeficiency virus is generally recognised as the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The virus can be passed on in several ways including through contaminated blood, bloodstained bodily fluids and infected

needles. This benefit is designed to cover people who are in special danger of getting HIV or AIDS through their work or who have become infected as a result of a physical assault or a blood transfusion in the European Union, North America, Australia and New Zealand. The infection must happen after the start date of the plan and must be appropriately reported and investigated in accordance with established procedures.

21. Kidney failure – requiring ongoing dialysis

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

In simpler terms:

The kidneys act as filters which remove waste materials from the blood. When the kidneys do not work properly, waste materials build up in the blood. This may lead to life-threatening problems. The body can function with only one kidney, but if both kidneys fail completely, dialysis (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 regular long-term dialysis.

22. Liver Failure – irreversible and end stage

A definite diagnosis, by a Consultant Physician, of irreversible end stage liver failure due to cirrhosis resulting in all of the following:

- Permanent jaundice
- Ascites, and
- Encephalopathy

For the above definition, the following is not covered:

- Liver failure secondary to alcohol or illegal drug misuse.

In simpler terms:

Liver failure is the inability of the liver to perform its normal synthetic and metabolic function. Liver failure occurs when a large portion of the liver is damaged.

You can claim if you are diagnosed by a Consultant Physician as having incurable liver failure caused by cirrhosis and showing particular symptoms. Jaundice is a yellow discoloration of the skin and eye whites due to abnormally high levels of bilirubin (bile pigment) in the blood stream. This jaundice must be a permanent feature. Ascites is a fluid build up in the abdomen caused by fluid leaks from the surface of the liver and intestines. It can occur if the blood or lymphatic flow through the liver is blocked. Encephalopathy caused by liver failure is the deterioration of brain function due to toxic substances building up in the blood which are normally removed by the liver.

You cannot claim if the liver failure occurs as a direct or indirect result of excess alcohol consumption or illegal drug use.

23. Loss of Independence – permanent and irreversible

The permanent and irreversible loss of the ability to function independently which is defined as follows:

1. Permanent confinement to a wheelchair, or
2. being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or
3. being permanently unable to fulfill at least three of the following activities unassisted by another person:
 - The ability to walk 100 metres unaided
 - The ability to get into and out of a vehicle unaided.
 - The ability to put on, take off, secure and unfasten all necessary garments and any braces, artificial limbs or other surgical appliances.
 - The ability to feed oneself once food and drink has been prepared and made available.
 - The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained
 - The ability to climb stairs without the assistance of special aids
 - The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.
4. or suffer from severe and permanent intellectual impairment which must,
 - a. result from organic disease or trauma, and
 - b. be measured by the use of recognized standardized tests and

- c. have deteriorated to the extent that requires the need for continual supervision and assistance of another person

The diagnosis must be confirmed to the satisfaction of the professional opinion of Irish Life's Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.

In all of the above permanent means that, even with the best treatment available, the life assured is not expected to recover. The condition must continue for at least six months following diagnosis before the benefit can be claimed.

In simpler terms:

This benefit is intended to make your total cover more wide-ranging and will be particularly valuable as you get older. By focusing on the disability rather than the specific illness, extra cover is provided for a variety of events which may radically change your life.

24. Loss of limbs – permanent physical severance

Permanent physical severance of any combination of 2 or more hands or feet at or above the wrist or ankle joints.

In simpler terms:

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

25. Loss of speech – permanent and irreversible

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

In simpler terms:

You will be able to claim only if you suffer from total and permanent loss of speech as a result of physical damage or disease.

26. Major organ transplant – specified organs

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

For the above definition, the following is not covered:

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

In simpler terms:

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

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.

27. Motor neurone disease – resulting in permanent symptoms

A definite diagnosis of motor neurone disease by a Consultant Neurologist.

There must be permanent clinical impairment of motor function.

In simpler terms:

Motor neurone disease is a disease which affects the central nervous system that controls movement. As the nerves deteriorate the muscles weaken. There is currently no known cure and the cause of the disease is also unknown.

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

28. Multiple sclerosis – with persisting symptoms

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

In simpler terms:

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

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

29. Paralysis of limbs – total and irreversible

Total and irreversible loss of muscle function to the whole of any 2 limbs.

Permanent Paraplegia or Quadriplegia are covered under this definition.

In simpler terms:

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

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

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

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability.

For the above definition, the following are not covered:

- Parkinson's disease secondary to chronic alcohol abuse or illegal drug abuse; and
- Impairment of motor function directly linked or associated with another separate medical condition.

In simpler terms:

Parkinson's Disease is a disease of the central nervous system which affects voluntary movement. It is characterised by muscle stiffness or rigidity, slow movements, shaking of the limbs and head and loss of balance. It normally takes hold gradually.

The term "idiopathic" means that the cause of the disease is not known, so any form of Parkinson's disease brought on by a known cause such as drugs, toxic chemicals or alcohol is not covered.

31. Primary Pulmonary Hypertension – of specified severity

A definite diagnosis of Primary Pulmonary Hypertension 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 classifications of functional capacity*

For the above definition, the following are not covered:

- Pulmonary hypertension secondary to any other known cause ie not primary

*NYHA Class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

In simpler terms:

Primary Pulmonary Hypertension is a disease which occurs 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. A higher pulmonary artery blood pressure means the heart has to work harder to pump sufficient blood into the lungs. Over time, the heart muscles weaken.

You can claim if you suffer from Primary Pulmonary Hypertension which is diagnosed by a Consultant Cardiologist. 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.

32. Progressive supranuclear palsy – resulting in permanent symptoms

A definite diagnosis by a Consultant Neurologist of Progressive Supranuclear Palsy. There must be permanent clinical impairment of eye movement and motor function, rigidity of movement and postural instability.

In simpler terms:

Progressive supranuclear palsy (PSP), also known as Steele-Richardson-Olzewski syndrome, is a degenerative disease that gradually destroys nerve cells in the parts of the brain that control eye movements, breathing and muscle co-ordination. The loss of nerve cells causes palsy or paralysis that slowly gets worse as the disease progresses.

The definition literally means:

- *progressive - it gradually gets worse over time.*
- *supranuclear - the area of the brain stem which controls the eye movements.*
- *palsy - a weakness (in this case, related to eye movement).*

You can claim if there is a definite diagnosis by a consultant neurologist that you are suffering from progressive supranuclear palsy.

33. Pulmonary Artery Surgery – with surgery to divide the breast bone

The actual undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

In simpler terms:

Pulmonary Artery surgery may be carried out for some disorders to the pulmonary artery, including pulmonary atresia (atresia means "no opening") and aneurysm. A claim can be made if the life insured undergoes open heart surgery involving the surgical division of the breastbone to replace the diseased pulmonary artery with a graft.

34. Respiratory Failure of specified severity

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

- The need for daily oxygen therapy on a permanent basis
- Evidence that the oxygen therapy has been required for a minimum period of six months
- FEV1 being less than 40% of normal, and
- Vital Capacity less than 50% of normal

In simpler terms:

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

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

35. Severe Burns/3rd Degree Burns

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

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You will be able to claim if you have suffered third-degree burns covering 20% or more of the surface area of your body.

36. Stroke – resulting in permanent symptoms

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in *permanent neurological deficit with persisting clinical symptoms**. A diagnosis of Subarachnoid Haemorrhage resulting in *permanent neurological deficit with persisting*

*clinical symptoms**, supported by CT or MRI evidence, is covered under this definition.

For the above definition, the following are not covered:

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

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

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

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

The following are not covered:-

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

In simpler terms:

The brain controls all the functions of the body, so damage to the brain can have serious effects. A stroke happens when there is severe damage to the brain caused by internal

bleeding (haemorrhage) or when the flow of blood in an artery has been blocked by a piece of tissue or a blood clot (a thrombus or embolus) resulting in the brain being starved of oxygen.

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

37. Systemic lupus erythematosus – of specified severity

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

- *Permanent neurological deficit with persisting clinical symptoms**, or
- Permanent impairment of kidney function tests as follows:
Glomerular Filtration Rate (GFR) below 30ml/min

***permanent neurological deficit with persisting clinical symptoms"* is clearly defined as: Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in

walking, lack of coordination, tremor, seizures, dementia, delirium and coma. For the purpose of this definition - lethargy will not be accepted as evidence of permanent neurological deficit.

The following are not covered:-

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

In simpler terms:

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease. The immune system attacks the body's cells and tissue resulting in inflammation and tissue damage. The course of the disease is unpredictable with periods of illness alternating with remission. SLE is a multi-system disease because it can affect many different organs and tissues in the body. Systemic lupus erythematosus can be a mild condition treated by medication or there can be life-threatening complications. The condition can be present for many years without progressing to brain and kidney involvement.

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

38. Traumatic head injury – resulting in permanent symptoms

Death of brain tissue due to traumatic injury resulting in *permanent neurological deficit with persisting clinical symptoms**. The diagnosis must be supported by an opinion of a Consultant Neurologist and agreed by our Chief Medical Officer.

For the above definition, the following is not covered:

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

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

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

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

The following are not covered:

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

In simpler terms:

A head injury caused by trauma can leave an individual with permanent brain/nerve damage.

You can claim if a Consultant Neurologist confirms that you have permanent neurological deficit with persisting clinical symptoms as a direct result of a head injury.

4.7 Partial Payment Specified Illness Cover

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

A life assured is 'diagnosed as having a specified illness' if on a date after the start date and before the expiry date of the specified illness cover benefit, the life assured has:

- had any surgery defined in a plan definition below; or
- been diagnosed as having one of the illnesses or medical conditions referred to in a plan definition below.

- (a) We will make a partial payment for specified illness cover if a life assured is diagnosed as having one of the specified illnesses below, on a date after the start date and before the expiry date of the specified illness cover benefit.

The total amount we will pay through partial payments is limited to the amount of your accelerated specified illness as shown on your schedule. You are only allowed to claim once for each of the illnesses defined below.

For the illness E Coronary Angioplasty - to

2 or more coronary arteries (defined below) the amount we will pay is:

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

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

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

The accelerated specified illness cover benefit will be that applicable on the date you are 'diagnosed as having a specified illness'.

For children, the partial payment is the lesser of €7,500 or half of the specified illness benefit amount. We will only make a partial payment once for each child.

- (b) We will only make one payment per life on the plan for each of the illnesses defined below under (a) above. This payment is independent of the main specified illness cover benefit amount. The total amount we will pay through partial payments is limited to the amount of your accelerated specified illness as shown on your schedule.
- (c) We will not pay any benefit under this section if a life assured dies within 14 days of a diagnosis as described in (a).
- (d) If there is a claim paid under a partial payment definition, you cannot claim the full sum insured under a related full payment specified illness cover definition

which occurs or is diagnosed within 30 days of the occurrence or diagnosis of the partial payment specified illness cover event. If an admissible claim arises within 30 days for a related condition, the full payment specified illness cover benefit will be paid less the amount previously paid under the partial payment definition. Once 30 days has elapsed since the occurrence or diagnosis of the partial payment specified illness, any admissible claim for a related condition under the full payment specified illness cover benefit will be assessed and paid independently.

In respect of a partial payment for serious accident cover, once 30 days have elapsed, in the event of a related claim for full payment specified illness cover the full payment specified illness cover benefit will be paid less the amount previously paid under the partial payment definition.

Conditions where this may occur are as follows:

- Carcinoma in Situ, Oesophagus - invasive cancer Oesophagus
- Angioplasty to correct Carotid Stenosis - Stroke/Heart Attack
- Treatment for Cerebral AVM - Stroke
- Surgical Removal of one eye - Blindness
- Ductal Carcinoma in Situ, Breast - invasive breast cancer
- Coronary Angioplasty - Heart attack
- Low Level Prostate Cancer - \geq T2 Prostate Cancer
- Severe Burns 10% body/25% face- Severe Burns 20% body

- Significant Visual impairment - blindness

Once a full payment specified illness cover benefit is paid, the Partial Payment Benefit ceases immediately.

- (e) All the normal plan terms and conditions including but not limited to sections 6.3, 6.4 and 7.2 apply to these limited payments.

Explanatory notes

The explanatory notes in the sections headed 'In simpler terms' are intended to provide a less technical explanation of the illness definitions, and some of the medical terms used within that definition. They are **not** intended as an alternative definition of the illness and will **not** be used to assess claims. In the event of any dispute, the illness 'definition' over rules the 'In simpler terms' explanation.

A Brain abscess drained via craniotomy

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

In simpler terms

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

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

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

B Carcinoma in Situ – Oesophagus, treated by specific surgery

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

For the above definition, the following are not covered:

- Treatment by any other method is specifically excluded.

In simpler terms

The oesophagus is a muscular, membranous tube approximately 25 cm long which connects the mouth to the stomach.

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

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

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

C Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty

We will make a limited payment under specified illness cover if a life assured undergoes endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

In simpler terms

Endarterectomy is a surgical procedure to remove atheromatous plaques (fatty tissue) or a blockage in the lining of an artery. It is carried out by separating the plaque from the arterial wall. An angioplasty is a procedure which uses a temporarily inflated balloon on a catheter (tube) to widen a narrowed or blocked blood vessel by compressing plaque against the artery wall. A stent is a device inserted into an artery to help keep it open.

You can claim if you have had a 70% narrowing or blockage of the carotid artery treated by either endarterectomy or angioplasty. We will require a copy of the angiogram report showing 70% stenosis in the carotid artery.

You cannot claim under this benefit for any other treatment of the carotid artery or vascular system.

D Cerebral arteriovenous malformation - treated by craniotomy or endovascular repair

We will make a limited payment for specified illness cover if a life assured undergoes

surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or malformation. Also, we will make a limited payment for specified illness cover if a life assured undergoes endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or malformation.

For the above definition, the following is not covered:

- Intracranial aneurysm

In simpler terms

A cerebral arteriovenous malformation (AVM) is an abnormal connection between arteries and veins in the brain 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 undergo a craniotomy or endovascular treatment using coils under the care of a Consultant Neurologist or Radiologist, as appropriate, to treat a cerebral AVM or AV fistula.

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

the brain. Endovascular treatment uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.

E Coronary Angioplasty - to 2 or more coronary arteries

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

Insertion of 2 stents in different arteries at different times (e.g. on different days several years apart) does qualify for payment, after the second artery has been stented.

2 stents to one artery, or branches of the same artery, does not qualify.

In simpler terms

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

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

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

If you have balloon angioplasty, atherectomy or laser treatment, you can claim if the treatment is to correct a 70% narrowing of at least two coronary arteries. We do not cover such treatment where only one artery is involved.

Treatment by balloon angioplasty, atherectomy or laser treatment, in 2 different arteries on two separate occasions, to treat narrowing or blockages of at least 70%, qualifies for payment after the second procedure has been carried out.

F Ductal Carcinoma in Situ – Breast, treated by surgery

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a ductal carcinoma in situ of the breast, which has been removed surgically by mastectomy, partial mastectomy, segmentectomy or lumpectomy. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

In simpler terms

Carcinoma in situ is an early form of carcinoma that involves only the cells in which it began and has not spread to other tissues. The term 'ductal' refers to the ducts in the milk glands in the breast.

You can claim if you are diagnosed as having a ductal carcinoma in situ of the breast which is removed surgically.

No benefit is payable under this benefit for any other breast disorder.

G Loss of one limb

We will make a limited payment under specified illness cover if a life assured permanently loses a hand from above the wrist or a foot from above the ankle joint. Permanent loss does not include loss of use or function only. It means having a hand or foot completely severed. To qualify for payment, the loss must happen on a date after the start date and before cover ends.

In simpler terms

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

No payment is made for loss of any individual fingers or toes or combination of fingers and toes.

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

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

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

For the above definition, the following are not covered:

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

In simpler terms

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

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

Plan definition

We will make a limited payment if a life assured suffers a serious accident resulting in severe physical injury where the life assured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

Severe physical injury means injury resulting solely and directly from unforeseen, external, violent and visible means and independent of any other causes.

We will also cover treatment in an inpatient rehabilitation centre, if the client is transferred directly from hospital to the rehabilitation centre for continuous treatment.

Only one partial payment or full payment will be paid resulting from the same accident.

For the above definition the following are not covered:

- Stays in hospital of less than 28 consecutive days
- Serious accident secondary to alcohol where there is a history of alcohol abuse
- Serious accident secondary to illegal drug abuse.

In simpler terms

You can claim if you have a serious accident and are hospitalised for at least 28 consecutive days to receive medical treatment for your injuries. The 28 consecutive days can include time spent in a rehabilitation centre if you are transferred there directly from the hospital to continue your treatment. You can only make one claim for partial payment resulting from the same accident.

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

Plan definition

We will make a limited payment for specified illness cover if a life assured suffers burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% and less than 20% of the body's surface area or at least 25% of the surface area of the face which for the purpose of this definition includes the forehead and the ears.

In simpler terms

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common

example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You will be able to claim if you have suffered third- degree burns covering at least 5% and less than 20% of the surface area of your body or 25% of the surface area of the face.

K Significant visual impairment – permanent and irreversible

Plan definition

We will make a limited payment for specified illness cover if a life assured suffers the permanent and irreversible reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/18 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lenses.

In simpler terms

You can only claim if you have irreversible loss of sight in both eyes to the extent that even using eye glasses or other visual aids, the sight in your better eye is confirmed by an Ophthalmologist or Consultant Physician and to the satisfaction of our Chief Medical Officer, as 6/18 or worse using the recognised sight test known as the Snellen eye chart. A Snellen chart is the test the Optician uses when you are asked read rows of letters. 6/18 is the measure when you can only see at six metres what someone with perfect sight would see at 18 metres away.

It is possible to be "registered blind" (as certified by an eye specialist) even though the

loss of sight may be only partial. Even if you are "registered blind", your claim will only be met if the loss of sight meets the criteria outlined in our definition and cannot be corrected.

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

Plan definition

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

For the above definition, the following are not covered:

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

In simpler terms

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

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

M Surgical removal of one eye

Plan definition

We will make a limited payment for specified illness cover if a life assured undergoes

surgical removal of a complete eyeball for disease or trauma. To qualify for payment, the removal of the eyeball must happen on a date after the start date and before cover ends.

In simpler terms

You can claim if you have to have an eyeball removed as a result of disease or injury.

No benefit is payable for loss of sight in one eye unless it was medically necessary to proceed and remove the eyeball.

4.8 Prepayment of surgery

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

- (a) If a life assured's specified illness cover has not ended, we will make an advance payment for specified illness cover if a life assured has to have coronary artery bypass surgery, heart valve replacement or repair, heart structural repair with surgery to divide the breast bone, or aorta graft surgery. You must provide proof (as set out below) of the need for the surgery before we will pay any benefit. We will not make a payment if the type of surgery is not included in a life assured's cover. The amount we will pay is:
- €30,000; or
 - the amount of specified illness cover the life assured has;
- whichever is lower.

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

Proof needed for coronary artery surgery

If a life assured needs coronary artery surgery, you must provide the following proof:

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

Proof needed for heart valve replacement or repair and heart structural repair with surgery to divide the breastbone.

If a life assured needs heart valve replacement or repair or open heart surgery with surgery to divide the breastbone to correct a structural abnormality, you must provide the following proof.

- Certification from a cardiologist or cardiac surgeon of a major hospital that the life assured is on a waiting list or scheduled for open heart surgery he or she definitely needs within one year in order to repair or replace one or more heart valves or to correct structural abnormalities. This need must be confirmed by our Chief Medical Officer.
- A report on the symptoms which

make the surgery necessary.

- The result of a recent echocardiogram and angiogram showing significant heart valve disease or a significant structural defect of the heart.

Proof needed for aorta graft surgery

If the life assured needs aorta graft surgery, you must provide the following proof.

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

- (b) We will only make one payment for a life assured under this section.
- (c) We will not make a payment under this section unless the life assured is alive when the claim is made.
- (d) If accelerated specified illness cover applies to a life assured:
 - (i) we will permanently reduce the level of specified illness cover and life cover the life assured has by the amount of any benefit we pay under this section;

- (ii) if we pay a benefit under this section and this reduces the amount of specified illness cover to nothing, all specified illness cover for the life assured will end;
- (iii) if we pay a benefit under this section and this reduces the life cover to nothing, all cover for the life assured will end; and
- (iv) we will pay any specified illness cover which is left after the life assured has the surgery.

The amount of children's specified illness cover benefit is the lower of €25,000 or half of your original specified illness benefit amount in all cases. We will pay the benefit for a child above the age of one year who survives for more than 14 days after being diagnosed as having a specified illness (see section 4.6). We will pay a benefit of €7,500 for a child suffering one of the conditions listed under the specified illness cover partial payment benefits (see section 4.7). We will only make a partial payment once for each child.

No other illnesses are covered.

4.9 Children's Life Cover

If cover has not ended, we will pay €6,000 for the funeral expenses of the child of a life assured (see definitions) if the child dies at least six months after the start date. However, the six-month restriction will not apply if the child dies as a result of an accident that happened after the start date. For each child we will only pay a total of €6,000.

We will not pay this benefit from more than one plan, even if both of the child's parents are lives assured and even if the life (or lives) assured is covered by more than one plan which provides similar benefits.

We will not pay children's specified illness cover benefit in the following circumstances:

- If, in the professional opinion of our Chief Medical Officer, a claim arises from any illness or condition (whether referred to in section 4.6 and/or 4.7 or not) which was known to exist or significant symptoms were present before the start date of the plan, before the child was one or before the child was adopted by the life assured.
- If the child is not alive on the date the claim is made.

4.10 Children's Specified Illness Cover

If your cover includes specified illness cover and this cover has not ended, any child (see definitions section) above the age of one year is covered for children's specified illness cover. We will only pay children's specified illness cover benefit once for each child. This is so even if both parents are lives assured with specified illness cover, or even if the life assured is covered under more than one plan which provides similar benefits.

All these terms and conditions apply to this cover as they apply to specified illness cover on the life assured including, but not limited to, section 7.4.

Changing the Level of Cover

Section 5

5.1 The amount of each benefit will reduce on a monthly basis over the full term of your plan. The table of protection benefits in the schedule shows this reduction on a monthly basis for the first year only. Although this reduction continues monthly, the table only indicates the amount of cover which applies at the start of each remaining year.

5.2 Guaranteed insurability option

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

- 50% of your initial life cover and / or specified illness cover benefit (or your new benefit amount if you have reduced your level of cover); or
- €125,000 life cover and / or specified illness cover.

And, you do not have to provide evidence of health. This applies within three months of:

- Being granted a new mortgage or an increase in an existing mortgage (the increase in cover cannot be higher than the mortgage or increase in mortgage), where the new or increased mortgage arises from a move to a new house or significant improvements to the existing house. The mortgage must be drawn down; or
- getting married; or
- having or adopting a child; or

- an increase in the life insured's salary, as a result of a change in job or getting a promotion. In this instance, the percentage increase in the sum assured is limited to the percentage increase in salary. Your employment status must be employee / employed. This is not available where your employment status is self-employed, company director or partner.

You must be aged 55 or under in order to exercise this option. If the basis of cover is Joint Life, the older life must be aged 55 or under.

You will need to provide independent proof of the mortgage, marriage, birth, adoption or salary increase before we can set up a new plan. You must ask for a new plan under this option within three months of the marriage, birth, adoption or salary increase, or the date of the mortgage drawdown.

If you want to take out additional specified illness cover, you must take out the plan before the specified illness cover benefit comes to an end.

The following conditions apply.

- You can only take advantage of this option twice.
- The plan or cover must not have already ended as a result of missed payments or a benefit event happening.
- You will be offered a decreasing term assurance plan with a guaranteed payment and fixed term, assuming we have such a product available at that time.

- The cost of the new decreasing term assurance plan will be based on the terms which apply at that time.
- We will issue the new plan under our normal terms which apply at the time this option is exercised.
- Any special conditions which attach to this plan will apply to the new plan, in particular, if you are classed as a smoker on your existing plan you will be classed as a smoker on the new plan.
- You must apply in writing before the expiry date of the benefit being applied for.
- This option will not apply to the new plan.
- If we no longer offer specified illness cover, you may only take out a new plan with life cover.
- The new plan will not provide cover for any illness or condition that is not covered under section 4 of this plan.
- If we have stopped giving cover for any of the illnesses or conditions in section 4 (if the life assured has this cover), these will not be covered under the new plan.
- If there are differences between the illness or condition definitions given in this plan and the new plan, the definitions in the new plan will apply.

5.3 Optional Flexibility

If your plan has not ended, subject to certain rules, you may ask us to:

- Reduce your cover or remove a benefit altogether.
- Reduce the term of your plan
- Increase your existing benefits
- Increase the term of your plan

The following conditions apply:

- You can only alter your benefits or the term of your plan during the first five years of your plan.
- To increase your benefits or the term of your plan you must be aged 49 or younger.
- The original term of your plan must be greater than ten years for you to be allowed to increase or reduce the term remaining on your plan.
- If you wish to increase your benefits or extend your term the current life cover amount cannot exceed €500,000, while the current specified illness cover amount cannot exceed €300,000 per life.
- The maximum benefit increase allowed is 20% of the current benefit amount
- The maximum term extension allowed is 5 years
- You cannot increase benefits or alter the term on plans that were rated or had exclusions at inception, nor is it permitted on cases that have submitted a claim prior to requesting the plan be altered.
- Where a benefit is being increased and / or a term is being extended, a declaration of health is required. You must pass this in order for the alteration to be accepted
- A benefit can only increase or have its term extended once.
- Any accelerated serious illness cover amount cannot be greater than the life cover amount.
- If you choose to alter your plan we will review your payments. Payments must be at least €13 a month (or another amount we may specify at the time).
- For your plan to continue, the life assured must always have life cover of at least €1,000.

Exclusions

Section 6

6.1 If a life assured dies within a year of the start date as a result of their own deliberate act or a penalty imposed by a court of law, we will not pay you any benefit under the plan. But if you transferred the plan to someone else (except for a next of kin of the life assured) before the act which caused the death or for which the penalty was imposed, we will pay the benefit.

6.2 If, within a year of the start date, a life assured is diagnosed as having a terminal illness as a result of their own deliberate act, we will not pay you any benefit under the plan. But if you transferred the plan to someone else (except for a next of kin of the life assured) before the act which caused the terminal illness, we will pay the benefit.

6.3 We will not pay accidental death cover benefit or specified illness cover benefit for cardiac arrest, coma, loss of independence, loss of two or more limbs, loss of one limb, traumatic head injury or paralysis of two or more limbs or the serious accident cover partial payment benefit, in any of the following circumstances.

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

inflicted or caused directly or indirectly by the life assured taking alcohol or taking illegal drugs.

- If the life assured failed to follow reasonable medical advice or failed to follow medically recommended therapies, treatment or surgery.
- If the condition or accidental death is caused by the life assured taking part in hazardous pursuits, including but not limited to the following.
 - Abseiling
 - Bobsleighbing
 - Boxing
 - Flying, taking part in any flying activity, other than as a passenger in a commercially licenced aircraft
 - Hang gliding
 - Horse racing
 - Motor car or motorcycle racing or sports
 - Mountaineering
 - Parachuting
 - Pot-holing or caving
 - Power boat racing
 - Rock climbing
 - Scuba diving.

6.4 We will only pay specified illness cover benefit, or life cover benefit for a life assured who has been diagnosed as having a terminal illness, if the life assured lives in one of the accepted countries. These are any Member State of the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland and the USA. We reserve the right to refuse to accept medical evidence produced from any

country, in respect of specified illness cover benefit, other than from a recognised hospital in Ireland or the UK or health professional resident in Ireland or the UK.

- 6.5 You must write and tell us immediately if a life assured starts living in a country that is not an accepted country. We will then decide whether cover will continue and on what basis.

Claims

Section 7

- 7.1 Your benefits have been calculated on the basis that the date of birth of the life assured is as shown on the application form. When you make a claim, we will ask you to provide proof of the date of birth. If the date of birth on the application form is not correct, we will recalculate the benefits in line with the correct date of birth.
- 7.2 We will not consider any claim until we have received the following:
- A properly filled-in claim form.
 - Proof that you are entitled to claim the benefits. This could include proof that you have followed these terms and conditions and any special conditions contained in the plan schedule. If someone else makes a claim on your behalf, or if you have died, we will ask the person making the claim for a power of attorney or a grant of probate or letters of administration.
 - Proof (in the form of a birth certificate) of the age of the life assured.
 - The original Terms and Conditions Booklet. If they are not available, whoever makes the claim must accept legal responsibility if it turns out that someone else is entitled to the benefit.
- 7.3 If you are claiming for the death of a life assured or the funeral expenses of a child, we are entitled to ask for proof of death in the form of a death certificate, and any other proof we reasonably

need.

- 7.4 If you are claiming life cover benefit for a terminal illness, or specified illness cover benefit or children's specified illness cover benefit you must tell us, in writing, about the surgery or diagnosis within six months of the day on which it occurred. If you do not, we may refuse to pay the benefit. You must provide and pay for any certificates, tests, information or evidence, which we reasonably need to prove your claim.

The life assured or child must agree to any medical examinations and tests which are necessary to prove your claim, and if they die we may ask for a post mortem examination. If you fail or the life assured or the child fails to meet these requirements within a reasonable time, or if the life assured or child fails to follow the advice of a registered medical practitioner, we will not pay the benefits claimed. We may also adjust the life cover benefits for the death of the life assured or child, or end the plan altogether.

- 7.5 If a claim is admitted for children's life cover or children's specified illness cover, we will pay the benefits directly to the life (or lives) assured. We will pay these directly to the life (or lives assured), rather than to any assignee, as these do not effect any lender's security under the plan.

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

Tax

Section 8

- 8.1 Under current law, tax does not have to be taken from life cover or specified illness cover benefits. A government levy is charged on payments that you make under this plan (as at May 2011).
- 8.2 Any taxes or levies imposed by the government will be deducted by Irish Life. We will deal with this plan in line with the requirements of the Revenue Commissioners. If tax laws or any other relevant laws change after the start date, we will change the terms and conditions of the plan if we need to do this to keep the plan in line with those changes. We will write and tell you about any changes in the terms and conditions.

Other information

notes:

Section 9

- 9.1 This plan does not have any cash-in value.
- 9.2 This plan is governed by the law of Ireland, and the Irish courts are the only courts which are entitled to hear any dispute.
- 9.3 If you assign (transfer) the plan to someone else, the person you assign it to must write and tell us at:

Irish Life Centre
Lower Abbey Street
Dublin 1.

notes:

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Contact us

Phone: 01 704 20 00

Fax: 01 704 19 00

Website: www.irishlife.ie

Email: customerservice@irishlife.ie

Write to: Irish Life Assurance plc, Lower Abbey St, Dublin 1.

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



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