GRA Specified Illness Cover Plan

Summary Booklet

Cornmarket

GRA Garda Representative Association

Vital protection for GRA members

Dealing with an illness can place significant strain on you and your family, not to mention the additional cost of:

- Travelling to and from hospital
- Childcare
- Loss of income
- Medical bills

Concerned with the financial insecurity members can face if diagnosed with a serious illness, the GRA launched the Specified Illness Cover Plan, which is administered by Cornmarket. The Plan is periodically reviewed to ensure that we continue to receive the best rates and benefits for our members.

Over 8,000 GRA members and their families already benefit from the financial protection that the GRA Specified Illness Cover Plan provides.

I would recommend all trainee Gardaí to avail of the opportunity to join this Plan during their training period.

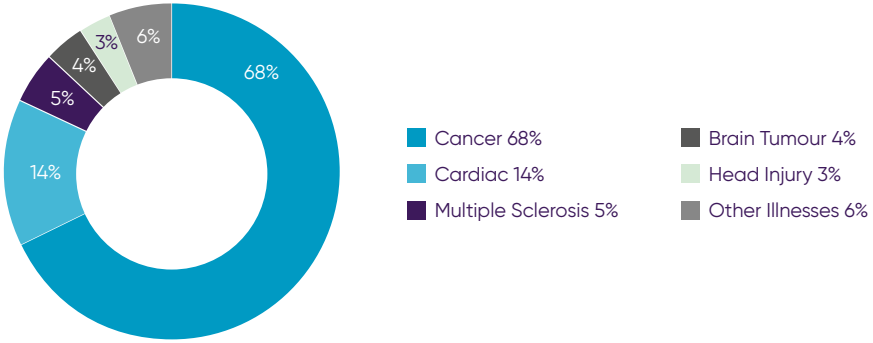
Pat Ennis
General Secretary
Garda Representative Association.

The Plan in action

The GRA Specified Illness Cover Plan delivers on its promise to members, with over **€8 million*** paid out to members in the last 3 years.

130 members* received a tax-free lump sum between 2014 and 2016.

Most common claims*



*Source: Friends First Claims Department, March 2017.

Who is Cornmarket?

With over 40 years' experience, Cornmarket is the largest financial services broker serving the Public Sector in Ireland. We work on behalf of GRA members to:

- Negotiate with the insurers (currently Friends First) to get the best possible rate and benefits for members
- Assist those who need to claim from the Plan, by guiding them through every stage of the claims process.

The GRA Specified Illness Cover Plan

Provides vital protection for GRA members, as follows:

1. Specified Illness Benefit

A tax-free lump sum (see values opposite) if you suffer one of the 40 Specified Illnesses* listed on page 9.

2. Partial Payment Specified Illness Benefit

A tax-free lump sum (see values opposite) if you suffer one of the 10 less severe Partial Payment Specified Illnesses* listed on page 10.

3. Children's Specified Illness Benefit

A tax-free lump sum (see values opposite) if your child aged 1-18 (or 1-25 if in full-time education) suffers one of the Specified Illnesses* listed on page 9, or one of the Partial Payment Specified Illnesses* listed on page 10.

* Please note that in order for a Specified Illness claim to be paid, the Specified Illness policy definition must be entirely fulfilled. Please see Appendices 1 & 2 on pages 23 & 33 for full details, in particular the policy definition of each Specified Illness and its pre-existing conditions.

The benefit you would receive depends on the type of member, please see table below:

Type Of Member	Specified Illness Benefit (see list of illnesses covered on page 9)	Partial Payment Specified Illness Benefit (see list of illnesses covered on page 10)
Trainee Gardaí	€42,500	€10,000
Trainee Gardaí Spouse/Partner**	€42,500	€10,000
Serving Member	€85,000	€15,000
Serving Member's Spouse/Partner**	€85,000	€15,000
Retired Member	€42,500	€10,000
Retired Member's Spouse/Partner**	€42,500	€10,000
Children	€25,000	€5,000

**For this benefit to apply, your spouse/partner must be nominated on your application form upon joining the Plan or by completing a Nominated Spouse/Partner Application Form. Please see page 14 for further details.

Important
Cover for Trainee Gardaí and their Spouse/Partner (if nominated) is provided **free of charge** for the first 64 weeks of training. To qualify for this period of free cover, you must be a GRA member and have satisfactorily completed an application form to join the Plan in the Garda Síochána College or before the end of your 64 weeks of training. After your 64 weeks of training, premiums will automatically be deducted from your salary and you will be eligible for Serving Member and Serving Member's Spouse/Partner (if nominated) benefits.

Protection for you and your family

1. Specified Illness Benefit - Illnesses Covered

The Plan provides a once-off lump sum (as shown on page 7) if you suffer one of the Specified Illnesses listed opposite. If you suffered from one of the Specified Illnesses covered before you joined the Plan, you will not be covered for that illness.

There is only 1 Specified Illness payment per life, per Plan. If you claim Specified Illness Benefit, your cover for this benefit and for the Partial Payment Specified Illness Benefit will end and you will no longer be able to claim these benefits.

Important
A claim for Specified Illness Benefit should be submitted as soon as possible after the date of diagnosis.

Late notification of claims
It is often not possible to assess the validity of a claim where a significant period of time has passed (approximately 3 months) since you were diagnosed with a Specified Illness. For this reason, it is vital that you register your claim promptly. In the case of late notification of a claim, cases will be assessed on individual merit and the insurer reserves the right to decline to assess the claim.

The 40 Specified Illnesses covered under this Plan are:

1. Alzheimer's disease before age 65 - resulting in permanent symptoms
2. Aorta graft surgery - for disease
3. Aplastic anaemia - of specified severity
4. Bacterial meningitis - resulting in permanent symptoms
5. Balloon valvuloplasty - to correct heart valve abnormalities
6. Benign brain tumour - resulting in permanent symptoms or surgical removal via craniotomy
7. Benign spinal cord tumour - resulting in permanent symptoms or requiring surgery
8. Blindness - permanent and irreversible
9. Cancer - excluding less advanced cases
10. Cardiomyopathy - of specified severity
11. Chronic lung disease - requiring long term oxygen therapy
12. Coma - resulting in permanent symptoms
13. Coronary artery surgery
14. Creutzfeldt-Jakob Disease - resulting in permanent symptoms
15. Deafness - permanent and irreversible
16. Encephalitis - resulting in permanent symptoms
17. Heart attack - of specified severity
18. Heart structural repair - with surgery to divide the breastbone
19. Heart valve replacement or repair
20. HIV infection - occupational/ assault/transfusion
21. Kidney failure - requiring dialysis
22. Liver failure
23. Loss of hands or feet - permanent physical severance
24. Loss of independent existence - permanent and irreversible
25. Loss of speech - permanent and irreversible
26. Major organ transplant
27. Motor Neurone Disease before age 65
28. Multiple Sclerosis
29. Multiple system atrophy - resulting in permanent symptoms
30. Paralysis of limbs - total and irreversible
31. Parkinson's Disease before age 65 - resulting in permanent symptoms
32. Pre-Senile dementia before age 65 - resulting in permanent symptoms
33. Primary Pulmonary Hypertension - of a specified severity
34. Progressive supranuclear palsy
35. Pulmonary artery surgery - with surgery to divide the breastbone
36. Rheumatoid arthritis - of specified severity
37. Stroke - resulting in permanent symptoms
38. Systemic lupus erythematosus - of specified severity
39. Third degree burns - covering 20% of the body's surface area or 50% of the surface area of the face
40. Traumatic head injury - resulting in permanent symptoms

Member and Spouse/Partner Benefit – Exclusion of Double Payment

If you are a serving/retired member of the Plan and also the spouse/partner of another serving/retired member of the Plan and both of you are paying for spouse/partner cover, then in the event of one of you claiming, only one benefit will be paid in respect of the condition for which you are claiming.

For example, if you claim for cancer under the member's benefit a second payment for that illness will not be paid to your spouse/partner if they claim under the spouse/partners' cover element of their Plan.

Cover for the Specified Illness Benefit ends at age 65.

Terms and conditions apply. Please note that in order for a Specified Illness claim to be paid, the Specified Illness policy definition must be entirely fulfilled. Please see the Appendix on page 23 for full details, in particular the policy definition of each Specified Illness and its pre-existing conditions.

2. Partial Payment Specified Illness Benefit - Illnesses Covered

The Plan provides a once-off lump sum (as shown on page 7) if you suffer one of the Specified Illnesses listed below.

The 10 Partial Payment Specified Illnesses covered under this Plan are:

1. Brain abscess drained via craniotomy
2. Carcinoma in situ – oesophagus, treated by specific surgery
3. Carotid artery stenosis – treated by endarterectomy or angioplasty
4. Cerebral arteriovenous malformation – treated by craniotomy or endovascular repair
5. Coronary angioplasty – to correct narrowing or blockage to 2 or more coronary arteries
6. Ductal carcinoma in situ – breast, treated by surgery
7. Low level prostate cancer with Gleason score between 2 and 6 - with specific treatment
8. Serious Accident Cover
9. Surgical removal of one eye
10. Third Degree Burns covering 5% to 19% of the body's surface area or 25% to 49% of the face's surface area

Based on claims experience, these conditions were identified by Friends First as less severe, but still life-altering. This benefit is designed to help with the additional expenses that members may incur.

If you suffered from one of the Partial Payment Specified Illnesses covered before you joined the Plan, you will not be covered for that illness. There is only 1 Partial Payment Specified Illness payment per life, per Plan.

This list of Partial Payment Specified Illnesses is separate from those covered under the main Specified Illness Benefit. In most cases, if you make a claim under the Partial Payment Specified Illness Benefit the benefit paid will not affect the amount you could receive if you make a Specified Illness Benefit claim at a later date.

However, if you are diagnosed with an illness under the main Specified Illness Benefit within 30 days of diagnosis of a Partial Payment Specified Illness, then the full payment will be made under the main Specified Illness Benefit only. Please see pages 8 and 19 for more information on the payment of Specified Illness Benefit.

Cover for the Partial Payment Specified Illness Benefit ends at age 65.

Terms and conditions apply. Please note that in order for a Partial Payment Specified Illness claim to be paid, the Specified Illness policy definition must be entirely fulfilled. Please see Appendix 2 on page 33 for full details, in particular the policy definition of each Partial Payment Specified Illness and its pre-existing conditions.

3. Children's Specified Illness Benefit

The Plan provides a once-off lump sum (as shown on page 7) if your child suffers one of the Specified Illnesses listed on page 9 or one of the Partial Payment Specified Illnesses listed on page 10.

Cover for Children's Specified Illness Benefit is provided from age 1-18 (or 1-25 if in full-time education).

- A member of the Plan may claim Children's Specified Illness Benefit for more than one child.
- Payment of Children's Specified Illness Benefit can be paid only once in respect of each child.
- The payment of either the Children's Specified Illness Benefit or the Children's Partial Payment Specified Illness Benefit does not affect either your or your spouse's cover.

Important note
There is only 1 Specified Illness Payment per child, per Plan. Other terms and conditions apply, please refer to page 8 for more information. Once a claim is paid under the main Children's Specified Illness Benefit, cover for that child will cease and you will no longer be able to claim Specified Illness Benefit for that child.

Who is eligible to join?

To be eligible to apply for membership of this Plan you must be:

1 A member of the Garda Representative Association **and**
2 A trainee at the Garda Síochána College **and**
3 Applying to join in the first 64 weeks after entering the Garda Síochána College.

Please note: You can only join the Plan while a trainee at the Garda Síochána College. GRA members who have already completed their 64 weeks of training cannot apply to join or re-enter the Plan.

Nominated Spouse/Partner*

To avail of this value added benefit, you must nominate your spouse/partner in the first available instance, either:

1) **When you are joining the Plan during your training in the Garda Síochána College** - if at the time of joining the Plan you have:
   A) a spouse or registered civil partner **or**
   B) a partner with whom you have been cohabiting for at least 12 months in a spousal type relationship.

Your spouse/partner must be nominated on your application form. You can't add them at a later date.

OR

2) **Within 12 months of getting married or within 12 months of completing a period of 12 months of cohabiting in a spousal type relationship -** If you do not have a spouse/partner at the time of joining, but at a later point do, you must nominate him/her within 12 months of completing a period of 12 months of cohabiting in a spousal type relationship or within 12 months of getting married, whichever is earliest.

Note: You may only have one spouse/partner nominated for this benefit at any given time.

***Definition of a spouse/partner**

- Your Legal Spouse, **or**
- Your Registered Civil Partner, **or**
- A person of the same or of the opposite sex with whom you are cohabiting, in a spousal type relationship, for 12 months or more at the date of application for cover.

Nominated Spouse/Partner Application Form:

To apply to add a new spouse/partner to the Plan or to apply to change your spouse/partner in the Plan at a later date, you must complete a Nominated Spouse/Partner Application Form. Please contact Cornmarket on **(01) 200 0100** for more information.

Important
If you have not nominated your spouse/partner on your application form or completed a Nominated Spouse/Partner Application Form within the timeframes set out on page 13, no benefit will be payable. This benefit is only payable once per member, irrespective of the number of spouses/partners you have.

How much does the Plan cost?

The Plan is designed to be affordable for every member. The rates and benefits are negotiated on a special 'group basis' for GRA members, to provide you with remarkably good value.

If you are a trainee Garda and apply to join the Plan while completing your 64 weeks training, you will be provided with **free membership**. To be eligible for this free membership you must be a member of the GRA and be accepted into the Plan. Your premiums will automatically commence at the end of your 64 weeks of training and will appear under pay code 6152 on your payslip.

After 64 weeks of training, the cost of membership is:

Benefit	Cost
Serving Member's Specified Illness Benefit	€5.80 per week
Serving Member's Spouse/Partner Specified Illness Benefit	€4.74 per week
Serving Member's Specified Illness Benefit & Serving Member's Spouse/Partner Specified Illness Benefit	€10.54 per week
Retired Member's Specified Illness Benefit	€25.13 per month
Retired Member's Spouse/Partner Specified Illness Benefit	€20.54 per month
Retired Member's Specified Illness Benefit & Retired Member's Spouse/Partner Specified Illness Benefit	€45.67 per month
Children's Specified Illness Benefit	Free of Charge

The Plan cost includes the Government Insurance Levy of 1%. These rates are guaranteed until the next review of the Plan which will take place on 1st April 2019.

Please remember it is your responsibility to make sure the correct deductions have been made and are cancelled if needed.

Important
You must be a member of the GRA or a full-time member of a recognised staff association in An Garda Síochána to be an eligible member of the Plan. On promotion you can continue your membership of the Plan as long as you are a full-time member of the recognised staff association for your rank. If you leave the GRA or the relevant staff association, you must inform Cornmarket in writing as you can no longer stay in the Plan and you will not be able to claim from it.
If you leave the Plan you will not be able to rejoin the Plan at a later date.

How to Join

Please complete an application form in the Garda Síochána College or before the end of your 64 weeks of training. As you are deemed to be joining the Plan at the first available opportunity, you are not required to provide medical information as part of your application.

Frequently Asked Questions

1. When does my membership begin?

Your membership begins from the date Friends First accepts your application. You will receive a letter from Cornmarket to confirm you have been accepted as a member of the Plan.

2. When does my membership end?

Membership of the Plan ends on the earliest of the following:

- You reach your 65th birthday **or**
- You retire and you have not opted for Retired Member's Specified Illness Benefit (please see question 3 *What happens at my retirement*? for more information) **or**
- You are paid a claim under the Specified Illness Benefit **or**
- You leave the GRA (or recognised staff association in An Garda Síochána) **or**
- Your premiums to the Plan cease **or**
- You die.

If your spouse/partner is also a member of the Plan, their membership will end at the earliest of the following:

- On their 65th birthday **or**
- The Serving Member retires and they have not opted for Retired Member's Specified Illness Benefit (please see question 3 What happens at my retirement? for more information) **or**
- They are paid a claim under the Specified Illness Benefit **or**
- Premiums to the Plan cease* **or**
- They die.

*Important: If you claim from the Plan and your membership ends, your spouse/partner can still be covered under the Plan once the correct premiums have been paid.

If your spouse/partner claims from the Plan and their membership ends, you can still be covered once the correct premiums have been paid.

3. What happens at my retirement?

When you retire, you can maintain your cover until age 65. If you would like to maintain your cover you must contact Cornmarket within 3 months of retiring.

If you do not contact Cornmarket within **3 months** of retiring, your membership of the Plan ceases and there is no option to rejoin the Plan.

4. When do I receive benefit payment?

Once Friends First accepts your claim, you will receive your once-off, tax-free lump sum. Please remember it can take around **3 months** to process your claim. Please see page 21, *How to claim from the Plan* for more information.

5. What if I take a career break, take unpaid leave or change my working hours?

If you plan to take a career break, unpaid leave or change your hours (such as job sharing) please contact Cornmarket on **(01) 200 0100** to discuss the options available.

6. Is there a Survival Period?

Yes. If you suffer a Specified Illness listed under the Specified Illness Benefit on page 9 or under the Partial Payment Specified Illness Benefit on page 10 and wish to make a claim from the Plan, you must 'survive for a minimum period' after the date on which the illness was diagnosed or surgery took place, in order for your claim to be paid. If your claim is accepted and you die within the 'minimum period', no Specified Illness Benefit is payable. The relevant periods are:

A) 6 months for Parkinson's Disease, Dementia (including Alzheimer's Disease) and loss of sight
B) 6 months for Bacterial Meningitis in respect of Children's Specified Illness Benefit
C) 12 months for loss of hearing and loss of speech
D) 14 days for all other Specified Illnesses.

Pre-existing conditions and other important exclusions

1. Pre-existing conditions for Member and Spouse/Partner Specified Illness Benefit

If prior to joining the Plan, you suffered from one of the Specified Illnesses, you will never be covered for that particular illness under the Plan and you can never claim for a recurrence of that illness in the future. For example, if you suffered from cancer prior to joining, you can never claim under the Plan in respect of cancer. You are covered for the remaining Specified Illnesses.

In addition, because of the links between heart attack, coronary artery by-pass surgery, heart transplant, angioplasty and stroke, if you have suffered or undergone one of these conditions before joining the Plan you cannot claim under the policy in respect of any of the other 4 illnesses. For example, if you underwent coronary artery by-pass surgery before joining you will never be covered for coronary artery by-pass surgery, heart attack, heart transplant, angioplasty or stroke.

If prior to joining the Plan, you suffered from a condition related to one of the Specified Illnesses and you contract that particular illness within 2 years of joining the Plan, you will not be covered. For example, a claim will not be paid for heart attack within the first 2 years of joining, if prior to joining you suffered from Diabetes. This is due to the recognised link between Diabetes and heart attack. However, a diabetic who first suffers a heart attack 3 years after joining the Plan will be eligible to claim.

In addition, no cancer claims will be paid where the condition presents within the first 3 months of a member joining the Plan. In this case, cover in respect of cancer ceases under the Plan.

Important
You will not be eligible to make a claim for Specified Illness Benefit if the illness claimed for relates to a condition which you were already suffering from at the time of your application and/or where you were under medical investigation, whether or not you were aware of the condition at that time.

2. Pre-existing conditions for Children's Specified Illness Benefit

Each member's child aged between 1 and 18 (or 1-25 if in full-time education) is automatically covered for Children's Specified Illness Benefit under the Plan. In the event of a claim, you must provide evidence of being the parent of the child by their birth/adoption certificate.

Friends First do not require medical information for a member's child before including them in the Plan. Therefore, the child is not covered for a Specified Illness they had since birth or prior to reaching age 1, or the legal date of adoption, if later. If a child is known to be suffering from a heart valve defect prior to commencement date of the Plan or prior to reaching age 1, Friends First will not pay a claim for heart valve surgery. However, if that child develops an unrelated condition such as cancer or kidney failure, Friends First will pay the claim. The child is covered for the same illnesses for which a member is covered.

3. Other exclusions

No Specified Illness Benefit will be paid:

- If a member travels or remains outside the Territorial Limits for more than 4 months in any calendar year. The Territorial Limits are the member states of the EU on the policy start date, the United States of America, Canada, New Zealand, Australia, Norway, Switzerland, Japan, Singapore and Iceland.
- If the circumstances giving rise to a claim are either directly or indirectly attributable to the abuse of alcohol, drugs or other dangerous substances.
- For illnesses arising directly or indirectly as a result of deliberate neglect of health by failure to seek or follow medical advice, or a wilful self-inflicted injury.
- If the member is shown to be carrying, or to have been carrying, a human immunodeficiency virus (H.I.V.) or antibodies to such a virus except where the virus has been contracted in the conditions set out in these conditions.
- For illnesses arising directly or indirectly from: any form of war, whether declared or not, or to participation in a riot, insurrection, civil commotion or criminal act; or participation in any of the following pursuits: abseiling, bobsleighing, boxing, hang-gliding, scuba diving, any type of equestrian event, motor or motorcycle sports, mountaineering, rock climbing, potholing and caving, parachuting, power-boat racing and aviation other than as a fair paying passenger on a regular public airline.

How to claim from the Plan – a step-by-step guide

Our Claims Team is experienced and knowledgeable in guiding members through the claims process. We are here to talk you through the claims process and explain the documentation you need to provide.

1. Contact Cornmarket

We are not automatically notified if you are diagnosed with a Specified Illness. Therefore, you should let us know as soon as you become aware that you need to make a claim from the Plan.

You can contact us by:

- Phone: **(01) 200 0100**
- Post: **GRA SIC Claims Department, Cornmarket Group Financial Services Ltd., Christchurch Square, Dublin 8.**
- Email: **gra.spsadmin@cornmarket.ie**

If you are making a claim, you may wish to nominate someone to contact Cornmarket on your behalf to assist you with your claim, such as your spouse or next of kin. If you wish to do this, please send Cornmarket a letter, signed and dated by you, outlining the name, address and date of birth of your nominated person.

Please be aware that if you nominate someone to assist you with your claim, they will have access to all of the information related to your claim; including medical and financial details. However, they cannot make changes to your policy or cancel your policy. Your nominated person will only be able to deal with Cornmarket regarding your claim. They will not be able to deal directly with the insurance company.

2. Your Claims Pack

Once you have informed us that you wish to make a claim, we will send you out a claim form and tell you what information is required for Friends First to assess your claim.

3. Processing your claim

Once we receive your completed claim form we will send the details to Friends First, so an assessment of your claim can begin immediately. We will send on all documents as we receive them from you and we will liaise between you and Friends First throughout the claims process.

It takes time to gather the necessary documents to assess your claim, such as medical evidence (for example specialist medical evidence and/or independent medical evidence).

For this reason, claims typically take around 3 months to process from the date the claim form is received until the decision is made.

4. Medical examination

The medical evidence that you and your doctors provide will be assessed by Friends First. In some cases they will request that you attend an independent medical examination (at Friends First's expense).

5. Additional medical evidence

Depending on the complexity of your condition, in some cases Friends First may require additional medical evidence from your doctors and/or specialists. You may be requested to attend a further medical examination (at Friends First's expense).

6. Decision on your claim

Once all the medical evidence and documentation has been received, Friends First will make a decision on your claim.

7. Your benefit

Once a new claim is accepted, benefit is paid by Friends First.

Important - Late notification of claims
It is often not possible to assess the validity of a claim where a significant period of time has passed (approximately 3 months) since you were diagnosed with a Specified Illness. For this reason, it is vital that you register your claim promptly. In the case of a late notification of a claim, cases will be assessed on individual merit and the insurer reserves the right to decline to assess the claim.

APPENDIX 1: Explanation of each Specified Illness and its pre-existing conditions

This section outlines:

- The policy definition of the Specified Illnesses that are covered under the Plan
- A simple explanation of each illness
- Information on related conditions which, if present before joining the Plan, means the member is not covered for the Specified Illness if diagnosis occurs within the first 2 years of cover.

1. Alzheimer's disease before age 65 – resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease before age 65 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.

2. Aorta Graft Surgery – for disease

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

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

For the above definition, the following are not covered:

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

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

All other forms of anaemia are specifically excluded.

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

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.

All other forms of meningitis including viral meningitis are not covered.

5. **Balloon Valvuloplasty** – to correct heart valve abnormalities

The insertion, on the advice of a Consultant Cardiologist, of a balloon catheter through the orifice of one of the valves of the heart, and the inflation of the balloon to relieve valvular abnormalities.

6. **Benign brain tumour** – resulting in permanent symptoms or surgical removal via craniotomy

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in either of the following:

- permanent neurological deficit with persisting clinical symptoms **or**
- Full or partial removal of the tumour by craniotomy (surgical opening of the skull)

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

7. **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 invasive surgery or stereotatic radiosurgery or which 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.

Angiomas are specifically excluded.

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

8. **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.

9. **Cancer** - excluding less advanced cases

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

The term malignant tumour includes leukaemia, lymphoma and sarcoma.

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 or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

Explanation of the TNM system
The three elements in the system relate to the primary tumour (T), the regional lymph nodes (N) and metastases (M) where the severity of each condition increases as each scale ascends to the maximum.

Once the tumour is T2 in size (large but restricted to the prostate) we pay out, it does not matter if there is lymph node involvement or distant metastasis, (distant spread of the disease). Scales of 0-4 are applied for T, 0-3 for N and 0-1 for M. A brief summary follows:

Primary Tumour (T)
Tis - carcinoma in situ
T0 - no evidence of primary tumour
T1 - small size, restricted to organ of origin
T2-4 - increasing size/local invasion

Regional Lymph Nodes
N0 - no nodal metastases
N1-3 - increasing degrees of nodal metastases

Distant Metastasis
M0 - no distant metastases
M1 - distant metastases present

10. **Cardiomyopathy** – of specified severity

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

For the purpose of this definition, NYHA Class III is heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.
All other forms of heart disease, heart enlargement and myocarditis are specifically excluded, as is cardiomyopathy directly related to alcohol or drug abuse.

11. **Chronic Lung Disease** – requiring long term oxygen therapy

Confirmation by a Consultant Physician of chronic lung disease which is evidenced by all of the following:

- The need for daily oxygen therapy for a minimum of 15 hours per day for a minimum period of 6 months **and**
- FEV1 being less than 40% of normal **and**
- Vital Capacity less than 50% of normal.

12. **Coma** – resulting in permanent symptoms

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

- requires the use of life support systems **and**
- results in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug abuse.

13. **Coronary artery surgery**

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

For the above definition, the following are not covered:

- Balloon angioplasty,
- Atherectomy,
- Rotablation,
- Insertion of stents **and**
- Laser treatment.

14. **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.

15. **Deafness** - 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.

16. **Encephalitis** - resulting in permanent symptoms

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

Encephalitis in the presence of HIV infection is specifically excluded.

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:

- New characteristic electrocardiographic changes,
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
  - Troponin T > 1.0 ng/ml
  - AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I 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.

18. **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.

19. **Heart valve replacement or repair**

The undergoing of surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

20. **HIV infection** - occupational / assault / transfusion

Infection by Human Immunodeficiency Virus, resulting from:

- a blood transfusion given as part of medical treatment **or**
- a physical assault **or**
- an incident occurring during the course of performing normal duties of employment from the eligible occupations listed* 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 one of the following countries: Australia, Austria, Belgium, Canada, the Channel Islands, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, the Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the United States of America.

For the above definition, the following is not covered:

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

*Eligible occupations are doctor, health worker, prison officer, Garda, fire officer, ambulance officer.

21. **Kidney failure** - requiring dialysis

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

22. Liver failure

End stage liver failure due to cirrhosis and resulting in all of the following:

- Permanent jaundice
- Ascites
- Encephalopathy

Liver disorder secondary to alcohol or drug misuse is excluded.

23. **Loss of hands or feet** - permanent physical severance

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

24. **Loss of independent existence** - permanent and irreversible

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

- Being permanently unable to fulfil at least three of the following activities unassisted by another person:
  - The ability to walk 100 metres on the flat
  - The ability to get in and out of a standard motor vehicle
  - 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 wash in the bath or shower (including getting into and out of the bath and shower) such that an adequate level of personal hygiene can be maintained

- The ability to climb a flight of 12 stairs without the assistance of special aids
- The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained

or

- Suffering from severe & permanent intellectual impairment which must:
  - Result from organic disease or trauma **and**
  - Be measured by the use of recognised standardised tests **and**
  - Have deteriorated to the extent that requires the need for continual supervision and assistance of another person throughout the day.

Friends First will not pay any benefit unless the Loss of Independent Existence has continued without interruption for 6 months in a row (the qualifying period) or for any longer period. Friends First may reasonably decide to be sure that the Loss of Independent Existence is permanent.

In making its assessment of any claim, Friends First will consider evidence from all the claimant's treatment options available, and the likelihood of recovery. In addition, Friends First may require an Independent Medical Assessment by a Consultant or other health professional.

The diagnosis must be confirmed to the satisfaction of our Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.

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.

26. Major organ transplant

The undergoing as a recipient of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or inclusion on an official Irish or UK waiting list for such a procedure.

For the above definition, the following is not covered:

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

27. Motor Neurone Disease before age 65 - Resulting in permanent symptoms

A definite diagnosis of Motor Neurone Disease before age 65 by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

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.

29. Multiple system atrophy - resulting in permanent symptoms

A definite diagnosis of multiple system atrophy confirmed by a Consultant Neurologist.

There must be evidence of permanent clinical impairment of either:

- motor function with associated rigidity of movement **or**
- the ability to coordinate muscle movement **or**
- bladder control and postural hypotension.

30. Paralysis of limbs - total and irreversible

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

31. Parkinson's Disease before age 65 - resulting in permanent symptoms

A definite diagnosis of Parkinson's disease before age 65 by a Consultant Neurologist.

There must be permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability.

For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse.

32. Pre-Senile Dementia before age 65 - resulting in permanent symptoms

A definite diagnosis of dementia 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.

Dementia directly related to alcohol or drug abuse is specifically excluded.

33. Primary Pulmonary Hypertension - of specified severity

A definite diagnosis by a Consultant Cardiologist of Primary Pulmonary Hypertension.

There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class III of the New York Heart Association (NYHA) classification of functional capacity.

For the purpose of this definition, NYHA Class III is heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

Pulmonary hypertension secondary to any other known cause is specifically excluded.

34. Progressive Supranuclear Palsy

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

35. Pulmonary Artery Surgery – with surgery to divide the breastbone

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 artery with a graft.

36. Rheumatoid Arthritis – of specified severity

Severe Rheumatoid Arthritis affecting 3 or more of the following joint areas: hands, wrists, elbows, neck, knees, ankles, and toes, to the extent that there is permanent and irreversible loss of the ability to fulfil at least 3 of the activities of daily living listed in the Loss of Independent Existence definition (see page 13).

37. 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.

For the above definition, the following are not covered:

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

38. Systemic Lupus Erythematosus – of specified severity

A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist where either of the following are also present:

- Severe kidney involvement with SLE as evidenced by:
  - Permanent impaired renal function with a glomerular filtration rate (GFR) below 30ml/min **and**
  - Abnormal urinalysis showing proteinuria or haematuria.

or

- Severe Central Nervous System involvement with SLE as evidenced by:
  - Permanent deficit of the neurological system as evidenced by at least any one of the following symptoms which must be present on clinical examination and expected to last for the remainder of the claimant's life – paralysis, localised weakness dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), difficulty in walking, lack of coordination, severe dementia where the Life Assured needs constant supervision or permanent coma.

For the purposes of this definition, seizures, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin will not be accepted as evidence of permanent deficit of the neurological system.

39. Third degree burns - covering 20% of the body's surface area, or 50% of the surface area of the face

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 or affecting at least 20% of the head and neck, or 50% of the face, which for the purposes of this definition, includes the forehead and ears.

40. Traumatic head injury - resulting in permanent symptoms

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.

For the purpose of the above definitions, 'Permanent Neurological Deficit with Persisting Clinical Symptoms' is defined as follows:

- 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 co-ordination, 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 or psychological or psychiatric origin.
- The policy definition of each Specified Illness where a Partial Payment will be made that is covered under the Plan
- A simple explanation of each illness
- Information on related conditions which, if present before joining the Plan, means the member is not covered for the Specified Illness if diagnosis occurs within the first 2 years of cover.

APPENDIX 2: Explanation of each Partial Payment Specified Illness and its pre-existing conditions

This section outlines:

1. Brain abscess drained via craniotomy

The undergoing of 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.

2. Carcinoma in Situ – oesophagus, treated by specific surgery

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.

Treatment by any other method is specifically excluded.

3. Carotid Artery Stenosis – treated by endarterectomy or angioplasty

The undergoing of 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.

4. Cerebral arteriovenous malformation - treated by craniotomy or endovascular repair

The undergoing of surgical treatment via:

- Craniotomy (surgical opening of the skull) by a Consultant Neurosurgeon of a cerebral AV fistula or malformation or
- The undergoing of endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or malformation.

Intracranial aneurysm is specifically excluded.

5. Coronary Angioplasty – to correct narrowing or blockage to 2 or more coronary arteries

The undergoing of balloon angioplasty, atherectomy, rotablation, laser treatment or stent insertion on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of two or more main coronary arteries.

For the purposes of this definition the main coronary arteries are defined as:

- Right coronary artery
- Left main stem
- Left anterior descending
- Circumflex

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.

The following are not covered:

- Two or more procedures in the same artery
- Procedures to any branches of the main coronary arteries

6. Ductal carcinoma in situ – breast, treated by surgery

A definite diagnosis of a ductal carcinoma in situ (DCIS) 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.

Prophylactic mastectomy at the request of the life assured, where no DCIS is found to be present, is specifically excluded.

7. Low level prostate cancer with Gleason score between 2 and 6 – and with specific treatment

A definite diagnosis of prostate cancer which has been histologically classified as having a Gleason score between 2 and 6 inclusive, 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.

Treatment with cryotherapy, transurethral resection of the prostate, 'experimental' treatments or hormone therapy, are all specifically excluded.

8. Serious Accident Cover

A serious accident means an 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.

For the purposes of this definition a Serious Accident means injury resulting solely and directly from unforeseen, external, violent and visible means, and independent of any other cause.

A Life Assured may only claim once under this cover.

An accident as a result of any of the following is specifically excluded under this cover:

Armed forces, hazardous pursuits, drug and alcohol, and self inflicted injury.

9. Surgical removal of one eye

Surgical removal of a complete eyeball for disease or trauma.

10. Third Degree Burns covering 5% to 19% of the body's surface area or 25% to 49% of the face's surface area

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 affecting between 5% and 20% of the head and neck, or between 25% and 50% of the surface area of the face, which for the purpose of this definition, includes the forehead and the ears.

Notes

Notes

GRA Specified Illness Cover Plan

This booklet outlines the main benefits of the GRA Specified Illness Cover Plan from 1st October 2017. It is issued subject to the provisions of the policy and does not create or confer any legal rights.

The information contained herein is based upon our current understanding of Revenue law and practice as at September 2017. The GRA Specified Illness Cover Plan is governed by the master Policy Document No. 706393 issued by Friends First. Members of the Plan may request a copy of the policy document from the Head Office of the GRA or the Dublin office of Cornmarket Group Financial Services Ltd.

If there is any conflict between this document and the Policy document, the Policy document will prevail.

Cornmarket is committed to providing a high level of service and has a complaint handling procedure in place. If you feel that you have not received a satisfactory level of service, please write in the first instance to the Compliance Department, Cornmarket Group Financial Services Ltd, Christchurch Square, Dublin 8.

If you are dissatisfied with the outcome of your complaint through Cornmarket, you may also contact the Financial Services Ombudsman's Office at financialombudsman.ie.

We're here to help you

To speak to a member of our team about a query or a claim:

Phone: **(01) 200 0100**

Email: **gra.spsadmin@cornmarket.ie**

Christchurch Square, Dublin 8 Tel: (01) 200 0100 Web: cornmarket.ie

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