SIPTU Nurses and Midwives Salary Protection Scheme

Cornmarket

SIPTU

Contents

This book is split into the following sections:

Important: You must remain a member of the SIPTU Nursing and Midwives Sector or the SIPTU National Ambulance Service Sector Grades to remain an eligible member of the Scheme. If you leave SIPTU you must inform Cornmarket in writing, as you can no longer stay in the Scheme and you will not be able to claim.

Disclaimers

This book is intended as a guide only. The Scheme is governed by the master Policy Document No. V000059E issued by New Ireland Assurance. Members of the Scheme may request a copy of the policy document from the Scheme owners or the Dublin office of Cornmarket Group Financial Services Ltd.

This book is issued subject to the provisions of the policy and does not create or confer any legal rights. The information contained herein is based on our current understanding of Revenue law and practice as of October 2018.

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

No part of this book should be read in isolation.

Please save a copy of this book for future reference.

Information in this book is correct as of October 2018 but may change. For the latest information, please see cornmarket.ie.

Where we say 'Insurer' in this book, we mean New Ireland.

Where we say 'we' or 'us' we mean Cornmarket.

1. Introduction

Overview of Key Benefits

1	**Disability Benefit**	A replacement income of up to **75%* of your annual salary** if you can't work due to illness or injury
2	**Death Benefit**	A Death Benefit of **twice your annual salary**. Also: • Accidental Death Benefit – **€15,000** • Children's Death Benefit – **€4,000** • Terminal Illness Benefit – **25% of Death Benefit**
3	**Spouses'/Civil Partners' Death Benefit or Single Members' Specified Illness Benefit**	In the event of your spouse or civil partner's death, **100% of the members' annual salary** will be paid to the member **or** A lump sum of **25% of salary** is payable if a single member suffers any of the 37 Specified Illnesses covered.**

*Less any other income that you may be entitled to e.g. half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration (previously known as Pension Rate of Pay), State Illness or Invalidly Benefit.
**Please see the Appendices from page 40 to 62 for full details, in particular the policy definition of each Specified Illness and its pre-existing and related conditions.

The Scheme in Action*

The true value of the Scheme can be seen in the **vital benefits** that it pays out to members and their families.

€5.1 million
Paid in Disability Benefit to date

€1.1 million
Paid in Disability Benefit since the 2013 review

960
Members currently in the Scheme†

€777,000
Paid in Death Benefit to date

€558,000
Currently paid annually in Disability Benefit to 35 members

€334,000
Paid in member's Death Benefit since the 2013 review

*Source: New Ireland & Irish Life, April 2018.
† Membership: Cornmarket, April 2018.

Eligibility

You may apply to join this Scheme if you are:

1) A member of the SIPTU Nursing and Midwives Sector or a member of the SIPTU National Ambulance Service Sector Grades.

   You must remain a member of the SIPTU Nursing and Midwives Sector or the SIPTU National Ambulance Service Sector Grades to remain an eligible member of the Scheme **and**

2) Under age 60 **and**

3) Employed as a Nurse or Midwife **or** Employed as part of the SIPTU National Ambulance Service Sector Grades **and**

4) Working 8 hours or more per week **and**

5) Employed under at least one of the following conditions:
   - On a permanent basis **or**
   - On a fixed-term contract of at least 12 months duration **or**
   - Working continuously for the past 12 months **or**
   - Working as an agency Nurse/ Midwife for 2 or more years **and**

6) Actively at work today.*

*Actively at work today
This means you:
- Are working your normal contracted hours
- Have not received medical advice to refrain from work
- Are not restricted from fully performing the normal duties associated with your occupation

You are considered to be 'actively at work' if you are on paid or unpaid maternity leave.

You are not considered to be 'actively at work' if you are on Career Break or any other forms of unpaid leave and cannot apply to join the Scheme.

Those who are job/work sharers (i.e. work 50% or less than the normal working week) and who satisfy the above criteria may apply to join.

Important: For Members of the SIPTU National Ambulance Service Sector Grades.

Membership of the Scheme is available to members of the SIPTU National Ambulance Service Sector Grades as a pilot programme for 12 months from the 1st October 2018. This arrangement will be reviewed on the 1st of October 2019 and may be reviewed annually thereafter. At a review it may be decided to remove this option for future new entrants. In the event that this occurs, any members accepted for benefits before the removal of this option will continue to have cover, provided they continue to satisfy the eligibility conditions. In addition, any member who is already receiving Disability Benefit will continue to receive that benefit under the terms of the Scheme.

Apply to join now, simply call us on **(01) 470 8054**

Roles

Cornmarket's role includes:

1. Negotiating with the Insurers to obtain the best possible benefits and cost.
2. Assisting members who wish to make a claim from the Scheme. Please see page 26 for more information.
3. Promoting the Scheme.

The Insurer's role includes:

1. Deciding the policy terms and conditions and creating a policy document to reflect these.
2. Medically assessing applications and claims. Please see page 26 for more information.
3. Deciding the various aspects of an individual member's cover e.g. if membership of the Scheme can be reactivated, if refunds can be made and if arrears and/or a declaration of health are required.

2. Benefits
i) Disability Benefit

In the event that your salary* is affected because you are unable to work due to illness or injury, this benefit aims to pay you an income of up to 75% of salary after a certain period of time.

The Disability Benefit paid is less any other income, reward, award, pension, or benefit that you are entitled to (regardless of whether you are receiving this amount or not). For example:

- Temporary Rehabilitation Remuneration (TRR) - May be paid by an employer to an employee subject to certain criteria.
- State Illness Benefit/State Invalidity Pension - Those paying PRSI at the 'A' rate may be entitled to this benefit from the State.
- Ill Health Early Retirement Pension (IHERP) - Those who retire on the grounds of ill health may be entitled to this from their employer.

This applies regardless of whether you are a 'D' or 'A' PRSI contributor and whether you contribute to the Superannuation Scheme or not.

There is no limit on the number of Disability Benefit claims you can make while a member of the Scheme.

*See page 12 for definition of Salary.

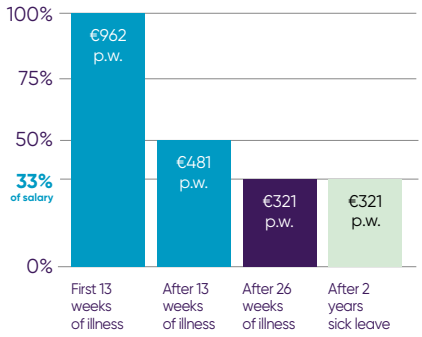
Example of how the Scheme works

This example is based on a Public Sector employee, who is a member of the Superannuation Scheme with 20 years' service earning €50,000 per annum, who is now unable to work due to illness or disability.

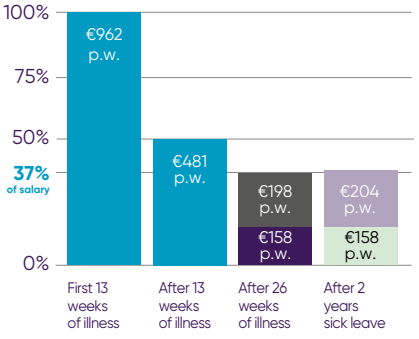
It is assumed that standard Public Sector sick leave arrangements apply, extended paid sick leave under the Critical Illness Protocol does not apply and Ill Health Early Retirement Pension is granted after 2 years.

WITHOUT Salary Protection

D Rate PRSI Example



A Rate PRSI Example



Sick Pay

Temporary Rehabilitation Remuneration

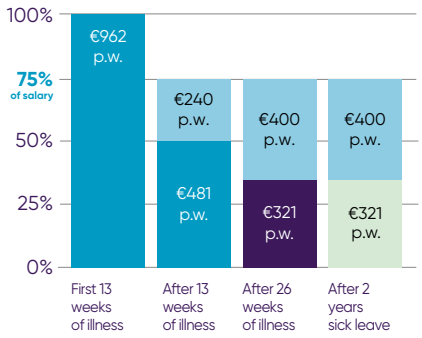
Ill Health Early Retirement Pension

State Illness Benefit

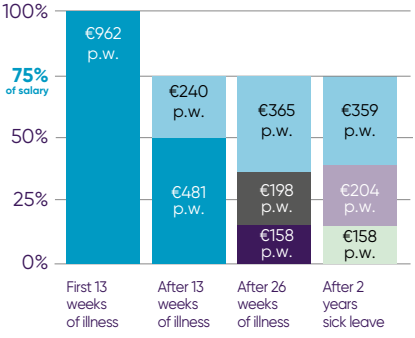
State Invalidity Pension

WITH Salary Protection

D Rate PRSI Example



A Rate PRSI Example



Scheme Benefit | Sick Pay | Temporary Rehabilitation Remuneration | Ill Health Early Retirement Pension | State Illness Benefit | State Invalidity Pension

Staff recruited to the Public Service on or after 6th April 1995 pay class A PRSI. Their Superannuation Scheme pension is integrated to take account of the value of the Contributory State Pension in calculating the pension payable. In the event of illness, they may typically claim State Illness Benefit.

Deferred Period

After you are accepted as a member of the Scheme, if you need to make a claim the Deferred Period is the waiting period before the Disability Benefit becomes payable.

For the purpose of this Scheme the Deferred Period is either:

- **13 weeks (92 days)** disability in a rolling 12 month period or 26 weeks (183 days) in a rolling 4 year period, where standard sick leave has been granted **or**
- **26 weeks (183 days)** disability in a 12 month period or 52 weeks (365 days) in a rolling 4 year period, where extended paid sick leave has been granted - referred to as Critical Illness Protocol.

If you have been accepted with an excluded condition, any sick leave relating to that condition will not be taken into account for the calculation of the Deferred Period.

Definition of Salary

For those who pay their premiums through **their salary**, salary is defined as:

(i) **For members of a Superannuation Scheme:** Gross basic annual salary at the end of the relevant Deferred Period, plus the average of any allowances received in the preceding 3 years, which are taken into account for sick pay and/or for the purposes of that Superannuation Scheme* **or**

(ii) **For those who are not members of a Superannuation Scheme:** Gross basic annual salary at the end of the relevant Deferred Period, plus the average of any allowances received in the preceding 3 years; which would be taken into account for sick pay and for the purposes of a Superannuation Scheme.*

For those who pay their premiums **by direct debit**, salary is defined as:

The lower of either the salary covered by your premiums or the actual salary you are earning at the end of the relevant Deferred Period, as confirmed by your employer. You must advise Cornmarket of any salary changes so that we can adjust your premium accordingly. This is to ensure that your cover is provided in line with your current gross annual salary and that you are paying the correct premium amounts.

For agency nurses/midwives joining the Scheme, your salary is based on self-declared earnings. Declared salary should be the average of the previous 2 years' earnings.

Periodically, you may review your declared earnings subject to proof of actual earnings e.g payslip or P60.

You must advise Cornmarket of any salary changes so that we can adjust your premium accordingly. This is to ensure that your cover is provided in line with your current gross salary and that you are paying the correct premium amounts.

*Depending on the type of claim being made, the salary will be established at different points in time e.g.

- Disability Benefit - the end of the relevant Deferred Period
- Death Benefit - on the date of death
- Specified Illness Benefit - on the date of diagnosis.

Disability Benefit Exclusions

There are no general exclusions on Disability Benefit.

However, when you apply to join the Scheme, the Insurer may offer you cover with some exclusions that apply specifically to you. For example, if you inform the Insurer that you have a back problem on your application form, they may offer you membership of the Scheme with a back exclusion. This means that you would never be able to claim for an illness or injury relating to your back.

If this happens, a form will be sent to you as part of the application process with the details of the exclusion(s) and you will have the opportunity to decide if you wish to accept the cover with the exclusion(s) or not. If an exclusion(s) applies to you, then sick leave used for the excluded condition(s) cannot be taken into account for the calculation of the Deferred Period.

Disability Benefit Limitations and Restrictions

Definition of Disability

In order for a claim to be paid, the Insurer must be satisfied that you are totally disabled. This means that you are totally unable to carry out the duties of your normal occupation because of illness or injury and that you are not engaged in any other occupation (whether or not for profit, reward, remuneration or benefit-in-kind).

Definition of Partial Disability

Following the payment of a disability claim, if:

- you return to work with the consent of the Insurer (either to your normal job or to a new job) **and**
- you are partially disabled due to illness or injury, the Insurer may continue to pay a partial disability claim if:
  - your monthly earnings are reduced due to the partial disability **and**
  - you are earning less than the average monthly earnings that you had in the 12 months immediately before your period of disability.

Important:

Late Notification of Claims: It is not often possible to retrospectively assess the validity of a claim in cases where a significant period of time (approx. 3 months) has elapsed after the end of the Deferred Period. For this reason, it is vital that you register your claim promptly in line with the guidelines given (the earlier of: 1 month after commencement of disability **or** 10-12 weeks before the end of the Deferred Period. 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.

Disability Benefit will not be paid if you cannot work due to strike or unemployment. The maximum benefit is €150,000 per year.

Any sick leave used before you are accepted as a Scheme member will not be used in the calculation of the Deferred Period.

If you have been accepted with an excluded condition, any sick leave relating to that condition, will not be taken into account for the calculation of the Deferred Period.

If your claim is admitted...

- 75% of salary will be paid for maximum of two years only. After this a pension amount will be deducted from the benefit regardless of whether or not you are in receipt of same. This is referred to as Notional Early Retirement Pension (NERP)
- the benefit you receive from the Insurer will be treated as income and as such is liable to income tax, PRSI, Universal Social Charge, etc. The Insurer will deduct any tax due from the Benefit made to the member, in the same way as an employer deducts tax from an employee.

If your claim is admitted, Disability Benefit will continue until:

- You recover
- You resign
- You go back to work (benefit may continue to be paid if the return is at a reduced level due to partial disability)
- the Insurer decides that you are fit to return to work based on medical evidence*
- You reside outside of Ireland for more than 12 calendar months (unless agreed otherwise with the Insurer in advance)
- You reach age 60
- You retire (unless you are claiming from the Scheme and retire on an Ill Health Early Retirement Pension)
- You die

whichever is earliest.

*If you have been in continuous receipt of Disability Benefit for more than 12 months, 3 months notice will be given before your Disability Benefit is ended.

ii) Death Benefit

In the event of your death, a once-off lump sum will be paid to your estate. For most members the amount paid will be **twice their gross annual salary***.

However, for some members who availed of the option to increase their Death Benefit, this will be 3 or 4 times their gross annual salary*.

If a Death Benefit claim is admitted, the benefit will be paid by the Insurer tax free. However, thereafter, beneficiaries of the estate will be subject to whatever taxes apply at the time of the inheritance and it will be their responsibility to ensure they are meeting their full tax liability.

Limitations and Restrictions

This Benefit ceases at age 65.

As this is a Group Scheme you cannot assign the Death Benefit against a mortgage.

Terminal Illness Benefit

In the event that you are certified by a medical specialist** with a terminal illness, with death expected within 12 months, and the Insurer accepts this; the Scheme will pay 25% of the Death Benefit to you tax-free.

**The specialist must be a medical specialist of a major hospital in Ireland or the United Kingdom.

Terminal Illness Benefit - Exclusions

There are no general exclusions on the Terminal Illness Benefit.

Terminal Illness Benefit - Limitations and Restrictions

This benefit ceases at age 63.

Life expectancy must be no greater than 12 months.

*See page 12 for definition of Salary.

Accidental Death Benefit

In the event of accidental death, a benefit of €15,000 is payable tax-free in addition to the normal Death Benefit. 'Accidental Death' is defined as 'death as a direct result of a bodily injury arising from an external and accidental cause' and is in no way linked to disease or physical disorder.

Accidental Death Benefit - Exclusions

Exclusions apply where death is caused directly or indirectly by:

1. Suicide, attempted suicide or intentional self inflicted injury
2. Death linked to alcohol or drugs (temporarily or otherwise)
3. Engaging in any hazardous activity or sports, including but not limited to:
   - scuba diving & water sports
   - motor sports
   - aviation
   - hang gliding & parachuting
   - horse racing
   - mountaineering, rock climbing & caving
   - winter/ice sports
4. Flying other than a fare paying passenger
5. Taking part in any riot, civil commotion, uprising or war whether declared or not
6. Failure to follow reasonable medical advice or failure to follow medically recommended therapies, treatment or surgery
7. Directly or indirectly by taking part in a criminal act.

Accidental Death Benefit - Restrictions and Limitations

This benefit ceases at age 65.

Children's Death Benefit

In the event that a member's child between the ages of 0-18 or 18-21 (if in full-time education) dies, a death benefit of €4,000 will be paid to the member tax-free. Children's Death Benefit applies to all natural or adopted children.

Children's Death Benefit - Exclusions

This benefit can only be claimed by the Scheme member. This means that the Scheme member's estate cannot claim it in the event that the Scheme member has died.

This benefit is payable once per member.

Children's Death Benefit - Restrictions and Limitations

This benefit ceases at age 18, or 21 if the child is in full-time education.

iii) Spouses'/Civil Partners' Death Benefit OR Single Members' Specified Illness Benefit

In addition to Disability Benefit and Death Benefit, the Scheme includes an additional valuable benefit for members in the form of **either**:

A. Spouses'/Civil Partners' Death Benefit **or**

B. Single Members' Specified Illness Benefit

Members can only ever benefit from either option A or B. The benefit is only payable once per member. Please see below for further information on each of these benefits and the terms and conditions that apply.

A. Spouses'/Civil Partners' Death Benefit

In the event of the death of a member's Spouse or Civil Partner, a lump sum of 100% of the member's annual salary* will be paid to the member.

Limitations and Restrictions

This benefit only applies if you are legally married or civil partnered at the date of their death, as defined in the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010. You can only claim from either the Specified Illness Benefit or the Spouses'/Civil Partners' Death Benefit; you cannot claim from both.

This benefit ceases on either:

- The members 65th birthday **or**
- The members spouse or civil partner's 65th birthday

whichever is earlier.

*Please refer to page 12 for definition of Salary.

B. Single Members' Specified Illness Benefit

Full Benefit

If you are diagnosed with one of the illnesses listed below, are single at the date of diagnosis and meet the definition/criteria of that illness (see Appendices from page 40-62), this benefit will pay a once-off, tax-free lump sum of **25% of your annual salary*** at the date of diagnosis.

Please note: The Specified Illnesses marked ❖ below, were introduced at the 1st June 2013 review. The other Specified Illnesses were introduced from 1st April 2007. Only diagnoses that occur after these dates are eligible to claim Specified Illness Benefit for these illnesses. If, prior to joining the Scheme, you have suffered from one of the Specified Illnesses you will never be covered for that illness.

- Alzheimer's Disease
- Aorta Graft Surgery
- Aplastic Anaemia ❖
- Bacterial Meningitis ❖
- Balloon Valvuloplasty ❖
- Benign Brain Tumour
- Benign Spinal Cord Tumour ❖
- Blindness
- Cancer
- Cardiomyopathy ❖
- Chronic Lung Disease
- Coma
- Coronary Artery By-Pass Graft
- Creutzfeldt-Jakob Disease
- Deafness ❖
- Dementia
- Encephalitis ❖
- Heart Attack
- Heart Structural Repair
- Heart Valve Replacement or Repair
- HIV Infection
- Kidney Failure
- Liver Failure ❖
- Loss of Hands or Feet
- Loss of Speech
- Major Organ Transplant
- Motor Neurone Disease
- Multiple Sclerosis
- Paralysis of 2 or more Limbs
- Parkinson's Disease (Idiopathic)
- Primary Pulmonary Hypertension ❖
- Progressive Supra-Nuclear Palsy ❖
- Pulmonary Artery Graft Surgery ❖
- Stroke ❖
- Systemic Lupus Erythematosus
- Third Degree Burns covering 20% of the body's surface area
- Traumatic Head Injury

*See page 12 for definition of Salary.

Partial Benefit

If you are diagnosed with one of the illnesses listed below, are single at the date of diagnosis and meet the definition/criteria of that illness (see Appendices from page 40-62), this benefit will pay a once-off, tax-free lump sum of the lesser of **€10,000 or 25% of your salary*** at the date of diagnosis.

Please note: The qualifying Specified Illnesses – Partial Payments below were introduced at the 1st June 2013 review. If, prior to joining the Scheme, you have suffered from one of the Specified Illnesses you will never be covered for that illness.

- Angioplasty for coronary artery disease – of specified severity
- Brain abscess drained via craniotomy
- Carcinoma in situ – oesophagus, treated by specific surgery
- Carotid artery stenosis – treated by endarterectomy or angioplasty
- Cerebral arteriovenous malformation – treated by craniotomy or endovascular repair
- Ductal carcinoma in situ – breast, treated by surgery
- Loss of one limb – permanent physical severance
- Low level prostate cancer with Gleason score between 2 and 6 – and with specific treatment
- Third degree burns – covering at least 5% of the body's surface area
- Surgical removal of one eye

*See page 12 for definition of Salary.

Single Members' Specified Illness Benefit

Exclusions

Specified Illness Benefit and Partial Specified Illness Benefit Claims will not be paid, if:

a) You are residing outside the following list of places for 13 or more weeks consecutively, 12 months prior to a Specified Illness Claim being made.*

- European Union (since 1st January 2013)
- Australia
- Canada
- New Zealand
- Norway
- Switzerland
- U.S.A.

b) If prior to your Specified Illness Benefit cover commencing you suffered from a condition related to one of the Specified Illnesses and you contract that particular illness within 2 years of joining the Scheme, you will not be covered. For example, a claim will not be paid for a 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 a heart attack. However, a diabetic who first suffers a heart attack 3 years after joining the Scheme will be eligible to claim.

c) If you suffered from one of the Specified Illnesses before your cover commenced, you will never be covered for that illness and cannot claim for that illness or a related Specified Illness. Due to the links between heart attack, coronary artery by-pass surgery, heart transplant, angioplasty and stroke, if you have suffered from or undergone surgery for one of these conditions before joining the Scheme you cannot claim under the policy in respect of any of the four 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.

d) No cancer claims will be paid where the condition presents within the first 6 months of a member joining the Scheme. In such circumstances cover in respect of cancer ceases.

The related Specified Illnesses and pre-existing conditions set out in Appendix 1 and 2 are examples which can result in a Specified Illness diagnosis. This is not an exhaustive list and New Ireland's Chief Medical Officer can look at other pre-existing conditions which may have caused a Specified Illness.

* Unless you have been on Career Break, prior agreement was received from the Insurer and the relevant premium was paid.

Single Members' Specified Illness Benefit

Limitations and Restrictions

You must be single i.e. not married or in a Civil Partnership at the date of diagnosis in order to be eligible for either the Full or Partial Single Members Specified Illness Benefit.

Specified Illness Benefit became a benefit of the Scheme on 1st April 2007. The Specified Illnesses marked ❖ on page 19, were introduced on 1st June 2013. The other Specified Illnesses were introduced on 1st April 2007. You can only claim for diagnoses that occur after these dates.

- Partial Payment Specified Illness Benefit became a benefit of the Scheme on 1st June 2013. Therefore, you can only claim for diagnosis that occur after this date.
- If you make a Full Specified Illness Claim, you will not be able to make a further Full or Partial Specified Illness Claim. If you make a Partial Specified Illness Claim, you will still be able to make a Full Specified Illness Claim.
- If you are diagnosed with one of the Full Specified Illnesses within 30 days of diagnosis of a Partial Specified Illness, a claim will be assessed on the Full Specified Illness only.
- A Specified Illness Claim will only be paid if the diagnosis/severity meets the specific definition/ criteria outlined for that illness in the Appendices on pages 40-62.
- You will not be able to make a Specified Illness Claim for an illness that:
  - You suffered from prior to joining the Scheme
  - Relates to a condition which you were already suffering from at the time of your application and/or where you were under medical investigation, regardless of whether you were aware of the condition at that time
  - Relates to a condition which you were already suffering from before the date that Specified Illness was introduced to the Scheme
- There is a waiting (deferred) period for some Specified Illnesses. Please see Appendices on pages 40-62 for more details.
- **Late notification clause:** You must make a Specified Illness Claim within 3 months of being diagnosed. Failure to make a claim within this time period may result in the Insurer declining to assess your claim.

- There is a survival period for some Specified Illnesses. You must survive for a minimum period after the date of diagnosis or surgery took place, before a payment can be made. In the event of death within this period no Specified Illness Benefit is payable. The relevant periods are:

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

  (b) 6 months for Parkinson's disease, Alzheimer's disease and loss of sight.

  (c) 12 months for loss of hearing and loss of speech.

Please see Appendices on pages 40-62 for more details.

The benefit ceases at age 65.

Definition of Salary for Specified Illness Benefit

Please refer to page 12 for definition of Salary.

3. Cost

The total Scheme premium is 2.50% of gross salary. This includes the 1% insurance levy.

Scheme cost

The breakdown of this premium is:

Disability Benefit	2.06%
Death Benefit	0.25%
Spouses' /Civil Partners Death Benefit or Single Members' Specified Illness Benefit	0.14%
Medical Immunity for Retired Members' Life Cover Plan*	0.05%
Total Cost	**2.50%**

*Allows members to join Cornmarket's Retired Members' Life Cover Plan, without medical underwriting. Terms & Conditions apply.

Warning: The current premium may increase after the next Scheme review which will take place on/after 1st June 2021.

Income Tax Relief

The portion of your Scheme premium that is paid towards Disability Benefit is eligible for Income Tax Relief.

Below are some examples of cost for various salary amounts taking income tax relief into account:

Income	Weekly premium	'Real' weekly premium after tax relief
€35,000	€16.77	€14.00*
€45,000	€21.56	€14.45**
€55,000	€26.35	€17.67**

*If you are paying income tax at 20% your net premium rate will be 2.09%
**If you are paying income tax at 40% your net premium rate will be 1.68%.

Cornmarket's Retired Members' Life Cover Plan Medical Immunity*

0.05% of your overall premium entitles you to join Cornmarket's Retired Members' Life Cover Plan when you retire, without any medical underwriting, once you apply to join within a certain time period of retiring.

For more details on this Plan, please contact us on **(01) 470 8054** or email **clientservices@cornmarket.ie**

*Cornmarket Retired Members' Life Cover Plan underwritten by Irish Life. Irish Life Assurance plc is regulated by the Central Bank of Ireland.

Payment Methods

Your premiums may be paid via deduction at source from salary or direct debit.

If you pay your premiums through salary

The premium will be split under two headings on your payslip. One heading reflects the Disability Benefit portion of your premium and automatically receives income tax relief, the other heading reflects the premium for the remaining benefits and does not receive income tax relief. You are eligible for income tax relief at your highest rate of income tax on the Disability Benefit premium.

Your premiums will increase and decrease in line with your salary changes and as a result, the salary covered by the Scheme will be your salary as confirmed by your employer on the last day of your Deferred Period. You must ensure that the premiums deducted from your salary are correct and reflect your salary.

If you pay your premium by direct debit

- You will need to send a Premium Statement to Revenue in order to claim income tax relief. If, throughout the course of your membership of the Scheme, your premium amount changes, you should request an up-to-date Premium Statement from Cornmarket to send to Revenue so that Revenue can amend your income tax relief accordingly.
- Your premiums will reflect the last gross salary you notified to Cornmarket or the last gross salary that we estimated for you at the last Scheme review. As a result, the salary covered by the Scheme will be based on either the salary covered by your premiums or the actual salary you are earning at the end of the Deferred Period as confirmed by your employer, whichever is lower. The onus is on you to ensure you advise Cornmarket of any salary changes so that we can adjust your premium accordingly so that your cover is provided in line with your current gross salary and you are paying the correct premium amounts
- You may incur charges from your bank.

Remember...

As this is an insurance policy, you must pay your premiums in order to stay on cover. Failure to pay premiums, could result in your membership of the Scheme being lapsed. This means you will no longer be a member of the Scheme and you will not be on cover for any benefits. In the event that you wish to become a member of the Scheme again, you would have to apply to be a member and be medically underwritten. Your application may be accepted, declined, postponed or accepted with exclusions.

4. Claims Roles

Cornmarket's Role

Cornmarket's role is to help guide members through the claims process. Cornmarket has considerable experience in this area and works closely with the claimant, Insurer and third parties to help get claims processed as efficiently as possible. Cornmarket has its own dedicated, in-house Claims Administration Team. The team members will do all they can to help in a member's time of need. If you need to make a claim, it will be dealt with in a professional and sensitive manner.

Our contact details for making a claim are:

Phone: **(01) 408 4018**
In the interest of Customer Service we may record and monitor calls.

Email: **spsclaims@cornmarket.ie**

Post: **SPS Claims Department, Cornmarket Group Financial Service Ltd, Christchurch Sq., Dublin 8**

Our offices are open Monday-Friday 9:00-17:30.

The Insurer's Role

The Insurer's role is to medically assess claims and decide whether or not claims should be paid. If they decide that a claim is payable, they will calculate and pay the benefit.

Disability and Specified Illness Benefit Claims

How to make a Disability or Specified Illness Benefit claim

Disability

Contact Cornmarket as soon as you think that your salary may reduce to half pay or cease altogether due to illness or injury because:

(i) Disability Benefit claims take approximately three months to process from the date your completed claim form is received. The exact length of time it will take to process a claim is dependent upon how long it takes for the Insurer to get data from third parties such as G.P.s, specialists, unions/associations and employers. With that information they must be satisfied that:

- A member is a valid member of the Scheme **and**
- A member is or was medically incapable of working for the period being claimed for **and**
- They are paying the correct benefit amount.

(ii) It is often not possible for the Insurer to retrospectively assess the medical validity of a claim. If they cannot medically assess a claim, the Insurer reserves the right to decline to assess the claim. See Late Notification clause on page 14.

Specified Illness

Contact Cornmarket as soon as possible, as it may take a number of weeks to process the claim. See Late Notification clause on page 23.

It is not often possible for the Insurer to retrospectively assess the medical validity of a claim. If they cannot medically assess a claim, the Insurer reserves the right to decline to assess the claim.

Can I nominate someone to contact Cornmarket on my behalf in relation to a Disability or Specified Illness Benefit claim?

You can nominate someone to contact Cornmarket on your behalf and to assist you with your claim, for example, a spouse, next of kin etc. If you wish to do so, please send us 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 act in this capacity, they will have access to the information related to your claim such as your medical, salary and financial details. However, they will not have the authority to make any changes, for example, to cancel your membership of the Scheme.

What will happen after I initially contact Cornmarket to make a Disability or Specified Illness Benefit claim?

Following an initial phone call, if appropriate, we will send you a claim form, information about the Scheme and details of the documentation you will need to provide.

You should return the forms and documentation to Cornmarket as soon as possible and we will send these to the Insurer. The Insurer will then start medically assessing your claim.

Are all Disability and Specified Illness Benefit claims medically assessed?

All claims will be medically assessed by the Insurer. If you have been granted Ill Health Early Retirement by your employer, this does not mean that you will be automatically entitled to Disability Benefit from the Scheme.

As part of their assessment, the Insurer may require you to:

1. provide medical evidence from your Doctor (your Doctor may charge you for this)
2. provide medical evidence from your Specialists
3. complete a Tele-claims Interview with a nurse
4. attend an Independent Medical Examination (IME) and/or the Insurer's Occupational Health and Safety Advisor to confirm that you meet the definition of disability. It generally takes about 3 weeks for the IME report to be returned to the Insurer.

Items 2, 3 and 4 are at the Insurer's expense and reasonable travel expenses will be covered, if travel is necessary.

We will liaise with your employer, the Insurer and you throughout the assessment.

What happens after my Disability Benefit claim is assessed?

Following the assessment, the Insurer will make a decision on your claim. Claims can be admitted or declined.

What will happen if my Disability Benefit claim is admitted?

- If your claim is admitted, and you have completed the relevant deferred period, the Insurer will arrange for benefit to be paid to your bank account. Disability Benefit will be paid in arrears and may be paid on a monthly basis. Therefore, it may take up to four weeks after your claim is admitted to receive your first benefit.
- If your claim is admitted after you have been reduced to half-pay or your pay has ceased altogether, the benefit may be backdated to the date when salary was first affected.
- As a benefit is subject to income tax, you can request the Revenue Commissioner to issue a Certificate of Tax to the Insurer. This will enable the Insurer to apply the correct tax rate for future benefits. However, the first benefit may have emergency tax rates applied. Any overpayment or underpayment of tax may be subsequently rectified.

- In order to ensure you continue to meet the definition of disablement, the Insurer may seek completed continuation forms, certificate of continued disablement, medical certificates from your Doctor, and/or require you to attend an independent medical examination and/or organise for a Health Claims Advisor to visit you. Claims in payment for greater than 10 years, will not be subject to ongoing medical assessments.
- In the event that you fail to follow medical advice, the Insurer may cease paying you benefits.
- You will not be expected to pay premiums towards the Scheme while claiming. However, if your benefit stops for some reason other than reaching the ceasing date of the benefit, you will be expected to start paying premiums again in order to maintain your cover. If you continue to receive Disability Benefit up to the ceasing age of the benefit, you can continue to avail of the other Scheme benefits without having to pay premiums for them up until the ceasing age of those benefits.
- While claiming Disability Benefit, any Death Benefit or Specified Illness Benefit that you have as a Scheme member remains in force until the ceasing date of those benefits. In the event that you will need to claim from these, the benefits will be based on the salary you were earning at the time your Disability Benefit commenced.
- The benefit paid to you by the Scheme increases by 1.5% each year, or the rate of increase in the Consumer Price Index (if lower). However, if the claim commenced before 1st June 2018, the benefit will continue to increase by 5% each year, or the rate of increase in the Consumer Price Index (if lower).
- If you plan to return to work or take up other paid work, you must inform the Insurer immediately.

What will happen if my Disability Benefit claim is declined?

- If your claim is declined, the Insurer will inform you of the reasons for the decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must do this within 3 months of the decline decision being made. The review of their decision may require you to attend further Independent Medical Examinations.
- If you do not appeal, premiums must continue or restart in order for you to remain a member of the Scheme.
- If your appeal with the Insurer is unsuccessful, you may bring your case to the Financial Services and Pensions Ombudsman.

What happens after my Specified Illness Benefit claim is assessed?

Following the assessment the Insurer will make a decision on your claim. Claims can be settled or declined.

Settled

- If your claim is settled, the Insurer will arrange for a payment to be sent to you.
- If you claimed from the Full Specified Illness Benefit, you will no longer be covered for Specified Illness Benefit and you will no longer be required to pay for it and we will reduce your premium accordingly. In the event that you pay your premiums by salary and your employer is unable to facilitate the reduced premium, you may need to switch to paying your premiums by direct debit.
- If you claimed from the Partial Specified Illness Benefit, you can still make a claim under the Full Specified Illness Benefit and so your premiums will not reduce.

Declined

- If your claim is declined, you will be informed of the reasons for that decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must do this within 18 months of the decline decision being made. The review of their decision may require you to attend further Independent Medical Examinations.
- If your appeal with the Insurer is unsuccessful, you may bring your case to the Financial Services and Pensions Ombudsman.

How does Ill Health Early Retirement Pension (IHERP) affect my Disability Benefit claim?

If you are making a claim and decide not to apply for IHERP, perhaps because you intend to return to work, and the Insurer agrees that there is a reasonable expectation for you to return to work, then the Insurer may pay a benefit of 75% of salary less any State Illness Benefit or Temporary Rehabilitation Remuneration for a maximum of 2 years. This means no deduction will be made from the Benefit for an amount equivalent to IHERP, as no IHERP is being claimed.

However, after 2 years a pension amount will be deducted from the benefit regardless of whether or not you are in receipt of same. This is referred to as Notional Early Retirement Pension (NERP).

If you retire subsequently and an IHERP is paid, the additional amount that was paid under the Scheme since the effective date of early retirement must naturally be repaid to the Insurer.

What if I am on a Fixed Term Contract and make a Disability Benefit claim?

If you are unable to work due to illness or injury and your contract ends before the expiry date of the Deferred Period, (13 weeks in any 12 month period), your claim will be considered subject to the usual medical evidence requirement. For example, if you suffer an illness with 3 months remaining on your contract and remain unable to work due to illness or injury to the end of the Deferred Period, your claim will be considered in the normal manner.

If my illness is due to an injury at work, how does this affect my Disability Benefit claim?

Please inform the Cornmarket Claims Administration team as soon as possible, if this applies to you.

If, as a result of your workplace injury, you are entitled to an additional payment, it may mean that your income remains higher than 75% of your salary and hence there will be no Disability Benefit payable from the Scheme.

What happens if I return to work after making a Disability Benefit claim?

If you return to your normal occupation at your normal hours, or to full salary (e.g. you take annual leave), you must ensure that premiums restart in order for you to remain a member of the Scheme.

If you return to your normal occupation at reduced hours, or to a different occupation at reduced pay, the Insurer may continue to pay you a benefit but at a proportionately reduced amount. This will be subject to medical evidence supporting the view that you are only partially fit for work.

If you return to work but have to stop working again due to illness or injury you may not have to complete the Deferred Period again. Please refer to the Deferred Period on page 12.

Tax Return Service for members making Disability Benefit Claims

Cornmarket's Tax Return Service is available to claimants who are in receipt of Disability Benefit for a continuous period of 3 months or more. Only claimants who submitted their claim after 1st June 2018 are eligible to avail of this service.

Cornmarket's Tax Return Service will prepare and file your tax return and act on your behalf with Revenue, to ensure that you do not pay any more tax than is necessary while you are receiving income from multiple sources. We will also reclaim any overpayments of tax which may have been made by you during the period of your claim. The service includes PAYE returns and up to two rental properties, where relevant. Additional properties or returns for non-PAYE income may attract extra charges, and/or may not be offered within this service.

For more information, please call **(01) 408 4106**

Cornmarket's Tax Return Service is not a regulated financial product. This service is provided by Cornmarket Retail Trading Ltd., a wholly-owned subsidiary of Cornmarket Group Financial Services Ltd. Telephone calls may be recorded for quality control and training purposes.

Death Benefit Claims

How to make a Death Benefit claim

Depending on the type of death claim being made, you or your Estate/Next of Kin/Solicitor should contact Cornmarket.

After initial contact is made, if appropriate, Cornmarket will advise of the documentation required to process the claim.

How long will it take to process a Death Benefit claim?

If your estate is being processed through the Probate Office, this may result in delays in the processing of the claim. These delays could take over 12 months. Once the Insurer receives all the required documentation and information and the Insurer decides to admit the claim, benefit is usually paid to the estate/ trustees within 10 working days.

5. Frequently Asked Questions

How can I apply to join the Scheme?

You can apply to join the Scheme:

(i) Over the phone - call **(01) 470 8054**

(ii) With your Cornmarket Consultant

(iii) By printing and completing an application form at **cornmarket.ie**.

To apply, you must complete an application form.

Applications may require underwriting (medical assessment) which may include providing medical information by telephone to a nurse or attending a medical examination at the Insurer's expense. Following the underwriting period, the Insurer may accept your application, postpone your application, decline your application or offer you membership of the Scheme with certain specified conditions excluded from cover.

During the application process it is important that you tell the Insurer all relevant medical information. This means information that the Insurer would regard as likely to influence the assessment and acceptance of your application. If you do not:

- your membership of the Scheme could be void; you will not be covered under the Scheme
- a claim will not be paid and the Insurer will not refund any premiums you have paid
- you may find it difficult to purchase another Life Insurance product.

What happens if my application is accepted?

Your cover begins from the date the Insurer accepts your application.

- You will be sent a formal acceptance letter.
- You will have 30 days after the date the acceptance letter is sent to you to cancel your membership of the Scheme and receive a full refund of any premiums paid.
- Premiums should start as soon as possible after you are accepted as a member.

What happens if my application is not accepted?

If your application is postponed, declined, or if you are offered acceptance with certain specified conditions excluded, you may request details for the reasons for the decision to be sent from the Insurer to your own doctor and you may appeal the decision.

What if I have unearned income?

In general, investment and rental income will not be taken into account when making a claim under the Scheme.

What if I plan to take a Career Break or take Unpaid Leave?

If you plan to take a Career Break or Unpaid Leave please contact us to discuss the options that may be available to you by calling **(01) 408 4195** or emailing **spsadmin@cornmarket.ie**.

If you wish to avail of the Career Break options, you must apply within 4 months of taking a Career Break. Otherwise your membership of the Scheme will cease. You must remain a member of the SIPTU Nursing and Midwives Sector or the SIPTU National Ambulance Service Sector Grades union for the duration of your Career Break.

If you wish to avail of the Unpaid Leave options you must notify us at least 4 weeks in advance of the commencement of unpaid leave.

Additionally, if you plan to do any of the following, please contact us in advance in order to ensure your membership of the Scheme does not lapse, and so that we can offer you any cost and/or benefit options which may be applicable:

- Acquire a second job
- Go on Secondment
- Change role/job
- Change terms of employment
- Start Job sharing/work sharing (i.e. work 50% or less of the normal working week).

What if I am placed on administration/special/gardening leave?

Please contact us on **(01) 408 4195** as soon as possible.

When does membership of the Scheme cease?

- Your 60th birthday for the Disability Benefit
- Your 63rd birthday for Terminal Illness Benefit
- Your 65th birthday for the Death Benefit and Spouses'/Civil Partners' Death Benefit or Single Members' Specified Illness Benefit.

Cover for all benefits ceases in the following situations:

- If you retire (other than on grounds of ill health) **or**
- If you resign **or**
- If you no longer fulfil the eligibility requirements **or**
- If you leave the SIPTU Nursing and Midwives Sector or the SIPTU National Ambulance Service Sector Grades **or**
- If your premiums cease **or**
- If you become unemployed **or**
- If you die.

Remember – Cornmarket will not be automatically informed if some of the above events occur so please ensure we are advised at the earliest opportunity.

Can I cancel my membership of the Scheme?

Yes. You may cancel your membership of the Scheme at any time by clearly instructing Cornmarket to do so in writing. Please ensure your name, address and date of birth is included on the cancellation instruction. If you cancel within 30 days of the acceptance letter being sent to you, we will cancel your membership of the Scheme and refund you any premiums you have paid.

If you cancel your membership of the Scheme, and then wish to become a member again, you will have to apply for membership again and provide information about the state of your health. If your health deteriorated between the time you cancelled your membership of the Scheme and re-applied, you may not be accepted as a member again or you may be accepted with an exclusion.

Is there a surrender or cash-in value associated with the Scheme?

No. There is no surrender or cash-in value associated with this Scheme; it is not a savings plan.

What commission does Cornmarket receive?

Initial charge	€400
Premium Deduction Charge	2.5%
Renewal charge paid by Insurer to Cornmarket	12.50%

What if I travel abroad?

In order to remain on cover under this Scheme you must remain a resident within Ireland.

If you travel briefly for normal holiday purposes this will not affect your cover under the Scheme. However, if you decide to reside or work abroad you must contact Cornmarket immediately. In such circumstances, the Insurer may decide to vary your premium and benefits accordingly or cease your membership of the Scheme.

If you are in receipt of Disability Benefit from the Scheme, the Insurer will pay this benefit to you if you are living anywhere in the world for a maximum of 12 months. The Insurer reserves the right for claimants to come back to Ireland for an Independent Medical Examination during this 12 month period. If during the 12 months you are required to attend a medical assessment you must return to Ireland for it, the expense of which must be agreed between you and the Insurer in advance. Only reasonable expenses will be covered by the Insurer.

After 12 months, you must reside in Ireland or the UK. In exceptional cases where a beneficiary is forced to live abroad, the Insurer will consider this on a case-by-case basis.

Are all claims paid?

The great majority of claims are paid.

When claims are not paid it is usually due to one or more of the following reasons:

- Medical opinion is that the member is not disabled from carrying out his or her normal occupation.

- When applying to join the Scheme, the member did not give all relevant, requested medical information (information that the Insurer would regard as likely to influence the assessment and acceptance of your application). This is called non-disclosure. In addition to being the reason for a claim not being paid, non-disclosure may also result in membership of the Scheme being cancelled. If this occurs, premiums will not be refunded.
- A claim is notified late, for example, approximately three months after the end of the Deferred Period/diagnosis has occurred and hence the Insurer is no longer in a position to medically assess the claim.
- The illness or injury is a result of one of the general exclusions that exist on the Scheme.
- The member attempts to claim for an illness or injury for which they received a specific exclusion.

What if I wish to make a complaint about the service I have received from Cornmarket?

Please write to:
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 submit your complaint to the Financial Services and Pensions Ombudsman, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, or log onto www.fspo.ie

General Scheme Information

Full Scheme Name: SIPTU Nurses and Midwives Salary Protection Scheme.

The Scheme owner is SIPTU.

The current Scheme broker is Cornmarket Group Financial Services Ltd.

The current Scheme Insurer is New Ireland Assurance plc.

The current policy number for this Scheme is V000059E.

This is a Group Protection Scheme. This means that the costs and benefits cannot be changed by any individual member. Instead, the Scheme owner reviews the Scheme periodically with the Scheme Broker and Insurers and then decides the best combination of benefits, cost, restrictions, limitations and features for all the members of the Scheme. At a review it may be decided that the Scheme should move Brokers and/or Insurers. In the event that this occurs, all Scheme membership data will be transferred to the new Broker and/or Insurer. Additionally, at a review, it may be decided to terminate the Scheme altogether. In the event that this occurs, any members who are already receiving a Disability Benefit will continue to receive that benefit under the terms of the Scheme. Decisions taken by the Scheme owner will be binding on all members.

The next Scheme review is due on or after 1st June 2021.

6. Specified Illnesses Appendices

NEW IRELAND ASSURANCE

Explanation of each Specified Illness and its pre-existing conditions

APPENDIX 1:

Specified Illnesses (Full Payment)

Important Note: The explanations under 'In simpler terms' in this section do not form part of the policy conditions and are provided solely for information purposes. In the event of a claim under Specified Illness Benefit or Partial Payment Specified Illness Benefit on your Policy, the 'Policy Definitions' will apply.

1. Alzheimer's disease - resulting in permanent symptoms

Policy Definition

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist or Geriatrician of a major Irish or United Kingdom Hospital. 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 is not covered:

- Alzheimer's disease secondary to alcohol or drug misuse.

In simpler terms

Alzheimer's disease is a progressive and degenerative disease. The nerve cells in the brain deteriorate over time and the brain substance shrinks. The symptoms can include a severe loss of memory and concentration and there is an overall decline in all mental faculties. A claim can be made if there is a definite diagnosis by a Consultant Neurologist or Geriatrician of Alzheimer's disease where judgement, understanding and rational thought processes have been seriously and permanently affected.

Pre-existing Conditions

Amnesia or memory loss

Related Specific Illnesses

Dementia

2. Aorta Graft Surgery - for disease or traumatic injury

Policy Definition

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

In simpler terms

The aorta is the main artery of the body and supplies blood rich with oxygen to all other arteries. The aorta may become narrowed, usually due to a build-up of fatty deposits on the wall of the artery, or it may become weakened because of an aneurysm (where the artery wall becomes thin and dilated).Surgery, as described in the above definition, to correct these conditions or repair for traumatic damage to the aorta with a graft is covered.

Pre-existing Conditions

Aortitis, Marfan's syndrome, Ehlers-Danlos syndrome, peripheral artery disease or syphilis

Related Specified Illnesses

None specified

3. Aplastic Anaemia - of specified severity

Policy Definition

A definite diagnosis by a Consultant Haematologist of a major Irish or United Kingdom Hospital of permanent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia and requires as a minimum one of the following treatments:

- Blood transfusion;
- Bone-marrow transplantation;

- Immunosuppressive agents;
- Marrow Stimulating agents.

All other forms of anaemia are specifically excluded.

In simpler terms

Aplastic anaemia is a disease of the bone marrow, which is the organ that produces the body's blood cells. The symptoms of aplastic anaemia are fatigue, bruising, infections and weakness. In patients with aplastic anaemia, the bone marrow goes into failure and stops producing, or produces too few red blood cells, white blood cells, and platelets. Without sufficient red blood cells, oxygen cannot reach organs and tissues throughout the body. A decrease in the number of white blood cells reduces the body's ability to fight infection. A decrease in platelets diminishes the body's clotting ability.

Pre-existing Conditions

None Specified

Related Specific Illnesses

Cancer, Bone Marrow Transplant (under Major Organ Transplant)

4. Bacterial Meningitis - resulting in permanent symptoms

Policy Definition

A definite diagnosis of Bacterial Meningitis by a Consultant Neurologist of a major Irish or United Kingdom Hospital causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms.*

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

***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 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 are permanent effects as outlined in the above definition, we would consider a claim. You can make a claim if a Consultant Neurologist confirms a diagnosis of bacterial meningitis which has resulted in permanent brain or nerve damage. All other forms of meningitis including viral meningitis are excluded.

Pre-existing Conditions

Osteomyelitis of the skull, tuberculosis.

Related Specific Illnesses

Encephalitis, Brain Abscess.

5. Balloon Valvuloplasty

Policy Definition

The actual insertion, on the advice of a Consultant Cardiologist of a major Irish or United Kingdom Hospital, 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.

In simpler terms:

The valves of the heart open and close as part of the pumping action, which circulates blood around the body. When these valves become diseased, the ability of the heart to pump properly is reduced. It is sometimes possible to open these valves with balloon valvuloplasty, where a small narrow tube containing a deflated balloon at its tip is advanced from a blood vessel in the groin through the aorta and into the heart. Once it is in place, the balloon is inflated until the flaps of the valve are opened.

Pre-existing Conditions

Any disease or disorder of the aortic, mitral, pulmonary or tricuspid valve(s); rheumatic fever, endocarditis, atrial or ventricular septal defect, patent ductus arteriosus, Fallot's tetralogy, Epstein's anomaly or any congenital or acquired structural cardiac abnormality.

Related Specific Illnesses

Heart Valve Replacement or Repair.

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6. Benign Brain tumour - resulting in permanent symptoms or requiring surgery

Policy Definition

A non-malignant tumour or cyst originating from 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 of a major Irish or United Kingdom Hospital and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Tumours arising from bone tissue.
- Angiomas and cholesteatoma.

The requirement for permanent neurological deficit will be waived if the benign brain tumour is removed (fully or partially) by invasive surgery or treated by stereotactic radiosurgery.

***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:

A benign brain tumour is a non-cancerous abnormal growth of tissue. It can be very serious because the growth may be pressing on areas of the brain. These growths can be potentially 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, an angioma is a benign growth made up of small blood vessels. You can make a 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 described in the above definition 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, tumours arising from bone tissue, angiomas or cholesteatomas.

Pre-existing conditions

Epilepsy, unilateral neural deafness, fits or blackouts, double vision, Von Recklinghausen's disease, tuberous sclerosis

Related Specified Illnesses

None Specified

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7. Benign Spinal Cord Tumour - resulting in permanent symptoms or requiring surgery

Policy Definition

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 of a major Irish or United Kingdom Hospital and must

be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Angiomas
- Prolapsed or herniated intervertebral disc.

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 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 make a 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 described in the above definition as a result of the tumour. Angiomas are benign tumours that are made up of small blood vessels. They usually appear at or near the surface of the skin and are not covered. Prolapsed or herniated intervertebral discs are also not covered.

Pre-existing Conditions

Von Recklinghausen's disease, tuberous sclerosis

Related Specified Illnesses

None Specified

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8. Blindness - permanent and irreversible

Policy Definition

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 make a claim if you have suffered severe loss of sight in both eyes. The loss of sight must be to the extent that, even when tested with the use of visual aids such as glasses or contact lenses, the sight in your better eye is confirmed by an Consultant Ophthalmologist or Physician and to the satisfaction of New Ireland's Chief Medical Officer, as 3/60 or worse using the recognised sight test known as the Snellen eye chart. 3/60 is the measure when you can only see an object up to 3 feet away that a person with normal eyesight could see if it were 60 feet away. This condition must be permanent and irreversible. It is important to realise that this definition is very specific. It may be possible to be "registered blind" but still not be covered by the above definition.

Pre-existing Conditions

Diabetes, glaucoma, hysteria, severe myopia, congenital nystagmus, retrobulbar or optic neuritis, retinitis pigmentosa

Related Specific Illnesses

None Specified

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9. Cancer - excluding less advanced cases

Policy Definition

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, sarcoma 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 of 7 or above or having progressed to at least clinical TNM classification T2bN0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Malignant melanoma unless it has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).
- Any other skin cancer (including cutaneous lymphoma) unless it has been histologically classified as having caused invasion in the lymph glands or spread to distant organs.
- Any urinary bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0
- All forms of lymphoma in the presence of any Human Immunodeficiency Virus
- Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus

No cancer claims will be paid where this condition is diagnosed within the first six months of the Commencement Date of Cover under the Plan. In such circumstances, cover in respect of cancer ceases.

In simpler terms:

The term 'cancer' is used to refer to all types of malignant tumours. A malignant tumour usually grows quickly, usually invades surrounding tissue as it expands, and can spread via the bloodstream or lymphatic system to form more growths in other parts of the body.

A claim can be made if you are diagnosed as suffering from a malignant tumour that has invaded surrounding tissue, unless the type of cancer is specifically excluded. Your claim must be supported by a microscopic examination of a sample of the relevant cells. This is known as 'histology' and would usually be carried out as part of a normal hospital investigation.

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. The Gleason score which is a method of measuring differentiation in cells is specifically designed to help evaluate the prognosis of those who have been diagnosed with prostate cancer scoring patients between 2 and 10, with 10 having the worst prognosis. Cancers with a Gleason score less than or equal to 6 are less aggressive, less likely to spread and have a better prognosis. The TNM classification system stages the extent and spread of the cancer in the body. The "T" element relates to the size of the tumour and whether it has invaded nearby tissue and is graded on a scale of 1 to 4, with 1 representing a small tumour confined to an organ or body part. The "N" element relates to any lymph node involvement and the "M" relates to a spread of cancer from one body part to another. We will not pay a claim for prostate cancer under this cancer definition unless the tumour has a Gleason score of greater than 6 (i.e. a Gleason score of 7 or above) or it has progressed to at least clinical TNM classification of T2bN0M0. Many forms of urinary 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 early stage superficial urinary bladder cancer is very good. We will not pay a claim for urinary bladder cancer under this cancer definition unless the tumour has progressed to at least clinical TNM classification of T2N0M0.

As part of this definition, we do not cover 'non-invasive cancer' or 'cancer in situ', which means that the cancer is in its early stages and has not spread to neighbouring tissue or is of a type that is contained and will not tend to spread. As these cancers have been detected at an early stage, they are unlikely to be life threatening.

Pre-existing Conditions

Polyposis coli, familial polyposis of the colon, Crohn's disease, ulcerative colitis, Barrett's Oesophagus, Carcinoma in situ other than of the breast or the oesophagus, a history of elevated prostate specific antigen (PSA) above 4.0 ng/ml, Bowen's disease, leukoplakia

Related Specified Illnesses

Ductal Carcinoma in Situ - Breast, Carcinoma in Situ - Oesophagus, Early Stage Prostate Cancer, Aplastic Anaemia

10. Cardiomyopathy - of specified severity

Policy Definition

A definite diagnosis by a Consultant Cardiologist from a major Irish or United Kingdom Hospital of cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 40% or less for at least 6 months when stabilised on therapy advised by the Consultant.

The diagnosis must also be evidenced by:

- Electrocardiographic changes; and
- Echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy.

For the above definition, the following are not covered:

- All other forms of heart disease and/or heart enlargement;
- Myocarditis; **and**
- Cardiomyopathy secondary to alcohol or drug misuse.

In simpler terms:

Cardiomyopathies are a group of disorders of the heart muscle, often of unknown cause, which can lead to sudden death and heart failure. The heart muscle can no longer effectively receive or pump blood throughout the body. The symptoms of cardiomyopathy include shortness of breath on moderate exercise, chest pain, and fainting. You can make a claim if you are diagnosed by a Consultant Cardiologist with cardiomyopathy which significantly hinders normal everyday activities and results in permanently impaired ventricular function as described in the above definition.

Pre-existing Conditions

Any disease or disorder of the heart including congenital malformations that have been treated such as heart valve defects. Any obstructive or occlusive arterial disease such as arteriosclerosis, aneurysm, coronary heart disease, endocarditis, diabetes, peripheral vascular disease, tachycardia, valvular heart disease, atrial fibrillation, hypertension, granulomatous disease e.g. sarcoidosis, Wegener's granulomatosis, infiltrations, e.g. heart tumours (primary), scleroderma, inflammatory process, e.g. carditis, myocarditis, collagenosis, post-cardiotomy syndrome, post-myocardial infarction syndrome, metabolic disorders, e.g. malnutrition, nutritional disorders (beri beri), family storage disorders, myopathies, e.g. progressive muscular dystrophy, neuropathies, e.g. Friedreich's ataxia obliterative (OCM) in conjunction with amyloidosis, endocardial fibrosis, fibroelastosis, Löffler's disease, haemochromatosis, hypothyroidism, chemotherapy or radiotherapy for cancer.

Related Specified Illnesses

Heart Attack, Stroke, Coronary Artery By-pass Grafts, Angioplasty for Coronary Artery Disease, Heart Transplant (under Major Organ transplant), Carotid Artery Stenosis.

11. Chronic Lung Disease - of specified severity

Policy Definition

Confirmation by a Consultant Physician of a major Irish or United Kingdom Hospital of chronic lung disease which is evidenced by all of the following:

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

In simpler terms:

You can make a claim if confirmation is provided by a Consultant Physician that you are suffering from severe and restrictive chronic lung disease which significantly hinders everyday activities and is evidenced by all the criteria described in the above definition.

Pre-existing Conditions

Emphysema, cystic fibrosis, pulmonary fibrosis, chronic asthma, chronic bronchitis, fibrosing alveolitis (cryptogenic and allergic) emphysema, fibrosing lung disorders, other systemic disorders that produce pulmonary fibrosis such as sarcoid, pulmonary fibrosis as a result of exposure to extrinsic organic or inorganic agents.

Related Specified Illnesses

Lung Transplant (under Major Organ Transplant)

12. Coma - resulting in permanent symptoms

Policy Definition

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

- Requires the use of life support systems for a continuous period of at least 96 hours; and
- Results in permanent neurological deficit with persisting clinical symptoms*

For the above definition, the following are not covered:

- A medically induced coma
- Coma secondary to alcohol or drug misuse.

***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:

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.

Pre-existing Conditions

Physical head injury or concussion, epilepsy, diabetes mellitus, aneurysm, transient cerebral ischaemia, any obstructive or occlusive arterial or vascular disease, hepatic encephalopathy.

Related Specified Illnesses

None Specified.

13. Coronary Artery By-pass Grafts - with surgery to divide the breastbone

Policy Definition

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist of a major Irish or United Kingdom Hospital 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;
- Laser treatment.

In simpler terms:

A coronary artery by-pass operation involving open heart surgery is one of the main methods of treating coronary artery disease, especially when a person suffers recurrent attacks of angina (heart related chest pain). The operation is necessary if one or more arteries, which supply blood to the heart are narrowed or blocked. The surgery involves taking a blood vessel, often from a limb, and using it to direct blood past the diseased or blocked artery. This is a major operation, involving the actual opening up of the chest wall to reach the heart inside.

Pre-existing Conditions

Any disease or disorder of the heart including congenital malformations that have been treated such as heart valve defects, any obstructive or occlusive arterial disease such as arteriosclerosis, aneurysm, coronary heart disease, diabetes, hypercholesterolaemia, peripheral vascular disease, tachycardia, valvular heart disease, atrial fibrillation, hypertension.

Related Specified Illnesses

Heart Attack, Stroke, Angioplasty for Coronary Artery Disease, Heart Transplant (under Major Organ Transplant), Carotid Artery Stenosis, Cardiomyopathy.

14. Creutzfeldt-Jakob disease (CJD) - resulting in permanent symptoms

Policy Definition

A definite diagnosis of Creutzfeldt-Jakob disease by a Consultant Neurologist of a major Irish or United Kingdom Hospital resulting in permanent neurological deficit with persisting clinical symptoms*.

***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:

Creutzfeldt-Jakob disease (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. There is no treatment and death usually occurs within 6-18 months of the onset of symptoms. A claim can be made if there is a definite diagnosis by a Consultant Neurologist that you are suffering from this disease.

Pre-existing Conditions

A history of involuntary movements, treatment with human growth hormone treatment prior to 1985.

Related Specified Illnesses

None Specified.

15. Deafness - permanent and irreversible

Policy Definition

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

In simpler terms:

Deafness means a profound loss of hearing (as defined in the above definition) in both ears where the condition cannot be cured and is permanent, with no chance of recovery. It may be possible to be "registered deaf" but still not be covered by the above definition.

Pre-existing Conditions

Any disorder or disease of the inner or middle ear or the acoustic nerve including Meniere's disease, labyrinthitis or tinnitus.

Related Specified Illness

None Specified.

16. Dementia - resulting in permanent symptoms

Policy Definition

A definite diagnosis of dementia by a Consultant Neurologist or Geriatrician of a major Irish or United Kingdom Hospital. There must be progressive and 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 is not covered:

- Dementia secondary to alcohol or drug misuse.

In simpler terms:

Dementia is a term used to describe a number of signs and symptoms characterised by the loss of cognitive functioning, intellect, and behavioural changes. Areas of cognition affected may be memory, concentration, language and problem solving. A claim can be made if there is a definite diagnosis by a Consultant Neurologist or Geriatrician of dementia where judgement, understanding and rational thought processes have been seriously and permanently affected. Dementia secondary to alcohol or drug misuse is not covered.

Pre-existing Conditions

Organic brain disease, circulatory brain disorder, disease of the central nervous system, epilepsy, depression, amnesia or memory loss, aphasia or psychosis.

Related Specified Illnesses

Alzheimer's Disease.

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17. Encephalitis - resulting in permanent symptoms

Policy Definition

A definite diagnosis of encephalitis by a Consultant Neurologist of a major Irish or United Kingdom Hospital resulting in permanent neurological deficit with persisting clinical symptoms.*

Under the above definition Myalgic Encephalomyelitis (ME) is not covered.

***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.

For the above definition, the following is not covered:

- Encephalitis in the presence of any Human Immunodeficiency Virus.

In simpler terms:

Encephalitis means inflammation of the brain. There are a number of causes which include infections (especially viral) and post-infectious autoimmune processes where the immune system attacks the brain in error. However, the causes of many cases of encephalitis remain unidentified. Encephalitis can be a life-threatening condition and can leave people with permanent neurological problems. You can make a claim if you have a diagnosis of encephalitis confirmed by a Consultant Neurologist and where there are permanent neurological symptoms as described in the above definition.

Pre-existing Conditions

Tuberculosis (TB).

Related Specific Illnesses

Bacterial Meningitis, Brain Abscess.

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18. Heart Attack - of specified severity

Policy Definition

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

The evidence must show a definite acute myocardial infarction.

For the above definition, the following is not covered:

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

In simpler terms:

If the blood supply to the heart is interrupted, this can cause a portion of the heart muscle to die. Doctors call this sudden death of heart muscle an acute myocardial infarction, but the condition is widely known as a heart attack. A heart attack is usually caused by a blocked artery (coronary occlusion) or a blood clot (coronary thrombosis) and causes permanent

damage to the part of the heart muscle affected. This damage can be detected using an ECG machine which traces the heartbeat. As a result of cell death chemicals such as cardiac enzymes and troponins are released into the blood stream and these are usually present for several days after the event and can be detected by a blood test. In order for a claim to be valid, you must have suffered a heart attack and be supported by an episode of typical chest pain, increase in cardiac enzymes or troponins as described in the above definition that are typical of a heart attack and new ECG changes that are typical of a heart attack.

Pre-existing Conditions

Any disease or disorder of the heart including congenital malformations that have been treated such as heart valve defects, any obstructive or occlusive arterial disease such as arteriosclerosis, aneurysm, coronary heart disease, diabetes, hypercholesterolaemia, peripheral vascular disease, tachycardia, valvular heart disease, atrial fibrillation, hypertension.

Related Specified Illnesses

Coronary Artery By-pass Grafts, Stroke, Angioplasty for Coronary Artery Disease, Heart Transplant (under Major Organ Transplant), Carotid Artery Stenosis, Cardiomyopathy.

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 of a major Irish or United Kingdom Hospital, to correct any structural abnormality of the heart.

For the above definition, the following is not covered:

- Heart Valve Replacement or Repair.

In simpler terms:

Structural abnormalities of the heart can take many forms including for example abnormal openings in the dividing wall separating the left and right chambers of the heart. Having structural abnormalities of the heart corrected is covered if the procedure is done using open-heart surgery involving the surgical division of the breastbone.

Pre-existing Conditions

Any disease or disorder of the aortic, mitral, pulmonary or tricuspid valve(s); ventricular aneurysm, constrictive pericarditis, rheumatic fever, endocarditis, atrial or ventricular septal defect, patent ductus arteriosus, Fallot's tetralogy, Epstein's anomaly or any congenital or acquired structural cardiac abnormality.

Related Specified Illnesses

None Specified.

20. Heart Valve Replacement or Repair - with surgery to divide the breastbone

Policy Definition

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist of a major Irish or United Kingdom Hospital to replace or repair one or more heart valves.

In simpler terms

When a heart valve is not working properly because it has become narrowed or is leaking, an operation may be required to repair or replace the valve. Having a defective heart valve replaced or repaired is covered if the procedure is done using open-heart surgery involving the surgical division of the breastbone.

Pre-existing Conditions

Any disease or disorder of the aortic, mitral, pulmonary or tricuspid valve(s); rheumatic fever, endocarditis, atrial or ventricular septal defect, patent ductus arteriosus, Fallot's tetralogy, Epstein's anomaly or any congenital or acquired structural cardiac abnormality.

Related Specified Illnesses

Balloon Valvuloplasty.

21. HIV Infection - contracted in any of the countries that were members of the European Union on the 1st January 2017, Australia, Canada, New Zealand, Norway, Switzerland or the United States of America from a blood transfusion, a physical assault or at work

Policy Definition

Infection by Human Immunodeficiency Virus resulting from:

- A blood transfusion given as part of medical treatment; **or**
- A physical assault; **or**
- Artificial insemination or in-vitro fertilisation given as part of medical treatment; **or**
- An incident occurring during the course of performing normal duties of employment after the Commencement Date of Cover and satisfying all of the following:
- The physical assault must have been reported to An Garda Síochána within 5 days of its occurrence
- The work incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is contracted through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the physical assault or work incident must be supported by a negative HIV antibody test taken within 5 days of the physical assault or work incident
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.

For the above definition, the following is not covered:

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

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 acquiring HIV or AIDS through their work or who have become infected as a result of a blood transfusion in the European Union, Australia, Canada, New Zealand, Norway, Switzerland or the United States of America. The infection must happen after the Commencement Date of Cover under the Plan.

Pre-existing Conditions

Haemophilia (for blood transfusion only).

Related Specified Illnesses

None Specified

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22. Kidney Failure - requiring permanent dialysis

Policy Definition

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

For the above definition, the following is not covered:

- Kidney failure secondary to alcohol or drug misuse.

In simpler terms

The kidneys act as filters that remove waste materials from the blood. When the kidneys do not function properly, a build-up of waste products in the blood can lead to life threatening problems. The body can function with only one kidney because the remaining kidney can take over the work of the damaged kidney. However, if both kidneys fail completely and irreversibly, and regular dialysis (a process using a machine to perform the functions of the kidneys) is permanently required or a kidney transplant is required then a claim can be made.

Pre-existing Conditions

Hypertension, polycystic kidney disease, glomerulonephritis, diabetes, nephrotic syndrome, or pre-existing renal impairment with raised serum creatinine.

Related Specified Illnesses

Kidney Transplant (under Major Organ Transplant), Systemic Lupus Erythematosus.

23. Liver Failure - irreversible and end stage

Policy Definition

Chronic liver disease, being end stage and irreversible liver failure due to cirrhosis and resulting in all of the following:

- Permanent jaundice
- Ascites; and
- Hepatic encephalopathy.

For the above definition, the following is not covered:

- Liver Failure secondary to alcohol or 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 make a claim if you are diagnosed by a Consultant Physician as having incurable end stage liver failure caused by cirrhosis and showing particular symptoms. Jaundice is a yellow discolouration of the skin and whites of the eyes 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. Liver Failure secondary to alcohol or drug misuse is not covered.

Pre-existing Conditions

Fibrosis, primary biliary cirrhosis, Wilson's disease, chronic hepatitis, cirrhosis, liver tumours, thalassaemia major, immune deficiency diseases, sickle cell anaemia, sarcoidosis, sclerosing cholangitis, haemochromatosis, myeloproliferative disease (polycythaemia vera, thrombocythaemia), neutropenia, pancreatitis, chronic kidney disease.

Related Specified Illnesses

Liver Transplant (under Major Organ Transplant).

24. Loss of Hands or Feet - permanent physical severance

Policy Definition

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 can make a claim if you have lost 2 or more limbs, where the limbs have been permanently severed above the wrist in the case of a hand or above the ankle in the case of a foot.

Pre-existing Conditions

Diabetes, peripheral vascular disease.

Related Specified Illnesses

None Specified

25. Loss of Speech - permanent and irreversible

Policy Definition

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

In simpler terms

You can make a claim if you suffer from total and permanent loss of speech as a result of physical injury or disease.

Pre-existing Conditions

Transient ischaemic attack (TIA), chronic laryngitis.

Related Specific Illnesses

None Specified

26. Major Organ Transplant - of specified organs from another person

Policy Definition

The undergoing as a recipient from another person of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or a lobe of liver, or a lobe of lung, or inclusion on an official programme waiting list of a Major Hospital in Ireland or the United Kingdom for such a procedure.

For the above definition, the following are not covered:

- Transplant of any other organs, parts of organs, tissues or cells
- Major organ transplant secondary to alcohol or drug misuse.

In simpler terms:

Serious disease or injury can severely damage the heart, lungs, kidneys, liver or pancreas. The only form of treatment available may be to replace the damaged organ with a healthy organ from a donor. This is a major operation and the tissues of the donor and patient must be matched accurately. For this reason a patient could be on a waiting list for a long period waiting for a suitable organ. Bone marrow transplant is also covered. You can make a claim if you have had a transplant of any of the organs listed above or are on an official programme waiting list of a major Irish or United Kingdom Hospital for such a procedure.

Pre-existing Conditions

Congestive cardiac failure, coronary artery disease, left ventricle failure, hypertensive heart disease, any congenital or acquired structural cardiac abnormalities, diabetes, cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic) emphysema, fibrosing lung disorders, primary biliary cirrhosis, Wilson's disease, chronic hepatitis, cirrhosis, liver tumours, thalassaemia major immune deficiency diseases, sickle cell anaemia, ischaemic heart disease, sarcoidosis, sclerosing cholangitis, haemochromatosis, myeloproliferative disease (polycythaemia vera, thrombocythaemia), neutropenia, chronic liver disease, Budd-Chiara syndrome, pancreatitis, chronic kidney disease.

Related Specified Illnesses

Kidney Failure, Chronic Lung Disease, Heart Attack, Coronary Artery By-pass Grafts, Angioplasty for Coronary Artery Disease, Liver Failure, Aplastic Anaemia, Cardiomyopathy, Systemic Lupus Erythematosus.

27. Motor Neurone Disease - resulting in permanent symptoms

A definite diagnosis of motor neurone disease by a Consultant Neurologist of a major Irish or United Kingdom Hospital. There must be permanent clinical impairment of motor function.

In simpler terms

Motor neurone disease is a rare progressive degenerative disorder, which affects the central nervous system that controls muscular activity. As the nerves degenerate the muscles weaken and deteriorate. The cause is unknown and there is no known treatment. You can make a claim if there is a definite diagnosis by a Consultant Neurologist that you are suffering from this disease.

Pre-existing Conditions

Muscle weakness in any limb.

Related Specified Illnesses

Paralysis of 2 or More Limbs

28. Multiple Sclerosis - with persisting symptoms

Policy Definition

A definite diagnosis of multiple sclerosis by a Consultant Neurologist of a major Irish or United Kingdom Hospital. 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 an autoimmune disorder in which the immune system attacks 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. The diagnosis must be confirmed by a Consultant Neurologist.

Pre-existing Conditions

Any form of neuropathy, encephalopathy or myelopathy (disorders of function of the nerves) including but not restricted to, abnormal sensation (numbness) of the extremities, trunk and face, weakness or clumsiness of a limb, double vision, partial blindness, ocular palsy, vertigo (dizziness) or difficulty of bladder control, retrobulbar or optic neuritis, facial paraesthesia, numbness or tingling of upper or lower limbs, trigeminal neuralgia, diplopia, unilateral weakness of lower limbs or incoordination of movement or speech.

Related Specified Illnesses

None Specified.

29. Paralysis of 2 or more limbs - total and irreversible

Policy Definition

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

In simpler terms

You can make a claim if you totally and irreversibly lose the ability to move or use any 2 limbs.

Pre-existing Conditions

Spinal cord injury or transient ischaemic attack (TIA).

Related Specified Illnesses

Motor Neurone Disease.

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

Policy Definition

A definite diagnosis of idiopathic Parkinson's disease by a Consultant Neurologist of a major Irish or United Kingdom Hospital. There must be permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability.

For the above definition, the following are not covered:

- Parkinson`s disease secondary to alcohol or drug misuse.
- Parkinsonian syndromes/Parkinsonism

In simpler terms:

Parkinson's disease is a progressive degenerative disorder of the brain that affects the central nervous system. This is characterised by uncontrollable shuffling, tremors in the limbs, slow movement, rigid facial expression and unstable gait. The progression of the disease is slow and there is no known cure. 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. You can make a claim if you have been diagnosed with idiopathic Parkinson's disease by a Consultant Neurologist and evidenced by the symptoms described in the above definition

Pre-existing Conditions

Tremor

Related Specified Illnesses

None Specified.

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31. Primary Pulmonary Hypertension - of specified severity

Policy Definition

A definite diagnosis of primary pulmonary hypertension by a Consultant Cardiologist of a major Irish or United Kingdom Hospital. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, 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.*

*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

Pulmonary hypertension is when the blood pressure in the pulmonary artery (the major artery connecting the heart to the lungs) is higher than normal. There is no apparent cause. This means that the heart is under pressure when pumping blood into the lungs and typical symptoms include the shortness of breath, fatigue and fainting. These and other symptoms appear much more severely when exercising. Over time the heart muscle weakens. You can make a claim if you have been diagnosed with primary pulmonary hypertension by a Consultant Cardiologist and which results in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity. The NYHA Function Classification is a measure used to classify the severity of heart failure.

Pre-existing Conditions

None Specified

Related Specified Illnesses

None Specified

32. Progressive Supra-nuclear Palsy - resulting in permanent symptoms

Policy Definition

A definite diagnosis by a Consultant Neurologist of a major Irish or United Kingdom Hospital of progressive supra-nuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

In simpler terms

Progressive supra-nuclear palsy (PSP) is a degenerative disease causing gradual deterioration and death of specific areas of the brain. The exact cause is unknown but there is evidence in some cases to suggest it may run in families. The disease affects the part of the brain above the nuclei ("supranuclear"), which are pea-sized structures in the part of the nervous system that controls eye movements. The symptoms of PSP usually appear slowly but get progressively worse. These symptoms include impairment of motor function, eye movement disorder and postural instability.

Pre-existing Conditions

Organic brain disease, circulatory brain disorder, disease of the central nervous system, epilepsy, depression, amnesia or memory loss, aphasia, psychosis, muscle weakness in any limb, double vision, partial blindness.

Related Specified Illnesses

None Specified.

33. Pulmonary Artery Graft Surgery - with surgery to divide the breastbone

Policy Definition

The actual undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon of a major Irish or United Kingdom Hospital 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 of the pulmonary artery including pulmonary atresia and aneurysm. You can make a claim if you have undergone open-heart surgery involving the surgical division of the breastbone on the advice of a Consultant Cardiothoracic Surgeon to replace the diseased pulmonary artery with a graft.

Pre-existing Conditions

None Specified.

Related Specified Illnesses

None Specified.

34. Stroke - resulting in permanent symptoms

Policy Definition

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 (TIA)
- Traumatic injury to brain tissue or blood vessels.
- Death of tissue of the optic nerve or retina/ eye stroke.

***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:
A stroke is caused by an interruption to the flow of blood to the brain. This can be due either to a blocked artery which prevents blood reaching the brain or a burst blood vessel in the brain.

In either case, a claim will be valid if it causes ongoing clinical symptoms of a stroke which are expected to be permanent. The policy does not cover 'transient ischaemic attacks' (known as mini-strokes) because there is only a short term interruption of the blood supply to the brain. This does not result in permanent damage to the brain. The symptoms may initially be similar to those of a stroke but patients normally recover within 24 hours.

Pre-existing Conditions

Any valvular disorder of the heart, diabetes, hypercholesterolaemia, aneurysm, atrial fibrillation, coronary heart disease, thrombotic disorders e.g. primary phospholipid syndrome, hyperviscosity states (polycythaemia), peripheral vascular disease, transient cerebral ischaemia, hypertension or any obstructive or occlusive arterial or vascular disease.

Related Specified Illnesses

Coronary Artery By-pass Grafts, Heart Attack, Angioplasty for Coronary Artery Disease, Heart Transplant (under Major Organ Transplant), Carotid Artery Stenosis, Cardiomyopathy, Cerebral Arteriovenous Malformation.

35. Systemic Lupus Erythematosus - of specified severity

Policy Definition

A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist of a major Irish or United Kingdom Hospital 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 - Abnormal urinalysis showing proteinuria or haematuria.

***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.

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

In simpler terms:

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease that develops slowly causing inflammation in joints and blood vessels, often with a rash on the skin. It can affect many systems of the body, including the kidneys, heart, skin, and central nervous system. Discoid lupus is generally restricted to the skin, is not life threatening and is not covered by this definition.

Pre-existing Conditions

Anti-phospholipid syndrome, discoid lupus, scleroderma, polyarteritis nodosa, dermatomyositis, mixed connective tissue disease, Wegener's granulomatosis

Related Specified Illnesses

Kidney Failure, Kidney Transplant (under Major Organ Transplant).

36. Third Degree Burns - covering 20% of the body's surface area

Policy Definition

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 also heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin. You can make a claim if you have suffered third-degree burns covering 20% or more of the surface area of your body.

Pre-existing Conditions

None Specified.

Related Specified Illnesses

None Specified.

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37. Traumatic Brain Injury - resulting in permanent symptoms

Policy Definition

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.* The diagnosis must be confirmed by a Consultant Neurologist of a major Irish or United Kingdom Hospital and agreed by New Ireland's Chief Medical Officer.

For the above definition, the following is not covered:

- Traumatic Brain Injury secondary to alcohol or drug misuse.

***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:

A head injury caused by trauma can leave an individual with permanent brain or nerve damage. You can make a claim if a Consultant Neurologist confirms that you have permanent neurological deficit with persisting clinical symptoms as described in the above definition, as a direct result of a traumatic brain injury.

Pre-existing Conditions

Physical head injury, epilepsy, aneurysm, any obstructive or occlusive arterial or vascular disease e.g. transient ischaemic attack.

Related Specified Illnesses

None Specified.

APPENDIX 2:

Explanation of each Partial Payment Specified Illness

Important Note: The explanations under 'In simpler terms' in this section do not form part of the policy conditions and are provided solely for information purposes. In the event of a claim under Specified Illness Benefit or Partial Payment Specified Illness Benefit on your Policy, the 'Policy Definitions' will apply.

1. Angioplasty for Coronary Artery Disease - of specified severity

Policy Definition

The undergoing of treatment for severe coronary artery disease, of any of the following:

- Balloon angioplasty
- Atherectomy
- Rotablation
- Laser treatment
- And/or insertion of stents to treat the narrowing or blockage in two or more Main Coronary Arteries. This procedure must have been carried out on the advice of a Consultant Cardiologist of a major Irish or United Kingdom Hospital. Angiographic evidence to support the necessity for the procedure will be required.

The intervention must be to treat at least 70% diameter narrowing in each vessel and must be carried out as a single procedure.

For the purposes of this definition Main Coronary Arteries are defined as being:

- Right Coronary Artery
- Left Main Stem
- Left Anterior Descending
- Circumflex.

Two or more procedures in the same Main Coronary Artery or procedures to any of the branches of a Main Coronary Artery are specifically excluded.

In simpler terms

There are several procedures involving the use of coronary catheters (flexible plastic tubes). One of these is balloon angioplasty, which involves the insertion of a catheter into the body; the catheter is then inflated to force the narrowed or blocked artery apart. A stent is a small permanent metal tube that acts as an internal support to the artery. Stenting is often used in conjunction with balloon angioplasty. Atherectomy and laser treatment are other techniques that involve the insertion of a catheter into a blocked artery to help clear it. Rotablation is when a small device is used to drill through the blockage in the coronary arteries.

Pre-existing Conditions

Any disease or disorder of the heart including congenital malformations that have been treated such as heart valve defects, any obstructive or occlusive arterial disease such as arteriosclerosis, aneurysm, coronary heart disease, diabetes, hypercholesterolaemia, peripheral vascular disease, tachycardia, valvular heart disease, atrial fibrillation, hypertension.

Related Specified Illnesses

Coronary Artery By-pass Grafts, Heart Attack, Stroke, Heart Transplant (under Major Organ Transplant), Carotid Artery Stenosis, Cardiomyopathy.

2. Brain Abscess drained via craniotomy

Policy Definition

Undergoing of surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon of a major Irish or United Kingdom Hospital. There must be evidence of an intracerebral abscess on CT or MRI imaging.

For the above definition, the following is not covered:

- Brain abscess secondary to Human Immunodeficiency Virus (HIV) infection.

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 involves the removal of part of the skull in order for the surgeon to access the brain. You can make a claim if you are diagnosed, with supporting CT or MRI evidence, as having an intracerebral abscess and where this abscess is removed through a craniotomy by a Consultant Neurosurgeon.

Pre-existing Conditions

Tuberculosis, head injury, chronic sinusitis

Related Specified Illnesses

Encephalitis, Bacterial Meningitis.

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3. Carcinoma in Situ - Oesophagus, treated by specific surgery

Policy Definition

A definite diagnosis of a carcinoma in situ of the oesophagus by a Consultant Physician of a major Irish or United Kingdom Hospital, 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 is not covered:

- Treatment by any other method is specifically excluded.

No carcinoma in situ – oesophagus claims will be paid where this condition is diagnosed within the first six months of the Commencement Date of Cover under the Plan. In such circumstances, cover in respect of carcinoma in situ – oesophagus ceases.

In simpler terms:

The oesophagus is a muscular tube through which food passes from the mouth to the stomach. Carcinoma in situ is an early form of carcinoma which affects only the cells in which it originated and has not yet begun to spread to other cells (i.e. it is non-invasive). You can make a claim if you have been diagnosed as having carcinoma in situ of the oesophagus and where this has been treated by the removal or partial removal of the oesophagus.

Pre-existing Conditions

Barrett's oesophagus, severe oesophageal reflux

Related Specified Illnesses

Cancer

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4. Carotid Artery Stenosis - treated by endarterectomy or angioplasty

Policy Definition

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.

In simpler terms

The carotid artery is the artery that supplies blood to the head and neck. This artery can narrow or become partially blocked by deposits of plaque (fatty tissue). These deposits are dangerous because if this material travelled to the brain it could cause a stroke. Carotid stenosis can be corrected by procedures such as carotid endarterectomy (where the surgeon opens up the artery and removes the plaque) or angioplasty with or without stents (where the surgeon uses a balloon to expand the artery). You can make a claim if you have undergone one of these procedures to correct carotid artery stenosis where the artery was at least 70% narrowed. Your doctor will need to provide angiographic evidence for a claim to be valid. You cannot make a claim for other treatments for carotid artery stenosis.

Pre-existing Conditions

Any valvular disorder of the heart, diabetes, hypercholesterolaemia, aneurysm, atrial fibrillation, coronary heart disease, peripheral vascular disease, transient cerebral ischaemia, hypertension or any obstructive or occlusive arterial or vascular disease.

Related Specified Illnesses

Coronary Artery By-pass Grafts, Heart Attack, Angioplasty for Coronary Artery Disease, Heart Transplant (under Major Organ Transplant), Stroke, Cardiomyopathy.

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5. Cerebral Arteriovenous Malformation - treated by craniotomy or endovascular repair

Policy Definition

Undergoing of treatment of a cerebral arteriovenous fistula or malformation by a Consultant Neurosurgeon of a major Irish or United Kingdom Hospital via craniotomy or endovascular treatment using coils to cause thrombosis of a cerebral arteriovenous fistula or malformation.

For the above definition, the following is not covered:

- Intracranial aneurysm.

In simpler terms

Cerebral arteriovenous malformation is a condition whereby there is an abnormal connection between arteries and veins in the brain that interrupts normal blood flow between them. An arteriovenous fistula (AV fistula) is one such abnormal connection. When this is present, blood flows directly from an artery into a vein bypassing the capillaries. This can cause a problem if oxygenated blood has not reached its intended destination within the brain. The most common symptoms include headaches and seizures. In more serious cases blood vessels may rupture and there will be haemorrhaging within the brain. A craniotomy involves the removal of part of the skull in order for the surgeon to access the brain. Endovascular treatment is where the surgeon accesses the brain via arteries using catheters, balloons, coils and stents. You can claim if you have a craniotomy or endovascular treatment using coils under the care of a Consultant Neurologist to treat a cerebral arteriovenous fistula or malformation.

Pre-existing Conditions

Aneurysm.

Related Specified Illness

Stroke

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6. Ductal Carcinoma in Situ - Breast, treated by surgery

Policy Definition

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.

No ductal carcinoma in situ – breast claims will be paid where this condition is diagnosed within the first six months of the Commencement Date of Cover under the Plan. In such circumstances, cover in respect of ductal carcinoma in situ – breast ceases.

In simpler terms

Ductal carcinoma in situ is a term used to describe an early form of carcinoma which affects only the cells in which it originated and has not yet begun to spread to other cells (i.e. it is non-invasive). Ductal means that these malignant cells develop within the milk ducts of the breast, so ductal carcinoma in situ means that the carcinoma has not moved outside of these cells and into the surrounding breast tissue or other parts of the body. A claim can be made if you have been diagnosed with having ductal carcinoma in situ of the breast and where this has been treated by the removal or partial removal of the breast or surgical removal of the tumour itself.

Pre-existing Conditions

Lumpy breast(s) (including mastitis, fibroadenosis, fibrocystic disease and mammary dysplasia), cystosarcoma phyllodes.

Related Specified Illnesses

Cancer.

7. Early Stage Prostate Cancer with Gleason score between 2 and 6 - and with specific treatment

Policy Definition

A definite diagnosis of prostate cancer by a Consultant of a major Irish or United Kingdom Hospital 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 Life Insured 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, hormone therapy

No early stage prostate cancer with Gleason score between 2 and 6 claims will be paid where this condition is diagnosed within the first six months of the Commencement Date of Cover under the Plan. In such circumstances, cover in respect of early prostate cancer with Gleason score between 2 and 6 ceases.

In simpler terms

The Gleason score which is a method of measuring differentiation in cells is specifically designed to help evaluate the prognosis of those who have been diagnosed with prostate cancer scoring patients between 2 and 10, with 10 having the worst prognosis. Cancers with a Gleason score less than or equal to 6 are less aggressive, less likely to spread and have a better prognosis. The TNM classification system stages the extent and spread of the cancer in the body. The "T" element relates to the size of the tumour and whether it has invaded nearby tissue and is graded on a scale of 1 to 4, with 1 representing a small tumour confined to an organ or body part. The "N" element relates to any lymph node involvement and the "M" relates to a spread of cancer from one body part to another. You can make a claim if you have been diagnosed with prostate cancer by an appropriate Consultant with a Gleason score between 2 and 6 and where the tumour has progressed to at least clinical TNM classification T1N0M0 and have also underwent treatment as described in the above definition.

Pre-existing Conditions

A history of elevated prostate specific antigen (PSA) above 4.0 ng/ml, carcinoma in situ of the prostate.

Related Specified Illnesses

Cancer

8. Loss of one Limb - permanent physical severance

Policy Definition

Permanent physical severance of a hand or foot at or above the wrist or ankle joints.

If a Life Insured loses a limb as a result of their own deliberate act, or a penalty imposed by a court of law, we will not pay any benefit under the Plan.

In simpler terms

You can make a claim if you have lost a hand or a foot, where the limb has been permanently severed above the wrist in the case of a hand or above the ankle in the case of a foot. If you lose a limb as a result of your own deliberate act, or a penalty imposed by a court of law, we will not pay any benefit under the Plan.

Pre-existing Conditions

Diabetes, peripheral vascular disease, osteomyelitis, chronic regional pain syndrome, compound fracture

Related Specified Illnesses

None Specified

9. Third Degree Burns - covering at least 5% of the body's surface area

Policy Definition

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 also heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin. You can make a claim if you have suffered third-degree burns covering at least 5% and less than 20% of the surface area of your body or at least 25% of the surface area of the face.

Pre-existing Conditions

None specified.

Related Specified Illnesses

None Specified.

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10. Surgical Removal of One Eye

Policy Definition

Surgical removal of a complete eyeball for disease or trauma.

In simpler terms:

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

Pre-existing Conditions

Glaucoma, eye tumour, uveitis, thyroid disease.

Related Specified Illnesses

None Specified.

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