cornmarket
group financial services ltd

Here to help you

Salary Protection Scheme

for INTO Members

into
Irish National Teachers' Organisation
Cumann Múinteoirí Éireann

Guide to your Benefits

Please print and/or save this booklet for your records

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Vital protection for INTO members

Sheila Nunan

The Salary Protection Scheme is well placed to provide vital protection for members.

If you fall ill your paid sick leave lasts for a defined period only. Changes introduced in September 2014 shorten the period of paid sick leave and also provide for a progression from full-pay to half-pay during the course of an illness.

The Salary Protection Scheme for INTO Members, administered by Cornmarket, provides members with financial security when their income is adversely affected due to illness.

The Salary Protection Scheme has been redesigned to link in with the revised sick leave arrangements. The Scheme will now cover short-term claims, such as when a teacher moves from full-pay to half-pay. This is a really important benefit for over 15,500* INTO Scheme members.

The INTO is confident that the Salary Protection Scheme is well placed to provide vital protection for members, at an affordable cost, for many years to come.

If you haven't already joined the Scheme, it has never been more important to consider doing so.

Yours sincerely,

Sheila Nunan,
INTO General Secretary.

*Source: Cornmarket (July 2015)

Cornmarket's role as Administrators

Cornmarket – working for you

Cornmarket has been administering the Salary Protection Scheme for INTO members for over 35 years. The Scheme aims to provide a realistic level of income in the event of loss of salary through illness or injury.

Our role includes:

1. Negotiating with the insurers (currently Irish Life) to obtain the most competitive rates and to secure the best possible benefits.
2. Assisting INTO members who wish to make a claim from the Scheme, by guiding them through every stage of the claims process.
3. Promoting the Scheme to INTO members.

With almost €204 million paid out to INTO members and their families to date, the Scheme provides invaluable peace of mind that you have a level of protection in place for when you may need it most.*

*Source: Irish Life Claims Department (June 2015).

A Claims Service you can trust

Cornmarket has its own dedicated, in-house Salary Protection Claims Team. The team members are specialised, well-informed and easy to talk to, and will do all they can to help in a member's time of need. They provide a vital 'hand-holding' function from start to finish of the claims process.

So should you need to make a claim, you can rest assured that it will be dealt with in the efficient, professional and sensitive manner that you deserve.

The Scheme in action

Through its various Salary Protection Schemes, Cornmarket has helped protect the financial security of more Public Sector employees than any other company in Ireland. But the real testament to the quality of these Schemes is the amount being paid out to beneficiaries, which is now counted in the hundreds of millions of Euro. Here's what just two of the people who have benefited from our Salary Protection Schemes have to say.

"While in work in March 2013, I had a brain aneurism which put me out of work. Only for the Plan, I'd have nothing to pay the bills or the mortgage, I honestly believe I would be homeless without it. Making the claim was very straightforward. I was on the phone to a representative from Cornmarket and I really felt they were there to help me, and they did. It was very easy. If you need your wages to pay your bills, you really have to have something there to back it up. No-one knows what tomorrow will bring, so you need some form of protection. I think Salary Protection is just invaluable."

Jackie O'Neill,
Scheme Beneficiary,
Co. Wicklow.

"I was at work one day, went to take something off a shelf and just felt a pop. Then after a couple of days it just snowballed and I ended up not being able to move my neck or shoulders. I realised I was going to be out of work for a while and my pay was due to run out, so I contacted Cornmarket. I didn't think I'd be out of work for as long as I have been and, thankfully, the cover has continued. Cornmarket want to ensure that you're well and that when you go back to work you're able to do your job long term. There's no pressure put on you to go back before you're ready. It really is such a relief! I would recommend joining Salary Protection to everyone."

Fiona Grace Purtill,
Scheme Beneficiary,
Co. Limerick.

Why you need the Salary Protection Scheme for INTO members

Although many members feel that they will never need the protection that the Scheme provides, sadly our experience has been that even the healthiest person can suffer unexpected illness or have a serious accident. What is more, the changes to Public Sector sick leave arrangements in effect since **1st September 2014** mean a dramatic drop in your paid sick leave. As a result of the changes, INTO members without Salary Protection face greater financial uncertainty should they fall ill as they will be taken off the payroll sooner than before.

Thankfully, the Scheme has made provision for these changes and will pay out Scheme benefits earlier than before, in line with members' needs. The Scheme provides essential protection for all INTO members and membership has never been more vital.

What happens to your income if you fall ill under the new sick leave arrangements?

Ordinary* Sick Leave

Under Public Sector sick leave arrangements (effective from 1st September 2014), typically you have access to paid sick leave of 13 weeks (92 days) at full pay in one year, followed by 13 weeks (91 days) at half pay. This is subject to a maximum of 26 weeks (183 days) in a rolling 4 year period. If you exceed 183 days paid sick leave you may receive Temporary Rehabilitation Remuneration for a further 18 months (548 days), subject to the terms of the Public Sector sick leave arrangements.

Extended Sick Leave for Critical Illness**

Under the Public Sector sick leave arrangements, there is a Critical Illness Protocol whereby employees may be granted extended paid sick leave of 26 weeks (183 days) at full pay in one year, followed by 26 weeks (182 days) at half pay, subject to a maximum of 52 weeks (365 days) in a rolling 4 year period.

If you exceed 365 days paid sick leave, you may receive Temporary Rehabilitation Remuneration for a further 12 months (365 days). Temporary Rehabilitation Remuneration may be extended for a further period up to a maximum of 2 years (730 days).

Temporary Rehabilitation Remuneration

Temporary Rehabilitation Remuneration is based on your accrued pension benefits that would have applied had you actually retired on ill health grounds. It may be granted where there is a realistic prospect of an individual returning to work. However, any added years arising from purchase of service arrangements are not taken into account, as no ill health retirement has actually taken place.

Ill Health Early Retirement Pension

Alternatively, if you retire on the grounds of ill health you may be entitled to an Ill Health Early Retirement Pension. Even if you have many years of service, your Ill Health Early Retirement Pension will only be a fraction of your salary. In addition, those paying PRSI at the 'A' rate may be entitled to a State Illness Benefit, but at just €9,776 per annum (2015 level), the State Illness Benefit provides a small income only.

The reality is that long-term illness inevitably means a severe drop in living standards. The need for some kind of additional income is vital.

If you retire from the Department of Education and Skills, you must retire on ill health grounds. Any retirement other than Ill Health Early Retirement, will adversely affect your claim.

How the Scheme works – Disability Benefit

Once your salary has reduced to half pay or Temporary Rehabilitation Remuneration is being paid, the Scheme aims to pay you an income of up to 75% of your salary less any other income (e.g. half pay, Temporary Rehabilitation Remuneration, Ill Health Early Retirement Pension, State Illness Benefit) to which you may be entitled.

The payment of the Disability Benefit will continue until you recover, go back to work, are deemed fit to return to work by Irish Life, die, or right up until the end of the school year in which you reach age 60/65***, if you are permanently disabled.

If a member making a claim decides not to apply for Ill Health Early Retirement Pension (perhaps because he/she intends to return to work) and Irish Life agrees that there is a reasonable expectation of returning to work, then Irish Life may pay a benefit of 75% of salary less any State Illness Benefit/Temporary Rehabilitation Remuneration for a maximum of 2 years. This means no deduction will be made from the benefit paid under the Scheme for an amount equivalent to Ill Health Early Retirement Pension, as no Ill Health Early Retirement Pension is being claimed. If a member retires subsequently and an Ill Health Early Retirement Pension 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.

*For the purpose of this book, where Ordinary Sick Leave is mentioned it can be assumed to mean Standard Sick Leave.

**There are certain criteria used to determine whether an illness qualifies for extended paid sick leave.

***If you entered Public Service before 1st April 2004: age 60 or after 1st April 2004: age 65.

Important: You must remain an INTO member to remain an eligible member of the Scheme. If you leave the Union you must inform Cornmarket in writing, as you can no longer stay in the Scheme and you will not be able to claim from it.

Membership of the Scheme is more vital than ever.

Example of how the Scheme works

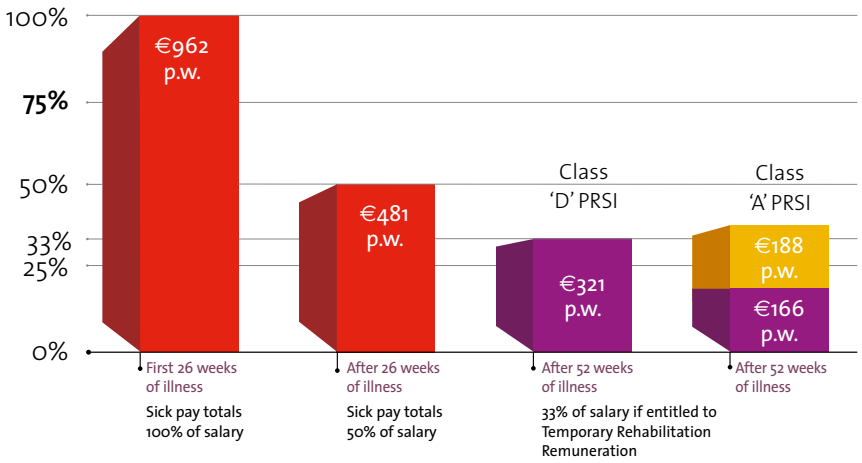
The example below is based on a Public Sector employee, who is a member of the Superannuation Scheme with 20 years' service earning €50,000 per annum, who is now unable to work due to illness or disability. It is assumed that Extended Sick Leave under the Critical Illness Protocol applies (i.e. 26 weeks full pay in a year, followed by 26 weeks half pay*). It is also assumed that Ill Health Early Retirement Pension is granted after 2 years (i.e. 12 months extended paid sick leave, followed by 12 months Temporary Rehabilitation Remuneration**).

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

An example of what happens when sick pay runs out

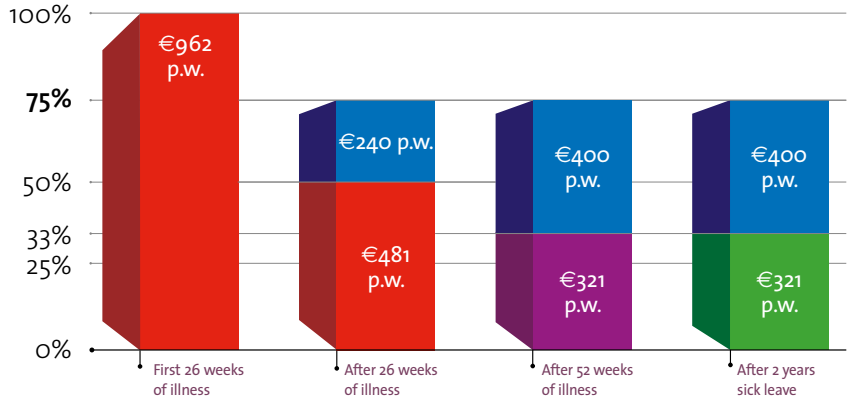
Staff recruited to the Public Service on or after 6th April 1995 pay class A PRSI. Their Superannuation Scheme pension is integrated to take account of the value of the Contributory State Pension in calculating the pension payable.

In the event of illness, they may typically claim State Illness Benefit.

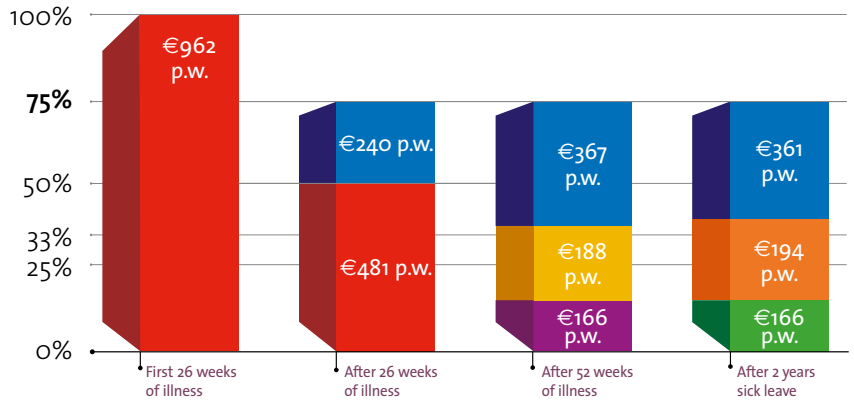


Examples of how the Scheme works

D Rate PRSI Example



A Rate PRSI Example



*Subject to a maximum of 52 weeks (365 days) paid sick leave in a rolling 4 year period.

**In some cases Temporary Rehabilitation Remuneration may be granted for a further period not exceeding 2 years.

Additional protection for you and your family

The main purpose of the Salary Protection Scheme is to provide you and your family with financial support in the event that you fall ill and find yourself unable to work. The Scheme provides additional benefits in the form of:

1 Specified Illness Benefit

Should you suffer a serious illness (regardless of whether or not this illness keeps you out of work sufficiently long to involve a loss of salary) the reality is that you may face significant extra expenses. The Scheme recognises this fact by providing an additional benefit in the form of a once-off lump sum of 25% of your annual salary in the event that you suffer a 'Specified Illness'. The lump sum this benefit provides can be vital as extra cash is often needed to pay for medical bills, travel to and from hospital, pay for extra childcare, etc. The benefit is provided up until 31st August following your 65th birthday, or when you retire (other than on grounds of ill health), or leave the service, if earlier.

Irish Life has identified 36 Specified Illnesses (see listing below) for which they will pay out this benefit.

Please note: The Specified Illnesses marked ❖ below, were introduced at the **1st April 2010** review. The other Specified Illnesses were introduced from **1st April 2006**. 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. Cover for that illness will be excluded.

Alzheimer's Disease	HIV infection
Aorta graft surgery	Kidney failure
❖ Aplastic Anaemia	❖ Liver failure
❖ Bacterial Meningitis	Loss of limbs
Benign brain tumour	Loss of speech
Benign spinal cord tumour	Major organ transplant
Blindness	Motor Neurone Disease
Cancer (malignant)	Multiple Sclerosis
Cardiomyopathy	Paralysis of Limbs
Coma	Parkinson's Disease
Coronary artery bypass grafts	Primary Pulmonary Hypertension
❖ Creutzfeldt-Jakob Disease	❖ Progressive Supranuclear Palsy
Deafness	❖ Pulmonary Artery Surgery
❖ Dementia	❖ Respiratory failure of specified severity
❖ Encephalitis	Severe 3rd-degree burns
Heart attack	Stroke
Heart structural repair with surgery to divide the breastbone	❖ Systemic Lupus Erythematosus
Heart valve replacement or repair	❖ Traumatic head injury resulting in permanent symptoms

Important: There is only one Specified Illness Benefit payment per life per policy. Other terms and conditions apply.

2 Specified Illness Benefit – Partial Payments

Based on recent claims experience, Irish Life has identified a further 10 less severe, but still life altering conditions that it will make an additional separate partial payment on (see listing below). The benefit you would receive should you suffer a Specified Illness covered under the Partial Payment section is the lesser of; €10,000 or 25% of salary. The benefit is provided up until 31st August following your 65th birthday, or when you retire (other than on grounds of ill health), or leave the service, if earlier.

Please note: The qualifying Partial Payment Specified Illnesses below were introduced at the 1st April 2010 review. Only diagnoses that occur after this date are eligible to claim Specified Illness Benefit under the Partial Payment section for these illnesses. If, prior to joining the Scheme, you have suffered from one of the Partial Payment Specified Illnesses you will never be covered for that illness.

Brain abscess drained *via* craniotomy	Ductal carcinoma in situ
Carcinoma in situ	Low level prostate cancer with Gleason score between 2 and 6
Carotid artery stenosis	Less severe 3rd-degree burns
Cerebral arteriovenous malformation	Loss of one limb
Coronary Angioplasty	Surgical removal of one eye

Important: There is only one Partial Payment per life per policy. Other terms and conditions apply.

Terms and conditions apply. Please refer to the Appendices on pages 30 - 43 which contain the policy definition of each illness and its pre-existing conditions.

3 Life Cover

Death Benefit

Should you die, the issue of financial support may be even more pressing for your family. Mortgage payments, day-to-day living expenses, credit card bills, etc. will still have to be met by those you have left behind. The Scheme recognises this fact by providing an important extra benefit in the form of a Death Benefit (typically equivalent to twice your annual salary), which is paid to your estate should you die. As with your Disability Benefit, this Death Benefit is salary linked – so it changes each year in line with your salary. This benefit is provided up until the 31st August after your 65th birthday, or retirement if earlier.

Terminal Illness Benefit

Irish Life will make an advance payment of 50% of the death benefit on diagnosis of a terminal illness with death expected within 12 months. Conditions attached to this are as follows:

- A life assured is diagnosed as having a terminal illness if a medical specialist certifies, and Irish Life accepts, that it is highly likely that the life assured will die from a worsening, incurable disease within 12 months
- This benefit will not apply to members over age 62.

Accidental Death Benefit

In the event of accidental death, a benefit of €15,000 is payable in addition to the normal Death Benefit of typically twice annual salary. 'Accidental Death' is defined as 'death as a direct result of a bodily injury arising from an external and accidental cause which leaves a visible bruise or wound'. The benefit is provided up until the 31st August following your 65th birthday, or when you retire or leave the Scheme, if earlier.

Children's Death Benefit (introduced in April 2006)

In the event that a member's child between the ages of 0 and 21 dies, a death benefit of €4,000 will be paid to the member. Children's Death Benefit applies to all natural or adopted children.

What happens at my retirement?

Our experience has been that the vast majority of members still need some element of Life Cover (Death Benefit) after they retire. For this reason, for a contribution of 0.05% of salary (built into the overall rate of contribution to the Scheme) members are entitled to join Cornmarket's Retired Members' Life Cover Plan on retirement, without having to undergo any medical underwriting once you join within **4 months** of your retirement, and you are a member of the Salary Protection Scheme at the date of your retirement. The Retired Members' Life Cover Plan provides for the payment of a tax-free lump sum to the member's estate on their death, in return for a modest monthly contribution (see page 25, Q3: *Can my Death Benefit remain in force after I retire?*).

Affordable for every member

How much does the Scheme cost?

As membership is so vital, the Scheme is designed to be affordable for every member. It is remarkably good value because it's negotiated on a special 'group basis' for INTO members. The contribution rate is currently set at 1.49% of gross salary and, for most members, is conveniently deducted from your salary by your employer. Please bear in mind that it is your responsibility to ensure that the correct deductions have, in fact, been made by your employer and that deductions are cancelled where appropriate.

SCHEME COST:

Disability Benefit	1.09%
Death Benefit	0.24%
Specified Illness Benefit	0.11%
Medical Immunity*	0.05%
Total cost	**1.49%** of salary

These rates includes the 1% insurance levy.

*Entitles members to join Cornmarket's Retired Members' Life Cover Plan, without medical underwriting. Terms & Conditions apply (see page 25 Q3: *Can my Death Benefit remain in force after I retire?*).

A helping hand from Revenue

You are eligible for tax relief at your highest rate of tax on the part of your contribution going towards Disability Benefit (1.09% of the total 1.49%). This means for most members the cost of membership is between €8 and €10 a week after tax.

EXAMPLE:

Income	Weekly contribution	'Real' weekly contribution after tax relief
€35,000	€9.99	€8.53*
€40,000	€11.42	€8.08**
€45,000	€12.85	€9.09**
€50,000	€14.28	€10.10**

*Real contribution rate of 1.27%, paying income tax @ 20%.

**Real contribution rate of 1.05%, paying income tax @ 40%.

Please note: This rate (based on the benefits in place at the 2014 review) is guaranteed until the next Scheme review on 1st April 2019.

How to join the Scheme

Who is eligible to join?

You may apply to join the Scheme if you are:

1. Under age 60, ***and***
2. A member of the INTO ***and***
3. Employed on a permanent basis (for 9 or more hours per week) ***or***

   On a contract of indefinite duration ***or***

   On a fixed-term contract (in this case your contract must be of at least 12 months' duration) ***and***
4. Actively at work.*

Please note: Members on paid or unpaid maternity leave are eligible to join the Scheme.

Job/Work sharers

Job sharing/work sharing members of the INTO who satisfy the eligibility conditions listed opposite may also apply to join the Scheme. The level of contribution and benefits which apply for them may differ from those relevant for permanent full-time members.

*Actively at work means that you:

- Are working your normal contracted number of hours
- Have not received medical advice to refrain from work
- Are not restricted from fully performing the normal duties associated with your occupation.

Important: You must remain a member of the INTO to remain an eligible member of the Scheme. If you leave the Union, you must inform Cornmarket in writing as you can no longer stay in the Scheme, and you will not be able to claim from it.

HOW TO JOIN

The Salary Protection Scheme for INTO Members helps INTO members maintain the standard of living they deserve. If you haven't already joined the Scheme, don't put it on the long finger.

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

Cover begins as soon as Irish Life accepts you as a member of the Scheme.

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Claimants' Tax Return Service

This service has been developed and incorporated into the Salary Protection Scheme for INTO Members, in response to previous feedback from Cornmarket claimants requesting help with their tax affairs.

The service offers new* claimants, who are in receipt of payment from the Scheme (for a continuous period of greater than 3 months), the additional benefit of complimentary tax advice from our tax team, in the form of a PAYE tax return for each year that a claim is in payment.

Our tax consultants will prepare and file your tax return and act on your behalf with the Revenue, to ensure that you do not pay any more tax than is necessary. They 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.

Who will benefit?

All claimants who submit a claim after 1st April 2014 will be contacted once their claim is accepted (and is deemed to be for a duration of greater than 3 months). Other Terms and Conditions apply, please contact us for more information.

Why would I need to do a tax return if I am not working?

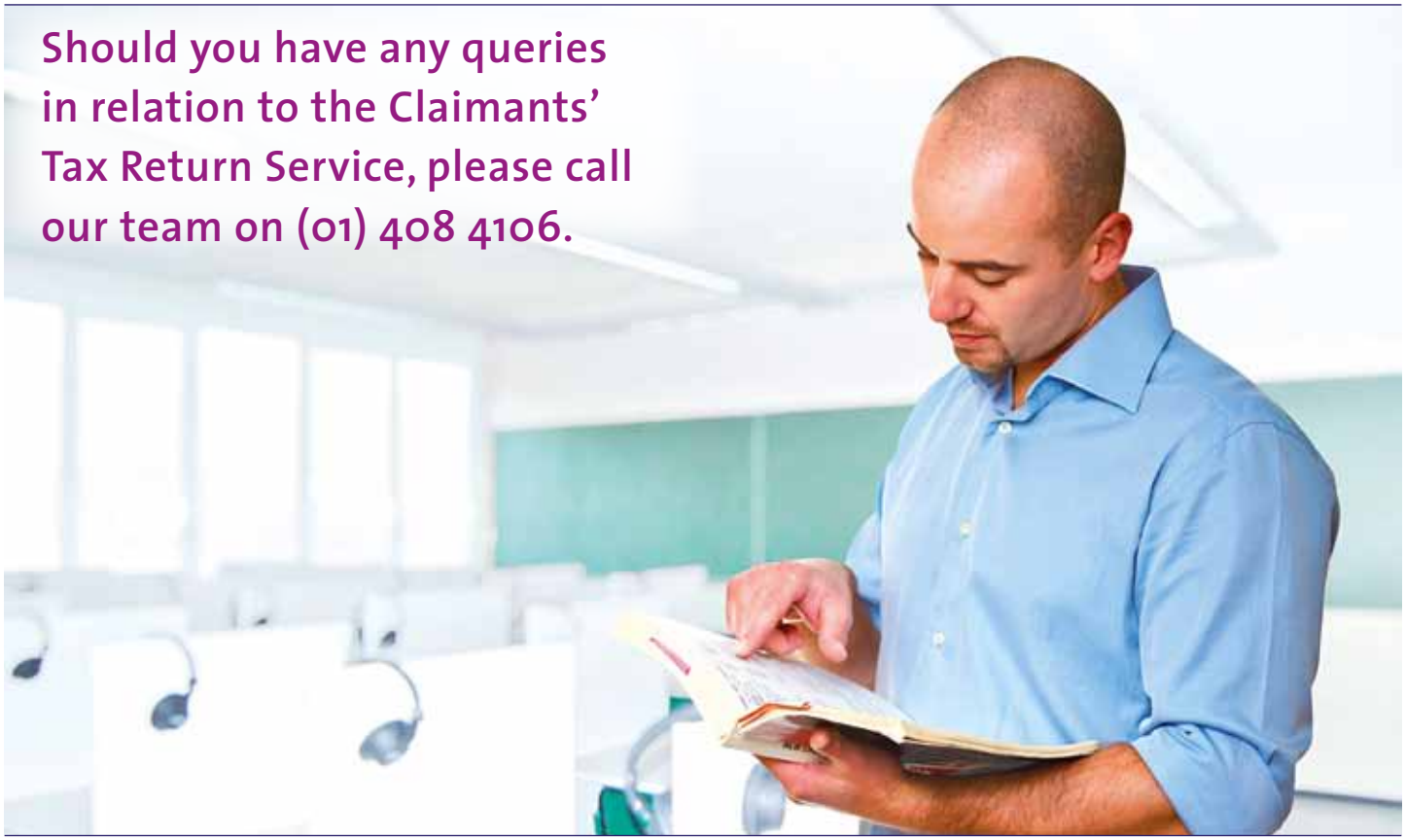
When claiming from the Scheme, you may have income from multiple sources e.g. Social Welfare, your employer, Salary Protection Benefit etc. This often results in incorrect tax being paid.

- The service reviews the allocation of your standard rate bands and tax credits to reflect your amended situation
- The service reviews your medical expenses and tax paid to date to assess if there is scope to claim back tax.

*As this benefit was added at the 2014 Scheme review, only claimants who submit a claim after 1st April 2014 are eligible to avail of this service.

This service is provided by Midas. Midas is a tax based service and not a regulated financial product. Cornmarket Retail Trading Ltd is a wholly-owned subsidiary of Cornmarket Group Financial Services Ltd. Telephone calls may be recorded for quality control and training purposes.

Should you have any queries in relation to the Claimants' Tax Return Service, please call our team on (01) 408 4106.



Frequently Asked Questions

Joining the Scheme

1 How do I join the Scheme?

To join the INTO Scheme you must complete an application form which consists of eight medical questions, and accept the declaration relating to the Scheme.

From time to time, a preferential application form may be available which provides the option to join the Scheme on the basis of a shortened medical declaration.

Call **(01) 470 8054** to request an application form or go to **www.cornmarket.ie/into** and select **'Salary Protection'.**

2 Who is eligible to join?

You may apply to join the Scheme if you are:

- Under age 60, ***and***
- A member of the INTO ***and***
- Employed on a permanent basis (for 9 or more hours per week) ***or***
  On a contract of indefinite duration ***or***
  On a fixed-term contract (in this case your contract must be of at least 12 months' duration) ***and***
- Actively at work*

Job/work sharers: Job/work sharing members of the INTO, who satisfy the eligibility conditions above may also apply to join the Salary Protection Scheme for INTO members. The level of contribution and benefits which apply for them may differ from those relevant for the full-time members.

*** Actively at work means that you:**

- Are working your normal contracted number of hours
- Have not received medical advice to refrain from work
- Are not restricted from fully performing the normal duties associated with your occupation.

Important: You must remain a member of the INTO to remain an eligible member of the Scheme. If you leave the Union you must inform Cornmarket in writing as you can no longer stay in the Scheme, and you will not be able to claim from it.

3 What is the 'deferred period'?

The deferred period is the waiting period before the Scheme benefit becomes payable.

For the purpose of this Scheme, from 1st September 2014, the deferred period is 13 weeks (92 days) disability in a 12 month period or 26 weeks (183 days) in a rolling 4 year period, where Standard Sick Leave has been granted. For cases where Extended Sick Leave has been granted, the deferred period is 26 weeks (183 days) disability in a 12 month period or 26 weeks (365 days) in a rolling 4 year period. (Please see page 5: *How the Scheme works* and page 21, Q7: *What happens if I have sick leave used prior to my acceptance into the Scheme?*).

4 When does my membership begin?

Your cover begins from the date Irish Life accepts your application to the Scheme. Members receive a formal acceptance letter confirming they have been included as members of the Salary Protection Scheme for INTO members. In some cases, medical evidence may be required before membership of the Scheme can be confirmed. This may involve providing further details over the telephone or attending a medical examination at Irish Life's expense.

Please note: Any sick leave accrued before you became a member of the Scheme will not be used in the calculation of the deferred period.

5 When does my membership end?

Membership of the Scheme ends:

- On 31st August following your 60th/65th* birthday as far as the Disability Benefit is concerned and on 31st August following your 65th birthday as far as the Death Benefit and Specified Illness Benefit are concerned (assuming you have not retired) ***or***
- If you leave teaching/resign ***or***
- If you no longer fulfil the eligibility requirements as set out, or if you leave the INTO Union.
  Note: you must remain a member of the INTO to remain an eligible member of the Scheme ***or***
- If your contributions to the INTO Scheme cease (please bear in mind that the responsibility to ensure that the correct contributions to the Scheme are paid, rests with you) ***or***
- On your retirement (other than on grounds of ill health) ***or***
- On your death,

whichever is earliest.

However, you do have the option to carry on an element of Death Benefit following your retirement if, at retirement, you decide to avail of the Cornmarket Retired Members' Life Cover Plan.

Notice period if you plan to retire: It is important to remember that Cornmarket may not be notified by your employer when you retire. It is vital therefore that you notify Cornmarket at least 10 weeks in advance of your retirement date so that we can offer you the option to join the Cornmarket Retired Members' Life Cover Plan or to stop your contributions to the Scheme.

*INTO members who entered/re-entered the Public Service after 1st April 2004 will enjoy cover until 31st August following their 65th birthday rather than 31st August following their 60th birthday which applies for all other members. If you re-entered service after 1st April 2004 with a break of more than 26 weeks that was not due to a career break or unpaid leave, you are also deemed to be a new entrant.

6 Are all applications accepted?

In a small percentage of cases, membership of the INTO Scheme may be refused. In such cases, applicants will receive a letter confirming that they have not been accepted into the INTO Scheme. In other cases, membership may be offered subject to the condition that certain specified conditions are excluded from cover.

7 What does it mean if my application is subject to exclusions, or even refused?

This means that Irish Life believes it cannot, because of your health history, offer you the cover sought, and may therefore exclude certain conditions or restrict the level of cover. Irish Life makes such decisions only after careful consideration of the information supplied by you on your application form, together with any details it has received from doctors you have attended, if applicable. Applicants may seek additional clarification from their own doctor, who can contact Irish Life to request reasons for its decision. You have the option to appeal this, **within 3 months** of the decision.

Important: Once an exclusion is applied, sick leave due to the excluded condition, including the calculation of the deferred period, cannot be included in relation to any aspect of the claim.

For further information contact Cornmarket on **(01) 408 4137**.

Terms of Employment

1 What if I have a second job?

This may be taken into account in calculating any benefit paid, should you make a claim from the Scheme. It is vital, therefore, that you notify Cornmarket in writing at the time of joining the INTO Scheme if you have a second job. Likewise, you should notify Cornmarket in writing if, after joining the Scheme, you take on a second job. In the event that you have a second job at the time of joining the Scheme, or take on a second job after joining the Scheme, Irish Life reserves the right to refuse cover or withdraw cover in respect of your normal job.

This could happen where, for instance, Irish Life believes that your second job involves a greater degree of risk than that involved in your normal job. The cover provided by the Scheme does not extend to your second job. If you would like disability cover on your second job, you should contact Cornmarket about the possibility of insuring yourself against disability through an individual policy.

2 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. Benefit from any accident or sickness policy will however be taken into account, except benefits paid under a Lump Sum Critical/Serious Illness Policy (see page 17, Q3: *What if I take out a Lump Sum Critical Illness Policy?* for details and see page 18, Q8: *What are the maximum benefits paid under the Scheme?*).

3 What if I take a career break?

Generally, members of the INTO Scheme who take a career break fall into one of the following four categories:

1. **Members who wish to continue their full cover (i.e. Disability, Death and Specified Illness Benefit) under the INTO Scheme for the duration of their career break because they are taking up alternative employment.**

   If you are in this category you may apply within **4 months** of taking a career break as consent from Irish Life must be obtained. The occupation being undertaken while on Career Break must be in the same risk category as teaching. Any occupation undertaken where the risk is deemed to be greater than teaching, by Irish Life, must be individually assessed before cover will be granted. Premiums and benefits will be based on the teaching salary prior to the commencement of the Career Break. The premium will be calculated at the commencement of the Career Break and must be paid annually in advance. It will be based on the current rate of 1.49% of gross salary at time of commencing Career Break. Members of the Scheme wishing to avail of this option must write to Cornmarket with a full job description. Cover cannot be extended beyond the maximum permissible term for a Career Break of five years.

2. **Members who wish to continue the Death Benefit and Specified Illness Benefit elements of their cover, while on career break, and who also wish to re-activate their membership of the Scheme on completing their career break without having to undergo any medical underwriting.**

If you are in this category you may apply **within 4 months** of taking a career break for immunity from medical underwriting. This will allow you to re-activate your Disability Benefit under the Scheme at the predetermined return to work date, without the need for medical underwriting. To maintain the Death Benefit and Specified Illness Benefit in force you must pay 100% of the contribution for Death Benefit and Specified Illness Benefit.

These payments are based on your pre-career break salary and must be paid annually in advance during your career break. The level of Death Benefit and Specified Illness Benefit during the career break will be based on your salary on the date you started your career break. To secure immunity from medical underwriting, you must notify Cornmarket of the dates of your career break prior to its commencement and complete the relevant forms.

If you extend your career break, or return to work, you must notify Cornmarket.

3 Members who do not wish to continue the Death or Specified Illness Benefit elements of their cover, but who wish to re-activate their membership on completing their career break without having to undergo any medical underwriting.

If you are in this category you may apply **within 4 months** of taking a career break for immunity from medical underwriting. This will allow you to re-activate your membership of the INTO Scheme at the predetermined return-to-work date. To secure immunity from medical underwriting, you must notify Cornmarket of the dates of your career break prior to its commencement and complete the relevant forms.

Should you be unable to return to work on your expected return to work date, due to illness or injury, the deferred period will start on this date.

4 Members who simply decide to discontinue membership of the Scheme.

If you are in this category or do not notify Cornmarket of your intention to take a career break, your cover under the Scheme will lapse as soon as your salary stops. Thereafter, you must complete a full medical application form and undergo medical underwriting should you wish to rejoin the Scheme upon returning to work.

Residency clause: If you are going to reside outside Ireland or the U.K. during your career break and wish to avail of option 1 or 2, you will need prior agreement from Irish Life. Please advise Cornmarket Group Financial Services Ltd. if this is the case.

You must remain a member of the INTO Union for the duration of your career break.

Members who extend their career break will only have the option to maintain the cover they chose for the first year of their career break or they may reduce it. In other words, the amount of cover that a member can choose in years two to five of their career break cannot be more than what they had in their first year.

4 What if I change my occupation or leave the INTO?

In such circumstances you are no longer eligible for membership of this Scheme. You should therefore write to Cornmarket to cancel your membership. Cornmarket may, depending on your circumstances, be able to offer you an individual policy providing similar cover. However, such policies may typically be more expensive than the Salary Protection Scheme for INTO Members.

Important: You must remain a member of the INTO to remain an eligible member of the Scheme. If you leave the Union, you must inform Cornmarket in writing as you can no longer stay in the Scheme and you will not be able to claim from it.

5 Is my benefit affected by the PRSI contribution I pay?

Many members are paying PRSI contributions on the lower 'D' PRSI rate and so pay less PRSI than those members on the 'A' PRSI rate. If a member paying PRSI at the 'D' rate retires on an Ill Health Early Retirement Pension (ERP) under the Superannuation Scheme, he or she is not entitled to any State Illness Benefit.

On the other hand members paying the higher 'A' PRSI rate may be entitled to a State Illness Benefit if they suffer prolonged illness. Members in this situation may also be entitled to an Ill Health Early Retirement Pension. The benefit payable under the Scheme is the amount needed to 'top up' any Temporary Rehabilitation Renumeration (TRR) or Ill Health Early Retirement Pension and any State Illness Benefit to 75% of salary.

In effect, this means that whether you are a 'D' or an 'A' PRSI contributor, taking either the Ill Health Early Retirement Pension, State Illness Benefit and Temporary Rehabilitation Remuneration into account, the combined amount you receive in the event of disability is the same.

Actual Disability Benefit amount may differ depending on 'D' or 'A' PRSI, but overall income after a claim will be unchanged at 75% of salary.

6 What if I am not in the Superannuation Scheme?

If you are not contributing to the Superannuation Scheme, you are not entitled to an Ill Health Early Retirement Pension should you become disabled. However, if you are not a member of the Superannuation Scheme you will be paying class 'A' PRSI contributions and therefore may be entitled to State Illness Benefit in the event of disability. Typically, if you are in this situation you are paid full salary for 13 weeks of illness in any 12 month period. After this your pay stops altogether and your only entitlement thereafter is to State Illness Benefit. If you are not a member of the Superannuation Scheme, any benefit under the INTO Salary Protection Scheme will be paid after you have been ill for 13 weeks in any 12 month period. The amount paid will be 75% of your salary less any State Illness Benefit and any other income you are receiving from your employer.

7 What happens if I change my terms of employment?

If your terms of employment change, this may affect your cover under the Scheme. For instance, if you join the Superannuation Scheme or if you reduce the overall number of hours you are working each week, your benefits under the Scheme may be affected. It is vital therefore that you notify Cornmarket in writing should you change your terms of employment. Similarly, if you change your job to one that may involve a greater degree of risk from an underwriting perspective, it is vital that you notify Cornmarket.

8 Are there any special considerations for part-time/ temporary teachers?

Yes. Amongst the issues you should consider:

1. Temporary/part-time INTO members are eligible to join only if they working on average more than 9 hours a week and, in the case of temporary part-time employees are on a contract of employment of at least 12 months duration (see page 12, Q2:*Who is eligible to join?*).
2. Eligible part-time teachers should also bear in mind that in some cases membership of the Scheme may not be suitable for them. This could be the case if, for instance, you are on a relatively low salary and are paying PRSI at the 'A' rate. This means that if you become disabled you would receive State Illness Benefit (€9,776 per annum – the 2015 level). If this is more than 75% of your salary you would not receive any benefit from the Scheme. This is due to the fact that you would already be receiving more than the maximum 75% of salary you are entitled to under the Scheme.
3. Eligible part-time teachers should also remember that benefits paid under the Scheme may be reduced if, for instance, you spent some years as a full-time teacher and were a member of the Superannuation Scheme. Assuming that you were contributing to the Superannuation Scheme for more than 5 years, this means that if you become disabled you would be entitled to receive an Ill Health Early Retirement Pension. If the greater portion of your Superannuation contributions were made while you were on a full-time salary, it may be the case that your Ill Health Early Retirement Pension (which might include many years of Superannuation contributions based on full-time income) is in fact very large in relation to your current part-time salary.

As a result, you would be eligible for little or no benefit under the Scheme as you would already be receiving close to, or more than, 75% of your salary in the form of an Ill Health Early Retirement Pension. For this reason, when calculating the amount of benefit to be paid under the Scheme in such cases, Irish Life may (at its discretion) reduce the deduction in respect of any Ill Health Early Retirement Pension in order to be fair to the member. A similar approach is applied for those who are job sharers.

9 What benefits does the Scheme provide for job sharers* and work sharers?

The benefits and contribution rate for job sharing and work sharing members are based on job sharing/work sharing salary i.e. 1.49% of the member's job sharing salary. In order to cater better for Job Sharers under the terms of the Scheme, a reduced rate of contribution in respect of the Disability Benefit for job sharers has been agreed at 0.94%.

This rate applies only to job sharers/work sharers who are working for 50% or less of the full-time working week.

In either case, the normal rate of contribution in respect of Death Benefit and Specified Illness Benefit i.e. 0.24% and 0.11% respective of actual salary (i.e. the job-sharing/work sharing salary) will apply. As a result, Death Benefit is based on twice job sharing/work sharing salary and Specified Illness Benefit is based on 25% of job sharing/work sharing salary at the date of diagnosis.

* Working 50% or less of the full-time working week.

Please note: No reduction in the Disability Benefit contribution rate will apply until the date that Cornmarket or Irish Life receive notice from the member in writing that he/she is job sharing/work sharing and therefore eligible for the reduced contribution rate. As a result, no refunds will be paid in such cases.

In the event of a claim, the Disability Benefit will be calculated based on your job-sharing salary at the end of the deferred period. In the event that you retire on ill health grounds, Irish Life may deduct a lesser amount than the actual Ill Health Early Retirement Pension entitlement from the benefit paid by the Salary Protection Scheme. This is because if Irish Life were to deduct the actual Ill Health Early Retirement Pension (which might include many years of Superannuation contributions based on full-time salary), the member's Ill Health Early Retirement Pension entitlement could come close to, or actually exceed, the benefit paid under the Scheme. This would mean little or no benefit would be paid under the Scheme. For this reason, when calculating the amount of benefit to be paid under the Scheme, Irish Life may reduce the deduction in respect of any Ill Health Early Retirement Pension in order to be fair and equitable to the member. A similar approach is applied for those who take up a part-time position following a period spent in full-time employment.

SPECIAL CONCESSION

Option to have cover based on full-time salary: In recognition of the fact that some members intend to go job sharing for a limited period of typically 1-2 years and would prefer to keep cover based on their full-time salary, Irish Life has agreed to provide an option for cover based on the member's full-time salary for a period of up to **5 years**, i.e. be treated on the basis that you are employed full-time and pay a contribution based on your full-time salary. In this event, the salary for benefit purposes will be the equivalent to full-time salary.

In order to avail of this option, members must pay 2.98% i.e. double the normal contribution rate (1.49% x 2) of salary, where applicable. Cornmarket will be able to advise you of the extra cost involved if you avail of this option.

You should note that the option of cover based on full-time salary is only available to full-time members who are already members of the Scheme and who subsequently elect to job share i.e. members who are job sharing at the time they join the Scheme cannot avail of cover based on full-time salary.

Important: If you intend to avail of this option and have cover based on your full-time salary equivalent, you must notify Cornmarket **in advance** of going job sharing or work sharing. If you do not contact Cornmarket, your contributions and benefit will automatically default to cover based on your job sharing or work sharing salary.

10 What if I take Unpaid Parental, Maternity or Adoptive Leave?

If you avail of your entitlement to take Unpaid Parental, Maternity, or Adoptive Leave, and are making your contributions to the Scheme through salary, no contributions will be collected in respect of periods for which you are on leave as you will not be paid a salary while on leave.

Nonetheless, your cover will continue unaffected while you are on leave and no repayment of the 'skipped' contributions will be sought. This is subject to the period of unpaid leave being no longer than **18 weeks in total**, in any 12 month period, if you take unpaid leave under **one** of the categories listed i.e. unpaid maternity, parental, adoptive or carer's leave.

Where the period of leave is more than 18 weeks in total in any 12 month period, members should contact Cornmarket for details of their options. These will be similar to those available to members who take a career break. You must notify Cornmarket at least **4 weeks** in advance of the commencement of unpaid leave.

If a member takes unpaid leave under **more than one** of these categories (for example unpaid Maternity Leave, followed by a period of unpaid Parental Leave), Irish Life will allow you to take up to 30 weeks in a 12 month period without having to pay a premium.

11 What if I take unpaid leave to take care of a dependant relative?

If you avail of your entitlement to take unpaid Carer's Leave, and are making your contributions to the Scheme through salary, no contributions will be collected in respect of periods for which you are on leave as you will not be paid a salary while on leave.

Nonetheless, your cover will continue unaffected while you are on leave and no repayment of the 'skipped' contributions will be sought. However, this is subject to the period of leave being no longer than 18 weeks in any 12 month period.

Cover for members who make their contributions by direct debit is likewise unaffected where such leave is for a period of **no longer than 18 weeks** in a 12 month period.

Where the period of leave is more than 18 weeks in a 12 month period, members should contact Cornmarket for details of their options. These will be similar to those available to members who take a career break.

You must notify Cornmarket at least 4 weeks in advance of the commencement of unpaid leave so that contributions can be cancelled.

12 What if I am on a temporary contract?

A claim in respect of a member on a temporary contract is treated in the normal manner (see page 21, Q11: *What benefits do members on temporary contracts get?* for details).

13 What if I am placed on Administration or Special Leave (Gardening Leave)?

If you are placed on any of the above types of leave (whether paid or not) please contact us immediately, as your membership may be affected.

14 What if I take Secondment?

If you are in this category, the Scheme allows you to maintain your membership while you are on secondment, however there are certain restrictions. You must notify Cornmarket 4 months in advance of taking secondment, as consent from Irish Life must be obtained. The secondment must be approved by the Department of Education and Skills and the occupation being undertaken while on secondment must be agreed in advance by Irish Life. You must continue to be paid by the Department of Education and Skills and premiums must continue as normal. You must remain a member of the INTO Union while on secondment.

Calculation of Benefit

1 On what salary is my cover based?

If, like most INTO members, you are making your contributions to the Scheme through salary, your cover and contributions are based on the income you receive from your employer. If you are paying by direct debit, your cover and contributions are based on the last salary you notified to Cornmarket. The level of cover you enjoy and the amount of contribution you pay may change periodically (see this page, Q4: *Does my cover change in line with changes in my salary?* for details).

Benefit will be based on the higher of your salary at the time your sick leave expires or your salary at 31st December 2009, prior to the salary reductions on 1st January 2010.*

* This is on the basis there are no further public sector salary reductions.

Your income will be calculated as basic salary as a teacher plus allowances for teaching qualifications and posts of responsibility as certified by the Department of Education and Skills, but excluding any other variable payments.

For the purpose of this policy, salary is defined as:

(i) In the case of an Insured Person who is a member of a Superannuation Scheme, their basic annual salary 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 ***and***

(ii) In the case of an Insured Person who is not a member of a Superannuation Scheme, their basic annual salary 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 had that Insured Person been a member of a Superannuation Scheme.

2 Does it affect my benefit under the Scheme if my disability is due to an injury at work?

Yes. If you are injured at work, depending on the circumstances (e.g. you are in receipt of State Illness Benefit), you may be entitled to payments in excess of 75% of salary. In such cases, please notify Cornmarket immediately. As you would already be receiving a payment greater than 75% of your salary, you would not be entitled to any benefit under the Scheme.

3 What if I take out a Lump Sum Critical/Serious Illness policy?

Lump Sum Critical/Serious Illness Policies (otherwise known as Serious Illness/Specified Illness Benefit) pay out a lump sum on the diagnosis of certain specified serious illnesses. Benefit paid under such policies are often taken into account when assessing the level of benefit to be paid under Salary Protection Schemes.

However, Irish Life has agreed special preferential arrangements for members of the Scheme. This means that currently payments under a 'critical illness' policy will not be taken into account when calculating the benefit to be paid to you under the Salary Protection Scheme for INTO Members.

4 Does my cover change in line with changes in my salary?

Members contributing by Deduction at Source: The vast majority of members make their contributions to the Scheme through salary. For such members, contributions and cover change automatically every time salaries change. This is because their contributions are linked to their salary and automatically change in line with salary changes, without any need on the part of the member to complete new application forms or undergo a medical examination. If your salary reduces as a result of your working hours reducing or a general pay reduction, your cover will automatically reduce in line with your revised salary. In certain circumstances, cover may not reduce if your salary reduces (see arrangements for Unpaid Leave and Job Sharers on page 16, Q10).

Members contributing by Direct Debit: For members who are contributing to the Scheme by direct debit from a current account, contributions and cover may be amended periodically. These amendments will be in line with either general salary changes, changes in the Consumer Price Index or Scheme reviews, since the last amendment was applied. Such amendments are currently applied without the need for medical underwriting and members will receive prior notification.

Regarding additional amendments in salary, for instance in the case of promotions, currently members contributing by direct debit may apply to amend their cover accordingly. You must apply for such amendments within **2 months** of receiving notification of your salary amendment, and you must provide evidence of that salary amendment (such as a recent pay slip or confirmation from your employer). The onus is on the member to ensure that the correct premium/level of cover is paid. Similarly, members who experience a reduction in salary must also notify Cornmarket of this fact.

Please note: If a Salary Protection claim is admitted, the benefit payable will be based on the salary that you were receiving from your employer at the time the claim arises; assuming that you were paying the correct premium for this level of cover.

5 If I am claiming from the Scheme, does the amount I receive increase each year?

Yes. The benefit paid to you by the Scheme increases by 5% each year, or the rate of increase in the Consumer Price Index (if lower). This helps ensure the benefit you receive remains realistic despite the effect of inflation. You should bear in mind that any Ill Health Early Retirement Pension you receive will generally increase each year in line with salary rises awarded to working members.

6 What if I already have some form of Salary Protection?

If you already have a Salary Protection or Permanent Health Insurance policy, you should bear in mind that the cover provided by such a policy may 'overlap' with that provided by this Scheme, i.e. it will be taken into account when calculating

how much benefit should be paid under the Scheme to ensure you receive no more than 75% of salary. You should, therefore, contact your local Cornmarket consultant for advice before applying to join the INTO Scheme.

7 Will I receive money back if I never claim under the Scheme?

No. As with health or car insurance, your contributions go to meet the cost of cover for you and your colleagues. This keeps the cost of membership to a minimum and means that there is no 'cash-in' value paid out to those who never make a claim under the Scheme.

8 What are the maximum benefits paid under the Scheme?

75% of your salary as paid by your employer less:

a) any amount of salary, earnings, profit, reward, or remuneration which you are in receipt of from your normal occupation or any other occupation or business ***and***

b) the Ill Health Early Retirement Pension/Temporary Rehabilitation Remuneration entitlement calculated on the normal basis as set down by your employer, irrespective of whether you are receiving this amount or not* ***and***

c) an amount equal to the State Illness Benefit payable to a single person, if you are entitled ***and***

d) any benefit you are receiving under the Social Welfare Acts other than sickness, disability or treatment benefits ***and***

e) any benefit you are entitled to under any other insurance against accident or sickness or other similar arrangement (where appropriate such an amount will be annualised), except benefits paid under a Lump Sum Critical/Serious Illness policy (see page 17, Q3: *What if I take out a Lump Sum Critical/Serious Illness policy?* for details) ***and***

f) any annualised amount awarded by a court of law, an agreed settlement sum or ex-gratia payment attributable to loss of earnings arising out of any action relating to your disablement ***or***

The maximum salary protection benefit – currently €130,000 p.a.

*However, in some cases the insurer may agree to pay a full 75% of salary without deductions for Ill Health Early Retirement Pension/ Temporary Rehabilitation Remuneration if they think there is a reasonable expectation of you returning to work. This is for a maximum of **2 years** (see page 20, Q4: *What happens if I do not want to retire?* for details).

Taxation

1 Do I have to pay tax on benefits from the Scheme?

Disability Benefit paid by the Scheme will be treated as normal income and, as such, is liable to income tax, PRSI and the Universal Social Charge (USC). Irish Life will deduct any tax, due from the payment made to the member, in the same way as an employer deducts PAYE and the USC from an employee.

Specified Illness Benefit is paid **free of tax** under current regulations.

Death Benefit is paid **free of tax** to your estate. Thereafter, beneficiaries of your estate will be subject to whatever taxes apply at the time of the inheritance.

2 How do I claim tax relief on my contributions?

If you are making your contributions through salary

Tax relief is provided automatically by your employer.

If you are paying your Scheme contributions by deduction at source, your Salary Protection Scheme deductions will appear under two separate headings on your payslip.

If you are making your contributions through Direct Debit

Once you have been accepted for membership of the Scheme, Cornmarket will forward you a letter confirming your membership. With this letter you will receive a premium statement for Revenue purposes. This should be forwarded to your local Revenue Office in order for them to grant you tax relief on your premium contributions to the INTO Scheme. Simply forward these details to your tax inspector together with a covering letter. Tax relief is usually granted within a few weeks of receipt of this information.

If you notify Cornmarket of any change in your salary, we will amend your contributions and forward you up-to-date details of the contributions you are making. You should, in turn, send this on to your tax inspector who will amend your tax relief accordingly. Please bear in mind that while tax relief is available on the part of your contribution relating to Disability Benefit (currently 1.09% of salary), it is not available on the part of your contribution relating to Death Benefit (currently 0.24% of salary), Specified Illness Benefit (currently 0.11% of salary), or the Medical Immunity Benefit (currently 0.05% of salary).

Claiming from the Salary Protection Scheme for INTO members

1 How do I claim from the Scheme?

Cornmarket's role is to help guide members through the claims process and to ensure that all legitimate claims are paid promptly by the insurers of the Scheme. Cornmarket has considerable experience in this area and, on behalf of claimants, works closely with Irish Life to ensure that all legitimate claims are paid.

Cornmarket is not automatically notified of your absence from work through illness. This means that if you intend to make a claim under the Scheme you must notify Cornmarket of this fact on (01) 408 4018. As soon as you become aware that, due to illness or injury, your salary is likely to reduce to half pay or cease altogether, please let us know. Ideally, we should be informed about approximately **8-9 weeks** in advance of your salary reducing to half pay or ceasing altogether, to enable Irish Life to assess your claim and gather the relevant medical and employer information. As we understand that this may not always be possible, Irish Life may not be able to pay your benefit at the time that your salary reduces or ceases. In such cases your benefit may, depending on the particular circumstances, be backdated to the date when your salary reduced to half pay or stopped altogether, where the claim is subsequently admitted.

IMPORTANT

Short-term claims

As a result of the changes to Public Sector sick leave arrangements, there is a likelihood of an increase in short-term claims. With some short-term claims, the medical evidence required may not be as detailed as that required for a long-term claim.

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 (approximately 3 months) has elapsed since your salary reduced or ceased. For this reason, it is vital that you register your claim promptly in line with the guidelines given (8-9 weeks before your salary reduces to half pay or ceases altogether). In the case of late notification of a claim, cases will be assessed on individual merit and Irish Life reserves the right to decline to assess the claim.

Our Claims Team will explain the claims process and the additional documentation you will need to submit. Prior to completing your claim form, please consult with Cornmarket. Upon receipt of your claim form, Irish Life will process your claim.

You should note the following:

- In some cases, Irish Life may require a member to provide medical evidence
- You may be required to undergo medical examinations (at Irish Life's expense) or an assessment by an occupational therapist or any other assessments or tests
- Admittance of a claim is subject to Irish Life being satisfied, based on medical evidence received, that you are totally disabled from following your normal occupation and you are not involved in another remunerative occupation (see page 20, Q2 for a definition of disablement)
- You may also be asked to undergo medical rehabilitation with a view to being rehabilitated back into the workforce.

Irish Life may also arrange for one of its Health Claims Advisors to call to your home address, either before any decision is made to admit the claim, or while the claim is in payment. The purpose of the home visit service is to explain the claims process, offer advice on Social Welfare and re-training if applicable, as well as outlining the various rehabilitation programmes available.

It must be emphasised that information required (including your claim form) by Irish Life as outlined above must be dealt with fully and promptly. **Undue delay, or failure to produce such information, may invalidate your claim.**

In the event of you failing to follow the advice of your own or any qualified medical practitioner, all benefits payable or being paid under the policy may cease.

See pages 23-24 for a step-by-step guide to claiming from the Salary Protection Scheme for INTO members.

2 How disabled do I have to be to qualify for benefit under the Scheme?

To qualify for benefit under the Scheme, Irish Life must be satisfied 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 for profit, reward or remuneration.

Definition of disablement:
(i) Total disablement shall be deemed to exist where (a) the insured person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the insured person is not engaging on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration including benefit in kind)
and
(ii) Partial disablement shall be deemed to exist where (a) following a period of total disablement as in Sub-Provision 1 (i) above, which period is to be decided by the Company, an Insured person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person with the written consent of the Company re-engages in his normal occupation with loss of earnings as a result or engages in some other occupation on a full-time or part-time basis (whether or not for profit or reward or remuneration, including benefit in kind).

3 Who decides whether or not I am fit to work?

Irish Life will decide whether you are fit to work based on an assessment of all medical information. To qualify for benefit under the Scheme, Irish Life must be satisfied that you are totally unable to carry out the duties pertaining to your normal occupation because of illness or injury and that you are not following any other occupation. In certain cases benefit may be paid where you return to work to take up another occupation, but at a reduced level of earnings due to partial disability (see page 22, Q2: *What happens if I return to work but at a reduced salary or take up a different, less well paid job?* for details).

While you are being paid benefit under the Scheme, Irish Life will seek regular medical certificates from your doctor(s). This is because you must continue to be disabled and unable to work in order to be entitled to continue to claim under the Scheme. Irish Life may also require an independent medical examination or specific information from your doctor(s). These medical examinations will be at Irish Life's expense. You may also be visited by an Irish Life Health Claims Advisor from time to time. In the event of you failing to follow medical advice during the course of benefit payments, Irish Life reserves the right to cease paying benefits.

Claims in payment for 6 years will not be subject to ongoing medical assessments. However, Irish Life will continue to manage the claim and will financially review all cases periodically. Irish Life also adopts an approach that continually encourages rehabilitation and will assist those claimants whose circumstances change in retraining and return to work programmes.

Please note: If you have been granted Ill Health Early Retirement on the grounds of ill health under the rules of the Superannuation Scheme, this does not mean that you will automatically be entitled to benefit under the Scheme. This is because Irish Life reserves the right to undertake its own medical examinations and its own determination as to whether you are disabled under the terms of the Scheme.

4 What happens if I do not want to retire?

If you have exhausted your sick pay entitlement and you decide not to apply for Ill Health Early Retirement Pension (perhaps because you intend to return to work) and Irish Life agrees that there is a reasonable expectation of returning to work, then Irish Life may pay a benefit of 75% of salary less any State Illness Benefit/Temporary Rehabilitation Remuneration for a maximum of **2 years**. This means that no deduction will be made from the benefit paid under the Scheme for an amount equivalent to Ill Health Early Retirement Pension, as no Ill Health Early Retirement Pension is being claimed. If a member retires subsequently and an Ill Health Early Retirement Pension is paid, the additional amount that was paid under the Scheme since the effective date of ill health early retirement must naturally be repaid to the insurer.

5 Are there any exclusions under the Scheme?

There are no exclusions under the Disability or Death Benefit of the Scheme. However, in some cases, membership may be offered with certain medical conditions excluded.

Please bear in mind that in some cases individual members may be accepted into the Scheme subject to exclusions in respect of specific conditions.

Once an exclusion is applied, sick leave due to the excluded condition, including the calculation of the deferred period, cannot be included in relation to any aspect of the claim.

Certain exclusions apply to the Accidental Death Benefit.

Exclusions apply to the Accidental Death Benefit where death is caused directly or indirectly by:

1. Taking part in any criminal act
2. Taking drugs (other than under the direction of his/her own or any other registered medical practitioner) or alcohol
3. Taking part in aviation (other than as a fare-paying passenger) or in motor car or motor cycle racing or
4. That Insured Person's own deliberate act.

These exclusions do not apply to the main Death Benefit element of the Scheme.

For the Specified Illness Cover, the following exclusions apply:

(a) Arising, in the opinion of Irish Life, directly or indirectly as a result of taking alcohol or drugs (other than under the direction of a registered medical practitioner) ***or***

(b) Arising, in the opinion of Irish Life, directly or indirectly as a result of failure to follow reasonable medical advice in relation to a cause or latent cause of sickness.

6 Are claims ever turned down by the Insurer?

The great majority of claims are paid. However, experience has shown that when difficulties do arise, they usually arise because:

1 **Medical opinion is that the member is not disabled from carrying out his or her normal occupation.**
Depending on the medical condition at issue, specialist opinion may be required. If ultimately in Irish Life's view, the medical opinion is that you are not disabled as defined under the INTO Scheme, benefit will not be paid regardless of whether you have been retired on an Ill Health Early Retirement Pension (see page 20, Q2 for the definition of disability).

2 **When joining, the member did not disclose his or her full medical history.**
In such cases, Irish Life reserves the right not to pay a claim. It is very important when applying to join the INTO Scheme that you ensure that you make a full disclosure in relation to any questions asked on the application form, and during any medical examination you may undergo. If you don't, any claim you make may be turned down and cover under the Scheme may be cancelled and premiums will not be refunded.

3 **Late Notification**
In the case of late notification of a claim (see page 19 for details), cases will be assessed on individual merit and the insurer reserves the right to decline to assess a claim.

In the event of a dispute, you may appeal to the insurer by providing additional objective specialist medical evidence. Should your appeal be unsuccessful, you have the right to appeal to the Financial Services Ombudsman (see this page, Q12: *What happens if my claim is rejected?* for more information).

7 What happens if I have sick leave used prior to my acceptance into the Scheme?

Naturally, you cannot be covered for a period of sick leave that occurred while you were not a member of the INTO Scheme. Sick leave used prior to your acceptance into the Scheme cannot be taken into account in the calculation of the expiry of the deferred period (see page 12, Q3: *What is the deferred period?* for details).

8 When does benefit payment under the Scheme begin?

Once Irish Life has accepted your claim and you have completed the relevant deferred period, benefit payment under the Scheme will commence.

Please remember that it can take **a number of weeks** to process your claim. As soon as you become aware that, due to illness or injury, your salary is likely to reduce to half pay or cease altogether, please let us know. ideally, we should be informed about **8-9 weeks** in advance of your salary reducing to half pay or ceasing altogether to enable Irish Life to assess your claim and gather the relevant medical and employer information. As we understand that this may not always be possible, Irish Life may not be able to pay your benefit at the time that your salary reduces or ceases. In such cases the benefit will be backdated where the claim is subsequently admitted.

9 For how long will I be paid a benefit under the Scheme?

The Scheme will continue to pay benefit as long as your illness or injury prevents you from doing your normal job and you are not following any other occupation. Disability Benefit payments will stop when either:

- You recover ***or***
- You resign ***or***
- Irish Life determines (based on medical evidence) that you are fit to return to work ***or***
- you return to work ***or***
- you die ***or***
- you reach the end of the school year following your 60th/65th* birthday,

whichever is earliest.

In certain cases, benefits may be paid where the member returns to work but at a reduced level of earnings due to partial disability.

*Depending on the date of entry/re-entry to the Public Sector i.e. pre/post 1st April 2004.

10 Do I have to pay my contributions if I am claiming from the Scheme?

No. While you are claiming Disability Benefit from the Scheme, no contributions are deducted in respect of the Salary Protection Scheme. The Death Benefit, Specified Illness Benefit and Medical Immunity Benefit are maintained free of charge.

11 What benefits do members on temporary contracts get?

A claim in respect of a member on a temporary contract is treated in the normal manner as outlined in questions 8 and 9 on this page. If a member is unable to work due to illness or injury and their contract expires before the expiry date of the deferred period, (13 weeks in any 12 month period), their claim will be considered subject to the usual medical evidence requirement. For example, if a member suffers an illness with 3 months remaining on their contract, and remains unable to work due to illness or injury to the end of the deferred period, their claim will be considered in the normal manner.

12 What happens if my claim is rejected?

Should a member of the Scheme wish to appeal a claims decision, they may make a Direct Appeal to Irish Life. In the event that a Direct Appeal is not successful and the claimant is not satisfied with the outcome, an appeal may be submitted to the Financial Services Ombudsman.

1 **Direct Appeal (within 3 months of decision):** This involves individual claimants making an appeal in which they should include any additional evidence to support their claim. Any such evidence is submitted for consideration by Irish Life. As part of the appeal process, Irish Life may require medical evidence such as an independent medical examination. If the evidence is accepted, the claim is paid.

If you do not appeal within the given three month timeframe, then premiums must recommence on your policy immediately or cover will lapse.

2 **Appeal to the Financial Services Ombudsman** (service is free of charge):

In the event that a Direct Appeal is not successful and the claimant is dissatisfied with the outcome, an appeal may be submitted to the Financial Services Ombudsman. In this instance, Irish Life will provide you with a letter to enable you to refer the matter to the Financial Services Ombudsman, if adjudication is required. When the complaint form is issued, the claimant should complete the form and return it, together with any relevant documentation, to the Financial Services Ombudsman. The Financial Services Ombudsman is a statutory officer who deals independently with complaints from consumers about their unresolved dealings with all financial services providers. Essentially, the Ombudsman acts as the arbiter of unresolved disputes and, very importantly, is impartial. This is done by engaging in dialogue with the claimant and the relevant financial service provider to try to resolve the complaint quickly and efficiently.

Findings: In some cases it may be possible to reach a settlement to the satisfaction of both parties. If this is not possible, the Ombudsman will adjudicate upon the matter. The findings of the Financial Services Ombudsman are legally binding on both parties, subject only to appeal by either party to the High Court. If the Ombudsman finds in favour of the claimant, he can and will award compensation and/or direct rectification where it is deemed appropriate. If the Financial Services Ombudsman finds against the claimant, the claimant may appeal the decision to the High Court if he or she wishes, within 21 calendar days from the date of the Financial Services Ombudsman's findings.

Notice period if claim is ended

In the case of claimants who have been in receipt of benefit for at least 1 year, where medical evidence indicates that a member is fit to return to work, Irish Life will give 3 months' notice before ending the payment of benefit. This only applies to those cases where a claim has been in continuous payment for a minimum of 12 months.

Returning to work after making a claim

1 What happens if I return to work only to find that I become ill again within a few months?

If you return to work after a period claiming benefit through the Scheme only to find that you fall ill again and, as a result, you have to stop working or you are not entitled to full/any sick pay from the Department of Education and Skills; then your claim will be considered straight away by Irish Life i.e. you will not have to wait the usual period before your benefit is paid. This is subject to Irish Life being satisfied that you are again totally unable to carry out the duties of your normal occupation because of illness or injury, and that you are not following any other occupation. In this instance, certain documentation may be required (e.g. a new Claim Notification Form, medical evidence, tests, sick leave certification etc.).

2 What happens if I return to work but at a reduced salary or take up a different, less well paid job?

If you are unfit to return to the full duties of your normal job as a result of your health but you return to partial/alternative duties at reduced pay or to a different job with reduced earnings, Irish Life will continue to pay you a benefit but at a proportionately reduced amount. This will be subject to medical evidence, satisfactory to Irish Life, supporting the view that you are only partially fit for work.

Claiming from the Scheme – a step-by-step guide

Cornmarket's role is to help guide members through the claims process. We have considerable experience in this area and, on behalf of claimants, work closely with the relevant insurance companies to ensure that all legitimate claims are promptly paid. We are here to talk you through the process and to explain any additional documentation that you may be required to provide.

1 Contact Cornmarket

Cornmarket is not notified automatically by your employer of your absence from work due to illness. It can take a number of weeks to process your claim, as various pieces of information must be gathered together for Irish Life about your health, salary etc. As soon as you become aware that, due to illness or injury, your salary is likely to reduce to half pay or cease altogether, please let us know. Ideally, we should be informed about **8-9 weeks** in advance of your salary reducing to half pay or ceasing altogether to enable Irish Life to assess your claim and gather the relevant medical and employer information. As we understand that this may not always be possible, Irish Life may not be able to pay your benefit at the time your salary reduces or ceases. In such cases your benefit may, depending on the particular circumstances, be backdated to the date when your salary reduced to half pay or stopped altogether, where the claim is subsequently admitted. You can contact us by:

- Calling the Claims Team on **(01) 408 4018**
- Emailing us at: **spsclaims@cornmarket.ie**
- Writing to us at:
  SPS Claims Department,
  Cornmarket Group Financial Services Ltd.,
  Christchurch Square, Dublin 8.

2 Your Claims Pack

Once you contact us we will send you a Claim Pack containing a Claim Notification Form and other required documents.

Form 1: Claim Notification Form

This is the first piece of documentation you will need to return to us. You should return this to us even before you have gathered together the other documentation. If you need any help in completing this form, simply contact our experienced team on **(01) 408 4018**.

Form 2: Checklist letter

A letter containing a list of the documents (listed below) you will need to provide in order for your claim to be processed.

Documents you will need to provide:

- Details of your State Illness Benefit (if applicable)
- A clear copy of your most recent Payslip
- A clear copy of your Medical Card (if applicable)
- A certified, clear copy of your Passport or Driving Licence
- A certified, clear copy of Proof of Current Address e.g. utility bill or bank statement no more than 6 months old
- A copy of your Marriage Certificate (only required if the name on your passport/licence is different to the name that we have addressed you by).

Form 3: Employer Authorisation Form

This authorises us to contact your employer to request the documentation listed below:

Documents we will get from your employer on your behalf:

- Confirmation of your salary (see page 17, Q1: *On what salary is my cover based?*)
- Confirmation of the date your salary ceased or reduced to half pay, and confirmation if you have been awarded extended paid sick leave under the Critical Illness Protocol
- Breakdown of your sick leave dates over the last 4 years
- Details of your Ill Health Early Retirement Pension/Temporary Rehabilitation Remuneration (if applicable).

3 Processing your claim

Once we receive your completed Claim Notification Form we will send the details to Irish Life, so that an assessment of your claim may begin immediately. Thereafter, we will send on any documentation as we receive it and we will liaise between you and Irish Life throughout the claims process.

4 Tele-claims Interview

Once Irish Life receives your completed Claim Notification Form, and if the case is suitable*, it will refer your claim to MorganAsh for claim form completion by tele-interview. You will be contacted by a trained nurse to schedule the tele-interview at a suitable time. When you have completed the interview, MorganAsh will issue you with a paper copy of the transcript of the interview for you to review. You should review the information and make any amendments you deem necessary and then **sign the declaration of consent and return it in the pre-paid envelope provided.**

* Some cases may not be suitable for tele-interview. In these cases, Irish Life will advise Cornmarket, who will arrange for the current paper Claim Form and Medical Certificate to be issued to you for completion.

5 Medical Examination

Medical evidence will be assessed by Irish Life. In a lot of cases, Irish Life will request that you attend an independent medical examination (at Irish Life's expense) to confirm you are unable to carry out your normal occupation because of your disability. Your medical examination may be arranged locally; however in some cases you may need to travel to attend your medical examination (only reasonable travel expenses will be covered).

Additional medical evidence

In some cases Irish Life may require additional medical evidence from doctors and/or specialists who have attended to you. You may possibly be requested to attend a further medical examination (again at Irish Life's expense).

Please note: During the assessment of your claim we will keep you up-to-date on medical reports and documentation received.

6 Decision on your claim

Once all the medical evidence and documentation has been received, Irish Life will make a decision on your claim. Should your claim be successful, we will write to you confirming the amount of benefit payable. Irish Life will then arrange to pay your benefit directly to your bank account. If your salary has stopped by the time your claim is approved, your benefit will be backdated to the date your salary was reduced/ceased.

Please note: If your claim is unsuccessful and you are unhappy with the outcome, a series of appeals procedures are available. You will find details of these on page 21, Q12: *What happens if my claim is rejected?* We will, of course, be happy to help you with any appeal you wish to make.

Payment of Claim

Once a claim is being paid, payment of the benefit is made by Irish Life monthly in arrears. Benefit payments are subject to income tax. You can request the Revenue Commissioner to issue a certificate of Tax to Irish Life (as the 'employer') in relation to your claim payment. This will enable Irish Life to apply the correct tax rate for future payments. However, the first payment may have emergency tax rates applied (any overpayment of tax may be subsequently claimed back by you).

7 Your benefit

Once a claim is being paid, payment of the benefit is made by Irish Life monthly in arrears. Benefit payments are subject to income tax. Your benefit will continue to be paid for as long as you remain unfit to carry out your normal occupation because of illness or injury. Benefit payments will stop when:

- You recover ***or***
- You resign ***or***
- Irish Life determines (based on medical evidence) that you are fit to return to work ***or***
- You return to work ***or***
- You die ***or***
- You reach the end of the school year following your 60th/65th* birthday,

whichever is the earliest.

In certain cases, benefit may be paid where you return to work at a reduced level of earnings due to partial disability.

From time to time, Irish Life may require medical evidence confirming that you remain unfit to work.

Death Benefit and Specified Illness Benefit cover ends on 31st August after your 65th birthday.

*Depending on the date of entry/re-entry to the Public Sector i.e. pre/post 1st April 2004.

8 Claimants' Tax Return Service

Claimants on the Scheme, whose claim is in payment for a minimum of 3 months, have the option to avail of the Claimants' Tax Return Service. See page 10 for details.

Midas is a tax-based service and not a regulated financial product. Cornmarket Retail Trading Ltd. is a wholly-owned subsidiary of Cornmarket Group Financial Services Ltd.

These steps are designed to help you through the claims process and ensure that any benefit you are entitled to is paid out in a timely fashion. If you have any questions please do not hesitate to contact us on (01) 408 4018.

Death Benefit

1 What benefit is paid on death?

A Death Benefit of typically twice your annual salary is included automatically in the Scheme (assuming you did not opt out of this benefit when it was first introduced). Some members may have availed of the option to increase their Death Benefit to a maximum of 4 times their salary (from time to time the underwriters provide this option). This amount will be paid tax free to your estate should you die. Please bear in mind that the estate of a deceased member could be processed through the Probate Office. This can result in delays to the payment of Death Benefit to the beneficiaries (anywhere between 3-12 months or more).

This benefit ceases on the 31st August following your 65th birthday, or when you retire or leave the Scheme, if earlier.

However, all members of the Scheme have an automatic option to join the Cornmarket Retired Members' Life Cover Plan, within 4 months of their retirement, without medical underwriting on completion of a shortened application form (see Q3 on this page: *Can my Death Benefit remain in force after I retire?* for details).

Terminal Illness Benefit

Irish Life will make an advance payment of 50% of the Death Benefit on diagnosis of a terminal illness with death expected within 12 months. Conditions attached to this are as follows:

- A Life assured is diagnosed as having a terminal illness if a medical specialist certifies, and Irish Life accepts, that it is highly likely that the life assured will die from a worsening, incurable disease within 12 months
- This clause will not apply to members over age 62.

Accidental Death Benefit

In the event of accidental death, a benefit of €15,000 is payable in addition to the normal Death Benefit of typically twice annual salary. Accidental Death is defined as 'death as a direct result of a bodily injury arising from an external and accidental cause which leaves a visible bruise or wound.' The benefit is provided up until the 31st August after your 65th birthday, or when you retire or leave the Scheme, if earlier.

Children's Death Benefit

In the event that a member's child between the ages of 0 and 21 dies, a Death Benefit of €4,000 will be paid out to the member.

Children's Death Benefit applies to all natural or adopted children.

2 Can my Death Benefit remain in force if I claim under the Disability Benefit?

If you are claiming Disability Benefit under the Scheme, your Death Benefit will remain in force (as will the Specified Illness Benefit). No deduction will be made in respect of the Death Benefit and Specified Illness Benefit while you are claiming from the Scheme, although you will continue to enjoy the security that these benefits provide.

Your Death Benefit and Specified Illness Benefit will continue, free of charge, up to 31st August following your 65 birthday (once your claim remains in payment up to the ceasing age of the Disability Benefit). Your Death Benefit will be based on the salary you were earning at the time your claim commenced.

Please note: When the Death Benefit was introduced in September 1983 some members chose to opt out of the Death Benefit element of the Scheme. In addition, some members may have availed of a previous offer to increase their Death Benefit up to a maximum of 4 times their annual salary.

In cases where a member (who has been claiming Disability Benefit under the Scheme) returns to work before age 60/65*, the Death Benefit element (based on the member's salary at the time of claiming) will, from the time the member returns to work, be based on his/her current salary and deductions will re-commence.

* Depending on the date of entry/re-entry to the Public Service, i.e. pre/post 1st April 2004.

3 Can my Death Benefit remain in force after I retire?

If you retire, your Death Benefit ceases. All retired and retiring members of the Scheme are eligible to apply to join Cornmarket's Retired Members' Life Cover Plan, **within 4 months** of their retirement, without having to undergo medical underwriting. This is provided that you are a member of the Salary Protection Scheme at the time of your retirement, and apply to join the Scheme either during the **4 month period before** your retirement or up until the **4 month period after** your retirement. The Plan provides for the payment of a tax-free lump sum in the event of death. The benefit payable is set out in the table below. Cover and premiums cease at age 85.

AGE AT DATE OF DEATH	LEVEL OF DEATH BENEFIT
50 - 59	150% x salary*
60 - 64	100% x salary
65 - 69	75% x salary
70 - 74	50% x salary
75 - 84	20% x salary

***Example of salary:**

Ann retires at age 61 on a pensionable salary of €60,000. The levels of cover and premiums payable under the Retired Members' Life Cover Plan are:

COVER:	€60,000
CONTRIBUTION:	0.5% x €60,000 = €25 per month

Please note: This example is for illustrative purposes. The actual level of benefit paid will depend on the age of the member at death.

This rate is guaranteed until the next Scheme review on 1st April 2019.

For more information, please contact Cornmarket on (01) 470 8054.

4 Payment of Death Benefit

As administrators of the Scheme, Cornmarket's role is to help guide members' families through the claims process. Once notified of a member's death, Cornmarket will send a letter to the next of kin/legal personal representative explaining the documentation that the underwriters may require in order to process the Death Benefit claim, including:

- Original or certified Death Certificate
- Confirmation of final annual salary
- Original or certified Birth Certificate
- Certified copy of the Will and Grant of Probate (or if there is no Will the underwriters may require Letters of Administration)
- Proof of ID and address for beneficiaries (requirement for Anti-Money Laundering documentation).

Please bear in mind that the estate of a deceased member could be processed through the Probate Office (the next of kin or solicitor can deal directly with the probate service). This may result in delays to the payment of Death Benefit to the beneficiaries.

Once Irish Life receives all the documents and information it requires, payment of the Death Benefit claim is usually made within 10 working days, subject to admission of claim.

Specified Illness Benefit

1 What is the Specified Illness Benefit?

The main purpose of Salary Protection is to provide you and your family with financial support in the event that you fall ill and find yourself unable to work. Of course, should you suffer a serious illness, regardless of whether or not this illness keeps you out of work sufficiently long to involve a loss of salary, the reality is that you may face significant extra expenses. The Scheme recognises this fact by providing an additional benefit in the form of a once-off lump sum of 25% of your annual salary at the date of diagnosis in the event that you suffer any of 36 'Specified Illness' (see table on page 28).

The lump sum this benefit provides can be vital, as extra cash is often needed to pay medical bills, travel to and from hospital, make up for lost overtime, and pay for extra childcare etc.

Important: Once you are paid a claim under the main Specified Illness Benefit, your cover will cease and you will no longer be able to claim under the Specified Illness Benefit. Consequently, you will no longer be required to pay the 0.11% Specified Illness Benefit premium, so your total contribution to the Scheme following a Specified Illness Benefit claim will be 1.38%.

2 What is the Partial Payment under the Specified Illness Benefit?

Irish Life has identified a further 10 less severe, but still life altering conditions that they will make an additional separate Partial Payment on (see table on page 28 for details). The benefit you would receive should you suffer a Specified Illness covered under the partial payment section is €10,000 or 25% of salary, if less.

Important note: We will only make one Partial Payment per person under the Specified Illness Cover Benefit. The list of Partial Payment Illnesses is totally separate from the main Specified Illness Benefit.

This means that it does not generally affect the amount you could receive if you need to make a Specified Illness Benefit Claim for one of the 36 conditions we cover on a full payment basis, at a later date (except in cases where you are diagnosed with a full payment illness within 30 days of diagnosis of a Partial Payment illness. In this case, the full payment will be made under the main Specified Illness Benefit).

3 Is there a 'survival period'?

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

(a) 14 days for heart attack, coronary artery surgery, angioplasty (two arteries),cancer, coma, emphysema, stroke, kidney failure, heart valve surgery, aorta graft surgery, major organ transplant, benign brain tumour, multiple sclerosis, motor neurone disease, severe burns, Creutzfeldt-Jakob disease (CJD), HIV infection, paralysis of two or more limbs and severance of two or more limbs.

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

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

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

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

The Specified Illness Benefit was first introduced on 1st April 2006. Further Specified Illnesses (marked❖) and Partial Payment Specified Illnesses were introduced from the 1st April 2010 (see lists on pages 28). The particular Specified Illnesses that you are covered for will depend on the date that you joined the Scheme.

For members who joined the Scheme PRIOR TO 1st April 2006 (❖ 1st April 2010)

1 If you joined the Scheme prior to 1st April 2006 and had one of the Specified Illnesses prior to 1st April 2006, you are not covered for that illness and you can never claim for a re-occurrence of that illness in the future. You will be covered for all other illnesses.

2 However, there is no waiting period for existing members with regard to related illnesses and pre-existing medical conditions, i.e. if you are an existing member and have a condition that is related to one of the main illnesses you will be covered for that illness once the date of diagnosis is after 1st April 2006. For example, if you had high blood pressure on 13th February 2006 and have a heart attack on 1st December 2006, you would be covered provided the heart attack meets the definition of the illness.

3 In addition, because of the links between heart attack, stroke, coronary artery surgery, angioplasty and heart transplant, if you have suffered or undergone one of these conditions before joining the Scheme you cannot claim under the policy in respect of any of the other four illnesses. For example, if you underwent coronary artery surgery before joining you will never be covered for coronary artery surgery or heart attack, stroke, angioplasty or heart transplant. You are covered for the remaining Specified Illnesses.

Important note for all members: If prior to joining the Scheme you have suffered from one of the Specified Illnesses, you will never be covered for that illness.

For members who joined the Scheme AFTER 1st April 2006 (❖ 1st April 2010)

Members do not have to provide any medical information in order to take out this cover. However, cover will not be provided for pre-existing conditions. The rules on this cover are as follows:

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

2 If, prior to joining the Scheme, 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 heart attack within the first 2 years of joining, if prior to joining you suffered from Diabetes. This is due to the recognised link between Diabetes and heart attack. However, a diabetic who first suffers a heart attack 3 years after joining the Scheme will be eligible to claim.

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

Important note for all members: If prior to joining the Scheme you have suffered from one of the Specified Illnesses, you will never be covered for that illness.

4 What Specified Illnesses are covered?

Alzheimer's Disease	HIV infection
Aorta graft surgery	Kidney failure
❖ Aplastic Anaemia	❖ Liver failure
❖ Bacterial Meningitis	Loss of limbs
Benign brain tumour	Loss of speech
Benign spinal cord tumour	Major organ transplant
Blindness	Motor Neurone Disease
Cancer (malignant)	Multiple Sclerosis
Cardiomyopathy	Paralysis of Limbs
Coma	Parkinson's Disease
Coronary artery bypass grafts	Primary Pulmonary Hypertension
❖ Creutzfeldt-Jakob Disease	❖ Progressive Supranuclear Palsy
Deafness	❖ Pulmonary Artery Surgery
❖ Dementia	❖ Respiratory failure of specified severity
❖ Encephalitis	Severe 3rd-degree burns
Heart attack	Stroke
Heart structural repair with surgery to divide the breastbone	❖ Systemic Lupus Erythematosus
Heart valve replacement or repair	❖ Traumatic head injury resulting in permanent symptoms

Important: There is only one Specified Illness Benefit payment per life per policy. The Specified Illnesses marked ❖ were introduced on 1st April 2010. Only diagnoses that occur after this date are eligible to claim Specified Illness Benefit for these illnesses.

A claim under the Specified Illness Benefit will only be paid if the severity of the condition suffered falls under the relevant definition in the Appendix of this booklet. Please refer to the Appendix on pages 30-40 for the full definition of each illness and its pre-existing conditions.

If prior to joining the Scheme, you have suffered from one of these illnesses, you will never be covered for that illness.

5 Specified Illness Benefit – Partial Payment

Based on recent claims experience, Irish Life has identified a further 10 less severe , but still life altering conditions that it will make an additional separate partial payment on (see listing below). The benefit you would receive should you suffer a Specified Illness covered under the Partial Payment section is the lesser of €10,000 or 25% of salary.

Brain abscess drained *via* craniotomy	Ductal carcinoma in situ
Carcinoma in situ	Low level prostate cancer with Gleason score between 2 and 6
Carotid artery stenosis	Less severe 3rd-degree burns
Cerebral arteriovenous malformation	Loss of one limb
Coronary Angioplasty	Surgical removal of one eye

Important: There is only one Partial Payment per life per Policy. Other terms and conditions apply. These Partial Payments are covered once the date of diagnosis is after 1st April 2010.

Please refer to Appendix 2 on pages 41-43 for the full definition of each illness and its pre-existing conditions.

If prior to joining the Scheme, you have suffered from one of these illnesses, you will never be covered for that illness.

Other common questions

1 What happens if I cancel my membership?

Membership of the INTO Scheme may be cancelled at any time by notifying Cornmarket or Irish Life in writing. As your contributions are designed to cover the cost of paying benefit to those members of the INTO Scheme who become unable to work due to illness or injury, there is no 'cash-in' value paid to you should you stop contributions to the Scheme. It is important that you think carefully before cancelling your membership of the INTO Scheme, as once you have left the INTO Scheme you will be required to provide information about your state of health should you apply for cover again. Should any medical problems have arisen in the interim, it is unlikely that you will be re-admitted to the INTO Scheme.

2 Under what circumstances can the Scheme be amended?

Benefit levels and the rate of contributions under the Scheme are reviewed on a regular basis. The next review of the Scheme is 1st April 2019. These reviews are designed to provide Cornmarket with an opportunity to canvass the market to ensure that the best deal is being provided for members. Similarly, the reviews provide the insurer with an opportunity to adjust the benefit levels and/or the rate of contribution in light of relevant factors such as membership level, age profile, the male/female ratio of membership, and the claims experience of the Scheme.

At such reviews, the Scheme's insurer reserves the right to increase or decrease the rate of contribution, and vary the benefit levels under the Scheme for all members or terminate the Scheme as a whole.

INTO represents the interests of members in the Scheme, and any decisions taken in these areas by INTO will be considered binding on all members of the Scheme. This is a condition of membership and entry to the Scheme is allowed to members only on this understanding. In the event of termination or amendment of the Scheme, those members who are already receiving benefit payments under the Scheme will continue to receive those benefit payments and any subsequent increases in those benefits due under the terms of the Scheme.

3 Who administers and insures the INTO Scheme?

The Salary Protection Scheme for INTO Members is administered by Cornmarket Group Financial Services Ltd. and is insured by Irish Life. For this important role, Cornmarket gets remunerated directly by the insurer (no direct charge to the client).

Initial charge (paid by Insurer to Cornmarket):	€0 - €275
Deduction at source charge (deducted by the employer):	0% - 2.5% (typically 2.5%)

Renewal charge (paid by Insurer to Cornmarket)

Disability Benefit:	12.5% - 17.5% (typically 12.5%)
Specified Illness Benefit:	12.5% - 17.5% (typically 12.5%)
Death Benefit:	12.5% - 17.5% (typically 12.5%)

4 What if I travel abroad?

As long as you remain resident within Ireland, you are covered wherever you travel in the world for holiday purposes. However, should you decide to reside abroad or work abroad temporarily, you should notify Cornmarket immediately as Irish Life reserves the right to vary your contributions or benefits or cancel membership of the INTO Scheme in such circumstances.

Irish Life will pay benefit to a member living anywhere in the world for a maximum of 6 months. After 6 months the beneficiary must reside in Ireland or the U.K. In exceptional cases where a beneficiary is forced to live abroad, Irish Life will consider this on a case-by-case basis.

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

This section outlines
- the policy definition of the Specified Illnesses that are covered under the Scheme
- a simple explanation of each illness
- information on related conditions which, if present before joining the Scheme, means the member is not covered for the Specified Illness if diagnosis occurs within the first two years of cover.

1 Alzheimer's Disease resulting in permanent symptoms

Plan definition
A definite diagnosis of Alzheimer's Disease by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:
- remember
- reason
- perceive, understand, express and give effect to ideas.

For the above definition, the following are not covered:
- Other types of dementia.

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

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

Pre-existing conditions
If you have been diagnosed with Alzheimer's Disease prior to the commencement date of cover, you can never claim for Alzheimer's Disease under the Specified Illness Cover plan.

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

Survival period: six months.

2 Aorta Graft Surgery – for disease or traumatic injury

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

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

For the above definition, the following are not covered:
- Any other surgical procedure, for example the insertion of stents or endovascular repair.

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

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

The aorta may also weaken because of an 'aneurysm'. This means that the artery wall becomes thin and expands. You might need a graft to bypass the narrowed or weakened part of the artery.

You can claim if you have had surgery to remove and replace a part of the thoracic or abdominal aorta, to correct narrowing or weakening, with a graft. Surgery to the branches of the aorta is not covered as this surgery is generally less critical.

Pre-existing conditions
If you have had aorta graft surgery prior to the commencement date of cover, you can never claim for aorta graft surgery under the Specified Illness Cover plan.

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

3 Aplastic Anaemia – of specified severity

Plan definition
A definite diagnosis by a Consultant Haematologist of permanent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:
- Blood transfusion
- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplant.

For the above definition, the following are not covered:
- All other types of anaemia.

In simpler terms
Aplastic anaemia is a failure of the bone marrow to produce enough blood cells for the circulation. When this function of the marrow reduces, the main parts of the blood (red cells, white cells and platelets) reduce or stop being produced and you gradually have to depend more on blood transfusions.

You can claim if a consultant haematologist diagnoses permanent bone marrow failure which is treated by having a blood transfusion, drugs to stimulate the bone marrow, immunosuppressive drugs or a bone-marrow transplant.

4 Bacterial Meningitis – resulting in permanent symptoms

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

For the above definition, the following are not covered:
- All other forms of meningitis including viral meningitis.

*** 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.

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

You can make a claim if a consultant neurologist diagnoses bacterial meningitis which results in permanent brain or nerve damage. Examples of this kind of damage include paralysis of the left or right hand side of the body or disturbed speech or hearing. We will not cover any other form of meningitis including viral meningitis.

Pre-existing conditions
If you have been diagnosed with bacterial meningitis prior to the commencement date of cover, you can never claim for bacterial meningitis under the Specified Illness Cover plan. If you have previously had shunts inserted for hydrocephalus prior to the commencement date of cover, no benefit will be payable under the specified illness cover plan and you will not to be covered for Bacterial Meningitis.

Survival period: six months in respect of children's cover.

5 Benign Brain Tumour – resulting in permanent symptoms or requiring surgery

Plan definition
A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.* The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:
- Tumours in the pituitary gland
- Angiomas.

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

*** permanent neurological deficit with persisting clinical symptoms is clearly defined as:**
– Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
– Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:
- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.

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

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

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

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

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

6 Benign Spinal Cord Tumour – resulting in permanent symptoms or requiring surgery

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

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

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

*** permanent neurological deficit with persisting clinical symptoms is clearly defined as:**
– Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
– Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:
- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.

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 the spinal canal. You can claim if you are diagnosed as having a benign spinal cord tumour and have had surgery to have it removed or are suffering from 'permanent neurological deficit with persisting clinical symptoms' as a result of the tumour. Neurological symptoms must be permanent. We do not cover angiomas of the spinal cord or spinal canal.

7 Blindness – permanent and irreversible

Plan 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.

To qualify for payment, blindness must happen on a date after the start date of the plan and before cover ends.

In simpler terms
You can claim only if you have permanent loss of sight with no possibility of improvement in both eyes and even if, using glasses or other visual aids, your sight in your better eye is confirmed by an ophthalmologist or consultant physician as 3/60 or worse using the recognised sight test known as the Snellen eye chart. An optician uses a Snellen chart (made up of rows of letters) to test your eyesight. 3/60 is the measure when you can only see at three feet away what someone with perfect sight could see at 60 feet away.

It is possible to be 'registered blind' (as confirmed by an eye specialist) even though the loss of sight may only be partial. Even if you are 'registered blind', we will only pay your claim if the loss of sight meets the definition above and cannot be corrected.

Pre-existing conditions
If you are diagnosed with loss of sight as described above prior to the commencement date of cover, you can never claim for blindness under the Specified Illness Cover plan.

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

Survival period: six months.

8 Cancer– excluding less advanced cases

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

The term malignant tumour includes leukaemia, lymphoma and sarcoma.

For the above definition, the following are not covered:
- All cancers which are histologically classified as any of the following:
  - pre-malignant
  - non-invasive
  - cancer in situ
  - having either borderline malignancy; or having low malignant potential
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (i.e. Gleason score 7 or above only) or having progressed to at least clinical TNM classification T2NoMo
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A
- Any skin cancer, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) i.e. >= Clark's level.
- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are non-malignant and are excluded from this cover
- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2NoMo
- If you are HIV (human immunodeficiency virus) positive, you will not be covered for lymphoma or Kaposi's sarcoma as these tumours are directly related to the virus.

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

A malignant tumour:
- may grow quickly
- often invades nearby tissue as it expands
- often spreads through the blood or the lymph vessels to other parts of the body
- usually continues to grow and is life-threatening unless it is destroyed or removed.

You can claim if you are diagnosed as suffering from a malignant tumour which has invaded surrounding tissue, unless we specifically do not cover the type of cancer or tumour. The claim must be supported by a microscopic examination of a sample of the tumour cells – this is known as 'histology'. The histology examination is carried out on tissue removed during surgery or by biopsy (a procedure to remove a sample of the tumour for examination).

We do not cover cancers 'in situ' (cancers in a very early stage that have not spread in any way to neighbouring tissue or pre-malignant and non-invasive tumours. These are well-recognised conditions, and cancers detected at this stage are not likely to be life-threatening and are usually easily treated. An example of this would be carcinoma (cancer) in situ of the cervix (neck of the womb) which is easy to treat and cure.

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. It is not possible to provide full Specified Illness Cover against these early prostate cancers. We will not pay a claim for prostate cancer under this definition of cancer unless the tumour has a Gleason score (a method of measuring differentiation in cells) of greater than 6 (in other words, a Gleason score of 7 or above) or it has progressed to at least clinical classification of T2NoMo. The 'Gleason score' and the 'TNM classification' are ways of measuring and describing how serious the cancer is, and whether it has spread beyond the prostate gland based on what it looks like under a microscope.

We will cover leukaemia (cancer of the white blood cells) and Hodgkin's disease (a type of lymphoma). However, for us to cover a claim for chronic lymphocytic leukaemia, it must have progressed to Binet Stage A (Binet Stage A is where there is no anaemia, no thrombocytopaenia and fewer than three areas of enlarged nodes).

Most forms of skin cancer are relatively easy to treat and are rarely life-threatening. This is because they do not spread out of control and do not produce growths in other parts of the body. The only form of skin cancer that we cover is malignant melanoma which has been classified as being a 'Clark level 2' or greater. Clark's system is an internationally recognised method of classifying skin melanomas and uses a scale of 1 to 5. A Clark level 1 reflects a very early melanoma which carries a favourable long-term outlook.

Many forms of bladder cancer have a slow course over many years and are managed by surgery or diathermy (using heat to treat body tissues with high-frequency electromagnetic currents). The outlook for patients with these superficial bladder cancers is very good. The TNM classification system is internationally recognised and used as a way of measuring a tumour. The 'T' part relates to the primary tumour and is graded on a scale of 1 to 4. T1 represents a small tumour restricted to the organ. We will not pay a claim for a T1 bladder cancer unless lymph nodes or metastases (the cancer spreading) are involved as measured by the 'N' and 'M' parts of TNM.

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

If you have a history of carcinoma in situ, Bowen's disease, familial polyposis of the colon, Hodgkin's disease, leukoplakia, Barrett's oesophagus, ulcerative colitis, Crohn's disease or a history of raised PSA (prostate specific antigen) above 4.0ng/ml prior to the commencement date of cover and you are found to have cancer within the first two years, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for cancer.

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

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

A New York Heart Association functional capacity of Class 1 or 2 does not qualify for payment.

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

For the above definition, the following are not covered:
- Cardiomyopathy secondary to alcohol or drug abuse
- All other forms of heart disease, heart enlargement and myocarditis.

In simpler terms
Cardiomyopathy is a disorder affecting the muscle of the heart. It is not known what causes cardiomyopathy. It may result in the heart becoming larger, heart failure, abnormal rhythms of the heart (arrhythmias) or an embolism (blockage of a blood vessel).

You can claim if you suffer cardiomyopathy which is permanent and causes symptoms which significantly hinder your normal everyday activities.

To qualify for a payment, your physical ability must be measurable and limited to a specific degree (New York Heart Association Class 3). The NYHA Function Classification is a measure used to classify the extent of heart failure.

Pre-existing conditions
If you have been diagnosed with Cardiomyopathy prior to the commencement date of cover, you can never claim for cardiomyopathy under the Specified Illness Cover plan.

10 Coma– of specific duration and resulting in permanent symptoms

Plan definition
A state of unconsciousness with no reaction to external stimuli or internal physiological needs which:
- Continues for a period of at least 96 hours
- Requires life supporting systems including assisted ventilation throughout the period of unconsciousness
- Results in permanent neurological deficit with persisting clinical symptoms.*

For the above definition, the following are not covered:
- Coma secondary to alcohol where there is a history of alcohol abuse
- Coma secondary to illegal drug abuse.

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

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

The following are not covered:
- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.

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
If you have had a coma prior to the commencement date of cover, you can never claim for coma under the Specified Illness Cover Plan.

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

11 Coronary Artery Bypass Grafts

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

For the above definition, the following are not covered:
- Balloon angioplasty, atherectomy, insertion of stents and laser treatment or any other procedures.

In simpler terms
You may need coronary artery surgery if one or more coronary arteries (the arteries which supply blood to the heart) are narrowed or blocked. The surgery is done to relieve the pain of angina or if the blocked artery is life-threatening.

Coronary artery bypass surgery is carried out by taking a vein, normally from the thigh, and using it to direct blood past the diseased or blocked artery.

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

Ischaemic heart disease happens if there is inadequate blood flow through the coronary arteries to the heart due to a build up of fatty materials (such as cholesterol) in the artery walls.

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

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

12 Creutzfeldt-Jakob Disease – resulting in permanent symptoms

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

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

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

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

The following are not covered:
- An abnormality seen on brain or other scans without definite related clinical symptoms
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms.

In simpler terms
CJD is a degenerative condition of the brain. As the disease gets worse, your muscular co-ordination reduces, and your intellect and personality are affected. You may also go blind. You can claim if your consultant neurologist confirms the diagnosis of CJD which has resulted in permanent neurological deficit.

Pre-existing conditions
If you have been diagnosed with Creutzfeldt-Jakob disease (CJD) prior to the commencement date of cover, you can never claim for CJD under the Specified Illness Cover plan.

If you have a history of dementia, involuntary movements or were treated with human growth hormone treatment (prior to 1985), prior to the commencement date of cover and you are found to have CJD within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for CJD.

13 Deafness – total, permanent and irreversible

Plan 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.

To qualify for payment, deafness must happen on a date after the start date of the plan and before cover ends.

In simpler terms
You can claim if you have a severe form of deafness (as described above) as measured by a pure tone audiogram. A pure tone audiogram is a hearing test used to identify hearing levels. The test will check the quietest sounds you can hear at different frequencies or pitches. A decibel is a measure of the volume of a sound.

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

Pre-existing conditions
If you have been diagnosed with loss of hearing as described above prior to the commencement date of cover, you can never claim for deafness under the Specified Illness Cover plan.

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

Survival period: Twelve months.

14 Dementia – resulting in permanent symptoms

Plan definition
A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of ability to do all of the following:
- Remember
- Reason
- Perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:
- Dementia secondary to alcohol or illegal drug abuse.

In simpler terms
Dementia is a term used to describe a number of signs and symptoms characterised by the loss of cognitive function and intellect, as well as changes in behaviour. The areas affected may be memory, concentration, language and problem-solving.

A claim can be made if you have been diagnosed by a consultant neurologist or consultant geriatrician or psychiatrist, as having dementia and your judgement, understanding and rational thought process have been seriously affected. These symptoms must be permanent.

Pre-existing conditions
If you have been diagnosed with dementia prior to the commencement date of cover, you can never claim for dementia under the Specified Illness Cover plan.

If you have a history of arteriosclerotic dementia, Alzheimer's disease, Lewy body disease secondary to Parkinson's disease, fronto-temporal dementia, Pick's disease, CJD or memory loss with or without associated behavioural and emotional changes within the first two years of the cover, no benefit will be payable under the specified illness cover plan and you will cease to be covered for dementia.

Survival period: six months.

15 Encephalitis – resulting in permanent symptoms

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

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

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

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

The following are not covered:

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

In simpler terms

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

You can claim if you have a diagnosis of encephalitis confirmed by a consultant neurologist if there are neurological symptoms which the neurologist says are permanent.

Pre-existing conditions

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

16 Heart Attack – of specified severity

Plan definition

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

- New characteristic electrocardiographic (ECG) changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:

  Troponin T > 1.0 ng/ml

  AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin 1 methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

In simpler terms

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

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

Your doctor will also take a blood sample. This can show that markers are present in the blood (in the form of enzymes or troponins) at a much higher level than is normally expected.

You can claim if you are diagnosed as having suffered death of heart muscle. Your claim must be supported by an increase in cardiac enzymes or troponins that are typical of a heart attack (released into the bloodstream from the damaged heart muscle) and new ECG changes typical of a heart attack.

Pre-existing conditions

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

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

17 Heart Structural Repair – with surgery to divide the breastbone

Plan definition

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

In simpler terms

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

You will be able to claim if, on the advice of a consultant cardiologist, you have open heart surgery (including surgery to divide the breastbone) to correct a structural abnormality of the heart.

Pre-existing conditions

If you have had structural heart repair prior to the commencement date of cover, you can never claim for heart structural repair under the Specified Illness Cover plan.

If you have a history of heart valve disease, cardiomyopathy, congenital heart disease, ventricular aneurysm, constrictive pericarditis, Fallot's tetralogy or transposition of great vessels prior to the commencement date of cover and you require structural heart repair within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for structural heart repair.

18 Heart Valve Replacement or Repair

Plan definition

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

In simpler terms

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

You will be able to claim if you have surgery to replace or repair a heart valve on the advice of a consultant cardiologist.

Pre-existing conditions

If you have had heart valve replacement or repair prior to the commencement date of cover you cannot make a claim under the Specified Illness Cover Plan.

If you have a history of any disorder of the aortic, mitral, pulmonary or tricuspid valves, rheumatic fever, endocarditis, Fallots tetralogy, Ebstein's anomaly or any congenital or acquired structural cardiac abnormality prior to the commencement date of cover and you require heart valve or structural surgery within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for heart valve replacement or repair.

19 HIV Infection

Plan definition

Infection by Human Immunodeficiency Virus resulting from:

- A blood transfusion given as part of medical treatment
- A physical assault
- An accident occurring during the course of performing normal duties of employment (from the eligible occupations listed below)

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

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

For the above definition, the following is not covered:

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

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

In simpler terms

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

This benefit is designed to cover people who are in special danger of getting HIV or AIDS through their work or who have become infected as a result of a physical assault or a blood transfusion in the European Union, North America, Australia and New Zealand.

The infection must happen after the start date of the plan and must be appropriately reported and investigated as described in the definition above.

Pre-existing conditions

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

20 Kidney failure – requiring ongoing dialysis

Plan definition

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

In simpler terms

The kidneys act as filters which remove waste materials from the blood. When the kidneys do not work properly, waste materials build up in the blood. This may lead to life-threatening problems. The body can function with only one kidney, but if both kidneys fail completely, dialysis (kidney machine treatment) or a kidney transplant will be necessary. In some circumstances it is possible for the kidneys to fail temporarily and recover following a period of dialysis.

You will be able to claim if both your kidneys fail completely and permanently and you need regular long-term dialysis or a kidney transplant.

Pre-existing conditions

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

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

21 Liver failure – requiring ongoing dialysis

Plan definition

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

- Permanent jaundice
- Ascites
- Encephalopathy.

For the above definition, the following is not covered:

- Liver failure secondary to alcohol or illegal drug misuse.

In simpler terms

Liver failure is the inability of the liver to perform its normal function. Liver failure happens when a large part of the liver is damaged.

You can claim if you are diagnosed by a consultant physician as having incurable liver failure caused by cirrhosis which shows 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 bloodstream.

This jaundice must be permanent. Ascites is a build up of fluid in the abdomen caused by fluid leaks from the surface of the liver and intestines. It can happen if the blood or lymphatic flow through the liver is blocked. Encephalopathy caused by liver failure is the deterioration of brain function due to poisonous substances, which are normally removed by the liver, building up in the blood.

You cannot claim if the liver failure happens as a direct or indirect result of drinking too much alcohol or using illegal drugs.

Pre-existing conditions

If you have ever been diagnosed with liver failure, cirrhosis, sclerosing cholangitis or portal hypertension prior to the commencement date of cover, you can never claim for liver failure under the Specified Illness Cover plan.

If you have a history of liver failure, cirrhosis, sclerosing cholangitis, hepatitis B or C infection, liver tumours/cancer, Budd-Chiari syndrome, haemochromatosis, sarcoidosis, portal hypertension or a metabolic disorder affecting the liver prior to the commencement date of cover and you are found to have liver failure within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for liver failure.

22 Loss of Limbs – permanent physical severance

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

To qualify for payment, the loss of two or more limbs must happen after the start date of the plan and before cover ends.

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

Pre-existing conditions
If you have previously suffered the loss of one or more limbs prior to the commencement date of cover, you can never claim for Loss of limbs under the Specified Illness Cover plan.

If you have a history of peripheral vascular disease or diabetes mellitus prior to the commencement date of cover and you suffer the loss of two or more limbs within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for loss of limbs.

23 Loss of Speech – permanent and irreversible

Plan definition
Permanent and irreversible loss of the ability to speak as a result of physical injury or disease.

To qualify for payment, loss of speech must happen on a date after the start date of the plan and before cover ends.

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

Pre-existing conditions
If you have been diagnosed with loss of speech prior to the commencement date of cover, you can never claim for loss of speech under the Specified Illness Cover plan.

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

Survival period: Twelve months

24 Major Organ Transplant – specified organs

Plan definition
The undergoing as a recipient of a transplant of bone-marrow or of a complete heart, liver, lung, or pancreas, or inclusion onto the official programme waiting list of a major Irish or U.K. hospital for a procedure as listed.

For the above definition, the following is not covered:
- Transplant of any other organs, parts of organs, tissues or cells.

In simpler terms
Serious disease or injury can severely damage the heart, lungs, liver or pancreas.

The only form of treatment available may be to replace the damaged organ with a healthy organ from a donor. This is a major operation and the tissues of the donor and patient must be matched accurately. For this reason you could be on a waiting list for a long period waiting for a suitable organ. We also cover bone-marrow transplants.

You can claim if you have had a transplant of any of the organs listed or are on an official Irish or U.K. programme waiting list for a transplant.

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

If you have a history of the following:
- **Heart conditions:** congestive cardiac failure, cardiomyopathy, coronary artery disease, left ventricular failure, hypertensive heart disease, any congenital or acquired structural cardiac abnormalities, ischaemic heart disease
- **Lung conditions:** cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic), pulmonary fibrosis, emphysema, chronic bronchitis, chronic asthma
- **Liver conditions:** liver failure, cirrhosis, hepatitis B or C, liver tumours, alcohol abuse, sclerosing cholangitis, Budd-Chiara syndrome
- **Blood disorders:** leukaemia, aplastic anaemia, thalassaemia major, immune deficiency disease, sickle cell anaemia, myeloproliferative disease (polycythaemia vera, thrombocythaemia), neutropenia
- **Inflammatory disorders:** systemic lupus erythematosus, sarcoidosis, pancreatitis
- **Metabolic disorders:** diabetes mellitus, haemochromatosis, Wilson's disease.

prior to the commencement date of cover and you are placed on an official waiting list for or require major organ transplant within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for major organ transplant.

25 Motor Neurone Disease

Plan definition
A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

In simpler terms
Motor neurone disease is a disease which affects the central nervous system that controls movement. As the nerves deteriorate, the muscles weaken. There is currently no known cure and the cause of the disease is also not known. You can claim if there is a definite diagnosis by a consultant neurologist that you are suffering from motor neurone disease.

Pre-existing conditions
If you have been diagnosed with motor neurone disease prior to the commencement date of cover, you can never claim for motor neurone disease under the Specified Illness Cover plan.

If you have a family history of motor neurone disease in a first degree relative (i.e. father, mother, brother or sister) or a history of muscle wasting in any limb, or weakness in any limb, or difficulty with speech or swallowing prior to the commencement date of cover and you are found to have motor neurone disease within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for motor neurone disease.

26 Multiple Sclerosis

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

In simpler terms
Multiple sclerosis is a disease of the central nervous system which destroys the protective covering (myelin) of the nerve fibres in the brain and spinal cord.

The symptoms depend on which areas of the brain or spinal cord have been affected. They include temporary blindness, double vision, loss of balance and lack of coordination.

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

Pre-existing conditions
If you have been diagnosed with multiple sclerosis prior to the commencement date of cover, you can never claim for multiple sclerosis under the Specified Illness Cover plan.

If you have a history of retrobulbar or optic neuritis, diplopia (double vision), paraesthesia, numbness, tingling or unilateral weakness of upper or lower limbs, trigeminal neuralgia, Bell's palsy or in-coordination of movement or speech prior to the commencement date of cover and you are found to have multiple sclerosis within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for multiple sclerosis.

27 Paralysis of limbs – total and irreversible

Plan definition
Total and irreversible loss of muscle function to the whole of any 2 limbs. Permanent Paraplegia or Quadriplegia are covered under this definition.

To qualify for payment, the total and irreversible paralysis of two or more limbs must happen on a date after the start date of the plan and before cover ends.

In simpler terms
The brain controls the movement of muscles in the body by sending messages through the spinal cord and nerves. Paralysis is normally caused by an injury to the spinal cord. You will be able to claim if you suffer complete and permanent loss of the use of two or more limbs.

Pre-existing conditions
If you have been diagnosed with total and irreversible paralysis of two of more limbs prior to the commencement date of cover, you can never claim for paralysis of limbs under the Specified Illness Cover plan.

If you have a history of multiple sclerosis, motor neurone disease, stroke, transient ischaemic attack, a spinal cord tumour or severe head injury prior to the commencement date of cover and you became paralysed within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for paralysis of two or more limbs.

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

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

For the above definition, the following is not covered
- Parkinson's disease secondary to chronic alcohol abuse or illegal drug abuse.

In simpler terms
Parkinson's disease is a disease of the central nervous system which affects voluntary movement. It is characterised by muscle stiffness or rigidity, slow movements, shaking limbs and head and loss of balance. It normally takes hold gradually. The term 'idiopathic' means that the cause of the disease is not known, so we will not cover any form of Parkinson's disease brought on by a known cause such as drugs, poisonous chemicals or alcohol.

Pre-existing conditions
If you have been diagnosed with Parkinson's disease prior to the commencement date of cover, you can never claim for Parkinson's disease under the Specified Illness Cover plan.

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

Survival period: six months.

29 Primary Pulmonary Hypertension – of specified severity

Plan definition
A definite diagnosis of Primary Pulmonary Hypertension by a Consultant Cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classifications of functional capacity.*

For the above definition, the following are not covered:
- Pulmonary hypertension secondary to any other known cause i.e. not primary.

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

In simpler terms
Primary pulmonary hypertension is a disease which happens when the blood pressure in your pulmonary artery or the major blood vessel connecting the right heart ventricle and the lungs is higher than normal. There is no obvious cause. A higher pulmonary artery blood pressure means the heart has to work harder to pump enough blood into the lungs. As a result, over time, the heart muscles weaken. You can claim if you suffer from primary pulmonary hypertension which is diagnosed by a consultant cardiologist. To qualify for a payment your physical ability must be measurable and limited to a specific degree (New York Heart Association Class 3). The NYHA Function Classification is a measure used to classify the extent of heart failure.

Pre-existing conditions
If you have a history of primary pulmonary hypertension prior to the commencement date of cover you can never claim under the Specified Illness Cover Plan.

30 Progressive Supranuclear Palsy – resulting in permanent symptoms

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

In simpler terms
Progressive supranuclear palsy (PSP), also known as Steele-Richardson-Olzewski syndrome, is a degenerative disease that gradually destroys

nerve cells in the parts of the brain that control eye movements, breathing and muscle co-ordination. The loss of nerve cells causes paralysis that slowly gets worse as the disease progresses.

The definition literally means:

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

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

Pre-existing conditions

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

If you have a history of encephalitis, encephalomyelitis or tremor prior to the commencement date of cover and you are found to have progressive supranuclear palsy within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for Progressive supranuclear palsy.

31 Pulmonary Artery Surgery – with surgery to divide the breast bone

Plan definition

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

In simpler terms

Pulmonary artery surgery may be carried out for some disorders to the pulmonary artery, including pulmonary atresia (atresia means 'no opening') and aneurysm. You can claim if you have open heart surgery involving surgically dividing the breastbone to replace the diseased pulmonary artery with a graft.

Pre-existing conditions

If you have a history of congenital heart disease requiring pulmonary artery surgery or have had pulmonary artery surgery prior to the commencement date of cover you cannot make a claim under the Specified Illness Cover Plan.

32 Respiratory Failure of Specified Severity

Plan definition

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

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

In simpler terms

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

You can claim if you have severe and long-term respiratory failure, as shown by lung function tests showing forced expiratory volume (FEV1) less than 40% of normal and a vital capacity (VC) less than 50% of normal and you need daily oxygen therapy. Forced expiratory volume is the maximum volume of air that can be forcibly blown out in the first second. It is measured in litres. Vital capacity (VC) is the volume of air that can forcibly be blown out after a full breath in, measured in litres.

Pre-existing conditions

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

If you have a history of cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic), pulmonary fibrosis, emphysema, chronic bronchitis, chronic asthma, other systemic disorders that produce pulmonary fibrosis such as sarcoid or pulmonary fibrosis as a result of exposure to extrinsic organic or inorganic agents prior to the commencement date of cover and you are found to have respiratory failure within the first two years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for respiratory failure.

33 Severe 3rd Degree Burns – covering at least 20% of the body's surface

Plan 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.

To qualify for payment, severe or 3rd degree burns covering at least 20% of the body's surface must happen on a date after the start date of the plan and before cover ends.

In simpler terms

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin. You will be able to claim if you have suffered third-degree burns covering 20% or more of the surface area of your body.

Pre-existing conditions: None.

34 Stroke – resulting in permanent symptoms

Plan definition

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.* A diagnosis of subarachnoid haemorrhage resulting in permanent neurological deficit with persisting clinical symptoms,* supported by CT or MRI evidence, is covered under this definition.

For the above definition, the following are not covered:

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

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

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

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

In simpler terms

The brain controls all the functions of the body. Damage to the brain can have serious effects. A stroke happens when there is severe damage to the brain caused by internal bleeding (haemorrhage) or when the flow of blood in an artery has been blocked by a piece of tissue or a blood clot (a thrombus or embolus) resulting in the brain being starved of oxygen.

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

Pre-existing conditions

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

If you have a history of intracranial aneurysm, atrial fibrillation, coronary artery disease, diabetes mellitus, peripheral vascular disease, hypercholesterolaemia, transient cerebral ischaemia, hypertension, arteriovenous malformation, thrombotic disorders e.g., primary phospholipid syndrome, hyperviscosity states (polycythaemia), heart valve disease and carotid atherosclerosis prior to the commencement date of cover and you suffer a stroke within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for stroke.

35 Systemic Lupus Erythematosus – of specified severity

Plan definition

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

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

  Glomerular Filtration Rate (GFR) below 30ml/min.

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

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

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

In simpler terms

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease. This means the immune system attacks the body's cells and tissue, resulting in inflammation and tissue damage. The course of the disease is unpredictable with periods of illness and periods of recovery. SLE is a multi-system disease because it can affect many different organs and tissues in the body.

Systemic lupus erythematosus can be a mild condition treated by medication or there can be life-threatening complications. The condition can be present for many years without moving on to involve the brain and kidneys.

You can claim if you are diagnosed, by a consultant rheumatologist, with systemic lupus erythematosus which is complicated because the brain is affected and this results in "permanent neurological deficit with persisting clinical symptoms", or the kidneys are involved and you have a GFR below 30ml/min.

Glomerular filtration rate (GFR) is a test used to check how well the kidneys are working. Specifically, it estimates how much blood passes through the tiny filters in the kidneys, called glomeruli, each minute.

Pre-existing conditions

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

If you have a history of inflammatory disease of the joints, including Rheumatoid Arthritis and related disorders, connective tissue disorder or anti-phospholipid syndrome prior to the commencement date of cover and you are found to have systemic lupus erythematosus within the first two years of cover no benefit will be payable under the specified Illness Cover plan and you will cease to be covered for systemic lupus erythematosus.

36 Traumatic Head Injury – resulting in permanent symptoms

Plan definition

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

For the above definition, the following are not covered:

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

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

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

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

The following are not covered:

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

In simpler terms

A head injury caused by trauma can leave you with permanent brain damage. You can claim if a consultant neurologist confirms that you have "permanent neurological deficit with persisting clinical symptoms" as a direct result of a head injury.

Pre-existing conditions

If you have suffered a traumatic head injury prior to the commencement date of cover, you can never claim for traumatic head injury under Specified Illness Cover plan.

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

This section outlines:

- the policy definition of each Specified Illness where a Partial Payment will be made that is covered under the Scheme
- a simple explanation of each illness
- information on related conditions which, if present before joining the Scheme, means the member is not covered for the Specified Illness if diagnosis occurs within the first two years of cover.

1 Brain Abscess drained *via* Craniotomy

Plan definition

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

If you are HIV (human immunodeficiency virus) positive, you will not be covered for brain abscess.

In simpler terms

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

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

You can claim if you are diagnosed with an intracerebral abscess which is treated by a consultant neurosurgeon surgically draining it using a craniotomy.

Pre-existing conditions

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

If you have a history of chronic middle ear infection prior to the commencement date of cover and you are found to have a brain abscess within the first two years, no benefit will be payable under the Specified Illness Partial Cover plan and you will cease to be covered for brain abscess.

2 Carcinoma in situ – Oesophagus, treated by specific surgery

Plan definition

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

For the above definition, the following are not covered:

- Treatment by any other method is specifically excluded.

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

In simpler terms

The oesophagus is a muscular tube made of membrane about 25 centimetres (cm) long which connects the mouth to the stomach. Carcinoma in situ is an early form of carcinoma that involves only the cells in which it began and has not spread to other tissues.

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

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

Pre-existing conditions

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

If you have a history of Barrett's oesophagus and/or persistent severe oesophageal reflux prior to the commencement date of cover and you are found to have carcinoma in situ within the first two years, no benefit will be payable under the Specified Illness Partial Cover plan and you will cease to be covered for carcinoma in situ of the oesophagus.

3 Carotid Artery Stenosis – treated by Endarterectomy or Angioplasty

Plan definition

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

In simpler terms

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

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

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

Pre-existing conditions

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

If you have a history of, coronary artery disease, diabetes mellitus, peripheral vascular disease, transient ischaemic attack, hypertension or hypercholesterolaemia prior to the commencement date of cover and you are found to have carotid artery stenosis within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for carotid artery stenosis.

4 Cerebral Arteriovenous Malformation – treated by Craniotomy or Endovascular repair

Plan definition

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

For the above definition, the following is not covered:

- Intracranial aneurysm.

In simpler terms
A cerebral arteriovenous malformation (AVM) is an abnormal connection between arteries and veins in the brain that interrupts normal blood flow between them. An AVM involves tangles of abnormal and enlarged blood vessels. In serious cases, the blood vessels rupture.

An arteriovenous fistula is an abnormal passageway between an artery and a vein.

Normally blood flows from arteries into capillaries and back to your heart in veins.

When you have an arteriovenous fistula, blood flows directly from an artery into a vein, bypassing the capillaries. If the volume of bloodflow diverted is large, some tissue will receive less blood. Also, there is a risk of heart failure due to the increased volume of blood returned to the heart.

You can claim if you have a craniotomy or endovascular treatment using coils under the care of a consultant neurologist or radiologist to treat a cerebral AVM or AV fistula.

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

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

Pre-existing conditions
If you have a history of cerebral arteriovenous malformation prior to the commencement date of cover, you can never claim for cerebral arteriovenous malformation under the Specified Illness Cover plan.

If you have a history of seizures or epilepsy prior to the commencement date of cover and are found to have a cerebral arteriovenous malformation, no benefit will be payable under the specified illness cover plan and you will cease to be covered for cerebral arteriovenous malformation.

5 Coronary Angioplasty – to 2 or more coronary arteries

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

- Insertion of 2 stents in different arteries at different times (e.g. on different days several years apart) does qualify for payment, after the second artery has been stented
- 2 stents to one artery, or branches of the same artery, does not qualify.

In simpler terms
Arteries can become blocked with fatty deposits, like the 'furring up' of a kettle. If the blockages are in the coronary arteries close to the heart, this causes extra strain on the heart, which then may lead to more serious heart disease.

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

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

If you have balloon angioplasty, atherectomy or laser treatment, you can claim if the treatment is to correct a 70% narrowing of at least two coronary arteries. We do not cover this treatment if only one artery is involved. We will need a copy of the angiogram reports showing at least 70% stenosis in the coronary arteries.

We will pay benefit for treatment by balloon angioplasty, atherectomy or laser treatment, in two different arteries on two separate occasions, to treat narrowing or blockages of at least 70%, after you have had the second procedure.

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

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

6 Ductal Carcinoma in situ – Breast, treated by surgery

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

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

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

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

We will not pay any claim under this benefit for any other breast disorder.

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

If you have a history of interstitial mastitis, fibrocystic disease or atypical cells of the breast prior to the commencement date of cover and you are found to have a ductal carcinoma in situ within the first two years, no benefit will be payable under the Specified Illness Partial Cover plan and you will cease to be covered for ductal carcinoma in situ of the breast.

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

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

- The tumour has progressed to at least clinical TNM classification T1NoMo
- The client has undergone treatment by prostatectomy, external beam or interstitial implant radiotherapy.

For the above definition, the following are not covered:
- Treatment with cryotherapy, transurethral resection of the prostate, 'experimental' treatments or hormone therapy.

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

In simpler terms
With increased and improved screening, prostate cancer is being detected at an earlier stage. If prostate cancer is caught early, when it is still classified as 'low grade', there is a good chance that treatment will be successful and the long-term outlook is good.

The 'Gleason score' and the 'TNM classification' are ways of measuring and describing how serious the cancer is, and whether it has spread beyond the prostate gland based on how it looks under a microscope. Cancers with a Gleason score less than or equal to 6 are less aggressive and have a better outlook.

Pre-existing conditions
If you have been diagnosed with prostate cancer prior to the commencement date of cover, you can never claim for low level Prostate cancer under the Specified Illness Cover plan.

If you have a history of raised PSA (prostate specific antigen) above 4.0 ng/ml prior to the commencement date of cover and you are found to have low level prostate cancer, no benefit will be payable under the Specified Illness Partial Cover plan and you will cease to be covered for low level prostate cancer.

8 Less Severe 3rd Degree Burns – covering at least 5% of the body's surface

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

To qualify for payment, less severe or 3rd degree burns covering at least 5% of the body's surface must happen on a date after the start date of the plan and before cover ends.

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

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

Pre-existing conditions
None.

9 Loss of One Limb

Plan definition
We will make a limited payment under specified illness cover if a life assured permanently loses a hand from above the wrist or a foot from above the ankle joint.

Permanent loss does not include loss of use or function only. It means having a hand or foot completely severed.

To qualify for payment, the loss of one limb must happen on a date after the start date of the plan and before cover ends.

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

We will not pay you for loss of any individual finger or toe, or combination of fingers and toes.

Pre-existing conditions
If you have previously suffered the loss of a limb prior to the commencement date of cover, you can never claim for loss of one limb under the Specified Illness Cover plan.

If you have a history of peripheral vascular disease, diabetes mellitus or gangrene prior to the commencement date of cover and you suffer the loss of one limb within the first two years of cover, no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for loss of one limb.

10 Surgical Removal of One Eye

Plan definition
We will make a limited payment for specified illness cover if a life assured undergoes surgical removal of a complete eyeball for disease or trauma.

To qualify for payment, the removal of the eyeball must happen on a date after the start date of the plan and before cover ends.

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

We will not pay benefit for loss of sight in one eye unless it was medically necessary to remove the eyeball.

Pre-existing conditions
If you have had an eyeball removed prior to the commencement date of cover, you can never claim for surgical removal of one eye under the Specified Illness Cover plan.

If you have a history of eye trauma or eye disease, including uveitis or retrobulbar carcinoma prior to the commencement date of cover and you have an eye surgically removed within 2 years of cover no benefit will be payable under the Specified Illness Cover plan and you will cease to be covered for surgical removal of one eye.

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Irish National Teachers' Organisation
Cumann Múinteoirí Éireann

Salary Protection Scheme for INTO Members

This guide provides an outline only of the main benefits of the Salary Protection Scheme for INTO Members as of January 2016. This is issued subject to the provisions of the policy and does not create or confer any legal rights.

The information contained herein is based upon our current understanding of Revenue law and practice as of January 2016.

The Salary Protection Scheme for INTO Members is governed by the master Policy Document No. 4383 issued by Irish Life. Members of the Scheme may request a copy of the policy document from the Head Office of INTO or the Dublin office of Cornmarket Group Financial Services Ltd.

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

If you are dissatisfied with the outcome of your complaint through Cornmarket, you may also submit your complaint to the Financial Services Ombudsman's Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, or log onto www.financialombudsman.ie.

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