Caledonian Life

Protecting you and your world

Specified Serious Illness Cover

Policy Conditions

Specified Serious Illness

Policy Conditions

IMPORTANT
Please keep these documents safely

- The utmost care should be taken of this policy as duplicates of lost policies can not generally be issued.
- You may wish to let one or more of the beneficiaries of this policy know where you intend to keep it.
- Any documents which affect the title to the policy (such as trust deeds or assignments) should also be kept safely as these will be required when a claim is made.

Any notices should be sent to:
The Existing Business Department at
Caledonian Life, Caledonian House, 47 St. Stephen's Green, Dublin 2, Ireland.

POLICY CONDITIONS

This is the policy conditions booklet which applies to the following Caledonian Life protection policies:

- Mortgage Protection with Accelerated Specified Serious Illness Cover
- Term Assurance with Specified Serious Illness Cover

Caledonian Life is a division of the Royal London Group which consists of The Royal London Mutual Insurance Society Limited and its subsidiaries. The Royal London Mutual Insurance Society Limited ("the Society") will pay out the life assurance cover shown in the policy schedule, provided the premiums are paid as shown in the policy schedule, and subject to the terms and conditions as set out in this policy conditions booklet.

Specified Serious Illness

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INTRODUCTION

This policy is designed to provide cover that pays a lump sum when a Life Assured dies or is diagnosed with any of the insured specified serious illnesses as defined in this policy conditions booklet.

This policy is provided by us (Caledonian Life, a division of The Royal London Mutual Insurance Society Limited in Ireland) to you (the policyholder(s) named in the policy schedule).

The policy consists of the policy schedule, any endorsements attaching to it, the policy conditions booklet, the proposal form and any related information provided by you or anybody acting on your behalf during the application process.

This policy is a protection plan only – there is no surrender value payable at any stage under the policy. Even if you have not made a claim by the time the period of cover ends, we will not return your premiums. All cover under the policy will end on the expiry date shown in the policy schedule, unless it has ended before that for any of the reasons explained in these policy conditions.

If you are making a claim under this policy, please contact us at our Head Office at:

Caledonian Life
Caledonian House
47 St. Stephen's Green
Dublin 2
Ireland

In legal disputes Irish law will apply. Premiums and benefits are payable in the currency of Ireland.

More detailed information on all these matters is in the relevant sections of this policy conditions booklet.

HOW DOES THE POLICY WORK?

You choose the type of cover you want and pay the premiums to us as set out in the policy schedule. If an event for which you are covered occurs during the term of the policy, we will pay you the appropriate benefit (the benefits are described in greater detail later on in this policy conditions booklet).

WHO RECEIVES THE MONEY WE PAY OUT?

The policyholder(s), as defined in the policy schedule, or their legal personal representatives, will receive the money we pay out.

However, if this policy has been assigned to someone else (for example, it is passed to a Building Society to be placed with title deeds as security for a mortgage), we will pay that person or organisation. If the policy is written under trust, we will pay the trustee(s) who are obliged to distribute the proceeds in accordance with the Trust Conditions. The right to receive the policy's benefits may also pass to other people, such as someone who holds a power of attorney.

WRITING TO US

If you need to write to us about this policy, please write to our Head Office at:

Caledonian Life
Caledonian House
47 St Stephen's Green
Dublin 2
Ireland

COOLING-OFF PERIOD

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

CANCELLATION

If this policy is to be cancelled, we must receive written notification, signed by you, to the address shown above.

If this policy has been issued in connection with a mortgage, or other loan, which is subsequently paid off or transferred to another lender, your cover will remain in place unless you inform us in writing that you wish to cancel this policy.

Until you have informed us that you no longer need this cover, we will continue to collect premiums and you will remain covered by the policy. You will not be entitled to any refund of premiums.

It is not possible to cancel one benefit under this policy whilst retaining another benefit in place. For example, you cannot cancel a Specified Serious Illness Cover benefit and keep a Life Cover benefit in place.

COMPLAINTS

Caledonian Life is committed to the provision of the highest standards of customer service. However, if you are dissatisfied with any aspect of our service, please let us know. We take all complaints very seriously. If you wish to complain about any aspect of the service you have received, please contact Caledonian Life directly. If your complaint is not dealt with to your satisfaction, you may refer your complaint to:

Financial Services Ombudsman's Bureau,
3rd Floor, Lincoln House,
Lincoln Place,
Dublin 2.

Lo Call: 1890 88 20 90
Tel: +353 (0)1 662 0899
Fax: +353 (0)1 662 0890
E-mail: enquiries@financialombudsman.ie
Website: www.financialombudsman.ie

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SECTION 1 – DEFINITIONS

AIDS
AIDS means Acquired Immune Deficiency Syndrome.

Benefit
The amount payable in the event of a claim under the policy.

Chief Medical Officer (CMO)
The Chief Medical Officer is a registered medical practitioner retained by Caledonian Life.

Consultant
A registered medical practitioner who has specialist qualifications in an appropriate branch of medicine and who is practising at a major hospital in the Republic of Ireland or UK.

Conversion Option Expiry Date (if the policy schedule shows that a conversion option applies)
If a conversion option applies to this policy, a conversion option expiry date will be shown on the policy schedule. You can only exercise the option before this date (see Section 9).

Diagnosis of an Insured Specified Serious Illness
A Life Assured is 'diagnosed as having an insured specified serious illness' if on a date after the start date of the policy and before the policy expiry date, the Life Assured has:

- been diagnosed as having one of the insured specified serious illnesses or medical conditions as defined in Section 5 of these policy conditions; or
- had a surgery defined in Section 5 of these policy conditions.

Dual Life
If there are two Lives Assured and cover is on a Dual Life basis (see policy schedule), cover is provided separately for the two lives. As the two lives are covered independently a claim for one Life Assured has no impact on the benefits relating to the second Life Assured (see Section 4). Dual Life is not available with a Mortgage Protection Policy.

European Union (EU)
Any country which is a member of the European Union (EU) at the date the policy commences.

HIV
HIV means Human Immunodeficiency Virus.

Increase Date (if the policy schedule shows that an indexation option applies)
This is each anniversary of the start date shown in the policy schedule. On this date each year the benefit and premium will increase if the indexation option applies at that time, subject to certain conditions (see Section 8).

Insured Specified Serious Illnesses
The insured specified serious illnesses as defined in Section 5 of this booklet which are covered by this policy, unless excluded in the policy schedule.

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

Joint Life
If there are two Lives Assured and cover is on a Joint Life basis (see policy schedule), a claim for one Life Assured will reduce the overall level of cover provided by the policy by the amount of the claim (excluding Children's Specified Serious Illness Cover claims). Where all cover under a policy has been reduced to nil as a result of a claim or claims the policy will cease immediately (see Section 4).

Life Assured or Lives Assured
The person or people named in the policy schedule as the life or lives covered. Payment of the benefits under the policy depends on the health and the lives of those people. Where we refer to 'Lives Assured' in these policy conditions, it is assumed to mean 'Life Assured' where there is only one life covered on the policy.

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Major Hospital
An institution in the Republic of Ireland or UK which has facilities for diagnosis, treatment and major surgery and has accommodation for in-patients. It does not include a long-term nursing unit, a geriatric or pre-convalescent ward, or an extended-care facility for convalescence, rehabilitation or other similar function.

Medical Specialist
A registered medical practitioner who has specialist qualifications in an appropriate branch of medicine and who is practising at a major hospital in the Republic of Ireland or UK.

Period of Grace
The period of time, after the date a premium payment is due, allowed for the payment of any outstanding premium(s). See Section 3 of this booklet.

Permanent
Expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

Permanent neurological deficit with persisting clinical symptoms
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, lethargy, dementia, delirium and coma.

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

Policy Schedule
This is part of the contract. It sets out the specific details of the policy such as:
- the start date;
- the expiry date;
- the Life or Lives Assured;
- the policyholder or policyholders;
- the Life Cover;
- the Specified Serious Illness Cover;
- the premium; and
- any special conditions that apply.

Policy Expiry Date
The expiry date shown in the policy schedule. All cover will end on this date unless it has ended earlier.

Premium
Either:
- the amount shown in the policy schedule under the relevant heading (or the amount to which it has been increased if an indexation option applies); or
- the amount payable if we reinstate cover under Section 3.3; or
- the reduced amount payable if there has been a claim on the Specified Serious Illness Cover (excluding Children's Specified Serious Illness Cover or Advance Payment of Benefit for Heart Surgery); or
- the reduced amount payable if there has been a claim on a Dual Life policy (excluding Children's Specified Serious Illness Cover or Advance Payment of Benefit for Heart Surgery); or
- the increased amount payable if an option covered under Section 7 of this booklet has been exercised.

Registered Medical Practitioner
A person who meets the legal requirements for carrying on a medical practice in the Republic of Ireland or UK and who actually practices medicine in either of those countries.

Start/Commencement date
The policy date shown in the policy schedule. Cover will start on this date.

Survival Period
For Stand-alone Specified Serious Illness Cover, a Life Assured must survive for a period of 14 days after the date of diagnosis of an insured specified serious illness in order to make a claim under the Specified Serious Illness Cover benefit. We will not pay any Specified Serious Illness Cover benefit for that Life Assured if they die within this period.

We/Us
Caledonian Life, a division of The Royal London Mutual Insurance Society Limited in Ireland.

You/Your (the policyholder)
The person (or people or organisation) named as the policyholder in the policy schedule, who is/are responsible for ensuring the premiums under the policy are paid. The policyholder is legally entitled to the policy benefit as long as the policy has not been assigned (passed) to someone else or issued in trust. If this policy has been assigned to someone else, 'you' refers to that assignee.

SECTION 2 – BASIS OF COVER

2.1 We have issued this policy to you on the understanding that the information contained in the proposal form and any related document or information obtained by us (including that provided by a third party on behalf of you or a Life Assured) is true and complete and that we have been given all relevant information. If this is not the case we will be entitled to declare the policy void. If this happens, you will lose all of your rights under the policy, we will not pay any claim and we will not refund any premiums. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of premiums or benefits, when deciding whether to provide cover at all or when deciding whether to attach conditions.

Relevant information includes, but is not limited to, details on the following:
- Personal health
- Occupation
- Residence or travel
- Participation in any hazardous leisure activities (as outlined in Section 10.2)
- Smoking habit
- Illegal drug use
- Family history.

2.2 If your cover ends because premiums have not been paid when due and it is reinstated under Section 3.3, we will reinstate it on the understanding that the information given in the declaration of health form and any related documents is true and complete and that all relevant information has been provided.

If this is not the case, we will be entitled to declare the policy void from the date of reinstatement. If this happens, you will lose all your rights under the policy from the date of reinstatement, we will not pay any claim and we will not refund any premiums. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of premiums or benefits, when deciding whether to reinstate cover at all or when deciding whether to attach conditions.

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SECTION 3 – PAYING PREMIUMS

3.1 Although each premium is due as shown in the policy schedule, we allow 30 days to pay the premium (the time allowed is known as a 'period of grace'). If you become entitled to a benefit during a period of grace, we will take from your benefit any premiums that have not been paid.

3.2 If a premium has not been paid by the end of the period of grace, the cover under the policy will end immediately. A premium is not paid until we have received it. It is the responsibility of those paying the premium to make sure that we receive it. We are entitled to pass on any charge which we have to pay because the premium (for example, a direct debit) is not paid.

3.3 If, within 12 calendar months of the first missed premium being due, we are asked to reinstate cover, the Life or Lives Assured must fill in a declaration of health form and all unpaid premiums must be paid. The declaration of health form includes questions which might influence the judgement of a reputable insurer when fixing the level of premiums or benefit. If the information on the declaration of health form shows any material change to that declared on the application form, we may refuse to reinstate cover or reinstate the cover with an increased premium or with new conditions or exclusions (this could include the removal of options).

If we agree to reinstate cover, all missed premiums must be paid and premiums must commence payment again. We will not pay benefits for anything that happens between:

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

If we accept a premium which is no longer due, we will return it as we will not have provided cover under the policy. We are entitled to apply a charge to cover the costs of reinstatement.

3.4 Monthly premiums must be paid by direct debit.

SECTION 4 – YOUR COVER

4.1 The following benefits are available:

- Life Cover
- Accelerated Specified Serious Illness Cover
- Stand-alone Specified Serious Illness Cover (Not available under a Mortgage Protection Policy)

Only the benefits shown on the policy schedule are included in the policy. Check your policy schedule to see which benefits apply to a Life Assured and in what amounts. Please also refer to your policy schedule for any additional conditions or exclusions that may apply to your policy.

Sections 4.11 and 4.12 set out what benefits may apply to a Life Assured's children.

4.2 If we accept a claim, we will pay the amount of benefit set out in the policy schedule for that Life Assured. This will be adjusted for the amount (if any) by which it has been:

- reduced due to the decreasing level of cover each month on a Mortgage Protection policy, details of which are contained in the policy schedule; or
- increased due to an indexation option, details of which are contained in the policy schedule; or
- reduced due to a Specified Serious Illness Cover claim or Advance Payment of Benefit for Heart Surgery.

If the Special Events Increase Benefit has been exercised the amount of benefit payable will be adjusted accordingly, subject to the same conditions above. See Section 7 for details.

4.3 Life Cover

Life Cover is payable when a Life Assured dies (assuming a Life Cover benefit applies to that Life Assured).

- If cover is on a Single Life basis, upon payment of this benefit all cover will end and the policy will cease immediately.
- If cover is on a Joint Life basis, this benefit is payable when the first of either Life Assured dies, after which all cover will end and the policy will cease immediately.

- If cover is on a Dual Life basis, upon payment of this benefit all cover will end immediately for that Life Assured. However, all benefits relating to the remaining Life Assured will be unaffected and the policy can continue on a Single Life basis.

The benefit payable will be the level of Life Cover for that Life Assured as at the date of death. If a Life Assured dies during a 'period of grace', we will reduce the benefit by the amount of any unpaid premiums.

4.4 Terminal Illness Benefit (Prepayment of Life Cover)

On proof of the diagnosis of a Terminal Illness, as defined below, of a Life Assured after the commencement date of the policy, we will pay the level of their Life Cover as at the date of diagnosis of the Terminal Illness (assuming a Life Cover benefit applies to that Life Assured).

- If cover is on a Single Life basis, upon payment of this benefit the Life Cover will reduce to nil. If there is no Specified Serious Illness Cover benefit all cover will end and the policy will cease immediately. If there is an Accelerated Specified Serious Illness Cover benefit, the Specified Serious Illness Cover will also reduce to nil and the policy will cease immediately. If there is a Stand-alone Specified Serious Illness Cover benefit, this will not be affected by the payment of the Terminal Illness benefit.
- If cover is on a Joint Life basis, this benefit is payable when the first of either Life Assured is diagnosed with a Terminal Illness, after which all cover will end and the policy will cease immediately.
- If cover is on a Dual Life basis, upon payment of this benefit the Life Cover will reduce to nil for that Life Assured. If there is no Specified Serious Illness Cover benefit for that Life Assured all cover will end immediately for that Life Assured. If there is an Accelerated Specified Serious Illness Cover benefit for that Life Assured, the Specified Serious Illness Cover will also reduce to nil for that Life Assured and all cover will end immediately for that Life Assured. If there is a Stand-alone Specified Serious Illness Cover benefit for that Life Assured, this will not be affected by the payment of the Terminal Illness benefit. Upon payment of the Terminal Illness benefit for a Life Assured, all benefits relating to the remaining Life Assured will be unaffected.

For the purposes of this policy, Terminal Illness is defined as:

- A definite diagnosis by the attending Consultant and Caledonian Life's Chief Medical Officer of an illness that satisfies both of the following:
- The illness either has no known cure or has progressed to the point where it cannot be cured; and
- In the opinion of the attending Consultant and Caledonian Life's Chief medical Officer is expected to lead to death within 12 months.

If a Life Assured contracts a Terminal Illness by his or her own act, no payment will be made under this section. If a Life Assured is diagnosed with a Terminal Illness during a 'period of grace', we will reduce the benefit by the amount of any unpaid premiums.

4.5 Accelerated Specified Serious Illness Cover

Accelerated Specified Serious Illness Cover is payable when a Life Assured is diagnosed as having an insured specified serious illness as defined in Section 5 (assuming an Accelerated Specified Serious Illness Cover benefit applies to that Life Assured).

- If cover is on a Single Life basis, once a claim has been paid under the Accelerated Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or Partial Payment Specified Serious Illness Cover), the Life Cover and Specified Serious Illness Cover will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover reducing to nil, the Specified Serious Illness Cover benefit will end. If this also results in the Life Cover reducing to nil, the Life Cover benefit will also end and the policy will cease immediately.
- If cover is on a Joint Life basis this benefit is payable when the first of either Life Assured is diagnosed as having an insured specified serious illness. Once a claim has been paid under the Accelerated Specified Serious Illness Cover on the

policy (excluding Children's Specified Serious Illness Cover or Partial Payment Specified Serious Illness Cover), the Life Cover and Specified Serious Illness Cover will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover reducing to nil, the Specified Serious Illness Cover benefit will end. If this also results in the Life Cover reducing to nil, the Life Cover benefit will also end and the policy will cease immediately.

- If cover is on a Dual Life basis, once a claim has been paid under the Accelerated Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or Partial Payment Specified Serious Illness Cover), the Life Cover and Specified Serious Illness Cover for that Life Assured will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover for that Life Assured reducing to nil, the Specified Serious Illness Cover benefit will end for that Life Assured. If this also results in the Life Cover reducing to nil for that Life Assured, the Life Cover benefit will also end for that Life Assured. However, all benefits relating to the remaining Life Assured will be unaffected and the policy can continue on a Single Life basis.

The benefit payable will be the level of Accelerated Specified Serious Illness Cover for that Life Assured as at the date of diagnosis of the insured specified serious illness. The benefit can only be paid once per policy for Single Life and Joint Life polices, and once per Life Assured for Dual Life policies (assuming an Accelerated Specified Serious Illness Cover benefit applies to that Life Assured). For example, the same Life Assured cannot claim for a heart attack and then claim for cancer. If a Life Assured is diagnosed with an insured specified serious illness during a 'period of grace', we will reduce the benefit by the amount of any unpaid premiums.

4.6 Stand-alone Specified Serious Illness Cover

Stand-alone Specified Serious Illness Cover is payable when a Life Assured is diagnosed as having an insured specified serious illness, as defined in Section 5, and survives for a period of 14 days (the 'survival period') after date of diagnosis (assuming a Standalone Specified Serious Illness Cover benefit applies to that Life Assured). We will not pay any Specified Serious Illness Cover benefit for a Life Assured if they die within the 'survival period'.

- If cover is on a Single Life basis, once a claim has been paid under the Stand-alone Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or Partial Payment Specified Serious Illness Cover), the Specified Serious Illness Cover will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover reducing to nil, the Specified Serious Illness Cover benefit will end and if there is no Life Cover under the policy, the policy will cease immediately.
- If cover is on a Dual Life basis, once a claim has been paid under the Stand-alone Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or Partial Payment Specified Serious Illness Cover), the Specified Serious Illness Cover for that Life Assured will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover for that Life Assured reducing to nil, the Specified Serious Illness Cover benefit will end for that Life Assured. If there is no Life Cover in respect of that Life Assured all cover will end immediately for that Life Assured. However, all benefits relating to the remaining Life Assured will be unaffected and the policy can continue on a Single Life basis.

The benefit payable will be the level of Stand-alone Specified Serious Illness Cover for that Life Assured as at the date of diagnosis of the insured specified serious illness. The benefit can only be paid once per policy for Single Life polices, and once per Life Assured for Dual Life policies (assuming a Standalone Specified Serious Illness Cover benefit applies to that Life Assured). For example, the same Life Assured cannot claim for a heart attack and then claim for cancer. If a Life Assured is diagnosed with an insured specified serious illness during a 'period of grace', we will reduce the benefit by the amount of any unpaid premiums.

4.7 Partial Payment Specified Serious Illness Cover

Partial Payment Specified Serious Illness Cover is payable when a Life Assured is diagnosed as having an insured specified serious illness as defined in Section 6, and survives for a period of 14 days (the 'survival period') after date of diagnosis (assuming an Accelerated or Standalone Specified Serious Illness Cover benefit applies to that Life Assured). We will not pay any Partial Payment Specified Serious Illness Cover benefit for a Life Assured if they die within the 'survival period'.

The society will pay the following amount on survival for 14 days after diagnosis:
€15,000 or 50% of the level of Specified Serious Illness Cover for the Life Assured under the policy as at the date of the event giving rise to the claim, whichever is lower.

The total amount we will pay through partial payments is limited to the amount of your Accelerated or Standalone Specified Serious illness. You are only permitted to claim once for each of the illnesses defined in Section 6. You are only permitted to claim once for a single event, for example:
If you claim under the cancer definition, payment will just be the full cover amount for cancer and no additional payment will be made if it is treated by lobectomy or pneumonectomy.

4.8 A Life Assured is 'diagnosed as having an insured specified serious illness' if on a date after the start date of the policy and before the policy expiry date, the Life Assured has:

- been diagnosed as having one of the insured specified serious illnesses or medical conditions as defined in Section 5 of these policy conditions; or
- had a surgery defined in Section 5 of these policy conditions.

4.9 All cover will end and the policy will cease at the earliest of the following:

- At the end of a period of grace, if a premium has not been paid;
- On the policy expiry date, as shown in the policy schedule;
- When all cover (both Life Cover and Specified Serious Illness Cover, as applicable) has reduced to nil as a result of a claim or claims, as per Sections 4.3, 4.4, 4.5 and 4.6.

4.10 Advance Payment of Benefit for Heart Surgery

If a Life Assured is diagnosed as needing Aorta Graft Surgery, Coronary Artery Bypass Graft Surgery, Pulmonary Artery Surgery, or Heart Valve Replacement or Repair Surgery and we have been given the evidence we need about the condition, as defined below, we will make an advance payment of their Specified Serious Illness Cover (up to €20,000).

The amount we will pay is €20,000 or their level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower. We will pay any remaining Specified Serious Illness Cover after the surgery has taken place (provided the Life Assured survives for a period of 14 days after the surgery if the Specified Serious Illness Cover is on a stand-alone basis). We will not make a payment if the type of surgery has been excluded from the Life Assured's cover. If cover is on a Single Life or Joint Life basis we will only make one advance payment as described in this section under the policy. If cover is on a Dual Life basis we will only make one advance payment per Life Assured as described in this section under the policy.

- For Accelerated Specified Serious Illness Cover, if the basis of cover is Single Life or Joint Life, once an advance payment has been made, the Life Cover and Specified Serious Illness Cover will reduce by the amount of the advance payment. If the basis of cover is Dual Life, once an advance payment has been made, the Life Cover and Specified Serious Illness Cover for that Life Assured will reduce by the amount of the advance payment. If this results in the Specified Serious Illness Cover for that Life Assured reducing to nil, the Specified Serious Illness Cover benefit will end for that Life Assured. If this also results in the Life Cover reducing to nil for that Life Assured, the Life Cover benefit will also end for that Life Assured. However, all benefits relating to the remaining Life Assured will be unaffected and the policy can

continue on a Single Life basis. Where all Life Cover and Specified Serious Illness Cover under a policy has been reduced to nil as a result of a claim, the policy will cease immediately.

- For Stand-alone Specified Serious Illness Cover, if the basis of cover is Single Life, once an advance payment has been made, the Specified Serious Illness Cover will reduce by the amount of the advance payment. If the basis of cover is Dual Life, once an advance payment has been made, the Specified Serious Illness Cover for that Life Assured will reduce by the amount of the advance payment. If this results in the Specified Serious Illness Cover for that Life Assured reducing to nil, the Specified Serious Illness Cover benefit will end for that Life Assured. If there is no Life Cover in respect of that Life Assured all cover will end immediately for that Life Assured. However, all benefits relating to the remaining Life Assured will be unaffected and the policy can continue on a Single Life basis. Where all Life Cover and Specified Serious Illness Cover under a policy has been reduced to nil as a result of a claim, the policy will cease immediately.

i. If a Life Assured needs Aorta Graft Surgery, you must provide the following proof:

- Certification from a Consultant Cardiologist or Vascular Surgeon of a major hospital in the Republic of Ireland or UK that the Life Assured is on a waiting list or scheduled for surgery he or she definitely needs in order to correct any narrowing or weakening of the thoracic or abdominal aorta. This must include a report on the nature of the disease and symptoms and be verified by our Chief Medical Officer.

ii. If a Life Assured needs Coronary Artery Bypass Graft Surgery, you must provide the following proof:

- Certification from a Consultant Cardiologist or Cardiac Surgeon of a major hospital in the Republic of Ireland or UK that the Life Assured is on a waiting list or scheduled for a coronary artery bypass graft through open-heart surgery (surgery to divide the breast-bone). This must include the result of a recent angiogram showing the extent of the coronary artery disease and be verified by Our Chief Medical Officer.

iii. If a Life Assured needs Pulmonary Artery Surgery, you must provide the following proof:

- Certification from a Consultant Cardiologist or Cardiac Surgeon of a major hospital in the Republic of Ireland or UK that the Life Assured is on a waiting list or scheduled for a pulmonary artery bypass graft through open-heart surgery (surgery to divide the breast-bone). This must include the result of a recent angiogram showing the extent of the pulmonary artery disease and be verified by Our Chief Medical Officer.

iv. If a Life Assured needs Heart Valve Replacement or Repair Surgery, you must provide the following proof:

- Certification from a Consultant Cardiologist or Cardiac Surgeon of a major hospital in the Republic of Ireland or UK that the Life Assured is on a waiting list or scheduled for open-heart surgery (surgery to divide the breast-bone) he or she definitely needs within one year in order to repair or replace one or more heart values or to correct structural abnormalities. This must include the result of a recent echocardiogram and angiogram showing significant heart valve disease or a significant structural defect of the heart and be verified by our Chief Medical Officer.

4.11 Children's Specified Serious Illness and Partial Payment Specified Serious Illness Cover

On acceptance that an eligible child, as defined below, of a Life Assured is diagnosed as having one of the insured specified serious illnesses (other than Loss of Independent Existence) and that this is not a pre-existing condition, as defined below, the society will pay the following amount on survival for 14 days after diagnosis (known as the 'survival period'):

- €25,000 or 25% of the level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is Single Life or Joint Life.
- €25,000 or 25% of the higher level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is Dual Life.

On acceptance that an eligible child, as defined below, of a Life Assured is diagnosed as having one of the insured Partial Payment Specified Serious Illnesses and that this is not a pre-existing condition, as defined below, the society will pay the following amount on survival for 14 days after diagnosis (known as the 'survival period'):

- €7,500 or 25% of the level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is Single Life or Joint Life.
- €7,500 or 25% of the higher level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is Dual Life.

The policy will not end upon payment of the lump sum and the level of Specified Serious Illness Cover will not be reduced. We will only pay the Children's Specified Serious Illness Cover once in respect of each child. This applies even if both parents are Lives Assured, or even if a Life Assured is covered under more than one policy which provides similar benefits. An eligible child is defined as a natural or legally adopted child who is between their 1st and 18th birthday at the date of diagnosis and whose mother or father is a Life Assured under the policy. If the child is in full-time education, the child will qualify for the Children's Specified Serious Illness Cover if they are between their 1st and 21st birthday at the date of diagnosis.

A pre-existing condition is a medical condition (including congenital defects) affecting a child which existed prior to the latest of the following dates:

- Commencement date of the policy;
- The child's first birthday;
- The legal adoption of the child.

Children's Specified Serious Illness Cover applies only to the diagnosis of an insured specified serious illness (other than Loss of Independent Existence) and not on the death of a child or diagnosis of a Terminal Illness. We will not pay any benefit if a child dies within the 'survival period'.

An advance payment may be made under the Advance Payment of Benefit for Heart Surgery definition, see Section 4.10 for details. Where applicable, the advance payment is €10,000 or 25% of the level of Specified Serious Illness Cover (based on the higher level of Specified Serious Illness Cover if the basis of cover is Dual Life) under the policy as at the date of the event giving rise to the claim, whichever is lower. However, the maximum total benefit per child for Children's Specified Serious Illness Cover is as defined in this section.

4.12 Children's Life Cover

On the death of an eligible child, as defined below, of a Life Assured (assuming a Life Cover benefit applies to that Life Assured) the society will pay €5,000.

The policy will not end upon payment of the lump sum and the level of life cover, if included, or Specified Serious Illness Cover will not be reduced. We will only pay the Children's Life Cover once in respect of each child. This applies even if both parents are Lives Assured, or even if a Life Assured is covered under more than one policy which provides similar benefits.

An eligible child is defined as a natural or legally adopted child who is aged between 3 months and their 18th birthday at the date of death and whose mother or father is a Life Assured under the policy. If the child is in full-time education, the child will qualify for the Children's Life Cover if they are aged between 3 months and 21st birthday at the date of death.

SECTION 5 – SPECIFIED SERIOUS ILLNESS COVER DEFINITIONS

Important Note: The explanations under "What does this mean" in this section DO NOT form part of the policy conditions for this policy and are provided solely for information purposes. In the event of a claim under the Specified Serious Illness Cover on this policy, the policy definitions will apply.

5.1 Alzheimer's Disease – resulting in permanent symptoms

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

For the above definition, the following are not covered:

- Other types of dementia (these are covered under the Dementia definition).

What does this mean?

Alzheimer's Disease is a progressive and degenerative disease. The nerve cells in the brain deteriorate and the brain shrinks. The symptoms can include a severe loss of memory and concentration but there is an overall decline in all mental faculties.

5.2 Aorta Graft Surgery – for disease

Policy 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 its branches. The undergoing of surgery for traumatic injury to the aorta needing excision and surgical replacement of a portion of the aorta with a graft is also covered.

For the above definition, the following is not covered:

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

What does this mean?

The aorta is the main artery in the body, which carries the blood through the thorax (chest) and abdomen. The aorta may be weakened by an aneurysm (which means a thinning and bulging of the arterial wall) or it may become narrowed by fatty deposits. An operation can be carried out to correct the narrowing or to replace or repair the damaged part of the aorta wall.

5.3 Aplastic Anaemia – of specified severity

Policy 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 is not covered:

- other forms of anaemia.

What does this mean?

Aplastic anaemia is a rare and very serious form of anaemia in which there is a decrease in the quantity of blood-forming cells in the bone marrow. This then causes impairment of all blood cell production. This condition can be present from birth or may develop in later life. In most cases the bone marrow failure is permanent. However, in some cases (for example due to drug or radiation treatment or to infection) it is temporary. *Temporary bone marrow failure would not be covered by the definition.*

5.4 Bacterial Meningitis – resulting in permanent symptoms

Policy definition

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

For the above definition, the following is not covered:

- all other forms of meningitis other than those caused by bacterial infection.

What does this mean?

Bacterial meningitis is a condition resulting from bacterial infection. This causes inflammation to the meninges, which is the protective layer around the brain. There are many forms of meningitis. It is only

bacterial meningitis that is covered; all other forms, including viral meningitis, are excluded.

5.5 Balloon Valvuloplasty to correct heart valve abnormalities

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

What does this mean?

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

5.6 Benign Brain Tumour – resulting in permanent symptoms

Policy 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.

For the above definition, the following are not covered:

- Tumours or lesions in the pituitary gland.
- Angiomas.

In addition, the requirement for permanent neurological deficit with persisting clinical symptoms will be waived if the benign brain tumour is surgically removed.

What does this mean?

Unlike cancer, which is a malignant tumour, benign tumours are localised and grow by expansion only. They therefore do not invade and destroy surrounding tissue and do not spread to other parts of the body. Once surgically removed they tend not to recur.

However, a benign tumour can still be very dangerous because it can put pressure on the brain and lead to possible damage, haemorrhage and ulceration. Deficit to the neurological system means muscle weakness or sensory loss. Surgery to cure the condition may not always be possible.

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

Policy definition

A non-malignant tumour of the spinal canal or spinal cord, causing pressure and or interfering with the function of the spinal cord which requires surgery or results in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following are not covered:

- Angiomas.

The requirement for permanent neurological deficit with persisting clinical symptoms will be waived if the benign spinal cord tumour is surgically removed either by invasive surgery or stereotactic radiosurgery.

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

What does this mean?

A benign tumour of the spinal canal or spinal cord is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of spinal cord or spinal canal. In order for a claim to be paid you must have undergone surgery to have it removed or are suffering from permanent neurological deficit as a result of the tumour.

5.8 Blindness – permanent and irreversible

Policy definition

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

What does this mean?
Sight can be lost because of an accident or illness. In order for a claim to be paid, the loss of sight must be permanent and irreversible. If the loss was only temporary, it would not be covered by the definition.

5.9 Cancer – excluding less advanced cases

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

The term malignant tumour includes leukaemia, sarcoma, and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).
For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
  - pre-malignant,
  - non-invasive;
  - cancer in situ;
  - having either borderline malignancy; or
  - having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

What does this mean?
Cancer is a malignant tumour or a malignancy. It causes uncontrolled growth of abnormal cells that invade, damage and destroy surrounding bodily tissue. These cells can then spread and cause damage to other parts of the body. Pre-malignant and non-invasive cancers and cancer in situ are very early stage cancers that have not invaded surrounding tissue and have not spread to other areas of the body. Treatment is relatively easy and successful and these cancers are not covered. With increased and improved screening prostate cancer is being detected at an earlier stage. Accordingly, the less advanced prostate cancers are not covered. More advanced and more aggressive cases (typically those that are currently detected) will continue to be covered.

Chronic lymphocytic leukaemia (CLL) occurs predominantly in later life and is often a chance finding with no symptoms. Binet stage A CLL is typically kept under review rather than actively treated. Most skin cancers, including cutaneous lymphoma, are also easy to treat and are also excluded. However, malignant melanoma is a very serious form of skin cancer that can very quickly spread throughout the body. This form of skin cancer is therefore included if it has invaded beyond the epidermis (outer layer of skin).

5.10 Cardiac arrest – with insertion of a defibrillator

Policy definition
Sudden loss of heart functions with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted.

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

For the above definition, the following are not covered:

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

What does this mean?
Cardiac arrest happens when the heart suddenly stops beating, sometimes because of an abnormal rhythm (arrhythmia) or coronary heart disease. This can stop the heart from pumping blood which can cause loss of consciousness due to lack of oxygen in the brain. A device known as an Implantable Cardioverter Defibrillator (ICD or CRT-D) can be implanted inside your body which will monitor the rhythm in your heart, delivering an electric pulse or

shock should your heart rhythm become abnormal. This will restore the rhythm back to normal and prevent a cardiac arrest.

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

5.11 Cardiomyopathy – of specified severity

Policy definition

A definite diagnosis by a Consultant Cardiologist of cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 40% or less for at least 6 months when stabilised on therapy advised by the Consultant. The diagnosis must also be evidenced by:

- electrocardiographic changes; and
- echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy. For the above definition, the following are not covered:

- all other forms of heart disease and/or heart enlargement;
- myocarditis; and
- cardiomyopathy related to alcohol or drug abuse.

What does this mean?

Cardiomyopathies are a group of disorders of the heart muscle, which can cause sudden death and heart failure. Cardiomyopathy can occur in young people and can be inherited. Myocarditis is an acute inflammation of the heart muscle, typically caused by infection, and is not covered by the definition.

5.12 Chronic Lung Disease – of specified severity

Policy definition

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

- the need for continuous daily oxygen therapy on a permanent basis;
- FEV1 being less than 40% of normal; and
- Vital Capacity less than 50% of normal.

What does this mean?

Chronic lung disease can be caused by a number of conditions such as severe chronic bronchitis and emphysema and lung fibrosis. It is associated with persistent breathlessness at rest, or on minimal exertion, requiring daily oxygen therapy.

5.13 Chronic Rheumatoid arthritis – of specified severity

Policy definition

The confirmation by a Consultant Rheumatologist of a definite diagnosis of chronic rheumatoid arthritis as evidenced by all of the following:

- The condition must be diagnosed, established and treated for a period of at least twelve months.
- There must be morning stiffness in the affected joints.
- There must be arthritis in at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a rheumatologist.
- The arthritis must involve at least one or more of the following sites:
  - Wrists or ankles
  - Hands and fingers
  - Feet and toes
- The arthritis must affect both sides of the body
- Presence of rheumatoid factor or anti-CCP antibodies, unless all other criteria are met
- There must be radiographic changes typical of active rheumatoid Arthritis.

What does this mean?

Rheumatoid Arthritis is a chronic disease involving inflammation of the joints and their surrounding tissue. This inflammatory process can result in progressive destruction and deformity of the affected joints. The joints most commonly affected are the hands, wrists, elbows, cervical spine (neck), knees, ankles and metacarpophalangeal joints in the feet (joints in the toes and feet). Before a claim can be made, the disease must have progressed to such severity that it satisfies all of the detailed conditions listed above.

5.14 Coma – resulting in permanent symptoms

Policy definition

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

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

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug abuse.

What does this mean?

A coma is a deep state of unconsciousness from which it is impossible to be aroused. The cause of the coma may be as a result of another illness such as a stroke, infection, and very low blood sugar or may be brought on by a serious accident. The coma needs to result in permanent damage to the nervous system in order to be covered by the definition.

5.15 Coronary Artery Bypass Graft Surgery – with surgery to divide the breastbone

Policy definition

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts. For the above definition, the following are not covered:

- balloon angioplasty;
- atherectomy;
- rotablation;
- insertion of stents; and
- laser treatment.
- Or any other procedures.

What does this mean?

If one or more of the coronary arteries, which supply oxygenated blood to the heart, becomes obstructed by the build up of fatty deposits angina can result and can even cause a heart attack. A coronary by-pass operation involves inserting a short length of artery or vein, the latter usually taken from the leg, around the narrowed coronary artery thus restoring an adequate supply of blood to the heart.

5.16 Creutzfeldt-Jakob Disease – resulting in permanent symptoms

Policy definition

A definite diagnosis of Creutzfeldt-jakob disease by a Consultant Neurologist. There must be permanent clinical loss of the ability to do all of the following:

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

- other types of dementia (these are covered under the dementia definition).

What does this mean?

Creutzfeldt-jakob disease is a degenerative organic brain disease which may be inherited or acquired. There is a progressive degeneration of the nerve cells of the central nervous system which will result in defective muscular control and dementia. There is no cure.

5.17 Deafness – permanent and irreversible

Policy definition

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

What does this mean?

Loss of hearing may be caused by illness or by a serious accident. The loss must be permanent and irreversible. If the loss was only temporary, it would not be covered by the definition.

5.18 Dementia – resulting in permanent symptoms

Policy definition

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

- remember;
- reason; and
- perceive, understand, express and give effect to ideas.

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

What does this mean?
Dementia is a disorder of the mental process and results in loss of memory and impairment of behaviour and recognition. There is no cure and the cause is unknown. Definite diagnosis must be established via accepted standard medical tests and questionnaires.

5.19 Encephalitis – resulting in permanent symptoms

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

For the above definition the following is not covered:
- myalgic encephalomyelitis and chronic fatigue syndrome.

What does this mean?
Encephalitis is inflammation of the brain. It can occur at any age. The inflammation is caused either by an infection invading the brain (infectious); or through the immune system attacking the brain in error (post-infectious/auto-immune encephalitis). The inflammation can damage nerve cells resulting in "acquired brain injury". Encephalitis frequently begins with a flu-like illness or headache. Typically more serious symptoms follow hours to days later.

5.20 Heart Attack – of specified severity

Policy definition
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:
- Typical clinical symptoms (for example, characteristic chest pain).
- New characteristic electrocardiographic changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
  – Troponin T > 1.0 ng/ml,
  – AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:
- Other acute coronary syndromes including but not limited to angina.

What does this mean?
The body needs oxygen to survive and it receives this from the blood. The heart is effectively a pump, which ensures that oxygenated blood circulates through the body to where it is needed. The heart itself also needs oxygen to continue to work effectively. If the supply of oxygen to the heart is cut off then a portion of the heart muscle is damaged. This can be caused by the blockage of a coronary artery. Arteries can become blocked by fatty material or by blood clots. Damage to the heart muscle usually causes severe pain and results in an increase in cardiac enzymes and Troponins, which are released into the blood. A heart attack will also result in new electrocardiograph changes. Angina produces similar symptoms to an actual heart attack, but is caused by a reduction in the supply of blood to the heart due to spasm or partial blockage, rather than a complete blockage. Heart muscle does not die as a result. Angina may be an early indication that a future heart attack is likely. Angina is not covered by the definition.

5.21 Heart Structural Repair – with surgery to divide the breastbone

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

What does this mean?
The surgical division of the breastbone and the opening up of the chest wall, for the purpose of correcting a structural abnormality of the heart, for example, the surgical correction of a ventricular septal defect.

5.22 Heart Valve Replacement or Repair

Policy definition
The undergoing of a surgical procedure on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

What does this mean?
The valves of the heart open and close as a part of the pumping action, which circulates blood around the body. When these valves become diseased, the ability of the heart to pump properly is reduced. Surgery can be undertaken to either repair or replace the damaged valve.

5.23 HIV infection

Infection by Human Immunodeficiency Virus resulting from:
a) a blood transfusion given as part of medical treatment;
b) a physical assault; or
c) an incident occurring during the course of performing normal duties of employment from the eligible occupations listed below after the start of the plan 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 five days of the incident;
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus;
- The incident causing infection must have occurred in one of the following countries: **European Union, Norway, Switzerland, Canada, North America, Australia, and New Zealand.**

For the above definition, the following is not covered:
- HIV infection resulting from any other means, including sexual activity or drug abuse.

Occupations covered:
- Ambulance workers
- Dental nurses
- Dental surgeons
- General practitioners and nurses employed by them
- Hospital caterers
- Hospital cleaners
- Hospital doctors/surgeons/consultants
- Hospital laboratory workers
- Hospital Laundry workers
- Hospital nurses
- Hospital porters
- Members of the Gardai
- Midwives
- Paramedics
- Prison officers
- Refuse collectors
- Social workers
- Taxi drivers

What does this mean?
Evidence suggests that infection with the Human Immunodeficiency Virus (HIV) can eventually lead to the development of Acquired Immune Deficiency Syndrome (AIDS). There is currently no cure for AIDS. It causes the body's defence mechanisms to break down leaving the sufferer open to various infections, which would normally pose little threat to people unaffected by AIDS. These infections usually prove to be fatal. More and more cases of physical assault are being reported to the police where the victim has been brought into contact with the HIV virus. A claim would be paid where the attack had been reported to the police and it is proved that the HIV infection was because of the attack.

5.24 Intensive Care – requiring mechanical ventilation for 10 consecutive days

Policy definition
Any sickness or injury resulting in the life assured requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an intensive care unit in an Irish or UK hospital.

For the above definition the following are not covered:
- sickness or injury as a result of drug or alcohol intake or other self-inflicted means;
- children under the age of 90 days.

What does this mean?
There are many causes leading to admission to an intensive care unit (ICU). Reasons include severe illness, accident or surgery. People in ICUs may have had multiple organ failure and require medical equipment to take the place of these functions while they recover. To meet our definition the life assured must not be able to breathe on their own and require mechanical ventilation.

5.25 Kidney Failure – requiring dialysis

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

What does this mean?
The function of the kidneys is to remove waste material from the bloodstream. If they do not work properly there can be a build up of waste material in the blood, which can become life threatening. The body can function perfectly well with only one kidney, but if both fail there will be a need for regular dialysis, to clean the blood artificially, or for a kidney transplant.

5.26 Liver Failure – end stage

Policy 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; and
- encephalopathy.

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

What does this mean?
The liver has many functions and is essential to life. Cirrhosis is due to longstanding damage to the liver caused by a number of conditions including viral infections, inflammation, biliary obstruction, alcohol and certain drugs. Liver failure results in jaundice (yellow skin), fluid in the abdomen (ascites) and damage to the brain (encephalopathy).

5.27 Loss of Independent Existence – permanent and irreversible

Policy definition
The permanent and irreversible loss of the ability to function independently which is defined as follows:
1. Permanent confinement to a wheelchair, or
2. Being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or
3. Being permanently unable to fulfil at least three of the following activities listed below without the help of another person, but with the use of appropriate assistive aids and appliances; and the disability is irreversible with no reasonable prospect of there ever being any improvement.
   - washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained
   - dressing – the ability to dress and undress, ability to fasten and unfasten all necessary clothing including any surgical devices worn.
   - transferring – the ability to move from a bed to an upright chair, or wheelchair, or to get on or off a commode or toilet.
   - mobility – the ability to move from one room to another on a level surface
   - continence – the ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained
   - feeding – the ability to eat and drink, once food or drink has been prepared and made available.

Permanent means that, even with the best treatment available, the life assured is not expected to recover. The condition must continue for at least six months following diagnosis by a Consultant neurologist, physician or geriatrician of a major hospital in Ireland or the UK.

What does this mean?
This benefit is not linked to any particular Serious Illness. It is based on your permanent inability to carry out a variety of events outlined above without the assistance of another person. It is intended to

provide more extensive cover for events where you suffer drastic lifestyle changes.

5.28 Loss of Limbs – permanent physical severance

Policy definition

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

What does this mean?

Loss of hands or feet could be caused by an accident or because of an illness.

5.29 Loss of Speech – permanent and irreversible

Policy definition

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

What does this mean?

Loss of speech may be caused if the vocal chords are damaged in an accident or by a disease such as cancer of the larynx. The loss must be total, permanent and irreversible. Therefore a claim would not be paid if the loss was only partial or was a temporary condition. It is possible for the power of speech to be lost without physical damage to the vocal chords, possibly because of a severe mental trauma or shock. However, in such cases it is nearly impossible to determine whether the loss is permanent and therefore a claim would not be paid.

5.30 Major Organ Transplant – specified organs

Policy definition

The undergoing as a recipient of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or inclusion on an official Irish or UK programme waiting list for such a procedure. For the above definition, the following is not covered:

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

What does this mean?

Sometimes a major organ of the body (such as the liver) becomes so diseased that it fails and becomes life threatening. It may therefore be essential to replace it with a healthy organ.

For some rare illnesses, such as aplastic anaemia, a major organ transplant (in this case of the bone marrow) may be the only long-term cure available. It can take a long time to find the right donor organ, and the waiting list for such operations is often long. The claim will be met therefore upon inclusion onto the official programme waiting list of a major Irish or UK Hospital for a transplant.

5.31 Motor Neurone Disease – resulting in permanent symptoms

Policy definition

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

What does this mean?

Motor neurone disease causes a rapid deterioration of the motor neurons. These are the nerve cells in the brain, brain stem and spinal cord, which are responsible for the movement of the body. The disease advances quite quickly and leads to severe disability and death usually within three to four years.

Unfortunately, there is no treatment that can alter the outcome of this serious condition.

5.32 Multiple Sclerosis – with persisting symptoms

Policy 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 six months.

What does this mean?

Multiple sclerosis (MS) is an incurable disease of the central nervous system. Nerve fibres are normally covered by a myelin sheath, which protects and insulates them. In MS this sheath degenerates which interrupts the smooth transmission of nerve impulses around the body, leading to loss of power and/or lack of co-ordination and/or sensory impairment usually affecting different parts of the body. The symptoms and signs can come and go over the years or can progressively worsen. Investigations such as an MRI

scan of the brain and/or spinal cord and examination of the cerebrospinal fluid can be helpful in supporting the diagnosis, but do not in themselves make a definite diagnosis.

5.33 Multiple System Atrophy – resulting in permanent symptoms

Policy definition

A definite diagnosis of multiple system atrophy confirmed by a Consultant Neurologist. There must be evidence of disease progression and permanent clinical impairment of:

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

What does this mean?

Multiple system atrophy is a progressive neurological disorder that affects adults (males and females). It is caused by degeneration or atrophy of nerve cells in several (or multiple) areas of the brain which can result in problems with movement, balance and automatic functions of the body. The cause is unknown. Multiple system atrophy develops gradually and is most often diagnosed in men older than 60.

5.34 Muscular Dystrophy

Policy definition

A hereditary muscular dystrophy confirmed by a Consultant neurologist resulting in the inability to fulfil at least three of the following activities listed below without the help of another person, but with the use of appropriate assistive aids and appliances:

- washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained
- dressing – the ability to dress and undress, ability to fasten and unfasten all necessary clothing including any surgical devices worn.
- transferring – the ability to move from a bed to an upright chair, or wheelchair, or to get on or off a commode or toilet.
- mobility – the ability to move from one room to another on a level surface
- continence – the ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained
- feeding – the ability to feed oneself once food and drink have been prepared and made available.

What does this mean?

Muscular Dystrophy is a genetic (inherited) condition where slow progressive muscle wasting leads to increasing weakness and disability.

5.35 Paralysis of Limbs – total and irreversible

Policy definition

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

What does this mean?

Paralysis or paraplegia of two or more limbs is evidenced by permanent and irreversible loss of movement and sensation. It could be caused by an accident or by an illness. Even more severe types of paralysis, tetraplegia and quadriplegia would therefore be covered.

5.36 Parkinson's Disease – resulting in permanent symptoms

Policy definition

A definite diagnosis of 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 are not covered:

- Parkinson's disease secondary to chronic alcohol abuse or illegal drug abuse.
- other Parkinsonian syndrome.

What does this mean?

Parkinson's disease causes a disturbance of voluntary movement. It causes tremors in the limbs and head and rigidity of the muscles. The condition usually takes a long time to progress and some drugs are available which can slow the process down even

further but treatment becomes less effective as time goes by.

For a claim to be paid the onset of Parkinson's disease must be idiopathic. This means it must have developed naturally rather than because of some other medical treatment or illness.

5.37 Pneumonectomy – removal of a complete lung

Policy Definition
The undergoing of surgery on the advice of an appropriate medical specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

For the above definition the following are not covered:
- removal of a lobe of the lungs (lobectomy)
- lung resection or incision.

What does this mean?
Pneumonectomy is the removal of a complete lung. It may also be the most appropriate treatment for a tumour located near the centre of the lung that affects the pulmonary artery or veins, which transport blood between the heart and lungs. In addition, pneumonectomy may be the treatment of choice when the patient has a traumatic chest injury that has damaged the main air passage (bronchus) or the lung's major blood vessels so severely that they cannot be repaired.

5.38 Primary Pulmonary Hypertension – of specified severity

Policy Definition
A definite diagnosis by a Consultant Cardiologist of primary pulmonary hypertension resulting in permanent loss of the ability to perform physical activities to at least Class III of the New York Heart Association (NYHA) classification. This means there is marked limitation of physical activities, with less than ordinary activity causing fatigue, palpitations or shortness of breath.

For the above definition the following is not covered:
- pulmonary hypertension secondary to any other known cause – in other words, not primary.

What does this mean?
Primary pulmonary hypertension is where the blood pressure is abnormally high in the arteries that provide blood to the lungs. In order to claim, the condition must have reached a position where there are symptoms of a particular severity as detailed in the definition and must be of a permanent nature. Because of the complexities involved in the diagnosis and classifying symptoms, the diagnosis must also be made by a Consultant Cardiologist (an expert in heart diseases). The NYHA classifications are an internationally recognised system of describing symptoms of heart disease.

Explanation of the NYHA classification is as follows:

Class	Symptoms
Class I **(Mild)**	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or shortness of breath.
Class II **(Mild)**	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation or shortness of breath.
Class III **(Moderate)**	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation or shortness of breath.
Class IV **(Severe)**	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

5.39 Progressive Supranuclear Palsy – resulting in permanent symptoms

Policy Definition
A definite diagnosis, by a Consultant Neurologist, of progressive supranuclear palsy. There must be permanent clinical impairment of eye movement and motor function with associated tremor, rigidity of movement and postural instability.

What does this mean?
Progressive supranuclear palsy causes a disturbance of voluntary movement. It causes tremors in the limbs and head and rigidity of the muscles. The condition usually takes a long time to progress and some drugs are available which can slow the process down even further but treatment becomes less effective as time goes by.

5.40 Pulmonary Artery Surgery – with surgery to divide the breastbone

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

What does this mean?
The surgical division of the breastbone and the opening up of the chest wall is performed to gain access to repair the diseased section of the pulmonary artery with a graft.

5.41 Stroke – resulting in permanent symptoms

Policy definition
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following is not covered:
- transient ischaemic attack.

What does this mean?
As with a heart attack the cause of a stroke is inadequate blood supply, this time to the brain. It can be caused by a blood clot becoming caught in an artery of the brain or the bursting of one of the brain's blood vessels. The event that triggers the stroke may result from problems within the body, such as clogged up arteries or weaknesses in the wall of a blood vessel. After a true stroke there is usually permanent brain damage, which can cause paralysis to the right or left sides of the body, loss of speech or sight and other effects such as loss of strength or mobility. In some cases, the damage may be quite minor, but it will depend upon which part of the brain was affected.

Transient ischaemic attacks are often known as ministrokes but do not result in permanent damage. They are therefore excluded.

5.42 Systemic Lupus Erythematosus – with severe complications

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

(i) Severe kidney involvement with systemic lupus erythematosus as evidenced by:
- permanent impaired renal function with a glomerular filtration rate below 30 ml/min/1.73m2, and
- abnormal urinalysis showing proteinuria or haematuria.

In addition to the above criteria, the disease must have been unresponsive to disease modifying drugs for a continuous period of at least 12 months.
or

(ii) Severe central nervous system involvement with systemic lupus erythematosus as evidenced by permanent deficit of the neurological system as evidenced by at least any one of the following symptoms, which must be present on clinical examination and expected to last for the remainder of the life of the life assured:
- paralysis
- dysarthria (difficulty with speech)
- aphasia (inability to speak)
- dysphagia (difficulty in swallowing)
- difficulty in walking
- lack of coordination
- severe dementia where the insured needs constant supervision; or
- permanent coma.

For the purposes of this definition seizures, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin nor injury secondary to alcohol or illegal drug abuse will not be accepted as evidence of permanent deficit of the neurological system.

What does this mean?
The body's immune system produces white blood cells and proteins called antibodies to destroy viruses and bacteria that are foreign to the body. Lupus, like other auto-immune diseases, mistakes your own tissue as foreign and attacks it causing inflammation. It can affect major organs in the body and stop them functioning properly.

5.43 Third Degree Burns – covering 20% of the body's surface area

Policy definition
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area or 50% loss of surface area of the face which for the purpose of this definition includes the forehead and ears.

What does this mean?
Third degree burns are the most serious type of burn. They involve the destruction of the full thickness of the skin and can cause damage to the fat, muscle and bone.

5.44 Traumatic Head Injury – resulting in permanent symptoms

Policy definition
Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms.
For the above definition, the following is not covered:

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

What does this mean?
Damage to brain tissue could be caused by an external trauma such as a severe head injury received in a road traffic accident.

SECTION 6 – PARTIAL PAYMENT SERIOUS ILLNESS COVER DEFINITIONS

6.1 Brain abscess drained via craniotomy

Policy definition
Undergoing 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.

What does this mean?
A brain abscess is a rare, life-threatening infection of the brain. When bacteria, fungi or parasite infect part of the brain, inflammation occurs. The infected brain cells accumulate causing our immune system to create a membrane to isolate the infection creating an abscess. As the abscess grows it places pressure on delicate brain tissue, which can become damaged or destroyed.

Craniotomy – this is a surgical operation in which an opening is made in the skull. The abscess is either drained of pus, or removed.

6.2 Carcinoma in Situ – Oesophagus, treated by specific surgery

Policy definition
Definite diagnosis of a carcinoma in situ of the oesophagus, which has been treated surgically by removal of a portion or all of the oesophagus. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

- Treatment by any other method is specifically excluded.

What does this mean?
The oesophagus is the portion of the digestive system that leads from the mouth to the stomach, sometimes called the gullet. This muscular passage carries food and liquids from the mouth to the stomach.

A carcinoma in situ is an early form of carcinoma. In situ means that these abnormal cells are found in the innermost layer of tissue lining the oesophagus. The policy will pay your claim if, after diagnosis of carcinoma in situ of the oesophagus, a surgeon removes a part or all of your oesophagus.

6.3 Carotid Artery Stenosis – treated by Endarterectomy or Angioplasty

Policy definition
Undergoing 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.

What does this mean?
Carotid Endarterectomy is the surgical procedure to remove fatty tissue from the neck arteries. Stenosis occurs when the arteries become blocked with the fatty tissue and the brain does not get enough oxygen.

An angioplasty involves the insertion of a balloon tipped tube into the blocked blood vessel. The balloon is inflated, compressing the fatty deposits against the arterial walls resulting in restoration of blood flow. A mechanical device known as a small metal mesh tube is placed inside the artery where the blockage occurred to widen the opening and support the artery wall. *This benefit does not cover any other treatment of the carotid artery or vascular system.*

6.4 Cerebral arteriovenous malformation – treated by craniotomy or endovascular repair

Policy definition
Undergoing surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or malformation. Or undergoing 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 are not covered
- Intracranial aneurysm

What does this mean?
A cerebral arteriovenous malformation (AVM) is an abnormal connection between the arteries and veins in the brain that usually forms before birth. The condition occurs when arteries in the brain connect directly to nearby veins, the blood does not flow into the capillaries which are the small vessels that normally transport blood from the arteries to the veins.

A cerebral arteriovenous malformation (AVM) rupture occurs because of pressure and damage to blood vessel tissue. This allows blood to leak into the brain or surrounding tissue reducing blood flow to the brain.

The surgical treatments are:
Craniotomy – this is a surgical operation in which an opening is made in the skull and the abnormal connection is removed by a Consultant neurosurgeon. Endovascular treatment is carried out by a Consultant neurosurgeon and involves the injection of a glue like substance into the abnormal vessels in the AVM via a micro-tube or catheter.

6.5 Coronary Angioplasty – to 2 or more coronary arteries

Policy definition
Undergoing 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.
For the purpose of this definition the main coronary arteries are defined as:
- Right coronary artery
- Left main stem
- Left anterior descending
- Circumflex

For the above definition the following are not covered:
- Two or more procedures in the same artery
- Procedures to any branches of the main coronary arteries
- Two procedures performed at different times other than for the insertion of two stents at different times as described.

What does this mean?
Fatty material builds up on the walls of the coronary artery blood vessels preventing the heart getting the blood supply it needs. There are several types of interventional procedures which may be used when performing angioplasty.

Balloon angioplasty involves the insertion of a thin plastic tube with a small balloon tip into the artery, once the balloon tip reaches the narrowed section of the artery the balloon is inflated and the fatty material is compressed into the artery wall increasing the blood flow to the heart. Stenting involves the insertion of a small metal mesh tube into the narrowed artery. Atherectomy and laser treatment are also techniques which involve passing a thin plastic tube (catheter) into the blocked artery.

A claim can only be made if the treatment is to correct at least 70% narrowing of at least two coronary arteries. If the two arteries are treated on two separate occasions then a claim can be made upon completion of the second procedure. We will require angiographic evidence showing at least 70% stenosis in the coronary arteries.

6.6 Ductal Carcinoma in Situ – Breast treated by surgery

Policy definition
A definite diagnosis of a ductal carcinoma in situ (DCIS) of the breast, which has been removed surgically by mastectomy, partial mastectomy, segmentectomy or lumpectomy. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

For the above definition, the following are not covered
- mastectomy, partial mastectomy, segmentectomy or lumpectomy, operations for reasons other than DCIS, for example, prophylactic mastectomy or lobular carcinoma in situ (LCIS).

What does this mean?
Ductal carcinoma in situ is a term used to describe an early stage of cancer where the abnormal cells remain confined to the milk ducts of the breast, they have not spread deeper into the breast tissue or to other parts of the body.

A claim can be made if treatment is carried out involving the removal or partial removal of the breast or surgical removal of the tumour itself following a diagnosis of ductal carcinoma in situ.

6.7 Loss of one limb

Policy definition
Permanent severance of 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.

For the above definition, the following are not covered
- Loss of any individual fingers or toes or combination of fingers and toes.

What does this mean?
A claim can be made if the life insured has lost one limb where the limb has been severed above the wrist in the event of loss of a hand and above the ankle in the event of loss of a foot.

6.8 Low level Prostate Cancer with Gleason score between 2 and 6 and with specific treatment

Policy definition
Postive diagnosis with a prostate cancer which has been histologically classified as having a Gleason score between 2 and 6 inclusive, provided:
- The tumour has progressed to at least clinical TNM classification T1N0M0 and

- The life assured 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.

What does this mean?
The prostate is a walnut sized gland in the male reproductive system located at the base of the bladder. Cancer of the prostate is one of the most common types of cancer in men. The Gleason score is a system of grading prostate cancer tissue based on how it looks under a microscope. The scores range from 2 to 10 and indicate how likely it is that a tumour will spread. A low Gleason score means the cancer is less likely to spread, a high Gleason score means that the cancer is more likely to spread. In order for a claim to be valid the histology report must show a Gleason score between 2 and 6. A Gleason score greater than 6 will result in a full Specified Serious Illness Cover claim.

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

Policy definition
A serious accident resulting in severe physical injury where the life assured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment. The 28 days can include a stay in a rehabilitation hospital as long as the life assured goes straight from the hospital to the rehabilitation centre.

Severe physical injury means injury resulting solely and directly from unforeseen, external violent and visible means and independent of any other cause. A life assured may claim only once under this cover.
For the above definition, the following are not covered
- Stays in hospital of less than 28 consecutive days
- An accident as a result of involvement in the armed forces
- An accident as a result of involvement in hazardous pursuits (as outlined in Section 10.2)
- An accident secondary to alcohol where there is a history of alcohol abuse
- An accident secondary to illegal drug abuse.

What does this mean?
A claim can be made for this benefit if the life assured following a serious accident is confined to hospital for at least 28 consecutive days in order to receive medical treatment for the injuries sustained in the accident. The 28 consecutive days can include time spent in a rehabilitation centre if the transfer is made directly from the hospital in order for treatment to be continued. Serious accident secondary to alcohol or drug abuse is not covered. You can only make one claim for injuries resulting from the same accident.

6.10 Significant visual impairment – permanent and Irreversible

Policy definition
Permanent and irreversible reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/18 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lenses.

For the above definition, the following are not covered
- If you are 'registered blind', your claim will only be met if the loss of sight meets the criteria outlined in the definition outlined above.

What does this mean?
In order for the life assured to claim under this definition the loss of sight in both eyes must be irreversible to the extent that that even when using glasses or other visual aids, the degree of loss is measured at 6/18 or worse on the Snellen eye chart. A Snellen chart is an eye chart used by eye care professionals to measure visual acuity. The chart consists of rows of letters that decrease in size downwards. A result of 6/18 indicates that the life assured can only see at 6 metres what someone with normal sight can see at 18 metres away.

6.11 Single Lobectomy – the removal of a complete lobe of a lung.

Policy definition

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

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For the above definition, the following are not covered

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

What does this mean?

A lobectomy is an operation during which a single lobe of the lung is removed. People have two lungs located on either side of the heart within the rib cage. They are not identical, the right lung has three lobes and the left one has two lobes.

6.12 Surgical removal of one eye

Policy definition

Undergoing surgical removal of a complete eyeball for disease or trauma.

What does this mean?

The surgical removal of an entire eyeball due to either disease or injury.

6.13 Third Degree Burns covering at least 10% of the body's surface

Policy definition

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 10% 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.

What does this mean?

There are only three degrees of burns and all three refer to how deep the burn goes through the skin, the higher the number the worse the burn. First and second degree burns can heal without scarring. 3rd degree burns are the most serious type of burn, they involve the destruction of the full thickness of the skin, fat, muscle and bone. In order for a claim to be valid burns must involve damage or destruction of the skin covering at least 10% and less than 20% of the body's surface area or at least 25% of the surface area of the face. Burns in excess of 20% of the body's surface area or at least 50% of the surface area of the face will result in a full Specified Serious Illness Cover claim.

SECTION 7 – SPECIAL EVENTS INCREASE BENEFIT

This benefit is also known as a Guaranteed Insurability Option.

7.1 This option is only available to a Life Assured if they were accepted on standard terms and is not available if any special conditions apply, for example, if we applied any exclusions to the cover or included an extra premium for special terms. If the basis of cover is Joint Life, this option will only apply to the policy if both Lives Assured were accepted on standard terms. If the basis of cover is Dual Life then this option may only apply to one Life Assured (or both lives). The availability of this option is subject to underwriting at the time the original policy is taken out.

7.2 If this option is included it allows you to increase the Life Cover and Specified Serious Illness Cover on the policy, up to the limits set out below, without the need to supply further medical evidence, following any of these events:

- Increase in mortgage by a Life Assured either to purchase a new main residence or for home improvement of main residence;
- The marriage of a Life Assured;
- The birth or legal adoption of a child by a Life Assured.

7.3 The Life Assured must be under 55 years old at the time the option is exercised. If the basis of cover is Joint Life, both Lives Assured must be under 55 years old at the time the option is exercised. If the basis of cover is Dual Life, this option may be exercised separately in respect of each Life Assured.

7.4 Any increase in Accelerated Specified Serious Illness Cover must be matched by the same increase in Life Cover. However, you can choose to increase the Life Cover only. Any increase in Stand-alone Specified Serious Illness Cover does not need to be matched by an increase in Life Cover.

7.5 You can increase your cover on more than one occasion, but the following limits apply:

The maximum increase in Life Cover for any one event is limited to whichever of the following amounts is lower:
- 50% of the relevant original level of Life Cover;
- or €100,000.

The maximum increase in Specified Serious Illness Cover for any one event is limited to whichever of the following amounts is lower:
- 50% of the relevant original level of Specified Serious Illness Cover;
- or €100,000.

The maximum total increase in Life Cover for all events over the term of the policy is limited to whichever of the following amounts is lower:
- the relevant original level of Life Cover;
- or €200,000.

The maximum total increase in Specified Serious Illness Cover for all events over the term of the policy is limited to whichever of the following amounts is lower:
- the relevant original level of Specified Serious Illness Cover;
- or €200,000.

7.6 This option cannot be exercised in respect of Specified Serious Illness Cover if the proposed increase in cover would take the level of Specified Serious Illness Cover above the maximum allowed under this policy at the time you wish to exercise the option. The current maximum level of Specified Serious Illness Cover is €1,400,000.

7.7 If the basis of cover is Joint Life, the maximum limits apply to the joint levels of cover and not individually. If the basis of cover is Dual Life, the maximum limits apply separately to each Life Assured's level of cover. In addition, if you have more than one policy with Caledonian Life, these limits apply across all of these polices and not separately to each of them.

7.8 Where the option is to be exercised for the purchase of a new main residence or home improvement, the maximum increase is also limited to the increase in the mortgage amount.

7.9 You must apply in writing to us within three months of the occurrence of the event if you wish to exercise this option. Caledonian Life will require evidence to show that the event has occurred.

7.10 You cannot increase your cover using this option:
- if we have already paid, or are currently considering, a Specified Serious Illness Cover claim or Partial Payment Specified Serious Illness claim (excluding Children's Specified Serious Illness Cover);
- or, if you are no longer resident in the Republic of Ireland;
- or, for the purchase of a secondary residence or an overseas property.

7.11 Any increase in cover will:
- be based on the normal terms and conditions applicable for policies of this type at the date the option is exercised;
- have a term equal to the remaining term of the original policy;
- include any special conditions or restrictions as per the original policy conditions and policy schedule.

7.12 If this option is exercised the premium will be recalculated accordingly each time the cover is increased. We will base your new premium on:
- the age of the Life Assured, or both Lives Assured if the basis of cover is Joint Life, at the date the increase in cover commences;

- the smoking habits of the Life Assured, or both Lives Assured if the basis of cover is Joint Life, at the date the increase in cover commences;
- any special terms as outlined in the original policy schedule or at any subsequent reinstatement under Section 2.2;
- and Caledonian Life's premium rates at the time of the increase.

SECTION 8 – INDEXATION OPTION

This section only applies if the policy schedule shows that an indexation option applies to this policy. This option works as follows:

8.1 At each increase date (see Section 1 – Definitions), we will automatically increase your cover (both Life Cover and Specified Serious Illness Cover, as applicable) unless you have told us in writing not to do so. The Lives Assured do not need to give evidence of health for these increases.

8.2 We will advise you at least four weeks before each increase date of the details of the increase. If you want to cancel an increase in cover, you must tell us in writing at least one week prior to the increase date. If you do not cancel an increase in cover, the increased premium will be due from the increase date and the increased level or levels of cover will apply. You can only cancel an increase in all cover under the policy: for example, you cannot cancel an increase in Life Cover and proceed with an increase in Specified Serious Illness Cover. If cover is on a Dual Life basis, you can only cancel an increase in cover in respect of both Lives Assured and not on one Life Assured only.

8.3 The increase in cover will be 5% each year and your premium will also increase by 5% each year.

8.4 The maximum level of Specified Serious Illness Cover is €1,400,000.

8.5 For policies with Accelerated Specified Serious Illness Cover, if the basis of cover is Single Life or Joint Life, once the maximum level of Specified Serious Illness Cover has been reached there will be no further increases in cover (Life Cover or Specified Serious Illness Cover) or premium. This may result in an increase in cover of less than 5% for the final increase. The premium will be increased accordingly. If the basis of the policy is Dual Life, once the maximum level of Specified Serious Illness Cover for a Life Assured has been reached there will be no further increases in cover for that Life Assured (Life Cover or Specified Serious Illness Cover). This may result in an increase in cover for that Life Assured of less than 5% for the final increase. The premium will be increased accordingly.

8.6 For policies with Stand-alone Specified Serious Illness Cover, once the maximum level of Specified Serious Illness Cover for a Life Assured has been reached there will be no further increases in the level of Specified Serious Illness Cover for that Life Assured. This may result in an increase in the level of their Specified Serious Illness Cover of less than 5% for the final increase. However, Life Cover (assuming a Life Cover benefit applies) can continue to increase, subject to Sections 8.7 and 8.8. Once the maximum level of Specified Serious Illness Cover for has been reached, any further increases in Life Cover (assuming a Life Cover benefit applies) will result in an increase in total premium of less than 5% to reflect the fact that the Specified Serious Illness Cover isn't increasing.

8.7 There will be no further increase in benefit or premium when the Life Assured, or the oldest Life Assured in the case of a Joint Life policy, reaches age 65. For Dual Life policies, the increase in benefit and premium for each Life Assured will cease when they have reached age 65.

8.8 If you cancel the increase three times during the term of the policy, you will not be entitled to any further increases.

SECTION 9 – CONVERSION OPTION

If the policy schedule shows that a conversion option applies, you can convert this policy into another policy provided by Caledonian Life without having to provide evidence of health. The new policy must commence on or before the conversion option expiry date, and (aside from waiving the medical underwriting requirements) will be subject to Caledonian Life's standard new business terms and conditions at the date of conversion. The following conditions apply:

9.1 The policy must not have already ceased as per Section 4.9.

9.2 The level of cover under the new policy cannot be greater than the level of cover under this policy on the date it is converted.

9.3 We will issue the new policy under our normal terms which apply at the time this policy is converted. The premium payable will be calculated based on the age of the lives assured and Caledonian Life's rates for the class of policy selected at the time.

9.4 Any special conditions which attach to this policy will apply to the new policy. If we have charged an extra premium on this policy (e.g. for health reasons), we will also charge an extra premium on the new policy based on the premium rates in place at the time of conversion.

9.5 You must apply in writing before the conversion option expiry date.

9.6 A conversion option will not be available under the new policy.

9.7 When you take out the new policy, the cover under this policy will be immediately reduced by the level of cover under the new policy. If the level of cover under this policy is reduced to nil, this policy will be immediately cancelled and no further benefit will be payable under it.

9.8 The new policy will be of a type offered by us at that time.

9.9 In some circumstances, the conversion option will be subject to financial underwriting – refer to policy schedule to see if this applies. Where it does apply, we have the right to reduce the level of cover on conversion or disallow the conversion altogether if the evidence of financial justification submitted at the time does not, in the opinion of our underwriters, warrant the level of cover requested.

9.10 The maximum term, in years, of the new policy will be equal to the lesser of 40 and 85 minus the age next birthday, at the date of conversion, of the oldest Life Assured in respect of whom the new policy applies. Caledonian Life's maximum age of cessation for new business policies at the time of conversion will also apply.

SECTION 10 – EXCLUSIONS

In addition to any conditions outlined on your policy schedule, the following exclusions apply to your policy. These exclusions are on top of any specific exclusions in the sections explaining the benefits themselves.

10.1 Life Cover & Terminal Illness Benefit

If a Life Assured dies or is diagnosed with a Terminal Illness within a year of the start date of the policy as a result of their own deliberate act, we will not pay any benefit under the policy. However if the policy was transferred to someone else (except for a husband, wife or next of kin of the Life Assured) before the act which caused the death or Terminal Illness, we will pay the benefit subject to having received all relevant information as outlined in Section 2.1.

10.2 Specified Serious Illness Cover (including Partial Payment Specified Serious Illness Cover)

There are a number of circumstances in which a claim for payment of Specified Serious Illness Cover will not be admitted.

These exclusions are as follows:

i. No benefit will be payable if a Specified Serious Illness Cover claim results directly or indirectly as a result of:
- War, civil war, riot, civil commotion or a similar event;
- Self-inflicted injury or illness whether the Life Assured is sane or insane;
- Improper use of drugs or alcohol;
- Failure to follow medical advice;
- The Life Assured taking part in a criminal act; or
- Any Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (outside of those outlined in Section 5 of this booklet).

ii. No benefit will be payable if a Specified Serious Illness Cover claim results directly or indirectly as a result of the Life Assured engaging in hazardous activities, examples of which are:
- Abseiling;
- Aviation other than a fare paying passenger on a regular public airline;
- Bobsleighing;
- Boxing;
- Equestrian Events;
- Hang-gliding;
- Motor or Motorcycle sports;
- Mountaineering;
- Parachuting;
- Paragliding;
- Pot holing or caving;
- Power boat racing;
- Rock climbing; or
- Scuba diving.

This is not an exhaustive list. If you are unsure whether you are covered for a particular activity you should contact us in writing.

10.3 Territorial Limits

Any claim in respect of Life Cover, for a Life Assured who has been diagnosed as having a Terminal Illness, or Specified Serious Illness Cover, will be invalid if the Life Assured is resident outside the following countries for more than 13 weeks in any 52 week period. A Children's Specified Serious Illness Cover claim will also be invalid if the child is resident outside the following countries for more than 13 weeks in any 52 week period.

The countries are:
- European Union
- Australia
- Canada
- New Zealand
- Norway
- South Africa
- Switzerland
- United States of America.

You must write and tell us immediately if a Life Assured starts living in a country which is not one of the accepted countries listed above. We will then decide whether cover will continue and on what basis. This may include an increase in premium and/or exclusions to the cover.

10.4 Pre-existing Medical Conditions

No benefit will be payable in respect of Life Cover or Specified Serious Illness Cover if in the opinion of our Chief Medical Officer a claim is made for a condition which was known or ought to reasonably have been known to exist prior to the start of the policy, unless we have received all relevant information as outlined in Section 2.1.

10.5 Children's Specified Serious Illness Cover (including Partial Payment Specified Serious Illness Cover)

No benefit for Children's Specified Serious Illness Cover is payable if the claim is as a result of a pre-existing condition, as defined below:

A pre-existing condition is a medical condition (including congenital defects) affecting a child which existed prior to the latest of the following dates:
- Commencement date of the policy;
- The child's first birthday;
- The legal adoption of the child.

The child must survive for at least 14 days (known as the 'survival period') following the diagnosis of the insured specified serious illness for the benefit to be payable.

Children's Specified Serious Illness Cover applies only to the diagnosis of an insured specified serious illness (other than Loss of Independent Existence) and not on the death of a child or diagnosis of a Terminal Illness. We will not pay under this benefit if a child dies within the 'survival period'.
No benefit for Children's Specified Serious Illness Cover will be admitted if the claim arises from any of the exclusions outlined in Section 10.2.

SECTION 11 – CLAIMS

11.1 Proof of Age

Your benefits have been calculated on the basis that the date of birth of each Life Assured is as shown on the policy schedule. In the event of a claim for a Life Assured, we will ask for proof of the date of birth. If the date of birth on the application is not correct, we may recalculate the benefits in line with the correct date of birth. In some circumstances, we may refuse to pay any benefit if we would not have provided cover initially had we known the correct date of birth.

11.2 Life Cover

We will consider a claim when we have received the following:

a. Proof of death in the form of a death certificate, or any other proof we reasonably need.
b. Proof of entitlement to claim the benefits. This could include proof that the policy conditions and any special conditions contained in the policy schedule have been followed. We may ask the person making the claim for a grant of probate or letters of administration.
c. Proof in the form of a birth certificate of the age of the Life Assured.
d. Original marriage certificate if the Life Assured is a married woman and her surname differs from the surname on her birth certificate.
e. The original policy documents. If they are not available, whoever makes the claim must accept legal responsibility and sign a document indemnifying us if it turns out that someone else is entitled to the benefit.

11.3 Specified Serious Illness Cover (including Partial Payment Specified Serious Illness and Children's Specified Serious Illness Cover) and Terminal Illness Benefit

All claims should be notified to us as soon as possible after the event. Any claim must be received within 3 months of the event or the diagnosis giving rise to the claim (except for the special procedures that apply to claims in relation to HIV/AIDS infection from blood transfusion, exposure to blood or physical assault which are outlined in Section 5.23 of this booklet). If you do not, we may refuse to pay the benefit.

We will consider a claim when we have received the following:

a. A completed claim form.
b. Proof of entitlement to claim the benefits. This could include proof that the policy conditions and any special conditions contained in the policy schedule have been followed.
c. Proof in the form of a birth certificate of the age of the Life Assured.
d. Original marriage certificate if the Life Assured is a married woman and her surname differs from the surname on her birth certificate.
e. The original policy documents. If they are not available, whoever makes the claim must accept legal responsibility and sign a document indemnifying us if it turns out that someone else is entitled to the benefit.

All items of proof, certificates, information, medical and other evidence that Caledonian Life may require in support of a claim must be provided at your own expense.

As part of our claims procedure, we will obtain a report from the Specialist who diagnosed the insured specified serious illness. It may also be necessary to obtain a report from the Life Assured's or child's Registered Medical Practitioner and/or any relevant Specialist in order to assess the claim. The Life Assured (or for a Children's Specified Serious Illness Claim the child's legal guardian) must agree to any medical examinations and tests which are necessary to prove the claim. If the Life Assured or child fails to

meet these requirements within a reasonable time, or if the Life Assured or child fails to follow the advice of a Registered Medical Practitioner, we will not pay the benefits claimed.

11.4 Remaining Cover after a Claim

Section 4 sets out what cover (if any) remains in place after a Life Cover or Specified Serious Illness Cover claim. Where all Life Cover and Specified Serious Illness Cover under a policy has been reduced to nil as a result of a claim, the policy will cease immediately.

If cover is on a Dual Life basis and the Life Cover and Specified Serious Illness Cover has reduced to nil for one Life Assured as a result of a claim, cover can continue on a Single Life basis for the second Life Assured provided that the premium is still paid. We will reduce the premium to reflect the fact that only one life is now covered.

11.5 Payment of the Claim

If any information we have been given is not correct, true or complete, we may not pay the claim. For Life Cover, if we have not paid the benefit two months after the date of notification of the death of the Life Assured, interest shall accrue monthly from that time (i.e. two months after the date of notification) until the benefit has been paid. For Specified Serious Illness Cover, interest shall be payable if we have not paid the benefit two months after the later of the following dates:

- Date of diagnosis
- Date of notification

Interest shall accrue monthly from that time (i.e. two months after the date of diagnosis or notification) until the benefit has been paid.
The rate of interest applicable shall be 0.25% per annum below the European Central Bank (ECB) base rate at all times. Where the ECB base rate changes during the period of time for which the interest calculation is being determined, the rate used in the calculation will also change accordingly

SECTION 12 – TAX

Under current law, we do not deduct any tax from the benefit. However, tax is payable on any interest we pay – see Section 11.5. In some circumstances a tax liability will be incurred following payment of a claim. For example, if a Life Cover benefit is paid to your estate, your beneficiaries may have to pay inheritance tax (there is no inheritance tax due on an inheritance between a married couple). If tax laws change after the start date, we may change the policy conditions of the policy if we need to keep the policy in line with those changes. We will write and tell you about any changes in the policy conditions.

SECTION 13 – DATA PROTECTION

All personal information supplied by you in connection with your application will be treated in confidence by Caledonian Life and will not be disclosed to any third parties, except where your consent has been received or where permitted by law.

SECTION 14 – OTHER INFORMATION

14.1 This policy does not have any encashment value.

14.2 This policy is governed by the laws of the Ireland and the Irish courts are the only courts which are entitled to hear any dispute. If any relevant laws change after the start date, we may change the policy conditions of the policy if we need to keep the policy in line with those changes. We will write and tell you about any changes in the policy conditions.

14.3 If you transfer the benefit of this policy to someone else, the person you assign it to must write and tell us at our Head Office at:

Caledonian Life
Caledonian House
47 St. Stephen's Green
Dublin 2
Ireland

Caledonian Life
Protecting you and your world

Operating in Ireland for over 140 years and building on the foundations of Caledonian Insurance Company and Guardian Life, Caledonian Life was launched in January 2001 as a new force in financial services. Caledonian Life policies are only sold through Brokers – financial advisers who are authorised by the Central Bank of Ireland.

Dedicated to providing some of the market's most competitive and comprehensive Protection products, Caledonian Life has offices in Dublin, Cork and Limerick. Caledonian Life is a division of the Royal London Group, the UK's largest mutual life and pensions provider, established in 1861 and currently responsible for funds under management of approximately €50 billion. The Group businesses serve around 3 million customers and employ 2,630 people*. So you can rest assured you're in safe hands.

Please visit www.royallondongroup.co.uk for more details.

* 01/07/2011

Broker Stamp

www.caledonianlife.ie

We'd be delighted to get your feedback on the content and clarity of this booklet, simply contact your Broker or email: feedback@caledonianlife.ie

All information is valid at the time of going to print at 31/10/2011.

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