NEW IRELAND
ASSURANCE

Life Choice - Home
Policy Conditions

Contents

Comhlucht na hÉireann um Árachas, cpt/New Ireland Assurance Company plc
Registered in Dublin, Ireland, Registered No.7336.
Registered Office: 11 – 12 Dawson Street, Dublin 2.

Introduction

This is the Policy Document for your Life Choice – Home policy. Together with the Policy Schedule which is contained in the pocket inside the front cover and any endorsements to this policy, it contains the details of your policy and the conditions and rules which set out how the policy works.

The Policy Document is a legal document and should be kept in a safe place. It would also be useful if your solicitor, a relative or a friend knew where it is kept.

Section A - General Conditions

1. Definitions

Accelerated Specified Illness Benefit
This benefit (if selected and accepted by the Company) provides for an amount to be paid if the Life Insured is diagnosed with a Specified Illness as outlined in Appendix A during the Term of Cover for this benefit.

Accident Payment
The amount of Accident Payment shown in the Policy Schedule as applying to a Life Insured, or as subsequently changed. Conditions applying to Accident Payment are described in Section C, Condition 2.2.

Actuary
New Ireland's Appointed Actuary.

Application
The completed application and/or all the information provided by you and/or the Lives Insured in connection with this policy to your intermediary and/or to the Company, or by your intermediary to the Company, prior to the commencement of the policy and any declarations signed by you and/or the Lives Insured.

Approved Territories
The countries of the European Union as at January 2013 (Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and United Kingdom), Australia , Canada, New Zealand, Norway, Switzerland and the United States of America.

Assigned
You can make the Protection Benefits under the policy payable to someone else by making your policy Assigned. This involves you and the other person making a legal agreement as to who will receive the Protection Benefits. Normally, this is done if this policy is used as security for a loan, and the Protection Benefits are paid to the lender. You are still liable to pay the Premiums.

Assignee
If you make your policy Assigned, then the person who has taken over the legal interest is known as the Assignee. It is this person to whom the Protection Benefits will be paid.

Broken Bones Payment
Conditions applying to Broken Bones Payment are described in Section C, Condition 2.4.

Consultant
A registered medical practitioner who has specialist qualifications in an appropriate branch of medicine and who is practising at a Major Hospital in one of the Approved Territories.

Where a Consultant is registered in a country other than Ireland or the United Kingdom, the Company reserves the right to seek an opinion of a Consultant practising in Ireland or the United Kingdom.

Expired Term
This is the number of policy anniversaries attained since the Policy Start Date.

Hospitalisation Payment
The daily amount of Hospitalisation Payment shown in the Policy Schedule as applying to a Life Insured, or as subsequently changed. Conditions applying to Hospitalisation Payment are described in Section C, Condition 2.3.

Insurer
New Ireland Assurance Company plc is the Company that has issued the policy. Wherever the words "we", "us", "New Ireland", "the Insurer" and "the Company" are used in the policy they refer to New Ireland Assurance Company plc. New Ireland

Assurance Company plc is regulated by the Central Bank of Ireland. A member of Bank of Ireland Group.

Life Insured
A person whose life is insured by the policy, and who is named in the Policy Schedule. If there are two lives insured named in the Policy Schedule then the policy is a joint life policy.

Lump Sum on Death Benefit
The amount of Lump Sum on Death Benefit shown in the Policy Schedule as applying to a Life Insured, or as subsequently changed.

Major Hospital
This is a medical institution registered with the relevant authority in one of the Approved Territories (unless otherwise stated), which has continuous facilities for diagnosis, treatment and major surgery, which is operated primarily for the surgical and medical treatment of acute illness and injury, and which provides accommodation for sick and injured people as in-patients. For the purposes of this policy "Major Hospital" does not include a hospice, convalescence, geriatric or rehabilitation facility or the National Rehabilitation Hospital (Dún Laoghaire, Co. Dublin).

Partial Payment Specified Illness Benefit
This benefit (which applies only if Accelerated Specified Illness Benefit has been selected and accepted by the Company) provides for an amount to be paid if the Life Insured is diagnosed with a Partial Payment Specified Illness as outlined in Appendix B during the Term of Cover for Accelerated Specified Illness Benefit. Conditions applying to Partial Payment Specified Illness Benefit are described in Section C, Condition 2.1.1.

Policy Anniversary
This is the date 12 months after the policy starts and every 12 months thereafter.

Policyholder
The person or persons with whom the contract of insurance is made and who is responsible for the payment of the Premiums. Wherever the words "you" and "your" are used in the policy, they refer to the Policyholder. The Policyholder is named in the Policy Schedule.

Policy Schedule
The Policy Schedule forms part of the policy and sets out the specific details of your policy.

Policy Start Date
This is the date that the policy starts. It is stated in your Policy Schedule.

Policy Term
This is the Term of Cover chosen for the Lump Sum on Death Benefit as stated in your Policy Schedule or any endorsement. The policy may end earlier than the expiry of the Term of Cover if Protection Benefits are paid or the policy lapses or ceases as set out in these policy conditions.

Premium or Premiums
The amount shown in the Policy Schedule or a revised amount as stated on any endorsement or letter from the Company as a result of voluntary revision. The frequency at which Premiums are payable is also shown in the Policy Schedule.

Protection Benefits
The Lump Sum on Death Benefit, Accelerated Specified Illness Benefit, Accident Payment, Hospitalisation Payment, Broken Bones Payment and Surgery Payment, as applicable, applying to a Life Insured are collectively referred to as the Protection Benefits.

Specified Illness
A Specified Illness is the definite diagnosis by a Consultant of a Major Hospital, and as verified by the Company's Chief Medical Officer, of the first occurrence of any of the illnesses outlined in

Appendix A and/or Appendix B during the Term of Cover for the Accelerated Specified Illness Benefit.

Surgery Payment
The amount of Surgery Payment and the conditions that apply are described in Section C, Condition 2.5. Surgery Payment only applies to a Life Insured if stated in the Policy Schedule or any endorsement.

Term of Cover
This is the period(s) of cover chosen for each of the Protection Benefits that have been selected under your policy. Cover for each of the Protection Benefits will end on the expiry of the chosen Term of Cover or, if earlier, the payment of Protection Benefit(s) or the lapse or cessation of the policy as set out in these policy conditions.

2. Legal Basis

The contract with New Ireland Assurance is a legal agreement and consists of:

- the Application (including any recorded telephone interview) completed by you and the Life Insured;
- this Policy Document which sets out the standard policy conditions;
- the Policy Schedule;
- any written statements made by you, and the Life Insured(s);
- any statements made by an authorised person on your behalf;
- changes in the policy conditions or Policy Schedule notified to you in writing by the Company (these are called endorsements); and
- any schedule of revised terms issued by the Company to you.

The above contains all the terms of the contract and we accept liability only in accordance with these terms.

For the policy to be valid, we require full and true disclosure in the Application and in any medical or other statements made by the Policyholder or Life Insured(s) or intermediary in connection with the Application.

The policy is governed by the laws of Ireland. The courts of Ireland shall have exclusive jurisdiction in relation to all matters arising under or in connection with the policy.

The Company will, subject to the payment of Premiums and the policy terms, pay the benefits provided by the policy. If there is any misrepresentation of or failure to disclose material facts by or on behalf of the Policyholder, or a Life Insured, the policy is void and all Premiums paid will be retained by us.

The policy and the benefits are payable under it are based on current legislation, including current taxation legislation. If there is any change in taxation or other legislation affecting the policy we will make such alterations to the terms of the policy as, in the Actuary's opinion, are necessary to take account of such changes.

Complaints and disputes arising in connection with your policy, which come to be resolved within the Company's internal complaints handling procedure may be referred to the Financial Services Ombudsmen. Details of the services provided by the Financial Services Ombudsmen may be obtained from www.financialombudsman.ie and your insurance advisor or New Ireland.

Any assignments of the policy to a third party must be notified to the Company at our head office, 11/12 Dawson Street, Dublin 2.

3. Payment of Benefits

Protection Benefits are payable to the legal owner of the policy. This will normally be the Policyholder, but if the right to receive the

Protection Benefits has been transferred or Assigned to some other person or organisation such as a bank or building society, the payment of the Protection Benefits will be made directly to them (unless we receive the written instructions of the legal owner to do otherwise).

For example, depending on the circumstances we may pay one of the following:

- the Policyholder;
- a trustee(s) of the policy;
- an executor(s) or administrator(s);
- an Assignee(s) of the policy.

If there are two Policyholders we will pay both jointly or the survivor if one has died. If at the time the benefit becomes payable the Policyholder has died, we will pay the Assignee or the executors or administrators dealing with the estate as appropriate. If the policy has been issued under Trust, we will pay the trustee who is responsible to the beneficiaries of the Trust.

Section B - Details of the Policy

1. Paying Premiums

Your first Premium is due on the Policy Start Date. Subsequent Premiums are payable at the frequency set out in your Policy Schedule or any endorsement.

It is your responsibility to ensure that all Premiums are received by us. Once cover has started, we will allow you 30 days for payment from the date that a Premium is due. If the Premium is not paid within 30 days, your policy and Protection Benefits will cancel immediately without further notice and you are no longer on cover for any Protection Benefits. If you inform us in writing within 30 days of the premium due date that you want to cancel your policy, it will be cancelled immediately. Where this policy is being replaced by a new policy, this policy will be cancelled (unless previously lapsed) with effect from the commencement date of the new policy.

If you have Assigned your policy, we are obliged to notify the Assignee that Premiums have not been paid and that cover no longer applies.

If a claim arises during the 30 day period after a Premium is due and has not been paid, but before the policy has been cancelled, we will deduct the amount of the unpaid Premium from the claim amount.

2. Amending your policy

2.1 Medical–Free Conversion Option

The Policy Schedule will state whether this option applies to your policy.

If the Policy Schedule states that the Medical-Free Conversion Option applies, then subject to the provisions set out below at any stage before the expiry of the Term of Cover you may either extend the Term of Cover for the relevant benefit or cancel this policy and take out a new policy with the Company without providing any additional medical evidence.

To extend the Term of Cover all of the following apply:

- The Life Insured (or the older Life Insured in the case of a joint life policy) must be under 65 years of age on the date the option is exercised.
- The premium charged for the extended Term of Cover will be determined by the Company based on its premium rates for that policy at the time and the age of the Life Insured(s) on at the date the option is exercised
- Any special terms which apply to the Protection Benefits will continue to apply for the extended Term of Cover.
- Financial Underwriting will apply.

To take out a new policy all of the following apply:

- The Life Insured (or the older Life Insured in the case of a joint life policy) must be under 65 years of age on the date the option is exercised.
- The new policy may be any of the Company's range of non-unit linked policies available to you at the time the option is exercised. The Company reserves the right to restrict and/or vary the definition of any Protection Benefits under the new policy to be consistent with this policy.
- The amount of any Lump Sum on Death or Lump Sum on Death with Accelerated Specified Illness Benefit provided by the new policy cannot be greater than the amount of any Lump Sum on Death and/or Accelerated Specified Illness Benefits provided by this policy at the time of conversion and may be for such lesser amounts as the Company at its discretion shall decide taking into account evidence as to the extent of any financial loss you would incur on the death or diagnosis of a Specified Illness of the Life Insured and any other financial evidence that the Company may require.

- If converting from a joint life policy to a dual life policy, the amount of any Lump Sum on Death and/or Accelerated Specified Illness Benefits provided by the new policy for each Life Insured will be half that of the Lump Sum on Death and Accelerated Specified Illness Benefit, provided by this policy.
- The Premium charged for the new policy will be determined by the Company based on its premium rates for that policy at the time the option is exercised.
- Any special terms which apply to the Protection Benefits will continue to apply for the new policy.

2.2 Life Events Option

With Life Events Option, you can increase the level of the Lump Sum on Death and/or Accelerated Specified Illness Benefit applying to a Life Insured within 3 months of the occurrence of any of the following life events without providing evidence of the Life Insured's current health and occupation:

(a) The Life Insured has increased a mortgage associated with this policy because the Life Insured has moved principal residence;

(b) The Life Insured has married;

(c) The Life Insured or a spouse of the Life Insured has given birth to a child or legally adopted a child.

In the case of each Life Insured, the option to increase a benefit without medical evidence will only apply if the Life Insured is already covered for that benefit within the policy.

The total amount of the relevant benefit after exercising the Life Events Option cannot exceed the maximum of (1) and (2) as follows:

(1) The amount of the benefit provided by this policy at the time of exercising the option

Plus

The lesser of:

(a) 50% of the amount of the benefit at the Policy Start Date (or, if the benefit was subsequently added to your policy, at the time it was first added),

and

(b) €100,000,

and

(2) The lesser of:

(a) The amount of the benefit at the Policy Start Date (or, if the benefit was subsequently added to your policy, at the time it was first added),

and

(b) €500,000.

Where the Life Events Option is exercised on more than one occasion, then the amount in (1) is restricted to a cumulative maximum increase of €200,000.

If you exercise the Medical-Free Conversion Option, then the maximum a benefit amount can be increased to under the Life Events Option, without providing additional medical evidence, is restricted to €200,000 over the amount of the benefit at the Policy Start Date or, if the benefit was subsequently added to your policy, at the time it was first added to the policy.

Where you have more than one policy with the Company, increases to other policies which have taken place under a Life Events Option will be taken into account for the purposes of calculating the maximum increase under this policy.

In the case of Accelerated Specified Illness Benefit, the conditions applicable to the increase and in particular the illnesses covered will be in accordance with the terms and conditions applicable at the date of the proposed increase.

The Life Events Option is subject to all of the following:

When exercising this option the Life Insured (or the older Life Insured in the case of a joint life policy) is under 55 years of age on the date of application to exercise this option.

You must notify us that you wish to exercise this option within 3 months after the date of the life event described in (a) to (c) above and provide us with the following evidence:

– Confirmation of the loan drawdown for the mortgage in the event of an increase in the mortgage and moving principal residence.

– A marriage certificate in the event of marriage.

– A birth certificate in the event of a birth/ legal adoption of a child together with a copy of an appropriate Adoption Order.

The Premiums must be paid in full when due up to the date of the exercise of the option.

2.3. Other Policy Options

Outside the terms set out in Conditions 2.1 and 2.2 above, at any stage throughout the Term of Cover you may request to amend the Term of Cover or the amount of Protection Benefits. You can also request the addition of or removal of Protection Benefits on your policy. Any amendments outside of Conditions 2.1 and 2.2 above will be subject to underwriting and acceptance by the Company. Where a request for such an amendment is accepted by the Company, this will result in your Premium being re-calculated to take account of the changes being made and will be confirmed by an endorsement to the Policy.

3. Restarting your Policy

If a Premium has not been paid within 30 days from the date it was due for payment, then as set out in Condition 1 of Section B, your policy and Protection Benefits will be cancelled. However, your policy may be restarted at our absolute discretion within one year from the date that the first unpaid Premium was due.

Restarting your policy is subject to payment of all Premiums outstanding and the completion of a Declaration of Health Form by each Life Insured. Depending on what is disclosed on this form the Company may request further medical and/or other information, accept or decline the reinstatement and/or make changes to the policy terms or conditions including the Premium to be paid.

4. Cancelling your Policy/Protection Benefits Ceasing

The Protection Benefit(s) will cease when any one of the following events occurs:

- A claim is made under the Lump Sum on Death Benefit, on a single life or the first death in a joint life policy.
- You make a claim under the Accelerated Specified Illness Benefit which reduces the Lump Sum on Death Benefit amount to zero.
- The Life Insured(s) reaches the end of the Term of Cover for the Protection Benefit(s).
- You give written notification that you wish to cancel your policy.
- We do not receive a premium on the date the Premium is due for payment and 30 days elapse since that date the premium remains unpaid.

The Company will retain any Premiums paid under the Policy.

5. Who is Covered

The Life Insured(s) is covered for the amount of the Protection Benefits that apply to the Life Insured(s) until the end of the Term of Cover for the Protection Benefits. The Life Insured(s) details and chosen benefits are stated in the Policy Schedule or any endorsement. The Life Insured(s) is covered

for the amount of the Protection Benefits that apply from the later of the Policy Start Date and the date we collect your first Premium.

We will require proof of the age of the Life Insured(s) either on Application or before we pay a claim. If it is discovered that the age or the sex of a Life Insured has been mis-stated, the amount payable under the provision of the policy will be adjusted as determined by the Actuary and may result in the non payment of the benefit. The Company will retain any Premiums paid under the Policy.

6. Settlement/Correspondence

We will make payments under your policy by direct credit to a nominated bank account. Other forms of payment can be arranged by agreement.

We will send your correspondence to the most recent address given by you. You must notify us if you change address. If you do not, we are not responsible for correspondence being delivered to the incorrect address.

Any letters or notices from you must be sent to us at our head office, 11/12 Dawson Street, Dublin 2.

7. No Policy Value

The purpose of this policy is to provide a lump sum payment in the event of death and/or (if selected) on the diagnosis of a Specified Illness of a Life Insured during the Term of Cover. This policy is not a savings policy and at no point during the Policy Term, or at the end of the Policy Term, will it have any monetary value.

8. The Actuary

The Insurer appoints an Actuary whose responsibilities include advising us on how the policy should provide you with what you reasonably expect to get from it. He/she will advise us how the interests of the Policyholders should be taken into account in any variation on these policy conditions that we may propose.

We may revise the conditions set out in this document if, in the opinion of the Actuary, circumstances outside our control have changed in a way which could not reasonably have been predicted at the start of the policy and where, if we were not to amend these policy conditions, the results would be unfair to the Insurer or to our Policyholders. Such circumstances might be:

- a change in the law under which these policies operate, or
- a change in the tax treatment of policy benefits or of life assurance companies and their funds.

When considering any proposals by the Insurer and how they affect your interests, the Actuary will refer to the Guidance Notes prepared independently by the Society of Actuaries in Ireland and to any legislation that affects the way that he/she must act in these circumstances. The Actuary is required to make a statement in the annual returns to the Central Bank of Ireland on whether he/she has conformed with the Guidance Notes.

9. Legal Interest in Your Policy

You can use this policy as security for a loan by signing over your legal interest to the lender. This is known as an "Assignment". A notice of Assignment must be received by us at our head office from the person who has taken over the legal interest. This person is known as the "Assignee". The notice must be in writing and must show the date and reason for the change in legal ownership. We cannot accept any responsibility for the legal effect or otherwise of any Assignments.

Section C - Benefits

This section contains details of the Protection Benefits provided by the policy and the circumstances in which they are payable. The particular benefits applying to a Life Insured are shown in the Policy Schedule or any endorsement. If a benefit is not shown on the Policy Schedule, that benefit is not provided by the policy. No benefit is payable after the expiry of the Term of Cover for that benefit and no Protection Benefits are payable after the expiry of the Policy Term.

All Protection Benefits provided by the policy are currently payable to the Policyholder free of taxation. Details of the circumstances when a claim may not be payable, and the procedure you must follow in order to make a claim, are contained in Section D "Claim Procedures and Exclusions".

1. Death Benefits

1.1. Lump Sum on Death

This benefit only applies to a Life Insured if stated on the Policy Schedule or subsequent endorsement.

This benefit provides for the payment of a lump sum amount as stated on the Policy Schedule or any endorsement on the death of the Life Insured (or the first of the Lives Insured to die if a joint life policy) during the Term of Cover for this benefit as stated in the Policy Schedule or any endorsement.

The Lump Sum on Death Benefit as stated on the Policy Schedule or subsequent endorsement will reduce at monthly intervals. The monthly reduction will be calculated with reference to the proportion of the balance outstanding on a repayment mortgage in an amount equal to the Lump Sum on Death Benefit and for the same term as the Term of Cover for the Lump Sum on Death Benefit and as calculated by the Actuary using an interest rate of 6% per annum.

If, under the terms Section B, Condition 2, the Term of Cover for the Lump Sum on Death Benefit has been extended or the amount of the Lump Sum on Death Benefit has been increased, the amount of the Lump Sum on Death Benefit will continue to reduce at monthly intervals in the manner outlined above with reference to the extended Term of Cover and/or any revision of the amount of the benefit.

Exactly when the Lump Sum on Death Benefit is paid is determined by the type of cover that was selected at the Policy Start Date and is stated on your Policy Schedule. The following versions of the policy are available:

- Single life means that the Lump Sum on Death Benefit is paid when the only Life Insured under the policy dies during the Term of Cover for Lump Sum on Death Benefit.
- Where there are two Lives Insured (joint life) the Lump Sum on Death Benefit is paid on the first death of the two Lives Insured under the policy during the Term of Cover for Lump Sum on Death Benefit.

The policy will cease on the payment of a Lump Sum on Death Benefit.

If Accelerated Specified Illness Benefit applies, then the Lump Sum on Death Benefit will be reduced (for both lives in the case of joint life policies) by any prior payment of any Accelerated Specified Illness Benefit. In this event the remaining Lump Sum on Death Benefit will reduce monthly in a manner consistent with an amendment under this condition.

No claim for Lump Sum on Death Benefit will be admitted if death arises from any of the exclusions contained in Section D which are applicable to Lump Sum on Death Benefit. The claims procedures described in Section D apply to claims for Lump Sum on Death Benefit.

1.1.1 Terminal Illness Benefit

This provides you with an early payment of the Lump Sum on Death Benefit if the Life Insured is diagnosed with a Terminal Illness during the Term of Cover for Lump Sum on Death Benefit.

Terminal Illness means an advanced or rapidly progressing incurable illness, where in the opinion of an attending medical Consultant of a Major Hospital and our Company's Chief Medical Officer, a Life Insured's life expectancy is no greater than 12 months. In the event of Terminal Illness, the Terminal Illness Benefit payment will not apply where there are less than 18 months to go to the end of the Term of Cover for Lump Sum on Death Benefit.

The Terminal Illness Benefit will be the Lump Sum on Death Benefit stated on the Policy Schedule. The policy will cease following the Terminal Illness Benefit being paid out.

In the case of a joint life policy this benefit is payable on the diagnosis of a Terminal Illness of the first of the Lives Insured.

In the event of Terminal Illness no claim will be admitted if Terminal Illness arises from any of the exclusions contained in Section D which are applicable to Terminal Illness Benefit. The claims procedures described in Section D apply to claims for Terminal Illness Benefit.

1.1.2 Accidental Death Benefit

If the Life Insured is under age 55 when both the initial application details and the duly signed initial application declarations were received at New Ireland's head office and you have chosen Lump Sum on Death as a benefit, then the policy will pay a benefit of the chosen Lump Sum on Death amount up to a maximum of €150,000 should the Life Insured die due to Accidental Death (or in the case of an Application for a joint life policy, on the Accidental Death of the first to die of the Lives Insured) from on or after the date when both the initial application details and the duly signed initial application declarations were received at New Ireland's head office.

Accidental Death means death resulting from an injury caused by accidental, violent, external and visible means and is in no way linked to sickness, disease or physical disorder of a Life Insured.

An Accidental Death does not include any of the following causes:

- suicide, attempted suicide or intentional self inflicted injury;
- death linked to being under the influence of or being affected (temporarily or otherwise) by alcohol or drugs;
- engaging in any hazardous activity or sports including but not limited to the following: scuba diving, motor sports, aviation, hang gliding, water sports, horse racing, parachuting, mountaineering, rock climbing, caving or winter/ice sports;
- flying, except as a fare paying passenger;
- taking part in any riot, civil commotion, uprising or war (whether declared or not) or any related act or incident;
- directly or indirectly by taking part in a criminal act; or
- failure to follow reasonable medical advice or failed to follow medically recommended therapies, treatment or surgery.

Accidental Death Benefit will cease on the earlier of the following:

- the day we issue notice of acceptance of the Application on normal terms
- the day we issue an offer of special terms
- the day we issue notice that the Application has been refused
- the day we issue notice that the Application has

been postponed

- 30 days have passed since the day both the initial application details and the duly signed initial application declarations were received at New Ireland's head office.

We will only pay once under Accidental Death Benefit in respect of any Life Insured, regardless of the number of applications a person has with New Ireland Assurance.

2. Additional Benefits

2.1. Accelerated Specified Illness Benefit
This cover applies to a Life Insured only if stated in the Policy Schedule or subsequent endorsement. The benefit is only payable if the Life Insured is diagnosed with a Specified Illness as outlined in Appendix A during the Term of Cover for the Accelerated Specified Illness Benefit as stated in the Policy Schedule.

This provides you with a lump sum amount if a Life Insured is diagnosed with a Specified Illness as outlined in Appendix A during the Term of Cover for the Accelerated Specified Illness Benefit. The benefit is only available with Lump Sum on Death Benefit and the Lump Sum on Death Benefit will be reduced by the amount of any Accelerated Specified Illness Benefit paid. The Accelerated Specified Illness Benefit decreases at the same intervals and in the same manner as the Lump Sum on Death Benefit, as described in Section C, Condition 1.

In the event of a claim for Accelerated Specified Illness Benefit which is related to one of the four Partial Payment Specified Illnesses listed in 2.1.1., the amount of any Accelerated Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid.

If the policy is a joint life policy, and Accelerated Specified Illness Benefit is stated to apply in the Policy Schedule, then the amount of Accelerated Specified Illness Benefit applies to both Lives Insured unless stated otherwise in the special provisions.

The Accelerated Specified Illness Benefit cover will cease upon payment of any claim for Accelerated Specified Illness Benefit.

2.1.1. Partial Payment Specified Illness Benefit
This is an additional benefit that automatically applies to a Life Insured if the Policy Schedule or subsequent endorsement states that Accelerated Specified Illness Benefit applies to the Life Insured.

This provides you with a lump sum if the Life Insured is diagnosed with a Partial Payment Specified Illness as outlined in Appendix B during the Term of Cover for the Accelerated Specified Illness Benefit.

For the Partial Payment Specified Illness Benefit Angioplasty for Coronary Artery Disease – of specified severity, (Number 1 of Appendix B) the maximum amount we will pay is the lower of:

- €40,000 or;
- 75% of the Accelerated Specified Illness Benefit at the time of the procedure taking place.

For the other Partial Payment Specified Illnesses outlined in Appendix B, the amount we will pay is the lower of:

- €15,000 or;
- 50% of the Accelerated Specified Illness Benefit remaining at the time of the illness being diagnosed or specified surgery taking place as appropriate.

We will make only one payment under this Partial Payment Specified Illness Benefit for each of the Partial Payment Specified Illnesses outlined in Appendix B.

The Partial Payment Specified Illness Benefit is independent of the Accelerated Specified Illness Benefit, with the exception of Partial Payment

Specified Illness Benefit paid in respect of;

- Crohn's Disease - treated with surgical intestinal resection (number 7 in Appendix B),
- Early Stage Urinary Bladder Cancer - of specified advancement (number 10 in Appendix B),
- Peripheral Vascular Disease - treated by angioplasty (number 12 in Appendix B), and
- Serious Accident Cover - resulting in at least 28 consecutive days in hospital (number 14 in Appendix B).

In the event of a claim for Accelerated Specified Illness Benefit which is related to one of the four Partial Payment Specified Illnesses listed above, the amount of any Accelerated Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid.

The total amount we will pay under Partial Payment Specified Illness Benefit is limited to the amount of the Accelerated Specified Illness Benefit.

We will not pay any Partial Payment Specified Illness Benefit if a Life Insured dies within 14 days of the date the Partial Payment Specified Illness is diagnosed or the specified surgery taking place, as appropriate.

If a claim under Partial Payment Specified Illness Benefit is paid and within 30 days of the diagnosis or surgery, as appropriate, an admissible claim arises under the Accelerated Specified Illness Benefit, then the overall amount paid out will be the Accelerated Specified Illness Benefit amount at that time. Once 30 days have elapsed since the diagnosis or surgery of a Partial Payment Specified Illness, as appropriate, then any admissible claim for the Accelerated Specified Illness Benefit will be assessed and paid independently, outside of the exceptions outlined above.

Once an Accelerated Specified Illness Benefit claim is paid, the Partial Payment Specified Illness Benefit ceases immediately.

2.1.2 Waiting List Benefit

If a Life Insured is making a claim relating to

- Coronary Artery By-pass Grafts - with surgery to divide the breastbone;
- Heart Structural Repair;
- Heart Valve Replacement or Repair – with surgery to divide the breastbone;
- Pulmonary Artery Graft Surgery - with surgery to divide the breastbone; or
- Aorta Graft Surgery – for disease or traumatic Injury,

and the claim is accepted by the Company, we will make a payment in advance of the Life Insured undergoing the surgery if a Consultant of an Irish or United Kingdom Major Hospital confirms to our Company's Chief Medical Officer's satisfaction that the surgery is necessary for medical reasons, and the Life Insured is on an Irish or United Kingdom Major Hospital waiting list. The advance payment will be 50% of the Accelerated Specified Illness Benefit at the time the Life Insured goes on the Major Hospital waiting list, subject to a maximum of €32,500.

Accelerated Specified Illness Benefit and Lump Sum on Death Benefit will be reduced (for both lives in the case of joint life policies) by the amount of the advance payment. The reduced Accelerated Specified Illness Benefit will become payable when the Life Insured actually undergoes the surgery.

In the event of a Waiting List Benefit being paid, the remaining Accelerated Specified Illness Benefit will reduce during the remaining Term of Cover in accordance with the principles outlined in relation to amendments in Section C, Condition 1.

For a claim for Accelerated Specified Illness Benefit (including Partial Payment Specified

Illness Benefit) to be valid you must notify us within 90 days of the diagnosis of the illness or the date of the specified surgery, as appropriate. The maximum amount paid out as Accelerated Specified Illness Benefit is that shown in the Policy Schedule as applying to a Life Insured, or as subsequently changed or reduced over the remaining term in line with the proportionate reduction described in Section C, Condition 1.

What happens on the diagnosis of a Life Insured with a Specified Illness depends on

- whether Accelerated Specified Illness Benefit applies to that Life Insured,
- the Specified Illness the Life Insured is diagnosed with, and
- whether the policy is a single or joint life policy.

No claim for Accelerated Specified Illness Benefit (including Partial Payment Specified Illness Benefit) will be admitted if the Specified Illness (including Partial Payment Specified Illness) arises from any of the exclusions contained in Section D which are applicable to Accelerated Specified Illness Benefit (including Partial Payment Specified Illness Benefit). The claims procedures described in Section D apply to claims for Accelerated Specified Illness Benefit (including Partial Payment Specified Illness Benefit)

2.2 Accident Payment

Accident Payment only applies to a Life Insured if stated in the Policy Schedule. The amount of benefit will be the lesser of 50% of the Life Insured's average gross weekly earnings in the twelve month period prior to the date of the claim and the amount of benefit stated in the Policy Schedule. Confirmation of earnings from an independent source may be required.

If a Life Insured is temporarily disabled due to an accident as defined in this Condition, for a continuous period of more than 2 weeks before his or her 65th birthday, Accident Payment is payable in respect of each whole week of temporary disability due to an accident after the later of the first 2 weeks and the date of notification of a claim for Accident Payment. Notification of a claim for Accident Payment must be received within 30 days of the event giving rise to such claim. We will only pay a maximum of 52 weeks benefit in total during the Term of Cover in respect of any Life Insured regardless of the number of policies a person has with New Ireland.

If two periods of temporary disability due to an accident are separated by less than a week, then they will be treated as one continuous period.

For this Condition, temporarily disabled due to an accident means that the Life Insured is, in the opinion of the Company's Chief Medical Officer, as a result of accidental injury, totally unable to carry out his or her normal occupation as stated in the Application form on a temporary basis, and is not carrying out any other gainful occupation.

Accidental injury and any resulting inability by the Life Insured to carry out his or her normal occupation must be verified, by a registered medical practitioner in the Republic of Ireland or the United Kingdom, to the satisfaction of the Company's Chief Medical Officer.

Accidental injury means that the injury must be caused by accidental, violent, external and visible means and is no way linked to sickness, disease or physical disorder of the Life Insured.

Accident Payment cover ceases on the Life Insured's 65th birthday or the expiry of the chosen Term of Cover or on payment of a claim for Accelerated Specified Illness Benefit, whichever first occurs.

No claim for Accident Payment is payable if the Life Insured is unemployed or redundant at the time of the event giving rise to a claim.

No claim for Accident Payment is payable unless

the Company receives written notification of the occurrence of the event giving rise to a claim for Accident Payment within 30 days of the date of such event.

No claim for Accident Payment will be admitted if temporary disability due to accident arises from any of the exclusions contained in Section D which are applicable to Accident Payment. The claims procedures described in Section D apply to claims for Accident Payment.

2.3. Hospitalisation Payment

Hospitalisation Payment only applies to a Life Insured if stated in the Policy Schedule.

The benefit is payable in respect of every day that each Life Insured is confined to a Major Hospital in Ireland or the United Kingdom as a result of sickness or injury, provided that the period is at least 3 days (or a continuous 24 hours if the Life Insured is in intensive care).

If a Life Insured is discharged from hospital, and is then re-admitted within 7 days, the two periods of hospitalisation will be treated as one continuous period.

Hospitalisation Payment cover ceases on the Life Insured's 65th birthday or the expiry of the chosen Term of Cover, whichever first occurs.

Hospitalisation Payment will not be paid for more than 365 days in total during the Term of Cover for Hospitalisation Payment.

For this Condition a "day" means a period of 24 consecutive hours.

No claim for Hospitalisation Payment will be admitted if hospitalisation arises from any of the exclusions contained in Section D which are applicable to Hospitalisation Payment. The claims procedures described in Section D apply to claims for Hospitalisation Payment.

2.4. Broken Bones Payment

Broken Bones Payment only applies to a Life Insured if stated in the Policy Schedule. The amount of benefit payable and the specified injuries covered are listed below. If an injury is not listed below then it is not covered.

Specified Injury	Definition	Amount
Upper leg fracture	Breaking the femur or hip.	€3,000
Hip dislocation	Displacement of the femur from the acetabulum.	€1,700
Open fracture of the skull	A compound fracture where the bone ends have pierced the overlying skin with significant damage to the surrounding tissues (the nasal bones are not included).	€3,000
Closed fracture of the skull	A simple fracture (including a hairline fracture) with little damage to the surrounding tissue and no break in the overlying skin (the nasal bones are not included).	€1,700
Lower leg or ankle fracture	Breaking the tibia, fibula, patella or tarsus (ankle bone).	€1,700
Ankle dislocation	Displacement of the talus bone from the socket formed by the lower end of the tibia and fibula.	€2,500
Arm fracture	Breaking the humerus or the upper two thirds of the radius or ulna.	€1,700
Wrist fracture	Breaking of any carpal bones or lower one third of the radius or ulna (excluding metacarpals and phalanges, which are in the hand).	€1,300
Jaw or cheekbone fracture	Breaking the mandible, maxilla or cheekbone (the nasal bones are not included).	€1,300
Foot fracture	Breaking the oscalcis, talus, the tarsal bones or metatarsal bones (the toes (phalanges) are not included).	€1,300
Elbow dislocation	Displacement of the ulna to radius bone in relation to the lower end of the humerus.	€1,700
Shoulder dislocation	Displacement of the head of the humerus from the glenoid fossa.	€1,300
Vertebrae, shoulder blade or sternum fracture	A breaking involving the body of any of the vertebrae, the scapula or the sternum.	€1,300
Rib or collar bone fracture	Breaking any of the ribs or clavicle.	€1,000

Broken Bones Payment is only payable in respect of accidental injuries that are verified to the satisfaction of the Company's Chief Medical Officer, that necessitate medical treatment by a registered medical practitioner in the Republic of Ireland or the United Kingdom. Accidental injury means the injury must be caused by accidental, violent, external and visible means and is in no way linked to sickness, disease or physical disorder of the Life Insured.

If a single accident results in more than one specified injury we will pay only one benefit and the amount payable will be the highest individual amount which would be paid in respect of the specified injuries suffered.

In the event of there being more than one accident in any four week period resulting in more than one specified injury we will pay only one benefit and the amount payable will be the highest individual amount which would be paid in respect of the specified injuries suffered.

The overall maximum amount payable during the Term of Cover in respect of a Life Insured under this benefit is €25,000. The benefit is cancelled in respect of the Life Insured when that limit is reached.

Broken Bones Payment ceases on the Life Insured's 65th birthday or the expiry of the chosen Term of Cover or on payment of a claim for Accelerated Specified Illness Benefit, whichever first occurs.

No claim for Broken Bones Payment will be admitted if the specified injury arises from any of the exclusions contained in Section D which are applicable to Broken Bones Payment. The claim procedures described in Section D apply to claims for Broken Bones Payment.

2.5. Surgery Payment

Surgery Payment only applies to a Life Insured if stated in the Policy Schedule. The amount of benefit payable and the surgical procedures covered are listed below. If a surgical procedure is not listed below, it is not covered.

Surgery is defined as requiring a surgical incision and operation to or on an organ or body part and must, in the opinion of the Company's Chief Medical Officer be medically neccessary, performed in a Major Hospital in Ireland or the United Kingdom and must be carried out under general or spinal anaesthesia.

In the event of the Life Insured undergoing one of the following surgical procedures, the amount of the benefit payable will be 12.5% of the Accelerated Specified Illness Benefit at the time of the surgery subject to a maximum of €32,500:

- Surgery to the brain or meninges of the brain excluding surgeries to the pituitary gland, pineal glands and cerebral arteries;
- Surgery to the cranial nerves;
- Surgery to the lungs
- Surgery to the liver

In the event of the Life Insured undergoing one of the following surgical procedures, the amount of benefit payable will be 5% of the Accelerated Specified Illness Benefit at the time of the surgery subject to a maximum of €13,000:

- Hip or knee replacement;
- Surgery to the intervertebral discs
- Surgery to the spinal cord or canal excluding spinal puncture or injection;
- Surgery to the kidneys or pancreas or spleen;
- Surgery to the urinary bladder excluding surgeries or procedures for urinary incontinence, bladder prolapse, rectal prolapse, vaginal prolapse or uterine prolapse
- Surgery to the larynx excluding benign polyps or nodules of the vocal chords;

- Surgery to the oesophagus including repair of hiatus hernia;
- Surgery to the colon and rectum excluding surgeries to the anus;
- Surgery to the pharynx excluding adenoids;
- Surgery to the cerebral or carotid or iliac or femoral arteries;
- Surgery to the pituitary or pineal glands;
- Surgery to the adrenal glands;
- Surgery to the stomach, duodenum, jejunum or ileum;
- Surgery to the thymus;
- Surgery to the thyroid or parathyroid;
- Surgery to the ureter;

Surgery Payment will only be payable a maximum of four times in respect of a Life Insured. The benefit is cancelled in respect of the Life Insured when that limit is reached. The overall maximum Surgery Payment payable in respect of a Life Insured under the policy is the lesser of €130,000 and 50% of the Accelerated Specified Illness Benefit at the time of the surgery.

If Accelerated Specified Illness Benefit is payable in respect of a Life Insured, Surgery Payment will be cancelled. If on receipt of a claim for Surgery Payment the Company is satisfied that the conditions of payment for Accelerated Specified Illness Benefit are fulfilled, the Company will pay the Accelerated Specified Illness Benefit provided by the policy and no Surgery Payment will be payable by the Company.

Surgery Payment cover ceases on the Life Insured's 65th birthday or the expiry of the chosen Term of Cover or on payment of a claim for Accelerated Specified Illness Benefit, whichever first occurs.

If the condition or surgery giving rise to a Surgery Payment claim also gives rise to a Partial Payment Specified Illness Benefit claim, then we will only pay out the higher benefit amount.

Where there are two or more valid Surgical Payment claims in respect of a Life Insured arising from surgical operations within 14 days of each other, only one Surgical Payment benefit will be paid.

We will only make one payment under this Surgery Payment for each of the surgeries outlined in this Condition.

No claim for Surgery Payment will be admitted if the surgical procedure arises from any of the exclusions contained in Section D which are applicable to Surgery Payment. The claims procedures described in Section D apply to claims for Surgery Payment.

3. Children's Protection Benefits

Children's Protection Benefits apply to all the natural or legally adopted children of a Life Insured who are aged between 6 months and 18 years at the date the benefit is payable and all natural or legally adopted children of a Life Insured aged, at the date the benefit is payable, between 18 and 21 years who are in full time education.

No claim for Children's Protection Benefits (including Partial Payment Specified Illness Benefit) will be admitted if the claim arises from any of the exclusions contained in Section D which are applicable to Children's Protection Benefits. The claim procedures described in Section D apply to claims for Children's Protection Benefits.

3.1. Children's Lump Sum on Death
An amount of €4,000 is payable on the death of a child of a Life Insured during the Term of Cover for Lump Sum on Death Benefit for a Life Insured.

The maximum amount of benefit payable in respect of any child from all policies issued by the Company cannot be more than €4,000.

3.2. Children's Specified Illness Benefit
If Accelerated Specified Illness Benefit applies to a Life Insured, the lesser of:

- 50% of the Accelerated Specified Illness Benefit at the time of the illness being diagnosed or the specified surgery taking place, as appropriate; and
- €25,000

is payable if a child of a Life Insured is diagnosed as having any of the Specified Illnesses as outlined in Appendix A during the Life Insured's Term of Cover for Accelerated Specified Illness Benefit.

If a child of a Life Insured is diagnosed as having any of the Partial Payment Specified Illnesses outlined in Appendix B during the Life Insured's Term of Cover for Accelerated Specified Illness Benefit, the amount we will pay is the lower of:

- €7,500; and
- 50% of the Life Insured's Accelerated Specified Illness Benefit at the time of being diagnosed or specified surgery taking place, as appropriate

The child must survive for at least 14 days following the diagnosis or the date of a specified surgery taking place as outlined in Appendix A and/or Appendix B for the Children's Specified Illness Benefit or Partial Payment Specified Illness Benefit to be payable. Children's Specified Illness Benefit and Partial Payment Specified Illness Benefit is only payable once in respect of any child and the maximum amount of benefit payable in respect of any child from all policies issued by the Company cannot be more than €25,000 in the case of Children's Specified Illness Benefit and €7,500 in the case of a Partial Payment Specified Illness Benefit.

The Partial Payment Specified Illness Benefit is independent of the Children's Specified Illness Benefit, with the exception of the Partial Payment Specified Illness Benefit paid in respect of;

- Crohn's Disease - treated with surgical intestinal resection (number 7 in Appendix B),
- Early Stage Urinary Bladder Cancer - of specified advancement (number 10 in Appendix B),
- Peripheral Vascular Disease - treated by angioplasty (number 12 in Appendix B), and
- Serious Accident Cover - resulting in at least 28 consecutive days in hospital (number 14 in Appendix B).

In the event of a claim for Children's Specified Illness Benefit which is related to one of the four Partial Payment Specified Illnesses listed above, the amount of any Children's Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit previously paid.

If a claim under Partial Payment Specified Illness Benefit is paid and within 30 days of the diagnosis or surgery, as appropriate, an admissible claim arises under the Children's Specified Illness Benefit, then the overall amount paid out will be the Children's Specified Illness Benefit amount at that time. Once 30 days have elapsed since the diagnosis or surgery of a Partial Payment Specified Illness, as appropriate, then any admissible claim for Children's Specified Illness Benefit will be assessed and paid independently, outside of the exceptions outlined above.

Once a Children's Specified Illness Benefit claim is paid, the Partial Payment Specified Illness Benefit ceases immediately for any child.

3.3. Children's Hospitalisation Payment

If Hospitalisation Payment applies to a Life Insured, a Children's Hospitalisation Payment of €35 per day applies to the children of the Life Insured. The Children's Hospitalisation Payment is payable in respect of every day that the child is confined to a Major Hospital in Ireland or the United Kingdom during the Life Insured's Term of Cover for Hospitalisation Payment as a result of sickness or injury, provided that the period is at least 3 days. For this condition a 'day' means a period of 24 consecutive hours. Children's Hospitalisation Payment will not be paid for more than 365 days in total during the Life Insured's Term of Cover for Hospitalisation Payment in respect of any child.

Unless a child has been legally adopted, the name of a Life Insured must appear as a parent on the child's birth certificate.

Section D – Claim Procedures and Exclusions

1. Claim Procedures

All claims must be notified in writing to New Ireland Assurance's head office at 11/12 Dawson Street, Dublin 2. While we recommend that claims be notified as soon as possible after the event, claims must be notified within 90 days of the event or the diagnosis giving rise to the claim except for:

- the special procedures that apply to claims in relation to HIV infection contracted from a blood transfusion, physical assault or at work as set out in Appendix A; and
- Accident Payment where we require written notification of the occurrence of the event giving rise to a claim for Accident Payment within 30 days of the date of such event.

New Ireland must receive the completed claim form together with this Policy Document and the Policy Schedule which forms part of this document. All items of proof, certificates, information, medical and other evidence that the Company may require in support of a claim must be provided at your own expense.

Where the conditions require the diagnosis by a Consultant, he or she must be a Consultant of a Major Hospital.

2. Exclusions

There are a number of circumstances in which a claim for payment of a Protection Benefit or a Children's Protection Benefit will not be admitted or paid. These exclusions, and the Protection Benefits to which they apply, are as follows:

- No claim for Hospitalisation Payment, Children's Hospitalisation Payment, Accident Payment, Surgery Payment or Broken Bones Payment is payable if a Life Insured, or where relevant the child of a Life Insured, is resident outside the Republic of Ireland or the United Kingdom for more than 13 weeks in any consecutive 12 month period prior to the time of claim.
- No claim for Accelerated Specified Illness Benefit or Children's Specified Illness Benefit (including Partial Payment Specified Illness Benefit) is payable if a Life Insured, or where relevant, the child of a Life Insured, is resident outside the Approved Territories for more than 13 weeks in any consecutive 12 month period prior to the time of claim.
- No Lump Sum on Death Benefit, Terminal Illness Benefit or Children's Lump Sum on Death Benefit is payable if the Life Insured or a child of the Life Insured dies by his or her own hand or act or is diagnosed as being terminally ill as a result of his or her own deliberate act within 1 year of the Policy Start Date or within 1 year of the date of any reinstatement of the policy or within 1 year of a voluntary increase in Lump Sum on Death Benefit, or within 1 year of being added on to the policy, whichever is applicable, except that if the policy has been Assigned to a third party in good faith, the benefit payable is limited to the interest of that third party which was acquired for monetary consideration.
- Any specific exclusions relating to particular illnesses covered by Accelerated or Children's Specified Illness Benefit (including Partial Payment Specified Illness Benefit) are contained in the relevant part of Appendix A and/or Appendix B.
- No claim for Hospitalisation Payment or Children's Hospitalisation Payment is payable within the first 9 months of the Policy Start Date or within the 9 months following any reinstatement of the policy, or within 9 months of a voluntary increase in Hospitalisation Payment, or within 9 months of the Hospitalisation Payment being added to the policy, if the hospitalisation is due to pregnancy or a pregnancy related complication.

- No claim for Hospitalisation Payment is payable within the first 2 years of the Policy Start Date or within the 2 years following any reinstatement of the policy or within 2 years of a voluntary increase in Hospitalisation Payment, or within 2 years of the Hospitalisation Payment being added on to the policy if hospitalisation is due to a condition from which the Life Insured suffered before the Policy Start Date or the date of any reinstatement of the policy, or the date of a voluntary increase in Hospitalisation Payment or the date Hospitalisation Payment was added to the policy, whichever is applicable.
- No claim for Hospitalisation Payment or Children's Hospitalisation Payment is payable if hospitalisation is due to cosmetic or elective surgery, psychiatric illness, or failure to seek or follow medical advice.
- No claim for Surgical Payment is payable in respect of procedures which are endoscopic, diagnostic, investigative, exploratory or cosmetic, organ or tissue donation, surgery to the tonsils, surgery to the appendix, surgery for haemorrhoids, surgery due to self inflicted injury, elective surgery, cosmetic surgery, diagnostic or exploratory surgery including genetic, foetal, contraceptive or contraceptive reversal procedures, infertility treatment, pregnancy, childbirth, or termination of pregnancy.
- No claim for Accident Payment, Surgery Payment or Broken Bones Payment is payable in respect of claims arising from accidents, injuries or illnesses which occur before the Policy Start Date or before the date of any reinstatement of the policy, or before the date that any of these benefits were added to the policy, or after the Life Insured passes his/her 65th birthday, and in addition in relation to Accident Payment before the date of a voluntary increase to this benefit.
- No claim for Children's Protection Benefits (including Partial Payment Specified Illness Benefit) is payable if the claim is, in the opinion of the Company's Chief Medical Officer, due to any congenital illness and/or medical condition which existed whether symptoms were present or not
  - before the Policy Start Date; or
  - before the date the Children's Protection Benefit becomes applicable under the policy; or
  - before the date of any increase in Protection Benefits; or
  - before the date of any reinstatement of the policy, where applicable; or
  - before the date the child was legally adopted; or
  - before the child was 6 months old.
- The specific exclusions relating to Accidental Death Benefit are contained in Section C, Condition 1.1.2.

Appendix A

Specified Illnesses

1. Alzheimer's Disease – resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist 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:

- Alzheimer's Disease secondary to alcohol or drug misuse

2. Aorta Graft Surgery – for disease or traumatic injury

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

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

For the above definition, the following is not covered:

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

3. Aplastic Anaemia - of specified severity

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

- Blood transfusion;
- Bone-marrow transplantation;
- Immunosuppressive agents;
- Marrow Stimulating agents.

All other forms of anaemia are specifically excluded.

4. Bacterial Meningitis - resulting in permanent symptoms

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

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

*Permanent neurological deficit with persisting clinical symptoms is defined as:

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

The following are not covered:-

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

5. Balloon Valvuloplasty

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

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

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

For the above definition, the following are not covered:

- Tumour in the pituitary gland
- Angiomas

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

*Permanent neurological deficit with persisting clinical symptoms is defined as:

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

The following are not covered:-

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

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

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

For the above definition, the following are not covered:

- Angiomas
- Prolapsed or herniated intervertebral disc

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

*Permanent neurological deficit with persisting clinical symptoms is defined as:

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

The following are not covered:-

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

- Symptoms of psychological or psychiatric origin.

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

9. Cancer – excluding less advanced cases
Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, lymphoma and sarcoma.

For the above definition, the following are not covered:

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

In the event of a claim for bladder cancer, the amount of any Accelerated Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Early Stage Urinary Bladder Cancer – of specified advancement (number 10 of Appendix B).

10. Cardiac Arrest – with insertion of a defibrillator
Sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted

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

For the above definition the following is not covered

- Insertion of a pacemaker
- Insertion of a defibrillator without cardiac arrest
- Cardiac arrest secondary to alcohol or drug misuse

11. Cardiomyopathy – of specified severity
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 secondary to alcohol or drug misuse.

12. Chronic Lung Disease - of specified severity

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

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

13. Coma - resulting in permanent symptoms

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

- requires the use of life support systems for a continuous period of at least 96 hours;

and

- results in permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug misuse.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

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

The following are not covered:-

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

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

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

For the above definition, the following are not covered:

- balloon angioplasty;
- atherectomy;
- rotablation;
- insertion of stents;
- laser treatment.

15. Creutzfeld-Jacob Disease – resulting in permanent symptoms

A definite diagnosis of Creutzfeld-Jacob disease by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

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

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis,

localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:-

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

16. Crohn's Disease – of specified severity

A definite diagnosis of Crohn's disease by a Consultant Gastroenterologist with fistula formation and intestinal strictures.There must have been two or more resections of the small or large intestine on separate occasions.

There must also be evidence of continued inflammation with ongoing symptoms, despite optimal therapy with diet restriction, medication use and surgical interventions.

In the event of a claim for this illness, the amount of any Accelerated Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Crohn's Disease – treated with surgical intestinal resection (number 7 of Appendix B).

17. Deafness – permanent and irreversible

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

18. Dementia – resulting in permanent symptoms

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

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

For the above definition, the following is not covered:

- Dementia secondary to alcohol or drug misuse.

19. Devic's Disease – with persisting symptoms

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

20. Encephalitis - resulting in permanent symptoms

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

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

*Permanent neurological deficit with persisting clinical symptoms is defined as:

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

The following are not covered:

- An abnormality seen on brain or other scans without definite related clinical symptoms.
- Neurological signs occurring without

symptomatic abnormality, e.g. brisk reflexes without other symptoms.

- Symptoms of psychological or psychiatric origin.

21. Heart Attack - of specified severity

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

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

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

22. Heart Structural Repair

The undergoing of heart surgery requiring thoracotomy on the advice of a Consultant Cardiologist, to correct any structural abnormality of the heart.

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

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

24. HIV infection

HIV infection – contracted in any of the Approved Territories from a blood transfusion, a physical assault or at work.

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment; or
- a physical assault; or
- artificial insemination or in-vitro fertilisation given as part of medical treatment; or
- an incident occurring during the course of performing normal duties of employment

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

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

For the above definition, the following is not covered:

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

25. Intensive Care – requiring mechanical ventilation for 10 consecutive days

Any sickness or injury resulting in the Life Insured 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 a Major Hospital.

For the above definition the following are not covered:

- sickness or injury as a result of drug or alcohol misuse or other self inflicted means
- children under the age of 90 days

26. Kidney Failure – requiring ongoing dialysis

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

For the above definition, the following is not covered:

- Kidney failure secondary to alcohol or drug misuse.

27. Liver Failure – Irreversible and End Stage

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

- permanent jaundice,
- ascites; and
- hepatic encephalopathy.

For the above definition, the following is not covered:

- Liver Failure secondary to alcohol or drug misuse.

28. Loss of one Limb – permanent physical severance

Permanent loss 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.

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

29. Loss of Speech – permanent and irreversible

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

30. Major Organ Transplant – specified organs

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

For the above definition, the following is not covered:

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

31. Motor Neurone Disease – resulting in permanent symptoms

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

32. Multiple Sclerosis – with persisting symptoms

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

33. Multiple System Atrophy – resulting in permanent symptoms

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

- motor function with associated rigidity of movement; or
- the ability to coordinate muscle movement; or

bladder control and postural hypotension

34. Muscular Dystrophy – resulting in permanent symptoms

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

*Permanent neurological deficit with persistent clinical symptoms is defined as:

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

The following are not covered

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

35. Paralysis of One limb - total and irreversible

Total and irreversible loss of muscle function to the whole of any one limb.

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

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must also be permanent clinical impairment that includes bradykinesia (slowness of movement) and at least one of the following:

- tremor; or
- muscle rigidity; or
- postural instability

For the above definition, the following is not covered:

- Parkinson's disease secondary to alcohol or drug misuse

37. Peripheral Vascular Disease – with bypass surgery

A definite diagnosis of peripheral vascular disease by a Consultant Cardiologist or Vascular Surgeon, due to atherosclerosis or Buerger's disease, with objective evidence from an ultrasound of obstruction in the arteries which results in by-pass graft surgery to an artery of the legs.

For the above definition, the following is not covered:

- Angioplasty

In the event of a claim for this illness, the amount of any Accelerated Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Peripheral Vascular Disease - treated by angioplasty (number 12 of Appendix B).

38. Pneumonectomy – removal of a complete lung

The undergoing of surgery on the advice of a Consultant Physician to remove an entire lung for disease or traumatic injury.

For the above definition, the following is not covered:

- removal of a lobe of the lungs (lobectomy);
- lung resection or incision

39. Primary Pulmonary Hypertension – of specified severity

A definite diagnosis of primary pulmonary hypertension by a Consultant Cardiologist. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classifications of functional capacity*.

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

40. Progressive Supra-nuclear Palsy resulting in permanent symptoms

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

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

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

42. Rheumatoid Arthritis - of specified severity

A definite diagnosis of chronic rheumatoid arthritis by a Consultant Rheumatologist resulting in all of the following:

- the condition must be diagnosed, established and treated for a period of at least 12 months;
- there must be morning stiffness in the affected joints of at least one-hour duration;
- there must be arthritis of 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 (anticyclic citrullin-ated protein) antibodies, unless all other criteria are met;
- there must be subcutaneous nodules (nodular swelling beneath the skin);
- there must be radiographic changes typical of active rheumatoid arthritis.

43. Stroke – resulting in permanent symptoms

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

For the above definition, the following are not covered:

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

*Permanent neurological deficit with persistent clinical symptoms is defined as:

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

seizures, dementia, delirium and coma.

The following are not covered

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

44. Systemic Lupus Erythematous – of specified severity

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

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

- Glomerular Filtration Rate (GFR) below 30ml/min.
- Abnormal urinalysis showing proteinuria or haematuria.

*Permanent neurological deficit with persisting clinical symptoms is defined as:

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

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

45. Third Degree Burns - covering 20% of the of body surface area

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 at least 25% surface area of the face which for the purpose of this definition includes the forehead and the ears.

46. Total and Permanent Disability

1. Total and Permanent Disability before age 65 means that in the opinion of the Company's Chief Medical Officer, the Life Insured is, because of illness or accident, permanently and irreversibly unable to carry out at least 3 of the 6 activities listed below or is permanently disabled by reason of mental incapacity. The person must have taken any appropriate prescribed medication and then be unable to perform the task on their own.

Total and Permanent Disability must persist for a continuous period of at least 12 months before any entitlement to Total and Permanent Disability Benefit arises.

The 6 activities are:

- Walking – the ability (using a walking stick for balance or confidence if necessary) to walk 200 meters on the flat without stopping or severe discomfort .
- Mobility – the ability to bend or kneel down to pick up something from the floor and straighten up again.
- Lifting – lifting a 1 kilogram weight from table height with either hand and carrying it for 5 meters.
- Manual Dexterity – using a pen, pencil or keyboard with either hand.
- Communication – the ability to answer a

telephone and reliably take a message.

- Climbing – the ability to climb up and then down a flight of 12 stairs with the use of a handrail if needed.

Permanently disabled by reason of mental incapacity means that the Life Insured is suffering from:

- an organic brain disease or brain injury which affects the Life Insured's ability to reason and understand, and
- the mental incapacity has deteriorated to the extent that continual supervision of the Life Insured and the assistance of another person is required, and
- the mental incapacity is irreversible with no reasonable prospect of there ever being any improvement in the Life Insured's condition.

For the above definition, the following is not covered:

- Total and Permanent Disability secondary to alcohol or drug misuse

2. Total and Permanent Disability at age 65 or over means that in the opinion of the Company's Chief Medical Officer, the Life Insured is, because of illness or accident, permanently and irreversibly unable to carry out at least 3 of the 6 activities listed below or is permanently disabled by reason of mental incapacity. The person must have taken any appropriate prescribed medication and then be unable to perform the task on their own, even with the use of appropriate assistive aids and appliances (e.g. a handrail to help getting into and out of the bath or shower).

Total and Permanent Disability must persist for a continuous period of at least 12 months before any entitlement to Total and Permanent Disability Benefit arises.

The 6 activities are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
- Feeding – The ability to feed one's self once food has been prepared and made available.
- Toileting – the ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.
- Mobility – the ability to move indoors from room to room on level surfaces.
- Transferring – The ability to move from bed to an upright chair or wheelchair and vice versa.

Permanently disabled by reason of mental incapacity means that the Life Insured is suffering from

- an organic brain disease or brain injury which affects the Life Insured's ability to reason and understand, and
- the mental incapacity has deteriorated to the extent that continual supervision of the Life Insured and the assistance of another person is required, and
- the mental incapacity is irreversible with no reasonable prospect of there ever being any improvement in the Life Insured's condition.

For the above definition, the following is not covered:

- Total and Permanent Disability secondary to alcohol or drug misuse.

47. Traumatic Head Injury – resulting in permanent symptoms

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

For the above definition, the following is not covered:

- Traumatic Head Injury secondary to alcohol or drug misuse.

* Permanent neurological deficit with persistent clinical symptoms is defined as:

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

The following are not covered

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

Appendix B

Partial Payment Specified Illnesses

1. Angioplasty for Coronary Artery Disease - of specified severity
Undergoing of treatment for severe coronary artery disease, of any of the following

- balloon angioplasty
- atherectomy
- rotablation
- laser treatment
- and / or insertion of stent(s)

to treat the narrowing or blockage in a Main Coronary Artery. This procedure must have been carried out on the advice of a Consultant Cardiologist.

Angiographic evidence to support the necessity for the procedure will be required. The intervention must be to treat at least 70% diameter narrowing in a Main Coronary Artery.

Provided the above requirements are met, we will make a payment of €5,000 on completion of balloon angioplasty, atherectomy, rotablation, laser treatment and/or insertion of stent(s), to correct at least 70% diameter narrowing in one Main Coronary Artery.

We will make a second payment on the completion of balloon angioplasty, atherectomy, rotablation, laser treatment and/or insertion of stent(s) to correct at least 70% diameter narrowing of one of the other Main Coronary Arteries. The second payment is the balance of the Partial Payment Specified Illness Benefit for Angioplasty for Coronary Artery Disease set out in Section C, for Condition 2.1.1.

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

- Right Coronary Artery

- Left Main Stem

- Left Anterior Descending

- Circumflex

Procedures to any of the branches of the above Main Coronary Arteries are specifically excluded.

2. Brain Abscess drained via craniotomy
Undergoing of 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.

3. Carcinoma in Situ – Oesophagus, treated by specific surgery
A definite diagnosis of a carcinoma in situ of the oesophagus by a Consultant Physician, which has been treated surgically by removal of a portion or all of the oesophagus. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

For the above definition, the following are not covered:

- Treatment by any other method is specifically excluded.

4. Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty
Undergoing of endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

5. Cerebral Aneurysm – treated by craniotomy, stereotactic radiosurgery or endovascular repair
Undergoing of treatment for a cerebral aneurysm by a Consultant Neurosurgeon or Radiologist via craniotomy, or stereotatic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral aneurysm.

For the above definition, the following is not covered:

- Cerebral arteriovenous malformation

6. Cerebral Arteriovenous Malformation – treated by craniotomy, stereotactic radiosurgery or endovascular repair

Undergoing of treatment of a cerebral arteriovenous fistula or malformation by a Consultant Neurosurgeon or Radiologist via craniotomy, or stereotactic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral arteriovenous fistula or malformation.

For the above definition, the following is not covered:

- Intracranial aneurysm

7. Crohn's Disease – treated with surgical intestinal resection

A definite diagnosis of Crohn's disease by a Consultant Gastroenterologist and where the Life Insured has undergone surgery to remove part of the small or large intestine.

The removed part of the small or large intestine must show histological confirmation of Crohn's disease.

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Intestinal biopsy

The amount of any Accelerated Specified Illness Benefit to be paid for Crohn's Disease – of specified severity (number 16 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Crohn's Disease – treated with surgical intestinal resection.

8. Ductal Carcinoma in Situ – Breast, treated by surgery

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

9. Early Stage Prostate Cancer with Gleason score between 2 and 6 – and with specific treatment

A definite diagnosis of prostate cancer by a Consultant which has been histologically classified as having a Gleason score between 2 and 6 provided:

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

For the above definition, the following are not covered:

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

10. Early Stage Urinary Bladder Cancer – of specified advancement

A definite diagnosis by a Consultant of urinary bladder cancer which has been histologically classified as having progressed to either:

- stage Tis - Carcinoma in situ – diffuse 'flat' non-papillary tumour; or
- stage T1N0M0 - Carcinoma which has invaded the sub-epithelial connective tissue

For the above definition, the following is not covered:

- Any urinary bladder tumour which has been histologically classified as stage Ta (non-invasive papillary carcinoma).

The amount of any Accelerated Specified Illness Benefit to be paid for bladder cancer (covered under Cancer, number 9 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Early Stage Urinary Bladder Cancer – of specified advancement.

11. Implantable Cardioverter Defibrillator (ICD) - for primary prevention of sudden cardiac death
Undergoing of the insertion of an Implantable Cardioverter-Defibrillator (ICD) on the advice of a Consultant Cardiologist for primary prevention of sudden cardiac death.

For the above definition, the following is not covered:

- Insertion of a pacemaker

12. Peripheral Vascular Disease - treated by angioplasty
Undergoing of balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant Cardiologist or Vascular Surgeon to correct at least 70% narrowing or blockage to an artery of the legs. Angiographic evidence will be required.

The amount of any Accelerated Specified Illness Benefit to be paid for Peripheral Vascular Disease – with bypass surgery (number 37 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Peripheral Vascular Disease - treated by angioplasty.

13. Pituitary Tumour – resulting in permanent symptoms or surgery
A definite diagnosis of a non-malignant tumour in the pituitary gland by a Consultant Neurologist or Neurosurgeon resulting in either of the following:

- Permanent neurological deficit with persisting clinical symptoms*; or
- Treatment of the tumour by surgery or stereotactic radiosurgery

* Permanent neurological deficit with persistent clinical symptoms is defined as:

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

The following are not covered

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

For the above definition, the following are not covered:

- Where symptoms of pituitary tumour are absent with on-going medical treatment
- Tumours in the brain

14. Serious Accident Cover – resulting in at least 28 consecutive days in hospital
A serious accident resulting in severe physical injury where the Life Insured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

For the purposes of this definition only, a hospital stay also includes treatment in an inpatient rehabilitation centre, if the Life Insured is transferred directly from hospital to the

rehabilitation centre for continuous treatment.

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

Only one Partial Payment Specified Illness Benefit will be paid for Partial Payment Specified Illnesses resulting from the same accident. Any Accelerated Specified Illness Benefit to be paid will be reduced by any Partial Payment Specified Illness Benefit paid where the Accelerated Specified Illness results from the same accident.

For the above definition the following are not covered:

- Stays in hospital of less than 28 consecutive days
- Serious accident injury secondary to alcohol or drug misuse

15. Significant Visual Impairment
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 6/36 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lens.

16. Single Lobectomy – the removal of a complete lobe of the lung
The undergoing of medically essential surgery to remove a complete lobe of a lung for disease or traumatic injury

For the above definition the following are not covered

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

17. Surgical Removal of One Eye
Surgical removal of a complete eyeball for disease or trauma.

18. Syringomyelia or Syringobulbia – treated by surgery
A definite diagnosis of Syringomelia or Syringobulbia by a Consultant Neurologist, which has been surgically treated. This includes surgical insertion of a permanent drainage shunt.

19. Third Degree Burns - covering at least 5% of the body's surface
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% and less than 20% of the body's surface area.

20. Ulcerative Colitis – treated with total colectomy
A definite diagnosis by a Consultant Gastroenterologist of ulcerative colitis which is treated by removal of the entire colon (large bowel).

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Partial removal of the colon

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