University of Galway Income Protection Plan

Cornmarket

Ollscoil na Gaillimhe
University of Galway

This Plan is underwritten by Aviva Life & Pensions Ireland DAC (Aviva).

Contents

This booklet is split into the following sections:

Disclaimers

This booklet is intended as a guide only. The Plan is governed by the master Policy Documents No. 727385 & 727389 issued by Aviva. Members of the Plan may request a copy of the policy documents from the Plan owners or the Dublin office of Cornmarket Group Financial Services Ltd.

This booklet is issued subject to the provisions of the policy and does not create or confer any legal rights. The information contained herein is based upon our current understanding of Revenue law and practice as of November 2024.

While great care has been taken in the preparation of this booklet, if there is any conflict between it and the policy documents, the policy documents will prevail.

No part of this booklet should be read in isolation.

Please save a copy of this booklet for future reference.

Information in this booklet is correct as of November 2024 but may change. For the latest information, please see cornmarket.ie

Where we say 'Plan', we mean University of Galway Income Protection Plan.

Where we say 'Insurer', we mean Aviva Life & Pensions Ireland DAC (Aviva).

Where we say 'we' or 'us', we mean Cornmarket Group Financial Services Ltd (up to page 35).

Where we say 'we' or 'us', we mean Aviva (pages 36-49 inclusive).

1. Introduction

Overview of Key Benefits

1	**Disability Benefit**	A replacement income of up to **75%* of your annual salary** if you cannot work due to illness or injury
2	**Full Specified Illness Benefit**	A once-off lump sum of **33% of your annual salary** if you are diagnosed with one of the Full Specified Illnesses covered**

Please ensure you read the entire booklet so that you are aware of all benefits, terms, conditions and exclusions associated with the Plan.

*Less any other income that you may be entitled to, for example half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration (previously known as Pension Rate of Pay), State Illness Benefit or Invalidity Pension.

**Please see the Appendices from page 36 to 49 for full details, in particular the policy definition of each Specified Illness and its pre-existing and related conditions.

Eligibility

All eligible new employees are automatically accepted into the Plan upon commencement of employment.

If you opted out* of the Plan you may still apply to join the Plan if you are:

1. A pensionable employee of the University of Galway **and**
2. Under age 66 **and**
3. Actively at work.
   As defined on the application form when applying to join the Plan.

Important:
You must remain an employee of the University of Galway to remain an eligible member of the Plan.

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

For employees not automatically included in the Plan on or after 1st April 2014 due to salary.

If your gross annual salary is €15,000 or less the benefit payable from the Plan is minimal when any other income you may be entitled to such as, half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration, State Illness Benefit or Invalidity Pension is accounted for in the calculation. Therefore, you were not automatically included in the Plan and do not pay premiums.

If your gross annual salary increases above €15,000, you can avail of the Plan without medical underwriting. You must contact University of Galway Pensions Office at pensions@universityofgalway.ie **within 31 days of your salary increase** to be eligible for this option.

After 31 days of your salary increase you may still apply to join the Plan, however, you must complete an application form which may be subject to medical underwriting.

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

*For information on opting out of the Plan please see page 17.

Roles

Cornmarket's role includes:

1. Negotiating with the Insurers to obtain the best possible benefits and cost.
2. Assisting members who wish to make a claim from the Plan.
3. Promoting the Plan.

The Insurer's role includes:

1. Deciding the policy terms and conditions and creating a policy document to reflect these.
2. Medically assessing applications and claims.
3. Deciding the various aspects of an individual member's cover, for example, if premium payment ceases, can membership be re-activated, is payment of arrears and/or a declaration of health required. Deciding if refunds can be made.

2. Benefits

Disability Benefit

In the event that your salary is affected because you are unable to work due to illness or injury, this benefit aims to pay you an income of:

- **up to 25%** of salary after a deferred period of 13 weeks has passed
- **up to 75%** of salary after a deferred period of 26 weeks has passed

See page 10 for definition of salary and details of the deferred period.

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

- Temporary Rehabilitation Remuneration (TRR) – May be paid by your employer to you where there is a reasonable prospect of you returning to work.
- State Illness Benefit/State Invalidity Pension – Those paying PRSI at the 'A' rate may be entitled to this benefit from the State.
- Ill Health Early Retirement Pension (IHERP) – Those who retire on the grounds of ill health may be entitled to this from their employer.
- Any annualised amount awarded by a court of law, an agreed settlement sum or ex-gratia payment attributable to loss of earnings arising out of any action relating to your disablement.

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

If you are in receipt of a Disability Benefit and return to work on a part time basis, you may, in some circumstances, still be paid a Disability Benefit under the Plan. This is referred to as a Proportionate Disability Benefit.

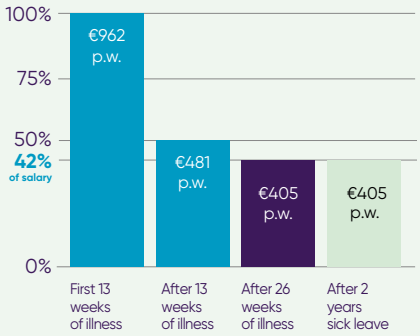
Example of how the Disability Benefit works

This example is based on a Public Sector employee, who is a member of the Superannuation Scheme with 27 years' service earning €50,000 per annum, who is now unable to work due to disability arising from illness or injury. It is assumed that standard Public Sector sick leave arrangements apply, extended paid sick leave under the Critical Illness Protocol does not apply and Ill Health Early Retirement Pension is granted after 2 years.

For those who are a class A PRSI contributor, their Superannuation Scheme Pension is integrated to take account of the value of the Contributory State Pension in calculating the pension payable. In the event of illness, they may typically claim State Illness Benefit.

D Rate PRSI Example

WITHOUT Income Protection



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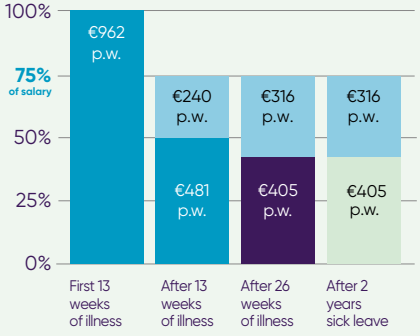
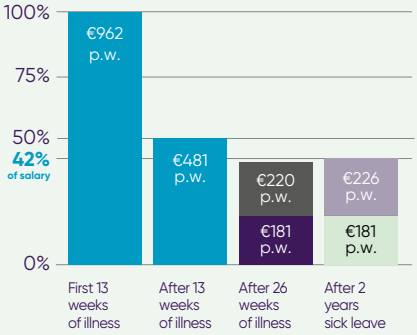


A Rate PRSI Example

WITHOUT Income Protection



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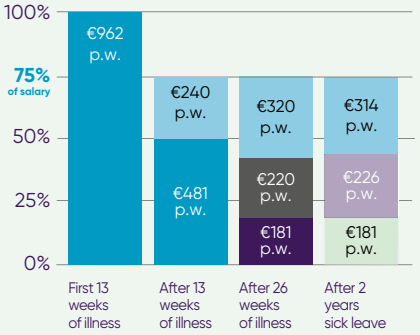

Plan Benefit | Sick Pay | Temporary Rehabilitation Remuneration | Ill Health Early Retirement Pension | State Illness Benefit | State Invalidity Pension

Disability Benefit

Deferred Period

After you are accepted as a member of the Plan, if you need to make a claim, the deferred period is the waiting period, before the Disability Benefit becomes payable. For the purposes of this Plan the waiting period is:

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

If you have been accepted with an excluded condition, any sick leave relating to that condition, will not be used in the calculation of the deferred period.

Definition of Salary

For those who pay their premiums by **deduction from salary**, salary is defined as:

(i) **For members of a Superannuation Scheme:** Gross basic annual salary plus the average of any allowances received in the preceding 3 years, which are taken into account for sick pay and/or for the purposes of that Superannuation Scheme, as confirmed by your employer, or

(ii) **For those who are not members of a Superannuation Scheme:** Gross basic annual salary plus the average of any allowances received in the preceding 3 years which would be taken into account for sick pay and for the purposes of a Superannuation Scheme had you been a member of a Superannuation Scheme, as confirmed by your employer.

If you pay your premiums through salary:

- The premium will be split under two headings on your payslip; one heading reflects the Disability Benefit portion of your premium and automatically receives income tax relief, the other heading reflects the premium for the remaining benefits and does not receive income tax relief. Your premiums will increase and decrease in line with your salary changes.
- You must ensure that the premiums deducted from your salary are correct and reflect your salary.

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

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

The lower of either the annual salary covered by your premiums or the actual annual salary you are earning as confirmed by your employer.

If you pay your premiums by direct debit:

- You can claim tax relief by including the eligible premiums you have paid by direct debit in the relevant year in your tax return using the Revenue Online System (my Account).

You should request an up-to-date Premium Statement from Cornmarket as Revenue may request to review this before issuing tax relief. Revenue requires documentation to be held for a minimum period of 6 years.

- Your premiums will reflect the last gross salary you notified us of, or the last gross salary that we estimated for you at the last Plan review.
- You may incur charges from your bank.

Depending on the type of claim being made, the salary will be established at different points in time, for example:

- Disability Benefit - the end of the relevant deferred period
- Specified Illness Benefit - on the date of diagnosis

Remember...
As this is an insurance policy, you must keep up your premium payments in order to stay on cover. Failure to pay premiums could result in your membership of the Plan lapsing. This means you will no longer be a member of the Plan and you will not be covered for any benefits. In the event that you wish to become a member of the Plan again, you would have to re-apply and your application would be medically underwritten. Your application may be accepted, postponed, declined or accepted with a medical condition(s) excluded.

Exclusions

There are general exclusions on Disability Benefit, in relation to illnesses or injuries resulting from:

- Wilfully self-inflicted injury
- Deliberate neglect of health by failure to seek or follow medical advice.

Excluded Condition(s)

When you apply to join the Plan, the Insurer may offer you cover with a medical condition(s) excluded that applies specifically to you. You cannot make a claim for excluded medical condition(s) applied specifically to you as no benefit will be payable for those excluded medical condition(s).

For example, if you inform the Insurer that you have a back problem on your application form, they may offer you membership of the Plan with a back exclusion. This means that you would never be able to claim for an illness or injury relating to your back.

If this happens, a form will be sent to you as part of the application process with the details of the exclusion(s) and you will have the opportunity to decide if you wish to accept the cover with the exclusion(s) or not.

If an exclusion(s) applies specifically to you, then sick leave used for the excluded medical condition(s) cannot be used for the calculation of the deferred period.

Disability Benefit

Limitations and Restrictions

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

Definition of Partial Disability
Following the payment of a disability claim, if you:

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

Disability Benefit will not be paid if you cannot work due to strike or unemployment.

The maximum benefit is €262,500 per year.

Any sick leave used before you are accepted as a Plan member will not be used in the calculation of the deferred period.

If your claim is admitted...

- The benefit you receive from the Insurer will be treated as income and as such is liable to income tax, PRSI, Universal Social Charge, etc. The Insurer will deduct any tax due from the Benefit made to the member, in the same way as an employer deducts tax from an employee.
- Provided you have not retired on grounds of ill health, a pension amount (Ill Health Early Retirement Pension) may not be deducted from your Disability Benefit for a maximum of 2 years. Any other income that you may be entitled to will still be deducted during this time (for example, half pay, Temporary Rehabilitation Remuneration, State Illness Benefit or Invalidity Pension). After 2 years, a pension amount will be deducted from the benefit regardless of whether or not you are in receipt of same. This is referred to as Notional Early Retirement Pension (NERP). See Page 27 for further details.

Disability Benefit will continue until:

- You recover,
- You resign, that is, you decide to leave your employment,
- You go back to work (Proportionate Benefit may continue to be paid if the return is at a reduced level due to partial disability),
- The Insurer decides that you are fit to return to work based on medical evidence*,
- You reside outside of the member states of the European Union for more than 13 weeks in any one year period subject to an overall limit of 39 weeks in total (unless agreed otherwise with the Insurer in advance),
- You retire (except if you are claiming from the Plan and retire on an Ill Health Early Retirement Pension),
- You reach age 66 **or**
- You die,

whichever is earliest.

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

Late Notification of Disability Benefit Claims

It is not often possible to retrospectively assess the validity of a claim in cases where a significant period of time (approximately 3 months) has passed since your sick leave commenced. For this reason, it is vital that you register your claim promptly in line with the guidelines given as a delay in notification may prejudice the Insurer's ability to properly assess the claim. In the event you notify your claim late, the Insurer may decline to assess your claim where they have been prejudiced by the delay. This will be decided on a case-by-case basis.

Early Intervention

Early Intervention is an exclusive service provided by Aviva to support members return to work following a period of absence.

Members of the Plan can avail of Early Intervention through Aviva which includes access to a network of both physical and mental health professionals, providing services such as dietetics, physiotherapy, counselling or psychotherapy. Aviva covers the cost for members to avail of these services.

To be eligible for Early Intervention you must:

- ✔ be a member of the University of Galway Income Protection Plan **and**
- ✔ be on paid or unpaid sick leave for a minimum period of 4 consecutive weeks **or** have previously used Early Intervention when on sick leave, and have since returned to work and continue to use Early Intervention **and**
- ✔ be, in the Insurer's opinion, likely to claim from the Plan.

How to use the service:

If 4 weeks of sick leave has passed, and you have not recovered enough to return to work, please contact us on **(01) 408 4018** as soon as possible.

We will then notify Aviva who will contact you directly to assess if Early Intervention is suitable for you. This is done on a case-by-case basis.

If you are suitable for Early Intervention, the Insurer will arrange the relevant services for you through their rehabilitation partners.

Four weeks absence is the ideal time to get in touch.
For more information contact us on **(01) 408 4018**

Early Intervention will be available to Plan members as long as the service is retained by Aviva.

Specified Illness Benefit

Full Specified Illness Benefit

If you are diagnosed with one of the illnesses listed below, this benefit will pay a once-off, tax-free lump sum of **33% of your annual salary** at the date of diagnosis. See page 10 for definition of salary.

Only one claim may be made on Full Specified Illness Benefit per member. If you make a Full Specified Illness Benefit claim, you will not be able to make a further Full or Partial Payment Specified Illness Benefit claim. You must meet the policy definition/ criteria of the illness to be eligible to claim (see Appendices from page 36-49).

Please note: The Full Specified Illnesses were introduced on the 1st February 2023. Only diagnoses that occur after this date are eligible to claim Full Specified Illness Benefit for these illnesses. If, prior to joining the Plan, you have suffered from one of the Full Specified Illnesses you will never be covered for that illness.

1. Alzheimer's Disease or Dementia
2. Aorta Graft Surgery
3. Aplastic Anaemia
4. Bacterial Meningitis
5. Balloon Valvuloplasty
6. Benign brain tumour
7. Benign spinal cord tumour
8. Blindness
9. Brain Injury due to anoxia or hypoxia
10. Cancer
11. Cardiac Arrest
12. Cardiomyopathy
13. Chronic Pancreatitis
14. Coma
15. Coronary artery by-pass grafts
16. Creutzfeldt-Jakob disease
17. Deafness
18. Devic's Disease
19. Encephalitis
20. Heart Attack
21. Heart valve replacement or repair
22. HIV
23. Intensive Care
24. Kidney Failure
25. Liver Failure
26. Loss of Hand or Foot
27. Loss of Independent Existence
28. Loss of Speech
29. Major Organ Transplant
30. Motor Neurone Disease
31. Multiple Sclerosis
32. Multiple System Atrophy
33. Necrotising fasciitis
34. Open heart surgery
35. Paralysis of Limb
36. Parkinson's Disease
37. Parkinson's plus syndromes
38. Peripheral Vascular Disease
39. Primary Pulmonary Hypertension
40. Primary Sclerosing Cholangitis
41. Progressive Supra-Nuclear Palsy
42. Pulmonary Artery Replacement
43. Severe Crohn's Disease
44. Severe Lung Disease
45. Short Bowel Syndrome
46. Spinal Stroke
47. Stroke
48. Systemic Lupus Erythematosus
49. Terminal illness
50. Third degree Burns
51. Total Pneumonectomy
52. Traumatic head Injury

Specified Illness Benefit

Partial Payment Specified Illness Benefit

If you are diagnosed with one of the illnesses listed on page 17, this benefit will pay a once-off, tax-free lump sum of the lesser of **€15,000 or 16.5% of your annual salary** at the date of diagnosis. See page 10 for definition of salary.

Only one claim may be made on Partial Payment Specified Illness Benefit per member. If you make a Partial Payment Specified Illness Benefit claim, you will still be able to make a Full Specified Illness Benefit claim.

You must meet the policy definition/criteria of the illness to be eligible to claim (see Appendices from page 36-49).

Please note: The Specified Illnesses covered under the Partial Payment Specified Illness Benefit on page 17 were introduced on the 1st February 2023. If, prior to joining the Plan, you have suffered from one of the Partial Payment Specified Illnesses you will never be covered for that illness.

1. Angioplasty- Single Vessel
2. Angioplasty - Two or more Vessels
3. Aortic Aneurysm
4. Carcinoma in Situ of the breast
5. Carcinoma in situ of the oesophagus
6. Carcinoma in Situ of the urinary bladder
7. Carotid Artery Stenosis
8. Central retinal artery occlusion or Central retinal vein occlusion
9. Cerebral abscess
10. Cerebral aneurysm
11. Cerebral arteriovenous malformation
12. Crohn's disease
13. Cystectomy
14. Early stage thyroid cancer
15. Gastrointestinal Stromal Tumour (GIST) of low or malignant potential
16. Implantable Cardioverter Defibrillator for Primary Prevention of sudden cardiac arrest
17. Less advanced cancer of the anus
18. Less advanced cancer of the appendix, colon or rectum
19. Less advanced cancer of the bile ducts
20. Less advanced cancer of the cervix
21. Less advanced cancer of the gallbladder
22. Less advanced cancer of the larynx
23. Less advanced cancer of the lung and bronchus
24. Less advanced cancer of the oral cavity or oropharynx
25. Less advanced cancer of the ovary
26. Less advanced cancer of the pancreas
27. Less advanced cancer of the renal pelvis and ureter
28. Less advanced cancer of the stomach
29. Less advanced cancer of the testicle
30. Less advanced cancer of the thymus
31. Less advanced cancer of the uterus
32. Less advanced cancer of the vagina
33. Less advanced cancer of the vulva
34. Liver resection
35. Low-grade prostate cancer
36. Neuroendocrine Tumour (NET) of low or malignant potential†
37. Peripheral vascular disease
38. Pituitary tumour
39. Serious Accident Cover
40. Significant Visual Impairment
41. Single Lobectomy
42. Surgical removal of one eye
43. Syringomyelia or Syringobulbia
44. Third degree burns
45. Ulcerative Colitis

Exclusions

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

a) In the opinion of the Insurer, the diagnosis arises directly or indirectly as a result of:
   - any form of war/conflict **or**
   - taking alcohol or drugs (other than under the direction of a registered medical practitioner) **or**
   - self-harm **or**
   - the deliberate neglect of health by failure to seek or follow medical advice **or**
   - Engaging in any hazardous activity or sports, including but not limited to the following: scuba-diving, climbing or mountaineering, potholing, motor racing, motorcycle racing, horse racing, any other form of racing other than on foot **or**
   - Flying, except as a fare paying passenger.

b) You are residing outside of the European Union, Western Europe (Andorra, Channel Islands, Gibraltar, Iceland, Isle of Man, Liechtenstein, Monaco, Norway, San Marino, Switzerland and the United Kingdom) and/or Australia and/or Canada and/or Hong Kong and/or New Zealand and/or Singapore and/or South Africa and/or United Arab Emirates and/or United States of America for more than 13 weeks in the 12 consecutive calendar months immediately preceding a claim, unless you have been on Career Break, prior agreement was received from the Insurer and the relevant premium was paid.

c) Prior to your Specified Illness Benefit cover commencing you were diagnosed with a condition related to one of the Specified Illnesses and you contract that particular illness within 2 years of joining the Plan.

   For example, a claim will not be paid for a heart attack within the first 2 years of joining, if prior to joining you were diagnosed with Diabetes. This is due to the recognised link between Diabetes and a heart attack. However, a diabetic who is first diagnosed with a heart attack 3 years after joining the Plan will be eligible to claim.

d) If you are shown to be carrying, or to have been carrying, a human immunodeficiency virus (H.I.V.) or antibodies to such a virus except where the virus has been contracted in the conditions set out in Specified Illness Appendices.

e) You suffered from one of the Specified Illnesses before your cover commenced, you will never be covered for that illness and cannot claim for that illness or a related Specified Illness.

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

Limitations and Restrictions

- Full Specified Illness Benefit became a benefit of the Plan on 1st February 2023. You can only claim for diagnoses that occur after this date.
- Partial Payment Specified Illness Benefit became a benefit of the Plan on 1st February 2023. Therefore, you can only claim for diagnoses that occur after this date.
- If you make a Full Specified Illness claim, you will not be able to make a further Full or Partial Payment Specified Illness claim.
- If you make a Partial Payment Specified Illness claim, you will still be able to make a Full Specified Illness claim.
- If you are diagnosed with one of the Full Specified Illnesses within 30 days of diagnosis of a Partial Payment Specified Illness, a claim will only be assessed by the Insurer on the Full Specified Illness and the Partial Payment Specified Illness Benefit will not be paid.
- A Specified Illness claim will only be paid if the diagnosis/severity meets the specific definition/criteria outlined for that illness in the Appendices on pages 36-49.
- You will not be able to make a Specified Illness claim for an illness that:
  - you suffered from prior to joining the Plan.
  - relates to a condition which you were already suffering from at the time of your application and/or where you were under medical investigation for this, regardless of whether you were aware of the condition at that time.
  - relates to a condition which you were already diagnosed with before the date that Specified Illness was introduced to the Plan.

This benefit ceases at age 66.

Notification of Specified Illness Claims

You should make a Specified Illness Claim within 3 months of having surgery or being diagnosed, as a delay in notification may prejudice the Insurer's ability to properly assess the claim. In the event you notify your claim late, the Insurer may decline to assess your claim where they have been prejudiced by the delay.

- There is a waiting (deferred) period for some Specified Illnesses.
- There is a survival period for some Specified Illnesses. You must survive for a minimum period after the date of diagnosis or surgery took place, before a payment can be made. In the event of death within this period no Specified Illness benefit is payable. The relevant periods are:
  (a) 6 months for Parkinson's disease, Dementia (including Alzheimer's disease) and loss of sight.
  (b) 12 months for loss of speech and loss of hearing.
  (c) 14 days for all other specified illnesses.

Please see Appendices on pages 36-49 for more details.

3. Cost

The total Plan premium is **0.85% of gross salary**. This includes the 1% insurance levy.

The breakdown of this premium is:

Disability Benefit	0.78%
Specified Illness Benefit*	0.07%
Total	**0.85%**

*The 0.07% Specified Illness Benefit cost will be collected from a separate deduction box on your payslip.

Warning: The current premium may increase after the next Plan review which should take place on or after 1st February 2028.

Income tax relief

The portion of your premium that is paid towards Disability Benefit is eligible for income tax relief.

If you are paying income tax at 20% your net premium rate will be 0.69%.

If you are paying income tax at 40% your net premium rate will be 0.54%.

The rate at which income tax relief is applied may depend on your individual tax circumstances.

Here are some examples of the cost per week for various salary amounts taking income tax relief into account:

Income	Gross cost	Net cost at 20% income tax	Net cost at 40% income tax
€35,000	€5.70	€4.66	n/a
€45,000	€7.33	€5.98	€4.64
€55,000	€8.96	n/a	€5.67
€65,000	€10.59	n/a	€6.70

Best Doctors Second Medical Opinion*

If you've been diagnosed with a serious illness, you'll have questions.

Best Doctors Second Medical Opinion service is now part of your Plan.

This service provides you with access to over 50,000 of the world's top physicians.

The service is available to:

- You **and**
- Your children up to age 18 (or 23 if in full-time education) **and**
- Your Spouse/Partner **and**
- Your parents and your Spouse/Partner's parents.

There are no additional costs for this benefit.

To find out more visit **aviva.ie/protection/best-doctors-second-medical-opinion****

If you wish to avail of this service call **1800 882 342**

*Best Doctors is an independent company, Cornmarket and Aviva will not be responsible for any actions taken or not taken as a consequence of recommendations made by Best Doctors.
**Cornmarket cannot be held responsible for information contained on external websites.

Best Doctors is not a regulated financial service.

Aviva Life & Pensions Ireland DAC does not guarantee the on-going availability of the Best Doctors service to members and may, at its sole discretion, withdraw access to the service at a month's notice.

Aviva Family Care Mental Health Support*

When life brings new and unexpected changes, it's normal to feel anxious, stressed or down.

Whatever your challenge, you're not alone. Aviva Family Care gives members and their family access to a wide variety of specialised forms of therapy, including counselling and Cognitive Behavioural Therapy.

The service is available to:

- You **and**
- Your children up to age 18 (or 23 if in full-time education) **and**
- Your Spouse/Partner.

The confidential phone line is available any time day or night, 7 days a week.

To find out more visit **aviva.ie/protection/family-care****

If you wish to avail of this service call **1800 816 560**

*Teladoc Health (who provide Aviva Family Care Benefit) is not a regulated financial service.
**Cornmarket cannot be held responsible for information contained on external websites.

Aviva Life & Pensions Ireland DAC does not guarantee the on-going availability of the Aviva Family Care Benefit (Mental Health Support) to members and may, at its sole discretion, withdraw access to the service at a month's notice.

4. Claims

Roles

Cornmarket's role

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

Our contact details for making a claim are:

- Phone: **(01) 408 4018**
  In the interest of Customer Service we may record and monitor calls.
- Email: **spsclaims@cornmarket.ie**
- Post: **SPS Claims Department, Cornmarket Group Financial Services Ltd, Christchurch Square, Dublin 8**.

The Insurer's role

The Insurer's role is to medically assess claims and decide whether claims should be paid. If they decide that a claim should be paid, they will calculate and pay the benefit directly to the claimant.

Disability and Specified Illness Benefit Claims

How to make a Disability or Specified Illness Benefit claim?

Disability Benefit

Contact us as soon as you start your sick leave because:

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

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

It is not often possible to retrospectively assess the validity of a claim where a significant period of time (approximately 3 months) has elapsed since your salary reduced or ceased. See Late Notification of Disability Benefit Claims on page 13.

Specified Illness Benefit

Contact us as soon as possible, as it may take a number of weeks to process the claim. If the Insurer cannot assess the claim due to unavailability of supporting medical evidence the Insurer can decline the claim. See Notification of Specified Illness Benefit Claims on page 19.

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

You can nominate someone to contact us on your behalf and to assist you with your claim, for example, your spouse, next of kin etc. If you wish to do this, please send us a letter, signed and dated by you, outlining the name, address, and date of birth of your nominated person. Please be aware that if you nominate someone to act in this capacity, they will have access to the information related to your claim such as your medical, salary and financial details. However, they will not have the authority to make any changes, for example, to cancel your membership of the Plan.

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

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

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

Are all Disability and Specified Illness Benefit claims medically assessed?

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

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

1. provide medical evidence from your doctor (your doctor may charge you for this) **and**/**or**
2. provide medical evidence from your specialist **and**/**or**
3. attend an Independent Medical Examination (IME). It generally takes about 3 weeks for the IME report to be returned to the Insurer.

Items 1-3 are at the Insurer's expense and reasonable travel expenses will be covered, if travel is necessary.

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

What happens after my Disability Benefit claim is assessed?

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

What will happen if my Disability Benefit claim is admitted and I have completed the relevant deferred period?

- The Insurer will arrange for benefit to be paid to your bank account. Disability Benefit will be paid in arrears and may be paid on a monthly basis. Therefore, it may take up to four weeks after your claim is admitted for you to receive your first benefit. If your claim is admitted after you have been reduced to half-pay or your pay has ceased altogether, the benefit may be backdated to the date your salary was first affected.
- As Disability Benefit is subject to income tax, you can request the Revenue Commissioners to issue a Revenue Payroll Notification (RPN) to the Insurer. This will enable the Insurer to apply the correct tax rate for future benefits. However, the first benefit may have emergency tax rates applied. Any overpayment or underpayment of tax may be subsequently rectified.
- To ensure you continue to meet the definition of disablement, the Insurer may seek completed continuation forms, certificates of continued disablement, medical certificates from your doctor, and/or require you to attend an independent medical examination and/or organise for a Health Claims Advisor to visit you.
- If you fail to follow medical advice, the Insurer may cease paying you benefits.
- You will not be expected to pay premiums towards the Plan while claiming. However, if your benefit stops for some reason other than reaching the ceasing date of that benefit, you will be expected to start paying premiums again in order to maintain your cover.
- If the ceasing age changes after your Disability Benefit claim went into payment, the revised ceasing age will not apply to you. However, if you return to work and your Disability Benefit stops, and you subsequently

submit a new Disability Benefit claim which is admitted, the ceasing age applicable will be the ceasing age for the benefits at that time.

- While claiming Disability Benefit, any Specified Illness Benefit that you have as a Plan member remains in force until the ceasing date of those benefits. In the event that you will need to claim from these, the benefits will be based on the salary you were earning at the time your Disability Benefit commenced.
- The Disability Benefit paid to you by the Plan increases by 5% each year, or the rate of increase in the Consumer Price Index if lower.

What will happen if my Disability Benefit claim is declined?

- If your claim is declined, the Insurer will inform you of the reasons for the decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must submit the appeal within 3 months of the decline decision being made. The review of their decision may require you to attend further Independent Medical Examinations.
- If you do not appeal your premiums must continue or restart in order for you to remain a member of the Plan.
- If your appeal with the Insurer is unsuccessful, you can log a complaint with the insurer. If you are dissatisfied with the outcome of your complaint, you may bring your case to the Financial Services and Pensions Ombudsman Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2 or log onto www.fspo.ie.

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

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

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

If a member retires subsequently and an IHERP is paid, any over-payment of benefit since the effective date of early retirement, will need to be repaid to the Insurer.

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

If you are unable to work due to illness or injury and your contract ends before the expiry date of the deferred period, your claim will be considered subject to the usual medical evidence requirement. For example, if a member suffers an illness with 2 months remaining on their contract, and remains unable to work due to illness or injury to the end of the deferred period, their claim will be considered in the normal manner.

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

Please inform our Claims team immediately if you are in receipt of or have applied for an injury at work payment through your employer as your premium payments may stop which will affect your Plan membership.

If as a result of your workplace injury, you are entitled to an additional payment from your employer, it may mean that your income remains higher than 75% of your salary. If your income exceeds the Plan's maximum benefit level, no Disability Benefit is payable under the Plan however the Insurer needs to be aware of your case so they can manage any potential claim. See Late Notification of Disability Benefit Claims on page 13.

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

If you return to your normal occupation at your normal hours, or to full salary (for example, you take annual leave), you must inform us at the earliest opportunity and ensure that premiums restart in order for you to remain a member of the Plan.

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

If you return to work but have to stop working again due to the same illness or injury within a period of 6 calendar months from the date of your return, you will not be expected to complete the deferred period again. This is referred to as a 'linked claim'.

What happens after my Specified Illness Benefit claim is assessed?

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

Settled

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

Declined

- If your claim is declined, the Insurer will inform you of the reasons for that decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must submit the appeal within 3 months of the decline decision being made. The review of their decision may require you to attend further Independent Medical Examinations.

- If your appeal with the Insurer is unsuccessful, you can log a complaint with the Insurer. If you are dissatisfied with the outcome of your complaint, you may bring your case to the Financial Services and Pensions Ombudsman Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2 or log onto www.fspo.ie.

What is the Tax Return Service for Disability Benefit claimants?

Cornmarket's Tax Return Service is available to claimants who are in receipt of Disability Benefit for a continuous period of 3 months or more. Only claimants who submitted their claim after 1st February 2023 are eligible to avail of this service.

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

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

Cornmarket Group Financial Services Ltd. is a member of the Irish Life Group Ltd. which is part of the Great-West Lifeco Group of companies. Cornmarket's Tax Return Service is not a regulated financial product. Telephone calls may be recorded for quality control and training.

5. Frequently Asked Questions

How can I apply to join the Plan?

All employees who meet the eligibility requirements are automatically accepted into the Plan.

If you **do not** wish to enter into the Plan, you can opt out by completing an Opt-out Form. You can request this form from the University of Galway Pensions Department at **pensions@universityofgalway.ie**.

However, if you opt out of the Plan you will not be automatically reaccepted (including at the start of a new contract of employment). If you wish to re-join the Plan you will have to apply to join by completing an application form which may be subject to full medical underwriting.

The Insurer may underwrite (medically assess) your application. This process may include providing medical information to a nurse over the telephone or attending a medical examination at the Insurer's expense. Following the underwriting period, the Insurer may accept your application, postpone your application, decline your application or offer you membership of the Plan with certain specified conditions excluded from cover.

During the application process it is important that you answer all the questions the Insurer asked in the application form and any subsequent questions fully, honestly, accurately and with reasonable care.

If you do not the Insurer may:

- cancel your membership & benefits from the start with/without a return of premium,
- refuse a claim with/without a return of premium,
- reduce the amount of any claim,
- reduce the amount of cover **and/or**
- change the terms of your membership from the date you were accepted into the Plan

You may find it difficult to purchase another Income Protection product.

What happens if my application is accepted?

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

- You will be sent a formal acceptance letter.
- If you are automatically accepted into the Plan upon commencement of employment, you will have **three months** after the date cover commences to opt-out of your membership of the Plan and receive a full refund of any premiums paid.
- If you apply to re-join the Plan, you will have **30 days** after the date the acceptance letter is sent to you to cancel your membership of the Plan and receive a full refund of any premiums paid.
- Premiums should start as soon as possible after you are accepted as a member.

What happens if my application is not accepted?

If your application is postponed, declined or if you are offered

acceptance with certain specified conditions excluded you may request details for the reasons for the decision to be sent from the Insurer to your own doctor and you may appeal the decision.

What if I have unearned income?

In general, investment and rental income will not be considered when making a claim under the Plan.

What if I plan to take a career break or unpaid leave?

If you plan to take a career break or unpaid leave please notify us in advance of the start date and contact us to discuss the options that may be available to you by calling **(01) 408 4195** or emailing **spsadmin@cornmarket.ie**.

If you wish to avail of the career break options, please apply prior to your career break start date. You must apply no later than **4 months** after the start date of your career break. Otherwise your membership of the Plan will cease. You must remain an employee of the University of Galway for the duration of your career break.

If you wish to avail of the unpaid leave options you must notify us at least **4 weeks** in advance of the start date of your unpaid leave.

What if I have a change in employment?

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

- Acquire a second job
- Go on secondment
- Avail of the Shorter Working Year Scheme
- Change role/job
- Change terms of employment
- Start job sharing/work sharing (this means working 50% or less of the normal working week).

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

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

What if I have another Salary Protection/Income Protection/Income Continuance Plan?

You may be over-insured as you cannot receive a benefit of more than 75% of your salary. In other words, you cannot receive benefit from both this plan and another similar plan. If you are in this situation, please contact us to arrange an appointment with one of our Consultants.

When does my cover under the Plan cease?

Cover ceases:

- On your 66th birthday **or**
- If you retire (other than on grounds of ill health) **or**
- If you resign **or**
- If you no longer fulfil the eligibility requirements **or**
- If you are no longer employed by the University of Galway **or**
- If your premiums cease **or**
- If you become unemployed **or**
- If you die.

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

Can I cancel my membership of the Plan?

Yes. You may cancel your membership of the Plan at any time by clearly instructing us to do so in writing. Please ensure your name, address and date of birth are included on the cancellation instruction. If you cancel within **three months** of cover commencing (if you were automatically entered into the Plan) or if you cancel within **30 days** of the acceptance letter being sent to you, we will cancel your membership of the Plan and refund you any premiums you have paid.

If you pay by salary deduction, the payment cycle operated between us and your employer only allows for changes on certain dates. It may therefore take between four and eight weeks for the cancellation instruction to take effect. Any deductions taken from your salary following your cancellation request to us will be refunded to you approximately four to six weeks after the deduction from your salary.

If you cancel your membership of the Plan, and then wish to become a member again, you will have to re-apply for membership and may need to provide information about the state of your health. If your health deteriorated between the time you cancelled your membership of the Plan and re-applied, you may not be accepted as a member again or you may be accepted with a medical condition(s) excluded.

What happens if I cease to be an employee of the University of Galway?

If you leave the University of Galway you must inform us. We will then cancel your membership of the Plan.

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

As with other insurance such as car insurance, your premiums meet the cost of your cover. If you do not have a claim admitted, you will not receive a benefit from the Plan.

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

What commission does Cornmarket receive from the Insurer?

Initial charge	€150
Premium Deduction Charge	2.5%
Renewal charge paid by the Insurer to Cornmarket	12.5%

What if I travel abroad?

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

Your cover under the Plan will not be affected if you travel briefly for normal holiday purposes. However, if you decide to reside or work abroad we must be contacted immediately. In such circumstances, the Insurer may decide to vary your premium and benefits accordingly or cease your membership of the Plan.

If you are in receipt of Disability Benefit from the Plan, the Insurer will pay this benefit to you if you are living anywhere

in the world for a maximum of 13 weeks in any one year period subject to an overall limit of 39 weeks. The Insurer reserves the right to request that claimants come back to Ireland for an Independent Medical Examination during this period. If during this period you are required to attend a medical assessment you must return to Ireland for it, the expense of which must be agreed between you and the Insurer in advance. Only reasonable expenses will be covered by the Insurer.

After this time, you must return to live within the member states of the European Union. If you do not comply with this condition your benefit will be ceased. In exceptional cases where a beneficiary is forced to live abroad, the Insurer will consider this on a case-by-case basis.

Are all claims paid?

Most claims are paid.

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

- Medical opinion is that the member is not disabled from carrying out their normal occupation.
- When applying to join the Plan, the member did not answer all the questions that were asked during the application process fully, honestly, accurately and with reasonable care. This is called non-disclosure/ misrepresentation. In addition to being the reason for a claim not being paid, non-disclosure may also result in membership of the Plan being cancelled. If this occurs, premiums may not be refunded.
- A disability claim is notified late, for example, outside of the timelines noted on page 13 and 19 and this has prejudiced the Insurer's ability to properly assess the claim.
- The illness or injury is a result of one of the general exclusions that exist on the Plan.
- The member attempts to claim for an illness or injury for which they received a specific exclusion.

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

Please write to: **Compliance Department, Cornmarket Group Financial Services Ltd, Christchurch Square, Dublin 8**.

or

Email: **complaints@cornmarket.ie**

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

6. General Plan Information

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

Decisions taken by the Plan owner will be binding on all members.

The Plan owner is the University of Galway.

The next Plan review is due on or after 1st February 2028.

The current Plan broker is Cornmarket Group Financial Services Ltd.

The current Plan Insurer is Aviva Life & Pensions Ireland DAC (Aviva).

The current Plan policy numbers are 727385 & 727389.

7. Specified Illnesses Appendices

Explanation of each specified illness we make a full payment on and its pre-existing conditions

APPENDIX A:

Full Payment Specified Illnesses

The Full Payment Specified Illnesses covered under this Policy, for the purposes of these Conditions, are defined below. No benefit will be payable in respect of any other condition or event, whether regarded as serious or not.

The text in italics immediately after the Specified Illness definitions is for further explanation only and does not form part of the definitions. In the event of any conflict between text in italics and the corresponding definition, the definition will apply.

1. Alzheimer's Disease or Dementia - *resulting in permanent symptoms*

A definite diagnosis of Alzheimer's disease or Dementia by a Consultant Neurologist, Psychiatrist or Geriatrician.

There must be permanent clinical loss of the ability to do all of the following:

- Remember;
- Reason;
- Perceive;
- Understand;
- Express and give effect to ideas.

For the above definition, the following are not covered:

- Dementia secondary to alcohol or drug abuse.

2. Aorta Graft Surgery - *for disease*

The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, none of the following are covered:

- Any other surgical procedure, for example the insertion of stents or endovascular repair;
- Surgery following traumatic injury to the aorta

3. Aplastic Anaemia - *of specified severity*

Confirmation by a Consultant Haematologist of a definite diagnosis of complete 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.

4. Bacterial Meningitis - *resulting in permanent symptoms*

Bacterial Meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be confirmed by a Consultant Neurologist. All other forms of meningitis including viral meningitis are not covered. A claim may be made if a consultant neurologist diagnoses meningitis caused by a bacterial infection which results in brain damage causing permanent functional impairment.

5. Balloon Valvuloplasty

The undergoing of balloon valvuloplasty on the advice of a Consultant Cardiologist in order to treat diseased heart valves.

6. Benign brain tumour - *of specified severity*

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

- permanent neurological deficit with persisting clinical symptoms, or
- removal of the tumour by craniotomy or treatment by stereotactic radiosurgery.

For the above definition, the following are not covered:

- Tumours in the pituitary gland;
- Angiomas.

7. Benign spinal cord tumour

A non-malignant tumour in the spinal canal or spinal cord, resulting in either of the following:

- permanent neurological deficit with persisting clinical symptoms, or
- invasive surgery to remove the tumour.

For the above definition, the following are not covered:

- radiotherapy for any tumour.

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. Brain Injury due to anoxia or hypoxia

Death of brain tissue due to reduced oxygen supply (anoxia or hypoxia) resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be made by a Consultant Neurologist or Neurosurgeon.

For the above definition the following are not covered:

- children under the age of 90 days
- symptoms secondary to alcohol or drug abuse.

10. 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, sarcoma, lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

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

11. Cardiac Arrest - *with insertion of a defibrillator*

Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- Implantable cardioverter-defibrillator (ICD), or
- Cardiac resynchronisation therapy with defibrillator (CRT-D).

For the above definition the following are not covered:

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

12. Cardiomyopathy - *of specified severity*

A definite diagnosis by a consultant cardiologist of primary cardiomyopathy. The disease must result in at least one of the following:

- Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months by an MRI scan
- Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months
- Implantation of a Cardioverter Defibrillator (ICD) on the specific advice of a cardiologist for the prevention of sudden cardiac arrest

The following are not covered:

- Any secondary cardiomyopathy

- All other forms of heart disease, heart enlargement and myocarditis

13. Chronic Pancreatitis

A definite diagnosis of Chronic Pancreatitis by a Consultant Gastroenterologist. The diagnosis must be evidenced by the following:

- calcification of the pancreas
- malabsorption due to failure of secretion of pancreatic enzymes
- chronic inflammation of the pancreas as shown by Endoscopic Retrograde Cholangiopancreatography (ERCP) or Magnetic Resonance Cholangiopancreatography (MRCP)
- pancreatic duct dilatation, beading and stricture.

For the above definition the following is not covered:

- chronic pancreatitis secondary to alcohol abuse
- acute pancreatitis.

14. 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 are not covered:

- Coma secondary to alcohol or drug abuse.

15. Coronary artery by-pass grafts - *with surgery to divide the breastbone*

The undergoing of 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 bypass grafts.

16. Creutzfeldt-Jakob disease - *resulting in permanent symptoms*

Confirmation by a Consultant Neurologist of a definite diagnosis of Creutzfeldt-Jakob disease resulting in permanent neurological deficit with persisting clinical symptoms.

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. 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.

19. Encephalitis - *resulting in permanent symptoms*

A definite diagnosis of Encephalitis by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms. Encephalitis in the presence of HIV infection is excluded.

20. 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> 1.0 ng/ml;
  - AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

21. Heart valve replacement or repair

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

22. HIV Infection *caught from a blood transfusion, a physical assault or at work in an eligible occupation*

Infection by Human Immunodeficiency Virus resulting from any of the following:

- A blood transfusion given as part of medical treatment;
- A physical assault;
- 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 caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident;
  - There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.

The eligible occupations for HIV caught at work are:

- The emergency services - Gardai, fire, ambulance;
- The medical profession - including administrators, cleaners, dentists, doctors, nurses and porters;
- The defence forces - Irish army, naval service, and air corps.

For the above definition, the following is not covered:

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

23. Intensive Care - *requiring mechanical ventilation for 10 days*

Any sickness or injury requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) in an authorised unit of an acute care hospital.

For the above definition, the following is not covered:

- sickness or injury as a result of drug or alcohol intake or other self-inflicted means.

24. Kidney Failure - *requiring dialysis*

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

25. Liver Failure - *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;
- encephalopathy.

For the above definition, the following is not covered:

- Liver disease secondary to alcohol or drug abuse.

26. Loss of Hand or Foot - *permanent physical severance*

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

27. Loss of Independent Existence – *permanent and irreversible*

Permanent and irreversible loss of the ability to function independently which is defined as follows: Being permanently unable to fulfil at least three of the following activities unassisted by another person:

- The ability to walk 100 metres on the flat;
- the ability to get in & out of a standard motor vehicle;
- the ability to put on, take off, secure & unfasten all necessary garments, and any braces, artificial limbs or other surgical appliances;
- the ability to wash in the bath or shower (including getting into and out of the bath & shower) such that an adequate level of personal hygiene can be maintained;
- the ability to climb a flight of 12 stairs without the assistance of special aids;
- the ability to manage bowel & bladder functions such that an adequate level of personal hygiene can be maintained.

OR, suffering from severe & permanent intellectual impairment which must:

- Result from organic disease or trauma, and

- be measured by the use of recognised standardised tests, and
- have deteriorated to the extent that requires the need for continual supervision & assistance of another person throughout the day.

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

In making its assessment of any claim, Aviva will consider evidence from all the claimant's treating consultants, the treatment options available, and the likelihood of recovery. In addition, Aviva may require an Independent Medical Assessment by a Consultant or other health professional. The diagnosis must be confirmed to the satisfaction of our Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.

28. Loss of Speech - *permanent and irreversible*

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

29. Major Organ Transplant

The undergoing as a recipient of a transplant from another donor, of bone marrow or of a complete heart, kidney liver, lung, or pancreas, or a lobe of liver, or a lobe of lung, or inclusion onto the official programme waiting list of a major Irish or UK hospital for such a procedure.

For the above definition, the following is not covered:

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

30. 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.

31. 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.

32. Multiple System Atrophy

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

- bladder control with postural hypotension, AND any 2 of the following:
  - Rigidity;
  - Cerebellar ataxia;
  - Peripheral neuropathy.

33. Necrotising fasciitis

A definite diagnosis of life-threatening necrotising fasciitis or gas gangrene by a Consultant Physician, requiring immediate surgery to remove necrotic tissue and intravenous antibiotic treatment to prevent imminent death.

For the above definition, the following is not covered:

- all other forms of gangrene or cellulitis

34. Open Heart Surgery- *with surgery to divide the breastbone*

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

35. Paralysis of Limb - *total and irreversible*

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

36. Parkinson's Disease - *resulting in permanent symptoms*

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

For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse;
- Other Parkinsonian syndromes.

37. Parkinson's plus syndromes

A definite diagnosis by a Consultant Neurologist of one of the following Parkinson Plus syndromes:

- multiple system atrophy
- progressive supranuclear palsy Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- corticobasal ganglionic degeneration
- diffuse Lewy body disease.

There must be also permanent clinical impairment of at least one of the following:

- motor function
- eye movement disorder
- postural instability; or
- dementia

38. Peripheral Vascular Disease - *with surgery*

A definite diagnosis of peripheral vascular disease with objective evidence from ultrasound of obstruction in the arteries which results in by-pass graft surgery to the arteries of the legs.

For this definition, the following is not covered:

- Angioplasty

39. Primary Pulmonary Hypertension - *of specified severity*

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

40. Primary Sclerosing Cholangitis - *of specified severity*

A definite diagnosis of Primary Sclerosing Cholangitis as evidenced by imaging confirmation of typical multifocal structuring and dilation of intrahepatic and/or extrahepatic bile ducts.

For the above definition, the following are not covered:

- All other causes of bile duct structuring and dilation;
- Primary Sclerosing Cholangitis secondary to liver disease which is associated with alcohol.

41. Progressive Supra-Nuclear Palsy - *resulting in permanent symptoms*

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

42. Pulmonary Artery Replacement - *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.

43. Severe Crohn's Disease - *with persisting symptoms that have not responded to surgical intestinal resection*

A definite diagnosis by a consultant gastroenterologist of Crohn's Disease with fistula formation and intestinal strictures. There must have been **two or more bowel segment resections** 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.

44. Severe 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.

45. Short Bowel Syndrome - *requiring permanent total parenteral nutrition*

A definite diagnosis by a Consultant Gastroenterologist, of short bowel syndrome, resulting from massive loss of the small intestine, and requiring total parenteral nutrition on a permanent basis.

46. Spinal Stroke

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in permanent neurological deficit with persisting clinical symptoms.

47. 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.

48. Systemic Lupus Erythematosus - *with severe complications*

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
- The permanent impairment of kidney function tests as follows; o Glomerular Filtration Rate (GFR) below 30 ml/min.

49. Terminal illness

A definite diagnosis by the attending Consultant of an illness that satisfies both of the following:

- The illness either has no known cure or has progressed to the point where it cannot be cured;
- In the opinion of the attending Consultant, the illness is expected to lead to death within 12 months.

50. Third degree Burns - *covering 20% of the body's surface area*

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

51. Total Pneumonectomy

The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung for any physical injury or disease.

52. Traumatic head Injury - *resulting in permanent symptoms*

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

APPENDIX B:

Partial Payment Specified Illnesses

The Partial Payment Specified Illnesses covered under this Policy, for the purposes of these Conditions, are defined below. No benefit will be payable in respect of any other condition or event, whether regarded as serious or not.

The text in italics immediately after the Specified Illness definitions is for further explanation only and does not form part of the definitions. In the event of any conflict between text in italics and the corresponding definition, the definition will apply.

1. Angioplasty - Single Vessel - *for coronary artery disease of specified severity*

The undergoing, to treat severe coronary artery disease, of any of the following:

- Atherectomy;
- Balloon Angioplasty;
- Rotablation;
- Laser treatment;
- Insertion of stents to treat the narrowing or blockage **in one Main Coronary Artery**.

This procedure must have been carried out on the advice of a Consultant Cardiologist. The intervention must be to treat at least 70% diameter narrowing in the vessel and must be carried out as a single procedure.

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

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

2. Angioplasty - Two or more Vessels - *for coronary artery disease of specified severity*

The undergoing, to treat severe coronary artery disease, of any of the following:

- Atherectomy;
- Balloon Angioplasty;
- Rotablation;
- Laser treatment;
- Insertion of stents to treat the narrowing or blockage **in two or more Main Coronary Arteries**.

This procedure must have been carried out on the advice of a Consultant Cardiologist. The intervention must be to treat at least 70% diameter narrowing in each vessel and must be carried out as a single procedure.

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

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

Two or more procedures in the same artery or procedures to any of the branches of the above arteries are specifically excluded.

3. Aortic Aneurysm - *with endovascular repair*

The undergoing of endovascular repair of an aneurysm of the thoracic or abdominal aorta with a graft.

For the above definition, the following are not covered:

- Procedures to any branches of the thoracic or abdominal aorta.

4. Carcinoma in situ of the breast - *with surgery to remove the tumour*

Breast cancer in situ positively diagnosed with histological confirmation by biopsy together with the undergoing of surgery to remove the tumour.

5. Carcinoma in situ of the oesophagus - *with surgery to remove the tumour*

Cancer of the oesophagus in situ positively diagnosed with histological confirmation by biopsy together with undergoing of surgery to remove the tumour.

For the above definition the following is not covered:

- Treatment by any other method;
- Treatment for Barrett's Oesophagus.

6. Carcinoma in situ of the urinary bladder - *requiring surgical removal*

Carcinoma in situ of the urinary bladder positively diagnosed with histological confirmation by biopsy which is treated by complete removal of the bladder

For the above definition, the following is not covered:

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

7. Carotid Artery Stenosis – *treated by endarterectomy or angioplasty*

The undergoing of endarterectomy or therapeutic angioplasty procedure with or without a stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery.

Angiographic evidence will be required.

8. Central retinal artery occlusion or Central retinal vein occlusion - resulting in permanent visual impairment

Death of the optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in permanent visual impairment of the affected eye.

For the above definition, the following are not covered:

- branch retinal artery or vein occlusion or haemorrhage
- traumatic injury to tissue of the optic nerve or retina.

9. Cerebral abscess - *requiring surgery*

The removal or drainage of a cerebral abscess through the undergoing of a craniotomy or burr hole (surgical opening of the skull) by a Consultant Neurosurgeon. There must be evidence of a cerebral abscess on CT or MRI imaging.

For the above definition, the following is not covered:

- Treatment by any other method.

10. Cerebral aneurysm - *with surgical repair*

The undergoing of either of the following surgical procedures in order to treat a cerebral aneurysm:

- Surgical correction via craniotomy;
- Endovascular treatment using coils or other materials (embolisation).

For the above definition, the following is not covered:

- Cerebral arteriovenous malformation.

11. Cerebral arteriovenous malformation - *requiring surgery*

The undergoing of surgery to reduce the risk of haemorrhage and stroke from cerebral arteriovenous malformation requiring craniotomy (surgical opening of the skull) or endovascular repair that reduces blood f low through the cerebral blood vessels.

For the above definition, the following is not covered:

- Intracranial aneurysm.

12. Crohn's disease - *treated with surgical intestinal resection*

A definite diagnosis by a consultant gastroenterologist of Crohn's disease which has been treated with surgical intestinal resection.

13. Cystectomy - *complete removal of the urinary bladder*

Complete surgical removal of the urinary bladder.

For the above definition, the following are not covered:

- urinary bladder biopsy
- removal of a portion of the urinary bladder.

14. Early stage thyroid cancer – *of specified advancement*

A definite diagnosis by a Consultant of invasive thyroid cancer which has been histologically classified as having progressed to TNM classification T1N0M0.

For the above definition, the following is not covered:

- Non-invasive follicular thyroid neoplasms with papillary like features (NIFTP).

15. Gastrointestinal Stromal Tumour (GIST) of low malignant potential – *with surgery*

A gastrointestinal stromal tumour (GIST) of low malignant potential diagnosed by histological confirmation and that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

- tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment.

16. Implantable Cardioverter Defibrillator for Primary Prevention of sudden cardiac death

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.

17. Less advanced cancer of the anus – *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the anus with surgery to remove the tumour.

For the above definition, the following are not covered:

- Anal Intraepithelial Neoplasia (AIN) grade 1 or 2, or low grade squamous intraepithelial lesionsjane (LGSIL).
- All non-surgical therapies which include but are not limited to all forms of ablative therapy and topical therapy

18. Less advanced cancer of the appendix, colon or rectum – *with specified surgery*

A positive diagnosis with histological confirmation of cancer in situ of the appendix, colon or rectum resulting in surgery to remove a portion of the colon, rectum or appendix.

19. Less advanced cancer of the bile ducts - *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the extra-hepatic bile ducts with surgery to remove the tumour.

20. Less advanced cancer of the cervix - *with specified surgery*

A positive diagnosis with histological confirmation of cancer in situ of the cervix uteri resulting in trachelectomy (removal of the cervix) or hysterectomy.

The following are not covered:

- loop excision
- laser surgery
- conization
- cryosurgery
- Cervical Intraepithelial Neoplasia (CIN) grade I or II, or low grade squamous intraepithelial lesions (LGSIL).

21. Less advanced cancer of the gallbladder - *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the gallbladder with surgery to remove the tumour.

22. Less advanced cancer of the larynx - *with specified treatment*

A positive diagnosis with histological confirmation of cancer in situ of the larynx treated with surgery, laser or radiotherapy.

23. Less advanced cancer of the lung and bronchus - *with specified surgery*

A positive diagnosis with histological confirmation of cancer in situ of the lung or bronchus or carcinoid tumour resulting in wedge resection or lobectomy.

24. Less advanced cancer of the oral cavity or oropharynx - *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the oral cavity or oropharynx with surgery to remove the tumour.

This includes lip, inside of cheek, floor of the mouth, tongue, gums, hard palate, soft palate and tonsils.

25. Less advanced cancer of the ovary - *with surgical removal*

A positive diagnosis with histological confirmation of ovarian tumour of borderline malignancy or low malignant potential which has resulted in surgical removal of an ovary.

The following is not covered:

- removal of an ovary due to a cyst.

26. Less advanced cancer of the pancreas - *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the pancreas with surgery to remove the tumour.

27. Less advanced cancer of the renal pelvis and ureter - *of specified severity*

A positive diagnosis with histological confirmation of cancer in situ of the renal pelvis or ureter.

The following are not covered:

- Non-invasive papillary carcinoma
- Tumours of TNM classification stage Ta.

28. Less advanced cancer of the stomach - with *surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the stomach with surgery to remove the tumour.

29. Less advanced cancer of the testicle - *with specified surgery*

A positive diagnosis with histological confirmation of intra-tubular germ cell neoplasia unclassified (ITGCNU) or benign testicular tumour resulting in orchidectomy (removal of a testicle).

30. Less advanced cancer of the thymus - *with surgical removal*

A positive diagnosis with histological confirmation of epithelial of the thymus with surgery to remove the tumour.

31. Less advanced cancer of the uterus - with *specified surgery*

A positive diagnosis with histological confirmation of cancer in situ of the lining of the uterus (endometrium) resulting in hysterectomy.

32. Less advanced cancer of the vagina - *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the vagina resulting in surgery to remove the tumour.

The following are not covered:

- all non-surgical therapies which include but are not limited to all forms of ablative therapy and topical therapy
- vaginal intraepithelial neoplasia (VAIN) grade 1 or 2 or low grade squamous intraepithelial neoplasia.

33. Less advanced cancer of the vulva - *with surgical removal*

A positive diagnosis with histological confirmation of cancer in situ of the vulva resulting in surgery to remove the tumour.

The following are not covered:

- all non-surgical therapies which include but are not limited to all forms of ablative therapy and topical therapy
- vulval intraepithelial neoplasia (VIN) grade 1 or 2 or low grade squamous intraepithelial neoplasia

34. Liver resection

The undergoing of a partial hepatectomy (liver resection) on the advice of a specialist surgeon in gastroenterology and hepatology.

For this definition, the following are not covered:

- surgery relating to liver disease resulting from alcohol abuse
- surgery for liver donation (as a donor)
- biopsy or any other diagnostic test.

35. Low-grade prostate cancer

Tumours of the prostate histologically classified as having a Gleason score between 2 and 6 inclusive provided:

- The tumour has progressed to at least clinical TNM classification T1NOMO; and the life assured has undergone treatment by prostatectomy, external beam or interstitial implant radiotherapy.

For the above definition the following are not covered:

- Cryotherapy;
- Other less radical treatment (e.g. transurethral resection of the prostate);
- Experimental treatments;
- Hormone therapy.

36. Neuroendocrine Tumour (NET) of low malignant potential – *with surgery*

A neuroendocrine tumour of low malignant potential diagnosed by histological confirmation and that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

- tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment.

37. Peripheral vascular disease - *with angioplasty*

The undergoing of a balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a cardiologist or vascular surgeon to correct a narrowing or blockage to an artery of the legs.

Angiographic evidence will be required.

38. Pituitary tumour – *resulting in permanent symptoms or surgery*

A definite diagnosis of a non-malignant tumour in the pituitary gland resulting in either of the following:

- permanent neurological deficit with persisting clinical symptoms; or
- treatment of the tumour by surgery or stereotactic radiosurgery.

For the above definition, the following are not covered:

- tumours in the brain; or
- where symptoms of pituitary tumour are absent with ongoing medical treatment.

39. Serious Accident Cover - *resulting in at least 28 consecutive days in hospital*

We will make a limited payment if a Life Insured suffers a serious accident resulting in a severe physical injury where the Life Insured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

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

We will also cover treatment in an inpatient rehabilitation centre, if the client is transferred directly from hospital to the rehabilitation centre for continuous treatment.

Only one partial payment will be paid resulting from the same accident.

For the above definition the following are not covered:

- Stays in hospital of less than 28 consecutive days;
- Serious accident secondary to alcohol where there is a history of alcohol abuse;
- Serious accident secondary to drug abuse.

40. Significant Visual Impairment - *permanent and irreversible*

We will make a limited payment for Specified Illness cover if a Life Insured suffers the permanent and irreversible reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/18 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lenses.

41. Single Lobectomy - *for disease or trauma*

The undergoing of 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.

42. Surgical removal of one eye

The permanent, surgical removal of one eye for disease or trauma.

43. Syringomyelia or Syringobulbia

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

44. Third degree burns - *covering 5% of the body's surface area*

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering between 5% and 20% of the body's surface area or between 25% and 50% loss of surface area of the face which for the purposes of this definition includes the forehead and ears.

45. Ulcerative Colitis - *treated with total colectomy (removal of the entire bowel)*

A definite diagnosis by a consultant gastroenterologist of ulcerative colitis, treated with total colectomy.

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