Fórsa Salary Protection Scheme

For Health & Welfare, Local Government & Local Services and Education Divisions

Summary Booklet

Cornmarket

FÓRSA

The Fórsa Salary Protection Scheme for Health & Welfare, Local Government & Local Services and Education Divisions

Key benefits include:

1	**Disability Benefit**	A replacement income of up to **75% of annual salary** if you can't work due to illness or injury*
2	**Specified Illness Benefit**	A benefit of **25% of annual salary** if you suffer a Specified Illness covered**
3	**Partial Payment Specified Illness Benefit**	A benefit of **€15,000 or 12.5% of annual salary** (whichever is less), if you suffer one of the further 10 less severe Partial Payment Specified Illnesses covered**
4	**Children's Specified Illness Benefit**	An additional benefit of **€15,000** if your child suffers a Specified Illness **or €7,500** if your child suffers a Partial Payment Specified Illness**
5	**Death Benefit**	A benefit of **twice your annual salary** • Accidental Death Benefit - **€15,000** • Children's Death Benefit - **€5,000** • Terminal Illness Benefit - **25% of Death Benefit**

Over **6,900** members already enjoy this financial security.†

*Less any other income to which you may be entitled e.g. half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration, State Illness or Invalidity Benefit. ** Please see the Appendices from page 36 onwards for full details, in particular the policy definition of each Specified Illness and its pre-existing and related conditions. †Source: Cornmarket, June 2018.

The Scheme in Action*

The Fórsa Salary Protection Scheme delivers on its promise to members, with over €19 million**paid out in Disability Benefit to members since 2005.

81 Fórsa members

are currently receiving Disability Benefit from the Scheme, with an annual benefit of over €1.4 million.

Over €3 million

has been paid out in Death Benefit to Fórsa members' families since the 2014 review of the Scheme.

Over €1.1 million

has been paid out in Specified Illness Benefit since the 2014 review of the Scheme.

97%

of Disability Benefit claims have been paid since the 2014 review of the Scheme.

*Source: Friends First, 2017. Friends First was the previous insurer of this Scheme.
**Source: Friends First, January 2017. Irish Life Claims Department, 2017. Irish Life was a previous insurer of the Scheme.

Why is Salary Protection so vital?

The reality is that if you are employed in the Public Sector you have less paid sick leave from your employer since 2014. If you fall ill, it may leave you with half your income or none at all, depending on your sick leave history.

Although many members think they will never need Salary Protection, sadly an unexpected illness or accident can happen to anyone, at any age.

The Fórsa Salary Protection Scheme aims to provide you with a replacement income to keep the important things in your life on track - like your bills, your mortgage or your savings for the future.

For more information on Public Sector sick pay arrangements, see page 7.

Who is Cornmarket?

We have been administering the Fórsa Salary Protection Scheme for Health & Welfare, Local Government & Local Services and Education Divisions since 2000. We work on behalf of Fórsa members to:

- Negotiate with the insurers (currently New Ireland Life Assurance) to get the best possible rate and benefits for members
- Assist those who need to claim from the Scheme, by guiding them through every stage of the claims process.

Here's what other members have to say about Salary Protection

"I would recommend everyone to avail of the option to be in the Scheme."

Shelly Barron,
Cornmarket Salary Protection Scheme Beneficiary.

"If I didn't have Salary Protection, I wouldn't have anything now – my home would be gone or I would be in very serious debt at this point. I never imagined I would need to claim from the Scheme for something as simple as a fall and a broken arm. Because of my injury, I went from being in a full time job and in the gym three nights a week, to literally not being able to drive or do anything on my own. Thanks to the Scheme, I could continue to pay my mortgage, my credit union loans, my grocery and mobile phone bills, and TV, electricity and broadband costs. The cost of the Scheme is a very small price to pay to ensure that your home and your standard of living are protected. I would recommend everyone to avail of the option to be in the Scheme".

"I would recommend joining Salary Protection to everyone."

Fiona Grace Purtill,
Cornmarket Salary Protection Scheme Beneficiary.

"I was at work one day, went to take something off a shelf and just felt a pop. Then after a couple of days it just snowballed and I ended up not being able to move my neck or shoulders. I realised I was going to be out of work for a while and my pay was due to run out, so I contacted Cornmarket. I didn't think I'd be out of work for as long as I have been and, thankfully, the cover has continued. I would recommend joining Salary Protection to everyone."

Public Sector Sick Leave Arrangements

Standard Sick Leave

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

Extended Sick Leave for Critical Illness*

Under Public Sector sick leave arrangements, there is a Critical Illness Protocol where you may be given extended paid sick leave of 26 weeks (183 days) at full pay in one year, followed by 26 weeks (182 days) at half pay, subject to a maximum of 52 weeks (365 days) in a rolling 4 year period. If you go over 365 days paid sick leave, you may receive Temporary Rehabilitation Remuneration for a further 12 months (365 days). Temporary Rehabilitation Remuneration may be extended for a further period up to a maximum of 2 years (730 days).

*There are certain criteria used to determine whether an illness qualifies for extended paid sick leave. Please contact your HR Department for more information.

Temporary Rehabilitation Remuneration

This may be granted where there is a realistic prospect of you returning to work and is based on the accrued pension benefits which would have applied if you retired on ill health grounds. Any added years which you purchased from service arrangements are not taken into account as no retirement has taken place.

Ill Health Early Retirement Pension

Alternatively, if you retire on ill health grounds you could be entitled to an Ill Health Early Retirement Pension. However, even with many years of service your Ill Health Early Retirement Pension will only be a fraction of your salary.

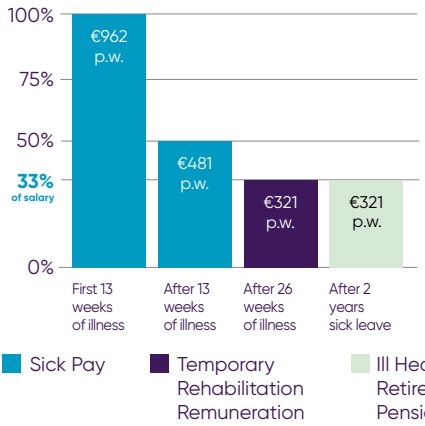
In addition, those paying PRSI at the 'A' rate may also be entitled to a State Illness Benefit, but at just €10,296 per year (2018 level) this benefit provides a very small income. Any retirement other than Ill Health Early Retirement, will adversely affect your claim.

How the Scheme works

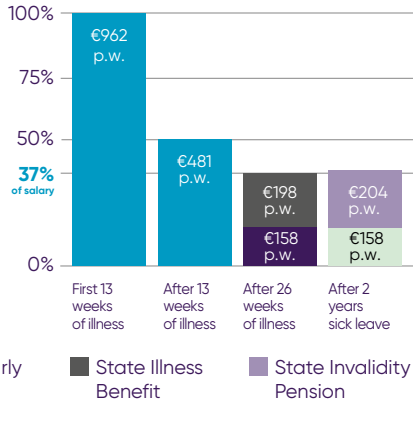
If you fall ill or become injured and are unable to work, the Scheme provides a replacement income of up to 75% of salary (less any other income to which you may be entitled e.g. half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration, State Illness or Invalidity Benefit).

WITHOUT Salary Protection

D Rate PRSI Example



A Rate PRSI Example



Sick Pay

Temporary Rehabilitation Remuneration

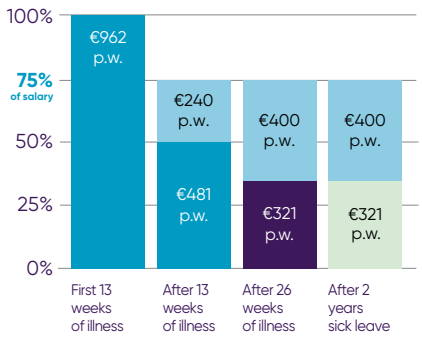
Ill Health Early Retirement Pension

State Illness Benefit

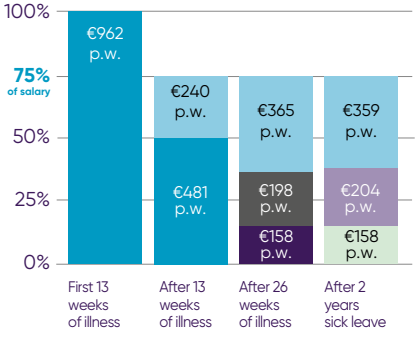
State Invalidity Pension

WITH Salary Protection

D Rate PRSI Example



A Rate PRSI Example



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

This example is based on a Public Sector employee, who is a member of the Superannuation Scheme with 20 years' service. They are earning €50,000 per annum and are now unable to work due to illness or injury. This example is based on the standard Public Sector sick leave arrangements (i.e. 13 weeks full pay in one year, followed by 13 weeks half pay). Extended paid sick leave under the Critical Illness Protocol does not apply and Ill Health Early Retirement Pension is granted after 2 years.

Protection for you and your family

1. Disability Benefit

If you can't work due to illness or injury, the Scheme aims to provide you with a replacement income of up to **75% of annual salary**, less any other income to which you may be entitled (e.g. half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration, State Illness or Invalidity Benefit etc.). The maximum benefit payable is €150,000 per year.

Disability Benefit is paid on completion of the Deferred Period and once you are unable to work due to illness or injury for a minimum of 10 consecutive days after the date that your pay reduces to half pay or ceases altogether if New Ireland admits your claim. If you are unable to work for 10 consecutive days, benefit is backdated to the date your pay reduced to half pay, ceases or the date you received Temporary Rehabilitation Remuneration.

The Scheme continues paying you until the earliest of the following:

- You recover **or**
- You resign **or**
- You retire (except if you are claiming from the Scheme and retire on an Ill Health Early Retirement Pension) **or**
- New Ireland determines (based on medical evidence) that you are fit to return to work **or**
- You return to work **or**
- Your 65th/67th* birthday **or**
- You die.

You may be entitled to an Ill Health Early Retirement Pension if you have more than 5 years' service and you are unable to return to work due to an ongoing illness.

If you are making a claim from the Scheme and you do not apply for Ill Health Early Retirement Pension (perhaps because you intend to return to work), and New Ireland agree that there is a reasonable expectation of you returning to work, then New Ireland may pay a benefit of 75% of salary less any State Illness or Invalidly Benefit or Temporary Rehabilitation Remuneration for a maximum of 2 years. In this instance as no Ill Health Early Retirement Pension is being claimed, this amount will not be deducted from the amount of Scheme benefit you receive.

If you do not apply for Ill Health Early Retirement Pension after 2 years, New Ireland will deduct that pension amount, even if it is not being paid. If you subsequently retire and the Ill Health Early Retirement Pension paid to you is higher than the amount New Ireland was deducting, then the additional amount of Disability Benefit paid since your early retirement must be repaid to the insurer.

*Fórsa members who entered/ re-entered the Public Service before 1st April 2004 are covered until age 65. Fórsa members who entered/ re-entered the Public Service on or after 1st April 2004 are covered until age 67. If you re-entered service on or after 1st April 2004 with a break of more than 26 weeks that was not due to a career break or unpaid leave, you are deemed to be a new entrant

2. Specified Illness Benefit

The Scheme provides a once-off lump sum of **25% of your annual salary** if you suffer a Specified Illness (See list on page 12).

Even if this illness does not result in a loss of salary, the reality is that you may face significant extra expenses, such as medical bills, travel to and from hospital, childcare and so on. This benefit is designed to help you with these extra costs.

The 38 Specified Illnesses covered under this Scheme are:

1. Alzheimer's Disease before age 65
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. Cancer
10. *Cardiomyopathy
11. Chronic Lung Disease
12. Coma
13. Coronary Artery By-Pass Graft
14. Creutzfeldt-Jakob Disease
15. Deafness
16. *Dementia before age 65
17. *Encephalitis
18. Heart Attack
19. Heart Structural Repair
20. Heart Valve Replacement or Repair
21. HIV Infection
22. Kidney Failure
23. *Liver Failure
24. Loss of Hands or Feet
25. Loss of Speech
26. Major Organ Transplant
27. Motor Neurone Disease before age 65
28. Multiple Sclerosis
29. *Multiple System Atrophy
30. Paralysis of 2 or more Limbs
31. Parkinson's Disease (Idiopathic) before age 65
32. *Primary Pulmonary Hypertension
33. *Progressive Supra-Nuclear Palsy
34. *Pulmonary Artery Graft Surgery
35. Stroke
36. Systemic Lupus Erythematosus
37. Third Degree Burns covering 20% of the body's surface area
38. *Traumatic Brain Injury

The Specified Illnesses marked * were introduced on the 1st January 2014 review. The other Specified Illnesses were introduced on 1st July 2005. Only members who are diagnosed after these dates are eligible to claim this benefit. If you suffered from one of the Specified Illnesses covered before you joined the Scheme, you will not be covered for that illness.

Please note from the 1st June 2017, the following two illnesses are no longer covered under the Specified Illness Benefit:

- Loss of independent existence
- Rheumatoid Arthritis

For a Specified Illness claim to be paid, you must fulfil the Specified Illness policy definition. Please see Appendix 1 from page 36 for more information, in particular the policy definition of each Specified Illness and its pre-existing conditions and related conditions.

There is only one Specified Illness Benefit payment per life per Scheme. If you are paid a claim for Specified Illness Benefit, your cover for this benefit and for the Partial Payment Specified Illness Benefit will end and you will no longer be able to claim for these benefits. As a result, you will no longer be required to pay the 0.15% Specified Illness Benefit premium.

Important
A claim for Specified Illness Benefit should be submitted as soon as possible after the date of diagnosis.

The Specified Illness Benefit lump sum is calculated based on your annual salary at the date of diagnosis. Please see page 19 if you are paying by Direct Debit.

Terms and conditions apply. Please see pre-exiting conditions and other important exclusions on page 32 and Appendix 1 from page 36 for more information.

3. Partial Payment Specified Illness Benefit

The Scheme provides a once-off lump sum of **€15,000 or 12.5% of annual salary** (whichever is less), if you suffer one of the Partial Payment Specified Illnesses listed below.

Based on claims experience, these conditions were identified by New Ireland as less severe, but still life-altering. This benefit is designed to help with the additional expenses you might incur.

The 10 Partial Payment Specified Illnesses covered under this Scheme are:

1. **Angioplasty for coronary artery disease** – of specified severity
2. **Brain abscess drained via craniotomy**
3. **Carcinoma in situ** – oesophagus, treated by specific surgery
4. **Carotid artery stenosis** – treated by endarterectomy or angioplasty
5. **Cerebral arteriovenous malformation** – treated by craniotomy or endovascular repair
6. **Ductal carcinoma in situ** – breast, treated by surgery
7. **Early stage prostate cancer with Gleason score between 2 and 6** – and with specific treatment
8. **Serious accident cover**
9. **Third degree burns** – covering at least 5% of the body's surface area
10. **Surgical removal of one eye**

Partial Payment Specified Illness Benefit was introduced on **1st January 2014**. Only members who are diagnosed after this date are eligible to claim this benefit.

If you suffered from one of the Partial Payment Specified Illnesses covered before you joined the Scheme, you will not be covered for that illness.

For a Partial Payment Specified Illness claim to be paid, you must fulfil the Partial Payment Specified Illness policy definition. Please see Appendix 2 on page 54 for more information, in particular the policy definition of each Specified Illness and its pre-existing conditions and related conditions.

There is only one Partial Payment Specified Illness Benefit payment per life, per Scheme. This list of Partial Payment Specified Illnesses is separate from those covered under the main Specified Illness Benefit. In most cases, if you make a claim under the Partial Payment Specified Illness Benefit, you would be eligible to claim Specified Illness Benefit at a later date.

However, if you are diagnosed with an illness under the main Specified Illness Benefit within 30 days of diagnosis of a Partial Payment Specified Illness, then only the full payment will be made under the main Specified Illness Benefit.

Important
A claim for Partial Payment Specified Illness Benefit should be submitted as soon as possible after the date of diagnosis.

The Partial Payment Specified Illness Benefit lump sum is calculated based on your annual salary at the date of diagnosis. Please refer to page 19 if you are paying by Direct Debit.

Terms and conditions apply. Please see pre-exiting conditions and other important exclusions on page 32 and Appendix 2 on page 54 for more information.

4. Children's Specified Illness Benefit

The Scheme provides an additional benefit to members in the form of Children's Specified Illness Benefit:

- A benefit of **€15,000** paid if your child is age 0-21 years and suffers one of the Specified Illnesses listed on page 12.
- A benefit of **€7,500** paid if your child is age 0-21 years and suffers one of the Partial Payment Specified Illnesses listed on page 14.

Please note:

- You can claim Children's Specified Illness Benefit for more than one child.
- You can claim for Specified Illness Benefit (€15,000) and Partial Payment Specified Illness Benefit (€7,500) for the same child but payment of each benefit will only be made once for each child.

Your name must appear as the child's parent on their birth certificate, unless the child has been legally adopted.

No claim for a Children's Specified Illness Benefit is paid for any illness or medical conditions which existed, whether symptoms were present or not:

- Since the date of birth of the Child **or**
- Before you joined the Scheme **or**
- Before the date the Child was legally adopted.

Cover for the Children's Specified illness benefit ends at the earliest of the following:

- Your child reaches age 21 **or**
- A claim for Specified Illness Benefit is paid for the child **or**
- A claim for Specified Illness Benefit is paid for you **or**
- Premiums to the Scheme cease **or**
- You retire (except if you are claiming from the Scheme and retire on an Ill Health Early Retirement Pension) **or**
- You no longer fulfil the Scheme eligibility criteria **or**
- They die **or**
- You die **or**
- You reach your 65th/67th* birthday.

If you have more than one child then please note that if one child claims, the others are still covered. In addition, if one or more children claim, you remain covered.

Terms and conditions apply. Please see pre-exiting conditions and other important exclusions on page 32 and Appendices from page 36 for more information.

*Please see page 11 for further details

5. Life Cover

Death Benefit
A benefit of typically **twice your annual salary** will be paid to your estate in the event of your death.

This benefit is linked to your salary and changes each year in line with your salary.

This is designed to provide financial support for your family at a difficult time; as mortgage payments, day-to-day living expenses, household bills and other expenses will still have to be paid by those you have left behind.

Accidental Death Benefit
An additional benefit of **€15,000** will be paid to your estate in the event of your Accidental Death; that is death resulting from an injury caused by accidental, violent, external or visible means and that is in no way linked to a sickness, disease or physical disorder that you have suffered from.

Children's Death Benefit
A benefit of **€5,000** will be paid in the event of the death of a member's child. Children's Death Benefit applies to all natural or legally adopted children aged 0-21 years. Your name must appear as the child's parent on their birth certificate, unless the child has been legally adopted.

Terminal Illness Benefit
The Scheme will make an advance payment of **25% of Death Benefit** if you are diagnosed with a terminal illness, with death expected within 12 months. The balance of Death Benefit will be paid on death.

Terminal illness means an advanced or rapidly progressing incurable illness where a member's life expectancy is no greater than 12 months (in the opinion of an attending medical consultant of a major hospital in Ireland or the United Kingdom, and New Ireland's Chief Medical Officer).

Cover for Terminal Illness Benefit ends at age 62.

How much does the Scheme cost?

The Scheme is designed to be affordable for every member. The rates and benefits are negotiated on a special 'group basis' for Fórsa members, to provide you with remarkably good value.

Tax Relief!

The Scheme cost is currently set at 1.94% of gross salary. You can claim tax relief on the Disability Benefit, so the net cost is just 1.38% for the higher rate tax payer:

Benefit	Gross cost	Net Cost – 40% tax relief	Net Cost – 20% tax relief
Disability Benefit	1.39%	0.83%	1.11%
Death Benefit	0.35%	0.35%	0.35%
Specified Illness Benefit	0.15%	0.15%	0.15%
Medical Immunity Benefit*	0.05%	0.05%	0.05%
Total Gross Cost	**1.94%**	**1.38%**	**1.66%**

The next Scheme review is scheduled to take place on the 1st June 2020 and the current premium may change after that date. The Scheme cost includes the Government Insurance Levy of 1%. *Allows members to join the Cornmarket Retired Members' Life Cover Plan, without medical underwriting. Terms & Conditions apply (underwritten by Irish Life).

Please remember it is your responsibility to make sure the correct deductions have been made by your employer and are cancelled if needed.

Cost examples

Income	Weekly Gross Cost	Weekly Net Cost
€30,000	€11.16	€7.94**
€40,000	€14.88	€12.73***
€50,000	€18.60	€15.92***
€70,000	€26.05	€22.29***

**If you are paying income tax at 20%, your net premium rate will be 1.66%. ***If you are paying income tax at 40%, your net premium rate will be 1.38%

How is it deducted from my payslip?

You will see two deductions on your payslip for your Scheme membership:

Deduction 1 – Eligible for Tax Relief
This will appear as 'Salary Protection' on your payslip and relates to Disability Benefit. As you receive tax relief on this deduction, the amount you actually pay is less than the amount on your payslip.

Deduction 2 – Not Eligible for Tax Relief
This will appear as 'Cornmarket Variable' on your payslip and relates to Death Benefit, Specified Illness Benefit and Medical Immunity Benefit. As you do not receive tax relief on this deduction, the amount on your payslip is what you actually pay.

Example Cost per Fortnight Based on a member earning €40,000 per annum, paying 40% income tax.	Amount on Payslip	Actual Cost
Deduction 1 (Disability Benefit)	€21.33	€12.73
Deduction 2 (Death Benefit, Specified Illness Benefit and Medical Immunity Benefit)	€8.44	€8.44
Total	**€29.77**	**€21.17**

Method of Payment

- If you pay your Scheme premiums **through your salary**, tax relief will be applied automatically by your employer so you don't have to submit a Tax Relief Claim Form.
- If you pay your Scheme premiums **by Direct Debit**, you will have to submit a Tax Relief Claim Form in order to claim. Please see revenue.ie for more information.

Please note
If you are paying by Direct Debit, it is essential that you notify Cornmarket of any change in your salary. Your cover will be based on either the salary covered by your premiums or the actual salary you are earning at the end of the Deferred Period as confirmed by your employer, whichever is lower.

Who is eligible to join?

You can apply to join the Scheme if you are:

1. A member of either the Health & Welfare, Local Government & Local Services, or Education divisions of Fórsa **and**
2. Under age 65 **and**
3. Working 8 hours or more per week **and either**
   - Employed on a permanent basis **or**
   - On a fixed - term contract of at least 12 months duration **or**
   - Working continuously for the last 12 months **and**
4. Actively at work today*

* Actively at work means that you:

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

Join the Scheme

To apply to join the Scheme, call us on **(01) 470 8054** or email **clientservices@cornmarket.ie**

Important:

- Members on **paid or unpaid maternity leave** are considered actively at work. Therefore those who meet the eligibility criteria can apply to join the Scheme.
- Members who are **job sharing or work sharing** and meet the eligibility criteria can apply to join the Scheme. The cost and benefits which apply may be different to those for permanent full-time members.
- Members on a **career break or any other unpaid leave** cannot apply to join the Scheme, as they do not meet the eligibility criteria.

Important
You must be a Fórsa member (of the Health & Welfare, Local Government & Local Services or Education Division) to be an eligible member of the Scheme. If you leave Fórsa you must inform Cornmarket in writing, as you can no longer stay in the Scheme and you will not be able to claim from it.

Arrangements for members with Diabetes

Cornmarket and New Ireland have agreed to make entry into the Scheme easier for those suffering from Diabetes or Diabetes-related conditions.

1. Disability Benefit

All Type 1 diabetes sufferers will be ineligible for cover.

Type 2 diabetes sufferers will be able to join the Scheme in the following circumstances:

- Applicants aged 41 to 50, with Type 2 Diabetes diagnosed after age 40, can apply for Disability cover. In the event of a claim arising directly or indirectly from diabetes or a diabetic related condition including but not limited to cerebrovascular disease, coronary artery disease, kidney disease, peripheral vascular disease, neuropathy or an eye disorder, Disability Benefit will only be payable for a maximum period of 3 years or upon reaching age 50 if earlier.
- Disability claims for other conditions will be paid as normal to a maximum age of 65/67*.

2. Death Benefit

Typically 80-90% of Type 1 and Type 2 Diabetes sufferers will be accepted into the Scheme for Death Benefit cover.

3. Specified Illness benefit

Specified Illness will not be offered to applicants with Type 1 or 2 diabetes.

*Please see page 11 for further details

Cornmarket's Retired Members' Life Cover Plan

Members of the Fórsa Salary Protection Scheme can apply to join Cornmarket's Retired Members' Life Cover Plan (underwritten by Irish Life)* when they retire, which provides a tax-free lump sum to your estate in the event of your death.

This is an extremely important benefit of membership, as the vast majority of Fórsa members still need Life Cover (Death Benefit) when they retire.

*Irish Life Assurance plc is regulated by the Central Bank of Ireland.

What's more, you can apply to join with no medical underwriting if you:

- Are a member of the Fórsa Salary Protection Scheme **and**
- Apply to join within **6 months** of your retirement.

For more information on Cornmarket's Retired Members' Life Cover Plan and the benefits that it provides, call us on **(01) 420 6767** or email **clientservices@cornmarket.ie**.

Frequently Asked Questions

1. When does my membership begin?

Your membership begins from the date New Ireland accepts your application. You will receive a letter from Cornmarket to confirm you have been accepted as a member of the Scheme. In some cases, medical evidence may be required before your membership can be confirmed. This evidence can be gathered by telephone or through a medical examination, at New Ireland's expense.

2. How do I qualify for Disability Benefit under the Scheme?

To qualify for Disability Benefit, New Ireland must be satisfied that you are totally unable to carry out the duties of your normal job due to disablement as a result of illness or injury and that you are not engaged in any other job for profit, reward or remuneration.

Definition of 'Disabled'
A member is disabled if, in the opinion of New Ireland, he/she is totally unable to engage in the duties of his/her normal job due to bodily injury sustained or from sickness or illness contracted and is not engaged in any other gainful job on a full-time or part-time basis.

Disability shall have a corresponding meaning. Partial disablement shall be deemed to exist where the member:

- remains partially disabled due to illness or injury following payment of Disability Benefit **and**
- undertakes a new job or his/her normal job for profit or reward, with the consent of New Ireland **and**
- his/her average monthly earnings are, in the opinion of New Ireland, reduced as a result of his/her partial disability to an amount less than his/her average monthly earnings during the twelve months immediately before the period of disability.

3. What is the Deferred Period?

The Deferred Period is the waiting period before you can claim Disability Benefit from the Scheme. The Deferred Period for this Scheme is as follows:

i. For Standard Sick Leave
13 weeks (92 days) in a 12 month period **or**
26 weeks (183 days) in a rolling 4 year period.

ii. For Extended Sick Leave
26 weeks (183 days) in a 12 month period **or**
52 weeks (365 days) in a rolling 4 year period.

Please refer to page 7 for an explanation on standard and extended sick leave.

Please note
To claim benefit under the Scheme, you must have accrued a minimum of 10 consecutive days sick leave after the date your pay reduced to half pay or ceased altogether and the completion of the Deferred Period. If you have taken sick leave before joining the Scheme, New Ireland will take this into account when calculating your Deferred Period.

4. Is there a survival period for Specified Illness Benefit?

Yes. If you or your child suffer a Specified Illness and wish to claim, you must survive for a minimum period after the date on which the illness was diagnosed or surgery took place, before any payment can be made. In the event of death within this period no Specified Illness Benefit or Partial Payment Specified Illness Benefit is paid. However, the normal Death Benefit (typically twice your annual salary) for the Members under the Scheme will be paid or the Children's Death benefit in the event of the death of a child.

The relevant periods are:

- 6 months for Parkinson's disease, Alzheimer's disease, Multiple System Atrophy and Blindness
- 12 months for Deafness and Loss of Speech
- 14 days for all other Specified Illnesses covered

5. What is the definition of salary?

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

If you are a member of the Superannuation Scheme
Your basic gross annual salary plus an average of any other payments in the 3 years prior to the claim date*, which are taken into account for sick pay and Superannuation purposes.

If you are not a member of the Superannuation Scheme
Your basic gross annual salary plus an average of any others payments in the 3 years prior to the claim date*, which would be taken into account for sick pay and Superannuation purposes if you were a member of the Superannuation Scheme.

*Claim date for Disability Benefit: end date of the Deferred Period. Claim date for Specified Illness Benefit: date of diagnosis. Claim date for Death Benefit: date of death.

6. When does my membership end?

Membership of the Scheme ends on the earliest of the following:

- You retire (except if you are claiming from the Scheme and retire on an Ill Health Early Retirement Pension) **or**
- You resign **or**
- You leave the Health & Welfare, Local Government & Local Services, or Education divisions of Fórsa **or**
- You no longer fulfil the Scheme eligibility criteria **or**
- Your premiums to the Fórsa Scheme cease **or**

- You reach your 65th/67th* birthday **or**
- You die.

Please note
If you are paid a claim for Specified Illness Benefit, your cover for this benefit will end and you can no longer claim Specified Illness Benefit. Your cover for Disability Benefit and Death Benefit will continue if applicable.

Important if you retire
Cornmarket may not be notified by your employer when you retire. Therefore it is vital that you notify Cornmarket at least **10 weeks** before your retirement date, in order to stop your premiums to the Scheme or to apply to join Cornmarket's Retired Members' Life Cover Scheme.

7. When does Disability Benefit payment under the Scheme begin?

Once New Ireland accepts your claim (and you have completed the relevant Deferred Period), payment of benefit will begin. Please remember it can take around 3 months to process your claim (see page 33 Claiming from the Scheme for more information).

*Please see page 11 for further details

8. How long will I be paid Disability Benefit under the Scheme?

The Scheme will continue to pay you for as long as you are unable to carry out your normal job (due to disability from illness or injury), and you are not engaged in any other job*. Disability Benefit payments will stop at the earliest of the following:

- You recover **or**
- You return to work **or**
- New Ireland decide (based on medical evidence) that you are fit to return to work **or**
- Your 65th/67th birthday** **or**
- You resign **or**
- You retire (except if you are claiming from the Scheme and retire on an Ill Health Early Retirement Pension) **or**
- You die

*In certain cases, a proportionate benefit may be paid where you return to work but at a reduced level of earnings due to partial disability.
**Please see page 11 for further details

Notice period if claim is ended: For members who have been claiming from the Scheme and receiving continuous payment for 12 months or more, New Ireland will give **3 months' notice** before ending the payment of benefit, if the medical evidence indicates that the member is fit to return to work on a full-time basis.

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

For claims admitted up to the 31st May 2017, if a claim is in payment for 12 continuous months, the amount of Disability Benefit paid will increase by the lesser of: 5% per annum or by the increase in the Consumer Price Index***. However, for new claims admitted on or after the 1st June 2017, the amount of Disability Benefit paid will not increase after a claim is in payment for 12 months.

***In the last 3 years, the annualised average Consumer Price Index has been less than 1%. (Source: cso.ie, July 2017).

10. What will happen if my Disability or Specified Illness Claim is declined?

If your claim is declined, the insurer will inform you of the reasons for the decision in writing. You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must do this within **3 months** of the declined decision being made for a Disability claim or within **18 months** for a Specified Illness claim. The review of their decision may require you to attend further Independent Medical Examinations.

If you do not appeal, premiums must continue or restart in order for you to remain a member of the Scheme.

If your appeal with the insurer is unsuccessful, you may bring your case to the Financial Services and Pensions Ombudsman.

11. What if I take a career break?

If you take a career break, you have a number of options:

A. You would like to maintain Death Benefit and Specified Illness Benefit cover while on career break and re-activate your Disability Benefit, without medical underwriting, when you finish your career break.

Ideally you should notify Cornmarket of your intention to take a career break and complete the relevant forms before you commence your career break. However, this option can be availed of once you apply within 4 months of taking a career break. You must also pay the premium for Death Benefit and Specified Illness Benefit to maintain your cover. The premium and benefit is based on your pre-career break salary. This premium must be paid annually in advance of your career break. If you are going to reside outside of Ireland or the U.K. during your career break and would like to maintain Death Benefit and Specified Illness Benefit, you will need prior agreement from New Ireland. Please notify Cornmarket if this is the case. If you extend your career break, or return to work, you must notify Cornmarket. This ensures you will not have to undergo medical underwriting when you return from career break.

B. You would like to suspend your membership of the Scheme while on career break and re-activate your membership, without medical underwriting, when you finish your career break.

Ideally you should notify Cornmarket of your intention to take a career break and complete the relevant forms before you commence your career break. However, this option can be availed of once you apply within 4 months of taking a career break. You will not have to pay premiums while on career break.

If you extend your career break, or return to work, you must notify Cornmarket. This ensures you will not have to undergo medical underwriting when you return from career break.

C. You would like to cancel your membership

If you would like to cancel your membership or you do not notify Cornmarket of your intention to take a career break, your premiums to the Scheme will cease and you will no longer be covered under the Scheme. If you wish to re-join the Scheme at the end of your career break, you must complete an application form with medical underwriting.

Please note
You must be a member of the Fórsa Union for the duration of your career break. If you extend your career break, you can only maintain the cover you selected upon taking your career break or reduce your cover. You cannot increase your cover while on career break. For example, the amount of cover that you choose in year 2 of your career break cannot be more than what you had in year 1.

You can avail of these career break options for a maximum of 5 years.

These options may be subject to change.

12. What if I take unpaid parental, maternity or adoptive leave?

You must notify Cornmarket at least 4 weeks before taking unpaid leave. If you take unpaid parental, maternity or adoptive leave and you pay your premiums to the Scheme through salary, no premiums will be collected while you are on leave as you will not be paid a salary. Your cover will continue while you are on leave and you will not have to repay any missed premiums. If you pay your Scheme premiums by Direct Debit, your cover will continue while you are on leave. Please contact Cornmarket to cancel your premiums to the Scheme for the duration of your unpaid leave.

This is subject to unpaid leave being no longer than 18 weeks in total in any 12 month period. Where the leave is more than 18 weeks in total in any 12 month period, your options will be similar to those provided for career breaks. Please see Q11 *What if I take a career break?* or contact Cornmarket for more information.

If you take unpaid leave under more than one of the categories above, for example unpaid maternity leave followed by unpaid parental leave, New Ireland will allow you to take up to 30 weeks in a 12 month period without having to pay premiums.

13. What if I take unpaid carer's leave?

You must notify Cornmarket at least 4 weeks before taking unpaid leave.

If you take unpaid carer's leave, and you pay your premiums to the Scheme through salary, no premiums will be collected while you are on leave as you will not be paid a salary. Your cover will continue while you are on leave and you will not have to repay any missed premiums.

If you pay your Scheme premiums by Direct Debit, your cover will continue while you are on leave. Please contact Cornmarket to cancel your premiums to the Scheme for the duration of your unpaid leave.

This is subject to unpaid leave being no longer than 18 weeks in total. Where the leave is more than 18 weeks, your options will be similar to those provided for career breaks. Please see Q11 *What if I take a career break?* or contact Cornmarket for more information.

Important note - Unpaid Leave: If you need to make a claim from the Scheme and you have not taken your unpaid leave all at once, for example you take one or two days unpaid leave each week, your benefit would be based on your full-time salary and not your reduced salary. This is subject to a maximum of two years unpaid leave. After two years, your benefit would be based on your reduced salary.

14. What if I avail of the Shorter Working Year Scheme?

You must notify Cornmarket at least 4 weeks before taking unpaid leave under the Shorter Working Year Scheme. The Shorter Working Year Scheme replaced the previous Term Time arrangements. The Scheme allows employees to take unpaid leave of a period of 2, 4, 6, 8, 10 or 13 consecutive weeks during a 12 month period.

Although it is unpaid leave, you can spread your salary over the whole year to cover the period of unpaid leave under the Shorter Working Year Scheme. Typically, if availing of the full 13 weeks your salary will be 75% of the salary you would receive if you were working a full 12 months. While Scheme premiums are based on the reduced salary you receive, your cover will be based on your full-time salary for up to 2 years.

If you avail of the Shorter Working Year Scheme on a regular basis, for example each year for more than 2 years, your benefits will be based on the reduced salary you received over the previous 12 months.

15. Are there any exclusions under the Scheme?

Exclusions to **Disability Benefit**:

In some cases individual members may be accepted into the Scheme subject to the exclusion of specific illnesses. Once an exclusion is applied, sick leave due to the excluded condition, including the calculation of the Deferred Period, cannot be included in relation to any aspect of a claim.

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

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

Exclusions to Specified Illness Benefit: Please see pre-exiting conditions and other important exclusions on page 32 and the Appendices from page 36 onwards for more information.

16. What benefits do members on a temporary contract get?

A claim from a member on a temporary contract is treated in the same way as other members. Please see page 33, *Claiming from the Scheme* for more information. If a member cannot work due to illness or injury and their contract expires before the end of the Deferred Period (13 weeks in any 12 month period), their claim will be considered subject to the normal medical evidence requirement. For example, if a member suffers an illness with 3 months or less remaining on their contract, and remains disabled to the end of the usual Deferred Period, their claim will be considered in the normal manner.

17. What if I travel abroad?

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

New Ireland will pay Disability Benefit to a member living anywhere in the world for a maximum of 12 months. After 12 months the beneficiary must reside in Ireland or the U.K. In exceptional cases where a beneficiary is forced to live abroad, New Ireland will consider this on a case-by-case basis. New Ireland reserves the right for claimants to come back to Ireland for an Independent Medical Examination during this 12 month period.

In cases where a non-Irish national member in the opinion of New Ireland, is permanently disabled and wishes to move home on a permanent basis, New Ireland will consider paying the member a benefit of up to and no more than 5 years benefit in one lump sum.

This is provided as a settlement of the member's claim provided the member has been in receipt of benefit for at least 12 months. The amount of benefit paid will be calculated by New Ireland.

18. Are there any territorial restrictions for Specified Illness Benefit?

Yes. Specified Illness Benefit or Partial Payment Specified Illness Benefit will not be paid if a you/your child has been resident outside the countries that were members of the European Union on the 1st June 2017 or Australia, Canada, New Zealand, Norway, Switzerland or the USA for more than 13 weeks in any consecutive 12 month period prior to the date of claim.

19. What if I have unearned income?

In most cases, investment and rental income will not be taken into account when making a claim under the Scheme. However, earned income or benefit from any accident or sickness policy will be taken into account, except once-off lump sum benefits paid under a Critical/Serious/Specified Illness Policy. Income from other sources, such as another employment, will be taken into consideration when calculating the amount of benefit payable under the Scheme.

20. Under what circumstances can the Scheme be amended?

The next review of the Scheme is scheduled to take place on 1st June 2020.

These reviews provide Cornmarket with an opportunity to canvass the market and secure the best deal for members.

At these reviews, New Ireland can also change the terms of the Scheme, rate of premium and the benefit levels for all members in the Scheme or terminate the Scheme altogether.

Fórsa represents the interests of members in the Scheme and any decisions made by Fórsa will be binding on all members.

21. Who administers and insures the Scheme?

The Scheme is administered by Cornmarket Group Financial Services Ltd. and is underwritten by New Ireland Assurance Company Plc.

22. What commission does Cornmarket receive?

Initial charge (paid by New Ireland to Cornmarket) €400

Deduction at source charge 2.5%

Renewal charge (paid by New Ireland to Cornmarket)

- Disability Benefit: 12.5%
- Death Benefit: 12.5%
- Specified Illness Benefit 12.5%

Specified Illness Benefit

Pre-existing conditions and other important exclusions

If you suffered from one of the Specified Illnesses covered before your cover for Specified Illness 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 suffered or undergone one of these conditions before joining the Scheme you cannot claim under the policy in respect of any of the other 4 illnesses. For example, if you underwent coronary artery by-pass surgery before joining you will never be covered for coronary artery by-pass surgery, heart attack, heart transplant, angioplasty or stroke.

If prior to your Specified Illness cover commencing, you suffered from a condition related to one of the Specified Illnesses and you contract that particular illness within 2 years of joining the Scheme, you will not be covered. For example, a claim will not be paid for heart attack within the first 2 years of joining, if prior to joining you suffered from high blood pressure of specific severity. This is due to the recognised link between high blood pressure and heart attack. However, a member with high blood pressure who first suffers a heart attack 3 years after joining the Scheme will be eligible to claim. In addition, no cancer claims will be paid where the condition presents within the first 3 months of a member joining the Scheme. In this case, cover in respect of cancer ceases under the Scheme.

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

The above also applies for Children's Specified Illness cover.

Specified Illness Benefit will not be offered to any Type 1 or Type 2 Diabetes sufferers.

How to claim Disability Benefit from the Scheme

Our Salary Protection Claims Team is experienced and knowledgeable in guiding members through the claims process. We are here to talk you through the claims process and explain the documentation you need to provide.

1. Contact Cornmarket

We are not automatically notified of your absence from work due to sick leave. Therefore you should let us know as soon as you become aware that, due to illness or injury, your salary is likely to reduce to half pay or cease altogether.

Therefore, it is vital that you contact Cornmarket about **10-12 weeks** in advance of your salary becoming affected to allow New Ireland to assess your claim and gather the relevant medical and employer information. If it is not possible to contact us within this timeframe, New Ireland may not be able to pay your benefit at the time your salary reduces or ceases.

You can contact us by:

Phone: **(01) 408 4018**

Post: **SPS Claims Department, Cornmarket Group Financial Services Ltd., Christchurch Square, Dublin 8.**

Email: **spsclaims@cornmarket.ie**

If you are making a claim, you may wish to nominate someone to contact Cornmarket on your behalf to assist you with your claim, such as your spouse or next of kin. If you wish to do this, please send Cornmarket 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 assist you with your claim, they will have access to all of the information related to your claim; including medical and financial details. However, they cannot make changes to your policy or cancel your policy. Your nominated person will only be able to deal with Cornmarket regarding your claim. They will not be able to deal directly with the insurance company.

2. Your claims pack

Once you have informed us that you wish to make a claim, we will send you out a claim form and tell you what information is required for New Ireland to assess your claim.

The information required depends on the type of claim you are submitting.

3. Processing your claim

Once we receive your completed claim form we will send the details to New Ireland, so an assessment of your claim can begin immediately. We will send on all documents as we receive them from you and we will liaise between you and New Ireland throughout the claims process.

It takes time to gather the necessary documents to assess the amount of benefit to be paid if your claim is admitted. Some of the documents include:

- Medical evidence to determine disablement (e.g. GP & specialist medical evidence and/or independent medical evidence) **and**
- Employer information (e.g. salary, sick leave, half and off pay dates, Temporary Rehabilitation Remuneration (TRR), Ill Health Early Retirement Pension).

For this reason, claims typically take around 3 months to process from the date the claim form is received until the decision is made. New Ireland endeavour to assess and process claims as quickly as possible.

4. Medical examination

The medical evidence you and your doctors provide will be assessed by New Ireland. In some cases they will request that you attend an independent medical examination (at New Ireland's expense) to help determine if you are able to carry out the duties of your normal job because of your illness or injury.

5. Additional medical evidence

Depending on the complexity of your condition, in some cases New Ireland may require additional medical evidence from your doctors and/or specialists. You may be requested to attend a further medical examination (at New Ireland's expense).

6. Decision on your claim

Once all the medical evidence and documentation has been received, New Ireland will make a decision on your claim (please see page 26, Q7, *When does Disability Benefit payment under the Scheme begin?* for more information).

7. Your benefit

Once a new claim is accepted, payment of the benefit is made by New Ireland monthly in arrears. Benefit payments are subject to income tax and USC.

Please see page 26, Q8 *How long will I be paid Disability Benefit under the Scheme?* for more information.

If your Disability claim is admitted and you were paying your premiums by Direct Debit, the benefit payable will be based on the salary that you were receiving from your employer at the time the claim arises; assuming that you were paying the correct premium for this level of cover.

Important:

Short-term claims: As a result of the 2014 changes to Public Sector sick pay arrangements, there has been an increase in short-term claims. With some short-term claims, the medical evidence required may not be as detailed as that required for a long-term claim.

Late Notification of claims: It is often not possible to assess the validity of a claim where a significant period of time has passed since your salary reduced or ceased. For this reason, it is vital that you register your claim promptly (10-12) weeks before your salary reduces to half pay or ceases altogether). In the case of a late notification of a claim, cases will be assessed on individual merit and the insurer reserves the right to decline to assess the claim.

NEW IRELAND
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Explanation of each Specified Illness and its pre-existing conditions

APPENDIX 1:

Specified Illnesses (Full Payment)

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

1. Alzheimer's Disease before age 65 – resulting in permanent symptoms

Policy Definition

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist or Geriatrician of a major Irish or United Kingdom Hospital. There must be permanent clinical loss of the ability to do all of the following:

- Remember;
- Reason; **and**
- Perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

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

In simpler terms

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

Pre-existing Conditions

Amnesia or memory loss

Related Specific Illnesses

Dementia

2. Aorta Graft Surgery – for disease or traumatic

Policy Definition

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

For the above definition, the following are not covered:

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

In simpler terms

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

Pre-existing Conditions

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

Related Specified Illnesses

None specified

3. Aplastic Anaemia - of specified severity

Policy Definition

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

- Blood transfusion;
- Bone-marrow transplantation;

- Immunosuppressive agents;
- Marrow Stimulating agents.

All other forms of anaemia are specifically excluded.

In simpler terms

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

Pre-existing Conditions

None Specified

Related Specific Illnesses

Cancer, Bone Marrow Transplant (under Major Organ Transplant).

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4. Bacterial Meningitis - resulting in permanent symptoms

Policy Definition

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

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

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

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

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

The following are not covered:

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

In simpler terms

Bacterial meningitis is a life-threatening illness that results from bacterial infection of the meninges (the layers of membrane that surround the brain and spinal cord). In many cases it is possible to recover fully from bacterial meningitis with no lasting ill-effects. However, if there are permanent effects as outlined in the above definition, we would consider a claim. You can make a claim if a Consultant Neurologist confirms a diagnosis of bacterial meningitis which has resulted in permanent brain or nerve damage. All other forms of meningitis including viral meningitis are excluded.

Pre-existing Conditions

Osteomyelitis of the skull, tuberculosis.

Related Specific Illnesses

Encephalitis, Brain Abscess.

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5. Balloon Valvuloplasty

Policy Definition

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specific Illnesses

Heart Valve Replacement or Repair.

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

Policy Definition

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

For the above definition, the following are not covered:

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

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

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

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

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

The following are not covered:

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

In simpler terms:

A benign brain tumour is a non-cancerous abnormal growth of tissue. It can be very serious because the growth may be pressing on areas of the brain. These growths can be potentially life threatening and may have to be removed by surgery. Other conditions that are not usually life-threatening are specifically excluded. The pituitary is a small gland at the base of the brain, an angioma is a benign growth made up of small blood vessels. You can make a claim if you are diagnosed as having a benign brain tumour of the brain and have had surgery to have it removed or are suffering from permanent neurological deficit as described in the above definition as a result of the tumour. Examples of tumours covered include gliomas, acoustic neuromas and meningiomas. Neurological symptoms must be permanent. We do not cover tumours or lesions in the pituitary gland, tumours arising from bone tissue, angiomas or cholesteatomas.

Pre-existing conditions

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

Related Specified Illnesses

None Specified.

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

Policy Definition

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

For the above definition, the following are not covered:

- Angiomas
- Prolapsed or herniated intervertebral disc.

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

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

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

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

The following are not covered:

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

In simpler terms:

A benign tumour of the spinal canal or spinal cord is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of spinal cord or spinal canal. You can make a claim if you are diagnosed as having a benign spinal cord tumour and have had surgery to have it removed or are suffering from permanent neurological deficit as described in the above definition as a result of the tumour. Angiomas are benign tumours that are made up of small blood vessels. They usually appear at or near the surface of the skin and are not covered. Prolapsed or herniated intervertebral discs are also not covered.

Pre-existing Conditions

Von Recklinghausen's disease, tuberous sclerosis.

Related Specified Illnesses

None Specified.

8. Blindness – permanent and irreversible

Policy Definition

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specific Illnesses

None Specified.

9. Cancer – excluding less advanced cases

Policy Definition

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
  - pre-malignant,
  - non-invasive,
  - cancer in situ,
  - having either borderline malignancy; or
  - having low malignant potential.

- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0.
- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Malignant melanoma unless it has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).
- Any other skin cancer (including cutaneous lymphoma) unless it has been histologically classified as having caused invasion in the lymph glands or spread to distant organs.
- Any urinary bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0
- All forms of lymphoma in the presence of any Human Immunodeficiency Virus
- Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus

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

In simpler terms:

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

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

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. The Gleason score which is a method of measuring differentiation in cells is specifically designed to help evaluate the prognosis of those who have been diagnosed with prostate cancer scoring patients between 2 and 10, with 10 having the worst prognosis. Cancers with a Gleason score less than or equal to 6 are less aggressive, less likely to spread and have a better prognosis. The TNM classification system stages the extent and spread of the cancer in the body. The "T" element relates to the size of the tumour and whether it has invaded nearby tissue and is graded on a scale of 1 to 4, with 1 representing a small tumour confined to an organ or body part. The "N" element relates to any lymph node involvement and the "M" relates to a spread of cancer from one body part to another. We will not pay a claim for prostate cancer under this cancer definition unless the tumour has a Gleason score of greater than 6 (i.e. a Gleason score of 7 or above) or it has progressed to at least clinical TNM classification of T2bN0M0. Many forms of urinary bladder cancer have a slow course over many years and are managed by surgery or diathermy (the generation of local heat in body tissues by high frequency electromagnetic currents). The prognosis for patients with early stage superficial urinary bladder cancer is very good. We will not pay a claim for urinary bladder cancer under this cancer definition unless the tumour has progressed to at least clinical TNM classification of T2N0M0.

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

Pre-existing Conditions

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

Related Specified Illnesses

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

10. Cardiomyopathy – of specified severity

Policy Definition

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

The diagnosis must also be evidenced by:

- Electrocardiographic changes; and
- Echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy

For the above definition, the following are not covered:

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

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

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11. Chronic Lung Disease – of specified severity

Policy Definition

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

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

Lung Transplant (under Major Organ Transplant)

12. Coma – resulting in permanent symptoms

Policy Definition

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

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

*** For the above definition, the following is not covered:**

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

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

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

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

The following are not covered:

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

In simpler terms:

A coma is a state where a person is unconscious and cannot be brought round. Someone in a coma will have little or no response to any form of physical stimulation and will not have control of their bodily functions. Comas are caused by brain damage, most commonly arising from a head injury, a stroke or lack of oxygen.

Pre-existing Conditions

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

Related Specified Illnesses

None Specified.

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

Policy Definition

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

For the above definition, the following are not covered:

- Balloon angioplasty;
- Atherectomy;
- Rotablation;
- Insertion of stents;
- Laser treatment.

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

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

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

Policy Definition

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

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

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

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

The following are not covered:

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

In simpler terms:

Creutzfeldt-Jakob disease (CJD) is a degenerative condition of the brain. As the disease progresses muscular co-ordination diminishes, the intellect and personality deteriorate and blindness may develop. There is no treatment and death usually occurs within 6-18 months of the onset of symptoms. A claim can be made if there is a definite diagnosis by a Consultant Neurologist that you are suffering from this disease.

Pre-existing Conditions

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

Related Specified Illnesses

None Specified.

15. Deafness – permanent and irreversible

Policy Definition

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illness

None Specified.

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16. Dementia before age 65 – resulting in permanent symptoms

Policy Definition

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

- Remember;
- Reason; **and**
- Perceive, understand, express and give effect to ideas.

For the above definition, the following is not covered:

Dementia secondary to alcohol or drug misuse.

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

Alzheimer's Disease.

17. Encephalitis – resulting in permanent symptoms

Policy Definition

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

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

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

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

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

The following are not covered:

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

For the above definition, the following is not covered:

- Encephalitis in the presence of any Human Immunodeficiency Virus.

In simpler terms:

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

Pre-existing Conditions

Tuberculosis (TB).

Related Specific Illnesses

Bacterial Meningitis, Brain Abscess.

18. Heart Attack – of specified severity

Policy Definition

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

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

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

In simpler terms:

If the blood supply to the heart is interrupted, this can cause a portion of the heart muscle to die. Doctors call this sudden death of heart muscle an acute myocardial infarction, but the condition is widely known as a heart attack. A heart attack is usually caused by a blocked artery (coronary occlusion) or a blood clot (coronary thrombosis) and causes permanent damage to the part of the heart muscle affected. This damage can be detected using an ECG machine which traces the heartbeat. As a result of cell death chemicals such as

cardiac enzymes and troponins are released into the blood stream and these are usually present for several days after the event and can be detected by a blood test. In order for a claim to be valid, you must have suffered a heart attack and be supported by an episode of typical chest pain, increase in cardiac enzymes or troponins as described in the above definition that are typical of a heart attack and new ECG changes that are typical of a heart attack.

Pre-existing Conditions

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

Related Specified Illnesses

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

19. Heart Structural Repair – with surgery to divide the breastbone

Policy Definition

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

For the above definition, the following is not covered:

Heart Valve Replacement or Repair.

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

None Specified.

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

Policy Definition

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

Balloon Valvuloplasty.

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

Policy Definition

Infection by Human Immunodeficiency Virus resulting from: • A blood transfusion given

as part of medical treatment; or • A physical assault; or

- Artificial insemination or in-vitro fertilisation given as part of medical treatment; or
- An incident occurring during the course of performing normal duties of employment

after the Commencement Date of Cover and satisfying all of the following:

• The physical assault must have been reported to An Garda Síochána within 5 days of its occurrence

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

For the above definition, the following is not covered:

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

In Simpler Terms:

Human immunodeficiency virus is generally recognised as the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The virus can be passed on in several ways including through contaminated blood, bloodstained bodily fluids and infected needles. This benefit is designed to cover people who are in special danger of acquiring HIV or AIDS through their work or who have become infected as a result of a blood transfusion in the European Union, Australia, Canada, New Zealand, Norway, Switzerland or the United States of America. The infection must happen after the Commencement Date of Cover under the Scheme.

Pre-existing Conditions

Haemophilia (for blood transfusion only).

Related Specified Illnesses

None Specified.

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22. Kidney Failure – requiring permanent dialysis

Policy Definition

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

For the above definition, the following is not covered:

- Kidney failure secondary to alcohol or drug misuse.

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

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

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23. Liver Failure – irreversible and end stage

Policy Definition

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

- Permanent jaundice
- Ascites; **and**
- Hepatic encephalopathy.

For the above definition, the following is not covered:

- Liver Failure secondary to alcohol or drug misuse.

In simpler terms:

Liver failure is the inability of the liver to perform its normal synthetic and metabolic function. Liver failure occurs when a large portion of the liver is damaged. You can make a claim if you are diagnosed by a Consultant Physician as having incurable end stage liver failure caused by cirrhosis and showing particular symptoms. Jaundice is a yellow discolouration of the skin and whites of the eyes due to abnormally high levels of bilirubin (bile pigment) in the blood stream. This jaundice must be a permanent feature. Ascites is a fluid build-up in the abdomen caused by fluid leaks from the surface of the liver and intestines. It can occur if the blood or lymphatic flow through the liver is blocked. Encephalopathy caused by liver failure is the deterioration of brain function due to toxic substances building up in the blood which are normally removed by the liver. Liver Failure secondary to alcohol or drug misuse is not covered.

Pre-existing Conditions

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

Related Specified Illnesses

Liver Transplant (under Major Organ Transplant).

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24. Loss of Hands or Feet – permanent physical severance

Policy Definition

Permanent physical severance of any combination of 2 or more hands or feet at or above the wrist or ankle joints.

In simpler terms:

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

Pre-existing Conditions

Diabetes, peripheral vascular disease.

Related Specified Illnesses

None Specified.

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25. Loss of Speech – permanent and irreversible

Policy Definition

Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease. In simpler terms: You can make a claim if you suffer from total and permanent loss of speech as a result of physical injury or disease.

Pre-existing Conditions

Transient ischaemic attack (TIA), chronic laryngitis.

Related Specific Illnesses

None Specified

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

Policy Definition

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

For the above definition, the following is not covered:

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

In simpler terms:

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

official programme waiting list of a major Irish or United Kingdom Hospital for such a procedure.

Pre-existing Conditions

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

Related Specified Illnesses

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

27. Motor Neurone Disease before age 65 – resulting in permanent symptoms

Policy Definition

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

In simpler terms:

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

Pre-existing Conditions

Muscle weakness in any limb.

Related Specified Illnesses

Paralysis of 2 or More Limbs

28. Multiple Sclerosis – with persisting symptoms

Policy Definition

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

In simpler terms:

Multiple sclerosis is an autoimmune disorder in which the immune system attacks the protective covering (myelin) of the nerve fibres in the brain and spinal cord. The symptoms depend on which areas of the brain or spinal cord have been affected. They include temporary blindness, double vision, loss of balance and lack of co-ordination. The diagnosis must be confirmed by a Consultant Neurologist.

Pre-existing Conditions

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

Related Specified Illnesses

None Specified.

Multiple System Atrophy – resulting in permanent symptoms

Policy Definition

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

- Motor function with associated rigidity of movement; or • The ability to coordinate muscle movement; **or**
- Bladder control and postural hypotension

In simpler terms:

Multiple system atrophy is a progressive

neurological disorder of unknown cause which affects nerve cells in specific areas of the brain. This results in problems with various bodily functions such as movement, balance and bladder control. You can make a claim if you have been unequivocally diagnosed with this condition by a Consultant Neurologist and evidenced by the symptoms described in the above definition.

Pre-existing Conditions

Tremor

Related Specified Illnesses

Parkinson's Disease

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30. Paralysis of 2 or More Limbs – total and irreversible Policy

Definition

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

In simpler terms:

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

Pre-existing Conditions

Spinal cord injury or transient ischaemic attack (TIA).

Related Specified Illnesses

Motor Neurone Disease.

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31. Parkinson's disease (idiopathic) before age 65 – resulting in permanent symptoms

Policy Definition

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

For the above definition, the following are not covered:

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

In simpler terms:

Parkinson's disease is a progressive degenerative disorder of the brain that affects the central nervous system. This is characterised by uncontrollable shuffling, tremors in the limbs, slow movement, rigid facial expression and unstable gait. The progression of the disease is slow and there is no known cure. The term "idiopathic" means that the cause of the disease is not known, so any form of Parkinson's disease brought on by a known cause such as drugs, toxic chemicals or alcohol is not covered. You can make a claim if you have been diagnosed with idiopathic Parkinson's disease by a Consultant Neurologist and evidenced by the symptoms described in the above definition

Pre-existing Conditions

Tremor

Related Specified Illnesses

None Specified.

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32. Primary Pulmonary Hypertension – of specified severity

Policy Definition

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

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

In simpler terms:

Pulmonary hypertension is when the blood pressure in the pulmonary artery (the major artery connecting the heart to the lungs) is higher than normal. There is no apparent cause. This means that the heart is under pressure when pumping blood into the lungs and typical symptoms include the shortness of breath, fatigue and fainting. These and other symptoms appear much more severely when exercising. Over time the heart muscle weakens. You can make a claim if you have been diagnosed with primary pulmonary hypertension by a Consultant Cardiologist and which results in the permanent loss of ability to perform

physical activities to at least Class 3 of the New York Heart Association (NYHA) classifications of functional capacity. The NYHA Function Classification is a measure used to classify the severity of heart failure.

Pre-existing Conditions

None Specified.

Related Specified Illnesses

None Specified.

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33. Progressive Supra-nuclear Palsy – resulting in permanent symptoms

Policy Definition

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

None Specified.

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34. Pulmonary Artery Graft Surgery – with surgery to divide the breastbone

Policy Definition

The actual undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Consultant Cardiothoracic Surgeon of a major Irish or United Kingdom Hospital for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft. In simpler terms: Pulmonary artery surgery may be carried out for some disorders of the pulmonary artery including pulmonary atresia and aneurysm. You can make a claim if you have undergone open-heart surgery involving the surgical division of the breastbone on the advice of a Consultant Cardiothoracic Surgeon to replace the diseased pulmonary artery with a graft.

Pre-existing Conditions

None Specified.

Related Specified Illnesses

None Specified.

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35. Stroke – resulting in permanent symptoms

Policy Definition

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

For the above definition, the following are not covered:

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

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

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

The following are not covered

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

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

- Symptoms of psychological or psychiatric origin.

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

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

36. Systemic Lupus Erythematosus – of specified severity

Policy Definition

A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist of a major Irish or United Kingdom Hospital resulting in either of the following:

- Permanent neurological deficit with persisting clinical symptoms,* **or**
- Permanent impairment of kidney function tests as follows: – Glomerular Filtration Rate (GFR) below 30ml/min – Abnormal urinalysis showing proteinuria or haematuria.

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

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

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

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

Kidney Failure, Kidney Transplant (under Major Organ Transplant)

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

Policy Definition

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

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically

known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can also heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin. You can make a claim if you have suffered third-degree burns covering 20% or more of the surface area of your body.

Pre-existing Conditions

None Specified.

Related Specified Illnesses

None Specified.

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38. Traumatic Brain Injury – resulting in permanent symptoms

Policy Definition

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

For the above definition, the following is not covered:

Traumatic Brain Injury secondary to alcohol or drug misuse.

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

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

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

The following are not covered:

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

None Specified.

APPENDIX 2:

Partial Payment Specified Illnesses

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

1. Angioplasty for Coronary Artery Disease – of specified severity

Policy Definition

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

- Balloon angioplasty
- Atherectomy
- Rotablation
- Laser treatment
- And/or insertion of stents

to treat the narrowing or blockage in two or more Main Coronary Arteries. This procedure must have been carried out on the advice of a Consultant Cardiologist of a major Irish or United Kingdom Hospital. Angiographic evidence to support the necessity for the procedure will be required.

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

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

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

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

In simpler terms

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

Pre-existing Conditions

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

Related Specified Illnesses

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

2. Brain Abscess drained via craniotomy

Policy Definition

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

For the above definition, the following is not covered:

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

In simpler terms:

A brain abscess results from an infection in the brain. Swelling and inflammation develop in response to the infection. Infected brain cells, white blood cells and organisms collect in an area of the brain, a membrane forms and creates the abscess. While this immune response can protect the brain from the infection, an abscess may put pressure on delicate brain tissue. A craniotomy involves the removal of part of the skull in order for the surgeon to access the brain. You can make a claim if you are diagnosed, with supporting CT or MRI evidence, as having an intracerebral abscess and where this abscess is removed through a craniotomy by a Consultant Neurosurgeon.

Pre-existing Conditions

Tuberculosis, head injury, chronic sinusitis

Related Specified Illnesses

Encephalitis, Bacterial Meningitis.

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

Policy Definition

A definite diagnosis of a carcinoma in situ of the oesophagus by a Consultant Physician of a major Irish or United Kingdom Hospital, which has been treated surgically by removal of a portion or all of the oesophagus. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer. Histological evidence will be required.

For the above definition, the following is not covered:

- Treatment by any other method is specifically excluded.

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

In simpler terms:

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

Pre-existing Conditions

Barrett's oesophagus, severe oesophageal reflux

Related Specified Illnesses

Cancer

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4. Carotid Artery Stenosis – treated by endarterectomy or angioplasty

Policy Definition

Undergoing of endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery. Angiographic evidence will be required.

In simpler terms:

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

Pre-existing Conditions

Any valvular disorder of the heart, diabetes, hypercholesterolaemia, aneurysm, atrial fibrillation, coronary heart disease, peripheral vascular disease, transient cerebral ischaemia,

hypertension or any obstructive or occlusive arterial or vascular disease.

Related Specified Illnesses

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

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

Policy Definition

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

For the above definition, the following is not covered:

- Intracranial aneurysm.

In simpler terms:

Cerebral arteriovenous malformation is a condition whereby there is an abnormal connection between arteries and veins in the brain that interrupts normal blood flow between them. An arteriovenous fistula (AV fistula) is one such abnormal connection. When this is present, blood flows

directly from an artery into a vein bypassing the capillaries. This can cause a problem if oxygenated blood has not reached its intended destination within the brain. The most common symptoms include headaches and seizures. In more serious cases blood vessels may rupture and there will be haemorrhaging within the brain. A craniotomy involves the removal of part of the skull in order for the surgeon to access the brain. Endovascular treatment is where the surgeon accesses the brain via arteries using catheters, balloons, coils and stents. You can claim if you have a craniotomy or endovascular treatment using coils under the care of a Consultant Neurologist to treat a cerebral arteriovenous fistula or malformation.

Pre-existing Conditions

Aneurysm.

Related Specified Illness

Stroke

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

Policy Definition

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

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

Cancer.

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

Policy Definition

A definite diagnosis of prostate cancer by a

Consultant of a major Irish or United Kingdom Hospital which has been histologically classified as having a Gleason score between 2 and 6 provided:

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

For the above definition, the following are not covered:

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

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

In simpler terms:

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

Pre-existing Conditions

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

Related Specified Illnesses

Cancer.

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

Policy Definition

A serious accident resulting in severe physical injury where the Life Insured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment. For the purposes of this definition only, a hospital stay also includes treatment in an inpatient rehabilitation centre, if the Life Insured is transferred directly from hospital to the rehabilitation centre for continuous treatment.

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

For the above definition the following are not covered:

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

In simpler terms:

You can make a claim if you have a serious accident and are hospitalised for at least 28 consecutive days to receive medical treatment for your injuries. The 28 consecutive days can include time spent in a rehabilitation centre if you are transferred there directly from the hospital to continue your treatment.

Pre-existing Conditions

None Specified

Related Specified Illnesses

None Specified

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

Policy Definition

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

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can also heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin. You can make a claim if you have suffered third-degree burns covering at least 5% and less than 20% of the surface area of your body or at least 25% of the surface area of the face.

Pre-existing Conditions

None specified.

Related Specified Illnesses

None Specified.

10. Surgical Removal of One Eye

Policy Definition

Surgical removal of a complete eyeball for disease or trauma.

In simpler terms:

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

Pre-existing Conditions

Glaucoma, eye tumour, uveitis, thyroid disease.

Related Specified Illnesses

None Specified.

Fórsa Salary Protection Scheme

This booklet outlines the main benefits of the Fórsa Salary Protection Scheme as of August 2018. It 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 at August 2018. The Fórsa Salary Protection Scheme is governed by the master Policy Document No. V000082E issued by New Ireland. Members of the Scheme may request a copy of the policy document from the Head Office of Fórsa or the Dublin office of Cornmarket Group Financial Services Ltd.

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

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

If you are dissatisfied with the outcome of your complaint through Cornmarket, you may also contact the Financial Services and Pensions Ombudsman at fspo.ie

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