POA Income Continuance Plan

Cornmarket

POA

Contents

This booklet is split into the following sections:

1. Introduction	4
2. Benefits	8
3. Cost	19
4. Claims	21
5. Frequently Asked Questions	27
6. Specified Illnesses Appendices	31

Disclaimers

This booklet is intended as a guide only. The Plan is governed by the master Policy Documents No. 710765 & 712074 issued by Aviva. Members of the Plan may request a copy of the policy document from the Plan owners or the Dublin office of Cornmarket Group Financial Services Ltd.

This booklet is issued subject to the provisions of the policy and does not create or confer any legal rights. The information contained herein is based upon our current understanding of Revenue law and practice as of December 2019.

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

No part of this booklet should be read in isolation.

Please save a copy of this book for future reference.

Information in this booklet is correct as of December 2019 but may change. For the latest information, please see cornmarket.ie

Where we say 'Plan', we mean the POA Income Continuance Plan.

Where we say 'Insurer', we mean Aviva.

Where we say 'we' or 'us', we mean Cornmarket Group Financial Service Ltd.

1. Introduction

Overview of Key Benefits

1	**Disability Benefit**	A replacement income of up to **75%* of your annual salary** if you cannot work due to illness or injury
2	**Specified Illness Benefit**	A once-off lump sum of **€10,000** if you are diagnosed with one of the Specified Illnesses covered**

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

*Less any other income that you may be entitled to e.g. half pay, Ill health early retirement Pension, Temporary Rehabilitation Remuneration (previously known as pension rate of pay), State Illness or Invalidity benefit.

**Please see the Appendices from page 31 - 39 for full details, in particular the policy definition of each Specified Illness and its pre-existing and related conditions.

Eligibility

You may apply to join this Plan if you are:

1. A member of the POA union. You must remain a member of the union to remain an eligible member of the Plan
2. Under age 55
3. Employed on a
   - Permanent basis **or**
   - Contract of indefinite duration **or**
   - Fixed-term contract of at least 12 months' duration **and**
4. Working 8 hours or more per week
5. A member of the Superannuation Scheme for Prison Officers
6. Actively at work. This means you:
   - are working your normal contracted hours **and**
   - have not received medical advice to refrain from work **and**
   - are not restricted from fully performing the normal duties associated with your occupation.

You are considered to be 'actively at work' if you are on paid or unpaid maternity leave.

You are not considered to be 'actively at work' if you are on any other form of unpaid leave or on Career Break.

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

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

Roles

Cornmarket's role includes:

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

The Insurer's role includes:

1. Deciding the policy terms and conditions and creating a policy document to reflect these.
2. Medically assessing applications and claims.
3. Deciding the various aspects of an individual member's cover e.g. if membership of the Plan can be reactivated, if refunds can be made and if arrears and/or a declaration of health are required.

2. Benefits

Disability Benefit

In the event that your salary is affected because you are unable to work due to illness or injury, this Benefit aims to pay you an income of up to 75% of salary after a certain period of time known as the deferred period. See page 10 for definition of salary and details of the deferred period.

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

- Temporary Rehabilitation Remuneration (TRR) – May be paid by your employer to you where there is a realistic prospect of you returning to work.
- State Illness Benefit/State Invalidity Pension – Those paying PRSI at the 'A' rate may be entitled to this benefit from the State.
- Ill Health Early Retirement Pension (IHERP) – Those who retire on the grounds of ill health may be entitled to this from their employer.

This applies regardless of whether you are a 'D' or 'A' PRSI contributor and whether you contribute to the Superannuation Scheme or not.

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

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

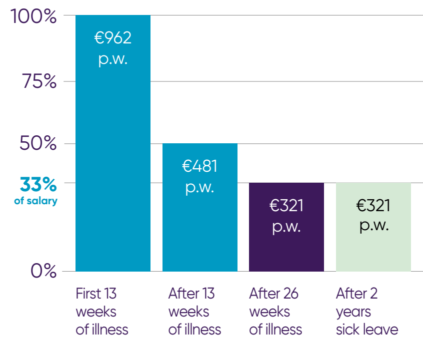
Example of how the Disability Benefit works

This example is based on a Public Sector employee, who is a member of the Superannuation Scheme with 20 years' service earning €50,000 per annum, who is now unable to work due to disability arising from illness or injury. It is assumed that standard Public Sector sick leave arrangements apply, extended paid sick leave under the Critical Illness Protocol does not apply and Ill Health Early Retirement Pension is granted after 2 years.

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

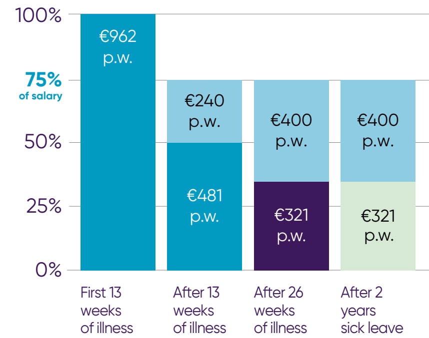
WITHOUT Income Continuance

D Rate PRSI Example



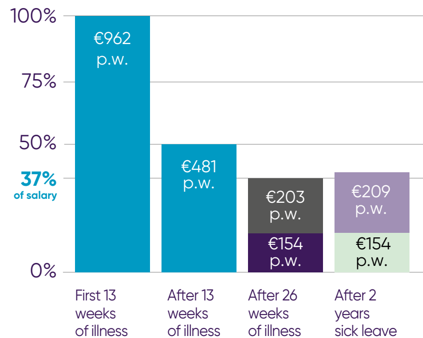
WITH Income Continuance

D Rate PRSI Example



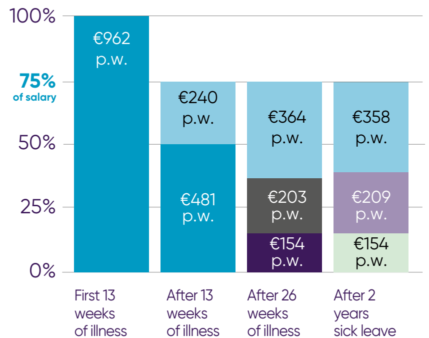
WITHOUT Income Continuance

A Rate PRSI Example



WITH Income Continuance

A Rate PRSI Example



Disability Benefit

Deferred Period

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

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

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

Definition of Salary

For the purpose of Disability Benefit, salary is defined as gross basic annual salary plus the average of any allowances received in the preceding 3 years, which are taken into account for sick pay and/or for the purposes of the Superannuation Scheme for Prison Officers. Salary will be established at the end of the relevant deferred period.

Exclusions

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

- self-harm
- the deliberate neglect of health by failure to seek or follow medical advice

When you apply to join the Plan, the Insurer may offer you cover with an exclusion(s) that applies specifically to you. For example, if you inform the Insurer that you have a back problem on your application form, they may offer you membership of the Plan with a back exclusion. This means that you would never be able to claim for an illness or injury relating to your back. If this happens, a form will be sent to you as part of the application process with the details of the exclusion(s) and you will have the opportunity to decide if you wish to accept the cover with the exclusion(s) or not. If an exclusion(s) applies to you, then sick leave used for the excluded condition(s) cannot be taken into account for the calculation of the deferred period.

Disability Benefit

Limitations and Restrictions

Definition of Disability

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

Definition of Partial Disability

Following the payment of a disability claim, if you:

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

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

Disability Benefit is limited to a maximum benefit of €250,000 per year.

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

If your claim is admitted...

- 75% of salary less any other income to which you may be entitled will be paid for a maximum of two years only. After this a pension amount will be deducted from the benefit regardless of whether or not you are in receipt of same. This is referred to as Notional Early Retirement Pension (NERP)
- the benefit you receive from the Insurer will be treated as income and as such is liable to income tax, PRSI, Universal Social Charge, etc. The Insurer will deduct any tax due from the Benefit made to the member, in the same way as an employer deducts tax from an employee.

If your claim is admitted, Disability Benefit will continue until:

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

whichever is earliest.

Ceasing Ages

Claims admitted after 1st July 2019 have a maximum ceasing age of the later of:

- age 55 **or**
- after 5 years in payment subject to a maximum ceasing age of 60.

Please see the below table:

Member's age when claim admitted	Payment of benefit will cease
Up to age 49	At age 55
Between age 50 and 54	After the claim has been in payment for 5 years
Age 55 and older	At age 60

Late Notification of Claims

It is not often possible to retrospectively assess the validity of a claim in cases where a significant period of time (approximately 3 months) has passed since your salary reduced or ceased. For this reason, it is vital that you register your claim promptly. In the event of late notification of a claim, the Insurer may decline to assess your claim. This will be decided on a case-by-case basis.

Specified Illness Benefit

Full Benefit

If you are diagnosed with one of the illnesses listed below, and meet the definition/criteria of that illness (see appendices from page 31 - 37), this benefit will pay a once-off, tax-free lump sum of **€10,000**.

Please note: The illnesses marked * below were introduced on the 1st November 2015 review. The other Specified Illnesses were introduced from 1st December 1997. Only diagnoses that occur after these dates are eligible to claim Specified Illness Benefit for these illnesses. If prior to joining the Plan you have suffered from one of the Specified Illnesses, you will never be covered for that illness.

- Alzheimer's Disease before age 65
- Aorta graft surgery
- Aplastic Anaemia*
- Bacterial Meningitis
- Balloon Valvuloplasty*
- Benign brain tumour
- Benign spinal cord tumour*
- Blindness
- Cancer
- Cardiomyopathy*
- Chronic Lung Disease*
- Coma
- Coronary artery surgery
- Creutzfeldt-Jakob Disease
- Deafness
- Encephalitis*
- Heart attack
- Heart structural repair*
- Heart valve replacement or repair
- HIV infection
- Kidney failure
- Liver failure
- Loss of hands or feet
- Loss of independent existence
- Loss of speech
- Major organ transplant
- Motor Neurone Disease before age 65
- Multiple Sclerosis
- Multiple System Atrophy*
- Paralysis of Limbs
- Parkinson's Disease before age 65
- Pre-Senile Dementia before age 65*
- Primary Pulmonary Hypertension
- Progressive Supranuclear Palsy*
- Pulmonary Artery Surgery*
- Rheumatoid Arthritis
- Stroke
- Systemic Lupus Erythematosus
- Third-degree burns covering 20% of the body's surface area, or 50% of the surface area of the face
- Traumatic head injury

Specified Illness Benefit

Partial Benefit

If you are diagnosed with one of the illnesses listed below, and meet the definition/criteria of that illness (see pages 38 - 39), this benefit will pay a once-off, tax-free lump sum of **€5,000**.

Please note: The qualifying Partial Payment Illnesses below were introduced on 1st November 2015. If prior to joining the Plan you have suffered from one of the Specified Illnesses you will never be covered for that illness.

The qualifying Partial Payment Specified Illnesses covered are:

- Brain abscess drained via craniotomy
- Carcinoma in situ of the oesophagus
- Carotid artery stenosis
- Cerebral arteriovenous malformation
- Coronary Angioplasty**
- Ductal carcinoma in situ of the breast
- Low level prostate cancer with Gleason score between 2 and 6
- Serious accident cover
- Surgical removal of one eye
- Third degree burns covering 5-19% of the body's surface area or 25-49% of the face's surface area

**Coronary Angioplasty was moved from the main Specified Illness category to the Partial Payments category on 1st November 2015.

Children's Specified Illness Benefit

A once-off lump sum of €3,500 will be paid to the member where a member's child (aged between 0 and 21 years) is diagnosed with one of the Specified Illnesses covered.

A once-off lump sum of €1,750 will be paid to the member where a member's child (aged between 0 and 21 years) is diagnosed with one of the Partial Benefit Specified Illnesses covered.

Exclusions

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

a) In the opinion of the Insurer, the diagnosis arises directly or indirectly as a result of:
   - any form of war/conflict **or**
   - taking alcohol or drugs (unless directed by a registered medical practitioner) **or**
   - self harm **or**
   - the deliberate neglect of health by failure to seek or follow medical advice **or**
   - Engaging in any hazardous activity or sports, including but not limited to the following: scuba diving, motor sports, aviation, hang gliding, water sports, horse racing, parachuting, mountaineering, rock climbing, caving or winter/ice sports **or**
   - Flying, except as a fare paying passenger.

b) You are residing outside of the member states of the EU as of 1st July 2019, the United States of America, Canada, New Zealand, Australia, Norway, Switzerland, Japan, South Africa, Singapore, Iceland and Saudi Arabia for more than three months in any calendar year, unless you have been on Career Break, prior agreement was received from the Insurer and the relevant premium was paid.

c) If prior to joining the Plan, you suffered from a condition directly or indirectly related to one of the Specified Illnesses and you contract that particular illness within 2 years of joining the Plan, you will not be covered. For example, if you suffered from diabetes prior to commencement of cover and suffered a heart attack within two years as a result of this illness, a claim would not be paid and cover for a heart attack would cease, however if a diabetic suffered a heart attack 3 years from commencing cover, they would be eligible to claim.

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

e) If you suffered from one of the Specified Illnesses before your cover commenced, you will never be covered for that illness and cannot claim for that illness or a related Specified Illness. For example, because of the links between heart attack, coronary artery by-pass surgery, heart transplant, angioplasty and stroke, if you have suffered from or undergone surgery for one of these conditions before joining the Plan you cannot claim under the policy in respect of any of these 5 illness. For example, if you underwent coronary artery by-pass surgery before joining you will never be covered for coronary artery bypass surgery, heart attack, heart transplant, angioplasty or stroke.

Specified Illness Benefit

Limitations and Restrictions

Specified Illness Benefit became a benefit of the Plan on 1st December 1997. The Specified Illnesses marked *, were introduced on 1st November 2015. You can only claim for diagnoses that occur after these dates.

- Partial Payment Specified Illness Benefit became a benefit of the Plan on 1st November 2015. Therefore, you can only claim for diagnoses that occur after this date.
- If you make a Full Specified Illness claim, you will not be able to make a further Full or Partial Specified Illness claim. If you make a Partial Specified Illness claim, you will still be able to make a Full Specified Illness claim.
- If you are diagnosed with one of the Full Specified Illnesses within 30 days of diagnosis of a Partial Specified Illness, a claim will be assessed on the Full Specified Illness only.
- A Specified Illness claim will only be paid if the diagnosis/severity meets the specific definition/criteria outlined for that illness in the Appendices from page 31 - 39.
- You will not be able to make a Specified Illness claim for an illness that:
    - you suffered from prior to joining the Plan.
    - relates to a condition which you were already suffering from at the time of your application and/or where you were under medical investigation, regardless of whether you were aware of the condition at that time.
    - relates to a condition which you were already suffering from before the date that Specified Illness was introduced to the Plan.

Late Notification of Claims

You must make a Specified Illness Claim within 3 months of being diagnosed. Failure to make a claim within this time period may result in the Insurer declining to assess your claim.

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

Please see Appendices from page 31 - 39 for more details.

The Benefit ceases at age 55.

Early Intervention (EI) Programme

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

Eligibility

In order to avail of EI, you must:

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

How to avail of EI

If 4 weeks of sick leave has passed, and you have not recovered enough to return to work, please contact us on (01) 408 4018 as soon as possible. We will then notify the Insurer and they will contact you directly to decide if EI is suitable for you. This is done on a case-by-case basis. If you are suitable for EI, the Insurer will arrange the relevant services for you through their rehabilitation partners.

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

3. Cost

The total Plan premium is **2.75% of gross salary**. This includes the 1% insurance levy.

Warning: The current premium may increase after the next Plan review which should take place on/after 1st July 2022.

Income Tax Relief

Your Plan premium is eligible for Income Tax Relief at your highest rate of income tax. The rate at which income tax relief is applied may depend on your individual tax circumstances.

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

Income	Weekly Gross Cost	Weekly Net Cost at 20% income tax*	Weekly Net Cost at 40% income tax**
€30,000	€15.81	€12.65	€9.49
€40,000	€21.08	€16.86	€12.65
€45,000	€23.72	€18.97	€14.23
€55,000	€28.99	€23.19	€17.39

*If you are paying income tax at 20% your net premium rate will be 2.20%.
**If you are paying income tax at 40% your net premium rate will be 1.65%.

Method of Payment

Your premiums are paid directly from your salary via deduction at source.

Income tax relief is applied automatically so there is no need to submit a Tax Relief Claim Form. Your premiums will increase and decrease in line with your salary changes and as a result, the salary covered by the Plan will be your salary as confirmed by your employer on the last day of your Deferred Period.

You must ensure that the premiums deducted from your salary are correct and reflect your salary.

Remember...

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

4. Claims

Roles

Cornmarket's role

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

Our contact details for making a claim are:

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

Our offices are open Monday - Friday 9:00 - 17:30.

The Insurer's role

The Insurer's role is to medically assess claims and decide whether or not claims should be paid. If they decide that a claim is payable, they will calculate and pay the benefit.

Disability and Specified Illness Benefit Claims

How to make a Disability or Specified Illness Benefit claim?

Disability

Contact us as soon as you think that your salary may reduce to half pay or cease altogether due to illness or injury because:

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

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

It is often not possible for the Insurer to retrospectively assess the medical validity of a claim. If they cannot medically assess a claim, the Insurer reserves the right to decline to assess the claim. See Late Notification of Disability Benefit Claims on page 12.

Specified Illness

Contact us as soon as possible, as it may take a number of weeks to process the claim. It is not often possible for the Insurer to retrospectively assess the medical validity of a claim. If they cannot medically assess a claim, the Insurer reserves the right to decline to assess the claim. See Late Notification of Specified Illness Benefit Claims on page 17.

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

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

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

Following an initial phone call, if appropriate, we will send you a claim form, information about the Plan and details of the documentation you will need to provide.
You should return the forms and documentation to us as soon as possible and we will send these to the Insurer. The Insurer will then start medically assessing your claim.

Are all Disability and Specified Illness benefit claims medically assessed?

All claims will be medically assessed by the Insurer. If you have been granted Ill Health Early Retirement by your

employer, this does not mean that you will be automatically entitled to Disability Benefit from the Plan.

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

1. provide medical evidence from your doctor **and/or**
2. provide medical evidence from your specialist **and/or**
3. attend an Independent Medical Examination (IME). It generally takes about 3 weeks for the IME report to be returned to the Insurer **and/or**
4. attend the Insurer's Occupational Health and Safety Advisor.

This is all at the Insurer's expense and reasonable travel expenses will be covered, if travel is necessary.
We will liaise with your employer, the Insurer and you throughout the assessment.

What happens after my Disability Benefit claim is assessed?

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

What will happen if my Disability Benefit claim is admitted?

- If your claim is admitted, and you have completed the relevant deferred period, the Insurer will arrange for benefit to be paid to your bank account. Disability Benefit will be paid in arrears and may be paid on a monthly basis. Therefore, it may take up to four weeks after your claim is admitted to receive your first benefit.
- If your claim is admitted after you have been reduced to half-pay or your pay has ceased altogether, the benefit may be backdated to the date when salary was first affected.
- As a benefit is subject to income tax, you can request the Revenue Commissioners to issue a Revenue Payroll Notification (RPN) to the Insurer. This will enable the Insurer to apply the correct tax rate for future benefits. However, the first benefit may have emergency tax rates applied. Any overpayment or underpayment of tax may be subsequently rectified.
- In order to ensure you continue to meet the definition of disablement, the Insurer may seek completed continuation forms, certificate of continued disablement, medical certificates from your doctor, and/or require you to attend an independent medical examination and/or organise for a Health Claims Advisor to visit you.
- In the event that you fail to follow medical advice, the Insurer may cease paying you benefits.
- You will not be expected to pay premiums towards the Plan while claiming. However, if your benefit stops for some reason other than reaching the ceasing date of that benefit, you will be expected to start paying premiums again in order to maintain your cover. If you continue to receive Disability Benefit up to the ceasing age of that benefit, you can continue to avail of the other Plan benefits without having to pay premiums for them up until the ceasing age of those benefits.
- While claiming Disability Benefit, any Specified Illness Benefit that you have as a Plan member remains in force until the ceasing date of that Benefit.

What will happen if my Disability Benefit claim is declined?

- If your claim is declined, the Insurer will inform you of the reasons for the decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. The review of their decision may require you to attend further Independent Medical Examinations.
- If you do not appeal, you must return to work and premiums must continue or restart in order for you to remain a member of the Plan.
- If your appeal with the Insurer is unsuccessful, you may bring your case to the Financial Services and Pensions Ombudsman.

What happens after my Specified Illness Benefit claim is assessed?

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

Settled

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

Declined

- If your claim is declined, you will be informed of the reasons for that decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must do this within 3 months of the decline decision being made. The review of their decision may require you to attend further Independent Medical Examinations.
- If your appeal with the Insurer is unsuccessful, you may bring your case to the Financial Services and Pensions Ombudsman.

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

If you make a claim and decide not to apply for IHERP, perhaps because you intend to return to work, and the Insurer agrees that there is a reasonable expectation of you returning to work, then the Insurer may pay a benefit of 75% of salary less any State Illness Benefit or Temporary Rehabilitation Remuneration for a maximum of 2 years. This means no deduction will be made from the Benefit for an amount equivalent to IHERP, as no IHERP is being claimed.
However, 2 years after the date Disability Benefit commences, a pension amount will be deducted from the benefit regardless of whether or not you are in receipt of same. This is referred to as Notional Early Retirement Pension (NERP).

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

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

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

Please inform our Claims Administration team as soon as possible, if this applies to you.

If, as a result of your workplace injury, you are entitled to an additional payment, it may mean that your income remains higher than 75% of your salary and hence there will be no Disability Benefit payable from the Plan.

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

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

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

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

5. Frequently Asked Questions

How can I apply to join the Plan?

To apply, you must complete an application form either:

- Over the Phone - Call **(01) 470 8054**
- With your Cornmarket Consultant
- By printing and completing an application form at **cornmarket.ie**.

Applications may require underwriting (medical assessment) which may include providing medical information by telephone to a nurse or attending a medical examination at the Insurer's expense. Following the underwriting period, the Insurer may accept your application, postpone your application, decline your application or offer you membership of the Plan with certain specified conditions excluded from cover.

During the application process it is important that you tell the Insurer all relevant medical information. This means information that the Insurer would regard as likely to influence the assessment and acceptance of your application. If you do not:

- your membership of the Plan could be void; you will not be covered under the Plan,
- a claim will not be paid and the Insurer will not refund any premiums you have paid,
- you may find it difficult to purchase another Life Insurance product.

What happens if my application is accepted?

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

- You will be sent a formal acceptance letter.
- You will have 30 days after the date the acceptance letter is sent to you to cancel your membership of the Plan and receive a full refund of any premiums paid.
- Premiums should start as soon as possible after you are accepted as a member.

What happens if my application is not accepted?

If your application is postponed, declined or if you are offered acceptance with certain specified conditions excluded you may request details for the reasons for the decision to be sent from the Insurer to your own doctor and you may appeal the decision.

What if I have unearned income?

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

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

If you plan to take a career break or unpaid leave please contact us

to discuss the options that may be available to you by calling **(01) 408 4195** or emailing **spsadmin@cornmarket.ie**.

If you wish to avail of the career break options, you must apply for these within 4 months of taking a career break. Otherwise your membership of the Plan will cease. You must remain a member of the POA union for the duration of your career break.

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

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

- Acquire a second job
- Go on secondment
- Change role/job
- Change terms of employment
- Start job sharing/work sharing (i.e. work 50% or less of the normal working week).

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

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

When does my cover under the Plan cease?

- Your 55th birthday (this may differ if you are in receipt of Disability Benefit, refer to Page 12)
- If you retire (other than on grounds of ill health) **or**
- If you resign **or**
- If you no longer fulfil the eligibility requirements **or**
- If you leave the POA union **or**
- If your premiums cease **or**
- If you become unemployed **or**
- If you die.

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

Can I cancel my membership of the Plan?

Yes. You may cancel your membership of the Plan at any time by clearly instructing us to do so in writing. Please ensure your name, address and date of birth is included on the cancellation instruction. If you cancel within 30 days of the acceptance letter being sent to you, we will cancel your membership of the Plan and refund you any premiums you have paid.

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

What happens if I cease to be a member of the POA union?

If you leave the union you must inform us in writing. We will then cancel your membership of the Plan.

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

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

What commission does Cornmarket receive from the Insurer?

Initial charge	€200
Premium Deduction Charge	2.5%
Renewal charge paid by the Insurer to Cornmarket	12.5%

What if I travel abroad?

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

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

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

After this time, you must return to live within the member states of the European Union. In exceptional cases where a beneficiary is forced to live abroad, the Insurer will consider this on a case-by-case basis.

Are all claims paid?

The great majority of claims are paid.

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

- Medical opinion is that the member is not disabled from carrying out his or her normal occupation.
- When applying to join the Plan, the member did not give all relevant, requested medical information (information that the Insurer would regard as likely to influence the assessment and acceptance of your application). This is called non-disclosure. In addition to being the reason for a claim not being paid, non-disclosure may also result in membership of the Plan being cancelled. If this occurs, premiums will not be refunded.
- A claim is notified late, for example, approximately three months after salary is affected/diagnosis has occurred and hence the Insurer is no longer in a position to medically assess the claim.
- The illness or injury is a result of one of the general exclusions that exist on the Plan.
- The member attempts to claim for an illness or injury for which they received a specific exclusion.

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

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

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

General Plan Information

Full scheme name: Prison Officers' Association Income Continuance Plan

The Plan owner is the Prison Officers' Association.

The current Plan broker is Cornmarket

Group Financial Services Ltd.

The current Plan Insurer is Aviva.

The current Plan policy numbers are 710765 and 712074.

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

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

The next Plan review is due on or after 1st July 2022.

6. Specified Illnesses Appendices

Explanation of each Specified Illness and its pre-existing conditions

APPENDIX 1:

Definitions of Specified Illnesses

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

A definite diagnosis of Alzheimer's disease before age 65 by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- remember;
- reason; **and**
- perceive, understand, express and give effect to ideas. For the above definition, the following are not covered:
- Other types of dementia.

2. Aorta graft surgery – for disease

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

The term aorta includes 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.

3. Aplastic Anaemia - of specified severity

A definite diagnosis by a Consultant Haematologist of permanent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood transfusion
- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplant

All other forms of anaemia are specifically excluded.

4. Bacterial Meningitis - resulting in permanent symptoms

Bacterial Meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms*. The diagnosis must be confirmed by a Consultant Neurologist.

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

5. Balloon Valvuloplasty – to correct heart valve abnormalities

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

6. Benign brain tumour – resulting in permanent symptoms or surgical removal via craniotomy

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

- permanent neurological deficit with persisting clinical symptoms*, **or**
- Full or partial removal of the tumour by craniotomy (surgical opening of the skull) For the above definition, the following are not covered:
- Tumours in the pituitary gland.
- Angiomas.

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

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

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

Angiomas are specifically excluded.

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

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8. Blindness – permanent and irreversible

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

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9. Cancer – excluding less advanced cases

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

The term malignant tumour includes leukaemia, lymphoma and sarcoma. For the above definition, the following are not covered:

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

Explanation of the TNM system

The three elements in the system relate to the primary tumour (T), the regional lymph nodes (N) and metastases (M) where the severity of each condition increases as each scale ascends to the maximum. Once the tumour is T2 in size (large but restricted to the prostate) we pay out, it does not matter if there is lymph node involvement or distant metastasis, (distant spread of the disease). Scales of 0-4 are applied for T, 0-3 for N and 0-1 for M. A brief summary follows:

Primary Tumour (T)

Tis – carcinoma in situ

T0 – no evidence of primary tumour

T1 – small size, restricted to organ of origin T2-4 – increasing size/local invasion

Regional Lymph Nodes

N0 – no nodal metastases

N1-3 – increasing degrees of nodal metastases

Distant Metastasis

M0 - no distant metastases

M1 – distant metastases present.

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10. Cardiomyopathy - of specified severity

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

For the purpose of this definition, NYHA Class III is heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

All other forms of heart disease, heart enlargement and myocarditis are specifically excluded, as is cardiomyopathy directly related to alcohol or drug abuse.

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11. Chronic Lung Disease – requiring long term oxygen therapy

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

- The need for daily oxygen therapy for a minimum of 15 hours per day for a minimum period of 6 months;
- FEV1 being less than 40% of normal; Vital Capacity less than 50% of normal.

12. Coma – resulting in permanent symptoms

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

- requires the use of life support systems; and
- results in permanent neurological deficit with persisting clinical symptoms*. For the above definition, the following is not covered:
- Coma secondary to alcohol or drug abuse.

13. Coronary artery surgery

The undergoing of surgery on the advice of a Consultant Cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

For the above definition, the following are not covered:

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

14. Creutzfeldt-Jakob Disease – resulting in permanent symptoms

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

15. Deafness – permanent and irreversible

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

16. Encephalitis – resulting in permanent symptoms

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

Encephalitis in the presence of HIV infection is specifically excluded.

17. Heart attack – of specified severity

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

- New characteristic electrocardiographic changes.
- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
  - Troponin T > 1.0 ng/ml
  - AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction. For the above definition, the following are not covered:

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

18. Heart structural repair – with surgery to divide the breastbone

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

19. Heart valve replacement or repair

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

20. HIV infection– Occupational / Assault / Transfusion

Infection by Human Immunodeficiency Virus, resulting from:

- a blood transfusion given as part of medical treatment;
- a physical assault; **or**
- an incident occurring during the course of performing normal duties of employment from the eligible occupations listed below 1;

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

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV

antibody test taken within 5 days of the incident.

- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.
- The incident causing infection must have occurred in one of the following countries: Australia, Austria, Belgium, Canada, the Channel Islands, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, the Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the United States of America.

For the above definition, the following is not covered:

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

1 Note: Eligible occupations are doctor, health worker, prison officer, Garda, fire officer, ambulance officer.

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21. Kidney failure – requiring dialysis

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

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22. Liver Failure

End stage liver failure due to cirrhosis and resulting in all of the following:

- Permanent jaundice
- Ascites
- Encephalopathy

Liver disorder secondary to alcohol or drug misuse is excluded.

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23. Loss of hands or feet – permanent physical severance

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

24. Loss of Independent Existence – permanent and irreversible

Permanent and irreversible loss of the ability to function independently which is defined as follows:

- Being permanently unable to fulfil at least three of the following activities unassisted by another person:
  - o The ability to walk 100 metres on the flat
  - o The ability to get in & out of a standard motor vehicle
  - o The ability to put on, take off, secure & unfasten all necessary garments, and any braces, artificial limbs or other surgical appliances
  - o The ability to wash in the bath or shower (including getting into and out of the bath & shower) such that an adequate level of personal hygiene can be maintained
  - o The ability to climb a flight of 12 stairs without the assistance of special aids
  - o The ability to manage bowel & bladder functions such that an adequate level of personal hygiene can be maintained
- **OR:** Suffering from severe & permanent intellectual impairment which must
  - o Result from organic disease or trauma, and
  - o Be measured by the use of recognised standardised tests, and
  - o Have deteriorated to the extent that requires the need for continual supervision & assistance of another person throughout the day.

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

In making its assessment of any claim, Aviva will consider evidence from all the claimant's treating consultants, the treatment options available, and the likelihood of recovery. In addition, Aviva may require an Independent Medical Assessment by a Consultant or other health professional.

The diagnosis must be confirmed to the satisfaction of our Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.

25. Loss of speech – permanent and irreversible

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

26. Major organ transplant

The undergoing as a recipient of a transplant of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or inclusion on an official Irish or UK waiting list for such a procedure.

For the above definition, the following is not covered:

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

27. Motor neurone disease before age 65 – resulting in permanent symptoms

A definite diagnosis of motor neurone disease before age 65 by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

28. Multiple sclerosis – with persisting symptoms

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

29. Multiple system atrophy – resulting in permanent symptoms

A definite diagnosis of multiple system atrophy confirmed 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 & postural hypotension.

30. Paralysis of limbs – total and irreversible

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

31. Parkinson's Disease before age 65 –resulting in permanent symptoms

A definite diagnosis of Parkinson's disease before age 65 by a Consultant Neurologist.

There must be permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability.

For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse.

32. Pre-Senile Dementia before age 65 – resulting in permanent symptoms

A definite diagnosis of dementia by a consultant neurologist, psychiatrist or geriatrician. There must be permanent clinical loss of the ability to do all of the following:

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

Dementia directly related to alcohol or drug abuse is specifically excluded.

33. Primary Pulmonary Hypertension – of specified severity

A definite diagnosis by a Consultant Cardiologist of Primary Pulmonary Hypertension.

There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least Class III of the New York Heart Association classification of functional capacity.

For the purpose of this definition, NYHA Class III is heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

Pulmonary hypertension secondary to any other known cause is specifically excluded.

34. Progressive Supranuclear Palsy

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

35. Pulmonary Artery Surgery – with surgery to divide the breastbone

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

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36. Rheumatoid Arthritis - of specified severity

Severe Rheumatoid Arthritis affecting three or more of the following joint areas: hands, wrists, elbows, neck, knees, ankles, and toes, to the extent that there is permanent and irreversible loss of the ability to fulfil at least three of the activities of daily living listed in the Loss of Independent Existence definition.

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37. Stroke – resulting in permanent symptoms

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

For the above definition, the following are not covered:

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

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38. Systemic Lupus Erythematosus – of specified severity

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

Severe kidney involvement with SLE as evidenced by:

- Permanent impaired renal function with a glomerular filtration rate (GFR) below 30ml/min; **and**
- Abnormal urinalysis showing proteinuria or haematuria. **OR**

Severe Central Nervous System involvement with SLE as evidenced by:

- Permanent deficit of the neurological system as evidenced by at least any one of the following symptoms which must be present on clinical examination and expected to last for the remainder of the claimant's life – paralysis, localised weakness dysarthria (difficulty with speech) aphasia (inability to speak), dysphagia (difficulty in swallowing), difficulty in walking, lack of coordination, severe dementia where the Life Assured needs constant supervision or permanent coma.

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

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39. Third degree burns – covering 20% of the body's surface area, or 50% of the surface area of the face

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

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40. Traumatic head injury – resulting in permanent symptoms

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

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*For the purpose of the above definitions, "Permanent Neurological Deficit with Persisting Clinical Symptoms" is defined as follows:

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 co-ordination, 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 or psychological or psychiatric origin.

APPENDIX 2:

Definitions of Partial Specified Illnesses

a) We will make one partial payment for Specified Illness cover if the life assured is diagnosed as having one of the Specified Illnesses listed below, on a date after the start date and before the expiry date of the Specified Illness cover benefit.

b) If you make a claim for a partial payment benefit and you are able to fulfil any of the main benefit definitions, then you will be paid the main benefit sum assured only. No partial payment benefit will be made and your contract will cease from the point the main benefit becomes payable.

c) We will only make one payment per life on the plan under (a) above. This payment is independent of the main Specified Illness cover amount.

d) We will not pay any benefit under this section if a life assured dies within 14 days of a diagnosis as described in (a).

e) All the normal plan terms and conditions apply to these partial payments

1. Brain abscess drained via craniotomy

The undergoing of the surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a Consultant Neurosurgeon. There must be evidence of an intracerebral abscess on CT or MRI imaging.

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

A definite diagnosis of a carcinoma in situ of the oesophagus, which has been treated surgically by removal of a portion or all of the oesophagus. A carcinoma in situ is a malignancy that has not invaded the basement membrane but shows cytologic characteristics of cancer.

Histological evidence will be required.

Treatment by any other method is specifically excluded.

3. Carotid Artery Stenosis – treated by Endarterectomy or Angioplasty

The 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.

4. Cerebral arteriovenous malformation – treated by craniotomy or endovascular repair

The undergoing of surgical treatment via Craniotomy (surgical opening of the skull) by a Consultant Neurosurgeon of a cerebral AV fistula or malformation.

Or the undergoing of endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or malformation.

Intracranial aneurysm is specifically excluded.

5. Coronary Angioplasty – to correct narrowing or blockage to 2 or more coronary arteries

The undergoing of balloon angioplasty, atherectomy, rotablation, laser treatment or stent insertion on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of two or more main coronary arteries.

For the purposes of this definition the main coronary arteries are defined as:

- Right coronary artery
- Left main stem
- Left anterior descending
- Circumflex

Angiographic evidence will be required.

Insertion of 2 stents in different arteries at different times (e.g. on different days several years apart) does qualify for payment, after the second artery has been stented.

The following are not covered:

- Two or more procedures in the same artery
- Procedures to any branches of the main coronary arteries

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

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

Histological evidence will be required.

Prophylactic mastectomy at the request of the life assured, where no DCIS is found to be present, is specifically excluded.

7. Low level prostate cancer with Gleason score between 2 and 6 – and with specific treatment

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

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

Treatment with cryotherapy, transurethral resection of the prostate, 'experimental' treatments or hormone therapy, are all specifically excluded.

8. Serious Accident Cover

A serious accident means an accident resulting in severe physical injury where the life assured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

For the purposes of this definition a Serious Accident means injury resulting solely and directly from unforeseen, external, violent and visible means, and independent of any other cause.

A Life Assured may only claim once under this cover.

An accident as a result of any of the following is specifically excluded under this cover: Armed forces, hazardous pursuits, drug and alcohol, and self inflicted injury.

9. Surgical removal of one eye

Surgical removal of a complete eyeball for disease or trauma

10. Third Degree Burns covering 5% to 19% of the body's surface area or 25% to 49% of the face's surface area

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% and less than 20% of the body's surface area, or affecting between 5% and 20% of the head and neck, or between 25% and 50% of the surface area of the face, which for the purpose of this definition, includes the forehead and the ears.

Apply to join the Plan:
Call us on **(01) 470 8054**
or email **clientservices@cornmarket.ie**

For general Plan queries:
Call us on **(01) 408 4195**
or email **spsadmin@cornmarket.ie**

To make a claim:
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14674 POA ICP Summary Booklet 12-19