Salary Protection Scheme

for Chartered Accountants Ireland (CAI) Members

Cornmarket

Chartered Accountants Ireland

The Scheme is underwritten by Zurich Life Assurance plc.

Contents

This booklet is split into the following sections:

Disclaimers

This booklet is intended as a guide only. The Scheme is governed by the master Policy Document Numbers G003603, G003602 & G03604 issued by Zurich Life Assurance plc. Members of the Scheme may request a copy of the policy document from the Scheme 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 July 2020.

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 booklet for future reference.

Information in this booklet is correct as of July 2020 but may change. For the latest information, please see cornmarket.ie

Where we say 'Scheme', we mean the Salary Protection Scheme for Chartered Accountants of Ireland (CAI) Members.

Where we say 'Insurer', we mean Zurich Life Assurance plc.

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

1. Introduction

Overview of Key Benefits

1	**Disability Benefit**	A replacement income of up to **70%* of your annual Declared Earnings**** if you cannot work due to illness or injury
2	**Death Benefit**	Death Benefit of **twice your annual Declared Earnings**
3	**Specified Illness Benefit**	A once-off lump sum of **25% of your annual Declared Earnings** if you are diagnosed with and meet the policy criteria of one of the Specified Illnesses covered***
4	**Pension Premium Protection Benefit**	A further **10% of your annual Declared Earnings**** paid in the form of a contribution to a Personal Retirement Savings Account (PRSA) if you are claiming Disability Benefit from the Scheme for more than 2 years.

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

*Less any other income that you may be entitled to, for example half pay, Ill health early retirement Pension, State Illness or Invalidity benefit.

**The maximum Disability Benefit payable from this Scheme is the lesser of 70% of Declared Earnings or €180,000 per annum plus a maximum Pension Premium Protection Benefit of €25,700. The maximum Declared Earnings should therefore be €257,000.

***Please see the Appendices from page 31 to 38 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 Scheme if you are:

1. A member of Chartered Accountants Ireland (CAI).
   You must remain a member of CAI to remain an eligible member of the Scheme
2. Under age 55
3. Working 8 hours or more
4. 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.

Those on paid or unpaid statutory maternity, adoptive or paternity leave are considered 'actively at work' as long as this period of leave is not in excess of 42 weeks in total. Your deferred period will only start on the day you are due to return to work.

Those on career break, carer's leave, parental leave or other forms of unpaid leave are not considered 'actively at work'.

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

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 Scheme.
3. Promoting the Scheme.

The Insurer's role includes:

1. Deciding the policy terms and conditions and creating a policy document to reflect these.
2. Medically assessing applications and claims.
3. Deciding the various aspects of an individual member's cover, for example, if membership of the Scheme 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 70% of Declared Earnings after a certain period of time; known as the deferred period. See below for details of the deferred period and page 9 for the definition of Declared Earnings.

The Disability Benefit paid is less any other income, reward, award, pension, or benefit that you are entitled to. For example:

- 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.

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

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 Scheme. This is referred to as a Partial Disability Benefit.

Deferred period

After you are accepted as a member of the Scheme, 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 Scheme the waiting period is any period of 26 consecutive weeks' sick leave.
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 Declared Earnings

Declared Earnings for the purposes of this Scheme are defined as:

- **For accountants who qualified more than five years ago**, the average declared earnings over the last three years.
- **For accountants who qualified less than five years ago**, the greater of the most recent year's declared earnings or the average declared earnings over the last three years.

Premiums are paid by direct debit, therefore:

- You must advise us of any salary changes so that we can adjust your premium accordingly. This is to ensure that your cover is provided in line with your current Declared Earnings and that you are paying the correct premium amounts.
- You will need to send a Premium Statement to Revenue in order to claim income tax relief. If, throughout the course of your membership of the Scheme, you change your cover and hence premium amount, you should request an up-to-date Premium Statement from Cornmarket to send to Revenue so that Revenue can amend your income tax relief accordingly.
- Your premiums will reflect the last Declared Earnings you notified us of, or the last Declared Earnings that we estimated for you at the last Scheme review.
- You may incur charges from your bank.

Remember...

As this is an insurance policy, you must keep up your premium payments in order to stay on cover. Failure to pay premiums, could result in your membership of the Scheme lapsing. This means you will no longer be a member of the Scheme and you will not be on cover for any benefits. In the event that you wish to become a member of the Scheme 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 a medical condition(s) excluded.

Exclusions

There are no general exclusions under the Disability Benefit of the Scheme.

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

Disability Benefit

Limitations and Restrictions

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

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**
- remain 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.

Partial Disability Benefit is payable for a maximum of 52 weeks from the date you recommence working.

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

The maximum Disability Benefit payable is €180,000 per year, therefore Declared Earnings should not exceed €257,000.

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

If your claim is admitted the benefit you receive from the Insurer will be treated as income and as such is liable to income tax, PRSI, Universal Social Charge, etc. The Insurer will deduct any tax due from the Benefit made to the member, in the same way as an employer deducts tax from an employee.

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

- You recover,
- You resign,
- You go back to work (partial benefit may continue to be paid for up to 52 weeks 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 accepted residences without the written consent of the Insurer in advance (See Page 27 for list of accepted residences),
- You retire (except if you are claiming from the Scheme and retire on an Ill Health Early Retirement Pension),
- You reach age 60 **or**
- You die,

whichever is earliest.

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

Late Notification of 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.

Death Benefit

In the event of your death, a once-off lump sum will be paid by the Insurer to your estate. For most members the amount paid will be **twice their annual Declared Earnings**. See page 9 for definition of Declared Earnings.

If a Death Benefit claim is admitted, the benefit will be paid by the Insurer tax free. However, thereafter, beneficiaries of the estate will be subject to whatever taxes apply at the time of the inheritance and it will be their responsibility to ensure they are meeting their full tax liability.

Limitations and Restrictions

Death Benefit ceases on your 65th birthday.

As this is a group scheme you cannot assign the Death Benefit against a mortgage.

Terminal Illness Advance Payment

If you are certified by a medical specialist as having a terminal illness with death expected within 12 months, and the Insurer accepts this, the Scheme will pay out the full Death Benefit.

In the event that this occurs, Death Benefit under the Scheme will cease.

This Benefit ceases at age 64.

Accidental Death

In the event of accidental death, a benefit of €15,000 is payable tax-free in addition to the normal Death Benefit. 'Accidental Death' is defined as 'death as a direct result of a bodily injury arising from an external and accidental cause which leaves a visible bruise or wound' and is in no way linked to disease or physical disorder.

Exclusions apply where death is caused directly or indirectly by:

1. Taking part in any criminal act.
2. Taking drugs (other than under the direction of his/her own or any other registered medical practitioner) or alcohol.
3. The member's own deliberate act.

This Benefit ceases at age 60.

Specified Illness Benefit

If you are diagnosed with one of the illnesses listed below, and meet the definition/criteria of that illness (see appendices from page 31-38), this benefit will pay a once-off, tax-free lump sum of **25% of your annual Declared Earnings** at the date of diagnosis. See page 9 for definition of Declared Earnings.

- Aorta graft surgery
- Benign brain tumour
- Cancer (invasive cancers)
- Coronary artery surgery
- Alzheimer's disease
- Heart attack
- Heart valve and structural surgery
- HIV/AIDS infection through blood transfusion
- Kidney/ Renal failure (end stage)
- Loss of hearing (permanent and total)
- Blindness (permanent and total loss of vision)
- Loss of speech (permanent and total)
- Major organ transplant
- Motor neurone disease
- Multiple sclerosis
- Parkinson's disease (idiopathic)
- Severe burns
- Stroke

Specified Illness Benefit

Exclusions

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:
   - taking part in any criminal act,
   - taking alcohol or drugs (other than under the direction of a registered medical practitioner),
   - wilfully self-inflicted injury (whether sane or insane) **or**
   - flying in any capacity other than as a fare paying passenger, or for military transportation purposes.

b) You are residing outside of the European Union (as at commencement of this policy), Australia, Canada, Czech Republic, Hong Kong, Iceland, Japan, New Zealand, Norway, Saudi Arabia, Singapore, South Africa, Switzerland and USA for more than 13 weeks in any 52 week period unless you have been on career break, prior agreement was received from the Insurer and the relevant premium was paid.

c) If prior to your Specified Illness Benefit 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 a heart attack within the first 2 years of joining, if prior to joining you suffered from Diabetes. This is due to the recognised link between Diabetes and a heart attack. However, a diabetic who first suffers a heart attack 3 years after joining the Scheme will be eligible to claim.

d) 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 surgery, heart transplant and stroke, if you have suffered from or undergone surgery for one of these conditions before joining the Scheme you cannot claim under the policy in respect of any of these 4 illnesses. For example, if you underwent coronary artery surgery before joining you will never be covered for coronary artery surgery, heart attack, heart transplant or stroke.

Specified Illness Benefit

Limitations and restrictions

- Specified Illness Benefit became a benefit of the Scheme on 1st January 2009. You can only claim for diagnoses that occur after this date.
- A Specified Illness claim will only be paid if the diagnosis/severity meets the specific definition/ criteria outlined for that illness in the Appendices on pages 31-38.
- You will not be able to make a Specified Illness claim for an illness that:
  - you suffered from prior to joining the Scheme.
  - 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 Scheme.

Late Notification of Claims

You must make a Specified Illness Claim within 6 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 Specified Illness Benefit. You must survive for a minimum of 14 days 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.

Specified Illness Benefit ceases on your 65th birthday.

3. Cost

The total Scheme premium is **1.82% of gross Declared Earnings**. This includes the 1% insurance levy.

Scheme cost

The breakdown of this premium is:

Disability Benefit	0.71%
Death Benefit	0.71%
Specified Illness Benefit	0.31%
Pension Premium Protection Benefit	0.09%
Total	**1.82%**

Warning: The current premium may increase after the next Scheme review which will take place on/after 1st December 2022.

Income Tax Relief

The portions of your premium that are paid towards Disability Benefit and Pension Premium Protection Benefit are eligible for Income Tax Relief.

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 1.50%.

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

Here are some examples of the cost per month for various Declared Earnings taking income tax relief into account:

Declared Earnings	Gross cost	Net cost at 20% income tax	Net cost at 40% income tax
€40,000	€60.67	€55.34	€50.00
€70,000	€106.17	€96.84	€87.50
€100,000	€151.67	-	€125.00
€130,000	€197.17	-	€162.50

4. Claims

Roles

Cornmarket's role

Our role is to help guide you/your representatives 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 at what may be a very difficult time. All claims are 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 should be paid, they will calculate and pay the benefit.

Disability and Specified Illness Benefit Claims

How to make a Disability or Specified Illness Benefit claim?

Disability

We recommend that you contact us if you have been unable to work for 8 consecutive weeks and are likely to remain unable to work for the remainder of the deferred period (See Page 8 for details).

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 Scheme **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 11.

Specified Illness

Contact us as soon as possible if you have been diagnosed with one of the Specified Illnesses, 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 16.

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 Scheme.

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 Scheme 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 Scheme.

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

1. provide medical evidence from your doctor (your doctor may charge you for this) **and/or**
2. provide medical evidence from your specialist **and/or**
3. complete a tele-claims interview with a nurse **and/or**
4. attend an Independent Medical Examination (IME). It generally takes about 3 weeks for the IME report to be returned to the Insurer **and/or**
5. attend the Insurer's Occupational Health Advisor

Items 2, 3, 4 and 5 are at the Insurer's expense and reasonable travel expenses will be covered, if travel is necessary.

We will liaise with your employer (if applicable), the Insurer and you throughout the assessment.

What happens after my Disability Benefit claim is assessed?

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

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

- The Insurer will arrange for benefit to be paid to your bank account. Disability Benefit will be paid in arrears and may be paid on a monthly basis. Therefore, it may take up to four weeks after your claim is admitted to receive your first benefit. If your claim is admitted after the end of the deferred period (See Page 8 for details) the benefit may be backdated to the date the deferred period expired.
- 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, certificates of continued disablement, medical certificates from your doctor, and/or require you to attend an independent medical examination and/or organise for a Health Claims Advisor to visit you.
- 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 Scheme 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 Scheme benefits without having to pay premiums for them up until the ceasing age of those benefits.

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

What will happen if my Disability Benefit claim is declined?

- If your claim is declined, the Insurer will inform you of the reasons for the decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. 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 Scheme.
- 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 claim Specified Illness Benefit, you will no longer be covered for any Specified Illness Benefit. You will no longer be required to pay for it and we will reduce your premium accordingly.

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 draw down a pension early on the grounds of ill health the pension amount will be deducted when calculating the benefit payable under the scheme.

If you are self-employed and have a Personal Pension (a Retirement Annuity Contract), taking pension early on the grounds of ill health will require approval from Revenue. For those with an Occupational Pension the employer's approval is required.

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

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

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 26 weeks 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'.

Death Benefit Claims

How to make a Death Benefit claim

To ensure we are notified in the unfortunate event of your death, it's best that you instruct your representatives/ Next of Kin/Solicitor to contact us.

After initial contact is made, if appropriate, we will advise of the documentation required to process the claim.

How long will it take to process a Death Benefit claim?

If your estate is being processed through the Probate Office, this may result in delays in the processing of the claim. These delays could take over 12 months.

Once the Insurer receives all documentation and information required, and the Insurer decides to admit the claim, Benefit is usually paid to the estate/trustees within 10 working days.

5. Frequently Asked Questions

How can I apply to join the Scheme?

You must complete an application form either:

– With your Cornmarket Consultant **or**

– Over the phone - call **(01) 470 8054**

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 Scheme 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 Scheme could be void; you will not be covered under the Scheme,
- 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 Scheme 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 Scheme.

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

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

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

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

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

You may be over-insured as you cannot receive a benefit of more than 70% of your Declared Earnings. In other words, you cannot receive benefit from both this Scheme and another similar Scheme. If you are in this situation, please contact us to arrange an appointment with one of our Consultants.

When does my cover under the Scheme cease?

- Your 60th birthday for Disability Benefit and Pension Premium Protection Benefit
- Your 65th birthday for Death Benefit and Specified Illness Benefit

Cover for all benefits cease in the following situations:

- If you retire (other than on grounds of ill health) **or**
- If you no longer fulfil the eligibility requirements **or**
- If you leave Chartered Accountants Ireland **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 Scheme?

Yes. You may cancel your membership of the Scheme 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 Scheme and refund you any premiums you have paid.

If you cancel your membership of the Scheme, 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 Scheme and re-applied, you may not be accepted as a member again or you may be accepted with a medical condition(s) excluded.

What happens if I cease to be a member of CAI?

If you leave CAI you must inform us. We will then cancel your membership of the Scheme.

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

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

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

What commission does Cornmarket receive from the Insurer?

Initial charge	€400
Premium Deduction Charge	1.0%
Renewal charge paid by the Insurer to Cornmarket	12.5%

What if I travel abroad?

In order to remain on cover under this Scheme you must remain a resident within the countries of the European Union, Switzerland, USA, Canada, Australia, New Zealand and South Africa.

Your cover under the Scheme will not be affected if you travel briefly for normal holiday purposes. However, if you decide to reside or work outside of these countries 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 Scheme.

You will not be permitted to reside outside of the accepted residences listed above if you are in receipt of Disability Benefit from the Scheme. The Insurer reserves the right to request that claimants come back to Ireland for an Independent Medical Examination while they are in receipt of Disability Benefit, the expense of which must be agreed between you and the Insurer in advance. Only reasonable expenses will be covered by the Insurer.

Are all claims paid?

Most claims are paid.

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

- Medical opinion is that the member is not disabled from carrying out their normal occupation.
- When applying to join the Scheme, 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 Scheme 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 Scheme.
- The member attempts to claim for an illness or injury for which they received a specific exclusion.

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

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

Or

Email: **complaints@cornmarket.ie**.

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

6. General Scheme Information

This is a group protection scheme. This means that the costs and benefits cannot be changed by any individual member. Instead, the Scheme owner reviews the Scheme 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 Scheme.
At a review it may be decided that the Scheme should move Brokers and/or Insurers. In the event that this occurs, all Scheme membership data will be transferred to the new Broker and/or Insurer. Additionally, at a review, it may be decided to terminate the Scheme 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 Scheme.

Decisions taken by the Scheme owner will be binding on all members.
The Scheme owner is the Institute of Chartered Accountants in Ireland.
The next Scheme review is due on or after 1st December 2022.

The current Scheme broker is Cornmarket Group Financial Services Ltd. The current Scheme Insurer is Zurich Life Assurance plc. The current Scheme policy numbers are G003603, G003602 & G03604.

7. Specified Illnesses Appendices

ZURICH

Explanation of each Specified Illness and its pre-existing conditions

APPENDIX 1:

Premiums, Critical Events and Pre-existing Conditions

Premiums

On the Commencing Date and on the Renewal Date, a premium shall be calculated by the Company in respect of the policy year commencing on that date, by applying the Premium Rates set out in the First Schedule to the relevant Serious Illness Benefits in respect of the Members on that date.

While premiums are payable to Zurich Life Assurance monthly in arrears each instalment will consist of the total premiums due for each Member over the relevant instalment period.

Notwithstanding the above, the extra premium payable in respect of any Member accepted by Zurich Life Assurance at other than standard rates, shall be determined by Zurich Life Assurance.

Critical Events

Definitions of the Critical Events covered are detailed in this Second Schedule. No other illnesses or medical conditions are covered.

Once liability has been admitted in respect of a Member, that Member's cover ceases.

Pre-existing Conditions and other important exclusions

Zurich Life Assurance has put in place certain 'pre-existing condition exclusions' which will apply to Serious Illness Benefits.

No Serious Illness Benefits shall be payable under this Policy for any Critical Event which a Member has suffered from prior to the inception of cover in respect of that Member. For example, if a Member contracted cancer a number of years prior to entry to the Scheme, that Member, can never claim for cancer but that Member is covered for the other Critical Events.

For the purpose of the pre-existing condition exclusion, the suffering or undergoing of heart attack, coronary artery by-pass surgery, heart transplant, angioplasty or stroke is considered to be the same disease, e.g. if a heart attack has been suffered prior to entry, no benefit shall be payable for future occurrence of heart attack, coronary artery by-pass surgery, angioplasty, heart transplant or stroke. The Member will be covered for the remaining critical events.

In the event of one of the Critical Events covered occurring within two years of the date a Member joined the Scheme, Serious Illness Benefit will not be paid and cover for that critical event will cease, if that critical event has resulted either directly or indirectly from any condition which the Member suffered from prior to the date he joined the Scheme.

It should be noted that this exclusion only arises if the Critical Event occurs within the first two years of cover.

Exclusions

No benefit will be payable where a Critical Event is caused by or arises in any way from any of the following:

- Wilfully self inflicted injury (whether sane or insane).
- Alcohol or drugs unless taken as prescribed by a registered medical practitioner.
- Participation in a criminal act.
- Flying in any capacity other than as a fare paying passenger, or for military transportation purposes.

Explanation of Critical Events and Pre-existing Conditions

This section sets out the policy definition for each of the Serious Illnesses/Critical Events covered under this Policy, a simple explanation of each illness, and information on the related conditions that preclude cover in the event of insured illnesses occurring within the first two years of cover. This should be read in conjunction with the pre-existing conditions included at the end of the illness explanation.

Alzheimer's Disease

Policy Definition

A global impairment of brain function such that permanent supervision or assistance by a third party is required. The diagnosis must be made by a consultant neurologist* who should be satisfied that there is no other discernible cause.

Alzheimer's disease is a progressive disease whereby the nerve cells in the brain deteriorate and the size of the brain reduces.

A claim can be made if there is a definite diagnosis by a consultant neurologist* that the Member is suffering from the disease resulting in the need for permanent supervision or assistance.

*Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: None.

Aorta graft surgery

Policy Definition

The undergoing of surgery to correct any narrowing, dissection, or aneurysm of the thoracic or abdominal aorta.

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). The aorta may also become torn (dissection), leading to a surgical emergency. Surgery to correct these conditions is covered.

Pre-existing conditions: If the Member has ever suffered from any disease or disorder of the heart, hypertension or any obstructive/occlusive arterial disease he can never claim for Aorta graft surgery.

Benign brain tumour

Policy definition

A non-cancerous tumour in the brain. Cysts, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas, and tumours in the pituitary gland, spinal cord, and acoustic nerve are not covered.

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. Cysts (fluid sacs) and granulomas (outgrowths of tissue), which can occur in the brain, are not covered because they are not tumours. Growths in the pituitary gland or spine are not covered because these are outside the actual brain. Malformations in, or of, the arteries or veins of the brain and haematomas, which are blood clots rather than growths of tissue, are also excluded.

Pre-existing conditions: None.

Blindness (permanent and total loss of vision)

Policy definition

Total, permanent, and irreversible loss of all vision in both eyes. Zurich Life Assurance can require confirmation that the loss of sight is total, permanent and irreversible from an ophthalmologist that has been appointed as a consultant physician*.

A claim can be made if the Member has total, permanent and irreversible loss of sight in both eyes (which means no vision whatsoever).

It is important to realise that this definition is very specific. It may be possible to qualify for a Department of Social Welfare blind pension but still not be covered by the above definition.

* Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: No benefit will be payable under the blindness critical condition in respect of a Member who, at any time prior to the date of entry into the scheme, has been registered blind.

Cancer (invasive cancers)

Policy definition

Any malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term 'cancer' includes leukaemia and Hodgkin's disease, but the following are excluded:

- all tumours that are histologically described as non-invasive, or cancer in situ;
- all forms of lymphoma in the presence of any Human Immuno-deficiency Virus;
- kaposi's sarcoma in the presence of any Human Immuno-deficiency Virus; and

- any skin cancer other than invasive malignant melanoma.

The term 'cancer' is used to refer to all types of malignant tumours. A malignant tumour usually grows quickly, often 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 the Member is diagnosed as suffering from a malignant tumour that has invaded surrounding tissue, unless the type of cancer is specifically excluded. The claim must be supported by a microscopic examination of a sample of the relevant cells. This is known as a histology and would usually be carried out as part of a normal hospital investigation.

All forms of lymphoma (a cancer of the lymphatic system), including non-Hodgkin's disease are covered. Malignant melanoma (a serious form of skin cancer) is the only form of skin cancer that is covered. This is because most other forms of skin cancer are relatively easy to treat and are rarely life threatening.

The policy does 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: If the Member has a history of Polyposis coli, Papilloma of the bladder, Crohn's disease, or an abnormal smear test or any carcinoma in situ, prior to the later of the Commencement Date or the date he joined the Scheme and is found to have cancer within the first two years of cover, no benefit will be payable under this Policy for that condition and he will cease to be covered for cancer.

Coronary artery surgery

Policy definition

The undergoing of open-heart surgery on the advice of a Consultant Cardiologist* to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

Coronary artery surgery may be required when the coronary arteries are narrowed or blocked. This is done by taking a blood vessel and using it to bypass the diseased or blocked artery in the heart.

It is possible to be diagnosed as suffering from coronary artery disease and to have it treated with non- surgical techniques (for example, balloon angioplasty or laser treatment). These treatments are not included under this particular definition because they do not require surgery, but they may be covered under the definition of "angioplasty".

* Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If the Member has ever suffered from any disease or disorder of the heart, hypertension or any obstructive/occlusive arterial disease he can never claim for Coronary artery surgery.

Heart attack

Policy definition

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

- an episode of typical chest pain;
- new electrocardiographic changes; and
- the characteristic rise of cardiac enzymes.

A heart attack (myocardial infarction) occurs when an area of the heart muscle dies because of a lack of oxygenated blood. This 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.

A claim can be made if the Life Insured has been diagnosed as suffering from a heart attack, provided that the claim is supported by the following:

- chest pains that are characteristic of a heart attack;
- new electrocardiogram (ECG) changes (an ECG is a graphical record of the electrical impulses that keep the heart beating); and
- an increase in cardiac enzymes that are released into his blood stream by damaged heart muscles.

It is important to understand that because angina pectoris and crescendo angina (chest pain and choking feeling) are not heart attacks, they are not covered by this definition.

Only a Member who fulfils the three conditions above can successfully claim under this definition.

Pre-existing conditions: If the Member has ever suffered from any disease or disorder of the heart, hypertension or any obstructive/occlusive arterial disease he can never claim for Heart Attack.

Heart valve and structural surgery

Policy definition

The undergoing of open-heart surgery on the advice of a cardiologist who has been appointed as a consultant physician* to correct valvular or structural abnormalities.

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.

Structural abnormalities include abnormal openings in the dividing wall separating the left and right chambers of the heart. The Member can claim if he undergoes open-heart surgery to correct valvular or structural abnormalities of the heart.

*Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If the Member has ever suffered from any disease or disorder of the heart, hypertension or any obstructive/occlusive arterial disease he can never claim for Heart valve and structural surgery.

HIV infection or AIDS as a result of a blood transfusion

Policy definition

Diagnosis of infection by any Human Immuno-deficiency Virus (HIV), as defined by the World Health Organisation at the Commencing Date of the policy, acquired from a transfusion of blood occurring in Ireland or the UK and given as part of medical treatment, such transfusion having occurred after the Commencement Date of the policy. The Company's Chief Medical Officer* must be provided with unequivocal evidence that AIDS or HIV was acquired in this manner.

AIDS is generally recognised as being caused by the Human Immuno-deficiency Virus (HIV). The transmission of HIV is usually through sexual contact, infected needles used by intravenous drug abusers, or contaminated blood products. Because blood transfusion is not the only possible source of HIV infection, the Company's Chief Medical Officer* must be satisfied that blood transfusion was the source of infection for a successful claim.

* Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: None

Loss of hearing (permanent and total)

Policy definition

Total, permanent and irreversible loss of hearing in both ears, as confirmed by an appropriate physician that has been appointed as a consultant physician*.

Although it may be possible to be diagnosed as 'deaf' while having a reduced hearing ability, this definition only covers total, permanent and irreversible loss of hearing in both ears with no chance of recovery.

* Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If the Member has a history of acoustic nerve tumour, neurofibromatosis or cholesteatoma prior to the later of the Commencement Date or the date he joined the Scheme and he suffers total, permanent and irreversible loss of hearing within the first two years of cover, no benefit will be payable under this Policy for that condition and he will cease to be covered for loss of hearing.

Loss of speech (permanent and total)

Policy definition

Total, permanent and irrecoverable loss of the ability to speak because of physical damage to the vocal cords. This loss must be established for a continuous period of twelve months. An appropriate physician that has been appointed as a consultant physician* must confirm that the loss of speech is both total, permanent and irreversible.

It is possible to suffer temporary speech loss (for example, as a result of severe trauma). This definition only covers total, permanent and irrecoverable loss of speech because of damage to the vocal cords.

*Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If the Member has a history of transient ischaemic attack, stroke, motor neurone disease, multiple sclerosis,

cancer, brain tumour, laryngeal polyps prior to the later of the Commencement Date or the date he joined the Scheme and he suffers total and permanent loss of speech within the first two years of cover, no benefit will be payable under this Policy for that condition and he will cease to be covered for loss of speech.

Major organ transplant

Policy definition

The actual undergoing of a necessary transplantation as a recipient of, or inclusion on an official 'hospital' waiting list for a transplant of a heart, a kidney, a liver, a lung, a pancreas or bone marrow.

Major organ transplant surgery is required when it is necessary to replace a severely diseased or damaged organ with a healthy organ. A claim can be made if a transplant of one or more organs, as listed in the definition, is carried out or the Member is placed on a recognised waiting list of a hospital* for such a transplant.

This definition does not cover organ donation.

* Please see note on Hospital in the Appendix.

Pre-existing conditions: If the Member has ever suffered from cardiomyopathy, coronary artery disease, cardiac failure, chronic liver disease, pancreatitis, pulmonary hypertension, chronic lung disease or chronic kidney disease prior to the later of the Commencement Date or the date he joined the Scheme he can never claim under any of these six illnesses.

Motor neurone disease

Policy definition

Unequivocal diagnosis of motor neurone disease by a neurologist that has been appointed as a consultant physician*.

Motor neurone disease is a progressive disorder of the central nervous system, which controls muscular activity. The disease is characterised by muscle weakness and muscle wasting.
A claim can be made if there is a definite diagnosis by a consultant neurologist* that the Member is suffering from the disease.

*Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If the Member has a history of progressive muscular atrophy, primary lateral sclerosis or progressive bulbar palsy prior to the later of the Commencement Date or the date he joined the Scheme and is found to have motor neurone disease within the first two years of cover, no benefit will be payable under this Policy for that condition and he will cease to be covered for motor neurone disease.

Multiple sclerosis

Policy definition

Unequivocal diagnosis of multiple sclerosis by a consultant neurologist* following more than one episode of well defined neurological symptoms and confirmed by modern investigative techniques such as image scanning.

Multiple sclerosis is a progressive disease of the central nervous system that destroys the protective covering (myelin) of the nerve fibres in the brain and spinal cord. The severity of the disease can vary considerably, and symptoms can differ depending upon which areas of the brain or spinal cord have been affected.

It is difficult to diagnose multiple sclerosis; however, a consultant neurologist* can perform various tests (for example, CT scan, lumbar puncture, MRI scan) to assist in making the diagnosis. In the early stages, symptoms can be quite unspecific, so a consultant neurologist* will not always be able to make a definite diagnosis.

A claim can be made if the Member is diagnosed by a consultant neurologist* as suffering from multiple sclerosis. A claim must be supported by the results of modern investigational techniques and the display of well-defined symptoms of the disease.

* Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If the Member has a history of any form of neuropathy, encephalopathy or myelopathy including, but not restricted to, the following:

- abnormal sensation (numbness) of the extremities, trunk or face;
- weakness or clumsiness of a limb;
- double vision;
- partial blindness;
- ocular palsy;
- vertigo (dizziness); or
- difficulty of bladder control;

prior to the later of the Commencement Date or the date he joined the Scheme and is found to

have multiple sclerosis within the first two years of cover, no benefit will be payable under this Policy for that condition and he will cease to be covered for multiple sclerosis.

Parkinson's disease (idiopathic)

Policy definition

Unequivocal diagnosis by a consultant neurologist* of idiopathic Parkinson's disease resulting in the need for permanent supervision and assistance.

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.

A claim can be made if the Member has idiopathic Parkinson's disease to the extent that he requires permanent supervision and assistance in daily tasks, such as dressing and eating. Idiopathic means that the disease has originated from an unknown cause. Non-idiopathic Parkinson's disease results from a known cause, such as certain drugs or toxic chemicals, and is not covered by this definition.

It is important to realise that diagnosis of idiopathic Parkinson's disease in itself is not covered by this definition: a Member must also require permanent supervision.

* Please see note on Medical Opinion in the Appendix.

Pre-existing conditions: If a Member has had treatment with psychotropic medication or suffered tremor or extra pyramidal disease prior to the later of the Commencement Date or the date he joined the Scheme will be taken as an indication that the Life Insured may be suffering from Parkinson's disease and no benefit will be payable on any future diagnosis.

Kidney failure (end stage)

Policy definition

End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis or renal transplant is initiated.

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, regular renal dialysis or a kidney transplant will be required; therefore, a claim can be made.

Pre-existing conditions: If the Member has a history of hypertension, familial polycystic kidney disease or any chronic renal disease or disorder prior to the later of the Commencement Date or the date he joined the Scheme and suffers kidney failure within the first two years of cover, no benefit will be payable under this Policy for that condition and he will cease to be covered for kidney failure.

Severe burns

Policy definition

Third degree burns covering at least 20% of the surface area of the Life Insured's body.

Medically, there are three levels of burns, which are defined by reference to the extent of the damage done to the skin:

- first degree burns are those which damage the top layer of skin (mild sun burn would be an example);
- second degree burns are those which go deeper into the layers of skin (some second degree burns heal without scarring); and
- third degree burns are the most serious because they destroy the full thickness of the skin.

For a valid claim, the Member must suffer third degree burns over at least 20% of the body's surface area. Pre-existing conditions: None.

Stroke

Policy definition

A cerebrovascular incident resulting in permanent neurological damage. Transient ischaemic attacks are specifically excluded.

As the brain controls all the functions of the body, any damage to it can have serious effects. A stroke happens when the brain is severely damaged due to internal bleeding (haemorrhage) or when the flow of blood in any artery leading to the brain has been blocked by

a piece of tissue (a thrombus) or a blood clot (an embolus).

A claim can only be made if the Member suffers a stroke that leaves evidence of permanent damage to the nervous system, such as disturbance of speech or vision or paralysis of the right or left side of the body.

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.

Pre-existing conditions: If the Member has ever suffered from hypertension, atrial fibrillation, transient ischaemic attacks, intracranial aneurysm or occlusive arterial disease he can never claim for Stroke.

A Note on Claims under this Policy

In the event of a claim under this Policy only the definitions in this Policy will be used to determine its validity. The contents of the membership booklet do not affect the interpretation of the policy rules.

For full details of the terms and conditions of any individual cover or any other aspect of the scheme this Policy should be consulted which is definitive in all matters of interpretation and entitlement to benefit. With regard to medical conditions there may be a difference between the Member's perception of some medical conditions and the actual medical definitions as set out in the Policy. In the event of a dispute the Company's Chief Medical Officer's* opinion will be final.

*Please see note on Medical Opinion in the Appendix.

APPENDIX 2:

Explanation of Technical Terms

Consultant

A physician that currently holds an appointment as a consultant by a hospital in Ireland or the United Kingdom.

Hospital

A hospital is a legally constituted institution that has the following characteristics:

- is licensed to carry out medical and surgical procedures; and
- is operated primarily for the care and treatment of sick and injured persons as in-patients; and
- continuously provides 24-hour medical care by registered nurses or doctors; and
- is equipped with an operating room in which anaesthesia is administered under proper medical supervision, and surgical operations are regularly performed by licensed physicians or surgeons; and
- is not primarily a clinic, health hydro, nursing home, rest home, convalescent home, or similar establishment.

In-patient

This is a patient in a hospital that occupies a bed overnight for the sole purpose of receiving surgical or medical procedures whose sole purpose is the cure or relief of acute illness or injury.

Medical Opinion

Where Medical Opinion is required, the Company will accept that of its Chief Medical Officer or a physician that currently holds an appointment as a consultant by a hospital in Ireland or the United Kingdom. In the event of a dispute with any Life Insured, the Insurer will seek the opinion of an appropriate independent physician. The Insurer will not accept the opinion of any medical expert normally operating outside the Territorial Limits.

Apply to join the Scheme:
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