



# POLICY CONDITIONS

Specified Serious Illness Cover

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## SPECIFIED SERIOUS ILLNESS COVER POLICY CONDITIONS

### 1 Introduction

This policy is provided by **us** (The **Royal London Mutual Insurance Society Limited**) to **you** (the policyholder(s) named in the **policy schedule**).

Words in **bold** are explained in Section 2.

The policy consists of the **policy schedule**, any endorsements attaching to it, the policy conditions booklet, the application and any related information provided by **you** or anybody acting on **your** behalf during the application process.

This policy is a protection plan only – there is no surrender value payable at any stage under the policy. Even if **you** have not made a claim by the time the period of cover ends, **we** will not return **your premiums**. All cover under the policy will end on the expiry date shown in the **policy schedule**, unless it has ended before that for any of the reasons explained in these policy conditions.

If **you** are making a claim under this policy, please contact **us** at **our** Head Office at:

**Royal London Group**  
47-49 St Stephen's Green  
Dublin 2  
Ireland

☎ +353 (0)1 429 3333

☎ +353 (0)1 662 5095

✉ service@royallondon.ie

In legal disputes Irish law will apply. **Premiums** and **benefits** are payable in the currency of Ireland.

More detailed information on all these matters is in the relevant sections of this policy conditions booklet.

### How does the policy work?

**You** choose the type of cover **you** want and pay the **premiums** to **us** as set out in the **policy schedule**. If an event for which **you** are covered occurs during the term of the policy, **we** will pay **you** the appropriate **benefit** (the **benefits** are described in greater detail later on in this policy conditions booklet).

### Who receives the money we pay out?

The policyholder(s), as defined in the **policy schedule**, or their legal personal representatives, will receive the money **we** pay out.

However, if this policy has been assigned to someone else (for example, it is passed to a Building Society to be placed with title deeds as security for a mortgage), **we** will pay that person or organisation. If the policy is written under trust, **we** will pay the trustee(s) who are obliged to distribute the proceeds in accordance with the Trust Conditions. The right to receive the policy's **benefits** may also pass to other people, such as someone who holds a power of attorney.

### Writing to us

If **you** need to write to **us** about this policy, please write to **our** Head Office, quoting **your** policy number, at:

**Royal London Group**  
47-49 St Stephen's Green  
Dublin 2  
Ireland

### Cooling-off period

If, after taking out this policy, **you** feel it is not suitable, **you** may cancel it by writing to **us** at the address shown above. If **you** do this within 30 days from the date **we** send **you** **your** policy documents (or a copy), **we** will return any **premiums** **you** have paid. **We** strongly recommend that **you** consult with **your** Financial Adviser before **you** cancel **your** policy.

### Cancellation

If this policy is to be cancelled, **we** must receive written notification, signed by **you**, to the address shown above.

If this policy has been issued in connection with a mortgage, or other loan, which is subsequently paid off or transferred to another lender, **your** cover will remain in place unless **you** inform **us** in writing that **you** wish to cancel this policy.

Until **you** have informed **us** that **you** no longer need this cover, **we** will continue to collect **premiums** and **you** will remain covered by the policy. **You** will not be entitled to any refund of **premiums**.

It is not possible to cancel one **benefit** under this policy whilst retaining another **benefit** in place. For example, **you** cannot cancel a Specified Serious Illness Cover **benefit** and keep a Life Cover **benefit** in place.



**Complaints**

**Royal London** is committed to the provision of the highest standards of customer service. However, if **you** are dissatisfied with any aspect of **our** service, please let **us** know. **We** take all complaints very seriously. If **you** wish to complain about any aspect of the service **you** have received, please contact **Royal London** directly. If **your** complaint is not dealt with to **your** satisfaction, **you** may refer **your** complaint to:

Financial Services  
Ombudsman’s Bureau,  
3rd Floor, Lincoln House,  
Lincoln Place,  
Dublin 2.

-  1890 88 20 90 (Lo Call)
-  +353 (0)1 662 0899
-  +353 (0)1 662 0890
-  enquiries@financialombudsman.ie
-  www.financialombudsman.ie

**2 Definitions**

**AIDS**

**AIDS** means Acquired Immune Deficiency Syndrome.

**Benefit**

The amount payable in the event of a claim under the policy.

**Chief Medical Officer (CMO)**

The **Chief Medical Officer** is a **registered medical practitioner** retained by **Royal London**.

**Consultant**

A **registered medical practitioner** who has specialist qualifications in an appropriate branch of medicine and who is practising at a **major hospital** in the Republic of Ireland or UK.

**Conversion Option Expiry Date (if the policy schedule shows that a conversion option applies)**

If a conversion option applies to this policy, a **conversion option expiry date** will be shown on the **policy schedule**. **You** can only exercise the option before this date (see Section 10).

**Diagnosis of an Insured Specified Serious Illness**

A **Life Assured** is ‘diagnosed as having an **insured specified serious illness**’ if on a date after the **start date** of the policy and before the **policy expiry date**, the **Life Assured** has:

- been diagnosed as having one of the **insured specified serious illnesses** or medical conditions as defined in Section 6 of these policy conditions; or
- had a surgery defined in Section 6 of these policy conditions.

**Dual Life**

If there are two **Lives Assured** and cover is on a **Dual Life** basis (see **policy schedule**), cover is provided separately for the two lives. As the two lives are covered independently a claim for one **Life Assured** has no impact on the **benefits** relating to the second **Life Assured** (see Section

5). **Dual Life** is not available with a Mortgage Protection Policy.

**European Union (EU)**

Any country which is a member of the **European Union (EU)** at the date the policy commences.

**HIV**

**HIV** means Human Immunodeficiency Virus.

**Increase Date (if the policy schedule shows that Indexation applies)**

This is each anniversary of the **start date** shown in the **policy schedule**. On this date each year the **benefit** and **premium** will increase if **Indexation** applies at that time, subject to certain conditions (see Section 9).

**Insured Specified Serious Illnesses**

The **insured specified serious illnesses** as defined in Section 6 of this booklet which are covered by this policy, unless excluded in the **policy schedule**.

**Irreversible**

An illness or condition is **irreversible** if after having appropriate treatment, including surgery, there is no reasonable hope of a recovery according to medical knowledge at that time.

**Joint Life**

If there are two **Lives Assured** and cover is on a **Joint Life** basis (see **policy schedule**), a claim for one **Life**

**Assured** will reduce the overall level of cover provided by the policy by the amount of the claim (excluding Children’s Specified Serious Illness Cover claims). Where all cover under a policy has been reduced to nil as a result of a claim or claims the policy will cease immediately (see Section 5).

**Life Assured or Lives Assured**

The person or people named in the **policy schedule** as the life or lives covered. Payment of the **benefits** under the policy depends on the health and the lives of those people. Where **we** refer to ‘**Lives Assured**’ in these policy conditions, it is assumed to mean ‘**Life Assured**’ where there is only one life covered on the policy.

**Major Hospital**

An institution in the Republic of Ireland or UK which has facilities for diagnosis, treatment and major surgery and has accommodation for in-patients. It does not include a long-term nursing unit, a geriatric or pre-convalescent ward, or an extended-care facility for convalescence, rehabilitation or other similar function.

**Medical Specialist**

A **registered medical practitioner** who has specialist qualifications in an appropriate branch of medicine and who is practising at a **major hospital** in the Republic of Ireland or UK.

**Partial Payment Specified Serious Illness**

The **partial payment specified**

**serious illnesses** as defined in Section 7 of this booklet which are covered by this policy, unless excluded in the **policy schedule**.

**Period of Grace**

The period of time, after the date a **premium** payment is due, allowed for the payment of any outstanding **premium**(s). See Section 4 of this booklet.

**Permanent**

Expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

**Permanent neurological deficit with persisting clinical symptoms**

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

The following are not covered:

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

e.g. brisk reflexes without other symptoms

- Symptoms of psychological or psychiatric origin.

**Policy Schedule**

This is part of the contract. It sets out the specific details of the policy such as:

- the **start date**;
- the expiry date;
- the Life or **Lives Assured**;
- the policyholder or policyholders;
- the Life Cover;
- the Specified Serious Illness Cover;
- the **premium**; and
- any special conditions that apply.

**Policy Expiry Date**

The expiry date shown in the **policy schedule**. All cover will end on this date unless it has ended earlier.

**Premium**

Either:

- the amount shown in the **policy schedule** under the relevant heading (or the amount to which it has been increased if **Indexation** applies); or
- the amount payable if **we** reinstate cover under Section 4.3; or
- the reduced amount payable if there has been a claim on the Specified Serious Illness Cover (excluding Children’s Specified Serious Illness Cover or Advance Payment of **Benefit** for Heart Surgery); or

- the reduced amount payable if there has been a claim on a **Dual Life** policy (excluding Children's Specified Serious Illness Cover or Advance Payment of **Benefit** for Heart Surgery); or
- the increased amount payable if an option covered under Section 8 of this booklet has been exercised.

### Registered Medical Practitioner

A person who meets the legal requirements for carrying on a medical practice in the Republic of Ireland or UK and who actually practices medicine in either of those countries.

### Start date

This is the date that the policy and the cover starts and the date that the first **premium** is due. It is stated in the **policy schedule**.

### Survival Period

For Stand-alone Specified Serious Illness Cover, a **Life Assured** must survive for a period of 14 days after the date of diagnosis of an **insured specified serious illness** in order to make a claim under the Specified Serious Illness Cover **benefit**. **We** will not pay any Specified Serious Illness Cover **benefit** for that **Life Assured** if they die within this period.

### We/Royal London/Our/Us

The **Royal London Mutual Insurance Society Limited**.

### You/Your (the policyholder)

The person (or people or organisation) named as the policyholder in the **policy schedule**, who is/

are responsible for ensuring the **premiums** under the policy are paid. The policyholder is legally entitled to the policy **benefit** as long as the policy has not been assigned (passed) to someone else or issued in trust. If this policy has been assigned to someone else, '**you**' refers to that assignee.

### 3 Basis of cover

**3.1** **We** have issued this policy to **you** on the understanding that the information contained in the application and any related document or information obtained by **us** (including that provided by a third party on behalf of **you** or a **Life Assured**) is true and complete and that **we** have been given all relevant information. If this is not the case **we** will be entitled to declare the policy void. If this happens, **you** will lose all of **your** rights under the policy, **we** will not pay any claim and **we** will not refund any **premiums**. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of **premiums** or **benefits**, when deciding whether to provide cover at all or when deciding whether to attach conditions.

Relevant information includes, but is not limited to, details on the following:

- Personal health
- Occupation
- Residence or travel
- Participation in any hazardous leisure activities (as outlined in Section 11.2)

- Smoking habit
- Illegal drug use
- Family history.

**3.2** If **your** cover ends because **premiums** have not been paid when due and it is reinstated under Section 4.3, **we** will reinstate it on the understanding that the information given in the declaration of health form and any related documents is true and complete and that all relevant information has been provided.

If this is not the case, **we** will be entitled to declare the policy void from the date of reinstatement. If this happens, **you** will lose all **your** rights under the policy from the date of reinstatement, **we** will not pay any claim and **we** will not refund any **premiums**. Information is 'relevant' if it might influence the judgement of a reputable insurer when fixing the level of **premiums** or **benefits**, when deciding whether to reinstate cover at all or when deciding whether to attach conditions.

### 4 Paying premiums

**4.1** Although each **premium** is due as shown in the **policy schedule**, **we** allow 30 days to pay the **premium** (the time allowed is known as a '**period of grace**'). If **you** become entitled to a **benefit** during a **period of grace**, **we** will take from **your benefit** any **premiums** that have not been paid.

**4.2** If a **premium** has not been paid by the end of the **period of grace**, the cover under the policy will end

immediately. A **premium** is not paid until **we** have received it. It is the responsibility of those paying the **premium** to make sure that **we** receive it. **We** are entitled to pass on any charge which **we** have to pay because the **premium** (for example, a direct debit) is not paid.

**4.3** If, within 12 calendar months of the first missed **premium** being due, **we** are asked to reinstate cover, the Life or **Lives Assured** must fill in a declaration of health form and all unpaid **premiums** must be paid. The declaration of health form includes questions which might influence the judgement of a reputable insurer when fixing the level of **premiums** or **benefit**. If the information on the declaration of health form shows any material change to that declared on the application form, **we** may refuse to reinstate cover or reinstate the cover with an increased **premium** or with new conditions or exclusions (this could include the removal of options).

If **we** agree to reinstate cover, all missed **premiums** must be paid and **premiums** must commence payment again. **We** will not pay **benefits** for anything that happens between:

- the end of the **period of grace**; and
- the date, following **our** agreement to reinstate cover, on which **we** receive all missed **premiums**.

If **we** accept a **premium** which is no longer due, **we** will return it as **we** will not have provided cover under the policy. **We** are entitled to apply a charge to cover the costs of reinstatement.

**4.4** Monthly **premiums** must be paid by direct debit.

### 5 Your Cover

**5.1** The following **benefits** are available:

- Life Cover
- Accelerated Specified Serious Illness Cover
- Stand-alone Specified Serious Illness Cover (Not available under a Mortgage Protection Policy)

Only the **benefits** shown on the **policy schedule** are included in the policy. Check **your policy schedule** to see which **benefits** apply to a **Life Assured** and in what amounts. Please also refer to **your policy schedule** for any additional conditions or exclusions that may apply to **your** policy.

Sections 5.11 and 5.12 set out what **benefits** may apply to a **Life Assured's** children.

**5.2** If **we** accept a claim, **we** will pay the amount of **benefit** set out in the **policy schedule** for that **Life Assured**. This will be adjusted for the amount (if any) by which it has been:

- reduced due to the decreasing level of cover each month on a Mortgage Protection policy, details of which are contained in the **policy schedule**; or
- increased due to **Indexation**, details of which are contained in the **policy schedule**; or
- reduced due to a Specified Serious Illness Cover claim or Advanced

Payment of **Benefit** for Heart Surgery.

If the Special Events Increase **Benefit** has been exercised the amount of **benefit** payable will be adjusted accordingly, subject to the same conditions above. See Section 8 for details.

### 5.3 Life Cover

Life Cover is payable when a **Life Assured** dies (assuming a Life Cover **benefit** applies to that **Life Assured**).

- If cover is on a Single Life basis, upon payment of this **benefit** all cover will end and the policy will cease immediately.
- If cover is on a **Joint Life** basis, this **benefit** is payable when the first of either **Life Assured** dies, after which all cover will end and the policy will cease immediately.
- If cover is on a **Dual Life** basis, upon payment of this **benefit** all cover will end immediately for that **Life Assured**. However, all **benefits** relating to the remaining **Life Assured** will be unaffected and the policy can continue on a Single Life basis.

The **benefit** payable will be the level of Life Cover for that **Life Assured** as at the date of death. If a **Life Assured** dies during a '**period of grace**,' **we** will reduce the **benefit** by the amount of any unpaid premiums.

### 5.4 Terminal Illness Benefit (Prepayment of Life Cover)

On proof of the diagnosis of a Terminal Illness, as defined below, of



a **Life Assured** after the **start date** of the policy, **we** will pay the level of their Life Cover as at the date of diagnosis of the Terminal Illness (assuming a Life Cover **benefit** applies to that **Life Assured**).

- If cover is on a Single Life basis, upon payment of this **benefit** the Life Cover will reduce to nil. If there is no Specified Serious Illness Cover **benefit** all cover will end and the policy will cease immediately. If there is an Accelerated Specified Serious Illness Cover **benefit**, the Specified Serious Illness Cover will also reduce to nil and the policy will cease immediately. If there is a Stand-alone Specified Serious Illness Cover **benefit**, this will not be affected by the payment of the Terminal Illness **benefit**.
- If cover is on a **Joint Life** basis, this **benefit** is payable when the first of either **Life Assured** is diagnosed with a Terminal Illness, after which all cover will end and the policy will cease immediately.
- If cover is on a **Dual Life** basis, upon payment of this **benefit** the Life Cover will reduce to nil for that **Life Assured**. If there is no Specified Serious Illness Cover **benefit** for that **Life Assured** all cover will end immediately for that **Life Assured**. If there is an Accelerated Specified Serious Illness Cover **benefit** for that **Life Assured**, the Specified Serious Illness Cover will also reduce to nil for that **Life Assured** and all cover will end immediately for that **Life Assured**. If there is a Stand-alone Specified Serious

Illness Cover **benefit** for that **Life Assured**, this will not be affected by the payment of the Terminal Illness **benefit**. Upon payment of the Terminal Illness **benefit** for a **Life Assured**, all **benefits** relating to the remaining **Life Assured** will be unaffected.

For the purposes of this policy, Terminal Illness is defined as:

- A definite diagnosis by the attending **Consultant** and **Royal London's Chief Medical Officer** of an illness that satisfies both of the following:
- The illness either has no known cure or has progressed to the point where it cannot be cured; and
- In the opinion of the attending **Consultant** and **Royal London's Chief Medical Officer** is expected to lead to death within 12 months.

If a **Life Assured** contracts a Terminal Illness by his or her own act, no payment will be made under this section. If a **Life Assured** is diagnosed with a Terminal Illness during a '**period of grace**,' **we** will reduce the **benefit** by the amount of any unpaid **premiums**.

**5.5 Accelerated Specified Serious Illness Cover**  
Accelerated Specified Serious Illness Cover is payable when a **Life Assured** is diagnosed as having an **insured specified serious illness** as defined in Section 6 (assuming an Accelerated Specified Serious Illness Cover **benefit** applies to that **Life Assured**).

- If cover is on a Single Life basis, once a claim has been paid under

the Accelerated Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or **Partial Payment Specified Serious Illness** Cover), the Life Cover and Specified Serious Illness Cover will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover reducing to nil, the Specified Serious Illness Cover **benefit** will end. If this also results in the Life Cover reducing to nil, the Life Cover **benefit** will also end and the policy will cease immediately.

- If cover is on a **Joint Life** basis this **benefit** is payable when the first of either **Life Assured** is diagnosed as having an **insured specified serious illness**. Once a claim has been paid under the Accelerated Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or **Partial Payment Specified Serious Illness** Cover), the Life Cover and Specified Serious Illness Cover will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover reducing to nil, the Specified Serious Illness Cover **benefit** will end. If this also results in the Life Cover reducing to nil, the Life Cover **benefit** will also end and the policy will cease immediately.
- If cover is on a **Dual Life** basis, once a claim has been paid under the Accelerated Specified Serious Illness Cover on the policy (excluding Children's Specified

Serious Illness Cover or **Partial Payment Specified Serious Illness** Cover), the Life Cover and Specified Serious Illness Cover for that **Life Assured** will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover for that **Life Assured** reducing to nil, the Specified Serious Illness Cover benefit will end for that **Life Assured**. If this also results in the Life Cover reducing to nil for that Life Assured, the Life Cover **benefit** will also end for that **Life Assured**. However, all **benefits** relating to the remaining **Life Assured** will be unaffected and the policy can continue on a Single Life basis.

The **benefit** payable will be the level of Accelerated Specified Serious Illness Cover for that **Life Assured** as at the date of diagnosis of the **insured specified serious illness**. The **benefit** can only be paid once per policy for Single Life and **Joint Life** policies, and once per **Life Assured** for **Dual Life** policies (assuming an Accelerated Specified Serious Illness Cover **benefit** applies to that **Life Assured**). For example, the same **Life Assured** cannot claim for a heart attack and then claim for cancer. If a **Life Assured** is diagnosed with an **insured specified serious illness** during a '**period of grace**,' **we** will reduce the **benefit** by the amount of any unpaid **premiums**.

**5.6 Stand-alone Specified Serious Illness Cover**  
Stand-alone Specified Serious Illness Cover is payable when a **Life**

**Assured** is diagnosed as having an **insured specified serious illness**, as defined in Section 6, and survives for a period of 14 days (the **survival period**) after date of diagnosis (assuming a Standalone Specified Serious Illness Cover **benefit** applies to that **Life Assured**). **We** will not pay any Specified Serious Illness

Cover **benefit** for a **Life Assured** if they die within the **survival period**.

- If cover is on a Single Life basis, once a claim has been paid under the Stand-alone Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or **Partial Payment Specified Serious Illness** Cover), the Specified Serious Illness Cover will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover reducing to nil, the Specified Serious Illness Cover **benefit** will end and if there is no Life Cover under the policy, the policy will cease immediately.
- If cover is on a **Dual Life** basis, once a claim has been paid under the Stand-alone Specified Serious Illness Cover on the policy (excluding Children's Specified Serious Illness Cover or **Partial Payment Specified Serious Illness** Cover), the Specified Serious Illness Cover for that **Life Assured** will reduce by the amount of the payment made. If this results in the Specified Serious Illness Cover for that **Life Assured** reducing to nil, the Specified Serious Illness Cover **benefit** will end for that **Life**

**Assured**. If there is no Life Cover in respect of that **Life Assured** all cover will end immediately for that **Life Assured**. However, all **benefits** relating to the remaining **Life Assured** will be unaffected and the policy can continue on a Single Life basis.

The **benefit** payable will be the level of Stand-alone Specified Serious Illness Cover for that **Life Assured** as at the date of diagnosis of the **insured specified serious illness**. The **benefit** can only be paid once per policy for Single Life policies, and once per **Life Assured** for **Dual Life** policies (assuming a Standalone Specified Serious Illness Cover **benefit** applies to that **Life Assured**). For example, the same **Life Assured** cannot claim for a heart attack and then claim for cancer. If a **Life Assured** is diagnosed with an **insured specified serious illness** during a '**period of grace**,' **we** will reduce the **benefit** by the amount of any unpaid **premiums**.

**5.7 Partial Payment Specified Serious Illness Cover**  
**Partial Payment Specified Serious Illness** Cover is payable when a **Life Assured** is diagnosed as having a **partial payment specified serious illness** as defined in Section 7, and survives for a period of 14 days (the **survival period**) after date of diagnosis (assuming an Accelerated or Standalone Specified Serious Illness Cover **benefit** applies to that **Life Assured**). **We** will not pay any **Partial Payment Specified Serious Illness** Cover **benefit** for a **Life Assured** if they die within the **survival period**.

With the exception of ‘Coronary Angioplasty – of specified severity’ the society will pay the following amount on survival for 14 days after diagnosis:

- €15,000 or 50% of the level of Specified Serious Illness Cover for the **Life Assured** under the policy as at the date of the event giving rise to the claim, whichever is lower.

In the case of ‘Coronary Angioplasty – of specified severity’:

- On survival for 14 days after the procedure, the amount payable on a first *Single Angioplasty Event* will be the lesser of: 50% of the level of Specified Serious Illness Cover for the **Life Assured** under the policy as at the date of the procedure, or €5,000.
- On survival for 14 days after the procedure, the amount payable on a second *Single Angioplasty Event* on the same **Life Assured** will be the lesser of: 50% of the level of Specified Serious Illness Cover for the **Life Assured** under the policy as at the date of the procedure, or €45,000.
- On survival for 14 days after the procedure, the amount payable on a *Double Angioplasty Event* will be the lesser of: 50% of the level of Specified Serious Illness Cover for the **Life Assured** under the policy as at the date of the procedure, or €50,000.
- After payment for a second *Single Angioplasty Event* or a *Double Angioplasty Event*, no further **benefit** will be paid for ‘Coronary

Angioplasty – of specified severity’ for that **Life Assured**.

The total amount **we** will pay through partial payments is limited to the amount of **your** Accelerated or Standalone Specified Serious Illness Cover. **You** are only permitted to claim once for each of the illnesses defined in Section 7. **You** are only permitted to claim once for a single event, for example: If **you** claim under the cancer definition, payment will just be the full cover amount for cancer and no additional payment will be made if it is treated by lobectomy or pneumonectomy.

**5.8** A **Life Assured** is ‘diagnosed as having an **insured specified serious illness**’ if on a date after the **start date** of the policy and before the **policy expiry date**, the **Life Assured** has:

- been diagnosed as having one of the **insured specified serious illnesses** or medical conditions as defined in Section 6 of these policy conditions; or
- had a surgery defined in Section 6 of these policy conditions.

**5.9** All cover will end and the policy will cease at the earliest of the following:

- At the end of a **period of grace**, if a **premium** has not been paid;
- On the **policy expiry date**, as shown in the **policy schedule**;
- When all cover (both Life Cover and Specified Serious Illness Cover, as applicable) has reduced to nil as a result of a claim or claims, as per Sections 5.3, 5.4, 5.5 and 5.6.

**5.10 Advance Payment of Benefit for Heart Surgery**

If a **Life Assured** is diagnosed as needing Aorta Graft Surgery, Coronary Artery Bypass Graft Surgery, Pulmonary Artery Surgery, or Heart Valve Replacement or Repair Surgery and **we** have been given the evidence **we** need about the condition, as defined below, **we** will make an advance payment of their Specified Serious Illness Cover (up to €20,000).

The amount **we** will pay is €20,000 or their level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower. **We** will pay any remaining Specified Serious Illness Cover after the surgery has taken place (provided the **Life Assured** survives for a period of 14 days after the surgery if the Specified Serious Illness Cover is on a stand-alone basis). **We** will not make a payment if the type of surgery has been excluded from the **Life Assured’s** cover. If cover is on a Single Life or **Joint Life** basis **we** will only make one advance payment as described in this section under the policy. If cover is on a **Dual Life** basis **we** will only make one advance payment per **Life Assured** as described in this section under the policy.

- For Accelerated Specified Serious Illness Cover, if the basis of cover is Single Life or **Joint Life**, once an advance payment has been made, the Life Cover and Specified Serious Illness Cover will reduce by the amount of the advance payment. If the basis of cover is **Dual Life**, once an advance

payment has been made, the Life Cover and Specified Serious Illness Cover for that **Life Assured** will reduce by the amount of the advance payment. If this results in the Specified Serious Illness Cover for that **Life Assured** reducing to nil, the Specified Serious Illness Cover **benefit** will end for that **Life Assured**. If this also results in the Life Cover reducing to nil for that **Life Assured**, the Life Cover **benefit** will also end for that **Life Assured**. However, all **benefits** relating to the remaining **Life Assured** will be unaffected and the policy can continue on a Single Life basis. Where all Life Cover and Specified Serious Illness Cover under a policy has been reduced to nil as a result of a claim, the policy will cease immediately.

- For Stand-alone Specified Serious Illness Cover, if the basis of cover is Single Life, once an advance payment has been made, the Specified Serious Illness Cover will reduce by the amount of the advance payment. If the basis of cover is **Dual Life**, once an advance payment has been made, the Specified Serious Illness Cover for that **Life Assured** will reduce by the amount of the advance payment. If this results in the Specified Serious Illness Cover for that **Life Assured** reducing to nil, the Specified Serious Illness Cover **benefit** will end for that **Life Assured**. If there is no Life Cover in respect of that **Life Assured** all cover will end immediately for that **Life Assured**. However, all

**benefits** relating to the remaining **Life Assured** will be unaffected and the policy can continue on a Single Life basis. Where all Life Cover and Specified Serious Illness Cover under a policy has been reduced to nil as a result of a claim, the policy will cease immediately.

- (i) If a **Life Assured** needs Aorta Graft Surgery, **you** must provide the following proof:
  - Certification from a **Consultant** Cardiologist or Vascular Surgeon of a **major hospital** in the Republic of Ireland or UK that the **Life Assured** is on a waiting list or scheduled for surgery he or she definitely needs in order to correct any narrowing or weakening of the thoracic or abdominal aorta. This must include a report on the nature of the disease and symptoms and be verified by **our Chief Medical Officer**.
- (ii) If a **Life Assured** needs Coronary Artery Bypass Graft Surgery, **you** must provide the following proof:
  - Certification from a **Consultant** Cardiologist or Cardiac Surgeon of a **major hospital** in the Republic of Ireland or UK that the **Life Assured** is on a waiting list or scheduled for a coronary artery bypass graft through open-heart surgery (surgery to divide the breast-bone). This must include the result of a recent angiogram showing the extent of the coronary artery disease and be verified by **Our Chief Medical Officer**.

(iii) If a **Life Assured** needs Pulmonary Artery Surgery, **you** must provide the following proof:

- Certification from a **Consultant** Cardiologist or Cardiac Surgeon of a **major hospital** in the Republic of Ireland or UK that the **Life Assured** is on a waiting list or scheduled for a pulmonary artery bypass graft through open-heart surgery (surgery to divide the breast-bone). This must include the result of a recent angiogram showing the extent of the pulmonary artery disease and be verified by **Our Chief Medical Officer**.
- (iv) If a **Life Assured** needs Heart Valve Replacement or Repair Surgery, **you** must provide the following proof:
  - Certification from a **Consultant** Cardiologist or Cardiac Surgeon of a **major hospital** in the Republic of Ireland or UK that the **Life Assured** is on a waiting list or scheduled for open-heart surgery (surgery to divide the breast-bone) he or she definitely needs within one year in order to repair or replace one or more heart valves or to correct structural abnormalities. This must include the result of a recent echocardiogram and angiogram showing significant heart valve disease or a significant structural defect of the heart and be verified by **our Chief Medical Officer**.

**5.11 Children’s Specified Serious Illness Cover and Partial Payment Specified Serious Illness Cover**  
On acceptance that an eligible child,



as defined below, of a **Life Assured** is diagnosed as having one of the **insured specified serious illnesses** (other than Loss of Independent Existence) and that this is not a pre-existing condition, as defined below, the society will pay the following amount on survival for 14 days after diagnosis (known as the **survival period**):

- €25,000 or 50% of the level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is Single Life or **Joint Life**.
- €25,000 or 50% of the higher level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is **Dual Life**.

No **benefit** for Children's Specified Serious Illness Cover is payable for Brain injury due to anoxia or hypoxia (condition 6.9) and Intensive Care – requiring mechanical ventilation for 10 consecutive days (condition 6.28), before the age of 90 days.

On acceptance that an eligible child, as defined below, of a **Life Assured** is diagnosed as having one of the insured **Partial Payment Specified Serious Illnesses** and that this is not a pre-existing condition, as defined below, the society will pay the following amount on survival for 14 days after diagnosis (known as the **survival period**):

- €7,500 or 50% of the level of Specified Serious Illness Cover

under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is Single Life or **Joint Life**.

- €7,500 or 50% of the higher level of Specified Serious Illness Cover under the policy as at the date of the event giving rise to the claim, whichever is lower, if the basis of cover is **Dual Life**.

The policy will not end upon payment of the lump sum and the level of Specified Serious Illness Cover will not be reduced. **We** will only pay the Children's Specified Serious Illness Cover once in respect of each child. This applies even if both parents are **Lives Assured**, or even if a **Life Assured** is covered under more than one policy which provides similar **benefits**.

An eligible child is defined as a natural or legally adopted child who has not reached their 18th birthday at the date of diagnosis and whose mother or father is **Life Assured** under the policy. If the child is in full-time education, the child will qualify for the Children's Specified Serious Illness Cover if they have not reached their 21st birthday at the date of diagnosis.

A pre-existing condition is a medical condition (including congenital defects) where symptoms first arose, the underlying condition was first diagnosed or either parent received counselling or medical advice in relation to the condition before:

- The **Start date** of the policy;
- The legal adoption of the child.

Children's Specified Serious Illness Cover applies only to the **diagnosis of an insured specified serious illness** (other than Loss of Independent Existence) and not on the death of a child or diagnosis of a Terminal Illness. **We** will not pay any **benefit** if a child dies within the **survival period**.

An advance payment may be made under the Advance Payment of **Benefit** for Heart Surgery definition, see Section 5.10 for details. Where applicable, the advance payment is €10,000 or 50% of the level of Specified Serious Illness Cover (based on the higher level of Specified Serious Illness Cover if the basis of cover is **Dual Life**) under the policy as at the date of the event giving rise to the claim, whichever is lower. However, the maximum total **benefit** per child for Children's Specified Serious Illness Cover is as defined in this section.

**5.12 Children's Life Cover**  
On the death of an eligible child, as defined below, of a **Life Assured** (assuming a Life Cover **benefit** applies to that **Life Assured**) the society will pay €5,000.

The policy will not end upon payment of the lump sum and the level of life cover, if included, or Specified Serious Illness Cover will not be reduced. **We** will only pay the Children's Life Cover once in respect of each child. This applies even if both parents are **Lives Assured**, or even if a **Life Assured** is covered under more than one policy which provides similar **benefits**.

An eligible child is defined as a natural or legally adopted child who is aged between 3 months and their 18th birthday at the date of death and whose mother or father is a **Life Assured** under the policy. If the child is in full-time education, the child will qualify for the Children's Life Cover if they are aged between 3 months and 21st birthday at the date of death.

**5.13 Donor Cover**  
If Specified Serious Illness Cover is included as part of your policy, this **benefit** will provide cover in the event that you need to donate a living organ to a family member. We will pay €2,500 as a once off lump sum if you donate any of the following organs:

- Kidney;
- Portion of Liver; or
- Portion of Lung; or
- Bone Marrow Transplant *provided that the recipient has undergone pre-conditioning with myeloablative chemotherapy and/or radiotherapy.*

For the above definition, the following are not covered:

- If before the **start date** the recipient had symptoms or an illness that eventually resulted in the transplant being necessary;
- Stem cell donation;
- Islet cell donation.

The policy will not end upon payment of the lump sum and the level of Specified Serious Illness will not be reduced. We will only pay this benefit once in respect of each **Life Assured**.

## 6 Specified Serious Illness Cover Definitions

**Important Note:** The explanations under “What does this mean?” in this section DO NOT form part of the policy conditions for this policy and are provided solely for information purposes. In the event of a claim under the Specified Serious Illness Cover on this policy, the policy definitions will apply.

### 6.1 Alzheimer's Disease – resulting in permanent symptoms

**Policy definition**  
A definite diagnosis of Alzheimer's disease 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 (these are covered under the Dementia definition).

**What does this mean?**  
Alzheimer's Disease is a progressive and degenerative disease. The nerve cells in the brain deteriorate and the brain shrinks. The symptoms can include a severe loss of memory and concentration but there is an overall decline in all mental faculties.

### 6.2 Aorta Graft Surgery – for disease

**Policy definition**  
The undergoing of surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches. The undergoing of surgery for traumatic injury to the aorta needing excision and surgical replacement of a portion of the aorta with a graft is also covered.

For the above definition, the following is not covered:

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

**What does this mean?**  
The aorta is the main artery in the body, which carries the blood through the thorax (chest) and abdomen. The aorta may be weakened by an aneurysm (which means a thinning and bulging of the arterial wall) or it may become narrowed by fatty deposits. An operation can be carried out to correct the narrowing or to replace or repair the damaged part of the aorta wall.

### 6.3 Aplastic Anaemia – of specified severity

**Policy definition**  
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.

For the above definition, the following is not covered:

- other forms of anaemia.

**What does this mean?**

Aplastic anaemia is a rare and very serious form of anaemia in which there is a decrease in the quantity of blood-forming cells in the bone marrow. This then causes impairment of all blood cell production. This condition can be present from birth or may develop in later life. In most cases the bone marrow failure is **permanent**. However, in some cases (for example due to drug or radiation treatment or to infection) it is temporary. *Temporary bone marrow failure would not be covered by the definition.*

**6.4 Bacterial Meningitis – resulting in permanent symptoms**

**Policy definition**

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

For the above definition, the following is not covered:

- all other forms of meningitis other than those caused by bacterial infection.

**What does this mean?**

Bacterial meningitis is a condition resulting from bacterial infection. This causes inflammation to the meninges, which is the protective layer around the brain. There are many forms of meningitis. It is only bacterial meningitis that is covered; all other forms, including viral meningitis, are excluded.

**6.5 Balloon Valvuloplasty – to correct heart valve abnormalities**

**Policy definition**

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.

**What does this mean?**

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

**6.6 Benign Brain Tumour – resulting in permanent symptoms**

**Policy definition**

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in **permanent neurological deficit with persisting clinical symptoms**.

For the above definition, the following are not covered:

- Tumours or lesions in the pituitary gland.
- Angiomas.

In addition, the requirement for **permanent neurological deficit with persisting clinical symptoms** will be waived if the benign brain tumour is surgically removed.

**What does this mean?**

Unlike cancer, which is a malignant tumour, benign tumours are localised and grow by expansion only. They therefore do not invade and destroy surrounding tissue and do not spread to other parts of the body. Once surgically removed they tend not to recur. However, a benign tumour can still be very dangerous because it can put pressure on the brain and lead to possible damage, haemorrhage and ulceration. Deficit to the neurological system means muscle weakness or sensory loss. Surgery to cure the condition may not always be possible.

**6.7 Benign Spinal Cord Tumour – resulting in permanent symptoms or requiring surgery**

**Policy definition**

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

For the above definition, the following are not covered:

- Angiomas.

The requirement for **permanent neurological deficit with persisting clinical symptoms** will be waived if the benign spinal cord tumour is surgically removed either by invasive surgery or stereotactic radiosurgery.

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

**What does this mean?**

A benign tumour of the spinal canal or spinal cord is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of spinal cord or spinal canal. In order for a claim to be paid **you** must have undergone surgery to have it removed or are suffering from **permanent** neurological deficit as a result of the tumour.

**6.8 Blindness – permanent and irreversible**

**Policy definition**

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

**What does this mean?**

Sight can be lost because of an accident or illness. In order for a claim to be paid, the loss of sight must be **permanent** and **irreversible**. If the loss was only temporary, it would not be covered by the definition.

**6.9 Brain injury due to anoxia or hypoxia – resulting in permanent symptoms**

**Policy Definition**

Death of brain tissue due to reduced oxygen supply resulting in **permanent neurological deficit with persisting clinical symptoms**.

For the above definition the following are not covered:

- Children under the age of 90 days.

**What does this mean?**

Anoxia (no oxygen) or hypoxia (a poor oxygen supply) can result in **permanent** brain damage leaving the individual with lifelong problems. There are many causes including carbon-monoxide poisoning, near drowning, poisoning by anaesthesia and others.

**6.10 Cancer – excluding less advanced cases**

**Policy definition**

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

The term malignant tumour includes leukaemia, sarcoma, and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following are not covered:

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

- having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

**What does this mean?**

Cancer is a malignant tumour or a malignancy. It causes uncontrolled growth of abnormal cells that invade, damage and destroy surrounding bodily tissue. These cells can then spread and cause damage to other parts of the body. Pre-malignant and non-invasive cancers and cancer in situ are very early stage cancers that have not invaded surrounding tissue and have not spread to other areas of the body. Treatment is relatively easy and successful and these cancers are not covered. With increased and improved screening prostate cancer is being detected at an earlier stage. Accordingly, the less advanced prostate cancers are not covered. More advanced and more aggressive cases (typically those that are currently detected) will continue to be covered.

Most skin cancers, including cutaneous lymphoma, are also easy to treat and are also excluded. However, malignant melanoma is a very serious form of skin cancer that can very quickly spread throughout the body. This form of skin cancer is therefore

included if it has invaded beyond the epidermis (outer layer of skin).

**6.11 Cardiac Arrest – with insertion of a defibrillator**

**Policy definition**

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

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

For the above definition, the following are not covered:

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

**What does this mean?**

Cardiac arrest happens when the heart suddenly stops beating, sometimes because of an abnormal rhythm (arrhythmia) or coronary heart disease. This can stop the heart from pumping blood which can cause loss of consciousness due to lack of oxygen in the brain. A device known as an Implantable Cardioverter Defibrillator (ICD or CRT-D) can be implanted inside **your** body which will monitor the rhythm in **your** heart, delivering an electric pulse or shock should **your** heart rhythm become abnormal. This will restore the rhythm back to normal and prevent a cardiac arrest.

**You** can claim if **you** had a cardiac arrest followed by the **permanent** insertion of an ICD or CRT-D. A cardiac arrest not accompanied by the insertion of an ICD or CRT-D is not covered under this condition. A cardiac arrest secondary to illegal drug misuse is not covered under this condition.

**6.12 Cardiomyopathy – of specified severity**

**Policy definition**

A definite diagnosis by a **Consultant** Cardiologist of cardiomyopathy resulting in permanently impaired ventricular function such that the ejection fraction is 40% or less for at least 6 months when stabilised on therapy advised by the **Consultant**. The diagnosis must also be evidenced by:

- electrocardiographic changes; and
- echocardiographic abnormalities.

The evidence must be consistent with the diagnosis of cardiomyopathy. For the above definition, the following are not covered:

- all other forms of heart disease and/or heart enlargement;
- myocarditis; and
- cardiomyopathy related to alcohol or drug misuse.

**What does this mean?**

Cardiomyopathies are a group of disorders of the heart muscle, which can cause sudden death and heart failure. Cardiomyopathy can occur in young people and can be inherited. Myocarditis is an acute inflammation of the heart muscle, typically caused by infection, and is not covered by the definition.

**6.13 Chronic Lung Disease – of specified severity**

**Policy definition**

Confirmation by a **Consultant** Physician of chronic lung disease resulting in all of the following:

- the need for continuous daily oxygen therapy on a **permanent** basis;
- FEV1 being less than 40% of normal; and
- Vital Capacity less than 50% of normal.

**What does this mean?**

Chronic lung disease can be caused by a number of conditions such as severe chronic bronchitis and emphysema and lung fibrosis. It is associated with persistent breathlessness at rest, or on minimal exertion, requiring daily oxygen therapy.

**6.14 Chronic pancreatitis – of specified severity**

**Policy Definition**

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

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

- pancreatic duct dilatation, beading and stricture.

For the above definition the following is not covered:

- Chronic pancreatitis secondary to alcohol or drug misuse.
- Acute pancreatitis.

**What does this mean?**

Pancreatitis is an inflammation of the pancreas, an organ that is important in both the digestive and endocrine systems of the body. Chronic pancreatitis is an ongoing, inflammatory process with continued and **permanent** injury to the pancreas.

Acute pancreatitis is a sudden inflammation of the pancreas. It can be serious with severe complications. However, it usually settles and the patient can make a full recovery.

ERCP (endoscopic retrograde cholangiopancreatography) is a procedure that uses an endoscope (a thin, flexible telescope) to look at the bile duct and pancreatic duct. A dye can be injected into the bile duct and pancreatic duct so that these can be seen clearly on an X-ray.

MRCP (magnetic retrograde cholangiopancreatography) is a medical imaging technique that uses magnetic resonance imaging to visualise the biliary and pancreatic ducts.

**6.15 Chronic Rheumatoid Arthritis – of specified severity**

**Policy definition**

The confirmation by a **Consultant** Rheumatologist of a definite

diagnosis of chronic rheumatoid arthritis as evidenced by all of the following:

- The condition must be diagnosed, established and treated for a period of at least twelve months.
- There must be morning stiffness in the affected joints.
- There must be arthritis in at least three joint groups with joint destruction and either soft tissue swelling or fluid observed by a rheumatologist.
- The arthritis must involve at least one or more of the following sites:
  - Wrists or ankles
  - Hands and fingers
  - Feet and toes
- The arthritis must affect both sides of the body
- Presence of rheumatoid factor or anti-CCP antibodies, unless all other criteria are met
- There must be radiographic changes typical of active Rheumatoid Arthritis.

**What does this mean?**

Rheumatoid Arthritis is a chronic disease involving inflammation of the joints and their surrounding tissue. This inflammatory process can result in progressive destruction and deformity of the affected joints. The joints most commonly affected are the hands, wrists, elbows, cervical spine (neck), knees, ankles and metacarpophalangeal joints in the feet (joints in the toes and

feet). Before a claim can be made, the disease must have progressed to such severity that it satisfies all of the detailed conditions listed above.

**6.16 Coma – resulting in permanent symptoms**

**Policy definition**

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

- Continues for a period of at least 96 hours
- Requires life supporting systems including assisted ventilation throughout the period of unconsciousness results in **permanent neurological deficit with persisting clinical symptoms**

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug misuse.

**What does this mean?**

A coma is a deep state of unconsciousness from which it is impossible to be aroused. The cause of the coma may be as a result of another illness such as a stroke, infection, and very low blood sugar or may be brought on by a serious accident. The coma needs to result in **permanent** damage to the nervous system in order to be covered by the definition.

**6.17 Coronary Artery Bypass Graft Surgery – with surgery to divide the breastbone**

**Policy definition**

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.
- Or any other procedures.

**What does this mean?**

If one or more of the coronary arteries, which supply oxygenated blood to the heart, becomes obstructed by the build up of fatty deposits angina can result and can even cause a heart attack. A coronary by-pass operation involves inserting a short length of artery or vein, the latter usually taken from the leg, around the narrowed coronary artery thus restoring an adequate supply of blood to the heart.

**6.18 Creutzfeldt-Jakob Disease – resulting in permanent symptoms**

**Policy definition**

A definite diagnosis of Creutzfeldt-jakob disease by a **Consultant** Neurologist. There must be **permanent** clinical loss of the ability to do all of the following:

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

For the above definition, the following is not covered:

- other types of dementia (these are covered under the dementia definition).

**What does this mean?**

Creutzfeldt-jakob disease is a degenerative organic brain disease which may be inherited or acquired. There is a progressive degeneration of the nerve cells of the central nervous system which will result in defective muscular control and dementia. There is no cure.

**6.19 Crohn’s disease – of specified severity**

**Policy definition**

A definite diagnosis by a **Consultant** Gastroenterologist of Crohn’s Disease with fistula formation and intestinal strictures. There must be evidence of ongoing symptoms despite optimal treatment and surgical interventions.

There must be evidence of continued inflammation of the bowel and all of the following:

- Stricture formation causing intestinal obstruction requiring admission to hospital.
- Fistula formation between the loops of the bowel or the bowel and another organ.
- At least two resections of a segment of the bowel.

In the event of a claim for this illness, the amount of any Life Insured’s Specified Serious Illness **Benefit** payment will be reduced by the amount of any Partial Payment

Specified Illness **Benefit** paid for Crohn’s Disease – treated with Surgical intestinal resection (condition number 7.14).

**What does this mean?**

Crohn’s Disease is an inflammatory disease that affects the digestive system. The main symptoms of the disease are stomach cramps, diarrhoea and tiredness.

A stricture is an abnormal blockage or partial blockage which forms in the bowel.

A fistula is an abnormal passageway that can form between parts of the body that are not normally connected.

A bowel resection is when a part of the diseased bowel is removed during surgery.

A claim can only be made if the **Life Assured** has had a part of the bowel removed on two or more separate occasions as well as experiencing ongoing symptoms, fistula formation and strictures in spite of ongoing treatment.

**6.20 Deafness – permanent and irreversible**

**Policy definition**

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

**What does this mean?**

Loss of hearing may be caused by illness or by a serious accident. The loss must be **permanent** and **irreversible**. If the loss was only

temporary, it would not be covered by the definition.

**6.21 Dementia – resulting in permanent symptoms**

**Policy definition**

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 and give effect to ideas.

For the above definition, the following is not covered:

- Dementia secondary to alcohol or illegal drug misuse.

**What does this mean?**

Dementia is a disorder of the mental process and results in loss of memory and impairment of behaviour and recognition. There is no cure and the cause is unknown. Definite diagnosis must be established via accepted standard medical tests and questionnaires.

**6.22 Devic’s (neuromyelitis) disease – with persisting symptoms**

**Policy definition**

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

For this definition the following is not covered:

- Multiple Sclerosis.

**What does this mean?**

Devic’s Disease is an autoimmune, inflammatory disorder in which a person’s own immune system attacks the optic nerves and spinal cord. This produces an inflammation of the optic nerve (optic neuritis) and the spinal cord (myelitis). Although inflammation may also affect the brain, the lesions are different from those observed in the related condition, multiple sclerosis. Spinal cord lesions lead to varying degrees of weakness or paralysis in the legs or arms, loss of sensation (including blindness), and/or bladder and bowel dysfunction. Devic’s Disease is also known as Neuromyelitis Optica (NMO), or Devic’s syndrome.

**6.23 Encephalitis – resulting in permanent symptoms**

**Policy definition**

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

For the above definition the following is not covered:

- myalgic encephalomyelitis and chronic fatigue syndrome.

**What does this mean?**

Encephalitis is inflammation of the brain. It can occur at any age. The inflammation is caused either by an infection invading the brain (infectious); or through the immune

system attacking the brain in error (post-infectious/auto-immune encephalitis). The inflammation can damage nerve cells resulting in “acquired brain injury.” Encephalitis frequently begins with a flu-like illness or headache. Typically more serious symptoms follow hours to days later.

**6.24 Heart Attack**

**Policy definition**

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

- the characteristic rise of cardiac enzymes or Troponins
- new characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests.

The evidence must show a definite acute myocardial infarction.

The following are not covered:

- other acute coronary syndromes
- angina without myocardial infarction.

**What does this mean?**

A heart attack is more usually referred to in medical terms as “myocardial infarction”. It is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot. The heart is a pump which ensures that oxygenated blood circulates through the body without which the cells in the body

would not survive. The heart itself also needs its own blood supply in order to function and if this is cut off then it can seriously damage the heart by causing part of the heart muscle to die. Coronary heart disease (CHD) is the leading cause of heart attacks and is a condition in which coronary arteries (the major blood vessels that supply blood to the heart) get clogged up with deposits of cholesterol. These deposits are called plaques. Before a heart attack, one of the plaques usually ruptures (bursts), causing a blood clot to develop at the site of the rupture. The clot may then block the supply of blood running through the coronary artery, triggering a heart attack. A heart attack can be diagnosed using various tests. Damage to the heart muscle usually causes severe pain and results in an increase in cardiac enzymes and Troponins, which are released and can be detected in the blood. An electrocardiogram (ECG) will also show specific findings. Angina is chest pain associated with CHD. However, it may occur without damage to the heart muscle and where this is the case it is not covered by the definition.

**6.25 Heart Structural Repair – with surgery to divide the breastbone**

**Policy definition**

The undergoing of heart surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a **Consultant** Cardiologist

to correct any structural abnormality of the heart.

**What does this mean?**

The surgical division of the breastbone and the opening up of the chest wall, for the purpose of correcting a structural abnormality of the heart, for example, the surgical correction of a ventricular septal defect.

**6.26 Heart Valve Replacement or Repair**

**Policy definition**

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

**What does this mean?**

The valves of the heart open and close as a part of the pumping action, which circulates blood around the body. When these valves become diseased, the ability of the heart to pump properly is reduced. Surgery can be undertaken to either repair or replace the damaged valve.

**6.27 HIV Infection**

**Policy definition**

Infection by Human Immunodeficiency Virus resulting from:

- (a) a blood transfusion given as part of medical treatment;
- (b) a physical assault; or
- (c) an incident occurring during the course of performing normal duties of employment from the

eligible occupations listed below after the **start date** 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 five 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: **European Union**, Norway, Switzerland, Canada, North America, Australia, and New Zealand.

For the above definition, the following is not covered:

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

Occupations covered:

- Ambulance workers
- Dental nurses
- Dental surgeons
- General practitioners and nurses employed by them

- Hospital caterers
- Hospital cleaners
- Hospital doctors/surgeons/consultants
- Hospital laboratory workers
- Hospital Laundry workers
- Hospital nurses
- Hospital porters
- Members of the Gardai
- Midwives
- Paramedics
- Prison officers
- Refuse collectors
- Social workers
- Taxi drivers

**What does this mean?**

Evidence suggests that infection with **HIV** can eventually lead to the development of **AIDS**. There is currently no cure for **AIDS**. It causes the body’s defence mechanisms to break down leaving the sufferer open to various infections, which would normally pose little threat to people unaffected by **AIDS**. These infections usually prove to be fatal. More and more cases of physical assault are being reported to the police where the victim has been brought into contact with the **HIV** virus. A claim would be paid where the attack had been reported to the police and it is proved that the **HIV** infection was because of the attack.

**6.28 Intensive Care – requiring mechanical ventilation for 10 consecutive days**

**Policy definition**

Any sickness or injury resulting in the **Life Assured** requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours per day) or more in an intensive care unit in an Irish or UK hospital.

For the above definition the following are not covered:

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

**What does this mean?**

There are many causes leading to admission to an intensive care unit (ICU). Reasons include severe illness, accident or surgery. People in ICUs may have had multiple organ failure and require medical equipment to take the place of these functions while they recover. To meet **our** definition the **Life Assured** must not be able to breathe on their own and require mechanical ventilation.

**6.29 Kidney Failure – requiring dialysis**

**Policy definition**

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

**What does this mean?**

The function of the kidneys is to remove waste material from

the bloodstream. If they do not work properly there can be a build up of waste material in the blood, which can become life threatening. The body can function perfectly well with only one kidney, but if both fail there will be a need for regular dialysis, to clean the blood artificially, or for a kidney transplant.

**6.30 Liver Failure – end stage**

**Policy definition**

A definite diagnosis, by a **Consultant** Physician, of **irreversible** end stage liver failure due to cirrhosis resulting in all of the following:

- permanent** jaundice;
- ascites; and
- encephalopathy.

For the above definition, the following is not covered:

- liver failure secondary to alcohol or drug misuse.

**What does this mean?**

The liver has many functions and is essential to life. Cirrhosis is due to longstanding damage to the liver caused by a number of conditions including viral infections, inflammation, biliary obstruction, alcohol and certain drugs. Liver failure results in jaundice (yellow skin), fluid in the abdomen (ascites) and damage to the brain (encephalopathy).

**6.31 Loss of Independent Existence – permanent and irreversible**



**Policy definition**

The **permanent** and **irreversible** loss of the ability to function independently which is defined as follows:

- (1) **Permanent** confinement to a wheelchair, or
- (2) Being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a **registered medical practitioner**, or
- (3) Being permanently unable to fulfil at least three of the following activities listed below without the help of another person, but with the use of appropriate assistive aids and appliances; and the disability is **irreversible** with no reasonable prospect of there ever being any improvement.
  - washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained
  - dressing – the ability to dress and undress, ability to fasten and unfasten all necessary clothing including any surgical devices worn.
  - transferring – the ability to move from a bed to an upright chair, or wheelchair, or to get on or off a commode or toilet.
  - mobility – the ability to move from one room to

another on a level surface

- continence – the ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained
- feeding – the ability to eat and drink, once food or drink has been prepared and made available.

The condition must continue for at least six months following diagnosis by a **Consultant** neurologist, physician or geriatrician of a **major hospital** in Ireland or the UK.

**What does this mean?**

This **benefit** is not linked to any particular Serious Illness. It is based on **your permanent** inability to carry out a variety of events outlined above without the assistance of another person. It is intended to provide more extensive cover for events where **you** suffer drastic lifestyle changes.

**6.32 Loss of Limb – permanent physical severance**

**Policy definition**

**Permanent** severance of one or more hands from above the wrist or one or more feet from above the ankle joint. **Permanent** loss does not include loss of use or function only. It means having a hand or foot completely severed.

For the above definition the following are not covered:

- Loss of any individual fingers or toes or combination of fingers and toes.
- Loss of a limb as a result of a life insured’s own deliberate act
- Loss of a limb as a result of a penalty imposed by a court of law

**What does this mean?**

A claim can be made if the life insured has lost one or more limbs where the limb or limbs have been severed above the wrist in event of loss of hands and above the ankle in the event of loss of feet.

**6.33 Loss of Speech – permanent and irreversible**

**Policy definition**

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

**What does this mean?**

Loss of speech may be caused if the vocal chords are damaged in an accident or by a disease such as cancer of the larynx. The loss must be total, **permanent** and **irreversible**. Therefore a claim would not be paid if the loss was only partial or was a temporary condition. It is possible for the power of speech to be lost without physical damage to the vocal chords, possibly because of a severe mental trauma or shock. However, in such cases it is nearly impossible to determine whether the loss is **permanent** and therefore a claim would not be paid.

**6.34 Major Organ Transplant – specified organs**

**Policy definition**

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 programme 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.

**What does this mean?**

Sometimes a major organ of the body (such as the liver) becomes so diseased that it fails and becomes life threatening. It may therefore be essential to replace it with a healthy organ.

For some rare illnesses, such as aplastic anaemia, a major organ transplant (in this case of the bone marrow) may be the only long-term cure available. It can take a long time to find the right donor organ, and the waiting list for such operations is often long. The claim will be met therefore upon inclusion onto the official programme waiting list of a major Irish or UK Hospital for a transplant.

**6.35 Motor Neurone Disease and specified diseases of the motor neurones – resulting in permanent symptoms**

**Policy definition**

A definite diagnosis of one of the following motor neurone diseases by

a **Consultant** Neurologist:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Kennedy’s disease, also known as spinal and bulbar muscular atrophy (SBMA)
- Spinal muscular atrophy (SMA).

There must be **permanent** clinical impairment of motor function.

**What does this mean?**

Motor neurone disease is a degenerative condition that results in weakness and the wasting of muscles. A claim can be made if there is a definite diagnosis by a **Consultant** Neurologist that the **Life Insured** is suffering from the disease.

**6.36 Multiple Sclerosis – resulting in specified symptoms**

**Policy definition**

A definite diagnosis of multiple sclerosis by a **Consultant** Neurologist that has resulted in either of the following:

- Current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least three months, or
- Two or more attacks of impaired motor or sensory function together with findings of clinical objective evidence on Magnetic Resonance Imaging (MRI).

All of the evidence must be consistent with multiple sclerosis.

**What does this mean?**

Multiple sclerosis (MS) is an incurable disease of the central nervous system. Nerve fibres are normally covered by a myelin sheath, which protects and insulates them. In MS this sheath degenerates which interrupts the smooth transmission of nerve impulses around the body, leading to loss of power and/or lack of co-ordination and/or sensory impairment usually affecting different parts of the body. The symptoms and signs can come and go over the years or can progressively worsen. Investigations such as an MRI scan of the brain and/or spinal cord and examination of the cerebrospinal fluid can be helpful in supporting the diagnosis, but do not in themselves make a definite diagnosis.

**6.37 Muscular Dystrophy**

**Policy definition**

A hereditary muscular dystrophy confirmed by a **Consultant** neurologist resulting in the inability to fulfil at least three of the following activities listed below without the help of another person, but with the use of appropriate assistive aids and appliances:

- washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained

- dressing – the ability to dress and undress, ability to fasten and unfasten all necessary clothing including any surgical devices worn.
- transferring – the ability to move from a bed to an upright chair, or wheelchair, or to get on or off a commode or toilet.
- mobility – the ability to move from one room to another on a level surface
- continence – the ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained
- feeding – the ability to feed oneself once food and drink have been prepared and made available.

**What does this mean?**

Muscular Dystrophy is a genetic (inherited) condition where slow progressive muscle wasting leads to increasing weakness and disability.

**6.38 Necrotising Fasciitis – requiring surgery**

**Policy definition**

A definite diagnosis of necrotising fasciitis or gas gangrene by a **Consultant** Physician, requiring surgery to remove necrotic tissue and intravenous antibiotic treatment.

For the above definition, the following is not covered:

- All other forms of gangrene or cellulitis.

**What does this mean?**

Necrotising fasciitis is an infection

caused by flesh-eating bacteria. It can destroy skin, fat and the tissue covering muscles in a short time period. A claim can be made if a **Consultant** Physician diagnoses necrotising fasciitis that requires treatment by surgery and intravenous antibiotics.

**6.39 Paralysis of one Limb – total and irreversible**

**Policy definition**

Total and **irreversible** loss of muscle function to the whole of one or more limbs. The paralysis must be **permanent** and confirmed by a **Consultant** Neurologist.

**What does this mean?**

Paralysis or paraplegia of one or more limbs is evidenced by **permanent** and **irreversible** loss of movement and sensation. It could be caused by accident or by an illness.

**6.40 Parkinson’s Disease – resulting in permanent symptoms**

**Policy definition**

A definite diagnosis of Parkinson’s disease 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 are not covered:

- Parkinson’s disease secondary to chronic alcohol misuse or illegal drug misuse.
- other Parkinsonian syndrome.

**What does this mean?**

Parkinson’s disease causes a disturbance of voluntary movement. It causes tremors in the limbs and head and rigidity of the muscles. The condition usually takes a long time to progress and some drugs are available which can slow the process down even further but treatment becomes less effective as time goes by.

For a claim to be paid the onset of Parkinson’s disease must be idiopathic. This means it must have developed naturally rather than because of some other medical treatment or illness.

**6.41 Parkinson Plus Syndromes – resulting in permanent symptoms**

**Policy Definition**

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

- Multiple System Atrophy
- Progressive Supranuclear Palsy
- Parkinsonism-Dementia-Amyotrophic lateral sclerosis complex
- Corticobasal Ganglionic degeneration
- Diffuse Lewy Body disease.

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

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

- dementia; or
- bladder control and postural hypotension.

**What does this mean?**

Parkinson Plus syndromes are a group of neurodegenerative disorders which share the features of idiopathic Parkinson’s disease but with other unique characteristics specific to the condition diagnosed.

A claim can be made if **you** are diagnosed by a **Consultant** Neurologist with one of the Parkinson Plus syndromes named above and **you** have **permanent** symptoms as defined.

**6.42 Peripheral Vascular Disease – treated with by-pass surgery**

**Policy definition**

A definite diagnosis of Peripheral Vascular Disease by a **Consultant** Cardiologist or Vascular Surgeon with objective evidence from ultrasound of an obstruction in the arteries that results in the claimant undergoing by-pass graft surgery to the leg.

For this definition the following is not covered:

- Angioplasty.

In the event of a claim for this illness, the amount of any Life Insured’s Specified Serious Illness **Benefit** payment will be reduced by the amount of any **Partial Payment Specified Serious Illness Benefit** paid for Peripheral Vascular Disease – treated with angioplasty (condition number 7.23).

**What does this mean?**

Peripheral vascular disease is the most common disease of the arteries and refers to any disease or disorder of the circulatory system outside of the brain and heart. It is caused by build-up of fatty material which causes an artery to gradually become blocked, narrowed, or weakened. Peripheral vascular disease is sometimes called arteriosclerosis, or hardening of the arteries. By-pass graft surgery is often performed for severe Peripheral vascular disease that is unresponsive to medication or angioplasty.

**6.43 Pneumonectomy – removal of a complete lung**

**Policy definition**

The undergoing of surgery on the advice of an appropriate **medical specialist** to remove an entire lung for disease or traumatic injury suffered by the **Life Assured**.

For the above definition the following are not covered:

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

**What does this mean?**

Pneumonectomy is the removal of a complete lung. It may also be the most appropriate treatment for a tumour located near the centre of the lung that affects the pulmonary artery or veins, which transport blood between the heart and lungs. In addition, pneumonectomy may be the treatment of choice when

the patient has a traumatic chest injury that has damaged the main air passage (bronchus) or the lung’s major blood vessels so severely that they cannot be repaired.

**6.44 Primary Pulmonary Hypertension – of specified severity**

**Policy Definition**

A definite diagnosis by a **Consultant** Cardiologist of primary pulmonary hypertension resulting in **permanent** loss of the ability to perform physical activities to at least Class III of the New York Heart Association (NYHA) classification. This means there is marked limitation of physical activities, with less than ordinary activity causing fatigue, palpitations or shortness of breath.

For the above definition the following is not covered:

- pulmonary hypertension secondary to any other known cause – in other words, not primary.

**What does this mean?**

Primary pulmonary hypertension is where the blood pressure is abnormally high in the arteries that provide blood to the lungs. In order to claim, the condition must have reached a position where there are symptoms of a particular severity as detailed in the definition and must be of a **permanent** nature. Because of the complexities involved in the diagnosis and classifying symptoms, the diagnosis must also be made by a **Consultant** Cardiologist (an expert in heart



diseases). The NYHA classifications are an internationally recognised system of describing symptoms of heart disease.

Explanation of the NYHA classification is as follows:

Class	Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or shortness of breath.
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation or shortness of breath.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation or shortness of breath.
Class IV (Severe)	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

**6.45 Primary Sclerosing Cholangitis – of specified severity**

**Policy Definition**  
A definite diagnosis of Primary Sclerosing Cholangitis as evidenced by imaging confirmation of typical multifocal formation of bile duct strictures and dilation of intrahepatic and/or extrahepatic bile ducts.

For the above definition, the following are not covered:

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

**What does this mean?**  
Primary Sclerosing Cholangitis (PSC) is a chronic (lasting years), progressive (worsening over time) disease of the bile ducts that channel bile from the liver into the intestines. PSC caused by alcohol is not covered.

**6.46 Pulmonary Artery Surgery – with surgery to divide the breastbone**

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

**What does this mean?**  
The surgical division of the breastbone and the opening up of

the chest wall is performed to gain access to repair the diseased section of the pulmonary artery with a graft.

**6.47 Short Bowel Syndrome – requiring permanent total parenteral nutrition**

**Policy definition**  
A definite diagnosis by a **Consultant** Gastroenterologist of a short bowel syndrome resulting in massive loss of the small intestine and requiring parenteral nutrition on a **permanent** basis.

**What does this mean?**  
Short Bowel Syndrome (SBS) occurs when there is impaired ability to absorb food nutrients in the intestinal tract usually caused by surgery, injury or trauma to the small intestine. It usually does not develop unless more than two thirds of the small intestine has been removed. Total parenteral nutrition is where a person needs to be fed intravenously, bypassing the usual process of eating and digestion with no significant nutrition being obtained by other routes.

**6.48 Spinal Stroke – resulting in permanent symptoms**

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

**What does this mean?**  
A spinal stroke occurs when there is an interruption in the flow of blood to the spinal cord. Like other strokes

these may occur when there is a blockage in the blood supply or there is a bleed due to a burst blood vessel.

**6.49 Stroke – resulting in specified symptoms**

**Policy definition**  
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either:

- permanent neurological deficit with persisting clinical symptoms**; or
- definite evidence of death of brain tissue or haemorrhage on a brain scan; and
- neurological deficit with persisting symptoms lasting at least 24 hours.

For the above definition, the following is not covered:

- transient ischaemic attack.
- Central Retinal Artery Occlusion or Central Retinal Vein Occlusion (Eye Stroke)

**What does this mean?**  
As with a heart attack the cause of a stroke is inadequate blood supply, this time to the brain. It can be caused by a blood clot becoming caught in an artery of the brain or the bursting of one of the brain’s blood vessels. The event that triggers the stroke may result from problems within the body, such as clogged up arteries or weaknesses in the wall of a blood vessel. A claim can be made if the event causes clinical symptoms

of a stroke which last at least 24 hours and results in evidence of brain damage. Transient ischaemic attacks are often known as mini-strokes but do not result in **permanent** damage. They are therefore excluded.

**6.50 Systemic Lupus Erythematosus – with severe complications**

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

(i) Severe kidney involvement with systemic lupus erythematosus as evidenced by:

- permanent** impaired renal function with a glomerular filtration rate below 30ml/min/1.73m², and
- abnormal urinalysis showing proteinuria or haematuria.

In addition to the above criteria, the disease must have been unresponsive to disease modifying drugs for a continuous period of at least 12 months.

or

(ii) Severe central nervous system involvement with systemic lupus erythematosus 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 life of the **Life Assured**:

- paralysis
- dysarthria (difficulty with speech)
- aphasia (inability to speak)
- dysphagia (difficulty in swallowing)
- difficulty in walking
- lack of coordination
- severe dementia where the insured needs constant supervision; or
- permanent** coma.

For the purposes of this definition seizures, headaches, fatigue, lethargy or any symptoms of psychological or psychiatric origin nor injury secondary to alcohol or illegal drug misuse will not be accepted as evidence of **permanent** deficit of the neurological system.

**What does this mean?**  
The body’s immune system produces white blood cells and proteins called antibodies to destroy viruses and bacteria that are foreign to the body. Lupus, like other auto-immune diseases, mistakes **your** own tissue as foreign and attacks it causing inflammation. It can affect major organs in the body and stop them functioning properly.

**6.51 Third Degree Burns – covering 20% of the body’s surface area**

**Policy definition**  
Burns that involve damage or destruction of the skin to its full

depth through to the underlying tissue and covering at least 20% of the body's surface area or 50% loss of surface area of the face which for the purpose of this definition includes the forehead and ears.

**What does this mean?**

Third degree burns are the most serious type of burn. They involve the destruction of the full thickness of the skin and can cause damage to the fat, muscle and bone.

**6.52 Traumatic Head Injury – resulting in permanent symptoms**

**Policy definition**

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

For the above definition, the following is not covered:

- Injury secondary to alcohol where there is a history of alcohol misuse.
- Injury secondary to illegal drug misuse.

**What does this mean?**

Damage to brain tissue could be caused by an external trauma such as a severe head injury received in a road traffic accident.

**7 Partial Payment Specified Serious Illness Cover Definitions**

**7.1 Brain Abscess drained via Craniotomy**

**Policy definition**

Undergoing 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.

**What does this mean?**

A brain abscess is a rare, life-threatening infection of the brain. When bacteria, fungi or parasite infect part of the brain, inflammation occurs. The infected brain cells accumulate causing **our** immune system to create a membrane to isolate the infection creating an abscess. As the abscess grows it places pressure on delicate brain tissue, which can become damaged or destroyed.

Craniotomy – this is a surgical operation in which an opening is made in the skull. The abscess is either drained of pus, or removed.

**7.2 Carcinoma in Situ of the Cervix – with surgery**

**Policy definition**

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

For the above definition the following are not covered:

- Loop excision
- Laser surgery
- Conisation
- Cryosurgery and Cervical Intraepithelial Neoplasia (CIN) grade I or II.

**What does this mean?**

Carcinoma in situ is an early form of cancer which affects only the cells in which it originated and has not begun to spread to other cells, i.e. it is non-invasive. The policy will pay your claim if, after diagnosis of carcinoma in situ of the cervix, your cervix is surgically removed or you undergo a hysterectomy.

**7.3 Carcinoma in Situ of the Colon or Rectum – resulting in intestinal resection**

**Policy definition**

A definite diagnosis with histological confirmation of carcinoma in situ of the colon or rectum resulting in intestinal resection.

For the above definition the following are not covered:

- Local excision
- Polypectomy.

**What does this mean?**

Carcinoma in situ is an early form of cancer which affects only the cells in which it originated and has not begun to spread to other cells, i.e. it is non-invasive. The policy will pay your claim if, after diagnosis of carcinoma in situ of the colon or rectum, you undergo a surgical resection of your intestines.

**7.4 Carcinoma in Situ – Oesophagus, treated by specific surgery**

**Policy definition**

Definite diagnosis of a carcinoma in situ of the oesophagus positively diagnosed with histological confirmation by biopsy, 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.

**What does this mean?**

The oesophagus is the portion of the digestive system that leads from the mouth to the stomach, sometimes called the gullet. This muscular passage carries food and liquids from the mouth to the stomach.

Carcinoma in situ is an early form of cancer. In situ means that these abnormal cells are found in the innermost layer of tissue lining the oesophagus. The policy will pay **your** claim if, after diagnosis of carcinoma in situ of the oesophagus, a surgeon removes a part or all of **your** oesophagus.

**7.5 Carcinoma in Situ of the Testicle – requiring surgical removal of one or both testicles**

**Policy Definition**

A definite diagnosis of carcinoma in situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU) supported by histological evidence, which has been treated surgically with a orchidectomy (complete removal of the testicle).

**What does this mean?**

Carcinoma in situ is an early form of cancer. In situ means that there are abnormal cells in the testicle

but they are completely contained and so cannot spread, as cancer cells can. Carcinoma in situ is most often found when a man has a testicular biopsy to investigate infertility. There is no lump and usually no other symptom. **You** can claim if **you** have been diagnosed as having carcinoma in situ of the testicle requiring surgical removal of one or both testicles.

**7.6 Carcinoma in Situ of the Urinary Bladder – requiring surgical removal**

**Policy definition**

A definite diagnosis of a carcinoma in situ of the urinary bladder positively diagnosed with histological confirmation by biopsy, which is treated by complete removal of the bladder.

For the above definition, the following is not covered:

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

**What does this mean?**

Carcinoma in situ is an early form of cancer. Carcinoma-in-situ of the urinary bladder affects the lining of the bladder without any invasion into the deeper tissues. **You** can claim if **you** have been diagnosed as having carcinoma-in-situ of the urinary bladder requiring surgical removal of the entire bladder.

**7.7 Carcinoma in Situ of the Vagina – resulting in surgery to remove the tumour**

**Policy definition**

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

For the above definition, the following are not covered:

- Laser surgery and diathermy
- Vaginal Intraepithelial Neoplasia (VAIN) grade 1 or 2.

**What does this mean?**

Carcinoma in situ is an early form of cancer which affects only the cells in which it originated and has not begun to spread to other cells, i.e. it is non-invasive. **You** can claim if **you** have been diagnosed with carcinoma in situ of the vagina resulting in surgical removal of the tumour.

**7.8 Carcinoma in Situ of the Vulva – resulting in surgery to remove the tumour**

**Policy definition**

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

For the above definition, the following are not covered:

- Laser surgery and diathermy
- Vulval Intraepithelial Neoplasia (VIN) grade 1 or 2.

**What does this mean?**

Carcinoma in situ is an early form of cancer which affects only the cells in which it originated and has not begun to spread to other cells, i.e. it is non-invasive. **You** can claim if **you**



have been diagnosed with carcinoma in situ of the vulva resulting in surgical removal of the tumour.

**7.9 Carcinoma in Situ (Other) – with surgery**

**Policy definition**

A definite diagnosis of carcinoma in situ based on histological confirmation, that has been treated by surgery to remove the tumour.

For the above definition, the following are not covered:

- Any skin cancer (including melanoma)
- Tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment; and
- Intra-epithelial neoplasia or pre-malignant conditions.

This definition excludes all other specified carcinoma in situ conditions listed in the **Partial Payment Specified Serious Illness** Cover section (i.e. condition numbers 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8 and 7.16). For example, if a claim is made for carcinoma in situ of the cervix and the definition specific to that condition is not met, the carcinoma in situ (other) definition cannot be used instead.

**What does this mean?**

Carcinoma in situ is an early form of cancer which affects only the cells in which it originated and has not begun to spread to other cells, i.e. it is non-invasive. **You** can claim if **you** have been diagnosed with carcinoma in situ

which results in surgery. This excludes all other carcinoma in situ sites specified as partial payments, which are subject to their own definitions.

**7.10 Carotid Artery Stenosis – treated by Endarterectomy or Angioplasty**

**Policy definition**

Undergoing 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.

**What does this mean?**

Carotid Endarterectomy is the surgical procedure to remove fatty tissue from the neck arteries. Stenosis occurs when the arteries become blocked with the fatty tissue and the brain does not get enough oxygen.

An angioplasty involves the insertion of a balloon tipped tube into the blocked blood vessel. The balloon is inflated, compressing the fatty deposits against the arterial walls resulting in restoration of blood flow. A mechanical device known as a small metal mesh tube is placed inside the artery where the blockage occurred to widen the opening and support the artery wall. *This **benefit** does not cover any other treatment of the carotid artery or vascular system.*

**7.11 Cerebral Aneurysm – treated by craniotomy or endovascular repair**

**Policy Definition**

Undergoing of either of the

following surgical procedures in order to treat a cerebral aneurysm:

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

For the above definition, the following is not covered:

- Cerebral arteriovenous malformation.

**What does this mean?**

The junctions of arteries in the brain may develop weak spots. Aneurysms occur when these weak spots balloon out and fill with blood. Aneurysms may leak or rupture, spilling blood into surrounding tissues.

The surgical treatments are:

Craniotomy – this is a surgical operation in which an opening is made in the skull and the abnormal connection is removed by a **Consultant** Neurosurgeon.

Endovascular treatment using coils or other materials to cause imbolisation is carried out by a **Consultant** Neurosurgeon and uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.

**7.12 Cerebral Arteriovenous Malformation – treated by Craniotomy or Endovascular Repair**

**Policy Definition**

Undergoing surgical treatment

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

For the above definition, the following is not covered:

- Intracranial aneurysm

**What does this mean?**

A cerebral arteriovenous malformation (AVM) is an abnormal connection between the arteries and veins in the brain that usually forms before birth. The condition occurs when arteries in the brain connect directly to nearby veins, the blood does not flow into the capillaries which are the small vessels that normally transport blood from the arteries to the veins.

A cerebral arteriovenous malformation (AVM) rupture occurs because of pressure and damage to the blood vessel tissue. This allows blood to leak into the brain or surrounding tissue reducing blood flow to the brain.

The surgical treatments are:

Craniotomy – this is a surgical operation in which an opening is made in the skull and the abnormal connection is removed by a **Consultant** neurosurgeon.

Endovascular treatment is carried out by a **Consultant** neurosurgeon and involves the injection of a glue

like substance into the abnormal vessels in the AVM via a micro tube or catheter.

**7.13 Coronary Angioplasty – of specified severity**

**Policy definition**

The undergoing of coronary artery angioplasty, atherectomy, laser treatment or stent insertion on the advice of a **Consultant** Cardiologist to any of the main coronary arteries to correct:

- narrowing or blockages of at least 70%, confirmed by angiographic evidence; or
- narrowing or blockages where there is a fractional flow reserve ratio of <0.8.

The Main Coronary Arteries for this purpose are defined as:

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

Two or more procedures on the same Main Coronary Artery or a branch of the same Main Coronary Artery or two or more procedures on multiple branches of the same Main Coronary Artery will be regarded as one *Single Angioplasty Event* even if the procedures are performed at different times.

The undergoing of the above procedures on two or more Main Coronary Arteries at the same time is regarded as a *Double Angioplasty Event*.

The amounts payable for a Single Angioplasty Event and a *Double Angioplasty Event* are set out in Section 5.7.

**What does this mean?**

Fatty material builds up on the walls of the coronary artery blood vessels preventing the heart getting the blood supply it needs. There are several types of interventional procedures which may be used when performing angioplasty.

Angioplasty involves the insertion of a thin plastic tube with a small balloon tip into the artery, once the balloon tip reaches the narrowed section of the artery the balloon is inflated and the fatty material is compressed into the artery wall increasing the blood flow to the heart. Stenting involves the insertion of a small metal mesh tube into the narrowed artery. Atherectomy and laser treatment are also techniques which involve passing a thin plastic tube (catheter) into the blocked artery. **We** will require angiographic evidence showing at least 70% stenosis in the coronary arteries.

**7.14 Crohn’s Disease – treated with surgical intestinal resection**

**Policy definition**

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

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Intestinal biopsy

The amount of any Specified Serious Illness **Benefit** to be paid for Crohn’s Disease – of specified severity (condition number 6.19) will be reduced by the amount of any **Partial Payment Specified Serious Illness Benefit** paid for Crohn’s Disease – treated with surgical intestinal resection.

**What does this mean?**  
Crohn’s Disease is an inflammatory disease that affects the digestive system. The main symptoms of the disease are stomach cramps, diarrhoea and tiredness.

A claim can only be made if the **Life Assured** has had an operation to surgically remove part of the small or large intestine (bowel) as a result of Crohn’s disease. A claim will not be considered for a diagnosis of Crohn’s disease unless it has resulted in surgery as shown in the definition.

**7.15 Cystectomy – Removal of a Complete Bladder**

**Policy definition**  
A complete surgical removal of the urinary bladder.

For the above definition the following are not covered:

- Urinary bladder biopsy;
- Removal of a portion of the urinary bladder.

**What does this mean?**  
A claim can be made only where an entire bladder has been removed as a result of injury or disease. Claims for removal of only part of the bladder will not be paid.

**7.16 Ductal Carcinoma in Situ – Breast, treated by surgery**

**Policy definition**  
A definite diagnosis of a ductal carcinoma in situ (DCIS) of the breast positively diagnosed with histological confirmation by biopsy, 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.

For the above definition, the following are not covered:

- mastectomy, partial mastectomy, segmentectomy or lumpectomy, operations for reasons other than DCIS, for example, prophylactic mastectomy or lobular carcinoma in situ (LCIS).

**What does this mean?**  
Ductal carcinoma in situ is a term used to describe an early stage of cancer where the abnormal cells remain confined to the milk ducts of the breast, they have not spread deeper into the breast tissue or to other parts of the body.

A claim can be made if treatment is carried out involving the removal or partial removal of the breast or surgical removal of the tumour itself following a diagnosis of ductal carcinoma in situ.

**7.17 Eye Stroke – Central Retinal Artery Occlusion or Central Retinal Vein Occlusion – resulting in permanent visual loss**

**Policy definition**  
Death of optic nerve or retinal tissue due to inadequate blood supply within the central retinal artery or vein. This must result in **permanent** visual impairment.

For the above definition the following are not covered:

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

**What does this mean?**  
The retina is the light-sensitive layer of tissue at the back of the eyeball. The central retinal artery and vein transport blood to and from the retina. Central retinal artery/vein occlusion occurs when these blood vessels become blocked causing **permanent** damage and visual loss.

**7.18 Implantable Cardioverter Defibrillator – for the primary prevention of sudden cardiac death**

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

For the above definition, the following is not covered:

- Insertion of a pacemaker.

**What does this mean?**  
An implantable cardioverter defibrillator (ICD) is a small electrical device implanted in patients who are at risk of sudden death due to life-threatening, irregular heart rhythms. The ICD monitors the rhythm of the patient’s heartbeat. When the ICD records arrhythmia (abnormal electrical activity in the heart), it acts to restore rhythm.

Inserting a pacemaker is excluded as this is a different device and is used to treat conditions that are generally less serious.

**7.19 Liver Resection**

**Policy Definition**  
Undergoing a partial hepatectomy (liver resection) on the advice of a specialist surgeon in gastroenterology and hepatology.

For this definition the following are not covered:

- Surgery relating to liver disease resulting from alcohol or drug misuse;
- Surgery for liver donation (as a donor);
- Liver Biopsy

**What does this mean?**  
A liver resection is surgery to remove part of the liver. There are many reasons for removing part of

the liver, including benign tumours, cysts, or traumatic injury.

**7.20 Low level Prostate Cancer – with Gleason score between 2 and 6 and with specific treatment**

**Policy definition**  
Positive diagnosis with a 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 **Life Assured** has undergone treatment by prostatectomy, external beam or interstitial implant radiotherapy.

For the above definition, the following are not covered:

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

**What does this mean?**  
The prostate is a walnut sized gland in the male reproductive system located at the base of the bladder. Cancer of the prostate is one of the most common types of cancer in men. The Gleason score is a system of grading prostate cancer tissue based on how it looks under a microscope. The scores range from 2 to 10 and indicate how likely it is that a tumour will spread. A low Gleason score means the cancer is less likely to spread, a high Gleason score means that the cancer is more

likely to spread. In order for a claim to be valid the histology report must show a Gleason score between 2 and 6. A Gleason score greater than 6 will result in a full Specified Serious Illness Cover claim.

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

**Policy definition**  
Neuroendocrine tumours of low malignant potential, including Merkel cell cancer of the skin, diagnosed by histological confirmation and that has been treated by surgery to remove the tumour.

The following are not covered:

- Tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment

**What does this mean?**  
A claim can be made if you have been diagnosed as having a neuroendocrine tumour and where this has been treated by surgery.

Your claim must be supported by a microscopic examination of a sample of the relevant cells. This is known as ‘histology’ and would usually be carried out as part of a normal hospital investigation.

**7.22 Ovarian Tumour of borderline malignancy/low malignant potential – with surgical removal of an ovary**

**Policy definition**  
An ovarian tumour of borderline



malignancy/low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.

For the above definition, the following is not covered:

- Removal of an ovary due to cyst.

**What does this mean?**

A claim can be made if you have been diagnosed as having an ovarian tumour of borderline malignancy/low malignant potential, and where this has been treated by surgery.

Your claim must be supported by a microscopic examination of a sample of the relevant cells. This is known as ‘histology’ and would usually be carried out as part of a normal hospital investigation.

**7.23 Peripheral Vascular Disease – treated with angioplasty**

**Policy Definition**

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

The amount of any Accelerated or Standalone Specified Serious Illness **Benefit** to be paid for Peripheral Vascular Disease – with bypass surgery (condition number 6.42) will be reduced by the amount of any **Partial Payment Specified Serious Illness**

**Benefit** paid for Peripheral Vascular Disease – treated by angioplasty.

**What does this mean?**

Peripheral vascular disease is the most common disease of the arteries and refers to any disease or disorder of the circulatory system outside of the brain and heart. It is caused by build-up of fatty material which causes an artery to gradually become blocked, narrowed, or weakened. Peripheral vascular disease is sometimes called arteriosclerosis, or hardening of the arteries.

Balloon angioplasty involves a surgeon passing a fine balloon catheter (a flexible plastic tube) into the narrowed artery. When the balloon reaches the place where the artery has narrowed, it is inflated to force the walls of the artery apart. Atherectomy and laser treatment are also techniques which involve passing a catheter into the blocked artery.

**7.24 Permanent Pacemaker**

**Policy Definition**

The permanent insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. The abnormal rhythm of the heart must have been documented on electrocardiograph (ECG) and be available to the company.

**What does this mean?**

A claim can be made if you are treated for an abnormal rhythm of the heart with insertion of a pacemaker. For the claim to be valid,

there must be supporting ECG evidence of the abnormal rhythm of the heart.

**7.25 Pituitary Tumour – resulting in permanent symptoms or surgery**

**Policy Definition**

A definite diagnosis of a non-malignant tumour in the pituitary gland by a **Consultant** Neurologist or Neurosurgeon resulting in either of the following:

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

For the above definition, the following are not covered:

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

**What does this mean?**

The pituitary gland makes hormones that control many other glands in the body. A pituitary tumour is a growth of abnormal cells in the pituitary gland. Most tumours of the pituitary gland are benign and slow-growing. However, they can cause a variety of symptoms including headache, loss of vision, and infertility. Treatment may include surgery, radiation therapy and drug therapy. Pituitary tumours where symptoms are controlled by ongoing medication only are excluded.

**7.26 Serious Accident Cover – resulting in at least 28 consecutive days in hospital**

**Policy definition**

A serious accident resulting in severe physical injury where the **Life Assured** is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment. The 28 days can include a stay in a rehabilitation hospital as long as the **Life Assured** goes straight from the hospital to the rehabilitation centre.

Severe physical injury means injury resulting solely and directly from unforeseen, external violent and visible means and independent of any other cause. A **Life Assured** may claim only once under this cover.

For the above definition, the following are not covered:

- Stays in hospital of less than 28 consecutive days
- An accident as a result of involvement in the armed forces
- An accident as a result of involvement in hazardous pursuits (as outlined in Section 11.2)
- An accident secondary to alcohol where there is a history of alcohol misuse
- An accident secondary to illegal drug misuse.

**What does this mean?**

A claim can be made for this **benefit** if the **Life Assured** following a serious accident is confined to hospital for at least 28 consecutive

days in order to receive medical treatment for the injuries sustained in the accident. The 28 consecutive days can include time spent in a rehabilitation centre if the transfer is made directly from the hospital in order for treatment to be continued. Serious accident secondary to alcohol or drug misuse is not covered. **You** can only make one claim for injuries resulting from the same accident.

**7.27 Significant visual impairment – permanent and irreversible**

**Policy definition**

**Permanent** and **irreversible** reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/18 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lenses.

For the above definition, the following are not covered

- If **you** are ‘registered blind,’ **your** claim will only be met if the loss of sight meets the criteria outlined in the definition outlined above.

**What does this mean?**

In order for the **Life Assured** to claim under this definition the loss of sight in both eyes must be **irreversible** to the extent that that even when using glasses or other visual aids, the degree of loss is measured at 6/18 or worse on the Snellen eye chart. A Snellen chart is an eye chart used by eye care

professionals to measure visual acuity. The chart consists of rows of letters that decrease in size downwards. A result of 6/18 indicates that the **Life Assured** can only see at 6 metres what someone with normal sight can see at 18 metres away.

**7.28 Single Lobectomy – removal of a complete lobe of a lung**

**Policy definition**

The undergoing of medically essential surgery to remove a complete lobe of a lung for disease or traumatic injury.

For the above definition, the following are not covered

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

**What does this mean?**

A lobectomy is an operation during which a single lobe of the lung is removed. People have two lungs located on either side of the heart within the rib cage. They are not identical, the right lung has three lobes and the left one has two lobes.

**7.29 Surgical removal of one eye**

**Policy definition**

Undergoing surgical removal of a complete eyeball for disease or trauma.

**What does this mean?**

The surgical removal of an entire eyeball due to either disease or injury.

**7.30 Syringomyelia or Syringobulbia – treated by surgery**

**Policy definition**

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

**What does this mean?**

Syringomyelia is a disorder in which a cavity forms in the spinal column. This cavity can extend or expand over time causing damage to the spinal cord.

Syringobulbia is a cavity that forms in the part of the brain called the brain stem. This cavity can extend or expand over time causing damage to the brain stem.

The symptoms of these disorders are wide ranging and may include for example pain, or loss of the ability to feel extreme heat or cold.

**7.31 Third Degree Burns – covering at least 10% of the body’s surface**

**Policy definition**

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 10% and less than 20% of the body’s surface area or at least 25% of the surface area of the face which for the purpose of this definition includes the forehead and the ears.

**What does this mean?**

There are only three degrees of burns and all three refer to how deep the burn goes through the skin, the higher the number the worse the burn. First and second degree burns can heal without scarring. 3rd degree burns are the most serious type of burn, they involve the destruction of the full thickness of the skin, fat, muscle and bone. In order for a claim to be valid burns must involve damage or destruction of the skin covering at least 10% and less than 20% of the body’s surface area or at least 25% of the surface area of the face. Burns in excess of 20% of the body’s surface area or at least 50% of the surface area of the face will result in a full Specified Serious Illness Cover claim.

**7.32 Total Colectomy – including a Total Colectomy performed as a result of Ulcerative Colitis**

**Policy definition**

The surgical removal of the entire colon.

For the above definition the following is not covered:

- Total Colectomy as a result of Crohn’s Disease.
- Partial removal of the colon.

**What does this mean?**

The colon is the final section of the digestive system linking the stomach to the anus.

Colectomies are used to treat a variety of medical conditions

including cancer, trauma of the colon, colon obstructions and intestinal irritants such as Ulcerative Colitis. A total colectomy is the surgical removal of the whole colon.

**8 Special Events Increase Benefit**

This **benefit** is also known as a Guaranteed Insurability Option.

**8.1** This option is only available to a **Life Assured** if they were accepted on standard terms and is not available if any special conditions apply, for example, if **we** applied any exclusions to the cover or included an extra **premium** for special terms. If the basis of cover is **Joint Life**, this option will only apply to the policy if both **Lives Assured** were accepted on standard terms. If the basis of cover is **Dual Life** then this option may only apply to one **Life Assured** (or both lives). The availability of this option is subject to underwriting at the time the original policy is taken out.

**8.2** If this option is included it allows **you** to increase the Life Cover and Specified Serious Illness Cover on the policy, up to the limits set out below, without the need to supply further medical evidence, following any of these events:

- Increase in mortgage by a **Life Assured** either to purchase a new main residence or for home improvement of main residence;
- The marriage of a **Life Assured**;
- The birth or legal adoption of a child by a **Life Assured**.

**8.3** The **Life Assured** must be under 55 years old at the time the option is exercised. If the basis of cover is **Joint Life**, both **Lives Assured** must be under 55 years old at the time the option is exercised. If the basis of cover is **Dual Life**, this option may be exercised separately in respect of each **Life Assured**.

**8.4** Any increase in Accelerated Specified Serious Illness Cover must be matched by the same increase in Life Cover. However, **you** can choose to increase the Life Cover only. Any increase in Stand-alone Specified Serious Illness Cover does not need to be matched by an increase in Life Cover.

**8.5** **You** can increase **your** cover on more than one occasion, but the following limits apply:

The maximum increase in Life Cover for any one event is limited to whichever of the following amounts is lower:

- 50% of the relevant original level of Life Cover;
- or €100,000.

The maximum increase in Specified Serious Illness Cover for any one event is limited to whichever of the following amounts is lower:

- 50% of the relevant original level of Specified Serious Illness Cover;
- or €100,000.

The maximum total increase in Life Cover for all events over the term of

the policy is limited to whichever of the following amounts is lower:

- the relevant original level of Life Cover;
- or €200,000.

The maximum total increase in Specified Serious Illness Cover for all events over the term of the policy is limited to whichever of the following amounts is lower:

- the relevant original level of Specified Serious Illness Cover;
- or €200,000.

**8.6** This option cannot be exercised in respect of Specified Serious Illness Cover if the proposed increase in cover would take the level of Specified Serious Illness Cover above the maximum allowed under this policy at the time **you** wish to exercise the option. The current maximum level of Specified Serious Illness Cover is €1,400,000.

**8.7** If the basis of cover is **Joint Life**, the maximum limits apply to the joint levels of cover and not individually. If the basis of cover is **Dual Life**, the maximum limits apply separately to each **Life Assured’s** level of cover. In addition, if **you** have more than one policy with **Royal London**, these limits apply across all of these policies and not separately to each of them.

**8.8** Where the option is to be exercised for the purchase of a new main residence or home improvement, the maximum increase is also limited to the increase in the mortgage amount.

**8.9** **You** must apply in writing to **us** within three months of the occurrence of the event if **you** wish to exercise this option. **Royal London** will require evidence to show that the event has occurred.

**8.10** **You** cannot increase **your** cover using this option:

- if **we** have already paid, or are currently considering, a Specified Serious Illness Cover claim or **Partial Payment Specified Serious Illness** claim (excluding Children’s Specified Serious Illness Cover);
- or, if **you** are no longer resident in the Republic of Ireland;
- or, for the purchase of a secondary residence or an overseas property.

**8.11** Any increase in cover will:

- be based on the normal terms and conditions applicable for policies of this type at the date the option is exercised;
- have a term equal to the remaining term of the original policy;
- include any special conditions or restrictions as per the original policy conditions and **policy schedule**.

**8.12** If this option is exercised the **premium** will be recalculated accordingly each time the cover is increased. **We** will base **your** new **premium** on:



- the age of the **Life Assured**, or both **Lives Assured** if the basis of cover is **Joint Life**, at the date the increase in cover commences;
- the smoking habits of the **Life Assured**, or both **Lives Assured** if the basis of cover is **Joint Life**, at the date the increase in cover commences;
- any special terms as outlined in the original **policy schedule** or at any subsequent reinstatement under Section 3.2;
- and **Royal London's premium** rates at the time of the increase.

## 9 Indexation

This section only applies if the **policy schedule** shows that **Indexation** applies to this policy. **Indexation** works as follows:

**9.1** At each **increase date** (see Section 2 – Definitions), **we** will automatically increase **your** cover (both Life Cover and Specified Serious Illness Cover, as applicable) unless **you** have told **us** in writing not to do so. The **Lives Assured** do not need to give evidence of health for these increases.

**9.2** **We** will advise **you** at least four weeks before each **increase date** of the details of the increase. If **you** want to cancel an increase in cover, **you** must tell **us** in writing at least one week prior to the **increase date**. If **you** do not cancel an increase in cover, the increased

**premium** will be due from the **increase date** and the increased level or levels of cover will apply. **You** can only cancel an increase in all cover under the policy: for example, **you** cannot cancel an increase in Life Cover and proceed with an increase in Specified Serious Illness Cover. If cover is on a **Dual Life** basis, **you** can only cancel an increase in cover in respect of both **Lives Assured** and not on one **Life Assured** only.

**9.3** The increase in cover will be 3% each year and **your premiums** will increase by 4% each year.

**9.4** The maximum level of Specified Serious Illness Cover is €1,400,000.

**9.5** For policies with Accelerated Specified Serious Illness Cover, if the basis of cover is Single Life or **Joint Life**, once the maximum level of Specified Serious Illness Cover has been reached there will be no further increases in cover (Life Cover or Specified Serious Illness Cover) or **premium**. This may result in an increase in cover of less than 3% for the final increase. A proportionate increase in **premium** of less than 4% will also apply. If the basis of the policy is **Dual Life**, once the maximum level of Specified Serious Illness Cover for a **Life Assured** has been reached there will be no further increases in cover for that **Life Assured** (Life Cover or Specified Serious Illness Cover). This may result in an increase in cover for that **Life Assured** of less than 3% for

the final increase. A proportionate increase in **premium** of less than 4% will also apply.

**9.6** For policies with Stand-alone Specified Serious Illness Cover, once the maximum level of Specified Serious Illness Cover for a **Life Assured** has been reached there will be no further increases in the level of Specified Serious Illness Cover for that **Life Assured**. This may result in an increase in the level of their Specified Serious Illness Cover of less than 3% for the final increase. However, Life Cover (assuming a Life Cover **benefit** applies) can continue to increase, subject to Sections 9.7 and 9.8. Once the maximum level of Specified Serious Illness Cover for has been reached, any further increases in Life Cover (assuming a Life Cover **benefit** applies) will result in an increase in total **premium** of less than 4% to reflect the fact that the Specified Serious Illness Cover isn't increasing.

**9.7** There will be no further increase in **benefit** or **premium** when the **Life Assured**, or the oldest **Life Assured** in the case of a **Joint Life** policy, reaches age 70. For **Dual Life** policies, the increase in **benefit** and **premium** for each **Life Assured** will cease when they have reached age 70.

**9.8** If **you** cancel the increase three times during the term of the policy or if **you** reduce the level of cover more than once, **you** will not be entitled to any further increases.

## 10 Conversion Option

If the **policy schedule** shows that a conversion option applies, **you** can convert this policy into another policy provided by **Royal London** without having to provide evidence of health. The new policy must commence on or before the **conversion option expiry date**, and (aside from waiving the medical underwriting requirements) will be subject to **Royal London's** standard new business terms and conditions at the date of conversion.

The following conditions apply:

**10.1** The policy must not have already ceased as per Section 5.9.

**10.2** The level of cover under the new policy cannot be greater than the level of cover under this policy on the date it is converted.

**10.3** **We** will issue the new policy under **our** normal terms which apply at the time this policy is converted. The **premium** payable will be calculated based on the age of the **Lives Assured** and **Royal London's** rates for the class of policy selected at the time.

**10.4** Any special conditions which attach to this policy will apply to the new policy. If **we** have charged an extra **premium** on this policy (e.g. for health reasons), **we** will also charge an extra **premium** on the new policy based on the **premium** rates in place at the time of conversion.

**10.5** **You** must apply in writing before the **conversion option expiry date**.

**10.6** **Indexation** will not be available under the new policy.

**10.7** When **you** take out the new policy, the cover under this policy will be immediately reduced by the level of cover under the new policy. If the level of cover under this policy is reduced to nil, this policy will be immediately cancelled and no further **benefit** will be payable under it.

**10.8** The new policy will be of a type offered by **us** at that time.

**10.9** In some circumstances, the conversion option will be subject to financial underwriting – refer to **policy schedule** to see if this applies. Where it does apply, **we** have the right to reduce the level of cover on conversion or disallow the conversion altogether if the evidence of financial justification submitted at the time does not, in the opinion of **our** underwriters, warrant the level of cover requested.

**10.10** The term of the new policy will be subject to **Royal London's** maximum age at cessation for relevant new business policies at the time of conversion, or age 90 if this is lower. The term also cannot be greater than 50 years (or 40 years if Specified Serious Illness is included on the new policy). For Joint and **Dual Life** policies the maximum age of cessation is based on the age of the oldest **Life Assured**.

## 11 EXCLUSIONS

In addition to any conditions outlined on **your policy schedule**, the following exclusions apply to **your** policy. These exclusions are on top of any specific exclusions in the sections explaining the **benefits** themselves.

### 11.1 Life Cover & Terminal Illness Benefit

If a **Life Assured** dies or is diagnosed with a Terminal Illness within a year of the **start date** of the policy as a result of their own deliberate act, **we** will not pay any **benefit** under the policy. However if the policy was transferred to someone else (except for a husband, wife or next of kin of the **Life Assured**) before the act which caused the death or Terminal Illness, **we** will pay the **benefit** subject to having received all relevant information as outlined in Section 3.1.

### 11.2 Specified Serious Illness Cover (including Partial Payment Specified Serious Illness Cover)

There are a number of circumstances in which a claim for payment of Specified Serious Illness Cover will not be admitted.

These exclusions are as follows:

- (i) No **benefit** will be payable if a Specified Serious Illness Cover claim results directly or indirectly as a result of:
  - War, civil war, riot, civil commotion or a similar event;

- Self-inflicted injury or illness whether the **Life Assured** is sane or insane;
  - Improper use of drugs or alcohol;
  - Failure to follow medical advice;
  - The **Life Assured** taking part in a criminal act; or
  - Any Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (outside of those outlined in Section 6 of this booklet).
- (ii) No **benefit** will be payable if a Specified Serious Illness Cover claim results directly or indirectly as a result of the **Life Assured** engaging in hazardous activities, examples of which are:
- Abseiling;
  - Aviation other than a fare paying passenger on a regular public airline;
  - Bobsleighing;
  - Boxing;
  - Equestrian Events;
  - Hang-gliding;
  - Motor or Motorcycle sports;
  - Mountaineering;
  - Parachuting;
  - Paragliding;
  - Pot holing or caving;
  - Power boat racing;
  - Rock climbing; or
  - Scuba diving.

This is not an exhaustive list. If **you** are unsure whether **you** are covered for a particular activity **you** should contact **us** in writing.

### 11.3 Territorial Limits

Any claim in respect of Life Cover, for a **Life Assured** who has been diagnosed as having a Terminal Illness, or Specified Serious Illness, will be invalid if the **Life Assured** is resident outside the following countries for more than 13 weeks in any 52 week period. A Children's Specified Serious Illness Cover claim will also be invalid if the child is resident outside the following countries for more than 13 weeks in any 52 week period.

The countries are:

- **European Union**
- Australia
- Canada
- New Zealand
- Norway
- South Africa
- Switzerland
- United States of America.

**You** must write and tell **us** immediately if a **Life Assured** starts living in a country which is not one of the accepted countries listed above. **We** will then decide whether cover will continue and on what basis. This may include an increase in **premium** and/or exclusions to the cover.

### 11.4 Pre-existing Medical Conditions

No **benefit** will be payable in respect of Life Cover or Specified Serious Illness Cover if in the opinion of our **Chief Medical Officer** a claim is made for a condition which was known or ought to reasonably have been known to exist prior to the **start date**, unless **we** have received all relevant information as outlined in Section 3.1.

### 11.5 Children's Specified Serious Illness Cover (including Partial Payment Specified Serious Illness Cover)

No **benefit** for Children's Specified Serious Illness Cover is payable if the claim is as a result of a pre-existing condition, as defined below:

A pre-existing condition is a medical condition (including congenital defects) where symptoms first arose, the underlying condition was first diagnosed or either parent received counselling or medical advice in relation to the condition before:

- The **Start date** of the policy;
- The legal adoption of the child.

The child must survive for at least 14 days (known as the **survival period**) following the diagnosis of the **insured specified serious illness** for the **benefit** to be payable.

Children's Specified Serious Illness Cover applies only to the **diagnosis of an insured specified serious illness** (other than Loss of Independent Existence) and not

on the death of a child or diagnosis of a Terminal Illness. **We** will not pay under this **benefit** if a child dies within the **survival period**.

No **benefit** for Children's Specified Serious Illness Cover is payable for Brain injury due to anoxia or hypoxia (condition 6.9) and Intensive Care – requiring mechanical ventilation for 10 consecutive days (condition 6.28), before the age of 90 days.

No **benefit** for Children's Specified Serious Illness Cover will be admitted if the claim arises from any of the exclusions outlined in Section 11.2.

## 12 Claims

### 12.1 Proof of Age

**Your benefits** have been calculated on the basis that the date of birth of each **Life Assured** is as shown on the **policy schedule**. In the event of a claim for a **Life Assured**, **we** will ask for proof of the date of birth. If the date of birth on the application is not correct, **we** may recalculate the **benefits** in line with the correct date of birth. In some circumstances, **we** may refuse to pay any **benefit** if **we** would not have provided cover initially had **we** known the correct date of birth.

### 12.2 Life Cover

**We** will consider a claim when **we** have received the following:

- (a) Proof of death in the form of a death certificate, or any other proof **we** reasonably need.
- (b) Proof of entitlement to claim the **benefits**. This could include proof

that the policy conditions and any special conditions contained in the **policy schedule** have been followed. **We** may ask the person making the claim for a grant of probate or letters of administration.

- (c) Proof in the form of a birth certificate of the age of the **Life Assured**.
- (d) Original marriage certificate if the **Life Assured** is a married woman and her surname differs from the surname on her birth certificate.
- (e) The original policy documents. If they are not available, whoever makes the claim must accept legal responsibility and sign a document indemnifying **us** if it turns out that someone else is entitled to the **benefit**.

### 12.3 Specified Serious Illness Cover (including Partial Payment Specified Serious Illness Cover and Children's Specified Serious Illness Benefit)

All claims should be notified to **us** as soon as possible after the event. Any claim must be received within 3 months of the event or the diagnosis giving rise to the claim (except for the special procedures that apply to claims in relation to **HIV/AIDS** infection from blood transfusion, exposure to blood or physical assault which are outlined in Section 6.23 of this booklet). If **you** do not, **we** may refuse to pay the **benefit**.

**We** will consider a claim when **we** have received the following:

- (a) A completed claim form.
- (b) Proof of entitlement to claim the **benefits**. This could include proof that the policy conditions and any special conditions contained in the **policy schedule** have been followed.
- (c) Proof in the form of a birth certificate of the age of the **Life Assured**.
- (d) Original marriage certificate if the **Life Assured** is a married woman and her surname differs from the surname on her birth certificate.
- (e) The original policy documents. If they are not available, whoever makes the claim must accept legal responsibility and sign a document indemnifying **us** if it turns out that someone else is entitled to the **benefit**.

All items of proof, certificates, information, medical and other evidence that **Royal London** may require in support of a claim must be provided at **your** own expense.

As part of **our** claims procedure, **we** will obtain a report from the Specialist who diagnosed the **insured specified serious illness**. It may also be necessary to obtain a report from the **Life Assured's** or child's **Registered Medical Practitioner** and/or any relevant Specialist in order to assess the claim. The **Life Assured** (or for a Children's Specified Serious Illness Cover Claim the child's legal guardian) must agree to any



medical examinations and tests which are necessary to prove the claim. If the **Life Assured** or child fails to meet these requirements within a reasonable time, or if the **Life Assured** or child fails to follow the advice of a **Registered Medical Practitioner**, **we** will not pay the **benefits** claimed.

**12.4 Remaining Cover after a Claim**

Section 5 sets out what cover (if any) remains in place after a Life Cover or Specified Serious Illness Cover claim. Where all Life Cover and Specified Serious Illness Cover under a policy has been reduced to nil as a result of a claim, the policy will cease immediately.

If cover is on a **Dual Life** basis and the Life Cover and Specified Serious Illness Cover has reduced to nil for one **Life Assured** as a result of a claim, cover can continue on a Single Life basis for the second **Life Assured** provided that the **premium** is still paid. **We** will reduce the **premium** to reflect the fact that only one life is now covered.

**12.5 Payment of the Claim**

If any information **we** have been given is not correct, true or complete, **we** may not pay the claim. For Life Cover, if **we** have not paid the **benefit** two months after the date of notification of the death of the **Life Assured**, interest shall accrue monthly from that time (i.e. two months after the date of notification) until the **benefit** has been paid. For Specified

Serious Illness Cover, interest shall be payable if **we** have not paid the **benefit** two months after the later of the following dates:

- Date of diagnosis
- Date of notification

Interest shall accrue monthly from that time (i.e. two months after the date of diagnosis or notification) until the **benefit** has been paid.

The rate of interest applicable shall be 0.25% per annum below the European Central Bank (ECB) base rate at all times. Where the ECB base rate changes during the period of time for which the interest calculation is being determined, the rate used in the calculation will also change accordingly

**13 Tax**

Under current law, **we** do not deduct any tax from the **benefit**. However, tax is payable on any interest **we** pay – see Section 12.5. In some circumstances a tax liability will be incurred following payment of a claim. For example, if a Life Cover **benefit** is paid to **your** estate, **your** beneficiaries may have to pay inheritance tax (there is no inheritance tax due on an inheritance between a married couple). If tax laws change after the **start date**, **we** may change the policy conditions of the policy if **we** need to keep the policy in line with those changes. **We** will write and tell **you** about any changes in the policy conditions.

**14 Data Protection**

**Use of information by Royal London**

**We** will use **your** personal information, and where applicable that of the **Life Assured** (including sensitive personal information relating to their physical or mental health) if this person is not the Policyholder, for the following purposes:

- Underwriting and administering **your** policy
- Providing and developing **our** products and services
- Improving customer care
- Verifying **your** identity and fraud prevention
- Research and analysis
- Legal and regulatory reasons

**We** will keep **your** personal information for a reasonable period and **we** may also share information about **you** and the **Life Assured** with other companies within the **Royal London Group**, **your** intermediary, **our** service providers and agents and with third parties such as auditors, underwriters, reinsurers, medical agencies, professional advisors, identity authentication and fraud prevention agencies, other financial institutions and legal and regulatory bodies, or where **we** are required by law to provide this information.

**Your** personal data may be processed in countries outside the European Economic Area. In this

event, the processing will be carried out by experienced and reputable organisations and only on terms which safeguard the security of **your** data and comply with the requirements of the Data Protection Acts 1988 and 2003.

**We** may carry out an electronic check to verify **your** identity. **We** will use a reputable reference agency that will access a range of data sources including information from the Electoral Register to carry out identity checks. Although **we** will retain a record of this search, **we** will not share this information outside of the **Royal London Group**.

**We** may also pass information to financial and other organisations involved in money laundering and fraud prevention to protect ourselves and **our** customers from theft and fraud. If **you** give **us** false or inaccurate information and **we** suspect fraud, **we** will record this and share this information with other organisations.

**We** may monitor and record phone calls and retain these for the purposes of training and quality assurance and to ensure that **we** have an accurate record of **your** instructions.

**You** have the right to ask for a copy of the information that **we** hold on **you**, for which **we** are entitled to charge a small fee. **You** can ask **us** to correct any inaccuracies in **your** information.

If **you** have any questions about how **we** will use **your** personal information, please write to:

Compliance Manager  
**Royal London Group**  
47-49 St Stephen's Green  
Dublin 2

**15 Other Information**

**15.1** This policy does not have any encashment value.

**15.2** This policy is governed by the laws of Ireland and the Irish courts are the only courts which are entitled to hear any dispute. If any relevant laws change after the **start date**, **we** may change the policy conditions of the policy if **we** need to keep the policy in line with those changes. **We** will write and tell **you** about any changes in the policy conditions.

**15.3** If **you** transfer the **benefit** of this policy to someone else, the person **you** assign it to must write and tell **us** at our Head Office at:

Existing Business Department  
**Royal London Group**  
47-49 St Stephen's Green  
Dublin 2









**Royal London**

47-49 St Stephen's Green, Dublin 2

T: 01 429 3333 F: 01 662 5095 E: [service@royallondon.ie](mailto:service@royallondon.ie)  
[royallondon.ie](http://royallondon.ie)

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