NEW IRELAND
ASSURANCE

Life Choice - Assets
Policy Conditions

Contents

Comhlucht na hÉireann um Árachas, cpt/New Ireland Assurance Company plc

Registered in Dublin, Ireland, Registered No.7336.

Registered Office: 5-9 South Frederick Street, Dublin 2.

Introduction

This is the Policy Document for your Life Choice – Assets policy. Together with the Policy Schedule and any endorsements to this policy, it contains the details of your policy and the conditions and rules which set out how the policy works. Please read them carefully to ensure they meet your requirements.

The Policy Document is a legal document and should be kept in a safe place. It would also be useful if your solicitor, a relative or a friend knew where it is kept.

We will send all correspondence to the most recent address provided by you. It is in your interest to notify us of any change of address at our office at 5/9 South Frederick Street, Dublin 2.

Section A - General Conditions

1.Definitions

Application
The completed application and/or all the information provided by you and/or the Lives Insured in connection with this policy to your intermediary and/or to the Company, or by your intermediary to the Company, prior to the commencement of the policy and any declarations signed by you and/or the Lives Insured.

Approved Territories
The countries of the European Union as at January 2013 (Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and United Kingdom), Australia , Canada, New Zealand, Norway, Switzerland and the United States of America.

Assigned
You can make the Protection Benefits under the policy payable to someone else by making your policy Assigned. This involves you and the other person making a legal agreement as to who will receive the Protection Benefits. Normally, this is done if this policy is used as security for a loan, and the Protection Benefits are paid to the lender. You are still liable to pay the Premiums.

Assignee
If you make your policy Assigned, then the person who has taken over the legal interest is known as the Assignee. It is this person to whom the Protection Benefits will be paid.

Consultant
A registered medical practitioner who has specialist qualifications in an appropriate branch of medicine and who is practising at a Major Hospital in one of the Approved Territories.

Where a Consultant is registered in a country other than Ireland or the United Kingdom, the Company reserves the right to seek an opinion of a Consultant practising in Ireland or the United Kingdom.

Insurer
New Ireland Assurance Company plc is the Company that has issued the policy. Wherever the words "we", "us", "New Ireland", "the Insurer" and "the Company" are used in the policy they refer to New Ireland Assurance Company plc. New Ireland Assurance Company plc is regulated by the Central Bank of Ireland and is a member of the Bank of Ireland Group.

Life Insured
A person whose life is insured by the policy, and who is named in the Policy Schedule. If there are two lives insured named in the Policy Schedule then the policy is a joint life policy.

Lump Sum on Death Benefit
The amount of Lump Sum on Death Benefit shown in the Policy Schedule as applying to a Life Insured, or as subsequently changed.

Major Hospital
This is a medical institution registered with the relevant authority in one of the Approved Territories (unless otherwise stated), which has continuous facilities for diagnosis, treatment and major surgery, which is operated primarily for the surgical and medical treatment of acute illness and injury, and which provides accommodation for sick and injured people as in-patients. For the purposes of this policy "Major Hospital" does not include a hospice, convalescence, geriatric or rehabilitation facility or the National Rehabilitation Hospital (Dún Laoghaire, Co. Dublin).

Partial Payment Specified Illness Benefit
This benefit (which applies only if Accelerated or Standalone Specified Illness Benefit has been

selected and accepted by the Company) provides for an amount to be paid if the Life Insured is diagnosed with a Partial Payment Specified Illness as outlined in Appendix B during the Term of Cover for Accelerated or Standalone Specified Illness Benefit. Conditions applying to Partial Payment Specified Illness Benefit are described in Section C, Condition 2.1.3.

Policy Anniversary
This is the date 12 months after the policy starts and every 12 months thereafter.

Policyholder
The person or persons with whom the contract of insurance is made and who is responsible for the payment of the Premiums. Wherever the words "you" and "your" are used in the policy, they refer to the Policyholder. The Policyholder is named in the Policy Schedule.

Policy Schedule
The Policy Schedule forms part of the policy and sets out the specific details of your policy.

Policy Start Date
This is the date that the policy starts. It is stated in your Policy Schedule.

Policy Term
This is the maximum Term of Cover chosen for the Protection Benefits as stated on your Policy Schedule or any endorsement. The Policy Term may end earlier than the expiry of the maximum Term of Cover if Protection Benefits are paid or the policy lapses or ceases as set out in these policy conditions.

Premium or Premiums
The amount shown in the Policy Schedule or a revised amount as stated on any endorsement or letter from the Company as a result of voluntary revision. The frequency at which Premiums are payable is also shown in the Policy Schedule.

Protection Benefits
The amounts, as applicable, of the Lump Sum on Death Benefit and Accelerated or Standalone Specified Illness Benefits, applying to a Life Insured are collectively referred to as Protection Benefits.

Specified Illness
A Specified Illness is the definite diagnosis by a Consultant of a Major Hospital and as verified by the Company's Chief Medical Officer, of the first occurrence of any of the illnesses outlined in Appendix A and/or Appendix B during the Term of Cover for the Accelerated or Standalone Specified Illness Benefit.

Accelerated or Standalone Specified Illness Benefit
This benefit (if selected and accepted by the Company) provides for an amount to be paid, if the Life Insured is diagnosed with a Specified Illness as outlined in Appendix A during the Term of Cover for this benefit.

Term of Cover
This is the period(s) of cover chosen for each Life Insured for each of the Protection Benefits that have been selected under your policy. The Term of Cover for each of the Protection Benefits will end on expiry of the chosen Term of Cover or, if earlier, the payment of Protection Benefit(s) or the lapse or cessation of the policy as set out in these policy conditions.

2. Legal Basis

The contract with New Ireland Assurance is a legal agreement and consists of:

- the Application (including any recorded telephone interview) completed by you and the Life Insured;
- this policy document which sets out the standard policy conditions;

- the Policy Schedule;
- any written statements made by you, and the Life Insured(s);
- any statements made by an authorised person on your behalf;
- changes in the policy conditions or Policy Schedule notified to you in writing by the Company (these are called endorsements); and
- any schedule of revised terms issued by the Company to you.

The above contains all the terms of the contract and we accept liability only in accordance with these terms.

For the policy to be valid, we require full and true disclosure in the Application and in any medical or other statements made by the Policyholder or Life Insured or intermediary in connection with the Application.

The policy is governed by the laws of Ireland. The courts of Ireland shall have exclusive jurisdiction in relation to all matters arising under or in connection with the policy.

The Company will, subject to the payment of Premiums and the policy terms, pay the benefits provided by the policy. If there is any misrepresentation of or failure to disclose material facts by or on behalf of the Policyholder, or a Life Insured, the policy is void and all Premiums paid will be retained by us.

The policy and the benefits payable under it are based on current legislation, including current taxation legislation. If there is any change in taxation or other legislation affecting the policy we will make such alterations to the terms of the policy as, in the Company's opinion, are necessary to take account of such changes.

Complaints and disputes arising in connection with your policy, which cannot be resolved within the Company's internal complaints handling procedure, may be referred to the Financial Services and Pensions Ombudsman. Details of the services provided by the Financial Services and Pensions Ombudsman may be obtained from www.fspo.ie, your insurance advisor or New Ireland.

Any assignments of the policy to a third party must be notified to the Company at our head office, 5-9 South Frederick Street, Dublin 2.

3. Payment of Benefits

Protection Benefits are payable to the legal owner of the policy. This will normally be the Policyholder, but if the right to receive the Protection Benefits has been transferred or Assigned to some other person or organisation such as a bank or building society, the payment of the Protection Benefits will be made directly to them unless we receive the written instructions of the legal owner to do otherwise.

For example, depending on the circumstances we may pay one of the following:

- the Policyholder;
- a trustee(s) of the policy;
- an executor(s) or administrator(s);
- an Assignee(s) of the policy.

If there are two Policyholders we will pay both jointly or the survivor if one has died. If at the time the Protection Benefits becomes payable the Policyholder has died, we will pay the Assignee or the executors or administrators dealing with the estate as appropriate. If the policy has been issued under Trust, we will pay the trustee who is responsible to the beneficiaries of the Trust.

Section B - Details of the Policy

1. Paying Premiums

Your first Premium is due on the Policy Start Date. Subsequent Premiums are payable at the frequency set out on your Policy Schedule or any endorsement.

It is your responsibility to ensure that all Premiums are received by us. Once cover has started, we will allow you 30 days for payment from the date that a Premium is due. If the Premium is not paid within 30 days your policy and Protection Benefits will cancel immediately without further notice and you are no longer on cover for any Protection Benefits. If you inform us in writing within 30 days of the premium due date that you want to cancel your policy, it will be cancelled immediately. Where this policy is being replaced by a new policy, this policy will be cancelled (unless previously lapsed) with effect from the commencement date of the new policy.

If you have Assigned your policy, we are obliged to notify the Assignee that Premiums have not been paid and that cover no longer applies.

If a claim arises during the 30 day period when a Premium is due and has not been paid, but before the policy has been cancelled, we will deduct the amount of the unpaid Premium from the claim amount.

2. Increasing Cover

Increasing Cover only applies if stated in the Policy Schedule.

If you have chosen Increasing Cover then, provided Premiums have been paid, we will increase the Premium and the Protection Benefits on each Policy Anniversary by 3% per annum.

Increasing Cover does not apply to Partial Payment Specified Illness Benefit.

If you wish to waive an increase in any year or cancel your Increasing Cover, you should notify us within 30 days prior to the date of increase. If you do not pay an increased Premium within 30 days of the date the increase was due to take effect, this will be deemed as notice that you have waived the increase for that year. If Increasing Cover has been waived in any year, the increase will apply as normal the following year unless we receive your written instruction to the contrary. If Increasing Cover is waived for 3 consecutive years, it will be cancelled from the policy.

If Increasing Cover is cancelled, future increases under this option will be subject to underwriting and acceptance by New Ireland

3. Amending your policy

3.1 Medical–Free Conversion Option

The Policy Schedule will state whether this option applies to your policy.

If the Policy Schedule states that the Medical-Free Conversion Option ("Option") applies, then at any stage before the expiry of your Term of Cover you may, subject to the provisions set out below, either extend the Term of Cover for your policy or cancel this policy and take out a new policy with the Company, without providing any additional medical evidence.

The Option is subject to the following provisions.

To extend the Term of Cover for your policy, the following provisions apply:

1. The relevant Life Insured (or the older Life Insured in the case of a joint life policy) must be under 65 years of age on the date the Option is exercised.
2. The amount of any benefit payable after conversion cannot be greater than the amount of the benefit provided under this policy immediately prior to conversion.
3. The premium charged for the extended Term of Cover, after the Option is exercised, will

be determined by the Company based on its premium rates for the policy at the time of conversion and the age of the Life Insured on the date the option is exercised.

4. Any special terms which apply to the Protection Benefits before the Option is exercised will continue to apply for the extended Term of Cover.
5. The extended Term of Cover for any benefit will be limited to the maximum term of cover for that benefit as advised by the Company, or the date upon which the Life Insured (or the older Life Insured in the case of a joint life policy) would reach the maximum age for that benefit, if earlier.
6. The Term of Cover in respect of Lump Sum on Death and Specified Illness, if these benefits have been selected, must be the same.
7. Increasing cover is available only in respect of those benefits to which increasing cover applied immediately before conversion.
8. The amount of any benefit after conversion may be for such lesser amount as the Company at its discretion shall decide taking into account evidence as to the extent of any financial loss you would incur on the death or diagnosis of a Specified Illness of the Life Insured and any other financial evidence that the Company may require.
9. Financial Underwriting will apply.

To take out a new policy (if available) all of the following provisions apply:

1. The relevant Life Insured (or the older Life Insured in the case of a joint life policy) must be under 65 years of age on the date the Option is exercised.
2. The new policy may be any of the Company's range of non-unit linked protection policies, offering comparable benefits, available at the time the Option is exercised. The benefits under any new policy will be restricted to those benefits which applied to your policy prior to conversion and which are available under any new policy. The Company reserves the right to restrict and/or vary the definition of any one or more of the Protection Benefits under the new policy to be consistent with this policy.
3. The amount of any benefit provided by the new policy cannot be greater than the amount of the benefit provided by this policy on the date the Option is exercised.
4. The Premium charged for the new policy will be determined by the Company based on its premium rates for that policy at the time the Option is exercised.
5. Any special terms which apply to the Protection Benefits will continue to apply for the new policy.
6. The Term of Cover on any benefits under your new policy will be limited to the maximum Term of Cover for that benefit under the new policy as advised by the Company, or the date upon which the Life Insured (or the older Life Insured in the case of a joint life policy) would reach the maximum age for that benefit under the new policy, if earlier.
7. Increasing Cover is available under any new policy only in respect of those benefits to which increasing cover applied immediately before conversion.
8. The amount of any benefit under a new policy may be for such lesser amount as the Company at its discretion shall decide taking into account evidence as to the extent of any financial loss you would incur on the death or diagnosis of a Specified Illness of the Life Insured and any other financial evidence that the Company may require.

9. If converting from a joint life policy to a dual life policy, the amount of any Lump Sum on Death and/or Specified Illness Benefits provided by the new policy for each Life Insured will be half that of the Lump Sum on Death and/or Specified Illness Benefit provided by this policy.
10. If this policy provides a Lump Sum on Death Benefit, the new policy may provide an Income on Death Benefit in lieu of this Lump Sum on Death Benefit. The amount of the Income on Death Benefit cannot be greater than the amount of the Lump Sum on Death Benefit provided by this policy, on the date the Option is exercised, divided by the number of months in the Term of Cover for the Income on Death Benefit provided by the new policy.
11. The lives insured by the new policy may not include any lives who are not insured by this policy.
12. Financial Underwriting will apply.

3.2. Other Policy Options

Outside the terms set out in Condition 3.1 above, at any stage throughout the Term of Cover you may request an amendment to the Term of Cover or the amount of Protection Benefits. You can also request the addition or removal of Protection Benefits to your policy. Any amendments outside of Condition 3.1 above will be subject to underwriting and acceptance by the Company. If your request is accepted your policy will result in your Premium being re-calculated to take account of the changes being made and will be confirmed by an endorsement to the policy.

4. Restarting your Policy

If a Premium has not been paid within 30 days from the date it was due for payment, then as set out in Condition 1 of Section B, your policy and Protection Benefits will be cancelled. However, your policy may be restarted at our absolute discretion within one year from the date that the first unpaid Premium was due.

Restarting your policy is subject to payment of all Premiums outstanding and the completion of a Declaration of Health Form by each Life Insured.

Depending upon what is disclosed on this form the Company may request further medical and/or other information, accept or decline the reinstatement and/or make changes to the policy terms or conditions including the premium to be paid.

5. Cancelling your Policy/Protection Benefits Ceasing

The Protection Benefits will cease when one of the following events occurs:

- A claim is made under the Lump Sum on Death Benefit (first claim on a joint life policy).
- You make a claim under the Accelerated Specified Illness Benefit (first claim on a joint life policy) which reduces the Lump Sum on Death Benefit amount to zero.
- You make a claim under Standalone Specified Illness Benefit and there is no Lump Sum on Death Benefit on the policy.
- The Life Insured reaches the end of the Term(s) of Cover for the Protection Benefit(s).
- You give written notification that you wish to cancel your policy.
- You do not pay us a Premium on the date the Premium is due for payment and 30 days elapse since that date the premium was due.

The Company will retain any Premiums paid under the policy.

6. Who is Covered

The Life Insured(s) is covered for the amount of the Protection Benefits that apply to the Life Insured(s) until the end of the Term of Cover for the Protection Benefits.

The Life Insured(s) details and chosen benefits are stated in the Policy Schedule or any endorsement. The Life Insured(s) is covered for the amount of the Protection Benefits that apply from the later of the Policy Start Date and the date we collect your first Premium.

We will require proof of the age of the Life Insured(s) either on Application or before we pay a claim. If it is discovered that the age or the sex of a Life Insured has been mis-stated, the amount payable under the provision of the policy will be adjusted as determined by the Company and may result in the non payment of the benefit. The Company will retain any Premiums paid under the policy.

7. Settlement/Correspondence

We will make payments under your policy by direct credit to a nominated bank account. Other forms of payment can be arranged by agreement.

We will send your correspondence to the most recent address given by you. You must notify us if you change address. If you do not, we are not responsible for correspondence being delivered to the incorrect address.

Any letters or notices from you must be sent to us at our head office, 5-9 South Frederick Street, Dublin 2.

8. No Policy Value

The purpose of this policy is to provide a lump sum payment in the event of death and/or (if selected) on the diagnosis of a Specified Illness, of a Life Insured during the Term of Cover. This policy is not a savings policy and at no point during the Policy Term, or at the end of the Policy Term, will it have any monetary value.

9. Revising the Policy

We may revise the conditions set out in this document if, in the opinion of the Company, circumstances outside our control have changed in a way which could not reasonably have been predicted at the start of the policy and where, if we were not to amend these policy conditions, the results would be unfair to the Insurer or to our Policyholders. Such circumstances might be:

- a change in the law under which these policies operate, or
- a change in the tax treatment of policy benefits or of life assurance companies and their funds.

When considering any proposals to amend these policy conditions and how they affect your interests, we will refer to the Guidance Notes prepared independently by the Society of Actuaries in Ireland and to any legislation or other regulation and/or requirement that affects the way that we must act in these circumstances.

10. Legal Interest in Your Policy

You can use this policy as security for a loan by signing over your legal interest to the lender. This is known as an "Assignment". A notice of Assignment must be received by us at our head office from the person who has taken over the legal interest. This person is known as the "Assignee". The notice must be in writing and must show the date and reason for the change in legal ownership. We cannot accept any responsibility for the legal effect or otherwise of any Assignments.

Section C - Benefits

This section contains details of the Protection Benefits provided by the policy and the circumstances in which they are payable. The particular benefits applying to a Life Insured are shown in the Policy Schedule or any endorsement. If a benefit is not shown on the Policy Schedule, that benefit is not provided by the policy. No benefit is payable after the expiry of the Term of Cover for that benefit and no Protection Benefits are payable after the expiry of the Policy Term.

All Protection Benefits provided by the policy are currently payable to the Policyholder free of taxation. Details of the circumstances when a claim may not be payable, and the procedure you must follow in order to make a claim, are contained in Section D "Claim Procedures and Exclusions".

1. Death Benefits

1.1. Lump Sum on Death

This benefit only applies to a Life Insured if stated on the Policy Schedule or subsequent endorsement.

This benefit provides for the payment of a lump sum amount as stated on the Policy Schedule or any endorsement on the death of a Life Insured (or the first of the Lives Insured to die if a joint life policy) during the Term of Cover for this benefit as stated on the Policy Schedule or any endorsement.

The benefit applying on the death of a Life Insured and the changes which are made to the policy, depend on whether the Policy Schedule states that the Lump Sum on Death Benefit applies to that Life Insured, and whether the policy is a single life or joint life policy.

- Single life means that the Lump Sum on Death Benefit is paid when the only Life Insured under the policy dies during the Term of Cover for Lump Sum on Death Benefit.
- Where there are two Lives Insured (joint life) the Lump Sum on Death Benefit is paid on the first death of the two Lives Insured under the policy during the Term of Cover for Lump Sum on Death Benefit.

The policy will cease on the payment of the Lump Sum on Death Benefit.

If Accelerated Specified Illness Benefit applies, then the Lump Sum on Death will be reduced by any prior payment of Accelerated Specified Illness Benefit.

No claim for Lump Sum on Death Benefit will be admitted if death arises from any of the exclusions contained in Section D which are applicable to Lump Sum on Death Benefit. The claims procedures described in Section D apply to claims for Lump Sum on Death Benefit

1.2. Terminal Illness Benefit

This benefit only applies if Lump Sum on Death Benefit is stated on the Policy Schedule or subsequent endorsement.

This benefit provides you with early payment of your Lump Sum on Death Benefit if a Life Insured is diagnosed with a Terminal Illness during the Term of Cover for Lump Sum on Death Benefit .

Terminal Illness means an advanced or rapidly progressing incurable illness, where in the opinion of an attending medical Consultant of a Major Hospital and our Company's Chief Medical Officer, the Life Insured's life expectancy is no greater than 12 months. In the event of a Terminal Illness, the Terminal Illness Benefit payment will not apply where there are less than 18 months to go to the end of the Term of Cover for Lump Sum on Death Benefit.

The Terminal Illness Benefit will be the Lump Sum on Death Benefit if stated in the Policy Schedule. The policy will cease following the Terminal Illness Benefit being paid out.

In the case of a joint life policy this benefit is payable on the diagnosis of a Terminal Illness of the first of the Lives Insured.

In the event of Terminal Illness no claim will be admitted if Terminal Illness arises from any of the exclusions contained in Section D which are applicable to Terminal Illness Benefit. The claims procedures described in Section D apply to claims for Terminal Illness Benefit.

1.3 Accidental Death Benefit

If the Life Insured is under age 55 when both the initial Application details and the duly signed initial Application declarations were received at New Ireland's head office and you have chosen Lump Sum on Death as a benefit, then the policy will pay a benefit of the chosen Lump Sum on Death amount up to a maximum of €150,000 should the Life Insured die due to Accidental Death (or in the case of an Application for a joint life policy, on the Accidental Death of the first to die of the Lives Insured) from on or after the date when both the initial Application details and the duly signed initial Application declarations were received at New Ireland's head office.

Accidental Death means death resulting from an injury caused by accidental, violent, external and visible means and is in no way linked to sickness, disease or physical disorder of the Life Insured.

An Accidental Death does not include any of the following causes:

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

Accidental Death Benefit will cease on the earlier of the following:

- the day we issue notice of acceptance of the Application on normal terms
- the day we issue an offer of special terms
- the day we issue notice that the Application has been refused
- the day we issue notice that the Application has been postponed
- 30 days have passed since the day both the initial application details and the duly signed initial application declarations were received at New Ireland's head office.

We will only pay once under Accidental Death Benefit in respect of any Life Insured, regardless of the number of applications a person has with New Ireland.

2. Additional Benefits

2.1. Accelerated or Standalone Specified Illness Benefit

Accelerated and Standalone Specified Illness Benefit only applies to a Life Insured if stated on the Policy Schedule or subsequent endorsement. The type of Specified Illness Benefit, the amount of the Specified Illness Benefit and the Term of Cover are as stated on the Policy Schedule.

2.1.1 Accelerated Specified Illness Benefit
This provides you with a lump sum amount if a Life Insured is diagnosed with a Specified Illness as outlined in Appendix A during the Term of Cover for this benefit. This benefit is only available if you selected a Lump Sum on Death Benefit for the relevant Life Insured on the policy and the Lump Sum on Death Benefit will be reduced by the amount of any Accelerated Specified Illness Benefit paid.

In the event of a claim for Accelerated Specified Illness Benefit which is related to one of the four Partial Payment Specified Illnesses listed in 2.1.3, the amount of any Life Insured's Accelerated Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid.

2.1.2. Standalone Specified Illness Benefit
This provides you with a lump sum amount if a Life Insured is diagnosed with a Specified Illness as outlined in Appendix A during the Term of Cover for this benefit. Payment of a Standalone Specified Illness Benefit will not affect any Lump Sum on Death Benefit, where applicable.

In the event of a claim for Standalone Specified Illness Benefit which is related to one of the four Partial Payment Specified Illnesses listed in 2.1.3, the amount of the Life Insured's Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid.

2.1.3. Partial Payment Specified Illness Benefit
This is an additional benefit that automatically applies to a Life Insured if their Policy Schedule or subsequent endorsement states that Accelerated or Standalone Specified Illness Benefit applies to that Life Insured.

This provides you with a lump sum if a Life Insured is diagnosed with a Partial Payment Specified Illness as outlined in Appendix B during the Term of Cover of the Accelerated Specified Illness Benefit or Standalone Specified Illness Benefit.

For the Partial Payment Specified Illness Benefit Angioplasty for Coronary Artery Disease – of specified severity, (Number 1 of Appendix B) the maximum amount we will pay is the lower of:

- €50,000 or;
- 75% of the Accelerated or Standalone Specified Illness Benefit at the time of the procedure taking place.

For the other Partial Payment Specified Illnesses outlined in Appendix B, the amount we will pay is the lower of:

- €15,000 or;
- 50% of the Accelerated or Standalone Specified Illness Benefit remaining at the time of the illness being diagnosed or specified surgery taking place as appropriate.

We will make only one payment under this Partial Payment Specified Illness Benefit for each of the Partial Payment Specified Illnesses outlined in Appendix B.

Where there are two or more valid Partial Payment Specified Illness Benefit claims in respect of a Life Assured arising from the same condition or surgery, only one Partial Payment Specified Illness Benefit will be paid.

The Partial Payment Specified Illness Benefit is independent of the Accelerated or Standalone Specified Illness Benefit, with the exception of Partial Payment Specified Illness Benefit paid in respect of;

- Crohn's Disease - treated with surgical intestinal resection (number 16 in Appendix B),
- Early Stage Urinary Bladder Cancer - of specified advancement (number 21 in Appendix B),
- Peripheral Vascular Disease - treated by

angioplasty (number 27 in Appendix B), and

- Serious Accident Cover - resulting in at least 28 consecutive days in hospital (number 30 in Appendix B).

In the event of a claim for the Accelerated or Standalone Specified Illness Benefit which is related to one of the four Partial Payment Specified Illnesses listed above, the amount of any Accelerated or Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid.

The total amount we will pay under Partial Payment Specified Illness Benefit is limited to the amount of the Accelerated or Standalone Specified Illness Benefit.

We will not pay any Partial Payment Specified Illness Benefit if a Life Insured dies within 14 days of the date the Partial Payment Specified Illness is diagnosed or the specified surgery taking place, as appropriate.

If a claim under Partial Payment Specified Illness Benefit is paid and within 30 days of the diagnosis or surgery, as appropriate, an admissible claim arises under the Accelerated or Standalone Specified Illness Benefit, then the overall amount paid out will be the Accelerated or Standalone Specified Illness Benefit amount at that time. Once 30 days have elapsed since the diagnosis or surgery of a Partial Payment Specified Illness, as appropriate, then any admissible claim for Accelerated or Standalone Specified Illness Benefit will be assessed and paid independently, outside of the exceptions outlined above.

Once an Accelerated or Standalone Specified Illness Benefit claim is paid, the Partial Payment Specified Illness Benefit ceases immediately.

2.1.4 Waiting List Benefit

If a Life Insured is making a claim relating to

- Coronary Artery By-pass Grafts,
- Heart Structural Repair,
- Heart Valve Replacement or Repair,
- Pulmonary Artery Graft Surgery - or
- Aorta Graft Surgery – for disease or traumatic injury

and the claim is accepted by the Company, we will make a payment in advance of the Life Insured undergoing the surgery if a Consultant of an Irish or United Kingdom Major Hospital confirms to our Company's Chief Medical Officer's satisfaction that the surgery is necessary for medical reasons, and the Life Insured is on an Irish or United Kingdom Major Hospital waiting list. The advance payment will be 50% of the Accelerated or Standalone Specified Illness Benefit at the time the Life Insured goes on the Major Hospital waiting list, subject to a maximum of €32,500.

The Accelerated or Standalone Specified Illness Benefit (and Lump Sum on Death Benefit in the case of Accelerated Specified Illness Benefit) will be reduced by the amount of the advance payment. The balance of any Accelerated or Standalone Specified Illness Benefit will become payable when the Life Insured actually undergoes the surgery.

For a claim for Accelerated or Standalone Specified Illness Benefit (including Partial Payment Specified Illness Benefit) to be valid you must notify us within 90 days of the diagnosis of the illness or the date of the specified surgery, as appropiate.

We will not pay any Standalone Specified Illness Benefit or Partial Payment Specified Illness Benefit if a Life Insured dies within 14 days of the date the illness is diagnosed or the specified surgery taking place, as appropriate.

The Accelerated or Standalone Specified Illness Benefit cover will cease upon payment of any claim for Accelerated or Standalone Specified Illness Benefit

No claim for Accelerated or Standalone Specified

Illness Benefit (including Partial Payment Specified Illness Benefit) will be admitted if the Specified Illness (including Partial Payment Specified Illness) arises from any of the exclusions contained in Section D which are applicable to Accelerated or Standalone Specified Illness Benefit (including Partial Payment Specified Illness Benefit) . The claim procedures described in Section D apply to claims for Accelerated or Standalone Specified Illness Benefit (including Partial Payment Specified Illness Benefit).

Section D – Claim Procedures and Exclusions

1. Claim Procedures

All claims must be notified in writing to New Ireland Assurance's head office at 5-9 South Frederick Street, Dublin 2. While we recommend that claims be notified as soon as possible after the event, claims must be notified within 90 days of the event or the diagnosis giving rise to the claim except for the special procedures that apply to claims in relation to HIV infection contracted from a blood transfusion, physical assault or at work as set out in Appendix A.

New Ireland must receive the completed claim form together with this Policy Document and the Policy Schedule which forms part of this document. All items of proof, certificates, information, medical and other evidence that the Company may require in support of a claim must be provided at your own expense.

Where the conditions require the diagnosis by a Consultant, he or she must be a Consultant of a Major Hospital.

2. Exclusions

There are a number of circumstances in which a claim for payment of a Protection Benefit will not be admitted. These exclusions, and the Protection Benefits to which they apply, are as follows:

- No claim for Accelerated or Standalone Specified Illness Benefit (including Partial Payment Specified Illness Benefit) is payable if a Life Insured is resident outside the Approved Territories for more than 13 weeks in any consecutive 12 month period prior to the time of claim.
- No Lump Sum on Death Benefit or Terminal Illness Benefit is payable if the Life Insured dies by his or her own hand or act or is diagnosed as being terminally ill as a result of his or her own deliberate act within 1 year of the Policy Start Date or within 1 year of the date of any reinstatement of the policy or within 1 year of a voluntary increase in Lump Sum on Death Benefit, or within 1 year of being added on to the policy, whichever is applicable, except that if the policy has been Assigned to a third party in good faith, the benefit payable is limited to the interest of that third party which was acquired for monetary consideration.
- Any specific exclusions relating to particular illnesses covered by Accelerated or Standalone Specified Illness Benefit (including Partial Payment Specified Illness Benefit) are contained in the relevant part of Appendix A and/or Appendix B.
- The specific exclusions relating to Accidental Death Benefit are contained in Section C, Condition 1.3.

Appendix A

Specified Illnesses

1. Alzheimer's Disease – resulting in permanent symptoms

A definite diagnosis of Alzheimer's disease by a Consultant Neurologist 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:

- Alzheimer's Disease secondary to alcohol or drug misuse

2. Aorta Graft Surgery – for disease or traumatic injury

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

The term aorta means the thoracic and abdominal aorta but not its branches.

For the above definition, the following is not covered:

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

3. Aplastic Anaemia - of specified severity

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

- Blood transfusion;
- Bone-marrow transplantation;
- Immunosuppressive agents;
- Marrow Stimulating agents.

All other forms of anaemia are specifically excluded.

4. Bacterial Meningitis - resulting in permanent symptoms

A definite diagnosis of bacterial meningitis by a Consultant Neurologist causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit with persisting clinical symptoms*.

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

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

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

The following are not covered:

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

5. Balloon Valvuloplasty

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

6. Benign Brain Tumour - resulting in permanent symptoms or undergoing specified treatments

A non-malignant tumour or cyst originating from in the brain, cranial nerves or meninges within the cranium, resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms*; or
- undergoing invasive surgery to remove all or part of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

For the above definition, the following are not covered:

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

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

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

The following are not covered:

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

7. Benign spinal cord tumour – resulting in permanent symptoms or undergoing specified treatments

A non-malignant tumour of the spinal canal or spinal cord, causing pressure and/or interfering with the function of the spinal cord resulting in any of the following:

- permanent neurological deficit with persisting clinical symptoms*; or
- undergoing invasive surgery to remove all or part of the tumour; or
- undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

For the above definition, the following are not covered:

- Angiomas
- Prolapsed or herniated intervertebral disc

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

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

The following are not covered:

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

8. Blindness – permanent and irreversible

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in the better eye using a Snellen eye chart or visual field is reduced to 20 degrees or less of an arc, as certified by an ophthalmologist.

9. Brain Abscess - undergoing specified treatments

A definite diagnosis of an intracerebral abscess within brain tissue by a Consultant Neurologist, resulting in either of the following:

- surgical removal;or
- surgical drainage of the abscess.

10. Brain Injury due to Anoxia or Hypoxia – resulting in permanent symptoms

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

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

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

The following are not covered:

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

11. Cancer – excluding less advanced cases

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

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

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
  - pre-malignant
  - non-invasive
  - cancer in situ
  - having either borderline malignancy; or
  - having low malignant potential.
  - All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least clinical TNM classification T2bN0M0.
  - Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
  - Malignant melanoma unless it has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).
  - Any other skin cancer (including cutaneous lymphoma) unless it has been histologically classified as having caused invasion in the lymph glands or spread to distant organs.
  - Any urinary bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0.
  - All thyroid tumours unless histologically classified as having progressed to at least TNM classification T2N0M0.

In the event of a claim for urinary bladder cancer, the amount of any Life Insured's Accelerated or Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Early Stage Urinary Bladder Cancer – of specified advancement (number 21 of Appendix B).

12. Cardiac Arrest – with insertion of a defibrillator

Sudden loss of heart function with cessation 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 is not covered:

- Insertion of a pacemaker
- Insertion of a defibrillator without cardiac arrest
- Cardiac arrest secondary to alcohol or drug misuse

13. Cardiomyopathy – of specified severity

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 secondary to alcohol or drug misuse.

14. Cauda Eqina - with permanent symptoms

A definite diagnosis by an appropriate Consultant of cauda equina syndrome evidenced by compression of the lumbosacral nerve roots (cauda equina) resulting in all of the following:

- permanent bladder dysfunction.
- permanent weakness and loss of sensation of the legs.

The diagnosis must be supported by appropriate neurological evidence.

15. Chronic Lung Disease - of specified severity

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

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

16. Chronic Pancreatitis – of specified severity

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 are not covered:

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

17. Coma - resulting in permanent symptoms

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

- requires the use of life support systems;

and

- results in permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following is not covered:

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

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

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

The following are not covered:

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

18. Coronary Artery By-pass Grafts

The undergoing of heart 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;
- laser treatment.

19. Creutzfeld-Jacob Disease – resulting in permanent symptoms

A definite diagnosis of Creutzfeld-Jacob disease by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

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

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

The following are not covered:

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

20. Crohn's Disease – of specified severity
A definite diagnosis of Crohn's disease by a Consultant Gastroenterologist with fistula formation and intestinal strictures.There must have been two or more resections of the small or large intestine on separate occasions.

There must also be evidence of continued inflammation with ongoing symptoms, despite optimal therapy with diet restriction, medication use and surgical interventions.

In the event of a claim for this illness, the amount of any Life Insured's Accelerated or Standalone Specified 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 (number 16 of Appendix B).

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

22. Dementia – resulting in permanent symptoms
A definite diagnosis of dementia by a Consultant Neurologist or Geriatrician. There must be progressive and permanent clinical loss of the ability to do all of the following:

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

For the above definition, the following is not covered:

- Dementia secondary to alcohol or drug misuse.

23. Devic's Disease
A definite diagnosis of Devic's disease by a Consultant Neurologist. There must have been clinical impairment of motor or sensory function caused by Devic's disease.

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

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

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

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

The following are not covered:

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

25. Heart Attack - definite diagnosis
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- New characteristic electrocardiographic (ECG) changes or other positive changes on diagnostic imaging tests.
- The characteristic rise of cardiac enzymes or troponins

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

- Other acute coronary syndromes.
- Angina without myocardial infarction.

26. Heart Structural Repair
The undergoing of heart surgery requiring thoracotomy on the advice of a Consultant Cardiologist to correct any structural abnormality of the heart.

27. Heart Valve Replacement or Repair
The undergoing of heart surgery on the advice of a Consultant Cardiologist to replace or repair one or more heart valves.

28. HIV infection - contracted in any of the Approved Territories from a blood transfusion, a physical assault or at work
Infection by Human Immunodeficiency Virus resulting from:

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

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

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

For the above definition, the following is not covered:

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

29. Intensive Care – requiring mechanical ventilation for 10 consecutive days
Any sickness or injury resulting in the Life Insured 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 a Major Hospital.

For the above definition the following are not covered:

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

30. Kidney Failure – requiring permanent dialysis
Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.

For the above definition, the following is not covered:

- Kidney failure secondary to alcohol or drug misuse.

31. Liver Failure – Irreversible and End Stage
Chronic liver disease, being end stage and irreversible liver failure due to cirrhosis and resulting in all of the following:

- permanent jaundice,
- ascites; and
- hepatic encephalopathy.

For the above definition, the following is not covered:

- Liver Failure secondary to alcohol or drug misuse.

32. Loss of one Limb – permanent physical severance
Permanent loss of a hand from above the wrist or a foot 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.

If a Life Insured loses a limb as a result of their own deliberate act, or a penalty imposed by a court of law, we will not pay you any benefit under the policy.

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

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

For the above definition, the following is not covered:

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

35. Motor Neurone Disease – resulting in permanent symptoms
A definite diagnosis of motor neurone disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function.

36. Multiple Sclerosis
A definite diagnosis of multiple sclerosis by a Consultant Neurologist. There must have been clinical impairment of motor or sensory function caused by multiple sclerosis.

37. Muscular Dystrophy – resulting in permanent symptoms
A definite diagnosis of muscular dystrophy by a Consultant Neurologist resulting in permanent neurological deficit with persisting clinical symptoms*.

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

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

The following are not covered:

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

38. Myasthenia Gravis - with specified symptoms

A definite diagnosis of myasthenia gravis by a Consultant Neurologist. There must have been clinical impairment of motor function in parts of the body other than the eye muscles caused by myasthenia gravis.

For the above definition, the following is not covered:

- Myasthenia gravis limited to eye muscles only.

39. Necrotising Fasciitis - requiring surgery

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.

40. Paralysis of One limb - total and irreversible

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

41. Parkinson's Disease (idiopathic) – resulting in permanent symptoms

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist or Geriatrician. There must also be permanent clinical impairment that includes bradykinesia (slowness of movement) and at least one of the following:

- tremor; or
- muscle rigidity; or
- postural instability

For the above definition, the following are not covered:

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

42. Parkinson Plus Syndromes - resulting in permanent symptoms

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

- Multiple system atrophy
- Progressive supranuclear palsy
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Corticobasal ganglionic degeneration
- Diffuse Lewy body disease

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

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

43. Peripheral Vascular Disease – with bypass surgery

A definite diagnosis of peripheral vascular disease by a Consultant Cardiologist or Vascular Surgeon, due to atherosclerosis or Buerger's disease, with objective evidence from an ultrasound of obstruction in the arteries which results in by-pass graft surgery to an artery of the legs.

For the above definition, the following is not covered:

- Angioplasty

In the event of a claim for this illness, the amount of any Life Insured's Accelerated or Standalone Specified Illness Benefit payment will be reduced by the amount of any Partial Payment Specified Illness Benefit paid for Peripheral Vascular Disease - treated by angioplasty (number 27 of Appendix B).

44. Pneumonectomy – removal of a complete lung
The undergoing of surgery on the advice of a Consultant Physician to remove an entire lung for disease or traumatic injury.

For the above definition, the following are not covered:

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

45. Primary Pulmonary Hypertension – of specified severity
A definite diagnosis of primary pulmonary hypertension by a Consultant Cardiologist. There must be substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classifications of functional capacity*.

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

46. Primary Sclerosing Cholangitis – of specified severity
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 extra hepatic bile ducts.

For the above definition, the following are not covered:

- All other causes of bile duct stricture formation and dilation
- Primary sclerosing cholangitis secondary to liver disease which is associated with alcohol.

47. Pulmonary Artery Graft Surgery
The undergoing of surgery on the advice of a Consultant Cardiothoracic Surgeon for a disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

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

49. Spinal Stroke - resulting in permanent symptoms
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*.

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

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

The following are not covered:

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

- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms
- Symptoms of psychological or psychiatric origin.

50. Stroke – resulting in specified symptoms
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 tissue or haemorrhage on a brain scan and neurological deficit with persistent clinical symptoms lasting at least 24 hours.

For the above definition, the following are not covered:

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

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

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

The following are not covered:

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

51. Syringomyelia or syringobulbia – with surgery
The undergoing of surgery to treat a syrinx in the spinal cord or brain stem.

52. Systemic Lupus Erythematosus – of specified severity
A definite diagnosis of systemic lupus erythematosus by a Consultant Rheumatologist resulting in either of the following:

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

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

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

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

53. Third Degree Burns - of specified surface area
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least the following:

- 20% of the body's surface area; or
- 20% surface area of the face which for the purpose of this definition includes the forehead and the ears.

54. Total and Permanent Disability

1. Total and Permanent Disability before age 65 means that in the opinion of the Company's Chief Medical Officer, the Life Insured is, because of illness or accident, permanently and irreversibly unable to carry out at least 3 of the 6 activities listed below or is permanently disabled by reason of mental incapacity. The person must have taken any appropriate prescribed treatment or medication and then be unable to perform the activity on their own, even with the use of appropriate assistive aids and appliances (e.g. using a walking stick).

The relevant Consultant must reasonably expect that the disability will last throughout life with no prospect of improvement irrespective of when the cover ends or the Life Insured expects to retire.

Total and Permanent Disability must persist for a continuous period of at least 12 months before any entitlement to Total and Permanent Disability benefit arises.

The 6 activities are:

- Walking – the ability to walk 200 meters on a level surface.
- Mobility – the ability to bend or kneel down to pick up something from the floor and straighten up again.
- Lifting – lifting a 1 kilogram weight from table height with either hand and carrying it for 5 meters.
- Manual Dexterity – using a pen, pencil or keyboard with either hand.
- Communication – the ability to answer a telephone and reliably take a message.
- Climbing – the ability to climb up and then down a flight of 12 stairs with the use of a handrail if needed.

Permanently disabled by reason of mental incapacity means that the Life Insured is suffering from:

- an organic brain disease or brain injury which affects the Life Insured's ability to reason and understand, and
- the mental incapacity has deteriorated to the extent that continual supervision of the Life Insured and the assistance of another person is required, and
- the mental incapacity is irreversible with no reasonable prospect of there ever being any improvement in the Life Insured's condition.

For the above definition, the following are not covered:

- Total and Permanent Disability secondary to alcohol or drug misuse
- Disabilities for which the relevant Consultant cannot give a clear prognosis.

2. Total and Permanent Disability at age 65 or over means that in the opinion of the Company's Chief Medical Officer, the Life Insured is, because of illness or accident, permanently and irreversibly unable to carry out at least 3 of the 6 activities listed below or is permanently disabled by reason of mental incapacity. The person must have taken any appropriate prescribed treatment or medication and then be unable to perform the activity on their own, even with the use of appropriate assistive aids and appliances (e.g. a handrail to help getting into and out of the bath or shower).

The relevant Consultant must reasonably expect that the disability will last throughout the Life Insured's life with no prospect of improvement, irrespective of when the cover ends or the Life Insured expects to retire.

Total and Permanent Disability must persist for a continuous period of at least 12 months before any entitlement to Total and Permanent Disability benefit arises.

The 6 activities are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
- Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
- Feeding – The ability to feed one's self once food has been prepared and made available.
- Toileting – the ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.
- Mobility – the ability to move indoors from room to room on level surfaces.
- Transferring – The ability to move from bed to an upright chair or wheelchair and vice versa.

Permanently disabled by reason of mental incapacity means that the Life Insured is suffering from

- an organic brain disease or brain injury which affects the Life Insured's ability to reason and understand, and
- the mental incapacity has deteriorated to the extent that continual supervision of the Life Insured and the assistance of another person is required, and
- the mental incapacity is irreversible with no reasonable prospect of there ever being any improvement in the Life Insured's condition.

For the above definition, the following are not covered:

- Total and Permanent Disability secondary to alcohol or drug misuse.
- Disabilities for which the relevant Consultant cannot give a clear prognosis.

55. Traumatic Brain Injury – resulting in permanent symptoms.

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:

- Traumatic Brain Injury secondary to alcohol or drug misuse.

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

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

The following are not covered:

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

Appendix B

Partial Payment Specified Illnesses

1. Angioplasty for Coronary Artery Disease - of specified severity

Undergoing of balloon angioplasty, atherectomy, rotablation, laser treatment or insertion of stent(s) on the advice of a Consultant Cardiologist to treat:

- 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.

Provided the above requirements are met, we will:

- make a payment of €10,000 on completion of balloon angioplasty, atherectomy, rotablation, laser treatment or insertion of stent(s) in one Main Coronary Artery and/or its branches.
- make a second payment on the completion of balloon angioplasty, atherectomy, rotablation, laser treatment or insertion of stent(s) provided it is not performed on the same Main Coronary Artery or its branches. The second payment is the balance of the Partial Payment Specified Illness Benefit for Angioplasty for Coronary Artery Disease set out in Section C, for Condition 2.1.3

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

- Right Coronary Artery

- Left Main Stem

- Left Anterior Descending

- Circumflex

2. Aortic Aneurysm - with endovascular repair

The undergoing of endovascular repair of an aneurysm of the thoracic or abdominal aorta with a graft. For the above definition, the following are not covered:

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

3. Carcinoma in Situ of the Appendix, Colon or Rectum - resulting in intestinal resection

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

For the above definition, the following is not covered:

- Local excision
- Polypectomy

4. Carcinoma in Situ of the Breast - treated by surgery

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

For the above definition, the following is not covered:

- Breast biopsy

5. Carcinoma in Situ of the Cervix – treated by specified surgery

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.

6. Carcinoma in situ of the oesophagus - treated by specific surgery

A definite diagnosis with histological confirmation of carcinoma in situ of the oesophagus by a Consultant Physician, which has been treated surgically by removal of a portion or all of the oesophagus.

For the above definition, the following are not covered:

- Treatment by any other method is specifically excluded.

7. Carcinoma in Situ of the Oral Cavity or Oropharynx – treated by surgery

A definite diagnosis of carcinoma in situ of the oral cavity or oropharynx with surgery to remove the tumour. Oropharynx includes lip, inside of cheek, floor of mouth, tongue, gums, hard palate, soft palate and tonsils.

For the above definition, the following is not covered:

- Treatment for leucoplakia.

8. Carcinoma in Situ of the Testicle - requiring surgical removal of one or both testicles

A definite diagnosis and specified treatment of carcinoma in situ of the testicle (also known as intratubular germ cell neoplasia unclassified or ITGCNU), histologically confirmed by biopsy, and as a result treated with an orchidectomy (complete surgical removal of the testicle).

This benefit will be payable only once even if both testicles are removed.

9. Carcinoma in Situ of the Vagina – treated by surgery

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 (VIN) grade 1 or 2.

10. Carcinoma in Situ of the Vulva – treated by surgery

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

11. Carcinoma in Situ (Other) – with surgery

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 Appendix B (i.e. condition numbers 3, 4, 5, 6, 7, 8, 9, 10). 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.

12. Carotid artery stenosis - treated by endarterectomy or angioplasty

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

13. Central Retinal Artery or Vein Occlusion – resulting in permanent visual loss

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

For the above definition the following are not covered:

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

14. Cerebral or Spinal aneurysm – undergoing specified treatments

Undergoing of treatment for a cerebral or spinal aneurysm by a Consultant Neurosurgeon or radiologist via surgery, stereotatic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral or spinal aneurysm.

For the above definition, the following is not covered:

- Cerebral or spinal arteriovenous malformation

15. Cerebral or Spinal arteriovenous malformation –undergoing specified treatments

Undergoing of treatment of a cerebral or spinal arteriovenous fistula or malformation by a Consultant Neurosurgeon or Radiologist via surgery, stereotactic radiosurgery, or undergoes endovascular treatment by using coils to cause thrombosis (embolization) of a cerebral or spinal arteriovenous fistula or malformation.

For the above definition, the following is not covered:

- Intracranial or spinal aneurysm

16. Crohn's disease – treated with surgical intestinal resection

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

The removed part of the small or large intestine must show histological confirmation of Crohn's disease.

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Intestinal biopsy

The amount of any Accelerated or Standalone Specified Illness benefit to be paid for Crohn's disease – of specified severity (number 20 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness benefit paid for Crohn's disease – treated with surgical intestinal resection.

17. Cystectomy – complete removal of the urinary bladder

The complete surgical removal of the urinary bladder as directed by a Genito-Urinary Consultant.

For the above definition the following are not covered:

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

18. Diabetes Mellitus - type 1

A definite diagnosis of type 1 diabetes mellitus, requiring the permanent use of insulin injections.

For the above definition, the following are not covered:

- Gestational diabetes
- Type 2 diabetes (including type 2 diabetes treated with insulin)
- Latent Autoimmune Diabetes of Adulthood (LADA), sometimes referred to as type 1.5 diabetes.

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

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

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

For the above definition, the following are not covered:

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

20. Early Stage Thyroid Cancer - of specified advancement

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

21. Early stage urinary bladder cancer – of specified advancement

A definite diagnosis by a Consultant of urinary bladder cancer which has been histologically classified as having progressed to either:

- stage Tis - carcinoma in situ – diffuse 'flat' non-papillary tumour; or
- stage T1N0M0 - carcinoma which has invaded the sub-epithelial connective tissue

For the above definition, the following is not covered

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

The amount of any Accelerated or Standalone Specified Illness benefit to be paid for urinary bladder cancer (covered under Cancer, number 11 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness benefit paid for early stage urinary bladder cancer – of specified advancement.

22. Gastrointestinal Stromal Tumour (GIST) of Low Malignant Potential – treated by surgery

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

For the above definition, the following is not covered:

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

23. Implantable cardioverter defibrillator (ICD) for primary prevention of sudden cardiac death

Undergoing of the insertion of an implantable cardioverter-defibrillator (ICD) on the advice of a Consultant Cardiologist for primary prevention of sudden cardiac death.

For the above definition, the following is not covered:

- Insertion of a pacemaker

24. Liver Resection

Undergoing of a partial hepatectomy (liver resection) on the advice of a Consultant surgeon in gastroenterology and hepatology.

For the above 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

25. Neuroendocrine Tumour of Low Malignant Potential – treated by surgery

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.

For the above definition, the following is not covered:

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

26. Ovarian Tumour of Borderline Malignancy / Low Malignant Potential – with surgical removal of an ovary

A definite diagnosis of 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 a cyst.

27. Peripheral vascular disease - treated by angioplasty

Undergoing of 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 Illness benefit to be paid for peripheral vascular disease – with bypass surgery (number 43 of Appendix A) will be reduced by the amount of any Partial Payment Specified Illness benefit paid for peripheral vascular disease - treated by angioplasty.

28. Permanent Pacemaker Insertion

The permanent insertion of an artificial pacemaker to correct an abnormal rhythm of the heart. There must be evidence of the abnormal rhythm of the heart documented on electrocardiograph (ECG).

For the above definition, the following is not covered:

- Any subsequent procedures or operations that arise after the initial pacemaker insertion, this includes the fitting of a new pacemaker.

29. Pituitary tumour – resulting in permanent symptoms or surgery

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

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

- Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the insured person's life.
- Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia

(difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following are not covered:

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

For the above definition, the following are not covered:

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

30. Serious accident cover – resulting in at least 28 consecutive days in hospital

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

For the purposes of this definition only, a hospital stay also includes treatment in an inpatient rehabilitation centre, if the Life Insured is transferred directly from hospital to the rehabilitation centre for continuous treatment.

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

Only one Partial Payment Specified Illness benefit will be paid for Partial Payment Specified Illnesses resulting from the same accident. Any Accelerated or Standalone Specified Illness benefit to be paid will be reduced by any Partial Payment Specified Illness benefit paid where the Accelerated or Standalone Specified Illness results from the same accident.

For the above definition the following are not covered:

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

31. Severe Sepsis

A definite diagnosis of sepsis by a Consultant Physician resulting in admission to either an intensive care (ICU) or a high dependency unit (HDU) for at least 3 continuous days.

32. Significant visual impairment – permanent and irreversible

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 6/36 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lens or visual field is reduced to 50 degrees or less of an arc, as certified by an opthalmologist.

33. Single lobectomy – the removal of a complete lobe of the lung

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

34. Surgical removal of one eye

Surgical removal of a complete eyeball for disease or trauma.

35. Third degree burns - covering at least 5% of the body's surface area

Burns that involve damage or destruction of the

skin to its full depth through to the underlying tissue and covering at least 5% and less than 20% of the body's surface area.

36. Ulcerative colitis – treated with total colectomy

A definite diagnosis by a Consultant Gastroenterologist of ulcerative colitis which is treated by removal of the entire colon (large bowel).

For the above definition, the following are not covered:

- Other types of inflammatory bowel disease
- Partial removal of the colon

NEW IRELAND
ASSURANCE

New Ireland Assurance Company plc.

5-9 South Frederick Street, Dublin 2.
T: 01 617 2000 F: 01 617 2075
E: info@newireland.ie W: www.newireland.ie

301672 V8.05.19