DCU
Income Protection Plan

Cornmarket

DCU Ollscoil Chathair Bhaile Átha Cliath Dublin City University

This Plan is underwritten by Aviva Life & Pensions Ireland DAC (Aviva).

Contents

This booklet is split into the following sections:

Disclaimers

This booklet is intended as a guide only. The Plan is governed by the master Policy Document Nos. 708218, 710496 & 712823 issued by Aviva. Members of the Plan may request a copy of the policy documents from the Plan owners or the Dublin office of Cornmarket Group Financial Services Ltd.

This booklet is issued subject to the provisions of the policy and does not create or confer any legal rights. The information contained herein is based upon our current understanding of Revenue law and practice as of August 2023.

While great care has been taken in the preparation of this booklet, if there is any conflict between it and the policy document, the policy document will prevail.

No part of this booklet should be read in isolation.

Please save a copy of this booklet for future reference.

Information in this booklet is correct as of August 2023 but may change. For the latest information, please see cornmarket.ie

Where we say 'Plan, we mean DCU Income Protection Plan.

Where we say 'Insurer', we mean Aviva Life & Pensions Ireland DAC (Aviva).

Where we say 'we' or 'us', we mean Cornmarket Group Financial Services Ltd (up to page 37).

Where we say 'we' or 'us', we mean Aviva Life & Pensions Ireland DAC (Aviva) (pages 38-46 inclusive).

1. Introduction

Overview of Benefits

1	**Disability Benefit**	A replacement income of up to **75% of your annual salary** up to a maximum benefit of €262,500 per annum, if you cannot work due to illness or injury.*
2	**Death Benefit**	A Death Benefit of **twice your annual salary**.
3	**Full Specified Illness Benefit**	A once-off lump sum of **25% of your annual salary** if you are diagnosed with one of the Full Specified Illnesses covered**
4	**Pension Premium Protection Benefit**	**5% of your annual salary** paid into a separate Personal Retirement Savings Account (PRSA) once a claim is in payment for more than 2 years***

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

*Less any other income that you may be entitled to, for example half pay, Ill Health Early Retirement Pension, Temporary Rehabilitation Remuneration, State Illness or Invalidity Benefit.

**Please see the Appendices from page 38 to 46 for full details, in particular the policy definition of each Specified Illness and its pre-existing and related conditions.

***This benefit will continue to be paid until your Disability Benefit Claim under the Plan ceases.

Eligibility

All eligible new employees are automatically accepted into the Plan upon commencement of employment.

If you opted out* of the Plan you may still apply to join the Plan if you are:

1. An employee of Dublin City University (DCU).
2. Under age 65
3. Employed in pensionable employment within DCU
4. Actively at work:

   As defined on the application form when applying to join the Plan.

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

Important: You must remain an employee of DCU to remain an eligible member of the Plan.

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

*For information on opting out of the plan see page 33.

Roles

Cornmarket's role includes:

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

The Insurer's role includes:

1. Deciding the policy terms and conditions and creating a policy document to reflect these.
2. Medically assessing applications and claims.
3. Deciding the various aspects of an individual member's cover, for example, if premium payment ceases, can membership be re-activated, is payment of arrears and/or a declaration of health required. Deciding if refunds can be made.

2. Benefits

Disability Benefit

In the event that your salary is affected because you are unable to work due to illness or injury, this Benefit aims to pay you an income of:

- **Up to 25%** of salary after a deferred period of 13 weeks has passed.
- **Up to 75%** of salary after a deferred period of 26 weeks has passed.

See page 9 for definition of salary and details of the deferred period.

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

- Temporary Rehabilitation Remuneration (TRR) – May be paid by your employer to you where there is a reasonable prospect of you returning to work.
- State Illness Benefit/State Invalidity Pension – Those paying PRSI at the 'A' rate may be entitled to this benefit from the State.
- Ill Health Early Retirement Pension (IHERP) – Those who retire on the grounds of ill health may be entitled to this from their employer.
- Any annualised amount awarded by a court of law, an agreed settlement sum or ex-gratia payment attributable to loss of earnings arising out of any action relating to your disablement. The weekly equivalent amount will be calculated by Aviva's actuary.

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

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

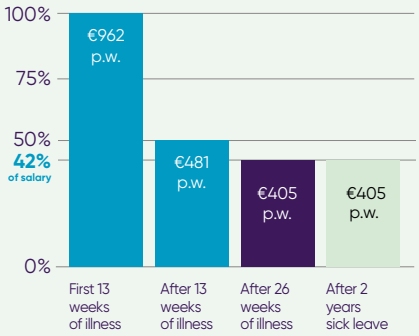
Example of how the Disability Benefit works

This example is based on a Public Sector employee, who is a member of the Superannuation Scheme with 27 years' service earning €50,000 per annum, who is now unable to work due to disability arising from illness or injury. It is assumed that standard Public Sector sick leave arrangements apply, extended paid sick leave under the Critical Illness Protocol does not apply and Ill Health Early Retirement Pension is granted after 2 years.

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

D Rate PRSI Example

WITHOUT Income Protection



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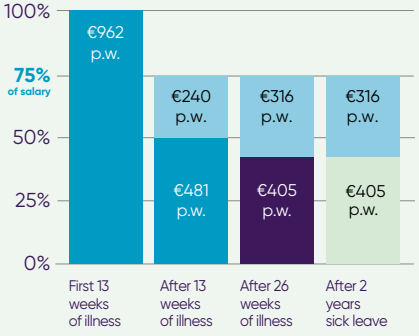
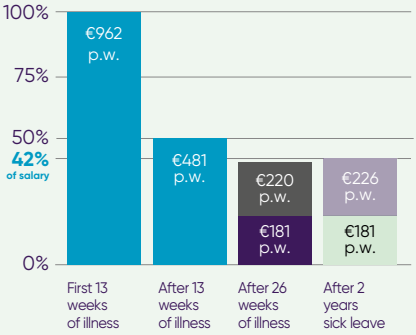


A Rate PRSI Example

WITHOUT Income Protection



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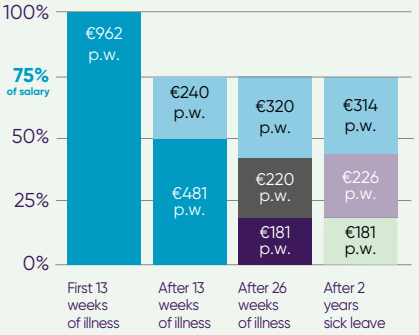

Plan Benefit | Sick Pay | Temporary Rehabilitation Remuneration | Ill Health Early Retirement Pension | State Illness Benefit | State Invalidity Pension

Deferred Period

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

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

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

Definition of Salary

For the purposes of this Plan salary is defined as Gross earned pensionable income for the period of one year immediately prior to the commencement of the period of disability or a period agreed by Aviva.

Pensionable income is defined as a portion of a member's earned income which is taken into consideration for pension benefits; and/or an amount that pension contributions are based on.

Depending on the type of claim being made, the salary will be established at different points in time, for example:

- Disability Benefit - the end of the relevant deferred period
- Death Benefit - on the date of death
- Specified Illness - on the date of diagnosis

Remember...

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

Exclusions

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

- Self harm.
- Deliberate neglect of health by failure to seek or follow medical advice
- Any form of war, whether declared or not **or**
- Participation in a riot, insurrection or civil commotion.

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

Limitations and Restrictions

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

Definition of Partial Disability
Following the payment of a disability claim, if you:

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

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

The maximum benefit is €262,500 per year.

If your claim is admitted...

- The benefit you receive from the Insurer will be treated as income and as such is liable to income tax, PRSI, Universal Social Charge, etc. The Insurer will deduct any tax due from the Benefit made to the member, in the same way as an employer deducts tax from an employee.
- Provided you have not retired on grounds of ill health, a pension amount (Ill Health Early Retirement Pension) may not be deducted from your Disability Benefit for a maximum of 2 years. Any other income that you may be entitled to will still be deducted during this time (for example, half pay, Temporary Rehabilitation Remuneration, State Illness or Invalidity benefit). After 2 years, a pension amount will be deducted from the benefit regardless of whether or not you are in receipt of same. This is referred to as Notional Early Retirement Pension (NERP). See Pages 28 & 29 for further details.

Disability Benefit will continue until:

- You recover,
- You resign,
- You go back to work (proportionate benefit may continue to be paid if the return is at a reduced level due to partial disability),
- The Insurer decides that you are fit to return to work based on medical evidence*,
- You reside outside of Ireland for more than 13 weeks in any 12-month period subject to an overall limit of 39 weeks in total.
- You retire (except if you are claiming from the Plan and retire on an Ill Health Early Retirement Pension),
- Your 65th Birthday, except Academic Staff, whose Ceasing Age is September 30th following 65th birthday** **or**
- You die,

whichever is earliest.

*If you have been in continuous receipt of Disability Benefit for more than 12 months, 3 months' notice will be given before your Disability Benefit is ended.
**Claims in payment before 1st November 2019 will cease on your 65th birthday.

Late Notification of Disability Benefit Claims

It is not often possible to retrospectively assess the validity of a claim in cases where a significant period of time (approximately 3 months) has passed since your sick leave commenced. For this reason, it is vital that you register your claim no later than 2 months before the expiry of the deferred period as a delay in notification may prejudice the Insurer's ability to properly assess the claim.

In the event you notify your claim late, the Insurer may decline to assess your claim where they have been prejudiced by the delay. This will be decided on a case-by-case basis.

Death Benefit

In the event of your death, a once-off lump sum of **twice your gross annual salary** will be paid by the Insurer to the Plan's Trustees.

See page 9 for definition of salary.

Important information regarding the payment of Death Benefit

Revenue rules permit the payment of a tax-free lump sum up to four times salary in the event of death in service before retirement. In certain circumstances, the benefit paid in the event of the death of the member may have to be restricted to ensure that Revenue limits are not exceeded. Usually, the full amount of Death Benefit is paid in the form of a tax-free lump sum.

Any lump sum Death Benefit will be paid by the Trustees of the Plan (to one or more dependants), in accordance with the Plan rules. Dependant means your spouse, civil partner, child or any other person, who in the opinion of the Trustees, is wholly or substantially dependent upon you for the ordinary necessaries of life, or who was dependent on you during the two years immediately preceding the date of your death.

Important: Some members chose not to have any Death Benefit when it was originally introduced in June 2008 and so they are not covered for any Death Benefit.

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

Exclusions

Exclusions apply where death is caused directly or indirectly:

1. By any war (whether there has been a declaration of war or not) **or**
2. From any cause if you become a member of the armed forces of any country or otherwise engaged in national service.

Limitations and Restrictions

This benefit ceases on your 65th Birthday, except Academic Staff, whose Ceasing Age is September 30th following 65th birthday.

As this is a group plan, you cannot assign the Death Benefit against a loan, for example, a mortgage.

Specified Illness Benefit

Full Specified Illness Benefit

If you are diagnosed with one of the illnesses listed below, this benefit will pay a once-off, tax-free lump sum of **25% of your annual salary** at the date of diagnosis. See page 9 for definition of salary.

Only one claim may be made on Full Specified Illness Benefit per member. You must meet the policy definition/criteria of the illness to be eligible to claim (see Appendices from pages 38 to 46).

Please note: The Specified Illnesses marked ❖ below, were introduced on the 1st of October 2016. The other Specified Illnesses were introduced from 1st June 2011. Only diagnoses that occur after these dates are eligible to claim Specified Illness Benefit for these illnesses. If, prior to joining the Plan, you have suffered from one of the Specified Illnesses you will never be covered for that illness.

1. Alzheimer's Disease before age 65
2. Aorta graft surgery
3. Aplastic Anaemia❖
4. Bacterial Meningitis❖
5. Balloon Valvuloplasty❖
6. Benign brain tumour
7. Benign spinal cord tumour❖
8. Blindness
9. Cancer
10. Chronic Lung Disease
11. Coma
12. Coronary artery surgery
13. Creutzfeldt-Jakob Disease
14. Deafness
15. Encephalitis❖
16. Heart attack
17. Heart Structural Repair
18. Heart valve replacement or repair
19. HIV infection
20. Kidney failure
21. Liver failure❖
22. Loss of hands or feet❖
23. Loss of independent existence❖
24. Loss of speech
25. Major organ transplant
26. Motor Neurone Disease before age 65
27. Multiple Sclerosis
28. Muscular system atrophy❖
29. Paralysis of Limbs
30. Parkinson's Disease before age 65
31. Pre-Senile Dementia before age 65❖
32. Primary Pulmonary Hypertension❖
33. Progressive Supranuclear Palsy❖
34. Pulmonary Artery Surgery❖
35. Rheumatoid Arthritis
36. Stroke
37. Systemic Lupus Erythematosus
38. Third Degree burns❖
39. Traumatic Head injury❖

Partial Payment Specified Illness Benefit

If you are diagnosed with one of the illnesses listed below, this benefit will pay a once-off, tax-free lump sum of the **lesser of €15,000 or 12.5% of your salary** at the date of diagnosis. See page 9 for definition of salary.

Only one claim may be made on Partial Payment Specified Illness Benefit per member. If you make a Partial Payment Specified Illness Benefit claim, you will still be able to make a Full Specified Illness Benefit claim. You must meet the policy definition/criteria of the illness to be eligible to claim (see Appendices from pages 38 to 46).

1. Brain Abscess (drained via craniotomy)
2. Carcinoma in Situ
3. Carotid Artery Stenosis
4. Cerebral Arteriovenous Malformation
5. Coronary Angioplasty
6. Ductal Carcinoma in Situ
7. Low Level Prostate Cancer with Gleason Score between 2 and 6
8. Serious Accident Cover
9. Surgical removal of one eye
10. Third Degree Burns covering 5% to 19% of the body's surface area or 25% to 49% of the face's surface area

Exclusions

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

a) In the opinion of the Insurer, the diagnosis arises directly or indirectly as a result of:
   - any form of war/conflict
   - taking alcohol or drugs (other than under the direction of a registered medical practitioner) or
   - failure to seek or follow reasonable medical advice or wilful self-inflicted injury.
   - participation in any of the following pursuits: abseiling, bobsleighing, boxing, hang-gliding, scuba-diving, any type of equestrian event, motor or motorcycle sports, mountaineering, rock climbing, potholing and caving, parachuting, power-boat racing and aviation other than as a fair paying passenger on a regular public airline.

b) If the Member is shown to be carrying, or to have been carrying, a human immunodeficiency virus (H.I.V.) or antibodies to such a virus, except where the virus has been contracted in the conditions set out in the policy document.

c) Prior to your Specified Illness Benefit cover commencing you were diagnosed with a condition related to one of the Specified Illnesses and you contract that particular illness within 2 years of joining the Plan. For example, a claim will not be paid for a heart attack within the first 2 years of joining, if prior to joining you were diagnosed with Diabetes. This is due to the recognised link between Diabetes and a heart attack. However, a diabetic who is first diagnosed with a heart attack 3 years after joining the Plan will be eligible to claim.

d) You were diagnosed with one of the Specified Illnesses before your cover commenced, you will never be covered for that illness and cannot claim for that illness or a related Specified Illness.

   For example, because of the links between heart attack, coronary artery by-pass surgery, heart transplant, angioplasty and stroke, if you have been diagnosed with or undergone surgery for one of these conditions before joining the Plan you cannot claim under the policy in respect of any of the 4 illnesses. For example, if you underwent coronary artery by-pass surgery before joining you will never be covered for coronary artery bypass surgery, heart attack, heart transplant, angioplasty or stroke.

e) No cancer claims will be paid by the Insurer where the condition presents within the first 3 months of a member joining the Plan. In such circumstances cover in respect of cancer ceases.

Limitations and Restrictions

- Full Specified Illness Benefit became a benefit of the Plan on 1st June 2011. The Specified Illnesses marked ❖ on page 16, were introduced on 1st October 2016. The other Specified Illnesses were introduced on 1st June 2011. You can only claim for diagnoses that occur after these dates.
- Partial Payment Specified Illness Benefit became a benefit of the Plan on 1st October 2016. Therefore, you can only claim for diagnoses that occur after this date.
- If you make a Full Specified Illness claim, you will not be able to make a further Full or Partial Payment Specified Illness claim. If you make a Partial Payment Specified Illness claim, you will still be able to make a Full Specified Illness claim.
- If you are diagnosed with one of the Full Specified Illnesses within 30 days of diagnosis of a Partial Payment Specified Illness, a claim will only be assessed by the Insurer on the Full Specified Illness and the Partial Payment Specified Illness Benefit will not be paid.
- A Specified Illness claim will only be paid if the diagnosis/severity meets the specific definition/ criteria outlined for that illness in the Appendices on pages 38 to 46.
- You will not be able to make a Specified Illness claim for an illness that:
  - you were diagnosed with prior to joining the Plan.
  - relates to a condition which you were already suffering from at the time of your application and/ or where you were under medical investigation for this, regardless of whether you were aware of the condition at that time.
  - relates to a condition which you were already diagnosed with before the date that Specified Illness was introduced to the Plan.

Notification of Specified Illness Claims

You should make a Specified Illness Claim within 3 months of having surgery or being diagnosed, as a delay in notification may prejudice the Insurer's ability to properly assess the claim. In the event you notify your claim late, the Insurer may decline to assess your claim where they have been prejudiced by the delay.

- There is a waiting (deferred) period for some Specified Illnesses.
- There is a survival period for some Specified Illnesses. You must survive for a minimum period after the date of diagnosis or surgery took place, before a payment can be made.

In the event of death within this period no Specified Illness benefit is payable. The relevant periods are:

a) 14 days for all specified illnesses except for those named in (b) and (c) below.

b) 6 months for Parkinson's Disease, Dementia (including Alzheimer's Disease) and loss of sight.

c) 12 months for loss of speech and loss of hearing.

Please see Appendices on pages 38 to 46 for more details.

The benefit ceases on your 65th birthday.

Cornmarket Retired Members' Life Cover Plan

You will be automatically enrolled into the Cornmarket Retired Members' Life Cover Plan by your employer when you retire or reach the ceasing age of this Plan. Terms & Conditions apply.

For more details on joining this Plan, please contact **(01) 470 8054** or email **clientservices@cornmarket.ie**

The Cornmarket Retired Members' Life Cover Plan is underwritten by Irish Life Assurance plc. Irish Life Assurance plc is regulated by the Central Bank of Ireland.

Pension Premium Protection Benefit

If you are claiming Disability Benefit from the Scheme for more than 2 years, the Scheme will pay a benefit equivalent to 5% of your Salary into a separate Personal Retirement Savings Account (PRSA). This applies to all claims admitted after 1st October 2016.

For members whose claim was admitted before 1st October 2016 the benefit was 10% of salary.

This benefit will continue to be paid until your Disability Benefit claim under the Plan ceases. Please see page 35 for explanation of when your Disability Benefit payment will cease under the Plan.

If your Disability Benefit claim is reaching its second year and you do not expect to work in the near future, please contact our Claims Team on **(01) 408 4018**

3. Cost

The total Plan premium is **1.90% of gross salary**. This includes the 1% insurance levy.

The breakdown of this premium is:

Disability Benefit	1.28%
Death Benefit	0.40%
Specified Illness Benefit	0.13%
Pension Protection Benefit	0.09%
Total	**1.90%**

Warning: The current premium may increase after the next Plan review which should take place on or after 1st November 2024.

For members with a salary of less than €15,000 per annum, the benefits of the Plan are provided free of charge. DCU will commence premiums when your salary reaches €15,000 or above.

Income Tax Relief

The portion of your premium that is paid towards Disability Benefit, Death Benefit and Pension Premium Protection Benefit is eligible for income tax relief.

If you are paying income tax at 20% your net premium rate will be 1.55%.

If you are paying income tax at 40% your net premium rate will be 1.19%.

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

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

Income	Gross cost	Net cost at 20% income tax	Net cost at 40% income tax
€30,000	€10.90	€8.89	n/a
€50,000	€18.21	n/a	€11.42
€70,000	€25.49	n/a	€15.99
€100,000	€36.41	n/a	€22.84

If you pay your premiums through salary:

- The premium will be split under two headings on your payslip; one heading reflects the Disability Benefit, Death Benefit and Pension Protection portion of your premium and automatically receives income tax relief, the other heading reflects the premium for the remaining benefits and does not receive income tax relief. Rate at which income tax relief will be applied on the Disability Benefit, Death Benefit and Pension Protection portion of your premium may depend on your individual tax circumstances.
- Your premiums will increase and decrease in line with your salary changes.
- You must ensure that the premiums deducted from your salary are correct and reflect your salary.

4. Claims

Roles

Cornmarket's role

Our role is to help guide you and/or your representatives through the claims process. We have considerable experience in this area and, work closely with the claimant, Insurer, and third parties to help get claims processed as efficiently as possible. We have our own dedicated, in-house Claims Team. The team will do all they can to help at what may be a very difficult time. All claims are dealt with in a professional and sensitive manner.

Our contact details for making a claim are:

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

The Insurer's role

The Insurer's role is to medically assess claims and decide whether or not claims should be paid. If they decide that a claim should be paid, they will calculate and pay the benefit directly to the claimant/Trustees. The insurer will continue to medically review disability claims to ensure they should continue to be paid.

Disability and Specified Illness Benefit Claims

How to make a Disability or Specified Illness Benefit claim?

Disability Benefit

Contact us as soon as you start your sick leave because:

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

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

It is not often possible to retrospectively assess the validity of a claim where a significant period of time (approx. 3 month) has elapsed since your salary reduced or ceased. See Late Notification of Disability Benefit Claims on page 14.

Specified Illness Benefit

Contact us as soon as possible, as it may take a number of weeks to process the claim. If the Insurer cannot assess the claim due to unavailability of supporting medical evidence the Insurer can decline the claim. See Notification of Specified Illness Benefit Claims on page 20.

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

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

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

Following an initial phone call, if appropriate, we will send you a claim form, information about the Plan and details of the documentation you will need to provide.

You should return the forms and documentation to us as soon as possible and we will send these to the Insurer. The Insurer will then start medically assessing your claim.

Are all Disability and Specified Illness Benefit claims medically assessed?

All claims will be medically assessed by the Insurer. If you have been granted Ill Health Early Retirement by your employer, this does not mean that you will be automatically entitled to Disability Benefit from the Plan.

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

1. provide medical evidence from your doctor (your doctor may charge you for this) **and/or**
2. provide medical evidence from your specialist **and/or**
3. attend an Independent Medical Examination (IME). It generally takes about 3 weeks for the IME report to be returned to the Insurer.

Items 1, 2 and 3 are at the Insurer's expense and reasonable travel expenses will be covered, if travel is necessary.

We will liaise with your employer, the Insurer and you throughout the assessment.

What happens after my Disability Benefit claim is assessed?

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

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

- If your claim is admitted, and you have completed the relevant deferred period, the Insurer will arrange for benefit to be paid to your bank account. Disability Benefit will be paid in arrears and may be paid on a monthly basis. Therefore, it may take up to four weeks after your claim is admitted to receive your first benefit. If your claim is admitted after you have been reduced to half-pay or your pay has ceased, the benefit may be backdated to the date when salary was first affected.
- As a benefit is subject to income tax, you can request the Revenue Commissioners to issue a Revenue Payroll Notification (RPN) to the Insurer. This will enable the Insurer to apply the correct tax rate for future benefits. However, the first benefit may have emergency tax rates applied. Any overpayment or underpayment of tax may be subsequently rectified.
- In order to ensure you continue to meet the definition of disablement, the Insurer may seek completed continuation forms, certificates of continued disablement, medical certificates from your doctor, and/or require you to attend an independent medical examination and/or organise for a Health Claims Advisor to visit you. Claims admitted by the Insurer after 1st November 2019, that are in payment for greater than 6 years, will not be subject to ongoing medical assessments.
- In the event that you fail to follow medical advice, the Insurer may cease paying you benefits.

- You will not be expected to pay premiums towards the Plan while claiming. However, if your benefit stops for some reason other than reaching the ceasing date of that benefit, you will be expected to start paying premiums again in order to maintain your cover.

  If you are in receipt of Disability Benefit up to your relevant ceasing age* for this benefit, you will not be required to pay premiums for any other associated benefits you are covered for under this Plan up until the relevant ceasing ages of those benefits. If the ceasing ages change after your claim went into payment, the revised ceasing ages will not apply to you. If you return to work in the future and you become a disability claimant again, your claim will be paid on the applicable relevant ceasing age to you at that time.
- While claiming Disability Benefit, any Death Benefit or Specified Illness Benefit that you have as a Plan member remains in force until the ceasing date of those benefits. In the event that you will need to claim from these, the benefits will be based on the salary you were earning at the time your Disability Benefit commenced.
- The Disability Benefit paid to you by the Plan increases by 5% each year, or the rate of increase in the Consumer Price Index if lower.

What will happen if my Disability Benefit claim is declined?

- If your claim is declined, the Insurer will inform you of the reasons for the decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. The review of their decision may require you to attend further Independent Medical Examinations.
- If you do not appeal, you must return to work and premiums must continue or restart in order for you to remain a member of the Plan.
- If your appeal with the Insurer is unsuccessful, you can log a complaint with the insurer. If you are dissatisfied with the outcome of your complaint, you may bring your case to the Financial Services and Pensions Ombudsman Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, or log onto www.fspo.ie.

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

If you make a claim and decide not to apply for IHERP, perhaps because you intend on returning to work, and the Insurer agrees that there is a reasonable expectation of you returning to work, then the Insurer may pay a benefit of 75% of salary less any State Illness Benefit or Temporary Rehabilitation Remuneration for a maximum of 2 years. This means no deduction will be made from the Benefit for an amount equivalent to IHERP, as no IHERP is being claimed.

However, 2 years after the date Disability Benefit commences, a pension amount will be deducted from the benefit regardless of whether or not you

*Relevant ceasing age means, the ceasing age that was applicable when your claim went into payment.

are in receipt of this. This is referred to as Notional Early Retirement Pension (NERP).

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

If you are unable to work due to illness or injury and your contract ends before the expiry date of the deferred period, your claim will be considered subject to the usual medical evidence requirement. For example, if a member suffers an illness with 3 months remaining on their contract and remains unable to work due to illness or injury to the end of the deferred period, their claim will be considered in the normal manner.

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

Please inform our Claims team immediately if you are in receipt of or have applied for an injury at work payment through your employer as your premium payments may stop which will affect your Plan membership.

If as a result of your workplace injury, you are entitled to an additional payment from your employer, it may mean that your income remains higher than 75% of your salary. If your income exceeds the Plans maximum benefit level, no Disability Benefit is payable under the Plan however the Insurer needs to be aware of your case so they can manage your claim. See Late Notification of Disability Benefit Claims on page 14.

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

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

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

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

What is the Tax Return Service for Disability Benefit claimants?

Cornmarket's Tax Return Service is available to claimants who are in receipt of Disability Benefit for a continuous period of 3 months or more. Only claimants who submitted their claim after 1st June 2022 are eligible to avail of this service.

The Cornmarket Tax Return Service will prepare and file your tax return and act on your behalf with Revenue, to ensure that you do not pay any more tax than is necessary from multiple sources. They will also reclaim any overpayments of tax which may have been made by you during the period of your claim. The service includes PAYE returns and up to two rental properties, where relevant. Additional properties or returns for non-PAYE income may attract extra charges, and/or may not be offered within this service.

For more information, please call **(01) 408 4106**

Cornmarket Group Financial Services Ltd. is a member of the Irish Life Group Ltd. which is part of the Great-West Lifeco Group of companies. Cornmarket's Tax Return Service is not a regulated financial product. Telephone calls may be recorded for quality control and training.

What happens after my Specified Illness Benefit claim is assessed?

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

Settled

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

Declined

- If your claim is declined, you will be informed of the reasons for that decision in writing.
- You may appeal the decision by sending additional evidence supporting the fact that your claim should be admitted to the Chief Medical Officer of the Insurer. You must do this within 3 months of the decline decision being made. The review of their decision may require you to attend further Independent Medical Examinations.
- If your appeal with the Insurer is unsuccessful, you can log a complaint with the insurer. If you are dissatisfied with the outcome of your complaint, you may bring your case to the Financial Services and Pensions Ombudsman Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, or log onto www.fspo.ie.

Death Benefit Claims

How to make a Death Benefit claim

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

The Death Benefit may be:

- paid to your legal personal representative/estate or a nominated beneficiary, **or**
- distributed at the discretion of the trustee.

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

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

If payment is to be made to your legal personal representatives/estate, a grant of probate or letters of administration, as appropriate, will be required before payment is made. These documents will be processed through the Probate Office and may, in some cases, take several months to be processed.

Once the Insurer receives all required documentation and relevant information, and admits the claim, the benefit is usually paid to the estate/ trustees within **10 working days**.

5. Frequently Asked Questions

How can I apply to join the Plan?

All employees who meet the eligibility requirements are automatically accepted into the Plan.

If you **do not** wish to enter into the Plan you can opt out by contacting your employer (DCU) or you can send an email to SPSAdmin@cornmarket.ie and we will action the cancellation and send instruction to DCU to cease deductions and refund premiums (where applicable).

If you opt out within the first 90 days you will receive a refund of all premiums paid.

However, if you opt out of the Plan you will not be automatically reaccepted (including at the start of a new contract of employment). If you wish to re-join the Plan you will have to apply to join by completing an application form which may be subject to full medical underwriting. You must complete an application form either:

- With your Cornmarket Consultant **or**
- Over the Phone - Call **(01) 408 4195**

The Insurer may underwrite (medically assess) your application. This process may include providing medical information to a nurse over the telephone or attending a medical examination at the Insurer's expense. Following the underwriting period, the Insurer may accept your application, postpone your application, decline your application, or offer you membership of the Plan with certain specified conditions excluded from cover.

During the application process it is important that you answer all the questions the Insurer asked in the application form and any subsequent questions fully, honestly, accurately and with reasonable care.

If you do not the Insurer may:

- cancel your membership & benefits from the start with/without a return of premium,
- refuse a claim with/without a return of premium,
- reduce the amount of any claim,
- reduce the amount of cover **and/or**
- change the terms of your membership from the date you were accepted into the Plan

You may find it difficult to purchase another Income Protection product.

What happens if my application is accepted?

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

- You will be sent a formal acceptance letter.
- If you are automatically accepted into the Plan upon commencement of employment, you will have **three months** after the date cover commences to opt-out of your membership of the Plan and receive a full refund of any premiums paid.
- You will have **30 days** after the date the acceptance letter is sent to you to cancel your membership of the Plan and receive a full refund of any premiums paid.

- Premiums should start as soon as possible after you are accepted as a member.

What happens if my application is not accepted?

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

What happens in the event of a judicial separation or divorce?

In the event of judicial separation or divorce, you can apply to obtain a Pension Adjustment Order which will set out the payment of Death Benefit under the Plan.

You are eligible to do this if you are:

- A member of the DCU Pension Scheme (not retired) **and**
- A member of the CU Group Income Protection Plan **and**
- Obtain a judicial separation or divorce.

What if I have unearned income?

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

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

If you plan to take a career break or unpaid leave please contact us to discuss the options that may be available to you by calling **(01) 408 4195** or emailing **spsadmin@cornmarket.ie**.

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

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

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

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

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

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

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

You may be over-insured as you cannot receive a benefit of more than 75% of your salary. In other words, you cannot receive benefit from both this plan and another similar plan. If you are in this situation, please contact us to arrange an appointment with one of our Consultants.

When does my cover under the Plan cease?

Cover ceases in the following situations:

- The 30th of September after your 65th birthday for all benefits
- If you no longer fulfil the eligibility requirements **or**
- If you are no longer in pensionable employment at DCU **or**
- If you die.

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

Can I cancel my membership of the Plan?

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

If you pay by salary deduction, the payment cycle operated between us and your employer only allows for changes on certain dates. It may therefore take between four and eight weeks for the cancellation instruction to take effect. Any deductions taken from your salary following your cancellation request to us will be refunded to you approximately four to six weeks after the deduction from your salary.
If you cancel your membership of the Plan, and then wish to become a member again, you will have to apply for membership again and provide information about the state of your health. If your health deteriorated between the time you cancelled your membership of the Plan and re-applied, you may not be accepted as a member again or you may be accepted with a medical condition(s) excluded.

What happens if I cease to be an employee of DCU?

If you cease to be employed by DCU you must inform us. We will then cancel your membership of the Plan.

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

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

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

What commission does Cornmarket receive from the Insurer?

Initial charge	€300
Premium Deduction Charge	2.50%
Renewal charge paid by the Insurer to Cornmarket	12.50%

What if I travel abroad?

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

Your cover under the Plan will not be affected if you travel briefly for normal holiday purposes. However, if you decide to reside or work abroad we must be contacted immediately. In such

circumstances, the Insurer may decide to vary your premium and benefits accordingly or cease your membership of the Plan.

If you are in receipt of Disability Benefit from the Plan, the Insurer will pay this benefit to you if you are living anywhere in the world for a maximum of 13 weeks in any 1 year period subject to an overall total of 39 weeks. The Insurer reserves the right to request that claimants come back to Ireland for an Independent Medical Examination during this period. If during this period you are required to attend a medical assessment you must return to Ireland for it, the expense of which must be agreed between you and the Insurer in advance. Only reasonable expenses will be covered by the Insurer.

After 39 weeks, you must reside in the European Union. If you do not comply with this condition your benefit will be ceased. In exceptional cases where a beneficiary is forced to live abroad, the Insurer will consider this on a case-by-case basis.

Are all claims paid?

Most claims are paid.

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

- Medical opinion is that the member is not disabled from carrying out their normal occupation.
- When applying to join the Plan, the member did not answer all the questions that were asked during the application process fully, honestly, accurately and with reasonable care.. This is called non-disclosure/ misrepresentation. In addition to being the reason for a claim not being paid, non-disclosure may also result in membership of the Plan being cancelled. If this occurs, premiums will not be refunded.
- A claim is notified late, for example, outside of the timelines noted on page 14 and 20 and this has prejudiced the Insurer's ability to properly assess the claim.
- The illness or injury is a result of one of the general exclusions that exist on the Plan.
- The member attempts to claim for an illness or injury for which they received a specific exclusion.

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

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

or

Email: **complaints@cornmarket.ie**

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

6. General Plan Information

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

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

The Plan owner is Dublin City University.

The next Plan review is due on or after 1st November 2024.

The current Plan broker is Cornmarket Group Financial Services Ltd.

The current Plan Insurer is Aviva Life & Pensions DAC (AVIVA).

The current Plan policy numbers are 708218, 710496 and 712823.

The current Plan Trustees are Freedom Trust Services Ltd.

The Death Benefit is provided for members under Group Life Plan No. 710496. This is:

a) a Defined Contribution Plan for the purposes of the Pensions Act 1990

b) designed to qualify as an exempt approved Plan under Chapter 1 of Part 30 of the Taxes Consolidation Act 1997

c) established under Trust with formal Rules.

The Revenue Approval number is SF 18365. The Pensions Authority register number is PB280403. You should bear in mind that the Group Life Plan cannot overrule the Trust Deed and Rules which govern the plan. These may be inspected by arrangement with your employer.

7. Specified Illnesses Appendices

Explanation of each Specified Illness and its pre-existing conditions

APPENDIX 1:

Definitions of Specified Illnesses

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

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

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

For the above definition, the following are not covered:

- Other types of dementia.

2. Aorta graft surgery – for disease

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

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

For the above definition, the following are not covered:

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

3. Aplastic Anaemia - of specified severity

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

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

All other forms of anaemia are specifically excluded.

4. Bacterial Meningitis - resulting in permanent symptoms

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

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

5. Balloon Valvuloplasty – to correct heart valve abnormalities

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

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

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

- permanent neurological deficit with persisting clinical symptoms*, **or**
- Full or partial removal of the tumour by craniotomy (surgical opening of the skull)

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

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

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

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

Angiomas are specifically excluded.

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

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.

9. Cancer – excluding less advanced cases

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

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

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

Explanation of the TNM system

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

Primary Tumour (T)

Tis – carcinoma in situ

T0 – no evidence of primary tumour

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

Regional Lymph Nodes

N0 –no nodal metastases

N1-3 –increasing degrees of nodal metastases

Distant Metastasis

M0- no distant metastases

M1 –distant metastases present

10. Chronic Lung Disease – requiring long term oxygen therapy

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

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

11. Coma – resulting in permanent symptoms

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

- requires the use of life support systems; and
- results in permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following is not covered:

- Coma secondary to alcohol or drug abuse.

12. Coronary artery surgery

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

For the above definition, the following are not covered:

- Balloon angioplasty;
- Atherectomy;

- Rotablation;
- Insertion of stents; and
- Laser treatment

13. Creutzfeldt-Jakob Disease – resulting in permanent symptoms

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

14. 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.

15. Encephalitis – resulting in permanent symptoms

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

Encephalitis in the presence of HIV infection is specifically excluded.

16. Heart attack – of specified severity

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

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

The evidence must show a definite acute myocardial infarction.

For the above definition, the following are not covered:

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

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

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

18. Heart valve replacement or repair

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

19. HIV infection– Occupational / Assault / Transfusion

Infection by Human Immunodeficiency Virus, resulting from:

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

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

- The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
- Where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
- There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.
- The incident causing infection must have occurred in one of the following countries: Australia, Austria, Belgium, Canada, the Channel Islands, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Greece, Hong Kong, Hungary, Iceland, the Isle of Man, Italy, Japan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain, Sweden, Switzerland, the

United Kingdom, and the United States of America.

For the above definition, the following is not covered:

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

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

20. Kidney failure – requiring dialysis

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

21. Liver Failure

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

- Permanent jaundice
- Ascites
- Encephalopathy

Liver disorder secondary to alcohol or drug misuse is excluded.

22. Loss of hands or feet – permanent physical severance

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

23. Loss of Independent Existence – permanent and irreversible

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

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

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

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

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

24. Loss of speech – permanent and irreversible

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

25. Major organ transplant

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

For the above definition, the following is not covered:

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

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

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

27. Multiple sclerosis – with persisting symptoms

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

28. Multiple system atrophy – resulting in permanent symptoms

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

- motor function with associated rigidity of movement; **or**
- the ability to coordinate muscle movement; **or**
- bladder control & postural hypotension

29. Paralysis of limbs – total and irreversible

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

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

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

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

For the above definition, the following is not covered:

- Parkinson's disease secondary to drug abuse.

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

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

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

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

32. Primary Pulmonary Hypertension – of specified severity

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

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

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

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

33. Progressive Supranuclear Palsy

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

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

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

35. Rheumatoid Arthritis - of specified severity

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

36. Stroke – resulting in permanent symptoms

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

For the above definition, the following are not covered:

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

37. Systemic Lupus Erythematosus – of specified severity

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

Severe kidney involvement with SLE as evidenced by:

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

Severe Central Nervous System involvement with SLE as evidenced by:

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

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

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

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

39. Traumatic head injury – resulting in permanent symptoms

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

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

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

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

The following are not covered:

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

APPENDIX 2:

Definitions of Partial Specified Illnesses

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

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

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

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

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

1. Brain abscess drained via craniotomy

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

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

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

Histological evidence will be required.

Treatment by any other method is specifically excluded.

3. Carotid Artery Stenosis – treated by Endarterectomy or Angioplasty

The undergoing of endarterectomy or therapeutic angioplasty with or without stent to correct symptomatic stenosis involving at least 70% narrowing or blockage of the carotid artery.

Angiographic evidence will be required.

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

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

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

Intracranial aneurysm is specifically excluded.

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

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

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

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

Angiographic evidence will be required.

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

The following are not covered:

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

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

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

Histological evidence will be required.

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

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

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

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

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

8. Serious Accident Cover

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

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

A Life Assured may only claim once under this cover.

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

9. Surgical removal of one eye

Surgical removal of a complete eyeball for disease or trauma.

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

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

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