



AIB Life Term Cover

Protecting the important things in life



This product is provided by Irish Life Assurance plc.

AIB has chosen Irish Life, Ireland's leading life and pensions provider, to provide its customers with a range of pension, protection, investments and savings products. As well as offering advice when you take out a plan, AIB will also help you with any questions about your plans and offer you a financial review every year in return for the fee AIB receive from Irish Life.

Allied Irish Banks, p.l.c. is a tied agent of Irish Life Assurance plc. This means that although AIB are distributing this product, the product information in this booklet has been written by Irish Life as product provider. If you choose this product, it will be provided by Irish Life. So, any reference to 'we' or 'us' refers to Irish Life. If you have any questions, your AIB Financial Adviser will be happy to help.



AIB Life Term Cover

Aim



To provide a lump sum if you die (if you choose life cover) or to provide a lump sum if you are diagnosed with a specified illness during the term of your plan (if you choose specified illness cover)

Cost of Cover



The cost of your cover will stay the same throughout the term of your plan (unless you choose inflation protection for example).

Time Period



Life cover: Two to 40 years, up to age 80.
Specified illness cover: Five to 40 years, up to age 75.

Jargon-free

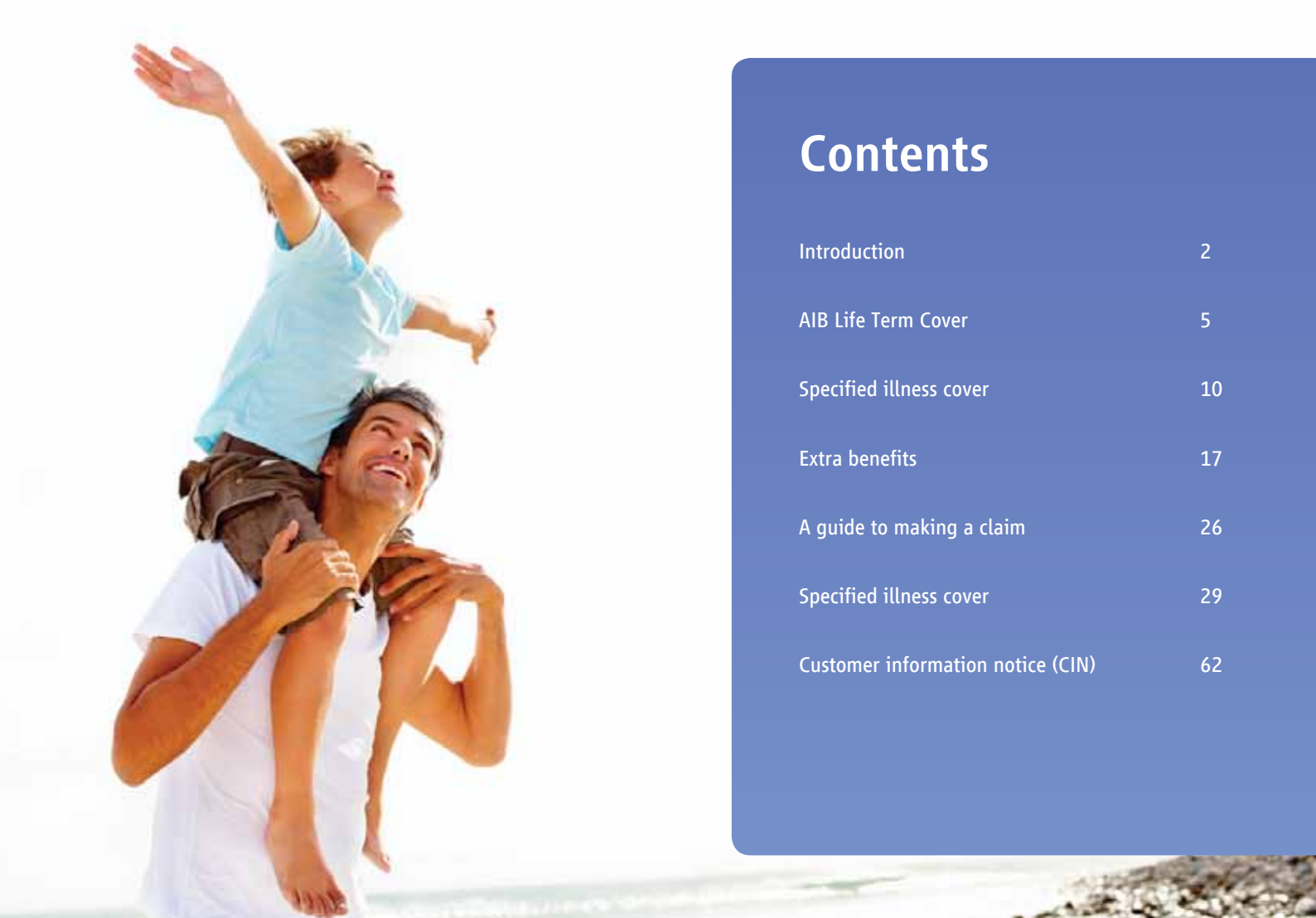


Yes

All information including the Terms and Conditions of your plan will be provided in English.

The information in this booklet was correct as at 2 April 2012 but may change.





Contents

Introduction	2
AIB Life Term Cover	5
Specified illness cover	10
Extra benefits	17
A guide to making a claim	26
Specified illness cover	29
Customer information notice (CIN)	62

Introduction

This booklet will give you details of the benefits available on the AIB Life Term Cover plan. It is designed as a guide that allows us to explain the product to you in short and simple terms. There will be more specific details and rules in your Terms and Conditions booklet which you should read carefully.



Putting you first

We are committed to providing excellent customer service to you at all times from the moment you apply for cover right throughout the life of your plan.

When you ring us you'll get straight through to the AIB service team, who'll be on hand to answer your questions and help you when you are looking for answers. Overleaf is just a sample of the services we offer to make the protection process a little easier for you.

You can change your mind

We want to make sure that you are happy with your decision to take out AIB Life Term Cover. If after taking out this plan you feel it is not suitable, we guarantee to pay all your money back within the first 30 days after we send you details of your plan. The 30-day period starts from the day we send you your AIB Life Term Cover welcome pack.

Keeping it simple – clear communication

Because financial products can be complicated and difficult to understand, we are committed to using clear and straightforward language on all our communications to you. As a result, we work with Plain English Campaign to make sure all our customer communications meet the highest standards of clarity, openness and honesty.

Keeping you up to date

We are committed to keeping you informed about your plan. Because of this, every year we will send you a statement to tell you what your protection benefits are.

Online services

We have a range of online services available for you.

You can check the details of your plan by visiting www.aib.ie/lifeandpensions and clicking into My Online Services. You will need a PIN, which you would have received when you started your plan. If you have lost your PIN or need a new one, contact our AIB service team on 1890 719 390.

European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004

If a financial service or product is provided on a 'distance basis' (in other words, with no face-to-face contact), we have to give you certain information. We have included this information under various headings in this booklet, in the customer information notice at the back of this booklet, in the Terms and Conditions Booklet and in your terms of business letter. All information (including the terms and conditions of your plan) will be in English.

How to contact us

If you want to talk to us, just phone the AIB service team on 1890 719 390. They can answer questions about your plan.

Our lines are open:

8am to 8pm Monday to Thursday

10am to 6pm Friday

9am to 1pm Saturday.

In the interest of customer service, Irish Life will record and monitor calls.

You can also contact us in the following ways:

Email: aibserviceteam@irishlife.ie

Fax: 01 704 19 00

Write to: AIB service team, Irish Life, Lower Abbey Street, Dublin 1.

Any problems?

If you experience any problems, please call your AIB Financial Adviser or contact the AIB service team. We monitor our complaint process to make sure it is of the highest standard. We hope you never have to complain. However, if for any reason you do, we want to hear from you. If, having contacted the AIB service team, you feel we have not dealt fairly with your query, you can contact:

The Financial Services Ombudsman

3rd Floor Lincoln House, Lincoln Place, Dublin 2.

Lo-call: 1890 88 20 90

Email: enquiries@financialombudsman.ie

Fax: 01 662 08 90

Website: www.financialombudsman.ie

AIB Life Term Cover



Life cover

You never know what's around the corner or what life will throw at you next. That's why planning ahead with protection is so important.

Life cover pays your family a lump sum if you die, giving them an income when they need it most. They can use this as they want, to pay bills, loans, or whatever matters most. Most importantly, life cover gives you peace of mind that your family will be secure financially when you are gone.

How much life cover do I need?

Your AIB Financial Adviser can help you work out how much life cover is appropriate to suit your needs. You'll certainly need enough cover to:

- pay off your mortgage;
- pay off other loans and bills; and
- cover the income your family will need to live on.

If you don't earn an income, but look after your children at home, you need enough cover to pay someone to do this.

AIB Life Term Cover – a simple guaranteed protection plan

With the AIB Life Term Cover protection plan, you can have peace of mind that if you die or are diagnosed with a specified illness, your family will not have to struggle to cope financially.

You can choose to take out life cover by itself to cover you if you die, or you can add any of the other benefits listed below.

The AIB Life Term Cover protection plan offers you a range of cover against things that could affect your family's future income. It offers you financial cover against:

- death;
- specified illnesses, such as malignant cancer, diagnosed heart attack and stroke (permanent symptoms);
- time spent in hospital; and
- accidents, resulting in time lost from work.

This plan will cover you for the term you choose. You must decide at the beginning what benefits and cover you will need after taking account of the level of payments you can afford to make.

Below are the benefits available under the AIB Life Term Cover plan

A	Life cover	Pays your family a lump sum if you die.
B	Specified illness cover	Pays you a lump sum if you are diagnosed with one of the 38 conditions we cover. We will also make one partial payment on a further 13 conditions. Please pages 10 - 16 for details.
C	Hospital cash cover	Pays you a daily amount while you are in hospital.
D	Accident cash cover	Pays you a weekly amount if you can't work because of an accident.
E	Inflation protection (indexation)	This allows you to increase your cover every year in line with inflation.
F	Guaranteed cover again	This allows you to change your cover to another guaranteed plan, at any stage throughout your plan, without you needing to give us any new evidence of your health.

How much do I pay?

The amount you pay will depend on:

- your sex;
- your age;
- your health;

- whether you smoke;
- how much protection you want; and
- how long you want the cover for.

The minimum you can pay each month is €15.

How do I pay?

We want to make paying as hassle-free as possible. As a result, with the AIB Life Term Cover plan you pay by direct debit. You can choose to pay a set amount every month, every three months, every six months or every year.

Who will the life cover protect?

You can protect:

- yourself (single cover), which means we could make the lump-sum life cover payment if you die within the term of the plan; or
- yourself and your partner (dual cover), which means that we could make the payment twice, once if you die within the term of the plan and once if your partner also dies within the term of the plan.

If you take out life cover, your children are automatically covered for the benefits you are covered for.

How long will I be covered for?

If you take out AIB Life Term Cover, you decide how long you want to be insured for (between two and 40 years). However, AIB Life Term Cover cannot continue after your 80th birthday. At the end of the period of cover you have chosen, you will no longer be protected.

If you feel the AIB Life Term Cover plan may not be suitable for you, please speak to your AIB Financial Adviser about the excellent range of products we offer.

Important points you need to know about AIB Life Term Cover

- If you die within the term of the plan, we will pay out a lump sum.
- You must be aged 18 to 77 to start this cover.
- The maximum term for life cover is 40 years or up to age 80, whichever is earlier.
- The amount you pay is guaranteed to stay the same for the whole period you are insured for (unless you choose the inflation protection option).
- If you stop making your regular payments, you will no longer be protected and we will not return your money to you.
- If you choose 'guaranteed cover again', you can change your cover to another guaranteed plan. Please see the 'Extra benefits' section on page 17 for more information on this.
- We will not pay claims in certain circumstances. For example, if you have not given us full information about your health, occupation, pastimes or hobbies. (You will find a summary of these situations in the section at the end of this booklet.)
- You cannot cash in your AIB Life Term Cover plan, it is not a savings plan.

Suitability snapshot

Below we have set out some important points for you to consider to help you decide if this plan is suitable for you. If you are in any doubt you should contact your AIB Financial Adviser.

AIB Life Term Cover might suit you if you:

- ✓ are aged 18 to 77;
- ✓ want a guaranteed protection plan with payments that don't change – unless you choose the indexation option;
- ✓ can afford regular payments of at least €15 a month;
- ✓ want life cover for two to 40 years and/or specified illness cover for five to 40 years (or both);
- ✓ want other optional benefits including: hospital cash cover, accident cash cover, indexation and guaranteed cover again;
- ✓ want benefits including children's cover, terminal illness cover and guaranteed insurability;
- ✓ are using it for mortgage protection and want mortgage cover that gives you some excess cover as your mortgage reduces.

AIB Life Term Cover might not suit you if you:

- ✗ are younger than 18 or older than 77;
- ✗ are looking for a plan with flexible payments;
- ✗ have less than €15 a month available to pay for cover; and
- ✗ are using it for mortgage protection and want the cheapest mortgage protection cover available.

Specified illness cover



Specified illness cover

Specified illness cover is a benefit which pays you a lump sum if you are diagnosed with one of 38 conditions we cover. You can use this lump sum to help maintain you and your family's standard of living, pay for medical bills and help you cope during a difficult time. What's more, because you may have to adapt your house to make your day-to-day life easier, specified illness cover could help with these outgoings too.

Specified illness cover will also provide you with a partial payment for a further 13 conditions. The partial payment is €15,000 or half your specified illness benefit amount, whichever is lower. However, for coronary angioplasty the partial payment is €40,000, or 75% of your specified illness cover amount - whichever is lower. Please see page 13 for details.

How can I buy specified illness cover?

You can choose to buy specified illness cover in the following ways:

1. Stand-alone specified illness cover (by itself)
2. Independent specified illness cover (with life cover) or
3. Accelerated specified illness cover (which you have to take out with life cover).

If you choose to take out specified illness cover, you are also entitled to an independent partial payment on the 13 conditions listed on page 13.

Specified illness cover protects

- yourself (single cover),
- you can protect you and your partner (dual cover),
- you can also protect your children. If you take out specified illness cover, for as long as you are covered, we will cover each of your children between the ages of one and 21, for €25,000 or half your specified illness benefit amount, whichever is lower.

How long will I be covered for?

If you take out specified illness cover it has to be for at least 5 years but no longer than 40 years up to your 75th birthday.

How much cover do I need?

If you take out specified illness cover, at the very least, you need enough cover to:

1. pay off your mortgage;
2. pay off other loans and bills; and
3. keep you going until you get back on your feet (on average we would recommend twice your yearly salary).

The illnesses we cover

We have identified 38 conditions that could change your life so much that you would need financial help. Within this we have a condition called 'loss of independence'. We include this condition to make your total cover more wide-ranging. It will be particularly valuable as you get older.

We have also identified a further 13 conditions that we will make partial payments on.

Listed below are the 38 conditions we cover for full payment. You will find detailed descriptions of these from page 29 onwards.

1. Alzheimer's disease
2. Aorta graft surgery
3. Aplastic anaemia
4. Bacterial meningitis
5. Benign brain tumour
6. Benign spinal cord tumour
7. Blindness
8. Cancer (malignant)
9. Cardiac arrest- with insertion of a defibrillator
10. Cardiomyopathy

11. Coma
12. Coronary artery bypass graft
13. Creutzfeldt-Jakob disease
14. Deafness
15. Dementia
16. Encephalitis
17. Heart attack (diagnosed)
18. Heart-valve replacement or repair
19. Heart structural repair with surgery to divide the breastbone.
20. HIV infection caught in the European Union, North America, Australia and New Zealand from a blood transfusion, a physical assault or at work in an eligible occupation
21. Kidney failure
22. Liver failure
23. Loss of independence
24. Loss of limbs
25. Loss of speech
26. Major organ transplant
27. Motor neurone disease

28. Multiple sclerosis
29. Paralysis of limbs
30. Parkinson's disease (idiopathic)
31. Primary pulmonary hypertension
32. Progressive supranuclear palsy
33. Pulmonary artery surgery
34. Respiratory failure of specified severity
35. Severe burns or third-degree burns
36. Stroke – permanent symptoms
37. Systemic lupus erythematosus
38. Traumatic head injury

We do not make a full payment for any other conditions.

Once you claim for your full specified illness cover, your specified illness cover ends and you cannot make any further specified illness claims, including a partial-payment claim.

Partial payment

At the time of suffering an illness we know that the last thing you want to worry about is your finances. We have identified 13 conditions that we will make an extra separate partial payment on if you have specified illness cover. This partial payment is €15,000 or half of your specified illness cover amount, whichever is lower. For coronary angioplasty, the partial payment is €40,000 or 75% of your specified illness cover amount, whichever is lower.

The partial payment on these illnesses is totally separate from your main specified illness cover benefit. That means it does not generally affect the amount you could receive if you need to make a specified illness claim for one of the 38 conditions we cover on a full payment basis at a later date.

We will only make one partial payment for each partial illness covered, for each person under any specified illness cover plan. The total amount of partial payments is limited to your specified illness benefit amount.

For example, if you were diagnosed as having one of the 13 conditions we cover for partial payment, and you received the partial payment, if at a later date you were diagnosed as having one of the 38 conditions we cover on the full-payment basis, you would still generally receive the full specified illness cover benefit.

For serious accident cover only one partial payment will be paid resulting from the same accident.

Listed below are the 13 conditions we cover for partial payment. You will find detailed descriptions of these from page 55 onwards.

1. Brain abscess drained using a craniotomy
2. Carcinoma in situ – oesophagus, treated by specific surgery
3. Carotid artery stenosis (treated by endarterectomy or angioplasty)
4. Cerebral arteriovenous malformation – treated by craniotomy or endovascular repair
5. Coronary angioplasty – to two or more coronary arteries
6. Ductal carcinoma in situ – breast, treated by specific surgery
7. Loss of one limb
8. Low-level prostate cancer with specific treatment
9. Serious accident cover - 28 consecutive days in hospital
10. Severe burns or third-degree burns covering at least 5% of the body's surface
11. Significant visual impairment - permanent and irreversible
12. Single lobectomy
13. Surgical removal of one eye

Mary's story

This is how specified illness cover can help you in your time of need

Mary is aged 57 and has €100,000 of Specified illness cover.

Mary is diagnosed with a brain abscess, which is one of the 13 conditions we cover for partial payment.

- We pay out one partial payment to Mary and it will not affect the rest of her specified illness cover.
- Mary receives €15,000 as a partial payment.

Mary is then diagnosed with malignant cancer, which is one of the 38 conditions we cover for full payment.

- We pay Mary €100,000 in specified illness cover.
- Once we have paid this, Mary has no specified illness cover left.

Paying surgery benefit immediately

If you are diagnosed as needing aorta graft surgery, coronary artery bypass graft or heart-valve replacement or repair or heart structural repair (with surgery to divide the breastbone) and you have given us the evidence we need about your condition, we will pay your specified illness cover (up to €30,000) immediately. We provide this benefit automatically with specified illness cover. It means that you will have a cash lump sum to help you decide when and where you will have your surgery. We will take the amount we pay from your total specified illness benefit.

In addition if you are diagnosed as needing a major organ transplant, we will pay out your full specified illness cover amount upfront. You will find full definitions of the surgery we cover in your terms and conditions booklet.

Important points about specified illness cover

- You must be aged between 18 and 59 to take out specified illness cover.
- We will not pay the specified illness cover if you die during the term of your plan, only if you are diagnosed with one of the 38 conditions we cover.
- At the start of your plan we may not agree to cover you against all these illnesses. If this is the case, we will tell you and we will refer to it in your plan schedule.
- If you suffer from an illness we do not cover, we will not make any payment.
- If you have children, they are also covered for one partial payment of €7,500 or half your specified illness benefit amount, whichever is lower. For more information, please see your terms and conditions.
- The partial payment is totally separate from your main specified illness cover benefit. However, you cannot claim under both the partial payment specified illness cover benefit and a full specified illness cover benefit for related conditions if the diagnoses or events leading to a claim are within 30 days of each other. In these circumstances, the total amount we pay will be the full payment specified illness cover benefit. Please see your terms and conditions for details.
- You can only receive one partial payment for each illness. If you suffer more than one of the conditions we pay partial benefit for, we will pay the benefit for each one until we reach the maximum for your specified illness cover. If the claims are from a single event or diagnosis, we will only make one partial payment.
- Once you claim your full specified illness cover payment, you will have no specified illness cover left and no option to claim for a partial payment.
- We guarantee the rates we charge won't change over the lifetime of your plan. This means your payment will not change (apart from any indexation changes you choose) so you will always know how much your regular payments will be.
- If you stop making your payments, you will no longer be protected and we will not return any money to you. You cannot cash in your plan. It is not a savings plan.
- If you are diagnosed as needing one of the four types of surgery we cover, we will pay €30,000 straight away or your specified illness cover amount, whichever is lower.
- If you have independent specified illness cover, we will only pay a claim if you survive for at least 14 days after having the surgery or being diagnosed as having one of the illnesses. This is longer for certain illnesses. You will find more details on each of the illnesses from page 29 onwards.

- We will not pay claims in certain circumstances, for example if you have not given us full information about your health. You will find a summary of these situations in the 'Guide to making a claim' section.
- If you choose guaranteed cover again, you can convert your cover to another guaranteed plan. Please see the 'Added benefits with AIB Life Term Cover' section for more information on guaranteed cover again.
- We do make a charge if you choose the specified illness cover option.
- The maximum term for specified illness cover is 40 years.
- Specified illness cover will end on the plan anniversary before your 75th birthday.
- This applies even if you have chosen life cover until your 80th birthday.
- For serious accident cover, we will only pay one amount full or partial that arises from the same event.

Extra Benefits

There is a wide range of benefits that are available with AIB Life Term Cover, we have explained them in this section.



Added Benefits

You do not pay any extra charges for the benefits listed below.

Protection flexibility

We know that when you take out one of our plans, sometimes your needs and circumstances can change. So, up to the fifth policy anniversary, we have introduced a flexibility option into our AIB Life Term plans. This allows you to make significant changes to your level of benefits or the term of your benefits without going through the hassle of cancelling your existing plan and taking out a new one. This flexibility option is available at no extra cost. However, when you change your benefits or plan term we will work out a new plan premium at that time. This may mean it goes up or down.

With this flexibility option you can:

- reduce or increase the term of your plan; and
- reduce or increase your existing cover.

The main rules apply to the flexibility option are as follows:

- You can only change the term if the original term you chose was more than 10 years.
- To increase benefit or extend the term:
 - you must be aged under 50;
 - your current life cover must not be more than €500,000 for each life covered, and €300,000 for specified illness cover.
- You cannot increase your benefit by more than 20% of the current benefit.
- You cannot extend the term by more than five years.
- You can only increase a benefit, or extend its term, or a combination of both, once.

There are detailed rules, restrictions and requirements related to this functionality set out in your terms and conditions.

Guaranteed Insurability

This benefit is available on both life and specified illness cover plans.

If you start life cover and before the age of 55 you then get married, have a child, take out a new or extra mortgage or get an increase in salary, you can ask us to set up a new life cover plan for:

- €125,000;
- half of your current benefit; or
- half of your original benefit;

whichever is lower.

You won't have to provide any information about your health.

This option is only available twice. Please see your terms and conditions booklet for detailed information.

Early payment if you are diagnosed with a terminal illness

A terminal illness is a condition that, in the opinion of the appropriate hospital consultant and our chief medical officer, meets both of the following:

- The illness has either no known cure or has progressed to a point where it cannot be cured.

- The illness is expected to lead to your death within 12 months.

Life cover

If you have life cover and are diagnosed as having a terminal illness, we will pay up to your full life cover benefit straight away.

Specified illness cover

If you have stand-alone specified illness cover (which means you have no life cover on this plan) and you are diagnosed as having a terminal illness, we will pay €15,000 of your specified illness cover straight away or half your specified illness benefit amount, whichever is lower.

This is an accelerated benefit, so the specified illness cover you have left will reduce by this amount. We will pay this benefit only if the terminal illness does not arise from one of the 38 conditions we cover on a full-payment basis.

Please see your terms and conditions booklet for detailed information.

Accidental death benefit

This is a temporary automatic benefit available while you are in the process of taking out life cover. We will pay the death benefit (up to €150,000) if you die as a result of an accident.

It covers you from the time we receive your filled-in application form, until any one of the following happen:

- We accept your application.
- We offer special terms.
- We refuse your application.
- We postpone your application.
- 30 days have passed.

You can only take advantage of this benefit if you are younger than 55. Once we have accepted you for life cover, this benefit will stop and your regular life cover starts.

Children's life and specified illness cover

Life cover

- If you take out life cover, we also automatically cover each of your children under 21 for €6,000 life cover for as long as you are covered.
- During the first six months, we only cover them for accidental death.
- We will only pay one claim for each child no matter how many plans you have with us.

Specified illness cover

- Your children between the ages of one and 21 are covered for up to €25,000 or half of your specified illness benefit amount, whichever is lower, for as long as you are covered.
- We will cover them for the same illnesses you are covered for.
- If you have more than one plan with us, we will pay only one claim for each child.
- They must also live for at least 14 days after they have been diagnosed or have had surgery.
- Your children are also covered for a partial payment of €7,500 or half your specified illness benefit amount, whichever is lower, for the 13 illnesses shown on page 13.
 - We will pay only one partial payment for each child, even if you have more than one contract with us. If at a later date the child is diagnosed with one of the 38 conditions we cover, we would still pay the full child specified illness cover amount.

As we do not ask for any medical details about your children before we include them in your plan, we will not pay a claim:

- that arises as a result of any medical condition they have had since birth or if they had significant symptoms of it; or
- for any medical condition you knew about before they reached the age of one or before the specified illness cover started.

For more information, please see your terms and conditions booklet.

NurseAssist 24/7

This confidential service allows you to phone a team of trained nurses who can help you answer a full range of questions or concerns you might have about your family's health.

You can call NurseAssist 24/7 on 1850 22 88 33 at any time, day or night. You will need to give them your member number, which is the same as your AIB Life Term Cover plan number. This will be on your welcome pack.

NurseAssist 24/7 is a confidential advisory service. It is not designed to replace your doctor. The team of nurses will not have access to your plan details or application form.

Counselling service

If you or your family are making a claim to help you during this difficult period, we offer you up to three counselling sessions at no extra cost to you with the Clanwilliam Institute. The Clanwilliam Institute is a registered Irish Charity that was established in 1982. The Institute provides counselling and psychotherapy services for individuals, couples and families who are going through difficulties such as serious illness and bereavement. For more information visit www.clanwilliam.ie.

If you would like to use this service, please contact the Clanwilliam Institute to arrange an appointment on 01 676 13 63 or 01 676 28 81.

Any counselling sessions you have with the Clanwilliam Institute will be strictly confidential.

The Clanwilliam Institute has offices in Dublin, Portlaoise, Kilkenny, Wexford, Dundalk, Wicklow, Roscommon, Galway, Sligo, Nenagh, Roscrea, Limerick, Cork and Dungarvan.

Optional benefits

Please note that you will pay an additional cost for these 'optional benefits'.

As well as the life cover and specified illness cover benefits, we have some other benefits you may choose to take out on your AIB Life Term Cover plan. We have outlined these benefits in this section. You will find more information in your terms and conditions booklet. You will pay extra for these options. Please speak to your AIB Financial Adviser for more information.

Inflation protection (indexation)

This option allows you to increase your cover every year (to keep in line with the cost of living). And, you do not have to provide evidence of your health. This is often called 'indexation'.

Why do I need inflation protection?

This option protects the real value of your cover as time passes. If you do not take this option, your cover will stay the same throughout the term of your plan.

How inflation protection works

- You will have to pay an extra charge for this benefit. This extra charge will depend on your age and the term of your plan.
- At the moment the amount you are covered for will increase by 5% a year. Your payment will go up by 8% each year to reflect the extra cover and the fact that you are older.
- If you refuse this option two years in a row, we will not offer you any further increases.

Guaranteed cover again (conversion option)

Guaranteed cover again allows you to convert your cover to another plan at any stage throughout the term of your plan. And, you do not have to provide any new evidence of health.

Why do I need guaranteed cover again?

In future years you can get cover without providing evidence of your health.

How guaranteed cover again works

- If you want to convert your cover, you can take out a new plan with guaranteed regular payments.
- You must be aged 18 to 60 to choose this option.
- The option to convert cover does not include any inflation protection on the extended cover.
- The option will apply to a life cover sum assured of no more than €5,000,000 and a specified illness cover sum assured of no more than €1,000,000. These limits apply to the total cover extended across all the policies you have with us. The payments you make will reflect this.
- This option to convert cover applies to life and specified illness cover but does not apply to your hospital cash cover or accident cash cover benefit.

Hospital cash cover

Hospital cash cover helps to pay some of your day-to-day bills if you are in hospital for at least three days in a row (72 hours). This cash is yours, tax-free, to spend in any way you want. You are covered for 365 days over the period of the cover, which ends on your plan anniversary before your 60th birthday.

How does it work?

We can cover you for a daily amount of between €70 and €260 – you choose. We pay 95% of all claims within three days of receiving the claim form. What's more, you can claim under this cover as well as under any other health insurance cover you may have.

Children's hospital cash cover

If you choose to take out hospital cash cover, all your children aged one to 21 get a quarter of your cover if they are in hospital for 72 hours or more. This applies as long as you are covered. This amount increases to half of your hospital cash cover if they are in hospital for two weeks or more. This increase applies from the 15th day. As we don't ask for any medical details about your children before we include them in your plan, we will not pay a claim:

- that arises as a result of a condition they have had since birth;
- where they already had significant symptoms; or
- that is caused by a condition you knew about before they reached the age of one or the start of the hospital cash cover.

The table below shows how much we will pay if your child is in hospital and one parent has cover of €200 a day.

Length of hospital stay	How much we will pay
Two days	Nothing
Three days	€150
14 days	€700
15 days	€800
20 days	€1,300

If both parents have cover of €200 a day, we will double these figures.

Important notes about hospital cash cover

- You must be aged between 18 and 54 to take out this cover.
- You must have at least €25,000 life cover to take out hospital cash cover.
- You are not covered if you are in hospital to be treated for mental illness, a psychiatric disorder, alcoholism, or any surgery that is not medically necessary.
- We will not pay a claim in the first two years of your cover if you are in hospital because of any illness or condition which you had, or knew about, before your cover started.
- There are some other reasons we will not pay a claim. You will find them in the 'Guide to making a claim' section on page 26.
- We will not pay a claim if you leave hospital in less than 72 hours.

Accident cash cover

If you are out of work for more than two weeks because of an accident, our accident cover will pay you a weekly amount of between €120 and €400. We will pay you from the start of the third week for up to one year, or until you go back to work. This amount is tax-free. You can cover yourself for up to 40% of your earnings before deductions. We will take off any other income or similar insurance you may have from any payment we make for accident cash cover.

Why do I need accident cash cover?

No matter how careful we are, accidents can happen - in the home, in the garden, playing sport, out and about or at work. Almost half of all accidents happen to people when playing a sport. Because of this, it makes sense to be prepared and insure your income against accidents.

How does it work?

If you earn €300 a week, you can cover yourself for up to €120 a week. We will then pay you this until you return to work or for up to 52 weeks. The cover ends on the plan anniversary before your 60th birthday.

To make things easier for you, for some specific injuries we will pay a number of weeks upfront without you having to prove that you are off work.

We pay 95% of upfront payments within three days of receiving the claim form.

Here is a list of those injuries and how many weeks we will pay upfront.

We will pay four weeks upfront for:

- fractured vertebrae, ribs, collarbone, jaw or skull; or
- a dislocated hip, ankle, elbow or shoulder.
- dislocated shoulders are only covered for one claim in any two-year period.

We will pay six weeks upfront for:

- a fractured wrist or foot.

We will pay 10 weeks upfront for:

- a fractured arm, ankle or leg below the knee.

We will pay 12 weeks upfront for:

- a fractured leg above the knee; or
- an open fracture of the skull.

If you cannot work when these upfront payments run out, you can then apply for normal weekly payments. But don't forget that you are not covered for your first two weeks off work.

For example, if you choose cover of €200 a week and break your leg above the knee, we'll pay you €2,400 upfront. This is for the first 14 weeks (that is, 12 weeks plus the first two weeks that aren't covered). If you still can't work after 14 weeks, we'll then start paying you €200 a week for each further week until you are fit to go back to work. This 12-week period counts towards the 52-week limit over the lifetime of your plan.

Important points about accident cash cover

- You must be aged between 18 and 54 to take out this cover.
- You must have at least €25,000 life cover to take out accident cash cover.
- You are only covered if you can't work as the direct result of a physical injury you have received in an accident. There must be no other cause. In particular we will not cover mental illnesses, including post-traumatic stress.
- If you are unemployed when you make a claim, we will reduce your cover.
- You are not covered for accidents involving a motorcycle that you are driving.
- There are some other reasons we will not pay a claim. You will find them in the 'A guide to making a claim' section on page 26.
- If you claim, the most we will pay is 40% of your earnings before deductions less any other income or disability or incapacity cover you have from any other source.
- No claims are payable within the first 6 months of cover other than the lump sum payments for fractures.
- There is no cover for children under accident cash cover.

A guide to making a claim

In the unfortunate event that you or your family have to make a life or specified illness cover claim, this section will show you the best way to go about it.

How to make a life cover claim

- When your personal representatives need to make a claim, they should contact your AIB Financial Adviser or the AIB service team on 1890 719 390.
- We will send them a claim form and explain what to do. We will always need a filled-in claim form, the plan schedule, and the original death certificate.



- In some circumstances, we will need a certified copy of the will and grant of probate. If there is no will, we may need letters of administration. It is our policy to start paying interest on any life cover claim from two months after the date of death. This is in line with industry standards.
- When we receive all the documents and information we need, we will normally make a payment within five days. If our payment is delayed, as a gesture of goodwill, we will pay interest from the date of death rather than from two months after the date of death.
- If your benefit has been legally transferred to your mortgage lender, we will pay the benefit to the lender. We do not pay any extra claim amount to cover the level of interest built up on a mortgage between the date of your death and the date we settle the claim.

How do I make a specified illness cover claim?

- If you need to make a claim, contact your AIB Financial Adviser or call the AIB service team on 1890 719 390.
- We will send you a claim form, asking for details of your condition and details of the doctors or consultants you have seen. We will try to pay all valid claims as soon as possible.
- You must let us know that you are making a claim within six months of when your condition is diagnosed or when you had surgery. We will need evidence from your doctor or consultant (or both). In some circumstances, we may ask for other medical examinations or tests to confirm the diagnosis.
- If your benefit has been legally transferred to your mortgage lender, we will pay the benefit to the lender. We do not pay any extra claim amount to cover the level of interest built up on a mortgage between the date you are diagnosed with a specified illness and the date we settle the claim.

Situations where we will not pay a claim

We have listed a summary of these situations below.

We may refuse to pay a claim if you have given incorrect information or did not tell us something that would have affected our assessment of your application when you first took out the plan. You must tell us, on your application form, everything relevant about your health, occupation, hobbies and pastimes. If you do not and you make a claim, we may not pay your benefit. We will send

you a summary of the medical information in your application form. You should check this to make sure that you have answered all the health questions accurately.

We will not pay life cover benefit if:

- your death is caused by suicide, or execution in a foreign country, within a year of the plan starting.

We will only pay hospital cash cover, accident cash cover, specified illness and terminal illness claims if:

- you were living in the European Union, Australia, Canada, New Zealand, Norway, South Africa, Switzerland or the United States of America. If you move outside of these countries, you must let us know immediately so that we can decide whether your benefits should continue.

We will not pay hospital cash cover or accident cash cover benefits if:

- the injury has been caused by war, riot, revolution or any similar event or by you committing a crime;
- the condition was self-inflicted or caused by you drinking alcohol or taking drugs, or if you failed to follow reasonable medical advice;
- the injury was caused by you taking part in any of the following activities;

Abseiling, bobsleighing, boxing, caving, flying (except as a paying passenger on a public airline), hang-gliding, horse racing, motor-car and motor-cycle racing or sports, mountaineering, parachuting, potholing, powerboat racing, rockclimbing or scuba-diving.

We will not pay specified illness cover benefit for:

- coma, loss of limbs, loss of independence, paralysis or traumatic head injury, and will not pay limited payments for losing one limb or surgical removal of an eye in the following situations:
- if the injury has been caused by war, riot, revolution or any similar event or by you committing a crime;
- if the condition was self-inflicted or caused by you drinking alcohol or taking drugs, or if you failed to follow reasonable medical advice;
- if the injury was caused by you taking part in any of the following activities. Abseiling, bobsleighing, boxing, caving, flying (except as a paying passenger on a public airline), hang-gliding, horse racing, motor-car and motor-cycle racing or sports, mountaineering, parachuting, potholing, powerboat racing, rock climbing or scuba diving.

Will any tax have to be paid on the benefits?

Usually tax does not have to be paid on life or specified illness benefits. In some circumstances tax may have to be paid on life cover. For example, if you die within the term of the plan and your life cover is paid to your estate, your beneficiaries may have to pay inheritance tax on the proceeds from the plan. You should ask your tax adviser or your accountant to tell you about the tax situation.

We will collect any levies or taxes imposed by the Government. The current government levy on life assurance payments is 1% (April 2012).

Specified illness cover definitions

Plain English Campaign's Crystal Mark does not apply to the following text.

Specified illness cover - the conditions we make a full payment on

If you decide to take out specified illness cover under the AIB Life Term Cover plan, we have defined the 38 conditions that you are protected for on the following pages.



Explanatory notes

The notes in the sections headed 'In simpler terms' are meant to provide a less technical explanation of the illness definitions, and some of the medical terms used in that definition. They are not an alternative definition of the illness and will not be used to assess claims. If there is any dispute, the illness 'definition' overrules the 'In simpler terms' explanation.

1. Alzheimer's disease – resulting in permanent symptoms

Plan definition:

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

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

For the above definition, the following are not covered:

- Other types of dementia.

In simpler terms:

Alzheimer's disease occurs when the nerve cells in the brain deteriorate over time and the brain shrinks. There are various ways in which this can affect someone, for example, severe loss of memory and concentration and mental ability gradually failing.

A claim can be made if the life covered has been diagnosed by a consultant neurologist or consultant geriatrician as having Alzheimer's disease and his/her judgement, understanding and rational thought process have been seriously affected.

2. Aorta graft surgery – for disease or traumatic injury

Plan definition:

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

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

For the above definition, the following are not covered:

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

We also cover surgery for traumatic injury to the aorta needing excision and surgical replacement of a portion of the aorta with a graft.

In simpler terms:

The aorta is the main artery of the body. It supplies blood containing oxygen to other arteries. The aorta can become narrow (often because of a build-up of fatty acids on its walls) or it may become weakened because of a split (dissection) in the internal wall.

The aorta may also weaken because of an 'aneurysm' which means that the artery wall becomes thin and expands. A graft might be necessary to bypass the narrowed or weakened part of the artery.

You can claim if you have had surgery to remove and replace a part of the thoracic or abdominal aorta, to correct narrowing or weakening, with a graft.

Surgery to the branches of the aorta are not covered as this surgery is generally less critical.

3. Aplastic anaemia - of specified severity

Plan definition:

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

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

For the above definition, the following are not covered:

- All other types of anaemia.

In simpler terms:

Aplastic anaemia is a failure of the bone marrow to produce sufficient blood cells for the circulation. When this function of the marrow declines, the main blood constituents (red cells, white cells, platelets) decline or cease production and the individual becomes progressively more dependent on blood transfusions.

You can claim if a Consultant Haematologist diagnoses permanent bone marrow failure which is treated by blood transfusion, agents to stimulate the bone marrow, immunosuppressive agents or a bone marrow transplant.

4. Bacterial Meningitis – resulting in permanent symptoms

Plan definition:

A definite diagnosis of 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.

For the above definition, the following are not covered:

- All other forms of meningitis including viral meningitis.

(Adult and Child cover)

***"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.

In simpler terms:

Bacterial meningitis is a life-threatening illness that results from bacterial infection of the meninges (the three layers of membrane that surround the brain and spinal cord). In many cases, it is possible to recover fully from bacterial meningitis with no lasting ill-effects. However, if there were lasting effects as outlined above, we would pay a claim.

You can make a claim if a consultant neurologist diagnoses bacterial meningitis which results in permanent brain/nerve damage. Examples of such damage include paralysis of the left- or right-hand side of the body or disturbed speech or hearing. All other forms of meningitis including viral are excluded.

5. Benign brain tumour – resulting in permanent symptoms or requiring surgery

Plan definition:

A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms*. The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Tumours in the pituitary gland.
- Angiomas.

The requirement for permanent neurological deficit will be waived if the benign brain tumour is surgically removed or treated by stereotactic radiosurgery.

“permanent neurological deficit with persisting clinical symptoms” is clearly 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.

In simpler terms:

A benign brain tumour is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of the brain.

These growths can be life-threatening and may have to be removed by surgery. Other conditions that are not usually life-threatening are specifically excluded. The pituitary is a small gland at the base of the brain, and an angioma is a benign growth made up of small blood vessels.

You can claim if you are diagnosed as having a benign brain tumour of the brain and have had surgery to have it removed or are suffering from permanent neurological deficit as a result of the

tumour. Examples of tumours covered include gliomas, acoustic neuromas and meningiomas. Neurological symptoms must be permanent. We do not cover tumours or lesions in the pituitary gland.

6. Benign spinal cord tumour – resulting in permanent symptoms or requiring surgery

Plan definition:

A non-malignant tumour of the spinal canal or spinal cord, causing pressure and/or interfering with the function of the spinal cord which requires surgery or results in permanent neurological deficit with persisting clinical symptoms*. The diagnosis must be made by a Consultant Neurologist or Neurosurgeon and must be supported by CT, MRI or histopathological evidence.

For the above definition, the following are not covered:

- Angiomas.

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

***"permanent neurological deficit with persisting clinical symptoms" is clearly 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.

In simpler terms:

A benign tumour of the spinal canal or spinal cord is a non-cancerous but abnormal growth of tissue. It can be very serious as the growth may be pressing on areas of spinal cord or spinal canal.

You can claim if you are diagnosed as having a benign spinal cord tumour and have had surgery to have it removed or are suffering from permanent neurological deficit as a result of the tumour.

Neurological symptoms must be permanent. We do not cover angiomas of the spinal cord or spinal canal.

7. Blindness – permanent and irreversible

Plan definition:

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

In simpler terms:

You can claim only if you have irreversible loss of sight in both eyes to the extent that even using eye glasses or other visual aids, the sight in your better eye is confirmed by an Ophthalmologist or Consultant Physician as 3/60 or worse using the recognised sight test known as the Snellen eye chart. A Snellen chart is the test an optician uses, where you are asked to read rows of letters. 3/60 is the measure when you can only see at three feet away what someone with perfect sight could see at 60 feet away.

It is possible to be 'registered blind' (as certified by an eye specialist) even though the loss of sight may only be partial. Even if you are 'registered blind', your claim will only be met if the loss of sight meets the criteria outlined in our definition and cannot be corrected.

8. Cancer – excluding less advanced cases

Plan definition:

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

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

For the above definition, the following are not covered:

- All cancers which are histologically classified as any of the following:
 - pre-malignant;
 - non-invasive;
 - cancer in situ;
 - having either borderline malignancy; or having low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (ie Gleason score 7 or above only) or having progressed to at least clinical TNM classification T2NOMO.

- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.
- Any skin cancer (including cutaneous lymphoma), other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) ie \geq Clarks level 2.
- Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin are non-malignant and are excluded from this cover.
- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2NOMO.
- Kaposi's sarcoma in the presence of any human immunodeficiency virus.

In simpler terms:

The term 'cancer' is used to refer to all types of malignant tumours (tumours which can spread to distant sites) as opposed to benign tumours (which do not spread elsewhere in the body). A tumour is caused when the process of creating and repairing body tissue goes out of control leading to an abnormal mass of tissue being formed.

A malignant tumour:

- May grow quickly;
- Often invades nearby tissue as it expands;

- Often spreads through the blood or the lymph vessels to other parts of the body; and
- Usually continues to grow and is life-threatening unless it is destroyed or removed.

You can claim if you are diagnosed as suffering from a malignant tumour which has invaded surrounding tissue, unless the type of cancer or tumour is specifically excluded. The claim must be supported by a microscopic examination of a sample of the tumour cells – this is known as ‘histology’. The histology examination is performed on tissue removed during surgery or by biopsy (a procedure to remove a sample of the tumour for examination).

Cancers ‘in situ’ (cancers in a very early stage that have not spread in any way to neighbouring tissue) as well as pre-malignant and non-invasive tumours are not covered under this definition (they may be covered on a partial payment basis, see section 4.7). These are well-recognised conditions and cancers detected at this stage are not likely to be life-threatening and are usually easily treated. An example of this would be carcinoma (cancer) in situ of the cervix (neck of the womb) which is easy to treat and cure.

With increased and improved screening, prostate cancer is being detected at an earlier stage. At early stages these tumours are treatable and the long-term outlook is good. It is not possible to provide full specified illness cover against these early prostate cancers. We will not pay a claim for prostate cancer under this cancer definition unless the tumour has a Gleason score (a method

of measuring differentiation in cells) of greater than 6 (ie a Gleason score of 7 or above) or it has progressed to at least clinical classification of T2N0M0. A partial payment benefit may be available where a life assured does not meet this definition (see section 4.7). The ‘Gleason score’ and the ‘TNM classification’ are ways of measuring and describing how serious the cancer is, and whether it has spread beyond the prostate gland based on its microscopic appearance.

Leukaemia (cancer of the white blood cells) and Hodgkin’s disease (a type of lymphoma) are both covered. However, please note there is a requirement for Chronic lymphocytic leukaemia to have progressed to Binet Stage A in order for a claim to be considered.

Most forms of skin cancer are relatively easy to treat and are rarely life threatening. This is because they do not spread out of control and do not produce growths in other parts of the body. The only form of skin cancer that we cover is malignant melanoma which has been classified as being a ‘Clark level 2’ or greater. Clark’s system is an internationally recognised method of classifying skin melanomas and uses a scale of 1 to 5. A Clark level 1 reflects a very early melanoma which carries a favourable long-term outlook.

Many forms of bladder cancer have a slow course over many years and are managed by surgery or diathermy (the generation of local heat in body tissues by high frequency electromagnetic currents). The prognosis for patients with these superficial bladder cancers is very good. The TNM classification system is internationally

recognized and used as a method of staging or measuring a tumour. The 'T' element relates to the primary tumour and is graded on a scale of 1 to 4 – 1 represents a small tumour restricted to the organ. We will not pay a claim for a T1 bladder cancer unless lymph nodes or metastases (the cancer spreading) are involved as measured by the 'N' and 'M' elements of TNM.

If you are HIV (Human Immunodeficiency Virus) positive, you will not be covered for lymphoma or Kaposi's sarcoma as these tumours are directly related to the virus.

9. Cardiac arrest – with insertion of a defibrillator

Plan definition:

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

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

For the above definition the following are not covered:

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

In simpler terms:

Cardiac arrest happens when the heart suddenly stops beating, sometimes because of an abnormal heart rhythm (arrhythmia) or coronary heart disease. This can stop the heart from pumping blood which prevents oxygen being delivered to the body. Lack of oxygen to the brain causes loss of consciousness which in turn means that you stop breathing. A brain injury or death can occur if the arrest goes untreated.

A device known as an Implantable Cardioverter Defibrillator (ICD or CRT-D) can be implanted inside your body which will monitor the rhythm in your heart. If the rhythm becomes abnormal, the device will deliver an electric pulse or shock which will restore the rhythm back to normal and prevent a cardiac arrest.

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

10. Cardiomyopathy - resulting in a marked loss of ability to do physical activity

Plan definition:

A definite diagnosis of cardiomyopathy by a Consultant Cardiologist. There must be clinical impairment of heart function resulting in

the permanent loss of ability to perform physical activities to at least Class 3 of the New York Heart Association classification of functional capacity*. The diagnosis should be supported by a current echocardiogram or cardiac MRI showing abnormalities consistent with the diagnosis of cardiomyopathy.

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

For the above definition, the following are not covered:

- Cardiomyopathy secondary to alcohol or drug abuse.
- All other forms of heart disease, heart enlargement and myocarditis.

In simpler terms:

Cardiomyopathy is a disorder affecting the muscle of the heart, the cause of which is unknown. It may result in enlargement of the heart, heart failure, abnormal rhythms of the heart (arrhythmias) or an embolism (blockage of a blood vessel).

You can claim if you suffer cardiomyopathy which is permanent and causing symptoms which significantly hinder your normal everyday activities. To qualify for payment your physical ability must be measurable and limited to a specific degree (New York Heart

Association Class 3). The NYHA Function Classification is a measure used to classify the extent of heart failure.

11. Coma – of specific duration and resulting in permanent symptoms

Plan definition:

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

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

For the above definition, the following is not covered:

- Coma secondary to alcohol where there is a history of alcohol abuse.
- Coma secondary to illegal drug abuse.

“permanent neurological deficit with persisting clinical symptoms” is clearly 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.

In Simpler terms:

A coma is a state where a person is unconscious and cannot be brought round. Someone in a coma will have little or no response to any form of physical stimulation and will not have control of their bodily functions. Comas are caused by brain damage, most commonly arising from a head injury, a stroke or lack of oxygen.

12. Coronary artery by-pass grafts

Plan definition:

The undergoing of surgery on the advice of a Consultant Cardiologist to correct at least 70% narrowing or blockage of one or more coronary arteries with by-pass grafts via a thoracotomy, a thoracoscope or mini thoracotomy.

For the above definition, the following are not covered:

- balloon angioplasty, atherectomy, insertion of stents and laser treatment or any other procedures.

In simpler terms:

Coronary artery surgery may be necessary if one or more coronary arteries (the arteries which supply blood to the heart) are narrowed or blocked. The surgery is done to relieve the pain of angina or if the blocked artery is life-threatening.

Coronary artery bypass surgery is carried out by taking a vein, normally from the thigh, and using it to direct blood past the diseased or blocked artery.

You will be able to claim if you have a coronary artery bypass surgery for ischaemic heart disease of at least 70% in one artery. You are not covered under this definition for any other intervention techniques such as angioplasty or laser relief.

13. Creutzfeldt-Jakob Disease – resulting in permanent symptoms

Plan definition:

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

***"permanent neurological deficit with persisting clinical symptoms" is clearly 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.

In simpler terms:

CJD is a degenerative condition of the brain. As the disease progresses muscular co-ordination diminishes, the intellect and personality deteriorate and blindness may develop.

You can claim if your Consultant Neurologist confirms the diagnosis of CJD which has resulted in permanent neurological deficit.

14. Deafness – total, permanent and irreversible

Plan definition:

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

In simpler terms:

You can claim if you have a severe form of deafness (to the degree described in our definition) as measured by a pure tone audiogram. A pure tone audiogram is a key hearing test used to identify hearing threshold levels in an individual. The test establishes the quietest sounds you are able to hear at different frequencies or pitches. A decibel is a measure of the volume of a sound.

You cannot claim if you have reduced hearing in one or both ears which does not meet this definition. You cannot claim if the deafness can be improved by the use of medical aids.

15. Dementia – resulting in permanent symptoms

Plan definition:

A definite diagnosis of dementia by a Consultant Neurologist, Psychiatrist or Geriatrician. There must be permanent clinical loss of ability to do all of the following:

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

For the above definition, the following is not covered

- Dementia secondary to alcohol or illegal drug abuse.

In simpler terms:

Dementia is a term used to describe a number of signs and symptoms characterised by the loss of cognitive functioning and intellect, and behavioural changes. Areas of cognition affected may be memory, concentration, language and problem solving.

A claim can be made if the life covered has been diagnosed by a consultant neurologist or consultant geriatrician or psychiatrist,

as having Dementia and his/her judgement, understanding and rational thought process have been seriously affected. These symptoms must be permanent.

16. Encephalitis – resulting in permanent symptoms

Plan definition:

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

***“permanent neurological deficit with persisting clinical symptoms” is clearly 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.

In simpler terms:

Encephalitis is an acute inflammation of the brain. The illness can vary from mild to life-threatening. Most people with a mild case can recover fully. More severe cases of Encephalitis may recover but there may be damage to the nervous system. This damage can be permanent.

You can claim if you have a diagnosis of Encephalitis confirmed by a Consultant Neurologist and where there are neurological symptoms which the Neurologist deems to be permanent.

17. Heart attack – of specified severity

Plan definition:

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

- Typical clinical symptoms (for example characteristic chest pain).
- New characteristic electrocardiographic (ECG) changes.

- The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher;
 - Troponin T > 1.0 ng/ml
 - AccuTnl > 0.5 ng/ml or equivalent threshold with other Troponin 1 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.

In simpler terms:

A heart attack (myocardial infarction) happens when an area of heart muscle dies because it does not get enough blood containing oxygen. It is usually caused by a blocked artery and causes permanent damage to the part of the heart muscle affected. The blockage is usually caused by a clot (thrombosis) where the artery has already grown narrow.

To confirm the diagnosis, your doctor will usually test your heart using a machine called an electrocardiograph (ECG). This tells the doctor if there have been any changes in the heart's function and if it is likely that a heart attack has occurred.

Your doctor will also take a blood sample. This can show that markers are present in the blood (in the form of enzymes or Troponins) at a much higher level than is normally expected.

You can claim if you are diagnosed as having suffered death of heart muscle. Your claim must be supported by an increase in cardiac enzymes or troponins that are typical of a heart attack (released into the blood stream from the damaged heart muscle) and new ECG changes typical of a heart attack.

18. Heart valve replacement or repair

Plan definition:

The actual undergoing of a surgical procedure (including balloon valvuloplasty) to replace or repair one or more heart valves on the advice of a Consultant Cardiologist.

In simpler terms:

Heart valves regulate and control the flow of blood to and from the heart. The valves may become narrow or leak, and if one of the four heart valves is not working properly, an operation may be necessary to repair or replace the valve.

You will be able to claim if you undergo surgery to replace or repair a heart valve on the advice of a Consultant Cardiologist.

19. Heart structural repair with surgery to divide the breastbone

Plan definition:

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

In Simpler terms:

Structural abnormalities include openings in the wall separating the left and right chambers of the heart.

You will be able to claim if on the advice of a Consultant Cardiologist, you have open heart surgery (including surgery to divide the breast bone) to correct a structural abnormality of the heart.

20. HIV infection – caught in the European Union, North America, Australia and New Zealand, from a blood transfusion, a physical assault or at work in an eligible occupation

Plan definition:

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment;

- a physical assault;
- an accident occurring during the course of performing normal duties of employment [from the eligible occupations listed below]*;
 - 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 the European Union, North America, Australia or New Zealand.

For the above definition, the following is not covered:

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

*Occupations Covered:

- Ambulance workers
- Dental nurses
- Dental surgeons
- District nurses
- Dublin Bus employees
- Fire brigade and firefighters
- General practitioners and nurses employed by them
- Hospital caterers
- Hospital cleaners
- Hospital doctors/surgeons/consultants
- Hospital laboratory workers
- Hospital laundry workers
- Hospital nurses
- Hospital porters
- Members of the Gardai
- Midwives
- Paramedics

- Prison officers
- Refuse collectors
- Social workers
- Taxi drivers

In simpler terms:

Human immunodeficiency virus is generally recognised as the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The virus can be passed on in several ways including through contaminated blood, bloodstained bodily fluids and infected needles. This benefit is designed to cover people who are in special danger of getting HIV or AIDS through their work or who have become infected as a result of a physical assault or a blood transfusion in the European Union, North America, Australia and New Zealand. The infection must happen after the start date of the plan and must be appropriately reported and investigated in accordance with established procedures.

21. Kidney failure – requiring ongoing dialysis or transplant

Plan definition:

Chronic and end stage failure of both kidneys to function, as a result of which long term regular dialysis is necessary and ongoing or a kidney transplant is necessary.

In simpler terms:

The kidneys act as filters which remove waste materials from the blood. When the kidneys do not work properly, waste materials build up in the blood. This may lead to life-threatening problems. The body can function with only one kidney, but if both kidneys fail completely, dialysis (kidney machine treatment) or a kidney transplant will be necessary. In some circumstances it is possible for the kidneys to fail temporarily and recover following a period of dialysis.

You will be able to claim if both your kidneys fail completely and the condition is chronic and you need regular long-term dialysis or a kidney transplant.

22. Liver Failure – irreversible and end stage

Plan definition:

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

- Permanent jaundice
- Ascites, and
- Encephalopathy.

For the above definition, the following is not covered:

- Liver failure secondary to alcohol or illegal drug misuse.

In simpler terms:

Liver failure is the inability of the liver to perform its normal synthetic and metabolic function. Liver failure occurs when a large portion of the liver is damaged.

You can claim if you are diagnosed by a Consultant Physician as having incurable liver failure caused by cirrhosis and showing particular symptoms. Jaundice is a yellow discoloration of the skin and eye whites due to abnormally high levels of bilirubin (bile pigment) in the blood stream. This jaundice must be a permanent feature. Ascites is a fluid build up in the abdomen caused by fluid leaks from the surface of the liver and intestines. It can occur if the blood or lymphatic flow through the liver is blocked. Encephalopathy caused by liver failure is the deterioration of brain function due to toxic substances building up in the blood which are normally removed by the liver.

You cannot claim if the liver failure occurs as a direct or indirect result of excess alcohol consumption or illegal drug use.

23. Loss of Independence – permanent and irreversible

Plan definition:

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

1. Permanent confinement to a wheelchair, or
2. being permanently hospitalised or resident in a nursing home as a result of a medical impairment on the advice of a registered medical practitioner, or
3. being permanently unable to fulfill at least three of the following activities unassisted by another person:
 - The ability to walk 100 metres unaided.
 - The ability to get into and out of a vehicle unaided.
 - The ability to put on, take off, secure and unfasten all necessary garments and any braces, artificial limbs or other surgical appliances.
 - The ability to feed oneself once food and drink has been prepared and made available.
 - The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained.
 - The ability to climb stairs without the assistance of special aids.
 - The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.
4. or suffer from severe and permanent intellectual impairment which must,

- a. result from organic disease or trauma, and
- b. be measured by the use of recognized standardized tests and
- c. have deteriorated to the extent that requires the need for continual supervision and assistance of another person

The diagnosis must be confirmed to the satisfaction of the professional opinion of Irish Life's Chief Medical Officer and by a consultant physician, neurologist or geriatrician of a major hospital in Ireland or the UK.

In all of the above permanent means that, even with the best treatment available, the life assured is not expected to recover. The condition must continue for at least six months following diagnosis before the benefit can be claimed.

In simpler terms:

This benefit is intended to make your total cover more wide-ranging and will be particularly valuable as you get older. By focusing on the disability rather than the specific illness, extra cover is provided for a variety of events which may radically change your life.

24. Loss of limbs – permanent physical severance

Plan definition:

Permanent physical severance of any combination of 2 or more hands or feet at or above the wrist or ankle joints.

In simpler terms:

You will be able to claim if you have lost two or more of your limbs above the wrist or ankle joint either by injury or because they have had to be removed. This loss must be permanent.

25. Loss of speech – permanent and irreversible

Plan definition:

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

In simpler terms:

You will be able to claim only if you suffer from total and permanent loss of speech as a result of physical damage or disease.

26. Major organ transplant – specified organs

Plan definition:

The undergoing as a recipient of a transplant of bone marrow or of a complete heart, liver, lung, or pancreas, or inclusion onto the official programme waiting list of a major Irish or UK hospital for such a procedure.

For the above definition, the following is not covered:

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

In simpler terms:

Serious disease or injury can severely damage the heart, lungs, liver or pancreas. The only form of treatment available may be to replace the damaged organ with a healthy organ from a donor. This is a major operation and the tissues of the donor and patient must be matched accurately. For this reason a patient could be on a waiting list for a long period waiting for a suitable organ. Bone marrow transplant is also covered.

You can claim if you have had a transplant of any of the organs listed or are on an official Irish or UK programme waiting list for a transplant.

27. Motor neurone disease – resulting in permanent symptoms

Plan definition:

A definite diagnosis of motor neurone disease by a Consultant Neurologist.

There must be permanent clinical impairment of motor function.

In simpler terms:

Motor neurone disease is a disease which affects the central nervous system that controls movement. As the nerves deteriorate the muscles weaken. There is currently no known cure and the cause of the disease is also unknown.

You can claim if there is a definite diagnosis by a consultant neurologist that you are suffering from motor neurone disease.

28. Multiple sclerosis – with persisting symptoms

Plan definition:

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.

In simpler terms:

Multiple sclerosis is a disease of the central nervous system which destroys the protective covering (myelin) of the nerve fibres in the brain and spinal cord. The symptoms depend on which areas of the brain or spinal cord have been affected. They include temporary blindness, double vision, loss of balance and lack of co-ordination.

You can claim if you are diagnosed by a consultant neurologist as suffering from multiple sclerosis and you have ongoing well –defined symptoms of the disease which have been present continuously for at least six months.

29. Paralysis of limbs – total and irreversible

Plan definition:

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

Permanent Paraplegia or Quadriplegia are covered under this definition.

In simpler terms:

The brain controls the movement of muscles in the body by sending messages through the spinal cord and nerves. Paralysis is normally caused by an injury to the spinal cord.

You will be able to claim if you suffer complete and permanent loss of the use of two or more limbs.

30. Parkinson's disease (idiopathic)– resulting in permanent symptoms

Plan definition:

A definite diagnosis of Idiopathic Parkinson's disease by a Consultant Neurologist. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability.

For the above definition, the following are not covered:

- Parkinson's disease secondary to chronic alcohol abuse or illegal drug abuse; and
- Impairment of motor function directly linked or associated with another separate medical condition.

In simpler terms:

Parkinson's Disease is a disease of the central nervous system which affects voluntary movement. It is characterised by muscle stiffness or rigidity, slow movements, shaking of the limbs and head and loss of balance. It normally takes hold gradually.

The term "idiopathic" means that the cause of the disease is not known, so any form of Parkinson's disease brought on by a known cause such as drugs, toxic chemicals or alcohol is not covered.

31. Primary Pulmonary Hypertension – of specified severity

Plan definition:

A definite diagnosis of Primary Pulmonary Hypertension by a Consultant Cardiologist. There must be clinical impairment of heart function 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*.

For the above definition, the following are not covered:

- Pulmonary hypertension secondary to any other known cause is not primary.

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

In simpler terms:

Primary Pulmonary Hypertension is a disease which occurs when blood pressure in the pulmonary artery or the major blood vessel connecting the right heart ventricle and the lungs is higher than normal. There is no apparent cause. A higher pulmonary artery blood pressure means the heart has to work harder to pump sufficient blood into the lungs. Over time, the heart muscles weaken.

You can claim if you suffer from Primary Pulmonary Hypertension which is diagnosed by a Consultant Cardiologist. To qualify for payment your physical ability must be measurable and limited to a specific degree (New York Heart Association Class 3). The NYHA Function Classification is a measure used to classify the extent of heart failure.

32. Progressive supranuclear palsy – resulting in permanent symptoms

Plan definition:

A definite diagnosis by a Consultant Neurologist of Progressive Supranuclear Palsy. There must be permanent clinical impairment

of eye movement and motor function, rigidity of movement and postural instability.

In simpler terms:

Progressive supranuclear palsy (PSP), also known as Steele-Richardson-Olzewski syndrome, is a degenerative disease that gradually destroys nerve cells in the parts of the brain that control eye movements, breathing and muscle co-ordination. The loss of nerve cells causes palsy or paralysis that slowly gets worse as the disease progresses.

The definition literally means:

- progressive - it gradually gets worse over time.
- supranuclear - the area of the brain stem which controls the eye movements.
- palsy - a weakness (in this case, related to eye movement).

You can claim if there is a definite diagnosis by a consultant neurologist that you are suffering from progressive supranuclear palsy.

33. Pulmonary Artery Surgery – with surgery to divide the breast bone

Plan definition:

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 and replace the diseased pulmonary artery with a graft.

In simpler terms:

Pulmonary Artery surgery may be carried out for some disorders to the pulmonary artery, including pulmonary atresia (atresia means “no opening”) and aneurysm. A claim can be made if the life insured undergoes open heart surgery involving the surgical division of the breastbone to replace the diseased pulmonary artery with a graft.

34. Respiratory Failure of specified severity

Plan definition:

Confirmation by a Consultant Physician of chronic lung disease resulting in:

- The need for daily oxygen therapy on a permanent basis
- Evidence that the oxygen therapy has been required for a minimum period of six months

- FEV1 being less than 40% of normal, and
- Vital Capacity less than 50% of normal.

In simpler terms:

Respiratory Failure is a condition where the level of oxygen in the blood becomes too low or the level of carbon dioxide in the blood becomes too high.

You can claim if you have severe and chronic respiratory failure, evidenced by lung function tests showing forced expiratory volume less than 40% of normal and a vital capacity less than 50% of normal and you require daily oxygen therapy. FEV and VC are ways of measuring lung function.

35. Severe Burns/3rd Degree Burns

Plan definition:

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20% of the body's surface area.

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as ‘first’, ‘second’ and ‘third’ degree. First-degree burns damage the upper layer of skin, but can heal without scarring

(a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-degree burns are the most serious as they destroy the full thickness of the skin.

You will be able to claim if you have suffered third-degree burns covering 20% or more of the surface area of your body.

36. Stroke – resulting in permanent symptoms

Plan definition:

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms*. A diagnosis of Subarachnoid Haemorrhage resulting in permanent neurological deficit with persisting clinical symptoms*, supported by CT or MRI evidence, is covered under this definition.

For the above definition, the following are not covered:

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

***"permanent neurological deficit with persisting clinical symptoms" is clearly 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.

In simpler terms:

The brain controls all the functions of the body, so damage to the brain can have serious effects. A stroke happens when there is severe damage to the brain caused by internal bleeding (haemorrhage) or when the flow of blood in an artery has been blocked by a piece of tissue or a blood clot (a thrombus or embolus) resulting in the brain being starved of oxygen.

This benefit does not cover 'transient ischaemic attacks' (also known as mini-strokes) where there is a short-term interruption of the blood supply to part of the brain, the main symptoms tend to be dizziness and temporary weakness or loss of sensation in part of the body or face.

37. Systemic lupus erythematosus – of specified severity

Plan definition:

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.

***"permanent neurological deficit with persisting clinical symptoms" is clearly 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 purpose of this definition – lethargy will not be accepted as evidence of permanent neurological deficit.

In simpler terms:

Systemic lupus erythematosus (SLE) is a chronic auto-immune connective tissue disease. The immune system attacks the body's cells and tissue resulting in inflammation and tissue damage. The course of the disease is unpredictable with periods of illness alternating with remission. SLE is a multi-system disease because it can affect many different organs and tissues in the body. Systemic lupus erythematosus can be a mild condition treated by medication or there can be life-threatening complications. The condition can be present for many years without progressing to brain and kidney involvement.

You can claim if you are diagnosed with systemic lupus erythematosus by a Consultant Rheumatologist which is complicated by brain involvement resulting in permanent neurological deficit with persisting clinical symptoms or kidney involvement with a GFR below 30ml/min.

38. Traumatic head injury – resulting in permanent symptoms

Plan definition:

Death of brain tissue due to traumatic injury resulting in permanent neurological deficit with persisting clinical symptoms*. The diagnosis must be supported by an opinion of a Consultant Neurologist and agreed by our Chief Medical Officer.

For the above definition, the following is not covered:

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

***"permanent neurological deficit with persisting clinical symptoms" is clearly 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.

In simpler terms:

A head injury caused by trauma can leave an individual with permanent brain/nerve damage.

You can claim if a Consultant Neurologist confirms that you have permanent neurological deficit with persisting clinical symptoms as a direct result of a head injury.

Specified Illness Cover - the conditions we make a partial payment on

A. Brain abscess drained via craniotomy

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes 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

In simpler terms:

A brain abscess results from an infection in the brain. Swelling and inflammation develop in response to the infection. Infected brain cells, white blood cells and organisms collect in an area of the brain, a membrane forms and creates the abscess. While this immune response can protect the brain from the infection, an abscess may put pressure on delicate brain tissue.

A craniotomy is a surgical operation in which part of the skull is removed in order to access the brain.

You can claim if you are diagnosed with an intracerebral abscess which is treated by surgical drainage by craniotomy by a Consultant Neurosurgeon. A craniotomy is a surgical operation in which part of the skull is removed in order to access the brain.

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

Plan definition:

We will make a limited payment for specified illness cover if a life assured has 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.

For the above definition, the following are not covered:

- Treatment by any other method is specifically excluded.

In simpler terms:

The oesophagus is a muscular, membranous tube approximately 25 cm long which connects the mouth to the stomach. Carcinoma in situ is an early form of carcinoma that involves only the cells in which it began and has not spread to other tissues.

You can claim if you have been diagnosed with a carcinoma in situ of the oesophagus and you have been treated surgically by removal of part or all of the oesophagus.

This benefit does not cover any other disease or disorder of the oesophagus.

C. Carotid Artery Stenosis - treated by Endarterectomy or Angioplasty

Plan definition:

We will make a limited payment under specified illness cover if a life assured undergoes 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.

In simpler terms:

Endarterectomy is a surgical procedure to remove atheromatous plaques (fatty tissue) or a blockage in the lining of an artery. It is carried out by separating the plaque from the arterial wall. An angioplasty is a procedure which uses a temporarily inflated balloon on a catheter (tube) to widen a narrowed or blocked blood vessel by compressing plaque against the artery wall. A stent is a device inserted into an artery to help keep it open.

You can claim if you have had a 70% narrowing or blockage of the carotid artery treated by either endarterectomy or angioplasty. We will require a copy of the angiogram report showing 70% stenosis in the carotid artery.

You cannot claim under this benefit for any other treatment of the carotid artery or vascular system.

D. Cerebral arteriovenous malformation - treated by craniotomy or endovascular repair

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes surgical treatment via craniotomy by a Consultant Neurosurgeon of a cerebral AV fistula or malformation. Also, we will make a limited payment for specified illness cover if a life assured undergoes endovascular treatment by a Consultant Neurosurgeon or Radiologist using coils to cause thrombosis of a cerebral AV fistula or malformation.

For the above definition, the following is not covered:

- Intracranial aneurysm.

In simpler terms:

A cerebral arteriovenous malformation (AVM) is an abnormal connection between arteries and veins in the brain that interrupts normal blood flow between them. An AVM is characterised by

tangles of abnormal and enlarged blood vessels. In serious cases, the blood vessels rupture.

An arteriovenous fistula is an abnormal passageway between an artery and a vein. Normally blood flows from arteries into capillaries and back to your heart in veins. When an arteriovenous fistula is present, blood flows directly from an artery into a vein, bypassing the capillaries. If the volume of blood flow diverted is large, tissues down stream receive less blood supply. Also, there is a risk of heart failure due to the increased volume of blood returned to the heart.

You can claim if you undergo a craniotomy or endovascular treatment using coils under the care of a Consultant Neurologist or Radiologist, as appropriate, to treat a cerebral AVM or AV fistula.

A craniotomy is a surgical operation in which part of the skull is removed in order to access the brain. Endovascular treatment uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.

E. Coronary Angioplasty - to 2 or more coronary arteries

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes a balloon angioplasty, atherectomy, laser treatment or stent insertion on the advice of a Consultant

Cardiologist to correct at least 70% narrowing or blockage of two or more coronary arteries. 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.

2 stents to one artery, or branches of the same artery, does not qualify.

In simpler terms:

Arteries can become blocked with fatty deposits, like the 'furring up' of a kettle. If the blockages are in the coronary arteries close to the heart, this causes extra strain on the heart, which then may lead to more serious heart disease. We will require a copy of the angiogram reports showing at least 70% stenosis in the coronary arteries.

Balloon angioplasty involves a surgeon passing a fine balloon catheter (a flexible plastic tube) down one of the arteries to the heart (a coronary artery). When the balloon reaches the place where the artery has narrowed, it is inflated to force the walls of the artery apart.

'Atherectomy' and 'laser treatment' are also techniques which involve passing a catheter into the blocked artery.

If you have balloon angioplasty, atherectomy or laser treatment, you can claim if the treatment is to correct a 70% narrowing of at least

two coronary arteries. We do not cover such treatment where only one artery is involved.

Treatment by balloon angioplasty, atherectomy or laser treatment, in 2 different arteries on two separate occasions, to treat narrowing or blockages of at least 70%, qualifies for payment after the second procedure has been carried out.

F. Ductal Carcinoma in Situ – Breast, treated by surgery

Plan definition:

We will make a limited payment for specified illness cover if a life assured has a definite diagnosis of a ductal carcinoma in situ 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.

In simpler terms:

Carcinoma in situ is an early form of carcinoma that involves only the cells in which it began and has not spread to other tissues. The term 'ductal' refers to the ducts in the milk glands in the breast.

You can claim if you are diagnosed as having a ductal carcinoma in situ of the breast which is removed surgically.

No benefit is payable under this benefit for any other breast disorder.

G. Loss of one limb

Plan definition:

We will make a limited payment under specified illness cover if a life assured permanently loses 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. To qualify for payment, the loss must happen on a date after the start date and before cover ends.

In simpler terms:

You will be able to claim if you have lost a limb above the wrist or ankle joint either by injury or because they have had to be removed. This loss must be permanent.

No payment is made for loss of any individual fingers or toes or combination of fingers and toes.

H. Low Level Prostate Cancer with Gleason score between 2 and 6 – and with specific treatment

Plan definition:

We will make a limited payment for specified illness cover if a life assured is diagnosed with a prostate cancer 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 client 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.

In simpler terms:

With increased and improved screening, prostate cancer is being detected at an earlier stage. If prostate cancer is caught early, when it is still classified as 'low-grade', there is a good chance that treatment will be successful and the long-term outlook is good. The 'Gleason score' and the 'TNM classification' are ways of measuring and describing how serious the cancer is, and whether it has spread beyond the prostate gland based on its microscopic appearance. Cancers with a Gleason score less than or equal to 6 are less aggressive and have a better prognosis.

I. Serious Accident Cover – resulting in at least 28 consecutive days in hospital

Plan definition:

We will make a limited payment if a life assured suffers a serious accident resulting in severe physical injury where the life assured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment.

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

We will also cover treatment in an inpatient rehabilitation centre, if the client is transferred directly from hospital to the rehabilitation centre for continuous treatment.

Only one partial payment or full payment will be paid resulting from the same accident.

For the above definition the following are not covered:

- Stays in hospital of less than 28 consecutive days.
- Serious accident secondary to alcohol where there is a history of alcohol abuse.
- Serious accident secondary to illegal drug abuse.

In simpler terms:

You can claim if you have a serious accident and are hospitalised for at least 28 consecutive days to receive medical treatment for your injuries. The 28 consecutive days can include time spent in a rehabilitation centre if you are transferred there directly from the hospital to continue your treatment. You can only make one claim for partial payment resulting from the same accident.

J. Severe Burns/3rd Degree Burns covering at least 5% of the body's surface

Plan definition:

We will make a limited payment for specified illness cover if a life assured suffers 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 at least 25% of the surface area of the face which for the purpose of this definition includes the forehead and the ears.

In simpler terms:

There are three levels (degrees) of burns. The degree of burning depends on how badly the skin has been damaged. They are medically known as 'first', 'second' and 'third' degree. First-degree burns damage the upper layer of skin, but can heal without scarring (a common example of this is sunburn). Second-degree burns go deeper into the layers of skin, but can heal without scarring. Third-

degree burns are the most serious as they destroy the full thickness of the skin.

You will be able to claim if you have suffered third-degree burns covering at least 5% and less than 20% of the surface area of your body or 25% of the surface area of the face.

K. Significant visual impairment – permanent and irreversible

Plan definition:

We will make a limited payment for specified illness cover if a life assured suffers the permanent and irreversible reduction in the sight of both eyes to the extent that even when tested with the use of visual aids, vision is measured at 6/18 or worse in the better eye using a Snellen eye chart, while wearing any corrective glasses or contact lenses.

In simpler terms:

You can only claim if you have irreversible loss of sight in both eyes to the extent that even using eye glasses or other visual aids, the sight in your better eye is confirmed by an Ophthalmologist or Consultant Physician and to the satisfaction of our Chief Medical Officer, as 6/18 or worse using the recognised sight test known as the Snellen eye chart. A Snellen chart is the test the Optician uses when you are asked read rows of letters. 6/18 is the measure when

you can only see at six metres what someone with perfect sight would see at 18 metres away.

It is possible to be “registered blind” (as certified by an eye specialist) even though the loss of sight may be only partial. Even if you are “registered blind”, your claim will only be met if the loss of sight meets the criteria outlined in our definition and cannot be corrected.

L. Single Lobectomy – the removal of a complete lobe of a lung

Plan definition:

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

For the above definition, the following are not covered:

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

In simpler terms:

The right lung is divided into three lobes and the left lung into two. The lobes of the lungs are further divided into segments. A lobectomy is an operation to remove one or more of the lobes from a lung.

You can claim if you have an operation to remove an entire lobe from the lung because it is diseased or because of a wound or an injury. You will not be able to claim if a segment of the lobe is removed, or for any other type of lung surgery. The operation to remove the entire lobe must be deemed medically essential by our Chief Medical Officer.

M. Surgical removal of one eye

Plan definition:

We will make a limited payment for specified illness cover if a life assured undergoes surgical removal of a complete eyeball for disease or trauma. To qualify for payment, the removal of the eyeball must happen on a date after the start date and before cover ends.

In simpler terms:

You can claim if you have to have an eyeball removed as a result of disease or injury.

No benefit is payable for loss of sight in one eye unless it was medically necessary to proceed and remove the eyeball.

Customer information notice - CIN



CONTENTS

INTRODUCTION

A. INFORMATION ABOUT THE POLICY

1. Make sure the policy meets your needs!
2. What happens if you want to cash in the policy early or stop paying premiums?
3. What are the projected benefits under the policy?
4. What intermediary/sales remuneration is payable?
5. Are returns guaranteed and can the premium be reviewed?
6. Can the policy be cancelled or amended by the insurer?
7. Information on taxation issues
8. Additional information in relation to your policy

- What are the benefits and options under this plan?
- What is the term of the contract?
- Are there any circumstances under which the plan may be ended?
- Is there an opportunity to change your mind?
- Law applicable to your plan
- What to do if you are not happy or have any questions?

B. INFORMATION ON SERVICE FEE.

C. INFORMATION ABOUT THE INSURER/INSURANCE INTERMEDIARY/ SALES EMPLOYEE.

D. INFORMATION TO BE SUPPLIED TO THE POLICYHOLDER DURING THE TERM OF THE INSURANCE CONTRACT.

Introduction

This notice is designed to highlight some important details about the plan and, along with the AIB Life Term Cover booklet, is meant to be a guide to help you understand your plan. Full details on the specific benefits and options that apply to you will be contained in your plan schedule (or certificate of membership, if applicable), Terms and Conditions Booklet and personalised customer information notice which you will receive when the contract is in place. It is important that you should read these carefully when you receive them as certain exclusions and conditions may apply to the benefits and options you have selected.

Any Questions?

If you have any questions on the information included in this customer information notice you should contact your AIB Financial Adviser or your insurer Irish Life, who will deal with your enquiry at our AIB service team, Irish Life, Lower Abbey Street, Dublin 1.

A. INFORMATION ABOUT THE POLICY

1. MAKE SURE THE POLICY MEETS YOUR NEEDS!

The AIB Life Term Cover plan is a regular payment term assurance plan. The plan provides protection benefits only i.e. life cover, specified illness cover and also a number of optional protection benefits over a fixed term. If you opt for the indexation option the level of benefits will automatically increase each year. The payment you make will also increase each year. Currently, the rate of increase for benefits is 5% each year and the rate of increase for the payment is 8% each year.

You are entering into a commitment to make a regular payment over a relatively long term. Unless you are fully satisfied as to the nature of this commitment having regard to your needs, resources and circumstances, you should not enter into this commitment.

Your AIB Financial Adviser must indicate whether paragraph a) or paragraph b) below applies.

- a. This plan replaces in whole or in part an existing plan with Irish Life, or with another insurer. Your AIB Financial Adviser will advise you as to the financial consequences of such replacement and of possible financial loss as a result. You will be asked at the beginning of your application form to confirm this in writing. Please ensure that you have completed this section of the form and that you are satisfied with the explanations provided by your AIB Financial Adviser before you complete the rest of the application form.

- b. This plan does not replace in whole or in part an existing plan with Irish life or with any other insurer.

2. WHAT HAPPENS IF YOU WANT TO CASH IN THE POLICY EARLY OR STOP PAYING PREMIUMS?

The plan does not acquire a cash or surrender value at any stage.

If you stop making payments, all cover under the plan will end and we will not refund any of your payments.

3. WHAT ARE THE PROJECTED BENEFITS UNDER THE POLICY?

The following payment and benefit details are for a typical AIB Life Term Cover plan. The figures will obviously vary based on each individual's personal details and choice of protection benefits. The figures below are based on the following details.

Protection Benefits: Life cover of €120,000

Accelerated specified illness cover of €120,000
Cover is on a dual life basis.

Lives Covered: Male, non-smoker aged 38 next birthday
Female, non-smoker aged 37 next birthday.

Payments: €113.52 per month payable by direct debit. This plan has guaranteed cover again. No indexation option has been selected.

Term: The term of the plan is 19 years.

The plan provides protection benefits up until the expiry date of the plan. The plan does not acquire a cash or surrender value at any stage.

ILLUSTRATIVE TABLE OF PROJECTED BENEFITS AND CHARGES

	A	B	C	D	$E = A + B - C - D$
Year	€	€	€	€	€
	Total amount of premiums paid into the policy to date	Projected investment growth to date	Projected expenses and charges to date	Projected cost of protection benefit to date	Projected policy value before payment of taxation
1	1,362	0	702	660	0
2	2,724	0	1,356	1,369	0
3	4,087	0	1,959	2,128	0
4	5,449	0	2,507	2,942	0
5	6,811	0	2,993	3,818	0
6	8,173	0	3,411	4,762	0
7	9,536	0	3,756	5,780	0
8	10,898	0	4,018	6,880	0
9	12,260	0	4,186	8,074	0
10	13,622	0	4,251	9,372	0
11	14,985	0	4,251	10,734	0
12	16,347	0	4,251	12,096	0
13	17,709	0	4,251	13,458	0
14	19,071	0	4,251	14,821	0
15	20,434	0	4,251	16,183	0
16	21,796	0	4,251	17,545	0
17	23,158	0	4,251	18,907	0
18	24,520	0	4,251	20,270	0
19	25,883	0	4,251	21,632	0

The payment made through the term of the plan includes the cost of the protection benefits, and all charges, expenses, intermediary remuneration and sales remuneration associated with your plan. It does not include any government levies that may be payable.

The charges shown in column C include the cost of intermediary/sales remuneration incurred by Irish Life, as described in section 4.

The premiums shown in column A do not include the government levy.

4. WHAT INTERMEDIARY/SALES REMUNERATION IS PAYABLE?

The level of intermediary/sales remuneration shown is based on the typical plan outlined in section 3 above. The figures will vary based on the exact plan details in each case. Figures for your specific plan details will be shown in your welcome pack.

ILLUSTRATIVE TABLE OF INTERMEDIARY/SALES REMUNERATION

Year	€	€
	Premium payable in that year	Projected total intermediary / sales remuneration payable in that year
1	1362	1526
2	1362	0
3	1362	477
4	1362	0
5	1362	0
6	1362	477
7	1362	41
8	1362	41
9	1362	41
10	1362	41
15	1362	41
19	1362	41

The projected intermediary/sales remuneration shown above includes the costs incurred by Irish Life in relation to the provision of sales advice, service and support for the plan. These costs are included in the plan charges set out in column C of the illustrative table of projected benefits and charges in section 3.

5. ARE RETURNS GUARANTEED AND CAN THE PREMIUM BE REVIEWED?

The payment is guaranteed to provide protection cover for a fixed term, assuming no changes to your payment or benefits (other than indexation increases).

6. CAN THE POLICY BE CANCELLED OR AMENDED BY THE INSURER?

We may cancel your plan if you stop making payments.

You must provide any information or evidence which we need to administer the plan.

If we receive evidence that your date of birth as shown on your application form is incorrect, we will adjust the benefits appropriately.

We may end your cover and refuse to pay a claim if you do not give us information (or if you give us incorrect information) regarding an illness or condition that will affect our assessment of your application for this plan. If that information is not true and complete or if we do not receive all relevant information, we may end your cover and refuse to pay any claim.

If this happens you will lose all rights under the plan and we will not refund your payments. Relevant information includes anything that a reputable insurer might regard as likely to influence the assessment and acceptance of your application. We will provide a copy of the information you gave us in your application or any other forms that you have filled in for us if you ask.

7. INFORMATION ON TAXATION ISSUES

Under current law (April 2012), tax does not usually have to be paid on life cover or specified illness cover benefits, but in some circumstances tax may be due. For example, if the life cover is paid to your estate, your beneficiaries may have to pay inheritance tax (there is no inheritance tax due on an inheritance between a married couple or registered civil partners).

Any taxes or levies imposed by the government will be collected by Irish Life and passed directly to the Revenue Commissioners.

Where the plan is owned by a company or where payments are made by anyone other than the legal owner of the plan, for example from a company or business account, there may be tax implications. In these circumstances we recommend that a financial adviser be consulted regarding any possible taxation implications.

Please contact your AIB Financial Adviser or Irish Life if you do not fully understand the likely tax treatment of any benefits payable in connection with your AIB Life Term Cover plan.

8. ADDITIONAL INFORMATION IN RELATION TO YOUR POLICY

WHAT ARE THE BENEFITS AND OPTIONS PROVIDED UNDER THIS PLAN?

You may select benefits from the following options in order to meet your particular needs.

LIFE COVER

We will pay the life cover you select plus any increases due to indexation in the event of the death of one of the lives covered during the term of the plan. If there is more than one life covered, this benefit can be paid on the death of either or both of the lives covered. If, at any stage, you choose to reduce your benefits and payments, the amount we pay in the event of death will be reduced accordingly.

INDEPENDENT SPECIFIED ILLNESS COVER

If this benefit applies we will pay the independent specified illness cover plus any increases due to indexation if either, or both, of the lives covered is diagnosed during the term of the plan as having one of the 38 specified illnesses listed in the Terms and Conditions Booklet, and survives for a certain period after having the surgery or being diagnosed as having any of the conditions covered. If one or more of those illnesses or conditions is not covered, this will be referred to in the plan schedule (or certificate of membership, if applicable).

No other illnesses or conditions are covered.

Independent specified illness cover is not payable in the case of death.

If, at any stage, you choose to reduce your benefits and payments, the amount we pay in the event of illness will be reduced accordingly.

ACCELERATED SPECIFIED ILLNESS COVER

If this benefit applies we will pay the accelerated specified illness cover plus any increases due to indexation if either, or both, of the lives covered is diagnosed during the term of the plan as having one of the 38 specified illnesses listed in the Terms and Conditions Booklet. If one or more of those illnesses or conditions is not covered, this will be referred to in the plan schedule (or certificate of membership, if applicable).

No other illnesses or conditions are covered.

The amount of life cover for a person will be reduced by the amount of any accelerated specified illness cover payment.

If, at any stage, you choose to reduce your benefits and payments, the amount we pay in the event of illness will be reduced accordingly.

PARTIAL PAYMENT ILLNESS BENEFIT

If specified illness cover applies, as well as the 38 specified illnesses mentioned above, we will pay €15,000 (or 50% of your specified illness cover amount, whichever is lower) if you are diagnosed with

one of 13 other illnesses. It is separate from your main specified illness benefit. The total amount we will pay through partial payments is limited to the amount of your specified illness cover as shown on your plan schedule (or your certificate of membership, if applicable). You are only allowed to claim once for each of the 13 illnesses. For details, please see your Terms and Conditions booklet.

HOSPITAL CASH COVER

We will pay the hospital cash cover daily benefit shown on your plan schedule (or certificate of membership, if applicable) plus any increases due to indexation if either of the lives assured are in hospital for more than 72 hours in a row (3 days). Each of the lives assured are covered for a maximum of 365 days in total over the duration of the plan.

Hospital cash cover ends on the policy anniversary before your 60th birthday if this is before the end of your plan.

CHILDREN'S HOSPITAL CASH COVER

If hospital cash cover applies we will pay 25% of each parent's benefit if your child (over the age of one and under the age of 21) is in hospital for more than 72 hours in a row (3 days). This benefit doubles after 14 consecutive days if the child is still in hospital. They are covered for a maximum of 365 days in total over the duration of the plan.

ACCIDENT COVER

If this benefit applies we will provide a specified cash payment if either of the lives covered are unable to work as a direct result of an injury sustained in an accident. We will pay the benefit from the start of the third week out of work until that person is fit enough to return to work. Throughout the term of the plan we will pay a maximum of 52 weeks benefit. Where either of the lives covered suffers one of 10 named fractures or 4 dislocations we will immediately pay a fixed number of weeks benefit. The maximum we will pay is 40% of your gross earnings less any similar insurance either of the lives covered may have.

Accident cover ends on the policy anniversary before your 60th birthday if this is before the end of your plan.

ACCIDENTAL DEATH BENEFIT

This is an automatic additional benefit. We will pay the death benefit (to a maximum of €150,000) on accidental death between the time the application is received by Irish Life (together with a completed direct debit) and the earlier of the following:

- the day of the final underwriting decision if terms are being offered
- the day of the underwriting decision if we are declining or postponing cover
- 30 days from the date we receive the application

For this benefit, "Accidental Death" means death caused solely and directly as a result of an accident caused by violent, visible and external means and independently of any other cause.

There are the following restrictions:

- The benefit payable is subject to the lower of the life sum assured or €150,000
- The benefit is subject to a maximum entry age of 55
- Exclusions apply around the nature of the death e.g. suicide or intentional self-inflicted injury causing death are excluded. There are further details of the exclusions in the terms and conditions booklet.

We will only pay once under Accidental Death Benefit in respect of any life, regardless of the number of plans or applications a person has with Irish Life.

GUARANTEED COVER AGAIN

This valuable option allows you to take out another Irish Life protection plan with the same level of cover provided under this plan, without having to provide medical evidence. This option can be exercised at any time before the expiry date of the relevant benefit, subject to the plan conditions and the benefits we offer at that time. To avail of this option you must apply in writing before the expiry date. This option will apply to a maximum life cover sum assured of €5,000,000 and a maximum specified illness cover sum assured of €1,000,000. The cost of the new plan will be based on

terms applying at that time. This option ceases if the plan has been cancelled for any reason before the expiry date e.g. as a result of not making payment or the payment of a benefit.

GUARANTEED INSURABILITY OPTION

This is an automatic additional benefit. If cover has not ended, you can ask us to set up a new Life Term Cover plan for the lesser of::

- 50% of your life and/or specified illness cover benefit; or
- €125,000

without having to provide evidence of health, within three months of:

- being granted a new mortgage or an increase in an existing mortgage (the increase in cover cannot be higher than the mortgage or increase in mortgage), where the new or increased mortgage arises from a move to a new house or significant improvements to the existing house. The mortgage must be drawn down.
- getting married; or
- having or adopting a child; or
- an increase in the life insured's salary, as a result of a change in job or getting a promotion. In this instance, the percentage increase in the sum assured is limited to the percentage increase in salary. Your employment status must be employee / employed.

This is not available where your employment status is self-employed, company director or partner.

You must be aged 55 or under in order to exercise this option.

The maximum number of times you may exercise this option is twice.

You will need to provide independent proof of the mortgage, marriage, birth, adoption or salary increase before we can set up a new plan. You must ask for a new plan under this paragraph within three months of the marriage, birth, adoption or salary increase, or the date of the mortgage drawdown. Please refer to your Terms and Conditions booklet for more details.

If you want to take out additional specified illness cover, you must take out the plan before the specified illness cover benefit comes to an end.

WHAT IS THE TERM OF THE CONTRACT?

The plan provides protection benefits for a fixed term. The specified illness cover may stop before the end of your plan term. Specified illness cover cannot continue past the policy anniversary before your 75th birthday.

ARE THERE ANY CIRCUMSTANCES UNDER WHICH THE PLAN MAY BE ENDED?

We may cancel your plan if you stop making payments.

IS THERE AN OPPORTUNITY TO CHANGE YOUR MIND?

You have an opportunity to cancel this plan if you are not satisfied that the benefits meet your needs. You may do this by writing to our AIB service team at Irish Life within 30 days of the date we send you the details of your plan. On cancellation all benefits will cease and Irish Life will refund your payments.

LAW APPLICABLE TO YOUR PLAN

Irish Law governs the plan and the Irish Courts are the only courts that are entitled to settle disputes.

WHAT TO DO IF YOU ARE NOT HAPPY OR HAVE ANY QUESTIONS?

If for any reason you feel that this plan is not right for you, or if you have any questions, you should contact AIB service team, Irish Life, Lower Abbey Street, Dublin 1 who will deal with your enquiry. Our AIB service team also operate an internal complaints procedure and any complaints you may have will, in the first instance, be fully reviewed by them. If you feel we have not dealt fairly with your complaint, you should contact the Financial Services Ombudsman at 3rd Floor, Lincoln House, Lincoln Place, Dublin 2.

B. INFORMATION ON SERVICE FEE

There are no charges payable to Irish Life other than those set out in your table of benefits and charges and in your Terms and Conditions booklet.

C. INFORMATION ABOUT THE INSURER/INSURANCE INTERMEDIARY/SALES EMPLOYEE

INSURER

The AIB Life Term Cover plan is provided by Irish Life Assurance plc, a company authorised in Ireland. Irish Life Assurance plc is regulated by the Central Bank of Ireland. You can contact us at AIB service team, Irish Life, Lower Abbey Street, Dublin 1, by telephone at 1890 719 390, by fax at 01 7041900, and by e-mail at aibserviceteam@irishlife.ie. In the interest of customer service, Irish Life will record and monitor calls.

INSURANCE INTERMEDIARY

The AIB Financial Adviser should insert details of their name, legal status, their address for correspondence and a contact telephone number/fax number or e-mail address and where relevant, the companies with whom agencies are held.

Allied Irish Banks, p.l.c. is a tied agent of Irish Life Assurance plc for life and pensions business.

Allied Irish Banks, p.l.c. and Irish Life Assurance plc are regulated by the Central Bank of Ireland.

Allied Irish Banks, p.l.c., Bankcentre, Ballsbridge, Dublin 4.

Telephone: 01 660 0311

Email: aibserviceteam@irishlife.ie

No delegated or binding authority is granted by Irish Life to your AIB Financial Adviser in relation to underwriting, claims handling or claims settlement.

D. INFORMATION TO BE SUPPLIED TO THE POLICYHOLDER DURING THE TERM OF THE INSURANCE CONTRACT

We at Irish Life are obliged by law to tell you if any of the following events occurs during the term of your contract:

- we change our name;
- our legal status changes;
- our head office address changes;
- an alteration is made to any term of the contract which results in a change to the information given in paragraph A(8) of this document.



We all want to do our bit for the environment. That's why AIB has created 'Add more green', a range of environmentally-friendly initiatives that will help us and our customers create a greener world. Even something as simple as signing up for eStatements can make a huge difference. Find out how you can help add more green at www.aib.ie/csr

Terms and conditions apply. If you have any questions, please contact your AIB Financial Adviser in your local branch or call the AIB service team at Irish Life on 1890 719 390. In the interest of customer service, Irish Life will record and monitor calls. Irish Life Assurance plc, Registered in Ireland number 152576, Vat number 9F55923G.



Allied Irish Banks, p.l.c. is a tied agent of Irish Life Assurance plc, for life and pensions business.
Allied Irish Banks, p.l.c. and Irish Life Assurance plc are regulated by the Central Bank of Ireland.

