**IMPACT Life Assurance and Critical Illness Insurance**

The policy is provided for you as a member of IMPACT to help protect against the effect of death or critical illness on you or your family.

The policy will cover you and your spouse if either of you die whilst you are a member of IMPACT or if you are diagnosed with one of the critical illnesses defined in this summary.

Subject to receiving satisfactory proof that a claim is covered under the policy, The Underwriter will pay the amount of EUR 5,000

**Definitions**

**Member**

A person who has current membership of IMPACT.

**Spouse**

Either:

- An eligible member’s partner in marriage or;
- An eligible member’s partner under a civil registered partnership or;
- Where an eligible member has been co-habiting with a partner for a minimum of 2 years.

**The Underwriter**

Tokio Marine Kiln which is the trading name of Tokio Marine Kiln Insurance Limited (Registered Number 989421) and Tokio Marine Kiln Syndicates Limited (Registered Number 729671). Tokio Marine Kiln are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

**Who is covered?**

Eligible members of IMPACT who are under the age of 66 and have been a member of IMPACT for a continuous period of 6 months.

Spouses of members of IMPACT who are under the age of 66

**Who is not covered?**

Members of IMPACT over the age of 65

Spouse of members of IMPACT who are over the age of 65

**What is covered?**

The death of a member of IMPACT.

The death of a Spouse of a member of IMPACT.

The critical Illness of a member of IMPACT.

**How long am I covered for?**

You will be covered as long as you remain a member of IMPACT and have not reached the age of 66.
How do I claim?

All claims and correspondence relating to claims should be addressed to:
Keaney Insurance Brokers Limited
30, Lower Leeson, Street, Dublin 2
Telephone: 01-661-8080
In the event of a claim in respect of a Spouse the Underwriter will require;

- Evidence of a joint bank account at the same address or
- Evidence of a joint mortgage or rental agreement at the same address or
- A utility bill showing both names at the same address or
- Correspondence acceptable to The Underwriter showing residence at the same address.

Claims must be made within 3 years of the date of death or diagnosis

Data Protection

The Underwriter has a Confidentiality Policy in place in accordance with The Data Protection Act 1998 which means that personal data is held securely and access is limited to authorised individuals who need to see it.

What if I have a query regarding the policy?

In the event of any query regarding this policy you should contact
Keaney Insurance Brokers Limited
30, Lower Leeson, Street, Dublin 2
Telephone: 01-661-8080

What if I need to complain about the policy?

Any complaint regarding the handling of this policy should initially be addressed to:
The Compliance Officer
Tokio Marine Kiln Syndicates Limited
20 Fenchurch Street
London
EC3M 3BY.

In the event that this proves unsatisfactory, written representation should be made to:

Policyholder & Market Assistance Lloyd’s Market Services,
One Lime Street,
London EC3M 7HA
Telephone: +44 (0)207 327 5693
Fax: +44 (0)207 327 5225
E-mail: complaints@lloyds.com

If your complaint remains unresolved, you may be entitled to refer it to the Financial Services Ombudsman, whose address is:

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

These arrangements for the handling of complaints are entirely without prejudice to a complainant’s rights in Irish law, and you are free at any stage to seek legal advice and take legal action.
FINANCIAL SERVICES COMPENSATION SCHEME
Lloyd's Insurers are covered by the Financial Services Compensation Scheme. You may be entitled to compensation from the Scheme if a Lloyd's Assurer is unable to meet its obligations to you under this contract. If you were entitled to compensation under the Scheme, the level and extent of the compensation would depend on the nature of this contract. Further information about the Scheme is available from the Financial Services Compensation Scheme (10th Floor, Beaufort House, 15, St Botolph Street, London, EC3A 7QU) and on their website (www.fscs.org.uk).
**CRITICAL ILLNESS**

The Underwriter will pay the Critical Illness Benefit to the Assured if an Eligible Member is diagnosed as suffering from or undergoes any one of the Medical Events as defined below, subject to the terms, conditions and exclusions herein. All diagnoses and medical opinions must be given by a medical specialist who:

- is a resident and a practising qualified doctor in any member country of the European Union, Australia, Canada, Channel Islands, Cyprus, Gibraltar, Iceland, Isle of Man, Malta, New Zealand, Norway, Switzerland, or the United States of America.
- is acceptable to our Chief Medical Officer; and
- is a specialist in an area of medicine appropriate to the cause of the claim.

**PROVIDED ALWAYS THAT** the Benefit provided by this Insurance shall be limited to the Benefit stated in the Schedule, and payment of such Benefit for any cause shall constitute a full discharge of the Underwriter’s liability under this Insurance to the extent of the amount of Benefit paid.

The Underwriter will pay the full amount of Death Benefit if the Member dies while this Insurance is in force, provided that a claim for Critical Illness Benefit has not already been paid.

If the Critical Illness Benefit has already been paid, the Underwriter’s liability in the event of subsequent death will be limited to the difference between the Death Benefit specified on the Schedule and the Critical Illness Benefit already paid.

**Summary of Illnesses Covered**

1. Cancer
2. Coronary artery bypass grafts
3. Heart attack
4. Kidney failure
5. Major organ transplant
6. Stroke
7. Loss of Limb
8. Blindness

**PLEASE READ FULL DEFINITIONS OF THESE ILLNESSES BELOW.**

**When does cover cease?**

Members shall cease to be covered under this Insurance once

- they reach age 66
- they leave the membership of the Assured
- they are paid a Critical Illness benefit under the plan or
- they die

whichever is the earliest.
**Does medical information have to be provided?**

There is no medical information required from Eligible Members before being covered. Normally all applicants for Critical Illness cover must complete an application form describing their past medical and family history. This is a screening process that invariably results in approximately 5% of all applicants being refused cover and a further 5% getting limited cover or cover subject to a substantial additional charge. As this process will not apply to this, the Underwriter have had to put three sets of provisions in place relating to what are known as ‘pre-existing conditions’ which should be noted.

**Pre-existing Conditions**

1. Where a Member has previously suffered, at any time prior to the commencement date of cover, from one of the Critical Illnesses covered they will never be covered for that Illness and cannot therefore claim for that Illness. For example, if they contracted cancer in 1990 they can never claim under cancer. In the example of cancer, however, they are covered for the remaining Critical Illnesses.

   In addition, because of the links between heart attack, stroke, coronary artery surgery, angioplasty and heart transplant, if they have ever suffered from or undergone one of the above prior to the commencement date of cover, they can never claim for heart attack, coronary artery bypass grafts, major organ transplant or stroke. For example, if they underwent coronary artery surgery in 1992, they will never be covered for and cannot claim in respect of heart attack, stroke, or coronary artery bypass grafts or heart transplant. They are, however, covered for the remaining Illnesses.

2. In the event of one of the Critical Illnesses covered occurring within two years of the commencement date of their cover, they will not be paid a claim for a particular Illness, and cover for that Illness will cease, if prior to the commencement date of their cover they suffered from one of a number of related conditions which are set out below for each Illness under "pre-existing conditions".

   For example, a claim would not be paid, and cover for kidney failure will cease, in the event of kidney failure occurring in the first two years of cover, if prior to the commencement date of cover they had suffered from polycystic kidney disease. Similarly, a claim would not be paid, and cover for heart attack will cease, in the event of a heart attack occurring in the first two years of cover, if prior to the commencement date of cover they had suffered from diabetes.

   It should be noted that the second set of provisions only arise if the event occurs within the first two years of cover. Thus a diabetic who first suffers a heart attack three years after the commencement date of cover will be eligible to claim.

3. No cancer claims will be paid where the condition presents within the first six months of joining the Assured; that is, during the six month waiting period before the Member becomes Eligible for cover after joining the Assured. In such circumstances Critical Illness cover in respect of cancer ceases.

**Explanation of each Critical Illness and its pre-existing conditions**

This section outlines the policy definition of the Critical Illnesses that are covered under the Insurance, a brief simple explanation of each Illness, and information on the related conditions that preclude cover in the event of Assured Illnesses occurring within the first two years of cover. These should be read in conjunction with paragraph 1 and 2 of Pre-existing Conditions.
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, lymphoma and sarcoma.

For the above definition, the following are not covered:

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

- All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 (i.e. Gleason score 7 or above only) or having progressed to at least clinical TNM classification T2N0M0.

- Chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A.

- Any skin cancer, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin) i.e. >=Clarks level 2.

- Basal Cell Carcinomas of the skin, as they are non-malignant.

- Squamous Cell Carcinomas of the skin unless they have spread to the lymph nodes or metastasised (spread to another part of the body).

- Any bladder cancer unless histologically classified as having progressed to at least TNM classification T2N0M0

- 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.

No cancer claims will be paid where the condition presents within the first six months of a Member joining the plan. In such circumstances cover in respect of cancer ceases.

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 we specifically do not cover the type of cancer or tumour. 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 carried out on tissue removed during surgery or by biopsy (a procedure to remove a sample of the tumour for examination).
We do not cover cancers ‘in situ’ (cancers in a very early stage that have not spread in any way to neighbouring tissue) or premalignant and non-invasive tumours. 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 Critical Illness cover against these early prostate cancers. We will not pay a claim for prostate cancer under this definition of cancer unless the tumour has a Gleason score (a method of measuring differentiation in cells) of greater than 6 (in other words, a Gleason score of 7 or above) or it has progressed to at least clinical classification of T2N0M0. 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 what it looks like under a microscope.

We will cover leukaemia (cancer of the white blood cells) and Hodgkin’s disease (a type of lymphoma). However, for us to cover a claim for chronic lymphocytic leukaemia, it must have progressed to Binet Stage A. (Binet Stage A is where there is no anaemia, no thrombocytopenia and fewer than three areas of enlarged nodes.)

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 forms of skin cancer that we cover are malignant melanoma which has been classified as being a ‘Clark level 2’ or greater, and squamous cell carcinoma which has spread to the lymph nodes or metastasised (spread to another part of the body). 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 (using heat to treat body tissues with high-frequency electromagnetic currents). The outlook for patients with these superficial bladder cancers is very good. The TNM classification system is internationally recognised and used as a way of measuring a tumour. The ‘T’ part relates to the primary tumour and is graded on a scale of 1 to 4. T1 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’ parts of TNM.

Pre-existing conditions:

If you have been diagnosed with cancer or ductal carcinoma in situ of the breast prior to the commencement date of your cover, you can never claim for Critical Illness benefit for cancer.

If you have a history of carcinoma in situ, Bowens disease, familial polyposis of the colon, Hodgkin’s disease, leukoplakia, Barrett’s oesophagus, ulcerative colitis or Crohn’s disease prior to the commencement date of your cover and you are found to have cancer within the first two years of your cover, no Critical Illness benefit will be payable and you will cease to be covered for cancer.
Coronary artery bypass 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:

You may need coronary artery surgery 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 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 techniques used, such as angioplasty or laser relief.

Ischaemic heart disease happens if there is inadequate blood flow through the coronary arteries to the heart due to a build-up of fatty materials (such as cholesterol) in the artery walls.

Pre-existing conditions

If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of your cover you can never claim for Critical Illness benefit under heart attack, coronary artery bypass grafts, major organ transplant or stroke.

If you have a history of coronary artery disease, aneurysm, atrial fibrillation, cardiomyopathy, diabetes mellitus, peripheral vascular disease, hypertension, hypercholesterolaemia, tachycardia or valvular heart disease, prior to the commencement date of cover and you require coronary artery bypass grafts within the first two years of your cover, no Critical Illness benefit will be payable and you will cease to be covered for coronary artery bypass grafts.
Heart attack – of Critical 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:

- 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
  - AccuTnI > 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 you have had a heart attack.

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 bloodstream from the damaged heart muscle) and new ECG changes typical of a heart attack.

Pre-existing conditions

If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of your cover, you can never claim for Critical Illness Benefit under heart attack, coronary artery bypass grafts, major organ transplant or stroke.

If you have a history of aneurysm, atrial fibrillation, cardiomyopathy, coronary artery disease, diabetes mellitus, peripheral vascular disease, hypertension, hypercholesterolaemia, tachycardia or valvular heart disease prior to the commencement date of cover and you suffer a heart attack within the first two years of your cover, no Critical Illness benefit will be payable and you will cease to be covered for heart attack.
Kidney failure – requiring ongoing dialysis

Plan definition:

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

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 permanently and you need regular long-term dialysis or a kidney transplant.

Pre-existing conditions:

If you have ever been diagnosed with kidney failure prior to the commencement date of your cover, you can never claim for Critical Illness benefit for kidney failure.

If you have a history of diabetes mellitus, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, hypertension, paraplegia or pre-existing renal impairment with raised serum creatinine prior to the commencement date of cover and you suffer kidney failure within the first two years of cover, no Critical Illness benefit will be payable and you will cease to be covered for kidney failure.
Major organ transplant – Critical 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 a procedure as listed.

For the above definition, the following are 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 you could be on a waiting list for a long period waiting for a suitable organ. We also cover bone-marrow transplants.

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

Pre-existing conditions

If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplasty, heart transplant or any other major organ transplant prior to the commencement date of cover you can never claim for Critical Illness benefit under heart attack, coronary artery bypass grafts, major organ transplant or stroke.

If you have a history of the following:

- Heart conditions - congestive cardiac failure, cardiomyopathy, coronary artery disease, left ventricular failure, hypertensive heart disease, any congenital or acquired structural cardiac abnormalities, ischaemic heart disease
- Lung conditions - cystic fibrosis, fibrosing alveolitis (cryptogenic and allergic), pulmonary fibrosis, emphysema, chronic bronchitis, chronic asthma
- Liver conditions – liver failure, any type cirrhosis, hepatitis B or C, liver tumours, alcohol abuse, sclerosing cholangitis, Budd-Chiara syndrome
- Blood disorders - leukaemia, aplastic anaemia, thalassaemia major, immune deficiency disease, sickle cell anaemia, myeloproliferative disease (polycythaemia vera, thrombocythaemia), neutropenia
- Inflammatory disorders - systemic lupus erythematosus, sarcoidosis, pancreatitis
- Metabolic disorders - diabetes mellitus, haemochromatosis, Wilson’s disease

prior to the commencement date of your cover and you are placed on an official waiting list for or require major organ transplant within the first two years of your cover, no Critical Illness benefit will be payable and you will cease to be covered for major organ transplant.
Stroke – resulting in permanent symptoms

Plan definition

The 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 Assured 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

In simpler terms

The brain controls all the functions of the body. 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 or TIAs), where there is a short-term interruption of the blood supply to part of the brain. The main symptoms of TIAs tend to be dizziness and temporary weakness or loss of sensation in part of the body or face.

Pre-existing conditions

If you have ever suffered from a heart attack or stroke or undergone coronary artery surgery, angioplasty or heart transplant prior to the commencement date of your cover you can never claim for Critical Illness under heart attack, coronary artery bypass grafts, major organ transplant or stroke.

If you have a history of intracranial aneurysm, atrial fibrillation, coronary artery disease, diabetes mellitus, peripheral vascular disease, hypercholesterolaemia, transient cerebral ischaemia, hypertension, arteriovenous malformation, thrombotic disorders e.g., primary phospholipid syndrome, hyperviscosity states (polycythaemia), heart valve disease and carotid atherosclerosis prior to the commencement date of cover and you suffer a stroke within the first two years of cover, no Critical Illness benefit will be payable and you will cease to be covered for stroke.
Loss of limb – permanent physical severance

Plan definition

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

To qualify for payment, the loss of limb must happen after the start date of the plan and before cover ends.

In simpler terms:

You will be able to claim if you have lost one 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.

Pre-existing conditions:

If you have previously suffered the loss of one or more limbs prior to the commencement date of your cover, you can never claim for Critical Illness benefit for Loss of limb.

If you have a history of peripheral vascular disease or diabetes mellitus prior to the commencement date of cover and you suffer the loss of a limb within the first two years of your cover, no Critical Illness benefit will be payable and you will cease to be covered for Loss of limb.
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.

To qualify for payment, blindness must happen on a date after the start date of the plan and before cover ends.

In simpler terms:

You can claim only if you have permanent loss of sight with no possibility of improvement in both eyes and even if, using glasses or other visual aids, your 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. An optician uses a Snellen chart (made up of rows of letters) to test your eyesight. 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 confirmed by an eye specialist) even though the loss of sight may only be partial. Even if you are ‘registered blind’, we will only pay your claim if the loss of sight meets the definition above and cannot be corrected.

Pre-existing conditions:

If you are diagnosed with loss of sight as described above prior to the commencement date of your cover, you can never claim for Critical Illness benefit for blindness.

If you have a history of diabetes mellitus, glaucoma, severe myopia, congenital nystagmus, retrobulbar or optic neuritis, retinitis pigmentosa, multiple sclerosis or hysteria prior to the commencement date of cover and you become blind within the first two years of your cover, no Critical Illness benefit will be payable and you will cease to be covered for blindness.