SUTTON

SPECIAL RISK

MANDATORY CRITICAL ILLNESS INSURANCE

FOR

UCCM Anishnaabe Police

POLICY NUMBER 056CI/031834A

This booklet contains important information and should be kept in a safe place known to you and your family.

This program is exclusively offered through Williams Leal & Vito Inc.

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SCHEDULE OF BENEFITS

GROUP POLICY NUMBER:	056CI/031834A
GROUP POLICYHOLDER:	UCCM Anishnaabe Police
CURRENCY:	All dollar values expressed in this Group Policy will be payable in Canadian currency

CLASSES OF ELIGIBLE PERSONS

Insured Persons under age 70 working a minimum average of 20 hours per week as classified below:

Class Number	Class Description	Waiting Period
1	All active Members in good standing residing in Canada and covered by a provincial government health insurance plan who are under age 70.	None

MEMBER MANDATORY CRITICAL ILLNESS INSURANCE

Benefit Amount:

Member: $10,000

Non-Evidence Benefit Maximum:

Member: $10,000

Psychological Therapy Benefit Maximum:

Maximum for Member: $1,000 for each covered Critical Illness each covered Critical Illness

DEFINITIONS

ACCIDENT means a single sudden and unexpected event, which:

a) occurs at an identifiable time and place;
b) causes unexpected bodily Injury at the time it occurs; and
c) arises from an external source to the Insured Person.

ACTIVELY AT WORK means an Member capable of working and present at the place of work to carry out normal duties in accordance with the Member's regular work schedule, on vacation or on a leave approved by the Employer.

ADMINISTRATOR means Sutton Special Risk Inc.

BENEFIT AMOUNT means the insurance benefits provided in the Group Policy as shown in the Schedule of Benefits.

CRITICAL ILLNESS means an illness, disorder or Surgery which is specifically covered and defined herein and which is not specifically excluded. See Insured Member Critical Illness Conditions Definitions and Limitations for definitions of Critical Illness conditions.

DATE OF DIAGNOSIS means the date of first Diagnosis of a covered Critical Illness. The Date of Diagnosis must be after the Insured Person's effective date of coverage or after the date of the most recent reinstatement of coverage and while the Group Policy is in force.

DIAGNOSIS means the certified diagnosis of a covered Critical Illness condition by a Specialist. In the absence or unavailability of a Specialist, and as approved by the Insurer, a Critical Illness condition may be diagnosed by a qualified medical Physician practicing in Canada, the United States, or in such other jurisdiction as the Insurer may approve.

DISEASE means any unhealthy condition of the body or any part thereof.

EVIDENCE means evidence deemed satisfactory by the Insurer to confirm a particular state or condition.

GROUP POLICY means this Critical Illness Group Insurance Policy.

GROUP POLICY ANNIVERSARY DATE means the first anniversary of the Group Policy Effective Date and each anniversary thereafter.

HOSPITAL means an institution that:

1) operates as a hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons; is a duly licensed institution, operated lawfully in its area;

2) provides 24-hour nursing service by registered nurses on duty or call;

3) has a staff of one or more licensed Physicians available at all times;

4) provides organized facilities for diagnosis, treatment and surgery, either

a) on its premises; or

b) in facilities available to it, on a pre-arranged basis;

5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a hospital used as such; and

6) is not a facility for the treatment of drug addiction, alcoholism, treatment of the aged.

The term **"Nurse"** as used herein means a graduate registered nurse (R.N.), or a nurse who is licensed to practice nursing services by a governmental agency which has jurisdiction over such licensing. Nurse can neither be the Insured Person himself nor an immediate family member.

INJURY means bodily injury caused solely by an Accident occurring while this Group Policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in Critical Illness covered by this Group Policy, anywhere in the world, but in no event shall injury mean Sickness or Disease howsoever caused unless caused by an Accident.

INSURED MEMBER means a Member who is insured under this Group Policy.

INSURED PERSON means an Insured Member eligible for insurance under this Group Policy, unless otherwise stated.

IRREVERSIBLE means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve undue risk to the Insured Person's health.

LIFE SUPPORT means the Insured Person is under the Regular Care and Attendance of a Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

The term "**Regular Care and Attendance**" means observation and treatment to the extent necessary under existing standards of medical practice for the condition requiring such treatment, disability, or causing Hospital confinement.

MEMBER means an active member in good standing of the Policyholder under the age of 70, who is covered by a provincial government health insurance plan and who resides in Canada.

PHYSICIAN means a person who is a qualified doctor of medicine. As such, he or she must be acting within the scope of his or her license under the laws in the jurisdiction in which he or she practices and providing only those medical services which are within the scope of his or her license or certificate. It does not include an Insured Person or an Insured Person's spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the previous include natural, adopted and step relationships), grandson, granddaughter, grandfather or grandmother or other relative..

SICKNESS means an impairment of normal physiological function and includes illness and infections.

SPECIALIST means a Physician registered and licensed to practice in Canada whose practice is limited to the particular branch of medicine relating to the applicable Critical Illness condition. The specialist must be a person other than the Insured Member or a relative.

SURGERY means that the Insured Person undergoes surgery which is specifically covered and defined herein and is performed on the written advice of a Specialist. The surgery must be performed by a Physician, in Canada, the United States, or in such other jurisdiction as the Insurer may approve. Surgery will include the medical procedure for transplanting bone marrow.

SURVIVAL PERIOD means the period starting on the Date of Diagnosis of the Critical Illness condition and ending thirty (30) days following the Date of Diagnosis of the Critical Illness condition, except where modified elsewhere under the Group Policy. The Survival Period does not include the number of days on Life Support. The Insured Person must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain during that period. The premium is still payable when due during a Survival Period.

ELIGIBILITY FOR INSURANCE

Members belonging to the Classes of Eligible Persons outlined in the Schedule of Benefits shall be eligible for insurance from the date they meet the eligibility requirements outlined in the Insured Person's Effective Date of Coverage Section, provided they are Actively at Work on that date.

Members not Actively at Work on the date on which they would otherwise be eligible for insurance shall become eligible for insurance on the first day of the month following the date of their return to work in a capacity under which they are eligible for insurance.

Participation in the Insurance Plan

For Members eligible for an Employer's mandatory insurance coverage, participation in the insurance plan is required.

INSURED PERSON'S EFFECTIVE DATE OF COVERAGE

MANDATORY INSURANCE

An Insured Person's insurance shall become effective on the date he becomes eligible provided if applicable an application has been received by the Administrator before such date or within the 31 days thereafter, otherwise, coverage becomes effective on the date of acceptance of the Evidence of insurability by the Insurer.

The Insured Person's effective date of coverage shall start at 12:01 a.m. at the address of the Insured Member.

CHANGES IN COVERAGE

The Group Policyholder agrees to notify the Administrator in writing within thirty-one (31) days of an occurrence that takes place affecting the class of insurance or revising the coverage of an Insured Person.

In case of an increase of coverage, the revised coverage shall become effective on the date the Administrator receives the notice from the Group Policyholder. If such notice is not received within the prescribed period, Evidence of insurability shall be required and the revised coverage shall become effective on the date of the acceptance of Evidence of insurability by the Insurer.

In the case of an increase of coverage and in the event that an Insured Member is not Actively at Work on the date on which his class of insurance or his coverage would normally be revised, the revised coverage will not become effective until the effective date of his return to work in the capacity for which the Insured Member is eligible for insurance.

In the case of a decrease of coverage, the revised coverage shall become effective on the date of the occurrence affecting the class of insurance or the coverage.

TERMINATION OF AN INSURED PERSON'S COVERAGE

The insurance of an Insured Person shall terminate on the earliest of:

a) the date the Group Policy terminates;

b) the last day of the month in which the Insured Member ceases to be eligible for insurance or chooses to terminate their coverage;

c) the last day of the month in which the Insured Person ceases to be eligible for insurance;

d) the premium due date following the date the Insured Member ceases to be Actively at Work on account of a leave of absence, lay-off, maternity leave, disability, resignation, or dismissal, except as provided under the Continuation of Individual Coverage or Waiver of Premium Sections;

e) The date on which the Waiver of Premium terminates if the premium is being waived, unless the Insured Member has resumed payment of premium as an Member;

f) the date a Loss of Independent Existence claim has been paid;

g) the date of the Insured Member's death; or

h) the date the Insured Person ceases to be a Canadian resident.

CONVERSION

Conversion to an Individual Insurance Contract is applicable only for an Insured Member.

If, with the exception of the termination of the Group Policy, an Insured Member's insurance coverage is terminated due to:

a) termination of the Insured Members's employment;
b) cessation of eligibility for insurance under this Group Policy; or
c) cessation of a period of total disability after which the Insured Member did not return to work for the Group Policyholder; and

prior to the attainment of age of 65, the Insured Member makes a written application to the Insurer within 31 days of the termination, the Insurer will, without Evidence of Insurability, issue on the life of such Insured Person an individual Critical Illness policy.

The amount of insurance that may be converted will not exceed the Insured Person's amount of insurance in effect on the date of termination and is subject to a maximum of $100,000 for all such conversions with the Insurer.

Premiums for an individual Critical Illness policy being issued in compliance with the aforementioned conditions will be calculated at the Insurer's manual rates then in force for the attained age of the Insured Person at the date of conversion. Premiums will be payable annually in advance and the individual Critical Illness policy will be issued on an annually renewable basis.

CONTINUATION OF AN INSURED PERSON'S COVERAGE

CONTINUATION OF COVERAGE

a) An Insured Member who ceases to be Actively at Work as a result of a Sickness or Injury may continue to be insured while disabled until the earlier of age 65 or until his employment in a class of Members eligible for insurance terminates, provided that the Group Policyholder pays to the Insurer the premium for such Insured Member.

b) An Insured Member who is no longer Actively at Work because of unpaid leave may continue to be insured during such leave until the earlier of age 65 or a maximum period of twelve (12) months of unpaid leave provided the Group Policyholder pays to the Insurer the premium for such Insured Member and within 31 days of the start of such leave the Group Policyholder informs the Administrator of the date such leave is due to end.

c) An Insured Member who ceases to be eligible for insurance on account of a temporary lay-off may continue to be insured during such lay-off until the earlier of age 65 or a maximum period of twelve (12) months of lay-off, provided the Group Policyholder pays the Insurer the premium for such Insured Member. Benefits will continue to apply in the same manner as if there had not been a temporary lay-off. The total premium is payable for the month during which the temporary lay-off began and is payable during the other months while the absence from work resulting from a temporary lay-off is continued.

d) An Insured Member who is no longer Actively at Work as a result of being suspended may continue to be insured while suspended until the earlier of age 65 or a maximum period of twelve (12) months of suspension provided the Group Policyholder pays to the Insurer the premium for such Insured Member.

e) An Member who at the very beginning of an unpaid leave, disability, suspension or lay-off does not continue to be insured for any reason under the provisions of items (a), (b), (c) or (d) above, cannot be insured thereafter.

f) The Group Policyholder must forward to the Administrator each month a list showing the name and the Group Policy number of Insured Members who are on unpaid leave, disability, suspended and laid-off and of Insured Members who are returning to work, specifying the date in each case.

EXTENSION OF COVERAGE

Coverage under this Group Policy may be continued for a period of up to twelve (12) months for an Insured Person whose employment has been terminated by the Group Policyholder provided such continuation of coverage is:

a) required by the Employment Standards Act, or

b) by a severance package agreement received by the Insured Person from the Group Policyholder and payment of premiums is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first day of the month following either the completion of the 12-month period or the date the Insured Person returns to work in any capacity, whichever is earlier.

The coverage which is continued under this clause will be subject to the terms and provisions of this Group Policy as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained in this Group Policy, in no event will benefits payable for any claim which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to the Insured Person at the date of termination of employment.

REINSTATEMENT OF COVERAGE

An Member who has not continued to be insured for any reason under the provisions of items (a), (b) or (c) under Continuation of Coverage and who returns to work within the six (6) months following the start of the disability, unpaid leave or temporary lay-off may be insured again without having to satisfy the applicable Waiting Period.

For an Member whose coverage was continued under the provisions of items (a), (b) or (c) under Continuation of Coverage and whose coverage was subsequently discontinued for any reason prior to returning to work and prior to the expiry of the maximum period available for Continuation of Coverage, coverage will end at the end of the month in which their coverage was discontinued. If the Member returns to work within the six (6) months following the start of a disability, unpaid leave or temporary lay-off, the Member may be insured again without having to satisfy the applicable Waiting Period.

WAIVER OF PREMIUM

The Insurer will waive all of an Insured Person's premium under the following circumstances:

If the Insured Member has Long Term Disability Insurance (LTD):

From the first day of the month following the date the Insured Member begins to receive monthly disability benefit payments through the LTD Insurance.

If the Insured Member does not have Long Term Disability Insurance (LTD):

When Injury or Sickness totally disables and prevents the Insured Member from engaging in each and every gainful occupation for which the Insured Member is or may become reasonably qualified by reason of education, training or experience, for a period of at least six (6) consecutive months, premiums will be waived on the first day of the month following that six (6) consecutive month period.

Notice of such disability must be submitted to the Insurer within twelve (12) months of the onset of total disability and due proof of disability must be submitted to the Insurer within three (3) months following the date notice was given.

Premiums will continue to be waived until the earliest of the following dates:

a) on the date the Group Policy is terminated;

b) on the date the Insured Member reaches 65 years of age;

c) on the date the Insured Member ceases to be totally disabled;

d) on the date the Insured Member fails to provide proof satisfactory to the Insurer of the continuance of total disability within 90 days of the request of such proof; or

e) on the date the Insured Member refuses to submit to examination.

The coverage which is continued under this clause will be subject to the terms and provisions of the Group Policy in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained in this Group Policy, in no event will benefits payable for any Diagnosis which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to the Insured Person at the date of commencement of disability.

The Insurer will have the right to request proof of the continuance of total disability, and may also require the disabled Insured Member to submit to examination by the Insurer's medical advisor, from time to time as the Insurer may reasonably require.

MEMBER MANDATORY CRITICAL ILLNESS INSURANCE

DESCRIPTION OF COVERAGE

In accordance with the provisions of this Group Policy, the Insurer will pay the Benefit Amount for Critical Illness, if the Insured Person is Diagnosed with a covered Critical Illness or undergoes a covered Surgery.

The Insured Person must survive the Survival Period and the Diagnosis must be made on or after the Insured Person's effective date of coverage or the date of the Insured Person's most recent Reinstatement, whichever is later, and while this Group Policy is in force.

Reduction in Benefit Amounts will apply if stipulated in the Schedule of Benefits.

The amount of Critical Illness Insurance for an Insured Person whose coverage is extended under the Continuation of Coverage or Waiver of Premium Sections due to disability of the Insured Member is equal to the amount in force at the onset of his disability and is not changed while the coverage is extended under those Sections.

INSURED MEMBER COVERED CRITICAL ILLNESS CONDITIONS

The following Critical Illness conditions and Surgeries are covered in this Group Policy for Insured Members.

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dilated Cardiomyopathy
- Fulminant Viral Hepatitis
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- Life Threatening Cancer
- Liver Failure of Advanced Stage
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure - Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Occupational HIV
- Paralysis
- Parkinson's Disease
- Primary Pulmonary Hypertension
- Progressive Systemic Sclerosis
- Severe Burns
- Stroke

INSURED MEMBER CRITICAL ILLNESS CONDITIONS DEFINITIONS AND LIMITATIONS

ALZHEIMER'S DISEASE means the Diagnosis of a progressive degenerative Disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of eight (8) hours of daily supervision. No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

AORTIC SURGERY means Surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery outlined above. The Surgery must be determined to be medically necessary by a Specialist.

APLASTIC ANEMIA means Diagnosis of chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one (1) of the following:

a) marrow stimulating agents;
b) immunosuppressive agents;
c) bone marrow transplantation.

BACTERIAL MENINGITIS means the Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least ninety (90) days from the Date of Diagnosis.

No benefit will be payable under this condition for viral meningitis.

BENIGN BRAIN TUMOUR means the Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Waiting Period from Effective Date of Coverage: No benefit will be payable under this condition if within the first ninety (90) days following the Insured Person's effective date of coverage or the effective date of the most recent reinstatement of coverage, whichever is later, an Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made; or a Diagnosis of Benign Brain Tumour is made.

The medical information as described above must be reported to the Insurer within six (6) months of the Date of Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Benign Brain Tumour or any Critical Illness caused by any Benign Brain Tumour or its treatment.

BLINDNESS means Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes; or the field of vision being less than 20 degrees in both eyes.

COMA means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

No benefit will be payable under this condition for:

a) a medically induced Coma;

b) a Coma which results directly from alcohol or drug use (except those taken as prescribed by a Physician); or

c) a Diagnosis of brain death.

CORONARY ARTERY BYPASS SURGERY means Surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery as outlined above. The Surgery must be determined to be medically necessary by a Specialist.

DEAFNESS means the Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

DILATED CARDIOMYOPATHY means the Diagnosis of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The Diagnosis of Dilated Cardiomyopathy must be made by a Specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least three (3) months.

New York Heart Association Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with Evidence of abnormal ventricular function on physical examination and laboratory studies.

No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of Dilated Cardiomyopathy.

FULMINANT VIRAL HEPATITIS means the Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

a) a rapidly decreasing liver size as confirmed by abdominal ultrasound;

b) necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;

c) rapidly deteriorating liver function tests; and

d) deepening jaundice.

No benefit will be payable under this condition for chronic hepatitis or liver failure caused by alcohol, toxins and/or drugs (except those taken as prescribed by a Physician).

HEART ATTACK means the Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:

a) heart attack symptoms;

b) new electrocardiogram (ECG) changes consistent with a heart attack; or

c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

No benefit will be payable under this condition for:

a) elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or

b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

HEART VALVE REPLACEMENT means Surgery to replace any heart valve with either a natural or mechanical valve. The Surgery must be determined to be medically necessary by a Specialist. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery as outlined above.

No benefit will be payable under this condition for heart valve repair.

KIDNEY FAILURE means a Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

LIFE THREATENING CANCER means the Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. No benefit will be payable under this condition for the following non-life-threatening cancers:

a) carcinoma in situ;

b) Stage 1A Malignant Melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);

c) any non-melanoma skin cancer that has not metastasized; or

d) Stage A (T1a or T1b) Prostate Cancer.

***Waiting Period from Effective Date of Coverage**:* No benefit will be payable under this condition if within the first ninety (90) days following the Insured Person's effective date of coverage or the effective date of their most recent reinstatement of coverage, whichever is later, the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Life Threatening Cancer (covered or excluded under the Group Policy), regardless of when the Diagnosis is made; or a Diagnosis of Life Threatening Cancer (covered or excluded under the Group Policy) occurs.

The medical information as described above must be reported to the Insurer within six (6) months of the Date of Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Life Threatening Cancer or, any Critical Illness caused by any Life Threatening Cancer or its treatment.

LIVER FAILURE OF ADVANCED STAGE means the Diagnosis of liver failure due to cirrhosis and resulting in permanent jaundice, ascites and encephalopathy. No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

LOSS OF INDEPENDENT EXISTENCE means the Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living or Cognitive Impairment, as defined below; for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

Activities of Daily Living*:*

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene.
- Bladder and Bowel Continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

The term **"Cognitive Impairment"** means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight (8) hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

LOSS OF LIMBS means Diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation.

LOSS OF SPEECH means the Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical Injury or Disease, for a period of at least one hundred eighty (180) days. No benefit will be payable under this condition for psychiatric related causes.

MAJOR ORGAN FAILURE – WAITING LIST means Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure - Waiting List, the Insured Person must become enrolled as the recipient at a recognized transplant centre in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person enrolls at the transplant centre.

MAJOR ORGAN TRANSPLANT means Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. For the purposes of the Survival Period, the Date of Diagnosis is the date that the Insured Person undergoes the transplant procedure as outlined above.

MOTOR NEURON DISEASE means the Diagnosis of one (1) of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

MULTIPLE SCLEROSIS means a Diagnosis of multiple sclerosis based on one (1) of the following:

a) two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
b) well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
c) a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

MUSCULAR DYSTROPHY means all of the following:

a) clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
b) characteristic electromyography changes; and
c) muscle biopsy confirming Diagnosis of Muscular Dystrophy.

OCCUPATIONAL HIV INFECTION means the Diagnosis of infection with human immunodeficiency virus (HIV) resulting from Injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids.

The Injury leading to the infection must have occurred after the later of the Insured Person's effective date of coverage or the effective date of their most recent reinstatement of coverage.

Payment under this condition requires satisfaction of all of the following:

a) The Injury must be reported to the Insurer within fourteen (14) days of the Injury;
b) A serum HIV test must be taken within fourteen (14) days of the Injury and the result must be negative;
c) A serum HIV test must be taken between ninety (90) days and one hundred eighty (180) days after the Injury and the result must be positive;
d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
e) The Injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

No benefit will be payable under this condition if:

a) The Insured Person has elected not to take any available licensed vaccine offering protection against HIV;
b) A licensed cure for HIV infection has become available prior to the Injury; or
c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

PARALYSIS means Diagnosis of the total loss of muscle function of two (2) or more limbs as a result of Injury or Disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event.

PARKINSON'S DISEASE means the Diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two (2) or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).

No benefit will be payable under this condition for all other types of Parkinsonism.

PRIMARY PULMONARY HYPERTENSION (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) means the Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The NYHA Class IV of cardiac impairment means that the patient is unable to engage in any physical activity without discomfort and that symptoms may be present even at rest.

No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.

PROGRESSIVE SYSTEMIC SCLEROSIS means the Diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological Evidence and with biopsy results when available.

No benefit will be payable under this condition for:

a) localized scleroderma (linear scleroderma or morphea);
b) eosinophilic fasciitis; or
c) CREST syndrome.

SEVERE BURNS means the Diagnosis of third-degree burns over at least 20% of the body surface.

STROKE means the Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:

a) acute onset of new neurological symptoms; and
b) new objective neurological deficits on clinical examination;

persisting for more than thirty (30) days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

No benefit will be payable under this condition for Transient Ischaemic Attacks, Intracerebral vascular events due to trauma or Lacunar infarcts which do not meet the definition of stroke as described above.

LIFE THREATENING CANCER RECURRENCE BENEFIT

The Insurer will pay the Benefit Amount if an Insured Member is diagnosed a subsequent time with Life Threatening Cancer if:

a) more than sixty (60) months have passed since the previous Life Threatening Cancer Diagnosis; and

b) no treatment relating directly or indirectly to Life Threatening Cancer has been received within that sixty (60) month period (treatment does not include preventative medications and follow up visits to the doctor).

The subsequent Diagnosis must be made while coverage is in force.

MULTIPLE EVENT COVERAGE

If an Insured Member is diagnosed with a covered Critical Illness for which the Benefit Amount has been paid and is then diagnosed with another covered Critical Illness, the Insurer will pay a Benefit Amount subject to the limitations specified in the Multiple Event Coverage Limitations Section.

To receive a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made at least ninety (90) days after payment of a Benefit Amount for a covered Critical Illness condition was made.

Multiple Event Coverage Limitations

If an Insured Member or is eligible for Multiple Event Coverage, payments are subject to the following limitations:

a) Following an Alzheimer's Disease claim, the Insured Person cannot claim for Alzheimer's Disease or Loss of Independent Existence.

b) Following an Aortic Surgery claim, the Insured Person cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

c) Following an Aplastic Anemia claim, the Insured Person cannot claim for Aplastic Anemia, Life Threatening Cancer, Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer or Stage 1A Malignant Melanoma.

d) Following a Bacterial Meningitis claim, the Insured Person cannot claim for Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke.

e) Following a Benign Brain Tumour claim, the Insured Person cannot claim for Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke.

f) Following a Blindness claim, the Insured Person cannot claim for Blindness or Loss of Independent Existence.

g) Following a Coma claim, the Insured Person cannot claim for Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke.

h) Following a Coronary Artery Bypass Surgery claim, the Insured Person cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

i) Following a Deafness claim, the Insured Person cannot claim for Deafness or Loss of Independent Existence.

j) Following a Dilated Cardiomyopathy claim, the Insured Person cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

k) Following a Fulminant Viral Hepatitis claim, the Insured Person cannot claim for Life Threatening Cancer, Ductal Carcinoma in Situ of the Breast, Fulminant Viral Hepatitis, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer or Stage 1A Malignant Melanoma.

l) Following a Heart Attack claim, the Insured Person cannot claim for Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

m) Following a Heart Valve Replacement claim, the Insured Person cannot claim for Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

n) Following a Kidney Failure claim, the Insured Person cannot claim for Coma, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

o) Following a Life Threatening Cancer claim, the Insured Person cannot claim for Aplastic Anemia, Life Threatening Cancer unless all the requirements in the Life Threatening Cancer Recurrence Benefit are met, Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer or Stage 1A Malignant Melanoma.

p) Following a Liver Failure of Advanced Stage claim, the Insured Person cannot claim for Aortic Surgery, Blindness, Life Threatening Cancer, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Ductal Carcinoma in Situ of breast, Heart Attack Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant, Multiple Sclerosis, Paralysis, Progressive Systemic Sclerosis, Stage 1A Malignant Melanoma, Stage A (T1a or T1b) Prostate Cancer or Stroke.

q) Following a Loss of Independent Existence claim, the Insured Person cannot claim for any other Critical Illness. The Critical Illness insurance coverage terminates.

r) Following a Loss of Limbs claim, the Insured Person cannot claim for Loss of Independent Existence or Loss of Limbs.

s) Following a Loss of Speech claim, the Insured Person cannot claim for Loss of Independent Existence or Loss of Speech.

t) Following a Major Organ Failure - Waiting List claim, the Insured Person cannot claim for Aplastic Anemia, Life Threatening Cancer, Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma or Stroke.

u) Following a Major Organ Transplant claim, the Insured Person cannot claim for Aplastic Anemia, Life Threatening Cancer, Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma or Stroke.

v) Following a Motor Neuron Disease claim, the Insured Person cannot claim for Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis or Stroke.

w) Following a Multiple Sclerosis claim, the Insured Person cannot claim for Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis or Stroke.

x) Following a Muscular Dystrophy claim, the Insured Person cannot claim for Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Loss of Speech, Major Organ Failure - Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis or Stroke.

y) Following an Occupational HIV Infection claim, the Insured Person cannot claim for Blindness, Life Threatening Cancer, Coma, Deafness, Ductal Carcinoma in Situ of the Breast, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma or Stroke.

z) Following a Paralysis claim, the Insured Person cannot claim for Coma, Loss of Independent Existence, Loss of Speech or Paralysis.

aa) Following a Parkinson's Disease claim, the Insured Person cannot claim for Coma, Loss of Independent Existence, Loss of Speech, Paralysis or Parkinson's Disease.

bb) Following a Primary Pulmonary Hypertension claim, the Insured Person cannot claim for Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, or Stroke.

cc) Following a Progressive Systemic Sclerosis Claim, the Insured Person cannot claim for Coma, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant, Progressive Systemic Sclerosis or Stroke.

dd) Following a Severe Burns claim, the Insured Person cannot claim for Loss of Independent Existence, Paralysis or Severe Burns.

ee) Following a Stroke claim, the Insured Person cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Major Organ Failure - Waiting List, Major Organ Transplant or Stroke.

EARLY DIAGNOSIS BENEFIT

If an Insured Member is diagnosed with one of the four (4) illnesses listed below while coverage under this Group Policy is in force and subject to all of the Group Policy conditions and limitations, the Insurer will pay the Insured Member if the Insured Member is diagnosed, 15% of their Benefit Amount, subject to a maximum of $1,500.

Only the following four (4) illnesses are covered under the Early Diagnosis Benefit.

a) Coronary Angioplasty

The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

b) Ductal Carcinoma in Situ of the Breast

The Diagnosis of this illness must be confirmed by biopsy.

c) Stage A (T1a or T1b) Prostate Cancer

The Diagnosis of this illness must be confirmed by pathological examination of prostate tissue.

d) Stage 1A Malignant Melanoma

The Diagnosis of melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

The payment of the Early Diagnosis Benefit can only be paid once in a lifetime, even if the Insured Person suffers more than one of the four covered illnesses.

PSYCHOLOGICAL THERAPY BENEFIT PROVISION

When an Insured Person is Diagnosed with a covered Critical Illness and a benefit is paid, We will reimburse the Insured Person for Reasonable and Customary charges for treatment or counseling for Psychological Therapy, up to the maximum amount listed in the Schedule of Benefits.

Benefit payments herein will be paid until the earliest of the following:

1. the maximum benefit amount has been paid;
2. two (2) years have elapsed from the Date of Diagnosis; or
3. death of the Insured Person.

The Psychological Therapy must be provided by a therapist or counsellor (who is not an Immediate Family Member of the Insured Person) who is licensed to provide such treatment, whether on an out-patient basis or while a patient at a medical facility licensed to provide such treatment.

"Reasonable and Customary" means the lesser of:

(a) the usual charge made by Physicians or other health care providers for a given service or supply; or

(b) the charge We determine to be the prevailing charge made by the Physicians or other health care providers for a given service or supply in a geographical area where it is furnished; or

(c) the amount negotiated by Us and the health care provider.

MEMBER CRITICAL ILLNESS INSURANCE GENERAL EXCLUSIONS

No Critical Illness Benefit Amount shall be due or payable if the Insured Person's Critical Illness or Surgery results directly or indirectly from any of the following:

a) the Insured Person does not satisfy the Survival Period;
b) intentionally self-inflicted injury or Sickness while sane or insane;
c) the use of illegal or illicit drugs or substances, or misuse of medication obtained with or without prescription; or
d) if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care or services including diagnostic measure as prescribed by his attending Physician.

In addition to the above exclusions, the Critical Illness benefit will not be payable for any Life Threatening Cancer that manifests itself prior to the Insured Person's effective date of coverage or the effective date of their most recent reinstatement of coverage, whichever is later, when the same Life Threatening Cancer either recurs or metastasizes after such effective date unless all the requirements of the Life Threatening Cancer Recurrence Benefit have been met.

Pre-Existing Condition Exclusion for Mandatory Coverage

No Critical Illness Benefit Amount shall be due or payable if the Insured Person's medical condition, one of the thirty-one (31) covered Critical Illness conditions, results directly or indirectly from a Pre-Existing Condition unless such Critical Illness is Diagnosed twenty-four (24) months after the Insured Person's effective date of coverage.

"Pre-Existing Condition" *means* the existence of symptoms which would cause an ordinary prudent person to seek care or treatment or it *means* an illness or condition for which the Insured Person was attended to or received medical treatment, consultation, care or services for by a Physician, including diagnostic measure for any symptom or medical problem within the 24-month period immediately before the Insured Person's effective date of coverage under the Group Policy.

For Mandatory coverage, if this Group Policy directly replaces a group Critical Illness policy from another insurer providing similar benefits with less than 18 illnesses:

An Insured Person who has satisfied the time period of a pre-existing condition limitation in a prior group Critical Illness policy will be deemed to have satisfied the time period in this Group Policy, but only to the extent of the Benefit Amount and Critical Illnesses covered in the prior policy. Any additional Benefit Amount or Critical Illnesses provided in this Group Policy over what was provided in the prior policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this Group Policy came into force.

An Insured Person who has not satisfied the time period of a pre-existing condition limitation in a prior Group Critical Illness policy will be allowed to apply any amount of time satisfied under the pre-existing condition limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Condition Exclusion, but only to the extent of the Benefit Amount and Critical Illnesses covered in the prior policy. Any additional Benefit Amount or Critical Illnesses provided in this Group Policy over what was provided in the prior policy will be subject to the complete terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this Group Policy came into force.

For Mandatory coverage, if this Group Policy directly replaces a group Critical Illness policy from another insurer providing similar benefits with 18 or more illnesses:

An Insured Person who has satisfied the time period of a pre-existing condition limitation in a prior group Critical Illness policy will be deemed to have satisfied the time period in this Group Policy. Any additional Benefit Amount provided in this Group Policy over what was provided in the prior policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this Group Policy came into force.

An Insured Person who has not satisfied the time period of a pre-existing condition limitation in a prior group Critical Illness policy will be allowed to apply any amount of time satisfied under the pre-existing condition limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Condition Exclusion. Any additional Benefit Amount provided in this Group Policy over what was provided in the prior policy will be subject to the complete terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this Group Policy came into force.

CLAIMS PROVISIONS

1. 1. **Notice and Proof of Claim**

The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall,

(a) give written notice of claim to the insurer,

(i) by delivery thereof, or by sending it by registered mail to the head office or chief agency of the insurer in the Province, or

(ii) by delivery thereof to an authorized agent of the insurer in the Province,

not later than thirty days from the date a claim arises under the contract on account of an accident, sickness or disability;

(b) within ninety days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the insurer such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby, the right of the claimant to receive payment, his age, and the age of the beneficiary if relevant; and

(c) if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such disability or sickness.

2. **Failure to Give Notice or Proof**

Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the accident or the date a claim arises under the contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

In the case of death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than one year after a court makes the declaration.

2. Insurer to Furnish Forms for Proof of Claim

The insurer shall furnish forms for proof of claim within fifteen days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

3. Rights of Examination

As a condition precedent to recovery of insurance moneys under this contract,

(a) the claimant shall afford to the insurer an opportunity to examine the person of the person insured when and so often as it reasonably requires while the claim hereunder is pending; and

(b) in the case of death of the person insured, the insurer may require an autopsy subject to any law

of the applicable jurisdiction relating to autopsies.

4. When Money Payable Other Than for Loss of Time

All money payable under this contract, other than benefits for loss of time, shall be paid by the insurer within sixty days after it has received proof of claim.

5. When Loss of Time Benefits Payable

The initial benefits for loss of time shall be paid by the insurer within thirty days after it has received proof of claim, and payment shall be made thereafter in accordance with the terms of the contract but not less frequently than once in each succeeding sixty days while the insurer remains liable for the payments if the person insured when required to do so furnishes before payment proof of continuing disability or sickness.

6. Limitation of Actions

An action or proceeding against the insurer for the recovery of a claim under this contract shall not be commenced more than one year after the date the insurance money became payable or would have become payable if it had been a valid claim*.

For British Columbia, in the case of death, an action must be commenced not later than the earlier of two years after the proof of claim is furnished or six years after the date of death. For all other cases, an action must be commenced not later than two years after the claimant knew or ought to have known of the first instance of the loss or occurrence giving rise to the claim for insurance money.

Ontario Statutory Condition 12 is repealed. See *The Limitations Act*, 2002, S.O. 2002, c. 24, Sched. B.

*Condition 12 is not part of contracts in Alberta and British Columbia.

ADDITIONAL PROVISIONS

BENEFICIARY: This Group Policy contains a provision removing or restricting the right of the group person insured to designate persons to whom or for whose benefit insurance money is to be payable. The Insured Member is the beneficiary for all indemnities payable for which the Member is insured.

If an Insured Member dies prior to the payment of the benefit, benefit payments shall be made to the estate of the Insured Member.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Group Policyholder, the Administrator or the Insurer will not invalidate coverage otherwise validly in force; nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Insurer and is rectified promptly upon discovery. No error will continue the insurance of an Insured Person beyond the date it should end under the Group Policy terms. After an error is found, appropriate action will be taken, which may include adjusting, collecting or refunding premium.

CONFORMITY WITH PROVINCIAL OR TERRITORIAL LAWS: Notwithstanding any other provision of this Group Policy, this Group Policy is subject to the statutory conditions of the provincial or territorial *Insurance Act* applicable to contracts of accident and sickness insurance for the Insured Person's province or territory of residence in Canada.

CURRENCY: Payments, reimbursements and amounts shown throughout this Group Policy are in the currency shown in the Schedule of Benefits, unless otherwise stated.

CYBER INCIDENTS: Benefits for bodily injury or illness caused by any application, software or program in connection with any electronic device (e.g. computer, laptop, smartphone, tablet or internet-capable electronic device) are payable subject to the terms, conditions, limitations and exclusions of this Policy.

EXTENSION OF COVERAGE UNDER PREVIOUS INSURANCE: If a group insurance policy covering the Members eligible for the present insurance is in effect immediately before the Policy Effective Date includes an extension of coverage, any Benefit Amount payable under this Group Policy shall be reduced by the payment amount that the previous insurer is liable to make under the extension of coverage for a similar benefit.

FRAUDULENT CLAIMS: Any claim for benefits under the Group Policy which is based on false or incorrect information on an application, claim form or other documents required to verify benefits will result in the benefits being denied or the liability assumed by the Beneficiary if the benefit has already been provided or performed.

INCONTESTABILITY: Except for nonpayment of premiums, The Insurer will not contest the validity of an Insured Person's coverage after it has been in force for two years from its date of issue. No statement made by an Insured Person relating to his or her insurability shall be used to contest the validity of his or her insurance after the insurance has been in force for two years during his or her lifetime, not unless it is contained in a written application signed by him/her.

INSURANCE DATA: The Insurer has the right to examine the Group Policyholder's and the Administrator's records relative to these benefits at any reasonable time while the Group Policy is in effect. The Insurer reserves this right until all rights and obligations under the Group Policy are complete.

MISREPRESENTATION AND FRAUD: This entire Group Policy will be void, whether before or after a claim, if the Insurer determines that the Group Policyholder; Insured Person; or its agent has concealed or misrepresented any material fact or circumstance concerning this Group Policy, including any claim or any case of fraud by the Group Policyholder; Insured Person; third party administrator; or other agent relating to this Group Policy. Misrepresentation relating to a later application for additional coverage or an increase in insurance will void the relevant change.

MISSTATED DATA: The Insurer has relied upon the underwriting information provided by the Group Policyholder; its third-party administrator; or other agent in the issuance of this Group Policy. Should subsequent information become known which, if known prior to issuance of this Group Policy, would have affected the rates, terms, or conditions for coverage, the Insurer will have the right to revise the rates; terms; or conditions as of the Group Policy Effective Date, by providing written notice to the Group Policyholder.

MISSTATEMENT OF TOBACCO USE: The Insurer uses a more favorable basis to calculate premiums and monthly charges for non-tobacco users. If the Insured Person falsely answers questions related to his tobacco use in any application for this coverage (including any application to reinstate), the Group Policy will be considered void from inception. The term "void" means that the Group Policy is no longer a binding contract and is cancelled from inception.

WAIVER: Failure of Us to strictly enforce Our rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by Us at any time under the same or different circumstances.

DISCLAIMER

This booklet is a summary of the principal features of the plan which is governed by the terms of the Group Master Policy, 056CI/031834A, with the Policyholder. In the event of any discrepancy between this booklet and the Group Master Policy, the Group Master Policy prevails.

UNDERWRITTEN BY

Certain Underwriters at Lloyd's, London through
Sutton Special Risk Inc.
33 Yonge Street, Suite 400
Toronto, Ontario M5E 1G4

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