SUTTON

SPECIAL RISK

OPTIONAL CRITICAL ILLNESS INSURANCE

FOR MEMBERS OF THE

U.C.C.M Anishnaabe Police

POLICY NUMBER 056CI/031835A

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.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS

Class Number	Class Description
1	Insured Persons under age 70 who are working a minimum of 20 hours per week and are residing in Canada and their eligible Spouse and Dependent Children.

OPTIONAL MEMBER, SPOUSE AND DEPENDENT CHILD CRITICAL ILLNESS INSURANCE

Benefit Amounts:

	Member	Spouse	Dependent Child
Minimum:	$5,000	$5,000	$5,000
Maximum:	$100,000	$100,000	$25,000
Unit Value:	$5,000	$5,000	$5,000

An Insured Spouse or Dependent Child cannot be insured for a Benefit Amount greater than the Insured Member's Benefit Amount. The Spouse and Dependent Child coverage pays a benefit in the event the Spouse or Dependent Child is diagnosed with a Critical Illness, as described in the Policy.

Combined Maximum Benefit Amount:

	Member and Spouse	Dependent Child
Maximum:	$200,000	$25,000

Non-Evidence Benefit Maximums:

Member:	$5,000
Spouse:	$5,000
Each Dependent Child:	$5,000

In the event that two (2) Members are Spouses and are eligible for insurance under this Policy, they can each be insured as both a Member and a Spouse, subject to a combined maximum Benefit Amount for each such Insured Person of $200,000. They will each be subject to an aggregate non-Evidence maximum of $10,000 ($5,000 as a Member and $5,000 as a Spouse).

In the event that two (2) Members are Spouses and are eligible for insurance under this Policy, they can both insure the same Dependent Child, subject to a combined maximum Benefit Amount of $25,000 per Insured Dependent Child, whether the Dependent Child is insured by one or both Insured Members.

Psychological Therapy Benefit Maximum:

Maximum for Member, Spouse and Dependent Child: $1,000 for each covered Critical Illness

DEFINITIONS

Certain words with specific meanings are capitalized throughout this booklet. The definition of any word, if not defined in the text where it is used, may be found in the Schedule of Benefits or in this Definitions Section.

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.

BENEFIT AMOUNT means the insurance benefits provided in the 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 and Insured Spouse Critical Illness Conditions Definitions and Limitations and Insured Dependent Children Critical Illness Conditions 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 Policy is in force.

DEPENDENT CHILD(REN) means all unmarried children of an Insured Member or Spouse who are a resident of the same country in which the Insured Member resides and:

a) are under age 21; or

b) are at least 21 years of age but less than 26, who are not regularly employed on a full-time basis and are primarily dependent upon the Insured Member or Spouse for support and maintenance and are enrolled as a full-time student at an accredited college, university or other institution of higher learning or a vocation or licensed technical school.

The age limitations will not apply to an Insured Member's or Spouse's unmarried Child who is incapable of self-support due to a mental disability or physical handicap. Proof of such incapacity must be furnished to Us when a claim arises for such Child.

The term "Child" as used herein means the Insured Member's or Spouse's natural child, legally adopted child, or child placed in the Insured Member's home for purposed of adoption, foster child, stepchild, or other child for whom the Insured Member or Spouse has legal guardianship (proof will be required). A child must reside with the Insured Member or Spouse in a parent-child relationship and be eligible to be claimed as an exemption on the Insured Member's or Spouse's federal income tax return. NOTE: In the event the Insured Member or Spouse shares physical custody of the child with another parent, the requirement that the child reside with the Insured Member or Spouse will be waived.

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, 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.

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.

IMMEDIATE FAMILY MEMBER means a person at least eighteen (18) years of age, who is the Insured Person's 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), Spouse, grandson, granddaughter, grandfather or grandmother.

INJURY means bodily injury caused solely by an Accident occurring while this 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 Policy, anywhere in the world, but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

The term "**Sickness**" means an impairment of normal physiological function and includes illness and infections.

INSURED DEPENDENT CHILD means a Dependent Child who is insured under this Policy.

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

INSURED PERSON means an Insured Member, an Insured Spouse or an Insured Dependent Child, if applicable, eligible for insurance under this Policy, unless otherwise stated.

INSURED SPOUSE means a Spouse who is insured under this Policy.

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 who is legally qualified and lawfully entitled to practice medicine in the jurisdiction where he or she provides medical services. 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 Immediate Family Member of an Insured Person.

POLICY means the Critical Illness Insurance Policy.

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.

SPOUSE means a person who is a resident of the same country in which the Insured Member resides and is an Insured Member's lawful spouse under age 70, or a partner of the same or opposite sex under age 70 who immediately prior to the Date of Diagnosis was residing with the Insured Member and who has been publicly represented as the partner of the Insured Member.

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 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.

WE, OUR, US means the Insurer providing this insurance or its authorized representative Sutton Special Risk Inc.

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 Classes of Eligible Persons in the Schedule of Benefits. The Member's Spouse and Dependent Child(ren) shall be eligible for insurance on the same date as the Member or on the subsequent date on which they become eligible under the Policy.

Spouses and Dependent Children are not eligible if the Member is not covered under this Policy as an Insured Member.

Optional Coverage
Participation in this plan is optional for eligible Members, Spouses and Dependent Children.

INSURED PERSON'S EFFECTIVE DATE OF COVERAGE

An Insured Person's insurance shall become effective on the date an application has been received by Us for Benefit Amounts that do not require Evidence.

For Benefit Amounts that require Evidence, insurance shall become effective on the date of acceptance of Evidence of insurability by Us.

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 Policyholder agrees to notify Us 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, a Member may only apply for an increase in coverage if they are actively at work or on an approved leave of absence (except for leave of absences due to disability).

The increase in coverage shall become effective as follows if the Member is actively at work:

a) If Evidence of insurability is not required, the date the plan administrator receives the request, or
b) If Evidence of insurability is required, the date of acceptance of Evidence of insurability by Us.

If the Member is not actively at work on the date coverage would otherwise increase, the increase in coverage will take effect on the date the Member returns to work.

In the case of a decrease of coverage, the revised coverage shall become effective on the date the plan administrator receives the request.

TERMINATION OF INSURANCE

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

a) the date the Policy terminates;
b) the last day of the month in which the Insured Member ceases to be eligible for insurance;
c) the last day of the month in which the Insured Person ceases to be eligible for insurance;
d) on the next premium due date that follows the date that a Member has given notice of cancellation to the Policyholder;
e) on the date a Loss of Independent Existence claim has been paid;
f) the date of the Insured Member's death;
g) the date the Insured Person ceases to be a Canadian resident;
h) the date the Insured Person ceases to be covered by a provincial government health insurance plan.

OPTIONAL MEMBER, SPOUSE AND DEPENDENT CHILD CRITICAL ILLNESS INSURANCE

DESCRIPTION OF COVERAGE

In accordance with the provisions of this Policy, We will pay the Benefit Amount for Critical Illness if the Insured Person is Diagnosed with a covered Critical Illness condition 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 effective date of the most recent reinstatement of coverage, whichever is later, and while this Policy is in force.

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

INSURED MEMBER AND INSURED SPOUSE COVERED CRITICAL ILLNESS CONDITIONS

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

- 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 AND INSURED SPOUSE 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 aSpecialist.

APLASTIC ANEMIA means the 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 itstreatment.

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 the Diagnosis of 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.

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 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 Policy), regardless of when the Diagnosis is made; or a Diagnosis of Life Threatening Cancer (covered or excluded under the Policy) occurs.

The medical information as described above must be reported to the Insurer within 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 the 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 the 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 or Insured Spouse 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 or Insured Spouse 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 Insured Spouse 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 or an Insured Spouse is diagnosed with one of the four (4) illnesses listed below while coverage under this Policy is in force and subject to all of the Policy conditions and limitations, the Insurer will pay the Insured Member if the Insured Member is diagnosed, or the Insured Spouse if the Insured Spouse is diagnosed, 15% of their Benefit Amount, subject to a maximum of $15,000.

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.

INSURED DEPENDENT CHILD COVERED CRITICAL ILLNESS CONDITIONS

The following Critical Illness conditions are covered in this Policy for an Insured Dependent Child.

- Blindness
- Cerebral Palsy
- Coma
- Congenital Heart Disease (Requiring Surgery)
- Cystic Fibrosis
- Deafness
- Diabetes Mellitus (Type 1)
- Down Syndrome
- Life Threatening Cancer
- Loss of Speech
- Major Organ Transplant
- Mental Deficiency
- Muscular Dystrophy
- Paralysis
- Severe Burns
- Spina Bifida Cystica

INSURED DEPENDENT CHILD CRITICAL ILLNESS CONDITIONS DEFINITIONS AND LIMITATIONS

BLINDNESS means the Diagnosis of 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.

CEREBRAL PALSY means the Diagnosis of cerebral palsy which is a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

COMA means the Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least ninety-six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

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.

CONGENITAL HEART DISEASE (REQUIRING SURGERY) means Surgery to correct a serious cardiac malformation present at birth. The Diagnosis of Congenital Heart Disease must be made and Surgery deemed necessary by a pediatric cardiologist.

CYSTIC FIBROSIS means the Diagnosis of cystic fibrosis which is a genetic Disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucus leading to chronic progressive respiratory Disease and nutritional problems.

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.

DIABETES MELLITUS (TYPE 1) means the Diagnosis of Diabetes Mellitus (Type 1), characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. There must be Evidence of dependence on insulin for a minimum of three months.

DOWN SYNDROME means the Diagnosis of Down syndrome which is a congenital condition caused by an extra copy of chromosome 21.

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 later of the Insured Dependent Child's effective date of coverage or the Insured Dependent Child's effective date of the most recent reinstatement of coverage the Insured Dependent Child has signs, symptoms or investigations, that lead to a Diagnosis of Life Threatening Cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or a Diagnosis of Life Threatening Cancer (covered or excluded under the Policy) occurs.

This 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.

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 all psychiatric related causes.

MAJOR ORGAN TRANSPLANT means the 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.

MENTAL DEFICIENCY means the Diagnosis of a state of mental deficiency as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70.

MUSCULAR DYSTROPHY means the Diagnosis of muscular dystrophy including 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.

PARALYSIS means the 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.

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

SPINA BIFIDA CYSTICA means the Diagnosis of spina bifida cystica which is a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

a) hydrocephalus;
b) paralysis;
c) bowel problems; and
d) bladder problems.

No benefit will be payable under this condition for spina bifida occulta.

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 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.

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, SPOUSE AND DEPENDENT CHILD OPTIONAL 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) intentionally self-inflicted injury while sane or insane;

b) use of illegal or illicit drugs or substances, or misuse of medication obtained with or without prescription; or

c) 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

This pre-existing condition exclusion does not apply if the Insured Person submitted Evidence and was approved by the Insurer.

If while Insured under this Policy an Insured Person increases their Benefit Amount which is available without submitting Evidence for additional insurance this pre-existing condition exclusion will be effective again on the Benefit Amount in excess of the prior Benefit Amount on the date of the increase.

No Critical Illness benefit shall be payable if twenty-four (24) months immediately prior to the Insured Person's effective date of coverage or the effective date of the most recent reinstatement of coverage, whichever is later, the Insured Person was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to a Diagnosis of or treatment for a Critical Illness condition unless the Diagnosis of the Critical Illness condition occurs later than twenty-four (24) consecutive months from the Insured Person's effective date of coverage or the effective date of the most recent reinstatement of coverage, whichever is later.

Exclusions Related to Policy Replacement

Pre-Existing Condition Exclusion

If this Policy directly replaces a policy with another insurer providing similar benefits, an Insured Person who has satisfied the time period of a pre-existing condition exclusion limitation in the prior policy will be deemed to have satisfied the time period in this 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 covered by this Policy will be subject to the terms of the Pre-Existing Condition Exclusion in this Policy. The prior policy must be cancelled within thirty-one (31) days prior to the date this Policy came into force for this provision to apply.

An Insured Person who has not satisfied the time period of the Pre-Existing Condition Exclusion limitation in a prior policy will be allowed to apply any amount of time satisfied under the Pre-Existing Condition Exclusion limitation of the prior policy toward the satisfaction of the time period requirement of the Pre-existing Condition Exclusion in this 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 covered by this Policy will be subject to the terms of the Pre-Existing Condition Exclusion in this Policy. The prior policy must be cancelled within thirty-one (31) days prior to the date this Policy came into force for this provision to apply.

Life Threatening Cancer Exclusion

If this Policy directly replaces one with another insurer providing similar benefits, an Insured Person who has satisfied the time period of the Life Threatening Cancer waiting period in a prior policy will be deemed to have satisfied the Life Threatening Cancer waiting period in this Policy, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this Policy will be subject to the terms of the Life Threatening Cancer waiting period from the effective date of coverage. The prior policy must be cancelled within thirty-one (31) days prior to the date this Policy came into force for this provision to apply.

An Insured Person who has not satisfied the time period of the Life Threatening Cancer waiting period in a prior policy will be allowed to apply any amount of time satisfied under the prior policy toward the satisfaction of the time period requirement of this Policy, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this Policy will be subject to the terms of the Life Threatening Cancer Waiting Period starting on the effective date of coverage of this Policy. The prior policy must be cancelled within thirty-one (31) days prior to the date this Policy came into force for this provision to apply.

Multiple Event Coverage Exclusions

If this Policy directly replaces one with another insurer providing similar benefits, and an Insured Member or Insured Spouse is diagnosed with a covered Critical Illness for which a Benefit Amount has been paid under the prior policy, and is then diagnosed with another covered Critical Illness while insured under this Policy, the Insurer will pay a Benefit Amount under this Policy subject to the Multiple Event Coverage Limitations. All claims paid under the prior policy for an Insured Person will be taken into consideration when applying the limitations for Multiple Event Coverage.

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 for a covered condition was made under the prior policy.

The prior policy must be cancelled within thirty-one (31) days prior to the date this Policy came into force for this provision to apply.

CLAIMS PROVISIONS

BENEFICIARY: This 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, including those payable for any Insured Dependent Children. The Insured Spouse is the beneficiary for all indemnities payable for which the Insured Spouse is insured.

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

NOTICE AND PROOF OF CLAIM: An Insured Person or the Insured Person's representative shall send written notice of claim to Us within ninety (90) days from the date a claim arises and furnish satisfactory proof to Us as soon as is reasonably possible, including providing Evidence of the claim and the Critical Illness, and any other information We may reasonably require to establish the validity of the claim.

CLAIMS FORMS: We shall furnish forms for filing proof of claim within fifteen (15) days after receiving notice of claim. If the claimant does not receive the claims forms, the claimant may submit proof of claim in the form of a written statement that describes the claim.

FAILURE TO GIVE NOTICE OF PROOF OF CLAIM: Failure to give notice of claim or furnish proof of claim within ninety (90) days 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 (1) year from the date a claim arises under the contract if it is shown that it was not reasonably possible to give notice or furnish proof within the time prescribed.

LIMITATION PERIOD: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or in other applicable legislation.

PHYSICAL EXAMINATION AND AUTOPSY: We reserve the right to: Examine the full details regarding the claim, including but not limited to non medical information (e.g. proof of employment); require the Insured Person to undergo a medical examination at the Insurer's expense; examine the Insured Person when and so often as it reasonably required while the claim hereunder is pending; or require an autopsy to be performed on the Insured Person in the event of death, unless prohibited by law or religious belief.

FRAUDULENT CLAIMS: Any claim for benefits under the 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.

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 and includes an extension of coverage, any Benefit Amount payable under this 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.

GENERAL POLICY PROVISIONS

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

CONFORMITY WITH PROVINCIAL OR TERRITORIAL LAWS: Notwithstanding any other provision of this Policy, this 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 Policy are in Canadian currency, 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.

INCONTESTABILITY: Except for nonpayment of premiums, We 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: We have the right to examine the Policyholder's records relative to these benefits at any reasonable time while the Policy is in effect. We reserve this right until all rights and obligations under the Policy are complete.

MATERIAL FACTS: No statement made by the Insured Person at the time of application for this contract shall be used in defense of a claim under or to avoid this contract unless it is contained in the application or any other written statement or answers furnished as Evidence ofinsurability.

MISREPRESENTATION AND FRAUD: This entire Policy will be void, whether before or after a claim, if We determine that the Policyholder; Insured Person; or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim or any case of fraud by the Policyholder; Insured Person; third party administrator; or other agent relating to this Policy.

MISSTATED DATA: We have relied upon the underwriting information provided by the Policyholder; its third party administrator; or other agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, terms, or conditions for coverage, We will have the right to revise the rates; terms; or conditions as of the Policy Effective Date, by providing written notice to the 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 Policy will be considered void from inception. The term "void" means that the Policy is no longer a binding contract and is cancelled from inception.

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/031068A, 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
P.O. Box 311
Toronto, Ontario
M5E 1G4