



# TANGIBLE

Canassurance Hospital Service Association and/or Canassurance Insurance Company, hereinafter called the Insurer, undertakes to fulfill, at his head office located in Montreal, Québec, the obligations mentioned in this contract, subject to the conditions stipulated herein.

Claude Boivin  
Chief Executive Officer

## CONTRACT SUMMARY

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**Name and address of Policyholder:**

Tangible Product  
550 Sherbrooke Street West, Suite B-9  
Montréal, Québec H3A 3S3

**Policy number:** TXXXXXX-X

**Renewal date:** October 1<sup>st</sup> of each year

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**Name of Primary Insured:**

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BENEFIT(S)	EFFECTIVE DATE	AMOUNT INSURED \$	PREMIUM (S) \$
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SPECIMEN

PAYABLE MONTHLY PREMIUM  
PAYABLE ANNUAL PREMIUM

TOTAL:  
TOTAL:

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## GENERAL PROVISIONS

### Contract

This policy, its summary, the insurance application and any other document that by agreement is part of the contract shall constitute the entire contract between the parties. No provision of the contract may be cancelled or modified except by written endorsement signed by a person authorized by the Insurer. No representative, agent or broker is authorized to modify the contract or waive any provision thereof.

### Purpose of the contract

The Insurer undertakes to pay the benefits provided for in the contract, subject to the conditions, limitations and exclusions herein described. However, no amounts are payable unless the applicable benefit is in force at the time of the event giving rise to the claim. If the Primary Insured holds several policies with the Insurer, the maximums specified in the **CONTRACT SUMMARY** as well as the limitations under the policy apply as if the Insured held only one policy.

### Rescission period

In the ten days following receipt of the contract, the Policyholder may request that it be cancelled by sending the Insurer a written notice to this effect. The contract is then declared null and void from its effective date, and any premium paid is fully refunded.

### Notice of correction

The Policyholder must notify the Insurer in writing within ten days of receiving the contract of any omission or other misstatement in the insurance application, particularly regarding the age, sex or medical record of any Primary Insured.

### Definitions

**Accident** means a sudden, unintentional, fortuitous and unforeseeable event due solely to a violent external cause and occurring while this contract is in force. If incapacity occurs more than 90 days after an accident, it is deemed to be due to illness.

**Activities of daily living** means the following:

- a) Bathing – washing oneself in a tub or shower or by sponge bath, with or without the aid of equipment
- b) Dressing – putting on and taking off all necessary items of clothing, including braces, artificial limbs or other surgical appliances
- c) Toileting – getting to and from the toilet and performing associated personal hygiene
- d) Contenance – managing bowel and bladder functions with or without protective undergarments, so as to maintain a level of personal hygiene compatible with general good health
- e) Transferring – moving into or out of a bed, chair or wheelchair, with or without the use of equipment
- f) Feeding – consuming food or drink that has been prepared and served, with or without the use of adaptive utensils.

**Age** means age on the last birthday.

**Amount insured** refers to the amount of insurance as specified in the **CONTRACT SUMMARY**.

**Assistance provider** refers to CanAssistance Inc.

**Benefit summary** refers to the summary of expenditures covered under the benefit.

**Claim** refers to any loss suffered by the Primary Insured that is covered by a benefit and for which a claim for indemnity can be made.

**Cognitive impairment** means mental deterioration and loss of intellectual ability evidenced by a deterioration in memory, orientation and reasoning that is measurable and that results from a demonstrable organic cause diagnosed by a specialist. The cognitive impairment must be severe enough to warrant continuous daily supervision.

Cognitive impairment shall be established on the basis of clinical evidence and standardized tests that reliably measure such impairments.

Mental or nervous disorders without demonstrable organic cause are not covered.

## GENERAL PROVISIONS

### Definitions (continued)

**Contract summary** refers to the summary of benefits mentioned on the first page.

**Day surgery** refers to surgery that is performed in a hospital or a service affiliated with a hospital but does not require hospitalization, the patient being discharged on the same day as the surgery.

### Duration of premium payment

The duration of premium payment for each benefit selected as indicated in the **CONTRACT SUMMARY**.

### Whole life option

The premium is payable until the Primary Insured's 100th birthday.

Thereafter, the benefit remains effective; however, no premiums are required.

### Paid-up at age 65 option

To be eligible for this option, the Primary Insured must be 55 years of age or younger.

The premium is payable until the Primary Insured's 65th birthday.

Thereafter, the benefit remains effective; however, no premiums are required.

### 20 payments option

The premium is payable for the first 20 years.

Thereafter, the benefit remains effective; however, no premiums are required.

### 20-65 option

Under this option, premiums are payable until the Primary Insured's 65th birthday, subject to a minimum of twenty years of insurance.

Thereafter, the benefit remains effective; however, no premiums are required.

**Facility** means a long-term care centre offering residential, assistance, support, supervisory and psychosocial services for persons suffering a loss of functional or psychological autonomy, notably elderly persons who cannot remain in their existing living environment.

The said facility must be the Primary Insured's principal residence while he/she is physically dependent.

**Facility care** means health and personal care services received in a facility.

**Health professional** means any health professional mentioned in the contract who is a member in good standing of his/her professional order or corporation and practices within the limits of his/her competence under the terms of the law.

**Home care** means health and personal care services received outside a facility.

**Hospital** refers to an acute care hospital or short-term care centre as defined under the legislation of the Primary Insured's province of residence and excludes any part of such hospital or centre reserved for long-term care.

**Hospitalization** means admission to a hospital to receive short-term care as a bedridden patient for a minimum stay of 18 hours.

Covered short-term care comprises preventive care, medical diagnosis and medical treatment (including surgery) for an acute illness and does not include convalescent care and physical or mental rehabilitation.

In the case of day surgery, the hospital stay is equivalent to 18 hours of hospitalization.

**Illness** means a deterioration of health or a physical disorder recognized by a physician that requires regular and continuous medical care considered satisfactory by the Insurer. Pregnancy is not considered an illness, except in case of pathological complications.

**Injury** means bodily harm caused by an accident, directly and independently of any other cause.

**Insurability** means the health status and age of the Primary Insured meet the Insurer's requirements for issuing insurance.

**Insurer** refers to the Canassurance Hospital Services Association (a nonprofit mutual benefit association) and/or Canassurance Insurance Company.

## GENERAL PROVISIONS

### Definitions (continued)

**Nonsmoker** means anyone who has not used tobacco in any form during the 12 months prior to the application for insurance or for revision of smoker/nonsmoker status, which may be revised if no other changes to the Primary Insured's insurability have occurred. The Insurer reserves the right to ask for additional evidence of insurability.

**Organic cause** means caused by structural change to tissue or an organ of the body.

**Physician** means anyone legally authorized to practice medicine in his/her field of expertise. The physician may not be the Primary Insured or a close relative of the latter.

**Policyholder** refers to the person who purchased the insurance.

**Pregnancy** includes pregnancy itself, delivery, abortion and miscarriage.

**Primary Insured** refers to the person insured under a benefit.

**Smoker** means anyone who uses tobacco in any form or has done so in the 12 months prior to the insurance application, regardless of the frequency of use.

**Survival period** means the period beginning on the date of diagnosis of the critical or noncritical illness and ending 30 days after the date of diagnosis of the illness, unless otherwise specified in this benefit. Days spent on artificial life support are not counted in the survival period.

**Total disability** (applicable to the waiver of premiums in case of disability of the Primary Insured)

#### **If the Primary Insured is gainfully employed:**

**Total disability** means that the Primary Insured is unable, during the first 24 months of benefit payments and due directly to accident or illness independently of any other cause, to perform the major duties of the occupation in which he/she was engaged at the onset of disability.

Thereafter, **total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to engage in any occupation for which he/she is reasonably suited by education, training or experience.

To be considered **totally disabled**, the Primary Insured must be under the continuous care of a physician providing care suitable for his/her disability at an appropriate frequency.

#### **If the Primary Insured is not gainfully employed:**

**Total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause to perform his/her usual daily tasks and any other tasks for which he/she is reasonably qualified by education or experience.

To be considered **totally disabled**, the Primary Insured must be under the continuous care of a physician providing care suitable for his/her disability at an appropriate frequency.

### Eligibility

To be eligible, the person to be insured must meet the following criteria:

- a) Be a beneficiary within the meaning of the health and hospital insurance acts in his/her province of residence
- b) Not be hospitalized and/or disabled on the effective date of the contract

### Misstatement of age

If a Primary Insured has understated or overstated his/her age in the insurance application, the following applies:

- a) the Policyholder shall pay the Insurer the difference, if any, between the premiums that would have been paid and those actually paid, in cash and with interest or, in case of overstatement of true age, the Insurer shall reimburse the difference in premiums; or
- b) the benefit shall be reduced or increased to correspond to the benefit amount that the premiums actually paid would have purchased if the true age had been declared.

## GENERAL PROVISIONS

### Misstatement of age (continued)

The Insurer reserves the right to decide how the adjustment, if any, shall be made.

If, as a result of a misstatement of age, the Insurer receives premiums covering a period beyond the termination date according to the Insured's true age, then the Insurer's liability is limited to refunding premiums paid for said period. Likewise, if a benefit could not have come into effect if true age had been declared, then the Insurer's liability is limited to refunding premiums paid for the period during which the benefit could not have been in force.

### Claims

The Insurer has no obligation under this contract unless the Insurer receives evidence of costs incurred, or information the Insurer deems useful regarding the cause, nature and duration of total disability or of the event from which the claim arises, within 90 days of the date the costs were incurred or of the onset of total disability, as the case may be.

Failure to submit a claim within said 90 days shall not annul or reduce the scope of the claim if it can be proved that it was physically impossible to submit the claim and that it was submitted as soon as possible within 12 months of the date the costs were incurred or of the onset of total disability.

### Request for information

The Insurer reserves the right to require submission of any records, information, details or medical observations related to the diagnosis, treatment or care given to a Primary Insured before or after the effective date of the contract.

Under the terms of this contract, the Insurer is liable only if the Primary Insured authorizes all individuals, companies, firms, institutions and organizations, specifically physicians, dentists, health professionals, hospitals and clinics, to give the above information directly to the Insurer.

### Proof of claim forms

The Insurer shall provide the proof of claim forms within 15 days of receiving the notice of claim. However, if the claimant has not received the forms within this time frame, he/she may submit the proof of claim in the form of a written

statement describing the cause or nature of the total disability giving rise to the claim.

### Terms and conditions of payment

The Insurer makes all reimbursements in the form of a cheque made out to the supplier of the service and/or the Primary Insured or the latter's assignee after receipt and evaluation of pertinent accounts and necessary related information, in accordance with stipulated procedures. However, in all cases the Insurer reserves the right to pay the supplier of the services directly.

Any amount paid by the Insurer or on the Insurer's behalf releases the Insurer from any liability up to said amount.

### Required proof

Before considering a claim under the contract and before awarding benefit payments, the Insurer is entitled to require satisfactory proof of the following:

- a) The event giving rise to the claim
- b) The circumstances of the accident, disease or death
- c) The age of the Primary Insured
- d) Any real costs incurred

The Primary Insured shall provide all information concerning other insurance covering the same expenses as well as all original documents and all information required to study the claim.

The Insurer has the right, and the claimant must make this possible, to have the Primary Insured examined by a physician chosen by the Insurer as often as the latter deems necessary while the claim is under settlement.

The Insurer may require that the Primary Insured be under the care of a specialist when his/her medical condition so warrants.

The Insurer reserves the right, before any payments are made under the contract, to have the Primary Insured examined at the Insurer's expense and, the law permitting, to have an autopsy performed in case of death.

# GENERAL PROVISIONS

## Claims (continued)

### Subrogation

If the Primary Insured has a claim against any individual or corporate body for compensation of a loss covered under this contract, the Insurer is subrogated to all the Primary Insured's rights against said third party, up to the amount paid by the Insurer and with priority to any residual rights of the Primary Insured. The Primary Insured shall sign and return the necessary documents to this effect and do everything required to protect his/her rights.

### Incontestability

Barring fraud, insurance in effect for at least two years may not be cancelled or reduced for misstatement or omission.

However, if a claim is made in the first two years of insurance, the preceding paragraph does not apply and the Insurer may cancel or reduce any benefits payable in case of misstatement or omission.

### Interest

No interest is paid on amounts payable under the contract unless otherwise required by law.

### Currency

All payments under this contract, whether to or by the Insurer, are payable in the legal currency of Canada.

### Premium

Depending on the benefit chosen, the premium may be based on the coverage selected when the application is signed and the Primary Insured's occupational category, smoker/nonsmoker status, sex and, in the case of a benefit with a levelled premium, his/her age at issue of the benefit.

### Payment of premiums

For the contract to become and remain effective, all premiums must be paid when due at the Insurer's head office or to any intermediary authorized by the Insurer.

### Non-payment of premiums

If the premium is unpaid on the due date, the Insurer grants a grace period of 30 days as of the due date—except for the first premium, which must be paid before the insurance comes into effect. If the premium is still unpaid at the end of the grace period, the Insurer shall mail a notice to the Policyholder at the last address shown in his/her records indicating that unless the premium is paid within 15 days, the contract shall be terminated retroactive to the due date.

If a cheque or other commercial paper remitted to the Insurer as payment of a premium is not honoured upon presentation, the premium is considered unpaid and any receipt issued with regard to payment of said premium is null and void.

### Contract commencement

The contract commencement date is shown in the **CONTRACT SUMMARY**.

### Reinstatement

If the policy or the coverage is cancelled for nonpayment of premium, the Policyholder may apply to have the policy reinstated in the 90 days following the cancellation. The Policyholder must, in this case, do the following:

- a) Pay the entire amount of the premium or premiums due
- b) Complete the reinstatement form provided by the Insurer and return it to the latter

The Insurer shall examine these documents and notify the Policyholder that the policy or benefit is reinstated, subject to any modifications in the reinstatement application and provided the Primary Insured meets the Insurer's underwriting standards. Otherwise, the Insurer may refuse to reinstate the insurance contract.

### Waiver

The Insurer is deemed to have waived a contract provision, in whole or in part, only if said waiver is clearly expressed in writing and is signed by a person duly authorized by the Insurer.

## GENERAL PROVISIONS

### Termination

The Policyholder may terminate the contract on written notice sent to the Insurer's head office. If the premium is paid annually, termination is effective on the date said notice is received.

If premiums are paid on a monthly basis, the refund is made as follows:

- a) If the Insurer receives the notice of cancellation before the premium due date and has cashed the premium due on said date, the extra amount paid is entirely refunded to the Policyholder and termination is effective on the due date.
- b) If the notice of cancellation is received after the due date and the Insurer has cashed the premium due on said date, then there is no refund, and contract termination is effective at the end of the period for which the last cashed premium was paid.

### Omission, fraud or attempted fraud

Any omission or misrepresentation which might influence risk appraisal by the Insurer will result in cancellation of the contract or rejection of a claim that would otherwise be valid.

The Primary Insured's entitlement to benefits is automatically revoked if he/she obtains or seeks to obtain a benefit payment under this contract by fraudulent means, directly or indirectly.

In such a case, the Insurer is released from all obligations under the contract as of the time of the fraud and reserves the right to require reimbursement of benefit payments already made. Any fraud or attempted fraud may lead to cancellation of the insurance.

### End of coverage

Coverage under the contract ends on the earliest of the following dates:

- a) When the contract is terminated by the Policyholder
- b) When premiums due are no longer paid to the Insurer, subject to the grace period and any premium waiver provisions

- c) When the Primary Insured commits or attempts to commit a fraudulent act with respect to the Insurer
- d) The death of the Primary Insured

### General provisions

The **GENERAL PROVISIONS** of the contract apply to all benefits, provided the provisions are not incompatible with the terms of any particular coverage.

# CRITICAL ILLNESS MULTI-PROTECTION

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Beneficiary the percentages stipulated in sections I and II of the amount insured specified in the **CONTRACT SUMMARY** should the Primary Insured be diagnosed with a critical or non-critical illness as defined in sections I and II.

However, the Primary Insured must be alive at the end of the Survival Period and must not have experienced an irreversible cessation of all functions of the brain.

If this benefit is still in effect on the contract anniversary coinciding with or following the Primary Insured's 100th birthday, the Insurer undertakes to pay the amount insured specified in the **CONTRACT SUMMARY**.

The diagnosis and treatment of any covered condition must be assumed by a physician licensed to practice in Canada or the United States (or another region, with the Insurer's approval).

## Eligibility

To be eligible for this benefit, the Primary Insured must be between 30 days and 15 years of age inclusive when the application is signed.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the Policyholder.

If the Policyholder is not alive when the amount insured is paid, the Insurer undertakes to pay the amount insured to the Policyholder's estate or heirs, which shall release the Insurer of any further responsibility.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Additional definition

**Artificial life support** means that the Primary Insured is under the care of a physician licensed to practice and is kept alive by nutritional, respiratory and/or cardiovascular support even in case of irreversible cessation of the functions of the brain.

## Automatic benefit increase option

The Policyholder may choose to enrol or not to enrol in this option, under which the initial amount insured is automatically increased by 15% without proof of insurability on the third, sixth and ninth anniversary of the contract.

The new amount insured is rounded to the nearest \$1 000; minimum increase is \$1 000 and maximum annual increase is \$25 000.

The automatic benefit increase does not apply if the contract was issued with an extra premium.

Automatic benefit increases cease if the Policyholder requests a decrease in the amount insured under this benefit or if premiums are waived under the premium waiver clause in the event of total disability of the Primary Insured.

# CRITICAL ILLNESS MULTI-PROTECTION

## Automatic benefit increase option (continued)

The Policyholder may ask that the amount insured not be increased. If the Policyholder makes such a request, the amount insured may no longer be increased automatically at a later date without proof of insurability.

## Premium refund upon death during the Survival Period

Should the Primary Insured die during the Survival Period, this protection provides for refund of policy fees, premiums and extra premiums paid for this benefit and any premiums paid for the **PREMIUM REFUND (20) – CRITICAL ILLNESS MULTI-PROTECTION** benefit less the amount of any benefits paid.

Any premiums waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit, taking into account any additions under the automatic benefit increase option.

## SECTION I

### Critical illness

Under this section, the Insurer undertakes to pay 100% of the amount insured specified in the **CONTRACT SUMMARY**. However, the amount insured may be paid only once.

### Definitions

#### 1. Stroke (Cerebrovascular Accident)

A cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by intracranial thrombosis or hemorrhage or by embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit.

#### Exclusion

Transient ischemic attacks are specifically excluded.

#### 2. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- a) Blood product transfusion
- b) Marrow stimulating agents
- c) Immunosuppressive agents
- d) Bone marrow transplantation

#### 3. Autism

An organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed by a specialist before the third birthday.

#### 4. Burns

Third degree burns over at least 20% of the body surface.

#### 5. Cancer

A tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Leukemia is a type of cancer that is covered under this benefit.

### Exclusions

1. The following cancers are excluded from coverage:
  - a) Carcinoma in situ
  - b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)
  - c) Any non-melanoma skin cancer that has not become metastatic (spread to neighbouring organs)
  - d) Stage A (T1a or T1b) prostate cancer
2. Furthermore, no benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit) if within the first 90 days after the effective date of the benefit or the effective date of last

# CRITICAL ILLNESS MULTI-PROTECTION

## Definitions (continued)

### 5. Cancer (continued)

#### Exclusions (continued)

reinstatement of the benefit, the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

### 6. Blindness

The total and irreversible loss of vision in both eyes as confirmed by an ophthalmologist, with the corrected visual acuity being 20/200 or less in each eye or the field of vision being less than 20 degrees in both eyes.

### 7. Coma

A state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of four days. The Glasgow coma score must be four or less continuously during the four days.

#### Exclusions

- a) A medically induced coma
- b) A coma which results directly from alcohol or drug use

### 8. Coronary Artery Bypass Surgery

The undergoing of heart surgery, when medically needed, to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

## Exclusion

Non-surgical techniques such as balloon angioplasty or laser relief of an obstruction are not covered.

### 9. Aortic Surgery

The undergoing of 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.

### 10. Type 1 Diabetes Mellitus

A diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made before the Primary Insured's 18th birthday by a qualified pediatrician or endocrinologist licensed and practising in Canada or the U.S.

Furthermore, there must be evidence of dependence on insulin for a minimum of three months.

### 11. Muscular Dystrophy

A definitive diagnosis, before the Primary Insured's 18th birthday, of muscular dystrophy, characterized by well-defined neurological abnormalities and confirmed by electromyography and muscle biopsy.

### 12. Cystic Fibrosis

A definitive diagnosis of cystic fibrosis confirmed by a specialist before the 18th birthday with evidence of chronic lung disease and pancreatic insufficiency.

### 13. Heart Attack (Myocardial Infarction)

The death of a portion of heart muscle as a result of inadequate blood supply as evidenced by the following:

- a) New electrocardiographic (ECG) changes indicative of a myocardial infarction, and
- b) The elevation of cardiac biochemical markers to levels considered diagnostic for infarction

# CRITICAL ILLNESS MULTI-PROTECTION

## Definitions (continued)

### 13. Heart Attack (Myocardial Infarction) (continued)

Heart attack during coronary angioplasty is covered provided there are diagnostic changes of new Q wave infarction on the ECG in addition to elevation of cardiac markers.

#### Exclusion

Heart attack does not include an incidental finding of ECG changes suggesting a prior myocardial infarction in the absence of a corroborating event.

### 14. Occupational HIV Infection

Diagnosis of Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Primary Insured's normal occupation which exposed the Primary Insured to HIV-contaminated body fluids.

#### Exclusions

No benefit is payable under this provision unless all of the following conditions are met:

- a) The accidental injury is reported to the Insurer within 14 days of its occurrence.
- b) An HIV test is performed within 14 days of the accidental injury and the result is negative.
- c) An HIV test is performed between 90 and 180 days after the accidental injury and the result is positive.
- d) All HIV tests are performed by facilities approved by the Insurer.
- e) The accidental injury is reported, investigated and documented in accordance with current Canadian workplace guidelines.

No payment will be made if any of the following apply:

- a) The Primary Insured elects not to take any available licensed vaccine offering protection against HIV.
- b) A licensed cure for HIV infection becomes available prior to the accidental injury.
- c) The HIV infection results from a non-accidental injury (including, but not limited to, sexual transmission or intravenous (IV) drug use).

### 15. Kidney failure

Chronic irreversible failure of both kidneys (end stage renal disease) necessitating treatment by regular hemodialysis, peritoneal dialysis or renal transplantation.

### 16. Alzheimer's Disease

A definitive clinical diagnosis by a specialist of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The Primary Insured must exhibit loss of intellectual capacity involving impairment of memory and judgement which results in a significant reduction in mental and social functioning such that he or she requires continuous daily supervision.

#### Exclusion

All other dementing organic brain disorders and psychiatric illnesses are excluded.

### 17. Parkinson's Disease

A definitive diagnosis by a specialist of primary idiopathic Parkinson's Disease characterized by two or more of the following clinical manifestations: muscle rigidity, tremor or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses). The Primary Insured must require substantial physical assistance from another adult to perform at least two of the six Activities of Daily Living (as defined in the **GENERAL PROVISIONS**).

#### Exclusion

All other types of Parkinsonism are specifically excluded.

### 18. Motor Neuron Disease

A definitive diagnosis of one 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 entities.

### 19. Bacterial Meningitis

A definitive diagnosis of bacterial meningitis that is confirmed by laboratory analysis of cerebrospinal fluid showing growth of pathogenic bacteria in culture and that causes permanent neurological deficit confirmed by a neurologist and documented for at least ninety days following the date of diagnosis.

# CRITICAL ILLNESS MULTI-PROTECTION

## Definitions (continued)

### 19. Bacterial Meningitis (continued)

#### Exclusion

Viral meningitis is not covered.

### 20. Paralysis

The complete and permanent loss of use of two or more limbs for a continuous period of ninety days following the precipitating events, during which time there has been no sign of improvement.

#### Exclusion

All psychiatric related causes are specifically excluded.

### 21. Cerebral Palsy

A definitive diagnosis of cerebral palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

### 22. Loss of Speech

Total and irreversible loss of the ability to speak as the result of physical injury or disease, the loss persisting for a continuous period of at least 180 days.

#### Exclusion

All psychiatric related causes are specifically excluded.

### 23. Loss of Autonomy

An unequivocal diagnosis, by a specialist, of either of the following for a continuous period of 90 days:

- a) Total and permanent inability to perform independently at least two of the six Activities of Daily Living (as defined in the **GENERAL PROVISIONS**), with no reasonable chance of recovery
- b) Cognitive impairment as defined in the **GENERAL PROVISIONS**

### 24. Loss of Limbs

The irreversible severance of two or more limbs from above the wrist or ankle joint as the result of an accident or medically required amputation.

### 25. Heart Valve Replacement

The undergoing of replacement of any heart valve with either a natural or mechanical valve when medically needed.

#### Exclusion

Heart valve repair is specifically excluded.

### 26. Multiple Sclerosis

A definitive diagnosis by a neurologist of multiple sclerosis, characterized by well-defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis.

### 27. Deafness

Total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within a speech threshold of 500 to 3000 cycles per second.

### 28. Major Organ Transplant or Major Organ Failure on Waiting List

Diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, with transplantation medically necessary.

To qualify under the insured condition of Major Organ Transplant, the Primary Insured must undergo surgery as the recipient for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

To qualify under the insured condition of Major Organ Failure on Waiting List, the Primary Insured must be eligible as a recipient in an approved government organ or bone marrow transplant program in Canada or the U.S. for one or more of the organs specified in this provision or for bone marrow. For purposes of the Survival Period, the date of diagnosis is the date the Primary Insured's enrolment in the transplant program takes effect.

### 29. Benign Brain Tumour

A non-malignant tumour arising from the brain or meninges. The histological nature of the tumour must be confirmed by examination of tissue (biopsy or surgical excision).

## CRITICAL ILLNESS MULTI-PROTECTION

### 29. Benign Brain Tumour (continued)

#### Exclusions

1. Tumours of the bony cranium and pituitary microadenomas (less than 10 mm in diameter) are excluded.
2. Furthermore, no benefit will be payable for benign brain tumour or for a subsequent diagnosis of any benign brain tumour or other covered conditions directly resulting from, or the treatment of, any benign tumour, if within the first 90 days following the effective date of the benefit or the effective date of last reinstatement of the benefit the Primary Insured has any of the following:
  - a) Signs or symptoms of benign brain tumour that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made
  - b) Medical consultations or tests that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made
  - c) A diagnosis of benign brain tumour

The Primary Insured must report this information to the Insurer within six months of the date of the diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for benign brain tumour or for any critical illness caused by benign brain tumour or its treatment.

## SECTION II

### Non-critical illness

Under this section, the Insurer undertakes to pay 10% of the amount insured indicated in the **CONTRACT SUMMARY**. However, the amount insured may be paid only once and may not exceed \$25 000.

#### Definitions

##### 1. Coronary Angioplasty

An interventional procedure to unblock and widen a vessel that supplies blood to the heart. Angioplasty must be medically necessary to allow an uninterrupted flow of blood and oxygen to the heart.

### 2. Non Life-Threatening Cancer

- a) Stage T1a or T1b (stage A) prostate cancer
- b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness)
- c) Ductal carcinoma in situ of the breast (DCIS, requires confirmation by biopsy)

#### Exclusions

No benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit), if within the first 90 days following the effective date of the benefit or the effective date of last reinstatement of the benefit the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of the diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

## SECTION III

### Reimbursement of expenses in case of critical or non-critical illness

Under this section, the Insurer undertakes to reimburse eligible expenses if the Primary Insured is diagnosed with a critical or non-critical illness covered under this benefit.

# CRITICAL ILLNESS MULTI-PROTECTION

## Additional definitions

**Permanent motor impairment** means a physical impairment that prevents production of a movement.

**Occupational therapist's role in adapting the principal residence and/or automobile** means assessment of the accessibility of the Primary Insured's main residence and/or automobile and development of recommendations to modify the physical environment of the home or the automobile for maximum autonomy of the Primary Insured. The occupational therapist must take into account not only the comprehensive functional assessment of the Primary Insured, the access condition at his/her home and/or the need for modifications to his/her automobile but also family, social and environmental factors and applicable municipal bylaws and government policies.

## Eligible expenses

### 1. Adaptation

Cost of services of an occupational therapist and of adaptations to the Primary Insured's car and principal residence rendered necessary as a result of a critical or non-critical illness, to a lifetime maximum benefit of \$5 000, should the Primary Insured suffer a permanent motor impairment.

The Insurer reserves the right to ask for new professional assessments if the Insurer considers the costs specified in the occupational therapist's report to be excessive.

The latter report must include a physical and functional evaluation of the Primary Insured, evaluation of the accessibility of his/her principal residence and/or automobile, adaptation recommendations and drawings illustrating the recommendations.

The report must also include plans of the home (rooms, exterior access) before and after the adaptations, an estimate of the cost of the work, a general description of the home and its architectural barriers and a detailed description of the demolition and construction work to be performed.

The Primary Insured or a member of his/her family must forward the following documents to the Insurer:

- a) An estimate of the cost of the work
- b) A copy of the deed of the home if the Primary Insured is the owner, or the landlord's agreement to performing the work if the Primary Insured is a tenant
- c) Agreement of the municipality, in case of special accommodations

When the Insurer has approved the adaptations, a written confirmation will be sent to the Primary Insured specifying the benefit granted, which will be equivalent to the least costly estimate. The Insurer shall also stipulate how the benefits will be paid (number of payments, timetable).

### 2. Travel expenses

Travel expenses incurred for the Primary Insured to receive care or for medical follow-up, to a lifetime maximum of \$2 500 including the following expenses:

- a) \$0.25/kilometre for trips in a private car or for taxi fare, to a maximum of \$50 of eligible expenses per day including any costs for parking
- b) Costs to take the Primary Insured by air or land to the medical establishment of his/her choice outside the province of residence

### 3. Costs of household help and/or childcare

Costs of household help and/or childcare provided by a person not residing with the Primary Insured, on recommendation of the attending physician, to help the Primary Insured, to a daily maximum of \$25 and a lifetime maximum of \$1 000.

## SECTION IV

### Accidental Fracture

Under this section, the Insurer undertakes to pay the beneficiary the benefit indicated in the table below should the Primary Insured suffer a fracture due to an accident that occurs during the coverage period.

# CRITICAL ILLNESS MULTI-PROTECTION

## SECTION IV (continued)

### Accidental Fracture (continued)

The fracture must be diagnosed within thirty days of the accident.

- a) The loss resulted, directly and independently of any other cause, from accidental drowning or injuries suffered during the period of coverage
- b) The loss was suffered within 365 days of the date of the accident

### Additional definition

**Fracture** means a violent bone break.

### Additional definition

**Loss** means the total and irreversible loss of sight, in the case of an eye; the total and irreversible loss of the ability to hear in both ears, in the case of hearing; the total and irreversible loss of the ability to make intelligible sounds, in the case of speech; total amputation at the first phalanx, in the case of the thumb or the fingers; total amputation or loss of use at or above the wrist or ankle in the case of the hands or feet; and total amputation or loss of use at or above the elbow or the knee, in the case of the arms or legs.

The loss must be deemed total and irreversible by a physician.

### Lump Sum Payable

Primary Insured	
Fracture	Amount insured
Skull	\$2 500
Spinal column	\$2 500
Pelvis	\$2 500
Femur	\$2 500
Hip	\$2 500
Sternum	\$625
Larynx	\$625
Trachea	\$625
Scapula	\$625
Coccyx	\$625
Radius	\$625
Humerus	\$625
Ulna	\$625
Kneecap	\$625
Tibia	\$625
Fibula	\$625
Other bone	\$250

### BENEFITS TABLE

Loss	% of the amount insured under the CRITICAL ILLNESS MULTI-PROTECTION benefit
Life	25%
Sight of both eyes	100%
Both hands or both feet	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Hearing and speech	100%
One arm or one leg	75%
One hand or one foot	50%
Sight of one eye or hearing or speech	50%
Thumb	25%
Finger other than the thumb	6.25%

### Limitation

No benefits are payable under the **ACCIDENTAL FRACTURE** provision once the Primary Insured reaches the age of 25.

## SECTION V

### Accidental death and loss of use

Under this section, if the Primary Insured suffers one of the losses listed in the **BENEFITS TABLE** due to an accident occurring while the benefit is in effect, the Insurer undertakes to pay the beneficiary the percentage indicated below of the amount insured under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit (as specified in the **CONTRACT SUMMARY**), provided the Insurer receives proof of the following that the Insurer deems satisfactory:

# CRITICAL ILLNESS MULTI-PROTECTION

## Disappearance

If the Primary Insured is missing following a known accident involving the disappearance or sinking of the aircraft, vehicle or vessel in which he/she was travelling, and if his/her body is not found in the following year, the Primary Insured will be presumed dead, in the absence of proof to the contrary, 365 days after the date of the accident, unless a declaratory verdict has determined another date of death.

## Limitations

- a) The maximum amount payable in one or more instalments for all losses subsequent to amputation of the thumb or fingers may not exceed 50% of the amount insured under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit specified in the **CONTRACT SUMMARY**.
- b) The maximum amount payable in one or more instalments for all losses over a period of 365 days stemming from any one accident may not exceed 100% of the amount insured specified in the **CONTRACT SUMMARY**.
- c) No benefits are payable under the **ACCIDENTAL DEATH AND LOSS OF USE** provision once the Primary Insured reaches the age of 25.

## SECTION VI

### Tuition

Under this section, the Insurer undertakes to reimburse the Primary Insured for eligible costs incurred due to an accident, a critical illness or a non-critical illness.

### Additional definitions

**Waiting period** refers, in the case of total disability of a student, to a period of seven consecutive days during which no benefit is payable.

**Student** refers to the Primary Insured between 17 and 25 years of age, provided he/she is attending an educational institution full time.

**Total disability** refers to a condition confirmed by a physician that requires medical care and that renders the student unable to study or to perform any summer job for which he/she is reasonably qualified.

**Critical illness** refers to diagnosis of one of the conditions defined in section I of this benefit.

**Non-critical illness** refers to diagnosis of one of the conditions defined in section II of this benefit.

## Eligible expenses

### 1. Total disability of a student

When a student becomes totally disabled as a result of an accident, a critical illness or a non-critical illness, the Insurer undertakes to pay him/her \$200 per week (or \$28.75 per day in the case of an incomplete week) for the period between June 1 and August 31 immediately following the date of the accident or the diagnosis of the critical or non-critical illness, provided the Primary Insured is still disabled during this period. The waiting period is however applicable.

### 2. Academic rehabilitation

The Insurer undertakes to pay tuition for private courses or for re-education, including school transportation, to a maximum of \$5 000 per accident or per critical or non-critical illness.

The Primary Insured must undertake rehabilitation within six months of the accident or the diagnosis of a critical or non-critical illness.

## Limitation

No benefits are payable under the **TUITION** provision once the Primary Insured reaches the age of 25.

# CRITICAL ILLNESS MULTI-PROTECTION

## **Waiver of premiums in case of disability of the Primary Insured or the Policyholder**

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

### **Primary Insured**

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Primary Insured become totally disabled between ages 16 and 59 inclusive.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

If the Policyholder is not the Primary Insured, then the waiver of premiums in case of disability of the Primary Insured comes into effect on the earlier of the following dates:

- a) The Primary Insured's 26th birthday
- b) The contract anniversary coinciding with or following the Policyholder's 65th birthday

### **Policyholder**

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Policyholder become totally disabled before his/her 59th birthday.

The waiver of premiums in case of disability ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Policyholder's 65th birthday
- b) The Primary Insured's 26th birthday—unless the Primary Insured is disabled on this day, in which case the waiver continues under the provision for waiver of premiums in case of disability of the Primary Insured

## **Benefit renewal**

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## **Protection after the end of coverage**

Any expenses mentioned in sections III and VI that are incurred after the date of the end of coverage are not covered unless related to a **CRITICAL ILLNESS** or a **NON-CRITICAL ILLNESS** for which a benefit was paid under section I or II.

## **Exclusions**

1. No benefits are payable if the claim stems directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs
  - b) The Primary Insured's service as an active member of the armed forces of any country
  - c) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country
  - d) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - e) Voluntary or involuntary inhalation of gas or ingestion of poison
  - f) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - g) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind

# CRITICAL ILLNESS MULTI-PROTECTION

## Exclusions (continued)

2. No benefits are payable under the exclusions specified in the definitions in sections I and II.
3. No benefits are payable under sections IV, V or VI if the claim is caused directly or indirectly by any of the following:
  - a) An accident sustained by the Primary Insured while participating in a sport for remuneration or in any kind of motor vehicle competition, race or speed contest
  - b) The Primary Insured's participation in a flight or a flight attempt in any aircraft in any capacity other than that of a passenger
4. No benefits are payable under section VI if the claim stems directly or indirectly from any of the following:
  - a) The disabled student performs remunerative work or the duties (remunerated or unremunerated) of such work
  - b) The disabled student studies full or part time, including correspondence courses, unless prior written consent has been obtained from the Insurer
  - c) The student refuses to submit to an examination requested by the Insurer or fails to submit to the Insurer evidence of persistence of the disability

## End of coverage

Coverage for the Primary Insured under this benefit ends on the earliest of the following dates:

- a) The date on which a benefit is paid for any critical illness covered under section I of this benefit
- b) The date on which the Primary Insured asks the Insurer for a full refund to which the Primary Insured is entitled under the **PREMIUM REFUND (20) – CRITICAL ILLNESS MULTI-PROTECTION** benefit
- c) The contract anniversary coinciding with or following the Primary Insured's 100th birthday

## PREMIUM REFUND (20) – CRITICAL ILLNESS MULTI-PROTECTION

### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to refund to the Beneficiary a percentage of the premiums paid for this benefit and for the **CRITICAL ILLNESS MULTI-PROTECTION** benefit.

To be entitled to this refund, the Policyholder must submit a written request to the Insurer asking that the **CRITICAL ILLNESS MULTI-PROTECTION** benefit be terminated.

In addition, this benefit provides for refund of premiums in the event of the death of the Primary Insured, unless said death occurs during the Survival Period.

The amount of the refund is equal to a percentage of the premiums and extra premiums paid (including policy fees and without interest) for an amount insured under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit.

The applicable percentage is shown below. It is based on the number of years during which the amount insured under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit was in effect.

Number of years in effect	Percentage of premiums refunded
Less than 10 years	0%
10 years	50%
11 years	55%
12 years	60%
13 years	65%
14 years	70%
15 years	75%
16 years	80%
17 years	85%
18 years	90%
19 years	95%
20 years and over	100%

Additions to the amount insured under the automatic benefit increase provision must be in effect for the number of years shown in the table above to be eligible for the corresponding refund.

Any premiums for the **CRITICAL ILLNESS MULTI-PROTECTION** and **PREMIUM REFUND (20) – C.I. MULTI-PROTECTION** benefits that have been waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit, taking into account any additions under the automatic benefit increase provision.

In all cases, claims paid under the **CRITICAL ILLNESS MULTI-PROTECTION** benefit are subtracted from the refund.

### Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 30 days and 15 years of age inclusive when the application is signed.
- b) He/she must have applied and been approved for the **CRITICAL ILLNESS MULTI-PROTECTION** benefit.

### Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

### Beneficiary

The beneficiary is the Policyholder.

If the Policyholder is not alive when the amount insured is paid, the Insurer undertakes to pay the amount insured to the Policyholder's estate or heirs, which shall release the Insurer of any further responsibility.

## **PREMIUM REFUND (20) – CRITICAL ILLNESS MULTI-PROTECTION**

### **Reduction in coverage**

The Policyholder may request a reduction in coverage, in which case he/she is entitled to a refund of a percentage of the premiums on the cancelled amount insured. The percentage is determined based on the table above.

### **Premium determination**

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

### **Duration of premium payment**

The duration of premium payment is indicated in the **CONTRACT SUMMARY** and must be the same as that of the **CRITICAL ILLNESS MULTI-PROTECTION** benefit.

### **Waiver of premiums in case of disability of the Primary Insured or the Policyholder**

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

### **Primary Insured**

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Primary Insured become totally disabled between ages 16 and 59 inclusive.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

If the Policyholder is not the Primary Insured, then the waiver of premiums in case of disability of the Primary Insured comes into effect on the earlier of the following dates:

- a) The Primary Insured's 26th birthday
- b) The contract anniversary coinciding with or following the Policyholder's 65th birthday

### **Policyholder**

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Policyholder become totally disabled before his/her 59th birthday.

The premium waiver ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Policyholder's 65th birthday
- b) The Primary Insured's 26th birthday— unless the Primary Insured is disabled on this day, in which case the waiver continues under the provision for waiver of premiums in case of disability of the Primary Insured

### **Benefit renewal**

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

### **Exclusions**

No benefits are payable if the claim is caused directly or indirectly by any of the following:

- a) The Primary Insured's service as an active member of the armed forces of any country
- b) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country

## **PREMIUM REFUND (20) – CRITICAL ILLNESS MULTI-PROTECTION**

### **End of coverage**

This coverage ends on the earlier of the following dates:

- a) The date on which the full refund to which the Policyholder is entitled under this benefit has been paid
- b) The date on which the **CRITICAL ILLNESS MULTI-PROTECTION** benefit ends

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# CRITICAL ILLNESS - BASIC BENEFIT

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured or the Beneficiary, as the case may be, the percentages stipulated in section I of the amount insured specified in the **CONTRACT SUMMARY** should the Primary Insured be diagnosed with a critical illness as defined in section I.

However, the Primary Insured must be alive at the end of the Survival Period and must not have experienced an irreversible cessation of all functions of the brain.

The diagnosis and treatment of any covered condition must be assumed by a physician licensed to practice in Canada or the United States (or another region, with the Insurer's approval).

## Eligibility

To be eligible for this benefit, the Primary Insured must be between 16 and 65 years of age inclusive when the application is signed.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when delivered to the Policyholder provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her.

The Insurer records the change requested but assumes no responsibility for its validity.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Additional definition

**Artificial life support** means that the Primary Insured is under the care of a physician licensed to practice and is kept alive by nutritional, respiratory and/or cardiovascular support even in case of irreversible cessation of the functions of the brain.

## Premium refund upon death during the Survival Period

Should the Primary Insured die during the Survival Period, this protection provides for refund of policy fees, premiums and extra premiums paid for this benefit, and any premiums paid for the **PREMIUM REFUND (20) – CRITICAL ILLNESS** benefit or the **PREMIUM REFUND (65) – CRITICAL ILLNESS** benefit, as the case may be, less the amount of any benefits paid.

Any premiums waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS** benefit.

# CRITICAL ILLNESS - BASIC BENEFIT

## SECTION I

### Critical Illness

Under this section, the Insurer undertakes to pay 100% of the amount insured specified in the **CONTRACT SUMMARY**. However, the amount insured may be paid only once.

### Definitions

#### 1. Stroke (Cerebrovascular Accident)

A cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by intracranial thrombosis or hemorrhage or by embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit.

#### Exclusion

Transient ischemic attacks are specifically excluded.

#### 2. Cancer

A tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Leukemia is a type of cancer that is covered under this benefit.

#### Exclusions

1. The following cancers are excluded from coverage:

- a) Carcinoma in situ;
- b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)
- c) Any non-melanoma skin cancer that has not become metastatic (spread to distant organs)
- d) Stage A (T1a or T1b) prostate cancer

2. Furthermore, no benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit) if within the

first 90 days after the effective date of the benefit or the effective date of last reinstatement of the benefit, the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

#### 3. Coronary Artery Bypass Surgery

The undergoing of heart surgery, when medically required, to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

#### Exclusion

Any non-surgical techniques such as balloon angioplasty or laser relief of an obstruction are not covered.

#### 4. Heart Attack (Myocardial infarction)

The death of a portion of heart muscle as a result of inadequate blood supply as evidenced by the following:

- a) New electrocardiographic (ECG) changes indicative of a myocardial infarction, and,
- b) The elevation of cardiac biochemical markers to levels considered diagnostic for infarction

# CRITICAL ILLNESS - BASIC BENEFIT

## Critical Illness (continued)

### Definitions (continued)

Heart attack during coronary angioplasty is covered provided that there are diagnostic changes of new Q wave infarction on the ECG in addition to elevation of cardiac markers.

#### Exclusion

Heart attack does not include an incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroboration event.

### 5. Kidney failure

Chronic irreversible failure of both kidneys (end stage renal disease) necessitating treatment by regular hemodialysis, peritoneal dialysis or renal transplantation.

## SECTION II

### Reimbursement of expenses in case of critical illness

Under this section, the Insurer undertakes to reimburse eligible expenses if the Primary Insured is diagnosed with a critical illness covered under this benefit.

### Additional definitions

**Permanent motor impairment** means a physical impairment that prevents production of a movement.

**Occupational therapist's role in adapting the principal residence and/or automobile** means assessment of the accessibility of the Primary Insured's main residence and/or automobile and development of recommendations to modify the physical environment of the home or the automobile for maximum autonomy of the Primary Insured. The occupational therapist must take into account not only the comprehensive functional assessment of the Primary Insured, the access conditions at his/her home and/or the need for modifications to his/her automobile, but also family, social and environmental factors and applicable municipal bylaws and government policies.

## Eligible expenses

### 1. Adaptation

Cost of services of an occupational therapist and of adaptations to the Primary Insured's car and principal residence rendered necessary as a result of a critical or non-critical illness, to a lifetime maximum benefit of \$5 000, should the Primary Insured suffer a permanent motor impairment.

The Insurer reserves the right to ask for new professional assessments if the Insurer considers the costs specified in the occupational therapist's report to be excessive.

The latter report must include a physical and functional evaluation of the Primary Insured, evaluation of the accessibility of his/her principal residence and/or automobile, adaptation recommendations and drawings illustrating the recommendations.

The report must also include plans of the home (rooms, exterior access) before and after the adaptations, an estimate of the cost of the work, a general description of the home and its architectural barriers and a detailed description of the demolition and construction work to be performed.

The Primary Insured or a member of his/her family must forward the following documents to the Insurer:

- a) An estimate of the cost of the work
- b) A copy of the deed of the home if the Primary Insured is the owner, or the landlord's agreement to performing the work if the Primary Insured is a tenant
- c) Agreement of the municipality, in case of special accommodations

When the Insurer has approved the adaptations, a written confirmation will be sent to the Primary Insured specifying the benefit granted, which will be equivalent to the least costly estimate. The Insurer shall also stipulate how the benefits will be paid (number of payments, timetable).

# CRITICAL ILLNESS - BASIC BENEFIT

## Eligible expenses (continued)

### 2. Travel expenses

Travel expenses incurred for the Primary Insured to receive care or for medical follow-up, to a lifetime maximum of \$2 500 including the following expenses:

- a) \$0.25/kilometre for trips in a private car or for taxi fare, to a maximum of \$50 of eligible expenses per day, including any costs for parking
- b) Costs to take the Primary Insured by air or land to the medical establishment of his/her choice outside the province of residence

### 3. Costs of household help and/or childcare

Costs of household help and/or childcare provided by a person not residing with the Primary Insured, on recommendation of the attending physician, to help the Primary Insured, to a daily maximum of \$25 and a lifetime maximum of \$1 000.

## Waiver of premiums in case of disability of the Primary Insured

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

To be eligible for this waiver, the Primary Insured must be between 16 and 55 years of age inclusive.

Under this provision, no premiums are payable for **CRITICAL ILLNESS BASIC BENEFIT** as of the fourth month after the onset of total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed and will be deemed renewed only if all premiums due before the renewal date have been paid and if the first premium instalment payable for the next insurance period was made on the date indicated on the premium notice.

## Protection after the end of coverage

Any expenses mentioned in section II that are incurred after the date of the end of coverage are not covered unless related to a **CRITICAL ILLNESS** for which a benefit mentioned in section I has been paid.

## Exclusions

1. No benefits are payable if the critical illness is caused directly or indirectly by any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs
  - b) The Primary Insured's service as an active member of the armed forces of any country
  - c) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country
  - d) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - e) Voluntary or involuntary inhalation of gas or ingestion of poison or drugs
  - f) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - g) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
2. No benefits are payable under the exclusions specified in the definitions in section I.

## CRITICAL ILLNESS - BASIC BENEFIT

### End of coverage

Coverage for the Primary Insured under this benefit ends on the earlier of the following dates:

- a) The date on which a benefit is paid for any critical illness covered under section I of this benefit
- b) The date on which the Primary Insured asked the Insurer for a full refund to which the Primary Insured was entitled under the **PREMIUM REFUND (20) – CRITICAL ILLNESS** benefit or the **PREMIUM REFUND (65) – CRITICAL ILLNESS** benefit

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# CRITICAL ILLNESS - DELUXE BENEFIT

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured or the Beneficiary, as the case may be, the percentages stipulated in sections I and II of the amount insured specified in the **CONTRACT SUMMARY** should the Primary Insured be diagnosed with a critical or non-critical illness as defined in sections I and II.

However, the Primary Insured must be alive at the end of the Survival Period and must not have experienced an irreversible cessation of all functions of the brain.

If this benefit is still in effect on the contract anniversary coinciding with or following the Primary Insured's 100th birthday, the Insurer undertakes to pay the amount insured specified in the **CONTRACT SUMMARY**.

The diagnosis and treatment of any covered condition must be assumed by a physician licensed to practice in Canada or the United States (or another region, with the Insurer's approval).

## Eligibility

To be eligible for this benefit, the Primary Insured must be between 16 and 65 years of age inclusive when the application is signed.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her.

The Insurer records the change requested but assumes no responsibility for its validity.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Additional definition

**Artificial life support** means that the Primary Insured is under the care of a physician licensed to practice and is kept alive by nutritional, respiratory and/or cardiovascular support even in case of irreversible cessation of the functions of the brain.

## Premium refund upon death during the Survival Period

Should the Primary Insured die during the Survival Period, this protection provides for refund of policy fees, premiums and extra premiums paid for this benefit, and any premiums paid for the **PREMIUM REFUND (20) – CRITICAL ILLNESS** benefit or the **PREMIUM REFUND (65) – CRITICAL ILLNESS** benefit, as the case may be, less the amount of any benefits paid.

Any premiums waived under the premium waiver clause are excluded from the refund.

# CRITICAL ILLNESS - DELUXE BENEFIT

## Premium refund upon death during the Survival Period (continued)

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS** benefit.

## SECTION I

### Critical Illness

Under this section, the Insurer undertakes to pay 100% of the amount insured specified in the **CONTRACT SUMMARY**. However, the amount insured may be paid only once.

### Definitions

#### 1. Stroke (Cerebrovascular Accident)

A cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by intracranial thrombosis or hemorrhage or by embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit.

#### Exclusion

Transient ischemic attacks are specifically excluded.

#### 2. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- a) Blood product transfusion
- b) Marrow stimulating agents
- c) Immunosuppressive agents
- d) Bone marrow transplantation

#### 3. Burns

Third degree burns over at least 20% of the body surface.

#### 4. Cancer

A tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Leukemia is a type of cancer that is covered under this benefit.

### Exclusions

1. The following cancers are excluded from coverage:

- a) Carcinoma in situ
- b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)
- c) Any non-melanoma skin cancer that has not become metastatic (spread to neighbouring organs)
- d) Stage A (T1a or T1b) prostate cancer

2. Furthermore, no benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit) if within the first 90 days after the effective date of the benefit or the effective date of last reinstatement of the benefit, the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

## CRITICAL ILLNESS - DELUXE BENEFIT

### Critical Illness (continued) Definitions (continued)

#### 5. **Blindness**

The total and irreversible loss of vision in both eyes as confirmed by an ophthalmologist, with the corrected visual acuity being 20/200 or less in each eye or the field of vision being less than 20 degrees in both eyes.

#### 6. **Coma**

A state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of four days. The Glasgow coma score must be four or less continuously during the four days.

#### **Exclusions**

- a) A medically induced coma
- b) A coma which results directly from alcohol or drug use

#### 7. **Coronary Artery Bypass Surgery**

The undergoing of heart surgery, when medically needed, to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

#### **Exclusion**

Non-surgical techniques such as balloon angioplasty or laser relief of an obstruction are not covered.

#### 8. **Aortic Surgery**

The undergoing of 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.

#### 9. **Heart Attack (Myocardial Infarction)**

The death of a portion of heart muscle as a result of inadequate blood supply as evidenced by the following:

- a) New electrocardiographic (ECG) changes indicative of a myocardial infarction, and
- b) The elevation of cardiac biochemical markers to levels considered diagnostic for infarction

Heart attack during coronary angioplasty is covered provided there are diagnostic changes of new Q wave infarction on the ECG in addition to elevation of cardiac markers.

#### **Exclusion**

Heart attack does not include an incidental finding of ECG changes suggesting a prior myocardial infarction in the absence of a corroborating event.

#### 10. **Occupational HIV Infection**

Diagnosis of Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Primary Insured's normal occupation which exposed the Primary Insured to HIV-contaminated body fluids.

#### **Exclusions**

No benefit is payable under this provision unless all of the following conditions are met:

- a) The accidental injury is reported to the Insurer within 14 days of its occurrence.
- b) An HIV test is performed within 14 days of the accidental injury and the result is negative.
- c) An HIV test is performed between 90 and 180 days after the accidental injury and the result is positive.
- d) All HIV tests are performed by facilities approved by the Insurer.
- e) The accidental injury is reported, investigated and documented in accordance with current Canadian workplace guidelines.

No payment will be made if any of the following apply:

- a) The Primary Insured elects not to take any available licensed vaccine offering protection against HIV.
- b) A licensed cure for HIV infection becomes available prior to the accidental injury.
- c) The HIV infection results from a non-accidental injury (including, but not limited to, sexual transmission or intravenous (IV) drug use).

## CRITICAL ILLNESS - DELUXE BENEFIT

### Critical Illness (continued)

#### Definitions (continued)

##### 11. Kidney failure

Chronic irreversible failure of both kidneys (end stage renal disease) necessitating treatment by regular hemodialysis, peritoneal dialysis or renal transplantation.

##### 12. Alzheimer's Disease

A definitive clinical diagnosis by a specialist of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The Primary Insured must exhibit loss of intellectual capacity involving impairment of memory and judgement which results in a significant reduction in mental and social functioning such that he/she requires continuous daily supervision.

#### Exclusion

All other dementing organic brain disorders and psychiatric illnesses are excluded.

##### 13. Parkinson's Disease

A definitive diagnosis by a specialist of primary idiopathic Parkinson's Disease which is characterized by two or more of the following clinical manifestations: muscle rigidity, tremor or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses). The Primary Insured must require substantial physical assistance from another adult to perform at least two of the six Activities of Daily Living (as defined in the **GENERAL PROVISIONS**).

#### Exclusion

All other types of Parkinsonism are specifically excluded.

##### 14. Motor Neuron Disease

A definitive diagnosis of one 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 entities.

##### 15. Bacterial Meningitis

A definitive diagnosis of bacterial meningitis that is confirmed by laboratory analysis of cerebrospinal fluid showing growth of pathogenic bacteria in culture and that causes permanent neurological deficit confirmed by a neurologist and documented for at least ninety days following the date of diagnosis.

#### Exclusion

Viral meningitis is not covered.

##### 16. Paralysis

The complete and permanent loss of use of two or more limbs for a continuous period of ninety days following the precipitating events, during which time there has been no sign of improvement.

#### Exclusion

All psychiatric related causes are specifically excluded.

##### 17. Loss of Speech

Total and irreversible loss of the ability to speak as the result of physical injury or disease, the loss persisting for a continuous period of at least 180 days.

#### Exclusion

All psychiatric related causes are specifically excluded.

##### 18. Loss of Autonomy

An unequivocal diagnosis, by a specialist, of either of the following for a continuous period of 90 days:

- a) Total and permanent inability to perform independently at least two of the six Activities of Daily Living (as defined in the **GENERAL PROVISIONS**), with no reasonable chance of recovery
- b) Cognitive impairment as defined in the **GENERAL PROVISIONS**

##### 19. Loss of Limbs

The irreversible severance of two or more limbs from above the wrist or ankle joint as the result of an accident or medically required amputation.

# CRITICAL ILLNESS - DELUXE BENEFIT

## Critical Illness (continued)

### Definitions (continued)

#### 20. Heart Valve Replacement

The undergoing of replacement of any heart valve with either a natural or mechanical valve when medically needed.

#### Exclusion

Heart valve repair is specifically excluded.

#### 21. Multiple Sclerosis

A definitive diagnosis by a neurologist of multiple sclerosis, characterized by well-defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis.

#### 22. Deafness

Total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within a speech threshold of 500 to 3000 cycles per second.

#### 23. Major Organ Transplant or Major Organ Failure on Waiting List

Diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, with transplantation medically necessary.

To qualify under the insured condition of Major Organ Transplant, the Primary Insured must undergo surgery as the recipient for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

To qualify under the insured condition of Major Organ Failure on Waiting List, the Primary Insured must be eligible as a recipient in an approved government organ or bone marrow transplant program in Canada or the U.S. for one or more of the organs specified in this provision or for bone marrow. For purposes of the Survival Period, the date of diagnosis is the date the Primary Insured's enrolment in the transplant program takes effect.

#### 24. Benign Brain Tumour

A non-malignant tumour arising from the brain or meninges. The histological nature of the tumour must be confirmed by examination of tissue (biopsy or surgical excision).

#### Exclusions

1. Tumours of the bony cranium and pituitary microadenomas (less than 10 mm in diameter) are excluded.
2. Furthermore, no benefit will be payable for benign brain tumour or for a subsequent diagnosis of any benign brain tumour or other covered conditions directly resulting from, or the treatment of, any benign tumour, if within the first 90 days following the effective date of the benefit or the effective date of last reinstatement of the benefit the Primary Insured has any of the following:
  - a) Signs or symptoms of benign brain tumour that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made
  - b) Medical consultations or tests that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made
  - c) A diagnosis of benign brain tumour

The Primary Insured must report this information to the Insurer within six months of the date of the diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for benign brain tumour or for any critical illness caused by benign brain tumour or its treatment.

## SECTION II

### Non-critical illness

Under this section, the Insurer undertakes to pay 10% of the amount insured indicated in the **CONTRACT SUMMARY**. However, the amount payable may be paid only once and may not exceed \$25 000.

# CRITICAL ILLNESS - DELUXE BENEFIT

## Definitions

### 1. Coronary Angioplasty

An interventional procedure to unblock and widen a vessel that supplies blood to the heart. Angioplasty must be medically necessary to allow an uninterrupted flow of blood and oxygen to the heart.

### 2. Non Life-Threatening Cancer

- a) Stage T1a or T1b (stage A) prostate cancer
- b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness)
- c) Ductal carcinoma in situ of the breast (DCIS, requires confirmation by biopsy)

## Exclusions

No benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit), if within the first 90 days following the effective date of the benefit or the effective date of last reinstatement of the benefit the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of the diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

## SECTION III

### Reimbursement of expenses in case of critical or non-critical illness

Under this section, the Insurer undertakes to reimburse eligible expenses if the Primary Insured is diagnosed with a critical or non-critical illness covered under this benefit.

### Additional definitions

**Permanent motor impairment** means a physical impairment that prevents production of a movement.

**Occupational therapist's role in adapting the principal residence and/or automobile** means assessment of the accessibility of the Primary Insured's main residence and/or automobile and development of recommendations to modify the physical environment of the home or the automobile for maximum autonomy of the Primary Insured. The occupational therapist must take into account not only the comprehensive functional assessment of the Primary Insured, the access conditions at his/her home and/or the need for modifications to his/her automobile, but also family, social and environmental factors and applicable municipal bylaws and government policies.

### Eligible expenses

#### 1. Adaptation

Cost of services of an occupational therapist and of adaptations to the Primary Insured's car and principal residence rendered necessary as a result of a critical or non-critical illness, to a lifetime maximum benefit of \$5 000, should the Primary Insured suffer a permanent motor impairment.

The Insurer reserves the right to ask for new professional assessments if the Insurer considers the costs specified in the occupational therapist's report to be excessive.

# CRITICAL ILLNESS - DELUXE BENEFIT

## Eligible expenses (continued)

### 1. Adaptation (continued)

The latter report must include a physical and functional evaluation of the Primary Insured, evaluation of the accessibility of his/her principal residence and/or automobile, adaptation recommendations and drawings illustrating the recommendations.

The report must also include plans of the home (rooms, exterior access) before and after the adaptations, an estimate of the cost of the work, a general description of the home and its architectural barriers and a detailed description of the demolition and construction work to be performed.

The Primary Insured or a member of his/her family must forward the following documents to the Insurer:

- a) An estimate of the cost of the work
- b) A copy of the deed of the home if the Primary Insured is the owner, or the landlord's agreement to performing the work if the Primary Insured is a tenant
- c) Agreement of the municipality, in case of special accommodations

When the Insurer has approved the adaptations, a written confirmation will be sent to the Primary Insured specifying the benefit granted, which will be equivalent to the least costly estimate. The Insurer shall also stipulate how the benefits will be paid (number of payments, timetable).

### 2. Travel expenses

Travel expenses incurred for the Primary Insured to receive care or for medical follow-up, to a lifetime maximum of \$2 500 including the following expenses:

- a) \$0.25/kilometre for trips in a private car or for taxi fare, to a maximum of \$50 of eligible expenses per day including any costs for parking
- b) Costs to take the Primary Insured by air or land to the medical establishment of his/her choice outside the province of residence

### 3. Costs of household help and/or childcare

Costs of household help and/or childcare provided by a person not residing with the Primary Insured, on recommendation of the attending physician, to help the Primary Insured, to a daily maximum of \$25 and a lifetime maximum of \$1 000.

## Waiver of premiums in case of disability of the Primary Insured

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

To be eligible for this waiver, the Primary Insured must be between 16 and 55 years of age inclusive.

Under this provision, no premiums are payable for the **CRITICAL ILLNESS — DELUXE BENEFIT** as of the fourth month after the onset of total disability and for as long as total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## Protection after the end of coverage

Any expenses mentioned in section III that are incurred after the date of the end of coverage are not covered unless related to a **CRITICAL ILLNESS** or a **NON-CRITICAL ILLNESS** for which a benefit was paid under section I or II.

## CRITICAL ILLNESS - DELUXE BENEFIT

### Exclusions

1. No benefits are payable if the critical or non-critical illness is caused directly or indirectly by any of the following:
    - a) Abuse of alcohol or drugs, or use of illegal drugs
    - b) The Primary Insured's service as an active member of the armed forces of any country
    - c) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country
    - d) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
    - e) Voluntary or involuntary inhalation of gas or ingestion of poison
    - f) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
    - g) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  2. No benefits are payable under the exclusions specified in the definitions in sections I and II.
- c) The contract anniversary coinciding with or following the Primary Insured's 100th birthday

### End of coverage

Coverage for the Primary Insured under this benefit ends on the earliest of the following dates:

- a) The date on which a benefit is paid for any critical illness covered under section I of this benefit
- b) The date on which the Primary Insured asked the Insurer for a full refund to which the Primary Insured was entitled under the **PREMIUM REFUND (20) – CRITICAL ILLNESS** benefit or the **PREMIUM REFUND (65) – CRITICAL ILLNESS** benefit

# PREMIUM REFUND (20) – CRITICAL ILLNESS

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to refund to the Primary Insured or the Beneficiary, as the case may be, a percentage of the premiums paid for this benefit and for the **CRITICAL ILLNESS** benefit.

To be entitled to this refund, the Policyholder must submit a written request to the Insurer asking that the **CRITICAL ILLNESS** benefit be terminated.

In addition, this benefit provides for refund of premiums in the event of the death of the Primary Insured, unless said death occurs during the Survival Period.

The amount of the refund is equal to a percentage of the premiums and extra premiums paid (including policy fees and without interest) for an amount insured under the **CRITICAL ILLNESS** benefit.

The applicable percentage is shown below. It is based on the number of years during which the amount insured under the **CRITICAL ILLNESS** benefit was in effect.

Number of years in effect	Percentage of premiums refunded
Less than 10 years	0%
10 years	50%
11 years	55%
12 years	60%
13 years	65%
14 years	70%
15 years	75%
16 years	80%
17 years	85%
18 years	90%
19 years	95%
20 years and over	100%

Any premiums for the **CRITICAL ILLNESS** and **PREMIUM REFUND (20) - CRITICAL ILLNESS** benefits that have been waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS** benefit.

In all cases, claims paid under the **CRITICAL ILLNESS** benefit are subtracted from the refund.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 16 and 65 years of age inclusive when the application is signed.
- b) He/she must have applied and been approved for the **CRITICAL ILLNESS** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

## **PREMIUM REFUND (20) – CRITICAL ILLNESS**

### **Reduction in coverage**

The Policyholder may request a reduction in coverage, in which case he/she is entitled to a refund of a percentage of the premiums on the cancelled amount insured. The percentage is determined based on the table above.

### **Premium determination**

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

### **Duration of premium payment**

The duration of premium payment is indicated in the **CONTRACT SUMMARY** and must be the same as that of the **CRITICAL ILLNESS** benefit.

### **Waiver of premiums in case of disability of the Primary Insured**

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

To be eligible for this waiver, the Primary Insured must be between 16 and 55 years of age inclusive.

Under this provision, no premiums are payable for the **PREMIUM REFUND (20) – CRITICAL ILLNESS** benefit as of the fourth month after the onset of total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

### **Benefit renewal**

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

### **Exclusions**

No benefits are payable if the claim is caused directly or indirectly by any of the following:

- a) The Primary Insured's service as an active member of the armed forces of any country
- b) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country

### **End of coverage**

This coverage ends on the earlier of the following dates:

- a) The date on which the full refund to which the Primary Insured is entitled under this benefit has been paid
- b) The date on which the **CRITICAL ILLNESS** benefit ends

# PREMIUM REFUND (65) – CRITICAL ILLNESS

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to refund to the Primary Insured or the Beneficiary, as the case may be, a percentage of the premiums paid for this benefit and for the **CRITICAL ILLNESS** benefit.

To be entitled to this refund, the Policyholder must submit a written request to the Insurer asking that the **CRITICAL ILLNESS** benefit be terminated.

In addition, this benefit provides for refund of premiums in the event of the death of the Primary Insured, unless said death occurs during the Survival Period.

The amount of the refund is equal to a percentage of the premiums and extra premiums paid (including policy fees and without interest) for an amount insured under the **CRITICAL ILLNESS** benefit.

The applicable percentage is shown below and is based on the age of the Primary Insured at the time of the refund.

Age of Primary Insured at the time of refund	Percentage of premiums refunded
Under 60 years of age	0%
60 years of age	75%
61 years of age	80%
62 years of age	85%
63 years of age	90%
64 years of age	95%
65 years of age or over	100%

Any premiums for the **CRITICAL ILLNESS** and **PREMIUM REFUND (65) - CRITICAL ILLNESS** benefits that have been waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS** benefit.

In all cases, claims paid under the **CRITICAL ILLNESS** benefit are subtracted from the refund.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- He/she must be between 16 and 45 years of age inclusive when the application is signed.
- He/she must have applied and been approved for the **CRITICAL ILLNESS** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

## Reduction in coverage

The Policyholder may request a reduction in coverage, in which case he/she is entitled to a refund of a percentage of the premiums on the cancelled amount insured. The percentage is determined based on the table above.

## PREMIUM REFUND (65) – CRITICAL ILLNESS

### Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

### Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY** and must be the same as that of the **CRITICAL ILLNESS** benefit.

### Waiver of premiums in case of disability of the Primary Insured

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

To be eligible for this waiver, the Primary Insured must be between 16 and 55 years of age inclusive.

Under this provision, no premiums are payable for the **PREMIUM REFUND (65) – CRITICAL ILLNESS** benefit as of the fourth month after the onset of total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

### Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first premium instalment payable for the next insurance period was made on the date indicated on the premium notice.

### Exclusions

No benefits are payable if the claim is caused directly or indirectly by any of the following:

- a) The Primary Insured's service as an active member of the armed forces of any country
- b) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country

### End of coverage

This coverage ends on the earlier of the following dates:

- a) The date on which the full refund to which the Primary Insured is entitled under this benefit has been paid
- b) The date on which the **CRITICAL ILLNESS** benefit ends

# LIFE 100

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes, on the death of the Primary Insured, to pay the designated beneficiary the amount insured under this life insurance benefit as specified in the **CONTRACT SUMMARY**.

## Eligibility

To be eligible for this benefit, the Primary Insured must be between 14 days and 65 years of age inclusive when the application is signed.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

## Cession or assignment

Subject to the provisions of the law, the Policyholder may at any time cede or assign this policy. The Insurer shall only recognize cession or assignment of which the Insurer is notified in writing and assumes no responsibility regarding the validity of any such cession or assignment.

## Suicide

Should the Primary Insured die of suicide, or of the consequences of a suicide attempt, in the first 24 months following the effective date of this coverage or of its reinstatement (or of any increase in the amount insured), whether or not he/she is of sound mind at the time of the suicide or the suicide attempt, the coverage (or the increase, as the case may be) shall be null and void and the Insurer's liability limited to refund of premiums collected for the coverage or for the increase in the amount insured, as the case may be.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed and the Insurer may not modify it under any circumstances.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Waiver of premiums in case of disability of the Primary Insured

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

To be eligible for this waiver, the Primary Insured must be between 16 and 55 years of age when the application is signed.

Under this provision, no premiums are payable for **LIFE 100** coverage as of the fourth month after the onset of total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

## LIFE 100

### **Benefit renewal**

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed and will be deemed renewed only if all premiums due before the renewal date have been paid and if the first premium instalment payable for the next insurance period was made on the date indicated on the premium notice.

### **End of coverage**

This coverage ends on the death of the Primary Insured.

SPECIMEN

# FACILITY CARE

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity for facility care specified in the **CONTRACT SUMMARY** should the Primary Insured be physically dependent.

Payment of the monthly indemnity commences when the waiting period ends and may not extend beyond the maximum indemnity period selected.

The Primary Insured must be in a facility and receiving from a physician continuous medical care suitable to his/her physical dependence.

## Eligibility

To be eligible for this benefit, the Primary Insured must be between 16 and 80 years of age inclusive when the application is signed.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 75th birthday, provided this benefit has been in effect for at least 20 years.

If the Primary Insured is paid up under the **20/65 OPTION** of the **Duration of premium payment** clause, then the premium is guaranteed and the Insurer may not modify it under any circumstances.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## FACILITY CARE

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

Premiums are waived as of the first payment of the monthly indemnity.

### Additional definitions

**Waiting period** refers to the first consecutive days of facility care during which the Primary Insured is physically dependent and for which no indemnity is payable by the Insurer.

The waiting period is specified in the **CONTRACT SUMMARY**.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Indemnity period

The maximum indemnity payment period is specified in the **CONTRACT SUMMARY**.

When the indemnity is payable for less than one month, the daily indemnity is equal to one-thirtieth of the monthly indemnity payable.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependence.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

### Successive periods of facility care

Successive periods of facility care are considered a single continuous period of care,

and a new waiting period is not required if the following apply:

- a) Both periods of facility care stem from the same cause and
- b) The second period of facility care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of facility care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods of facility care.

### Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for more than 12 months, then the indemnity paid to the Primary Insured for facility care is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

### Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for facility care shall be increased on January 1 of every year by the percentage the Policyholder has selected, subject to a maximum indemnity of \$10 000.

### Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following dates:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured's facility care ends
- c) The expiration of the indemnity period specified in the **CONTRACT SUMMARY**

# FACILITY CARE

## Termination of indemnity (continued)

- d) The date of death of the Primary Insured
- e) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

## Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

## Exclusions

1. No indemnity is payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency due to treatment approved by a physician for an injury or illness)
  - b) Direct or indirect commission or attempted commission by the Insured of a criminal act under the Criminal Code or under a similar law in another country
  - c) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - d) Voluntary or involuntary inhalation of gas or ingestion of poison
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - g) Mental or nervous disorder without a demonstrable organic cause
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

# PREMIUM REFUND UPON DEATH FACILITY CARE

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to refund a percentage of the premiums paid for this benefit and for the **FACILITY CARE** benefit upon the death of the Primary Insured, provided no claims have been paid under the **FACILITY CARE** benefit.

Any premiums waived under the premium waiver clause are excluded from the refund.

The amount of the refund is equal to a percentage of the premiums and extra premiums paid (including policy fees and without interest) for an amount insured under the **FACILITY CARE** benefit.

The applicable percentage is shown below. It is based on the number of years during which the amount insured under the **FACILITY CARE** benefit was in effect.

Number of years in effect	Percentage of premiums refunded
Less than 6 years	0%
6 years	30%
7 years	40%
8 years	50%
9 years	60%
10 years	70%
11 years and over	80%

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- He/she must be between 16 and 80 years of age inclusive when the application is signed.
- He/she must have applied and been approved for the **FACILITY CARE** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in

the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 75th birthday, provided this benefit has been in effect for at least 20 years.

If the Primary Insured is paid up under the **20/65 OPTION** of the **Duration of premium payment** clause, then the premium is guaranteed and the Insurer may not modify it under any circumstances.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## **PREMIUM REFUND UPON DEATH FACILITY CARE**

### **Benefit amendment**

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### **Duration of premium payment**

The duration of premium payment is indicated in the **CONTRACT SUMMARY** and must be the same as the duration of premium payment for the **FACILITY CARE** benefit.

### **Premium waiver**

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

Premiums are waived as of the first payment of the monthly indemnity.

### **Exclusions**

No benefits are payable for claims arising directly or indirectly from any of the following:

- a) The Primary Insured's service as an active member of the armed forces of any country
- b) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country

### **End of coverage**

This benefit ends on the date the **FACILITY CARE** benefit ends.

# HOME CARE

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity for **HOME CARE** specified in the **CONTRACT SUMMARY** should the Primary Insured be physically dependent.

Payment of the monthly indemnity commences when the waiting period ends and may not extend beyond the maximum indemnity period selected.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 16 and 80 years of age inclusive when the application is signed.
- b) He/she must have applied and been approved for the **FACILITY CARE** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 75th birthday, provided this benefit has been in effect for at least 20 years.

If the Primary Insured is paid up under the **20/65 OPTION** of the **Duration of premium payment** clause, then the premium is guaranteed and the Insurer may not modify it under any circumstances.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

Premiums are waived as of the first payment of the monthly indemnity.

# HOME CARE

## Additional definitions

**Waiting period** refers to the first consecutive days during which the Primary Insured is physically dependent and for which no indemnity is payable by the Insurer.

The waiting period is specified in the **CONTRACT SUMMARY**.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

## Indemnity period

The maximum indemnity payment period is specified in the **CONTRACT SUMMARY**.

When the indemnity is payable for less than one month, the daily indemnity is equal to one-thirtieth of the monthly indemnity payable.

## Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependency.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

## Successive periods of physical dependence

Successive periods of physical dependence are considered a single continuous period and a new waiting period is not required if the following apply:

- a) Both periods of physical dependence stem from the same cause and
- b) The second period of physical dependence begins within 180 days of the end of the first and one of the following applies:

- i) The preceding period of physical dependence entitled the Primary Insured to an indemnity under this benefit.
- ii) The waiting period was filled by successive periods of physical dependence.

## Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

## Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for home care shall be increased on January 1 of every year by the percentage the Policyholder has selected, subject to a maximum indemnity of \$10 000.

## Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following dates:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured receives facility care
- c) The expiration of the indemnity period specified in the **CONTRACT SUMMARY**
- d) The date of death of the Primary Insured
- e) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

## HOME CARE

### Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

### Exclusions

1. No indemnity is payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency due to treatment approved by a physician for an injury or illness)
  - b) Direct or indirect commission or attempted commission by the Insured of a criminal act under the Criminal Code or under a similar law in another country
  - c) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - d) Voluntary or involuntary inhalation of gas or ingestion of poison
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - g) Mental or nervous disorder without a demonstrable organic cause
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

# PREMIUM REFUND UPON DEATH HOME CARE

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to refund a percentage of the premiums paid for this benefit and for the **HOME CARE** benefit upon the death of the Primary Insured, provided no claims have been paid under the **HOME CARE** benefit.

Any premiums waived under the premium waiver clause are excluded from the refund.

The amount of the refund is equal to a percentage of the premiums and extra premiums paid (including policy fees and without interest) for an amount insured under the **HOME CARE** benefit.

The applicable percentage is shown below. It is based on the number of years during which the amount insured under the **HOME CARE** benefit was in effect.

Number of years in effect	Percentage of premiums refunded
Less than 6 years	0%
6 years	30%
7 years	40%
8 years	50%
9 years	60%
10 years	70%
11 years and over	80%

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- He/she must be between 16 and 80 years of age inclusive when the application is signed.
- He/she must have applied and been approved for the **HOME CARE** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in

the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 75th birthday, provided this benefit has been in effect for at least 20 years.

If the Primary Insured is paid up under the **20/65 Option** of the **Duration of premium payment** clause, then the premium is guaranteed and the Insurer may not modify it under any circumstances.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

# PREMIUM REFUND UPON DEATH HOME CARE

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY** and must be the same as the duration of premium payment for the **HOME CARE** benefit.

## Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

Premiums are waived as of the first payment of the monthly indemnity.

## Exclusions

No benefits are payable for claims arising directly or indirectly from any of the following:

- a) The Primary Insured's service as an active member of the armed forces of any country
- b) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country

## End of coverage

This benefit ends on the date the **HOME CARE** benefit ends.

# HOSPITALIZATION AND LOSS OF AUTONOMY

## BENEFIT SUMMARY

<b>Section I</b>		
<b>Eligible expenses</b>	<b>Percentage reimbursed</b>	<b>Maximum reimbursed</b>
1. Hospitalization	100%	\$50 per day Lifetime maximum: 180 days
2. Laboratory analysis	80%	Unlimited
3. CT scans	80%	\$250 per calendar year
4. Magnetic resonance imaging	80%	\$675 per calendar year
5. Ultrasound	80%	\$100 per calendar year
6. Polysomnography	80%	\$100 per period of 24 consecutive months
<b>Section II</b>		
1. Audiologist	100%	\$500 per calendar year
2. Occupational therapist	100%	\$500 per calendar year
3. Physiotherapist	100%	\$500 per calendar year
4. Respiratory therapist	100%	\$500 per calendar year
5. Dietician	100%	\$500 per calendar year
6. Registered nurse or certified nursing assistant	100%	\$70 per day, 100 days per calendar year
7. Psychosocial services for informal caregiver	100%	\$500 per calendar year
8. Respite services	100%	\$600 per calendar year
9. Wheelchair	80%	\$750 lifetime
Hospital-type bed		\$1 500 lifetime
10. Purchase or rental of equipment	80%	Unlimited
11. Support hose	80%	\$100 per calendar year
12. Orthopedic shoes	80%	Unlimited
13. Ostomy supplies	80%	Unlimited
14. Accessories for diabetics	80%	Unlimited
15. Medical supplies	80%	\$1 000 per calendar year
16. Transportation expenses	100%	\$500 per calendar year
17. Ambulance	100%	Unlimited
18. Health monitoring system	100%	\$300 per calendar year
19. Moving allowance	100%	\$1 000 lifetime
20. Home conversion expenses	100%	\$5 000 lifetime
21. Meals	100%	\$150 per month
<b>Maximum coverage applicable to Sections I and II</b>		\$10 000 lifetime

# HOSPITALIZATION AND LOSS OF AUTONOMY

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the **HOSPITALIZATION AND LOSS OF AUTONOMY** benefit covers the Primary Insured for medical and hospital expenses incurred in his/her province of residence.

The percent of eligible expenses reimbursed under each section is specified in the **BENEFIT SUMMARY**, subject to the overall maximum specified in the **CONTRACT SUMMARY**.

For purposes of benefit calculation, the Primary Insured is considered covered under the health insurance act and the hospital insurance act of his/her province of residence. Amounts paid by the Insurer may not, under any circumstances, exceed those that would have been paid if the Primary Insured had been covered under these acts.

## Eligibility

To be eligible for this benefit, the Primary Insured must be between 55 and 80 years of age inclusive when the application is signed.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

## Maximum coverage

Maximum coverage under this benefit is specified in the **CONTRACT SUMMARY**.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

Throughout the term of the benefit, whenever a new law or an amendment to a provincial or federal law or to one of its regulations leads to a change in amounts payable under the benefit, the Insurer reserves the right, at the Insurer's discretion, to change the premium based on the new law or the amendment or calculate the benefits based on the laws or regulations in effect at the time the premiums were initially set.

## Benefit amendment

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

# HOSPITALIZATION AND LOSS OF AUTONOMY

## Additional definitions

**Informal caregiver** refers to a nonprofessional who provides care and/or support to a family member, friend or neighbour who is physically dependent.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

**Eligible expenses** mean expenses incurred for customary, medically necessary care recommended in advance by a physician.

## COVERAGE

### SECTION I

#### Eligible expenses (BENEFIT SUMMARY specifies percentage reimbursed)

The Insurer agrees to reimburse the following expenses incurred due to illness or injury (**Section I** expenses).

##### 1. Hospitalization

This benefit covers charges exceeding those refundable under the government plan for private or semi-private accommodations in a general and specialized hospital centre (general hospital) to receive short-term care, subject to the maximum reimbursement specified in the **BENEFIT SUMMARY**.

A benefit of hospitalization equal to 50% of the maximum reimbursable amount indicated in the **BENEFIT SUMMARY** shall be paid starting the fourth day of hospitalization inclusive if the Primary Insured must stay in a ward because no private or semi-private rooms are available. The three-day waiting period applies to each new hospital admission.

Short-term medical care covered are prevention care, medical diagnosis and medical treatment for acute illness and do not include convalescence, or physical and intellectual rehabilitation care.

##### 2. Laboratory analysis

This benefit covers costs of laboratory tests (blood tests, urinalysis, throat culture, cytology) required due to an accident or for diagnosis or treatment of an illness.

##### 3. CT scans

This benefit covers costs of CT scans required to diagnose or treat an illness or injury when prescribed by the attending physician up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

##### 4. Magnetic resonance imaging

This benefit covers costs of magnetic resonance imaging required for diagnosis or treatment of an illness or injury when prescribed by the attending physician, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

##### 5. Ultrasound

Expenses for ultrasound scans required for the diagnosis or treatment of an illness or injury, when prescribed by the attending physician, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

##### 6. Polysomnography

Expenses for polysomnography required for diagnosis, when prescribed by the attending physician, up to a maximum reimbursement indicated in the **BENEFIT SUMMARY**.

### SECTION II

#### Eligible expenses

The Insurer agrees to reimburse the following expenses when incurred while the Primary Insured is physically dependent (**Section II** expenses).

# HOSPITALIZATION AND LOSS OF AUTONOMY

## SECTION II (continued)

### Eligible expenses (continued)

Services of the following health professionals are covered, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**, for each of the following specialists:

1. Audiologist
2. Occupational therapist
3. Physiotherapist
4. Respiratory therapist
5. Dietician

#### 6. Registered nurse or certified nursing assistant

Expenses for the services of a certified nursing assistant or a nursing aide from an agency specializing in home care, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

However, the nursing care may not be provided by the Primary Insured or a close relative.

#### 7. Psychosocial services for informal caregiver

Charges for services of a specialist providing psychosocial support for the informal caregiver to facilitate his/her involvement, to the maximum reimbursement indicated in **BENEFIT SUMMARY**

#### 8. Respite services

Charges for respite care for the Primary Insured to give the informal caregiver respite and time off, to the maximum reimbursement indicated in the **BENEFIT SUMMARY**.

### Eligible expenses (**BENEFIT SUMMARY** specifies percent reimbursed)

#### 9. Wheelchair or hospital-type bed

Rental charges, for a temporary use not exceeding three (3) months, of a wheelchair or for a person who is confined to a hospital-type bed up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

After three months of rental, the Insurer must be consulted and may then decide to purchase the equipment, in which case the Insurer is entitled to require that the property be returned at the end of the treatment or when the Primary Insured cancels his/her insurance contract.

#### 10. Purchase or rental of equipment

Costs of lease (or purchase, if the Insurer deems it more economical) of the following: crutches, walkers, canes, casts, trusses, spinal braces and oxygen systems, as well as costs of temporary lease of a respirator

The Primary Insured must obtain prior authorization from the Insurer before leasing any respirator, wheelchair or hospital-type bed otherwise the Insurer may refuse the claim.

#### 11. Support hose

Purchase of support hose up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

#### 12. Orthopedic shoes

Purchase of orthopedic shoes or foot orthoses prescribed by a physician and purchased in a specialized centre licensed by the ministry.

#### 13. Ostomy supplies

The cost of purchase of accessories required for ostomates.

#### 14. Accessories for diabetics

The cost of purchase of syringes, hypodermic needles, reagent strips for diabetics.

#### 15. Medical supplies

Costs incurred for purchase of medical supplies required to treat an illness or an accident when the Primary Insured receives care from a registered nurse in his/her home, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

# HOSPITALIZATION AND LOSS OF AUTONOMY

## Eligible expenses (BENEFIT SUMMARY specifies percent reimbursed) (continued)

### 16. Transportation expenses

Costs of transporting the Primary Insured to receive care or medical follow-up: \$0.25/km for use of a private automobile or for the cost of a taxi ride, to a maximum of \$50 of eligible expenses daily (including parking costs, if applicable), up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

### 17. Ambulance

Charges for transportation by ambulance are covered when, for reasons the Insurer deems valid, the Primary Insured must be transported to or from the nearest hospital where he/she can receive required emergency care.

### 18. Health monitoring system

Charges for a wrist-worn or pendant alarm and health-monitoring system, to the maximum reimbursement indicated in the **BENEFIT SUMMARY**.

### 19. Moving allowance

Expenses for moving the Primary Insured to a residential and long-term care centre, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

### 20. Home conversion expenses

Expenses for converting the Primary Insured's home, up to a maximum reimbursement indicated on the **BENEFIT SUMMARY**.

### 21. Meals

Charges for preparing meals cooked outside the home, to the maximum reimbursement indicated in the **BENEFIT SUMMARY**.

## Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependence.

## Exclusions

1. No benefits are payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency due to treatment approved by a physician for an injury or illness)
  - b) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - c) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - d) Cosmetic care or treatment
  - e) Mental or nervous disorder without a demonstrable organic cause
2. No benefits are payable if the Primary Insured receives facility care.
3. No benefits are payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

## Coordination of benefits

If the Insured is entitled to similar benefits under any other insurance, the benefits payable under this coverage shall be coordinated so that total payment from all coverages shall not exceed the amount for which the claim is made.

The Insurer deducts from the benefits payable any amounts that have been paid or would have been paid if the claim had been submitted under said other insurance.

## Claim

In case of hospitalization in a private or semi-private room, the Primary Insured generally needs only to present his/her insurance certificate on admission and the Insurer will pay the costs of the private or semi-private accommodations directly to the hospital; the Policyholder does not have to submit a claim.

# HOSPITALIZATION AND LOSS OF AUTONOMY

## **Claim (continued)**

For other care, the procedures specified in the **GENERAL PROVISIONS** of this contract apply.

## **Terms of payment**

The amounts payable are paid to the Primary Insured.

However, in all cases the Insurer reserves the right to pay the supplier of the services directly.

Any amount paid by the Insurer or on the Insurer's behalf, releases the Insurer from any liability up to said amount.

## **Alternative treatment**

Costs covered under this benefit are limited to customary, reasonable and justified charges. If the health professional consulted by the Insurer deems the selected treatment to be unnecessary, the benefits payable shall be based on the cost of the alternative treatment said professional recommends.

## **Pre-treatment estimate**

If the Primary Insured requires a treatment costing more than \$2 500, a pre-treatment estimate form must be completed by the health professional and submitted to the Insurer.

The pre-treatment estimate must list the services required for the treatment and the fees requested by the health professional.

# CRITICAL ILLNESS – HYBRID COVERAGE

## SPECIAL PROVISIONS

### Eligibility

To be eligible for this benefit, the Primary Insured must be between 30 days and 60 years of age inclusive when the application is signed.

### Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

### Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

### Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

### Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed and will be deemed renewed only if all premiums due before the renewal date have been paid and if the first premium instalment payable for the next insurance period was made on the date indicated on the premium notice.

### Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

### Waiver of premiums in case of disability of the Primary Insured or the Policyholder

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

## CRITICAL ILLNESS – HYBRID COVERAGE

### Waiver of premiums in case of disability of the Primary Insured or the Policyholder (continued)

(Optional provision)

#### Primary Insured

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Primary Insured become totally disabled between ages 16 and 59 inclusive.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

If the Policyholder is not the Primary Insured, then the waiver of premiums in case of disability of the Primary Insured comes into effect on the earlier of the following dates:

- a) The Primary Insured's 26th birthday
- b) The contract anniversary coinciding with or following the Policyholder's 65th birthday

#### Policyholder

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Policyholder become totally disabled before his/her 59th birthday.

The waiver of premium in case of disability ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Policyholder's 65th birthday
- b) The Primary Insured's 26th birthday—unless the Primary Insured is disabled on this day, in which case the waiver continues under the waiver of premiums in case of disability of the Primary Insured

#### Premium refund

To be eligible for the premium refund provision, the Primary Insured must be between 30 days and 55 years of age inclusive when the application is signed.

On the contract anniversary coinciding with or following the Primary Insured's 65th birthday, the Insurer undertakes to refund 25% of the premiums paid for this benefit if the Primary Insured decides not to take advantage of the **FACILITY CARE** benefit and accordingly cancels the **CRITICAL ILLNESS – HYBRID COVERAGE** benefit.

Any premiums waived under the premium waiver clause are excluded from the refund.

### **HOSPITALIZATION AND LOSS OF AUTONOMY enrolment without proof of insurability**

Provided the Primary Insured is not physically dependent on the contract anniversary coinciding with or following his/her 65th birthday, he/she may enrol in the **HOSPITALIZATION AND LOSS OF AUTONOMY** benefit (to a lifetime maximum of \$10,000) without providing the Insurer the proof of insurability required for this benefit.

### **BENEFIT: CRITICAL ILLNESS**

#### **Purpose of the benefit**

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured or the Beneficiary, as the case may be, the percentages stipulated in sections I and II of the amount insured specified in the **CONTRACT SUMMARY** should the Primary Insured be diagnosed with a critical or non-critical illness as defined in sections I and II.

However, the Primary Insured must be alive at the end of the Survival Period and must not have experienced an irreversible cessation of all functions of the brain.

The diagnosis and treatment of any covered condition must be assumed by a physician licensed to practice in Canada or the United States (or another region, with the Insurer's approval).

# CRITICAL ILLNESS – HYBRID COVERAGE

## Additional definition

**Artificial life support** means that the Primary Insured is under the care of a physician licensed to practice and is kept alive by nutritional, respiratory and/or cardiovascular support even in case of irreversible cessation of the functions of the brain.

## Premium refund in the event of death during the Survival Period

Should the Primary Insured die during the Survival Period, this protection provides for refund of policy fees, premiums and extra premiums paid for this benefit, less the amount of any benefit paid.

Any premiums waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **CRITICAL ILLNESS – HYBRID COVERAGE** benefit.

## Reduction in the amount insured

The amount insured payable is a percentage of the initial amount insured indicated in the **CONTRACT SUMMARY** and is based on the Primary Insured's age, as specified in the following table:

Age of the Primary Insured	% of the initial amount insured
30 days to 55 years of age	100%
56 years of age	90%
57 years of age	80%
58 years of age	70%
59 years of age	60%
60 years of age	50%
61 years of age	40%
62 years of age	30%
63 years of age	20%
64 years of age	10%
65 years of age and over	0%

## SECTION I

### Critical illness

Under this section, the Insurer undertakes to pay 100% of the amount insured specified in the **CONTRACT SUMMARY**. However, the amount insured may be paid only once.

### Definitions

#### 1. Stroke (Cerebrovascular Accident)

A cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by intracranial thrombosis or hemorrhage, or embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit.

#### Exclusion

Transient ischemic attacks are specifically excluded.

#### 2. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood product transfusion
- Marrow stimulating agents
- Immunosuppressive agents
- Bone marrow transplantation.

#### 3. Burns

Third degree burns over at least 20% of the body surface.

#### 4. Cancer

A tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Leukemia is a type of cancer that is covered under this benefit.

# CRITICAL ILLNESS – HYBRID COVERAGE

## Definitions (continued)

### 4. Cancer (continued)

#### Exclusions

1. The following cancers are excluded from coverage:

- a) Carcinoma in situ;
- b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)
- c) Any non-melanoma skin cancer that has not become metastatic (spread to neighbouring organs)
- d) Stage A (T1a or T1b) prostate cancer

2. Furthermore, no benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit) if within the first 90 days after the effective date of the benefit or the effective date of last reinstatement of the benefit, the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made,
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

### 5. Blindness

The total and irreversible loss of vision in both eyes as confirmed by an ophthalmologist, with the corrected visual acuity being 20/200 or less in each eye or the field of vision being less than 20 degrees in both eyes.

### 6. Coma

A state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of four days. The Glasgow coma score must be four or less continuously during the four days.

#### Exclusions

- a) A medically induced coma
- b) A coma which results directly from alcohol or drug use

### 7. Coronary Artery Bypass Surgery

The undergoing of heart surgery, when medically needed, to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

#### Exclusion

Non-surgical techniques such as balloon angioplasty or laser relief of an obstruction are not covered.

### 8. Aortic Surgery

The undergoing of 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.

### 9. Heart Attack (Myocardial infarction)

The death of a portion of heart muscle as a result of inadequate blood supply as evidenced by the following:

- a) New electrocardiographic (ECG) changes indicative of a myocardial infarction, and
- b) The elevation of cardiac biochemical markers to levels considered diagnostic for infarction

## CRITICAL ILLNESS – HYBRID COVERAGE

### Definitions (continued)

#### 9. Heart Attack (Myocardial infarction) (continued)

Heart attack during coronary angioplasty is covered provided there are diagnostic changes of new Q wave infarction on the ECG in addition to elevation of cardiac markers.

##### Exclusion

Heart attack does not include an incidental finding of ECG changes suggesting a prior myocardial infarction in the absence of a corroboration event.

#### 10. Occupational HIV Infection

Diagnosis of Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Primary Insured's normal occupation which exposed the Primary Insured to HIV-contaminated body fluids.

##### Exclusions

No benefit is payable under this provision unless all of the following conditions are met:

- a) The accidental injury is reported to the Insurer within 14 days of its occurrence.
- b) An HIV test is performed within 14 days of the accidental injury and the result is negative.
- c) An HIV test is performed between 90 and 180 days after the accidental injury and the result is positive.
- d) All HIV tests are performed by facilities approved by the Insurer.
- e) The accidental injury is reported, investigated and documented in accordance with current Canadian workplace guidelines.

No payment will be made if any of the following apply:

- a) The Primary Insured elects not to take any available licensed vaccine offering protection against HIV.
- b) A licensed cure for HIV infection becomes available prior to the accidental injury.

- c) The HIV infection results from a non-accidental injury (including, but not limited to, sexual transmission or intravenous (IV) drug use).

#### 11. Kidney failure

Chronic irreversible failure of both kidneys (end stage renal disease) necessitating treatment by regular hemodialysis, peritoneal dialysis or renal transplantation.

#### 12. Alzheimer's Disease

A definitive clinical diagnosis by a specialist of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The Primary Insured must exhibit loss of intellectual capacity involving impairment of memory and judgement which results in a significant reduction in mental and social functioning such that he/she requires continuous daily supervision.

##### Exclusion

All other dementing organic brain disorders and psychiatric illnesses are excluded.

#### 13. Parkinson's Disease

A definitive diagnosis by a specialist of primary idiopathic Parkinson's Disease which is characterized by two or more of the following clinical manifestations: muscle rigidity, tremor or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses). The Primary Insured must require substantial physical assistance from another adult to perform at least two of the six Activities of Daily Living (as defined in the GENERAL PROVISIONS).

##### Exclusion

All other types of Parkinsonism are specifically excluded.

#### 14. Motor Neuron Disease

A definitive diagnosis of one 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 entities.

## CRITICAL ILLNESS – HYBRID COVERAGE

### Definitions (continued)

#### 15. Bacterial Meningitis

A definitive diagnosis of bacterial meningitis that is confirmed by laboratory analysis of cerebrospinal fluid showing growth of pathogenic bacteria in culture and that causes permanent neurological deficit confirmed by a neurologist and documented for at least ninety days following the date of diagnosis.

##### Exclusion

Viral meningitis is not covered.

#### 16. Paralysis

The complete and permanent loss of use of two or more limbs for a continuous period of ninety days following the precipitating events, during which time there has been no sign of improvement.

##### Exclusion

All psychiatric related causes are specifically excluded.

#### 17. Loss of Speech

Total and irreversible loss of the ability to speak as the result of physical injury or disease, the loss persisting for a continuous period of at least 180 days.

##### Exclusion

All psychiatric related causes are specifically excluded.

#### 18. Loss of Autonomy

An unequivocal diagnosis, by a specialist, of either of the following for a continuous period of 90 days:

- a) Total and permanent inability to perform independently at least two of the six Activities of Daily Living (as defined in the **GENERAL PROVISIONS**), with no reasonable chance of recovery
- b) Cognitive impairment as defined in the **GENERAL PROVISIONS**

#### 19. Loss of Limbs

The irreversible severance of two or more limbs from above the wrist or ankle joint as the result of an accident or medically required amputation.

#### 20. Heart Valve Replacement

The undergoing of replacement of any heart valve with either a natural or mechanical valve when medically needed.

##### Exclusion

Heart valve repair is specifically excluded.

#### 21. Multiple Sclerosis

A definitive diagnosis by a neurologist of multiple sclerosis, characterized by well defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis.

#### 22. Deafness

Total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within a speech threshold of 500 to 3000 cycles per second.

#### 23. Major Organ Transplant or Major Organ Failure on Waiting List

Diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, with transplantation medically necessary.

To qualify under the insured condition of Major Organ Transplant, the Primary Insured must undergo surgery as the recipient for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

To qualify under the insured condition of Major Organ Failure on Waiting List, the Primary Insured must be eligible as a recipient in an approved government organ or bone marrow transplant program in Canada or the U.S. for one or more of the organs specified in this provision or for bone marrow. For purposes of the Survival Period, the date of diagnosis is the date the Primary Insured's enrolment the transplant program takes effect.

# CRITICAL ILLNESS – HYBRID COVERAGE

## Definitions (continued)

### 24. Benign Brain Tumour

A non-malignant tumour arising from the brain or meninges. The historical nature of the tumour must be confirmed by examination of tissue (biopsy or surgical excision).

#### Exclusions

1. Tumours of the bony cranium and pituitary microadenomas (less than 10 mm in diameter) are excluded.
2. Furthermore, no benefit will be payable for benign brain tumour or for a subsequent diagnosis of any benign brain tumour or other covered conditions directly resulting from, or the treatment of, any benign tumour, if within the first 90 days following the effective date of the benefit or the effective date of last reinstatement of the benefit the Primary Insured has any of the following:
  - a) Signs or symptoms of benign brain tumour that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made
  - b) Medical consultations or tests that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made
  - c) A diagnosis of benign brain tumour

The Primary Insured must report this information to the Insurer within six months of the date of the diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for benign brain tumour or for any critical illness caused by benign brain tumour or its treatment.

## SECTION II

### Non-critical illness

Under this section, the Insurer undertakes to pay 10% of the amount insured indicated in the **CONTRACT SUMMARY**. However, the amount payable may be paid only once and may not exceed \$25 000.

## Definitions

### 1. Coronary Angioplasty

An interventional procedure to unblock and widen a vessel that supplies blood to the heart. Angioplasty must be medically necessary to allow an uninterrupted flow of blood and oxygen to the heart.

### 2. Non Life-Threatening Cancer

- a) Stage T1a or T1b (stage A) prostate cancer
- b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness)
- c) Ductal carcinoma in situ of the breast (DCIS, requires confirmation by biopsy)

#### Exclusions

No benefit will be payable for cancer or for a subsequent diagnosis of any cancer or other covered conditions directly resulting from, or the treatment of, any cancer (covered or excluded under this benefit), if within the first 90 days following the effective date of the benefit or the effective date of last reinstatement of the benefit the Primary Insured has any of the following:

- a) Signs or symptoms of cancer that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- b) Medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this benefit), regardless of when the diagnosis is made
- c) A diagnosis of cancer (covered or excluded under this benefit)

The Primary Insured must report this information to the Insurer within six months of the date of the diagnosis. If the Primary Insured does not disclose this information, the Insurer has the right to deny any claim for cancer or for any critical illness caused by cancer or its treatment.

# CRITICAL ILLNESS – HYBRID COVERAGE

## SECTION III

### Reimbursement of expenses in case of critical or non-critical illness

Under this section, the Insurer undertakes to reimburse eligible expenses if the Primary Insured is diagnosed with a critical or non-critical illness covered under this benefit.

### Additional definitions

**Permanent motor impairment** means a physical impairment that prevents production of a movement.

**Occupational therapist's role in adapting the principal residence and/or automobile** means assessment of the accessibility of the Primary Insured's main residence and/or automobile and development of recommendations to modify the physical environment of the home or the automobile for maximum autonomy of the Primary Insured. The occupational therapist must take into account not only the comprehensive functional assessment of the Primary Insured, the access conditions at his/her home and/or the need for modifications to his/her automobile, but also family, social and environmental factors and applicable municipal bylaws and government policies.

### Eligible expenses

#### 1. Adaptation

Cost of services of an occupational therapist and of adaptations to the Primary Insured's car and principal residence rendered necessary as a result of a critical or non-critical illness, to a lifetime maximum benefit of \$5 000, should the Primary Insured suffer a permanent motor impairment.

The Insurer reserves the right to ask for new professional assessments if the Insurer considers the costs specified in the occupational therapist's report to be excessive.

The latter report must include a physical and functional evaluation of the Primary Insured,

evaluation of the accessibility of his/her principal residence and/or automobile, adaptation recommendations and drawings illustrating the recommendations.

The report must also include plans of the home (rooms, exterior access) before and after the adaptations, an estimate of the cost of the work, a general description of the home and its architectural barriers and a detailed description of the demolition and construction work to be performed.

The Primary Insured or a member of his/her family must forward the following documents to the Insurer:

- a) An estimate of the cost of the work
- b) A copy of the deed of the home if the Primary Insured is the owner, or the landlord's agreement to performing the work if the Primary Insured is a tenant
- c) Agreement of the municipality, in case of special accommodations

When the Insurer has approved the adaptations, a written confirmation will be sent to the Primary Insured specifying the benefit granted, which will be equivalent to the least costly estimate. The Insurer shall also stipulate how the benefits will be paid (number of payments, timetable).

#### 2. Travel expenses

Travel expenses incurred for the Primary Insured to receive care or for medical follow-up, to a lifetime maximum of \$2 500 including the following expenses:

- a) \$0.25/kilometre for trips in a private car or for taxi fare, to a maximum of \$50 of eligible expenses per day including any costs for parking
- b) Costs to take the Primary Insured by air or land to the medical establishment of his/her choice outside the province of residence

#### 3. Cost of household help and/or childcare

Costs of household help and/or childcare provided by a person not residing with the Primary Insured, on recommendation of the attending physician, to help the Primary Insured, to a daily maximum of \$25 and a lifetime maximum of \$1 000.

## CRITICAL ILLNESS – HYBRID COVERAGE

### Protection after the end of coverage

Any expenses mentioned in section III that are incurred after the date of the end of coverage are not covered unless related to a critical or non-critical illness for which a benefit was paid under section I or II.

### Exclusions

1. No benefits are payable if the critical or non-critical illness is caused directly or indirectly by any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs
  - b) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - c) The Primary Insured's service as an active member of the armed forces of any country
  - d) Direct or indirect commission or attempted commission by the Primary Insured of a criminal act under the Criminal Code or under a similar law in another country
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - g) Voluntary or involuntary inhalation of gas or ingestion of poison or drugs
2. No benefits are payable under the exclusions specified in the definitions in sections I and II.

### End of CRITICAL ILLNESS coverage

Coverage under this benefit ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

## BENEFIT: FACILITY CARE

### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity for facility care should the Primary Insured be physically dependent.

The Primary Insured must be in a facility and receiving from a physician continuous medical care suitable to his/her physical dependence.

This protection comes into effect on the Primary Insured's 56th birthday.

The monthly indemnity is determined based on the percentage conversion selected by the Policyholder and the amount insured specified in the **CONTRACT SUMMARY**, in accordance with the age and percentages specified in the following table:

Age of the Primary Insured	Percentage conversion selected	
	2.0%	5.0%
30 days to 55 years of age	0%	0%
56 years of age	0.2%	0.5%
57 years of age	0.4%	1.0%
58 years of age	0.6%	1.5%
59 years of age	0.8%	2.0%
60 years of age	1.0%	2.5%
61 years of age	1.2%	3.0%
62 years of age	1.4%	3.5%
63 years of age	1.6%	4.0%
64 years of age	1.8%	4.5%
65 years of age and over	2.0%	5.0%

The percentage conversion payable stays the same as long as the Primary Insured remains physically dependent.

### Additional definition

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

# CRITICAL ILLNESS – HYBRID COVERAGE

## Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependence.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

## Successive periods of facility care

Successive periods of facility care are considered a single continuous period of care, and a new waiting period is not required if the following apply:

- a) Both periods of facility care stem from the same cause and
- b) The second period of facility care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of facility care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods of facility care.

## Indexation of the monthly indemnity

In the case of a monthly indemnity payment during a period of more than 12 months, then the indemnity paid to the Primary Insured for facility care is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

## Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for facility care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

## Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following dates:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured no longer resides in a facility
- c) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program
- d) The date of death of the Primary Insured

## Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

## Exclusions

1. No indemnity is payable if claims for the **FACILITY CARE** benefit arise directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment for an injury or illness)
  - b) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - c) Direct or indirect commission or attempted commission by the Primary Insured of a criminal act under the Criminal Code or under a similar law in another country
  - d) Mental or nervous disorder without a demonstrable organic cause
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - g) Voluntary or involuntary inhalation of gas or ingestion of poison

## CRITICAL ILLNESS – HYBRID COVERAGE

### Exclusions (continued)

2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

### End of coverage

This coverage ends on the date of payment of the amount insured if the payment is made to the Primary Insured for a diagnosis of loss of autonomy and the Primary Insured is 55 years of age or younger.

SPECIMEN

# HOME CARE – HYBRID COVERAGE CRITICAL ILLNESS

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity specified in the **CONTRACT SUMMARY** should the Primary Insured be physically dependent.

Payment of the monthly indemnity commences when the waiting period ends and may not extend beyond the maximum indemnity period selected.

The monthly indemnity is determined based on the percentage conversion selected by the Policyholder and the amount insured specified in the **CONTRACT SUMMARY**, in accordance with the age and percentages specified in the following table:

Age of the Primary Insured	Percentage conversion selected	
	2.0%	5.0%
30 days to 55 years of age	0%	0%
56 years of age	0.2%	0.5%
57 years of age	0.4%	1.0%
58 years of age	0.6%	1.5%
59 years of age	0.8%	2.0%
60 years of age	1.0%	2.5%
61 years of age	1.2%	3.0%
62 years of age	1.4%	3.5%
63 years of age	1.6%	4.0%
64 years of age	1.8%	4.5%
65 years of age and over	2.0%	5.0%

The percentage conversion payable stays the same as long as the Primary Insured remains physically dependent.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- He/she must be between 30 days and 60 years of age inclusive when the application is signed.
- He/she must have applied and been approved for the **CRITICAL ILLNESS – HYBRID COVERAGE** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

# HOME CARE – HYBRID COVERAGE CRITICAL ILLNESS

## Benefit amendment (continued)

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Additional definitions

**Waiting period** refers to the first consecutive days of home care during which the Primary Insured is physically dependent and for which no indemnity is payable by the Insurer.

The waiting period is specified in the **CONTRACT SUMMARY**.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

## Indemnity period

The maximum indemnity payment period is specified in the **CONTRACT SUMMARY**.

When the indemnity is payable for less than one month, the daily indemnity is equal to one-thirtieth of the monthly indemnity payable.

## Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependency.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

## Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

## Waiver of premiums in case of disability of the Primary Insured or the Policyholder

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **contract summary**.

### Primary Insured

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Primary Insured become totally disabled between ages 16 and 59 inclusive.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

If the Policyholder is not the Primary Insured, then the waiver of premiums in case of disability of the Primary Insured comes into effect on the earlier of the following dates:

- a) The Primary Insured's 26th birthday
- b) The contract anniversary coinciding with or following the Policyholder's 65th birthday

### Policyholder

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Policyholder become totally disabled before his/her 59th birthday.

## HOME CARE – HYBRID COVERAGE CRITICAL ILLNESS

### Waiver of premiums in case of disability of the Primary Insured or the Policyholder (continued)

(Optional provision)

The premium waiver ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Policyholder's 65th birthday
- b) The Primary Insured's 26th birthday—unless the Primary Insured is disabled on this day, in which case the waiver continues under the provision for waiver of premiums in case of disability of the Primary Insured

### Successive periods of home care

Successive periods of home care are considered a single continuous period and a new waiting period is not required if the following apply:

- a) Both periods of home care stem from the same cause and
- b) The second period of home care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of home care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods

### Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

### Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for

home care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

### Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured receives facility care
- c) The expiration of the indemnity period specified in the **CONTRACT SUMMARY**
- d) The date of death of the Primary Insured
- e) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

### Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

### Exclusions

1. No indemnity is payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment for an injury or illness)
  - b) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - c) Direct or indirect commission or attempted commission by the Insured of a criminal act under the Criminal Code or under a similar law in another country
  - d) Mental or nervous disorder without a demonstrable organic cause
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act

## HOME CARE – HYBRID COVERAGE CRITICAL ILLNESS

### Exclusions (continued)

- f) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - g) Voluntary or involuntary inhalation of gas or ingestion of poison
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

### End of coverage

This coverage ends on the date of payment of the amount insured under the **CRITICAL ILLNESS – HYBRID COVERAGE** benefit if the payment is made to the Primary Insured for a diagnosis of loss of autonomy and the Primary Insured is 55 years of age or younger.

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# LOSS OF AUTONOMY – HYBRID COVERAGE

## SPECIAL PROVISIONS

### Eligibility

To be eligible for this benefit, the Primary Insured must be between 16 and 60 years of age inclusive when the application is signed.

### Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

### Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

### Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

### Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was made on the date indicated on the premium notice.

### Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

### Waiver of premiums in case of disability of the Primary Insured

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

## LOSS OF AUTONOMY – HYBRID COVERAGE

### Waiver of premiums in case of disability of the Primary Insured (continued)

Under this provision, no premiums are payable for the **LOSS OF AUTONOMY – HYBRID COVERAGE** benefit as of the fourth month after the onset of the Primary Insured's total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

### Premium refund

To be eligible for the premium refund provision, the Primary Insured must be between 16 and 55 years of age inclusive when the application is signed.

On the contract anniversary coinciding with or following the Primary Insured's 65th birthday, the Insurer undertakes to refund 25% of the premiums paid for this benefit if the Primary Insured decides not to take advantage of the **FACILITY CARE** benefit and accordingly cancels the **LOSS OF AUTONOMY – HYBRID COVERAGE** benefit.

Any premiums waived under the premium waiver clause are excluded from the refund.

### HOSPITALIZATION AND LOSS OF AUTONOMY enrolment without proof of insurability

Provided the Primary Insured is not physically dependent on the contract anniversary coinciding with or following his/her 65th birthday, he/she may enrol in the **HOSPITALIZATION AND LOSS OF AUTONOMY** benefit (to a lifetime maximum of \$10,000) without providing the Insurer the proof of insurability required for this benefit.

## BENEFIT: LOSS OF AUTONOMY

### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured or the Beneficiary, as the case may be, after the waiting period, the amount insured specified in the **CONTRACT SUMMARY** should the Primary Insured be diagnosed with total and permanent loss of autonomy.

### Additional definitions

**Waiting period** refers to the period beginning on the date of diagnosis of total and permanent loss of autonomy and ending 180 days after this date.

**Total and permanent loss of autonomy** refers to a definitive diagnosis by a specialist of at least one of the following for a continuous period of at least 180 days:

- a) Total and permanent inability to perform unassisted at least two of the six Activities of Daily Living (specified in the **GENERAL PROVISIONS**) without reasonable chance of cure
- b) Cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to a total and permanent loss of autonomy.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

### Premium refund upon death during the waiting period

Should the Primary Insured die during the waiting period, this provision provides for refund of policy fees, premiums and extra premiums paid for this benefit.

## LOSS OF AUTONOMY – HYBRID COVERAGE

### Premium refund upon death during the waiting period (continued)

Any premiums waived under the premium waiver clause are excluded from the refund.

Under no circumstances may the total refund exceed the amount insured under the **LOSS OF AUTONOMY – HYBRID COVERAGE** benefit.

### Reduction in the amount insured

The amount insured payable is a percentage of the initial amount insured indicated in the **CONTRACT SUMMARY** and is based on the Primary Insured's age, as specified in the following table:

Age of the Primary Insured	% of the initial amount insured
16 to 55 years of age	100%
56 years of age	90%
57 years of age	80%
58 years of age	70%
59 years of age	60%
60 years of age	50%
61 years of age	40%
62 years of age	30%
63 years of age	20%
64 years of age	10%
65 years of age and over	0%

### Exclusions – TOTAL AND PERMANENT LOSS OF AUTONOMY COVERAGE

No benefits are payable if the total and permanent loss of autonomy results directly or indirectly from any of the following:

- Abuse of alcohol or drugs, or use of illegal drugs
- Attempted suicide or intentional self-injury, regardless of the Insured's state of mind
- The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
- The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country

- The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
- The Primary Insured's service as an active member of the armed forces of any country
- Voluntary or involuntary inhalation of gas or ingestion of poison

### End of coverage – TOTAL AND PERMANENT LOSS OF AUTONOMY

The **LOSS OF AUTONOMY** coverage ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

### BENEFIT: FACILITY CARE

#### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured a monthly indemnity for facility care if the Primary Insured is physically dependent.

The Primary Insured must be in a facility and must be receiving from a physician continuous medical care suitable to his/her physical dependence.

This protection comes into effect on the Primary Insured's 56th birthday.

The monthly indemnity is determined based on the percentage conversion selected by the Policyholder and the amount insured specified in the **CONTRACT SUMMARY**, in accordance with the age and percentages specified in the following table:

## LOSS OF AUTONOMY – HYBRID COVERAGE

### Purpose of the benefit (continued)

Age of the Primary Insured	Percentage conversion selected	
	2.0%	5.0%
16 to 55 years of age	0%	0%
56 years of age	0.2%	0.5%
57 years of age	0.4%	1.0%
58 years of age	0.6%	1.5%
59 years of age	0.8%	2.0%
60 years of age	1.0%	2.5%
61 years of age	1.2%	3.0%
62 years of age	1.4%	3.5%
63 years of age	1.6%	4.0%
64 years of age	1.8%	4.5%
65 years of age and over	2.0%	5.0%

The percentage conversion payable stays the same as long as the Primary Insured remains physically dependent.

### Additional definition

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependence.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

### Successive periods of facility care

Successive periods of facility care are considered a single continuous period of care and a new waiting period is not required if the following apply:

- a) Both periods of facility care stem from the same cause and

- b) The second period of facility care begins within 180 days of the end of the first and one of the following applies:

- i) The preceding period of facility care entitled the Primary Insured to an indemnity under this benefit
- ii) The waiting period was filled by successive periods of facility care

### Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity paid to the Primary Insured for facility care is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

### Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for facility care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

### Termination of indemnity

The Insurer shall cease paying indemnities under this benefit on the earliest of the following:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured no longer resides in a facility
- c) The date on which the Primary Insured refuses a recognized therapy or participation in a rehabilitation program
- d) The date of death of the Primary Insured

# LOSS OF AUTONOMY – HYBRID COVERAGE

## Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

## Exclusions

1. No indemnity is payable if claims for the **FACILITY CARE** benefit arise directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment for an injury or illness)
  - b) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - c) Direct or indirect commission or attempted commission by the Primary Insured of a criminal act under the Criminal Code or under a similar law in another country
  - d) Mental or nervous disorder without a demonstrable organic cause
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - g) Voluntary or involuntary inhalation of gas or ingestion of poison
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

## End of coverage

This benefit ends on the date of payment of the amount insured if the Primary Insured is 55 years of age or younger on said date.

# HOME CARE – HYBRID COVERAGE LOSS OF AUTONOMY

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity specified in the **CONTRACT SUMMARY** should the Primary Insured be physically dependent.

Payment of the monthly indemnity commences when the waiting period ends and may not extend beyond the maximum indemnity period selected.

The monthly indemnity is determined based on the percentage conversion selected by the Policyholder and the amount insured specified in the **CONTRACT SUMMARY**, in accordance with the age and percentages specified in the following table:

Age of the Primary Insured	Percentage conversion selected	
	2.0%	5.0%
16 and 55 years of age	0%	0%
56 years of age	0.2%	0.5%
57 years of age	0.4%	1.0%
58 years of age	0.6%	1.5%
59 years of age	0.8%	2.0%
60 years of age	1.0%	2.5%
61 years of age	1.2%	3.0%
62 years of age	1.4%	3.5%
63 years of age	1.6%	4.0%
64 years of age	1.8%	4.5%
65 years of age and over	2.0%	5.0%

The percentage conversion payable stays the same as long as the Primary Insured remains physically dependent.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 16 and 60 years of age inclusive when the application is signed.
- b) He/she must have applied and been approved for the **LOSS OF AUTONOMY – HYBRID COVERAGE** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

## HOME CARE – HYBRID COVERAGE LOSS OF AUTONOMY

### Benefit amendment (continued)

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

### Additional definitions

**Waiting period** refers to the first consecutive days of home care during which the Primary Insured is physically dependent and for which no indemnity is payable by the Insurer.

The waiting period is specified in the **CONTRACT SUMMARY**.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Indemnity period

The maximum indemnity payment period is specified in the **CONTRACT SUMMARY**.

When the indemnity is payable for less than one month, the daily indemnity is equal to one-thirtieth of the monthly indemnity payable.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependency.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

### Waiver of premiums in case of disability of the Primary Insured

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

Under this provision, no premiums are payable for the **HOME CARE – HYBRID COVERAGE – LOSS OF AUTONOMY** benefit as of the fourth month after the onset of the Primary Insured's total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

### Successive periods of home care

Successive periods of home care are considered a single continuous period and a new waiting period is not required if the following apply:

- a) Both periods of home care stem from the same cause and
- b) The second period of home care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of home care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods of home care.

# HOME CARE – HYBRID COVERAGE LOSS OF AUTONOMY

## Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

## Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for home care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

## Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured receives facility care
- c) The expiration of the indemnity period specified in the **CONTRACT SUMMARY**
- d) The date of death of the Primary Insured
- e) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

## Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

## Exclusions

1. No indemnity is payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment for an injury or illness)
  - b) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - c) Direct or indirect commission or attempted commission by the Primary Insured of a criminal act under the Criminal Code or under a similar law in another country
  - d) Mental or nervous disorder without a demonstrable organic cause
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - g) Voluntary or involuntary inhalation of gas or ingestion of poison
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

## End of coverage

This coverage ends on the date of payment of the amount insured under the **LOSS OF AUTONOMY – HYBRID COVERAGE** benefit if the Primary Insured is 55 years of age or younger on said date.

# LIFE – HYBRID COVERAGE

## SPECIAL PROVISIONS

### Eligibility

To be eligible for this benefit, the Primary Insured must be between 14 days and 60 years of age inclusive when the application is signed.

### Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

### Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

### Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

### Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

### Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### Beneficiary

The beneficiary is the person so designated by the Policyholder on the insurance application and may be replaced on written request. If the beneficiary is designated as irrevocable, however, he/she must explicitly approve any request to replace him/her. The Insurer records the change requested but assumes no responsibility regarding its validity.

### Cession or assignment

Subject to the provisions of the law, the Policyholder may at any time cede or assign this policy. The Insurer shall only recognize cession or assignment of which the Insurer is notified in writing and assumes no responsibility regarding the validity of any such cession or assignment.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

## LIFE – HYBRID COVERAGE

### **Waiver of premiums in case of disability of the Primary Insured or the Policyholder**

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

#### **Primary Insured**

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Primary Insured become totally disabled between ages 16 and 59 inclusive.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

If the Policyholder is not the Primary Insured, then the waiver of premiums in case of disability of the Primary Insured comes into effect on the earlier of the following dates:

- a) The Primary Insured's 26th birthday
- b) The contract anniversary coinciding with or following the Policyholder's 65th birthday

#### **Policyholder**

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Policyholder become totally disabled before his/her 59th birthday.

The waiver of premiums in case of disability ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Policyholder's 65th birthday
- b) The Primary Insured's 26th birthday—unless the Primary Insured is disabled on this day, in which case the waiver continues under the provision for waiver of premiums in case of disability of the Primary Insured

### **Premium refund**

To be eligible for the premium refund provision, the Primary Insured must be between 14 days and 55 years of age inclusive when the application is signed.

On the contract anniversary coinciding with or following the Primary Insured's 65th birthday, the Insurer undertakes to refund 25% of the premiums paid for this benefit if the Primary Insured decides not to take advantage of the **FACILITY CARE** benefit and accordingly cancels the **LIFE – HYBRID COVERAGE** benefit.

Any premiums waived under the premium waiver clause are excluded from the refund.

### **HOSPITALIZATION AND LOSS OF AUTONOMY enrolment without proof of insurability**

Provided the Primary Insured is not physically dependent on the contract anniversary coinciding with or following his/her 65th birthday, he/she may enrol in the **HOSPITALIZATION AND LOSS OF AUTONOMY** benefit (to a lifetime maximum of \$10 000) without providing the Insurer the proof of insurability required for this benefit.

### **BENEFIT: LIFE**

#### **Purpose of the benefit**

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the designated beneficiary on the death of the Primary Insured the amount insured under this life insurance benefit as specified in the **CONTRACT SUMMARY**.

## LIFE – HYBRID COVERAGE

### Reduction in the amount insured

The amount insured payable is a percentage of the initial amount insured indicated in the **CONTRACT SUMMARY** and is based on the Primary Insured's age, as specified in the following table:

Age of the Primary Insured	% of the initial amount insured
14 days to 55 years of age	100%
56 years of age	90%
57 years of age	80%
58 years of age	70%
59 years of age	60%
60 years of age	50%
61 years of age	40%
62 years of age	30%
63 years of age and over	25%

### Suicide

Should the Primary Insured die of suicide, or of the consequences of a suicide attempt, in the first 24 months following the effective date of this benefit or its reinstatement (or of any increase in the amount insured), whether or not he/she is of sound mind at the time of the suicide or the suicide attempt, the coverage (or the increase, as the case may be) shall be null and void and the Insurer's liability limited to refund of premiums collected for the coverage or for the increase in the amount insured, as the case may be.

### BENEFIT: FACILITY CARE

#### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured a monthly indemnity for facility care if the Primary Insured is physically dependent.

The Primary Insured must be in a facility and must be receiving from a physician continuous medical care suitable to his/her physical dependence.

This protection comes into effect on the Primary Insured's 56th birthday.

The monthly indemnity is determined based on the percentage conversion selected by the Policyholder and the amount insured specified in the **CONTRACT SUMMARY**, in accordance with the age and percentages specified in the following table:

Age of the Primary Insured	Percentage conversion selected	
	2.0%	5.0%
14 days to 55 years of age	0%	0%
56 years of age	0.2%	0.5%
57 years of age	0.4%	1.0%
58 years of age	0.6%	1.5%
59 years of age	0.8%	2.0%
60 years of age	1.0%	2.5%
61 years of age	1.2%	3.0%
62 years of age	1.4%	3.5%
63 years of age	1.6%	4.0%
64 years of age	1.8%	4.5%
65 years of age and over	2.0%	5.0%

The percentage conversion payable stays the same as long as the Primary Insured remains physically dependent.

### Additional definition

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependence.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

## LIFE – HYBRID COVERAGE

### Successive periods of facility care

Successive periods of facility care are considered a single continuous period of care, and a new waiting period is not required if the following apply:

- a) Both periods of facility care stem from the same cause and
- b) The second period of facility care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of facility care entitled the Primary Insured to benefits under this benefit.
  - ii) The waiting period was filled by successive periods of facility care.

### Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity paid to the Primary Insured for facility care is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

### Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for facility care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

### Termination of indemnity

The Insurer shall cease paying indemnities under this benefit on the earliest of the following dates:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured no longer resides in a facility

- c) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program
- d) The date of death of the Primary Insured

### Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

### Exclusions

1. No indemnity is payable if claims under the **FACILITY CARE** benefit arise directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency due to treatment approved by a physician for an injury or illness)
  - b) The Primary Insured's direct or indirect commission or attempted commission of a criminal act under the Criminal Code or under a similar law in another country -
  - c) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - d) Voluntary or involuntary inhalation of gas or ingestion of poison
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - g) Mental or nervous disorder without a demonstrable organic cause
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

# HOME CARE – HYBRID COVERAGE LIFE

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity specified in the **CONTRACT SUMMARY** should the Primary Insured be physically dependent.

This protection comes into effect on the Primary Insured's 56th birthday.

Payment of the monthly indemnity commences when the waiting period ends and may not extend beyond the maximum indemnity period selected.

The monthly indemnity is determined based on the percentage conversion selected by the Policyholder and the amount insured specified in the **CONTRACT SUMMARY**, in accordance with the age and percentages specified in the following table:

Age of the Primary Insured	Percentage conversion selected	
	2.0%	5.0%
14 days to 55 years of age	0%	0%
56 years of age	0.2%	0.5%
57 years of age	0.4%	1.0%
58 years of age	0.6%	1.5%
59 years of age	0.8%	2.0%
60 years of age	1.0%	2.5%
61 years of age	1.2%	3.0%
62 years of age	1.4%	3.5%
63 years of age	1.6%	4.0%
64 years of age	1.8%	4.5%
65 years of age and over	2.0%	5.0%

The percentage conversion payable stays the same as long as the Primary Insured remains physically dependent.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 14 days and 60 years of age inclusive when the application is signed.

- b) He/she must have applied and been approved for the LIFE – HYBRID COVERAGE benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

# HOME CARE – HYBRID COVERAGE LIFE

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## Additional definitions

**Waiting period** refers to the first consecutive days of home care during which the Primary Insured is physically dependent and for which no indemnity is payable by the Insurer.

The waiting period is specified in the **CONTRACT SUMMARY**.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

## Indemnity period

The maximum indemnity payment period is specified in the **CONTRACT SUMMARY**.

When the indemnity is payable for less than one month, the daily indemnity is equal to one-thirtieth of the monthly indemnity payable.

## Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependency.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

## Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

## Waiver of premiums in case of disability of the Primary Insured or the Policyholder

(Optional provision)

This waiver applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

## Primary Insured

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Primary Insured become totally disabled between ages 16 and 59 inclusive.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

If the Policyholder is not the Primary Insured, then the waiver of premiums in case of disability of the Primary Insured comes into effect on the earlier of the following dates:

- a) The Primary Insured's 26th birthday
- b) The contract anniversary coinciding with or following the Policyholder's 65th birthday

# HOME CARE – HYBRID COVERAGE LIFE

## Waiver of premiums in case of disability of the Primary Insured or the Policyholder (continued)

(Optional provision)

### Policyholder

Under this provision, no premiums are payable for this benefit as of the fourth month after the onset of total disability and for as long as the disability lasts should the Policyholder become totally disabled before his/her 59th birthday.

The premium waiver ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Policyholder's 65th birthday
- b) The Primary Insured's 26th birthday—unless the Primary Insured is disabled on this day, in which case the waiver continues under the provision for waiver of premiums in case of disability of the Primary Insured

## Successive periods of home care

Successive periods of home care are considered a single continuous period and a new waiting period is not required if the following apply:

- a) Both periods of home care stem from the same cause and
- b) The second period of home care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of home care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods of home care.

## Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

## Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for home care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

## Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following dates:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured receives facility care
- c) The expiration of the indemnity period specified in the **CONTRACT SUMMARY**
- d) The date of death of the Primary Insured
- e) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

## Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

## Exclusions

1. No indemnity is payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment for an injury or illness)
  - b) Direct or indirect commission or attempted commission by the Insured of a criminal act under the Criminal Code or under a similar law in another country

## HOME CARE – HYBRID COVERAGE LIFE

### Exclusions (continued)

- c) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - d) Voluntary or involuntary inhalation of gas or ingestion of poison
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - g) Mental or nervous disorder without a demonstrable organic cause
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

SPECIMEN

# DISABILITY – HYBRID COVERAGE

## SPECIAL PROVISIONS

### Eligibility

To be eligible for this benefit, the Primary Insured must be between 16 and 55 years of age inclusive when the application is signed.

### Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

### Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

If the Primary Insured is 45 years of age or younger when the benefit is issued, then the premium is payable until the Primary Insured's 65th birthday. Thereafter, the benefit remains effective but there are no premiums to pay.

If the Primary Insured is 46 years of age or older when the benefit is issued, then the premium payable is reduced on the contract anniversary coinciding with or following the Primary Insured's 65th birthday. Thereafter, the benefit remains effective and the premium ceases to be payable on the 20th anniversary of the contract.

### Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

### Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed and will be deemed renewed only if all premiums due before the renewal date have been paid and if the first premium instalment payable for the next insurance period is made on the date indicated on the premium notice.

### Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

### Waiver of premiums in case of disability of the Primary Insured

Under this provision, no premiums are payable for the **DISABILITY – HYBRID COVERAGE** benefit as of the fourth month after the onset of the Primary Insured's total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

## DISABILITY – HYBRID COVERAGE

### Waiver of premiums in case of disability of the Primary Insured (continued)

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

### Premium refund

On the contract anniversary coinciding with or following the Primary Insured's 65th birthday, the Insurer undertakes to refund 25% of the premiums paid for this benefit if the Primary Insured decides not to take advantage of the FACILITY CARE benefit and accordingly cancels the DISABILITY – HYBRID COVERAGE benefit.

Any premiums waived under the premium waiver clause are excluded from the refund.

### HOSPITALIZATION AND LOSS OF AUTONOMY benefit enrolment without proof of insurability

Provided the Primary Insured is not physically dependent on the contract anniversary coinciding with or following his/her 65th birthday, he/she may enrol in the HOSPITALIZATION AND LOSS OF AUTONOMY benefit (to a lifetime maximum of \$10 000) without providing the Insurer the proof of insurability required for this benefit.

### BENEFIT: DISABILITY

#### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly benefit specified in the CONTRACT SUMMARY should he/she become totally disabled.

#### Additional definitions

**Average monthly earned income** refers to income earned during the last complete year prior to the onset of disability, divided by 12.

**Commissioned employee** means anyone whose income is composed at least 50% of commissions.

**Earned income** refers to the sum of all payments the Primary Insured receives from all his/her occupations, including wages, fees, bonuses, deposits, commissions on new sales and 50% of any renewal commissions, before income taxes and less business expenses deductible for income tax purposes.

Excluded is all income that does not derive directly from employment, including income from interest, investments, rents, author's fees, royalties, retirement plans, annuity contracts, profit-sharing plans, deferred compensation plans or any other income that is not received directly in return for services rendered.

To determine eligible income, the Insurer uses the higher of the following amounts: a) annual earned income over the last complete year; b) average earned income of the three best of the last five years.

At the onset of total disability giving rise to benefits, the Primary Insured must, on request, provide proof of income earned.

The Insurer may request copies of the following documents as proof of income earned:

- a) Income tax return
- b) Financial statements
- c) Any other document the Insurer deems appropriate

If the amount paid is less than the insured benefit, the Insurer has no obligation to reimburse the surplus premium.

**Partial disability** means that the Primary Insured is not totally disabled but that both of the following apply due to accident or illness:

- a) The Primary Insured is unable to perform one or more of the major duties of his/her occupation.
- b) The Primary Insured is unable to work more than half the normal required hours per week and is under the continuous care and treatment of a physician.

## DISABILITY – HYBRID COVERAGE

### Additional definitions (continued)

**Permanent total disability** means a permanent and irreversible inability to perform usual daily tasks or any remunerative work.

### Total disability

#### Primary Insured under 65 years of age

- Occupational category 4A

**Total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to perform the major duties of the occupation in which he/she was engaged at the onset of disability.

- Occupational category 3A

**Total disability** means, during the first 60 months of benefit payments, that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to perform the major duties of the occupation in which he/she was engaged at the onset of disability.

Thereafter, **total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to engage in any occupation for which he/she is reasonably suited by education, training or experience.

- Other occupational categories

#### 2A, A and B

**Total disability** means, during the first 24 months of benefit payments, that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to perform the major duties of the occupation in which he/she was engaged at the onset of disability.

Thereafter, **total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to engage in any occupation for which he/she is reasonably suited by education, training or experience.

For all occupational categories, to be considered **totally disabled**, the Primary Insured must be under the continuous care of a physician providing medical care suitable for the disability at an appropriate frequency and must not be engaged in any remunerative work.

**Total disability in case of unemployment** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, of looking for gainful employment for which he/she is reasonably suited by education, training or experience.

**Vocational rehabilitation program** means a program designed to restore the Primary Insured to gainful employment and approved by the Insurer.

**Waiting period** refers to the first consecutive days of the Primary Insured's total disability due to accident or illness during which no benefit is payable by the Insurer. The waiting period is specified in the **CONTRACT SUMMARY**.

Consecutive periods of disability (minimum five days per period) for the same cause may be accumulated to satisfy waiting periods of 30 days or more.

#### Categories 4A and 3A

Consecutive periods of disability may be accumulated over a period of 365 days.

#### Categories 2A, A and B

Consecutive periods of disability may be accumulated over a period of 180 days.

The Primary Insured selects the length of the waiting period. If he/she has selected a 30-day waiting period but the disability requires hospitalization for more than 18 hours, benefits are payable as of the first day following hospitalization.

# DISABILITY – HYBRID COVERAGE

## Return-to-work bonus

To help the Primary Insured adjust to an active return to his/her work environment prior to disability, a lump-sum benefit equal to a multiple of the monthly benefit payable in the month preceding the return to work shall be paid, as follows:

Duration of disability (months)	Bonus benefit
24 to 59	3 x monthly benefit
60 or more	6 x monthly benefit

In case of recurrence of disability, the lump sum paid under the **RETURN-TO-WORK BONUS** provision is subtracted from future payments.

## Benefit period

Maximum benefit payment period is specified in the **CONTRACT SUMMARY**.

When the benefit is payable for less than one month, the daily benefit is equal to one-thirtieth of the monthly benefit payable.

## Organ donation

If the Primary Insured becomes totally disabled due to transplant of an organ from his/her body to another person, he/she is eligible for organ-donation related disability insurance benefits provided his/her disability insurance was in effect for at least 12 months before the onset of disability.

## Rehabilitative employment

Should the Primary Insured become totally disabled, he/she may nonetheless perform remunerative work within a vocational rehabilitation program approved by the Insurer— for a maximum of 24 months but not exceeding the benefit period specified in the **CONTRACT SUMMARY**.

Fifty percent of any income the Primary Insured earns in such a program is deducted from the monthly payments made under this benefit.

## Indexation of benefits

(Optional clause)

This indexation provision applies when selected by the Policyholder, as specified in the **CONTRACT SUMMARY**.

If a disability lasts more than 12 months, then benefits paid for continuing total disability are indexed annually on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, subject to a maximum indexation of 3%.

## Integration

If the Primary Insured is enrolled in one or more **DISABILITY INSURANCE, DISABILITY – HYBRID COVERAGE, MONTHLY INDEMNITY** or **MONTHLY INDEMNITY EXPRESS** benefits with the Insurer, then these benefits are treated like a single benefit and only one integration calculation is performed with the total of the amounts insured.

If the amount paid is less than the insured benefit, the Insurer has no obligation to reimburse the surplus premium.

For the first 24 months of disability benefit payments, the first \$1 000 are guaranteed. Only the amount in excess of \$1 000 is reduced by the amount of any benefits payable under other plans.

After 24 months of disability benefit payments, the total benefit is reduced from the initial amount payable for total disability in consideration of the following:

- Any federal or provincial plan
- Any other federal or provincial law

Cost-of-living benefit increases are not considered in the reduction specified above. The Insurer reserves the right to reduce the monthly benefit if the Primary Insured fails or refuses to collect what he/she is entitled to under said laws or plans.

# DISABILITY – HYBRID COVERAGE

## Integration (continued)

If the amounts payable under said laws or plans are lump-sum amounts to compensate for a loss of income, the Insurer shall calculate a monthly equivalent, which will then be deducted from the monthly benefit payable under this coverage.

The child's benefit payable under the applicable provincial plan or the *Canada Pension Plan* in case of disability of the Primary Insured does not affect the calculation of benefits payable under this insurance.

## Coordination of non-taxable benefits

In the event of total disability due to accident, the Primary Insured is entitled to benefits under public plans, and the appropriate public agencies must be informed of his/her condition.

Monthly benefits are reduced to match the Primary Insured's average monthly earned income after taxes in the fiscal year prior to the onset of disability if monthly benefits payable by the Insurer, or the sum of monthly benefits payable by the Insurer and the amounts listed below, exceed 100% of said average income after taxes:

- Compensation from another personal insurance plan
- Compensation from group insurance
- Compensation or income from provincial or federal plans (excluding any subsequent cost-of-living increases in such income)

## Coordination of taxable benefits

In the event of total disability due to accident, the Primary Insured is entitled to benefits under public plans, and the appropriate public agencies must be informed of his/her condition.

Monthly benefits are reduced to match 90% of the Primary Insured's average monthly earned income after taxes in the fiscal year prior to the onset of disability if monthly benefits payable by the Insurer or if the sum of the monthly benefits payable by the Insurer and the amounts listed below exceeds 90% of said average income after taxes:

- Compensation from another personal insurance plan
- Compensation from group insurance
- Compensation or income from provincial or federal plans (excluding any subsequent cost-of-living increases in such income)

## Partial disability

### Categories 4A and 3A

(with remunerative work at the onset of disability)

In the event of partial disability due to accident or illness, the Insurer undertakes to make monthly benefit payments equal to the following:

- 50% of the benefit provided for in the **CONTRACT SUMMARY** for the first 24 months of partial disability, and
- 25% of the benefit provided for in the **CONTRACT SUMMARY** for any partial disability lasting more than 24 months, without exceeding the benefit period specified in the **CONTRACT SUMMARY**

### Categories 4A and 3A

(without remunerative work at the onset of disability)

In the event of partial disability as a result of a total disability lasting at least the duration of the waiting period and not less than 30 days, the Insurer undertakes to make monthly benefit payments equal to the following:

- 50% of the benefit provided for in the **CONTRACT SUMMARY** for the first 24 months of partial disability, and
- 25% of the benefit provided for in the **CONTRACT SUMMARY** for any partial disability lasting more than 24 months, without exceeding the benefit period specified in the **CONTRACT SUMMARY**

# DISABILITY – HYBRID COVERAGE

## Partial disability (continued)

### Categories 2A, A and B

In the event of partial disability as a result of a total disability lasting the duration of the waiting period and not less than 30 days, the Insurer undertakes to make monthly benefit payments equal to 50% of the benefit provided for in the **CONTRACT SUMMARY** for a maximum benefit period of 12 months.

## Increase in benefit

Should a total disability prevent the Primary Insured from performing at least two activities of daily living, as described in the **GENERAL PROVISIONS**, the Primary Insured's monthly benefit shall be increased by 25%.

## Lump-sum payment upon permanent total disability

Twelve months after any accident that causes permanent total disability, the Insurer undertakes to pay, in addition to any other amounts provided for in the contract, a lump sum amount equal to 50 times the monthly benefit specified in the **CONTRACT SUMMARY** (to a maximum of \$100 000), provided the Primary Insured is still surviving at that time.

Permanent total disability as defined in this benefit must be proved to the Insurer's satisfaction within 12 months of the accident and before the Primary Insured's 65th birthday.

## Successive periods of disability

Successive periods of total disability are considered a single continuous period of total disability, and a new waiting period does not apply in case of the following:

### Categories 4A and 3A

- a) Both periods of disability are caused by the same accident or illness and
- b) The second period of total disability begins within 365 days of the end of the first and one of the following applies:

- i) The preceding period of total disability entitled the Primary Insured to benefits under this coverage.
- ii) The waiting period was filled by successive periods of disability.

### Categories 2A, A and B

- a) Both periods of disability are caused by the same accident or illness and
- b) The second period of total disability begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of total disability entitled the Primary Insured to benefits under this coverage.
  - ii) The waiting period was filled by successive periods of disability.

## Death benefit

If the Primary Insured is totally disabled for more than 12 months and the disability results in death, an amount equal to three monthly benefit payments will be paid to the deceased's estate.

## Extension of benefits

If the Primary Insured is a commissioned employee recognized as disabled for more than six months, he/she is entitled, on return to work, to a maximum of three additional months of disability benefits per disability, the amount of said additional benefit being equal to a percentage of the monthly benefit payable in the month preceding the return to work, as follows:

First month of return to work	75%
Second month of return to work	50%
Third month of return to work	25%

The benefits contemplated in the preceding paragraph shall be reduced by any additional benefits payable under the **RETURN-TO-WORK BONUS** provision.

## DISABILITY – HYBRID COVERAGE

### Insurance extension in case of unemployment

During a period of unemployment, the Primary Insured remains insured if the total disability is due to any of the following occurring during the first 12 months of employment:

- a) An accident
- b) One of the following:
  - i) Cerebrovascular accident (stroke)
  - ii) Cancer
  - iii) Heart attack (myocardial infarction)
  - iv) Kidney failure
  - v) Coronary artery bypass

### Termination of benefits

The Insurer ceases to make disability benefit payments under this coverage on the earliest of the following dates:

- a) When the total disability ends
- b) On the contract anniversary date coinciding with or following the Primary Insured's 65th birthday
- c) On expiry of the benefit period specified in the **CONTRACT SUMMARY**
- d) When the Primary Insured performs remunerative work, whether or not he/she is totally disabled, except within a vocational rehabilitation program approved by the Insurer
- e) When the Primary Insured is unable or refuses to give the Insurer satisfactory evidence of his/her total disability
- f) When the Primary Insured refuses recognized therapy that could promote his/her return to work
- g) On the death of the Primary Insured

### Exclusions

No benefits are payable if the total disability is caused directly or indirectly by any of the following:

- a) An accident sustained by the Primary Insured while participating in a sport for remuneration or in any kind of motor vehicle competition, race or speed contest

- b) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
- c) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
- d) The Primary Insured's participation in a flight or a flight attempt in any aircraft in any capacity other than that of a passenger
- e) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
- f) Cosmetic care or treatment
- g) Experimental care or treatments, or new procedures or therapies not yet commonly used

In addition, no benefits are payable during the following periods:

- a) Any period during which the Primary Insured moves outside Canada, unless both of the following conditions are met:
  - i) The Primary Insured continues to receive regular medical care from a health professional in Canada or in the United States.
  - ii) The Primary Insured receives such care at least 30 days prior to departure and as often as the Insurer deems necessary, and he/she is ready to be medically examined by a licensed physician in Canada or the United States at the Insurer's expense when required.
- b) Any period during which the Primary Insured receives a full or partial salary (with the exception of commissions for sales completed before the onset of total disability of a commissioned employee)
- c) Any period during which the Primary Insured is entitled to paid sick leave or receives maternity benefits for maternity leave or parental leave taken as per federal or provincial law or an agreement between the Primary Insured and his/her employer.

## DISABILITY – HYBRID COVERAGE

### Exclusions (continued)

No benefits are payable for a disability beginning during a period when the Primary Insured is not gainfully employed, subject to the section above entitled **INSURANCE EXTENSION IN CASE OF UNEMPLOYMENT**.

No benefits are payable unless the Primary Insured is receiving continuous care from a physician appropriate for his/her disability.

### End of DISABILITY coverage

**DISABILITY** coverage ends on the earliest of the following dates:

- a) On the contract anniversary coinciding with or following the Primary Insured's 65th birthday
- b) On the date the Primary Insured retires, provided the Primary Insured is at least 55 years of age on said date

## BENEFIT: FACILITY CARE

### Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured a monthly indemnity for facility care should the Primary Insured be physically dependent.

The Primary Insured must be in a facility and receiving from a physician continuous medical care suitable to his/her physical dependence.

This protection comes into effect on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Primary Insured's 65th birthday
- b) The date on which the Primary Insured retires, provided the Primary Insured is at least 55 years of age on said date and sends the Insurer a written request to this effect

The monthly indemnity is determined as follows: 50% of the initial amount insured (specified in the **CONTRACT SUMMARY**), subject to a maximum of \$10 000.

### Additional definitions

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependence.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

### Successive periods of facility care

Successive periods of facility care are considered a single continuous period of care, and a new waiting period is not required if the following apply.

- a) Both periods of facility care stem from the same cause and
- b) The second period of facility care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of facility care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods of facility care.

### Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for more than 12 months, then the indemnity paid to the Primary Insured for facility care is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, subject to a maximum indexation of 3%.

## DISABILITY – HYBRID COVERAGE

### Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for facility care shall be increased 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

### Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earlier of the following dates:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured no longer resides in a facility
- c) The date of death of the Primary Insured
- d) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

### Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

### Exclusions

1. No indemnity is payable if a claim for the **FACILITY CARE** benefit arises directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however, this exclusion does not apply to a drug dependency due to treatment approved by a physician for an injury or illness)
  - b) Direct or indirect commission or attempted commission by the Primary Insured of a criminal act under the Criminal Code or under a similar law in another country

- c) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
  - d) Voluntary or involuntary inhalation of gas or ingestion of poison
  - e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
  - f) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind
  - g) Mental or nervous disorder without a demonstrable organic cause
2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.

# REGULAR OCCUPATION

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the definition of total disability for the **DISABILITY – HYBRID COVERAGE** benefit is replaced by one of the following specific definitions:

## Specific definitions

### If the Primary Insured has remunerative work at the onset of disability:

**Total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to perform the major duties of the occupation in which he/she was engaged at the onset of disability.

This definition applies for the waiting period and for the duration of the regular occupation mentioned in the **CONTRACT SUMMARY**.

Thereafter, **total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause, to engage in any occupation for which he/she is reasonably suited by education, training or experience.

### If the Primary Insured is without remunerative work at the onset of disability:

**Total disability** means that the Primary Insured is unable, due directly to accident or illness independently of any other cause to perform his/her usual daily tasks and any other tasks for which he/she is reasonably qualified by education or experience.

This definition applies for the waiting period and for the duration of benefits mentioned in the **CONTRACT SUMMARY**.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 16 and 55 years of age inclusive when the application is signed
- b) He/she must have applied and been approved for the **DISABILITY – HYBRID COVERAGE** benefit

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when it is delivered to the Policyholder, provided that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and determined based on the Primary Insured's age at issue.

## Duration of premium payment

The premium is payable until the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was made on the date indicated on the premium notice.

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in premium at least 30 days before the anticipated renewal date.

## REGULAR OCCUPATION

### Benefit amendment (continued)

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

### Waiver of premiums in case of disability of the Primary Insured

Under this provision, no premiums are payable for the **REGULAR OCCUPATION** benefit as of the fourth month after the onset of the Primary Insured's total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

### End of coverage

Coverage under this benefit ends on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Primary Insured's 65th birthday
- b) The date on which the **DISABILITY – HYBRID COVERAGE** benefit ends

# HOME CARE – HYBRID COVERAGE DISABILITY

## Purpose of the benefit

Subject to the provisions of this benefit and the contract, the Insurer undertakes to pay the Primary Insured the monthly indemnity specified in the **CONTRACT SUMMARY** should the Primary Insured be physically dependent.

This protection comes into effect on the earlier of the following dates:

- a) The contract anniversary coinciding with or following the Primary Insured's 65th birthday
- b) The date on which the Primary Insured retires, provided the Primary Insured is at least 55 years of age on said date and sends the Insurer a written request to this effect

The monthly indemnity is determined as follows: 50% of the initial amount insured (specified in the **CONTRACT SUMMARY**), subject to a maximum of \$10 000.

Payment of the monthly indemnity commences when the waiting period ends and may not extend beyond the maximum indemnity period selected.

## Eligibility

The Primary Insured must meet the following eligibility criteria:

- a) He/she must be between 16 and 55 years of age inclusive when the application is signed.
- b) He/she must have applied and been approved for the **DISABILITY – HYBRID COVERAGE** benefit.

## Benefit commencement

The benefit takes effect when the application is approved by the Insurer, provided that it is approved without modification, that the first premium has been paid and that no changes in the insurability of the Primary Insured have occurred since the signing of the application.

Otherwise, the benefit only takes effect when the contract is delivered to the Policyholder, provided no changes in the insurability of the Primary Insured have occurred since the signing of the application.

## Premium determination

The premium is levelled and is established based on the age of the Primary Insured when this benefit is issued.

The premium is guaranteed as of the Primary Insured's 65th birthday, provided this benefit has been in effect for at least 20 years.

## Benefit renewal

Subject to the conditions set forth below, the benefit is renewed from year to year on the anniversary date indicated in the **CONTRACT SUMMARY**.

The Insurer may not terminate a benefit as long as the Policyholder pays the premium.

A benefit may be renewed only if all premiums due before the renewal date have been paid and if the first instalment of the premium payable for the next insurance period was paid on the date indicated on the premium notice.

## Benefit amendment

(This clause applies only if compatible with the terms of the **Premium determination** clause.)

At the time of renewal, the Insurer sets the premium amount for the next 12 months. The Policyholder must be advised of any change in the premium at least 30 days before the anticipated renewal date.

The Insurer reserves the right to modify unit rates at the time of benefit renewal, provided unit rates of all identical benefits are modified.

## Duration of premium payment

The duration of premium payment is indicated in the **CONTRACT SUMMARY**.

## HOME CARE – HYBRID COVERAGE DISABILITY

### Additional definitions

**Waiting period** refers to the first consecutive days of home care during which the Primary Insured is physically dependent and for which no indemnity is payable by the Insurer.

The waiting period is specified in the **CONTRACT SUMMARY**.

**Physical dependence** means the Primary Insured is unable to perform unassisted two or more of the Activities of Daily Living or has a cognitive impairment as defined in the **GENERAL PROVISIONS**.

### Indemnity period

The maximum indemnity payment period is specified in the **CONTRACT SUMMARY**.

When the indemnity is payable for less than one month, the daily indemnity is equal to one-thirtieth of the monthly indemnity payable.

### Medical certificates

The Primary Insured's attending physician must provide medical information specifying the diagnosis giving rise to the physical dependency.

The Insurer reserves the right to have the Primary Insured examined by a physician of the Insurer's choice before authorizing payment of the indemnity.

### Premium waiver

Under this provision, no premiums are payable for this benefit when the Primary Insured is physically dependent and for as long as this physical dependence lasts.

### Waiver of premiums in case of disability of the Primary Insured

Under this provision, no premiums are payable for the **HOME CARE – HYBRID COVERAGE – DISABILITY** benefit as of the fourth month after the onset of the Primary Insured's total disability and for as long as the total disability lasts should the Primary Insured become totally disabled before his/her 60th birthday.

The premium waiver ends on the contract anniversary coinciding with or following the Primary Insured's 65th birthday.

### Successive periods of home care

Successive periods of home care are considered a single continuous period and a new waiting period is not required if the following apply:

- a) Both periods of home care stem from the same cause and
- b) The second period of home care begins within 180 days of the end of the first and one of the following applies:
  - i) The preceding period of home care entitled the Primary Insured to an indemnity under this benefit.
  - ii) The waiting period was filled by successive periods.

### Indexation of monthly indemnity

If the Primary Insured receives a monthly indemnity for a period of more than 12 months, then the indemnity is indexed every year on January 1 according to the *Consumer Price Index* published annually by *Statistics Canada*, to a maximum indexation of 3%.

# HOME CARE – HYBRID COVERAGE DISABILITY

## Cost-of-living increase

(Optional provision)

This provision applies when selected by the Policyholder as indicated in the **CONTRACT SUMMARY**.

After the first 12 months following the effective date of this benefit, the monthly indemnity for home care shall be increased by 3% on January 1 of every year, subject to a maximum indemnity of \$10 000.

## Termination of indemnity

The Insurer shall cease paying the indemnity under this benefit on the earliest of the following:

- a) The date on which the Primary Insured is no longer physically dependent
- b) The date on which the Primary Insured receives facility care
- c) The expiration of the indemnity period specified in the **CONTRACT SUMMARY**
- d) The date of death of the Primary Insured
- e) The date on which the Primary Insured refuses recognized therapy or participation in a rehabilitation program

## Limitation

Under no circumstances shall the monthly indemnity exceed \$10 000, this including any additions under the cost-of-living increase clause and the indexation of monthly indemnity clause.

## Exclusions

1. No indemnity is payable for claims arising directly or indirectly from any of the following:
  - a) Abuse of alcohol or drugs, or use of illegal drugs (however this exclusion does not apply to a drug dependency sustained or acquired at the hands of or while under treatment for an injury or illness)
  - b) Attempted suicide or intentional self-injury, regardless of the Primary Insured's state of mind

- c) Direct or indirect commission or attempted commission by the Primary Insured of a criminal act under the Criminal Code or under a similar law in another country
- d) Mental or nervous disorder without a demonstrable organic cause
- e) The Primary Insured's active participation in a public confrontation, riot, insurrection, war or act of war (declared or not) or any other warlike act
- f) The Primary Insured's operation of a motor vehicle or a boat with an alcohol level exceeding 80 mg per 100 mL of blood or under the influence of any drug
- g) Voluntary or involuntary inhalation of gas or ingestion of poison

2. No indemnity is payable for physical dependence during which the Primary Insured resides outside Canada or the United States.