myHSA plus
Multi-Coverage Insurance

Policy # MYH1001- Policyholder Number

Name of Broker

THE WAWANESA LIFE INSURANCE COMPANY

400-200 Main Street, Winnipeg, MB R3C 1A8
Toll Free: 1-888-997-9965

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Insuring Agreement

The Wawanesa Life Insurance Company hereby contracts with:

Name and Address of Policyholder:

Policyholder Name
Policyholder Address Line 1
Policyholder Address Line 2

"Member Client" *means* clients who are participating in the benefit programs administered by the Policy Administrator.

Policy Effective Date: _______ 1, 201_ at 12:01 A.M. standard time at the head office address of the Policyholder as stated above.

It continues in force for the period for which premium has been paid.

Renewal Date _______ 1, 201_ and each ______ 1 thereafter, subject to the terms of this policy.

Premiums Due Payment is due on the first day of each month and a period of 60 days is allowed for the payment of every premium starting on the premium due date.

The Wawanesa Life Insurance Company ("Insurer") agrees with the Policyholder named above ("Policyholder") to insure eligible persons specified herein ("Insured Employee") and their eligible spouses and dependent children, if any, ("Insured Spouse" and "Insured Dependent Child", respectively) and promises to pay for the benefits specified in this policy; to the extent herein limited and provided.

This agreement is made in consideration of the Policyholder's payment of the required premium.

Signed by The Wawanesa Life Insurance Company at its Executive Office in Winnipeg, Manitoba, Canada on the Master Policy Effective Date.

Louise Mitchell
President

Pat Horncastle
Vice President and Chief Operating Officer

Schedule

1. **Eligible Employee Class:**

   Class I: All permanent Employees under the Age of 65 working a minimum of 15 hours per week (averaged over the latest three-month period of being Actively at Work) who have satisfied their Employer's Waiting Period.

2. **Waiting Period:** ___________

3. **Deductible:**

   Excess Medical Deductible: $2,500 per person per calendar year

4. **Aggregate Limit of Indemnity:** $2,000,000

5. **Grace Period for premium payment:** 30 days

6. **Non-Evidence Benefit Maximums:**

Benefit	Maximum
Employee Life Insurance	$ 15,000
Spouse Life Insurance	$ 10,000
Dependent Child Life Insurance (Each Child)	$ 5,000
Employee Accidental Death or Dismemberment Benefit	$ 60,000
Employee Critical Illness Insurance	$ 15,000
Travel Emergency Medical	$ 1,000,000
Excess Medical	$ 250,000

7. Benefit Amounts

Coverage A: Employee Mandatory Life insurance ....$ 15,000

Coverage B: Dependent Mandatory Life Insurance:

Spouse Life Insurance ....$ 10,000

Dependent Child Life Insurance (Each Child)................$ 5,000

Coverage C: Employee Mandatory Accidental Death or

Dismemberment Benefit ....$ 60,000

Coverage D: Employee Mandatory Critical Illness Insurance $ 15,000

Coverage E: Travel Emergency Medical (Benefit Maximums)

Medical Expenses Lifetime ....$ 1,000,000

Appliances and Durable Equipment ....$ 2,000

Emergency Dental Treatment..$ 2,000

Hotel Convalescence..$ 1,000

Nursing Care ....$ 5,000

Meals and Accommodation ....$ 1,500

Paramedical ....$ 300

Physiotherapy...$ 1,000

Return of Remains..$ 5,000

Vehicle Return ....$ 2,000

Coverage F: Excess Medical (Benefit Maximums)

Lifetime Maximums

Benefits Lifetime, total of all expenses ....$ 250,000

Benefits, total of all expenses per calendar year...........$ 125,000

Benefits Lifetime, per listed expense item ....$ 50,000

Yearly Maximums

Ambulance ....$ 25,000

Dental Injury...$ 25,000

Drug Therapy ....$ 25,000

Durable Equipment..$ 25,000

Nursing Care ....$ 25,000

Paramedical...$ 25,000

Semi Private Room Costs ....$ 25,000

General Policy Definitions

"Accident" *means* a single sudden and unexpected event, which:

(a) occurs at an identifiable time and place;

(b) causes unexpected bodily Injury at the time it occurs; and

(c) arises from an external source to the Insured Person.

"Actively at Work" *means* an Employee capable of working and present at the place of work to carry out normal duties in accordance with the Employee's regular work schedule, on vacation or on a leave approved by the Employer.

"Additional Insurance" *means* the Benefit Amount exceeding the non-evidence benefit maximums of each benefit.

"Administrator" *means* myHSA Ltd.

"Age" *means* the attained Age of an Insured Person (last birthday).

"Airfare" *means* the regular fare charged for an economy class seat on a regular flight by a domestic or international scheduled air carrier, which holds an operating certificate issued by Transport Canada or by a similar governmental authority having jurisdiction over such air carrier in the country of its certification.

"Benefit Amount" *means* the insurance benefits provided in the policy and is the amount of insurance issued as shown on the Schedule.

"Dependent Child(ren)" *means* all unmarried children of an Insured Employee, of a Spouse or of both. This includes legally adopted children, and those children (in the case of a minor) for whom the Insured Employee or Spouse exercise (or would exercise) parental authority and whom the Insured Employee or Spouse support and who are:

(a) under Age 21; or

(b) at least Age 21, but under Age 25, and are full-time students at an accredited educational institution, subject to proof of registration to the satisfaction of the Insurer; or

(c) regardless of Age, suffering from a severe, incurable and chronic physical or mental disability while meeting the requirements indicated above of Dependent Children, rendering such children unable to pursue a substantially gainful occupation, subject to adequate medical Evidence;

and who:

(a) are covered by a Provincial Health insurance plan; and

(b) reside in Canada.

Dependent Children will be covered from birth provided such children are born alive.

A Dependent Child will only be considered an Insured Dependent Child once under this policy.

"Dependents" *means* collectively, an Insured Spouse and/or an Insured Dependent Child, if applicable, eligible for insurance under a provision of this contract.

"Disease" *means* any unhealthy condition of the body or any part thereof occurring while this policy is in force with respect to the Insured Person whose disease is the basis of claim and for which expenses are incurred as described in the Description of Coverage section(s) of this policy.

"Emergency" *means* sudden, unexpected and not preplanned.

"Employee" *means* a person who is under Age 65 and who is:

(a) employed on a full-time, part-time or permanent basis by the Employer; or

(b) a sole proprietor, partner or shareholder of the Employer; and

(c) a Canadian citizen or permanent resident of Canada; and

(d) residing in Canada.

Partners, proprietors, corporation officers or directors, or Dependents will be considered as Employees only if they are Actively at Work.

A person insured as an Employee will not be eligible to be insured again as a Spouse or Dependent Child.

"Employer" *means* the Policyholder or any employer whose Employees or a category of Employees are represented by the Policyholder of this policy.

"Evidence" *means* evidence deemed satisfactory by the Insurer to confirm a particular state or condition.

"Hospital" *means* an institution licensed as a Hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one or more Physicians available at all times and which continuously provides 24-hour nursing service by graduate registered Nurses. It provides organized facilities for diagnostics and Surgery, is an active treatment Hospital and not primarily a clinic, rest home, nursing home, convalescent Hospital or similar establishment. For the purposes of this definition, Hospital will include a facility or part of a facility used for rehabilitative care. For the purposes of this definition, Physicians and Nurses will not exclude an Immediate Family Member.

"Illness" *means* a Disease, mental infirmity or Sickness. Any surgery needed to donate a body part to another person, which causes Total Disability, will be considered an Illness.

"Immediate Family Member" *means* a person at least 18 years of Age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), Spouse, grandson, granddaughter, grandfather or grandmother of an Insured Person.

"Injury" *means* bodily Injury to an Insured Employee caused solely by an Accident which occurs while this policy is in force. The Injury must be the basis of a claim and result directly and independently of all other losses covered by this policy, 24 hours a day, anywhere in the world. In no event shall Injury mean Sickness or Disease unless caused by an Accident.

"Insured Person" *means* collectively, an Insured Employee, an Insured Spouse or an Insured Dependent Child, if applicable, eligible for insurance under a provision of this policy, unless otherwise stated in this policy.

"Medically Necessary" *in reference to a given service or supply, means* such service or supply:

(a) is appropriate and consistent with the diagnosis according to accepted community standard of medical treatment;

(b) is not experimental or investigative in nature; and

(c) cannot be omitted without adversely affecting the condition or quality of medical care.

"Month" *means* a period starting at 12:01 A.M. on the first day in a given calendar Month, and ending at 12:01 A.M. on the first day in the next calendar Month.

"Nurse" means a graduate registered nurse (R.N.), or a Nurse who is licensed to practice nursing services by a governmental agency that has jurisdiction over such licensing. A Nurse cannot be the Insured Person nor an Immediate Family Member.

"Physician" *means* a doctor of medicine (other than an Insured Person or Immediate Family Member) who is licensed to practice medicine by:

(a) a recognized medical licensing organization in the locale where the treatment is rendered, provided he or she is a member in good standing of such licensing body; or

(b) a governmental agency which has jurisdiction over such licensing in the locale where the treatment is rendered.

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

"Residence" means both the primary dwelling in Canada of which an Insured Person is an occupant and the premises on which it is situated.

"Sickness" *means* an impairment of a normal physiological function and includes infections occurring while this policy is in force as the Insured Person whose sickness is the basis of claim and for which expenses are incurred as described in the Description of Coverage sections of this policy.

"Spouse" *means* an individual residing in Canada and covered by a Provincial Health insurance plan under the age of 65:

(a) to whom the Insured Employee is legally married; or

(b) with whom the Insured Employee has continuously cohabited in a conjugal relationship for a minimum of one year immediately before a loss is incurred under the policy.

Only one individual will qualify as a Spouse. If the Insured Employee is legally married but is also cohabiting with an individual as described under item (b) above, the Insured Employee may elect in writing which one of the individuals will qualify as a Spouse under the policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Employee is legally married.

"Totally Disabled/Total disability" *means* an Insured Employee is prevented from engaging in every occupation or employment for compensation or profit for which he or she is, or may become, reasonably qualified by reason of education, training or experience.

"Travelling Companion" means a person who is sharing the same booked accommodation with the Insured Person.

"Trip" *means* travel which commences on the date of departure from the Insured Person's province of Residence and continues until the return date of the Insured Person's province of Residence, subject to a maximum duration of 60 consecutive days.

General Policy Provisions

1 - Eligibility for Insurance

1.1 Eligibility

Class I Employees of the Employer will be eligible for insurance from the date as outlined in the Waiting Period mentioned in the Schedule, provided they are Actively at Work at such date.

An Employee's Dependents will be eligible for insurance on the same date as the Employee, or on a subsequent date on which they become Dependents of the Employee.

Employees not Actively at Work on the date on which they would otherwise be eligible for insurance will become eligible for insurance on the 1st day of the Month following the date of their return to work in the capacity for which they are made eligible for insurance.

Insured Persons must be full-time residents of Canada and be covered under their Provincial Government Health care plans.

If two Insured Employees are Spouses of each other and are eligible for insurance under this policy, one of the two may choose to be insured as an Insured Spouse of the other, in which case they will not be considered to be an Insured Employee. Otherwise both may choose to be covered as an Insured Employee, in which case neither will be eligible as a Spouse.

Subject to preceding paragraphs, Employees who are Actively at Work on the Master Policy Effective Date whose coverage under another group insurance policy terminates on such date shall be eligible for insurance on the date on which the present policy shall come into force.

1.2 Participation in the Insurance Plan

For Employees, Spouses, and Dependent Children eligible for an Employer's mandatory insurance, participation in the insurance plan is required.

2 - Effective Date of Individual Insurance

2.1 Employee Insurance

An Employee's insurance will become effective on the date he or she becomes eligible, on condition that an application has been received by the Administrator before such date, or within the 31 days thereafter; otherwise, coverage becomes effective on the first day of the month following acceptance of Evidence of insurability by the Insurer.

2.2 Spouse and Dependent Children

Coverage for a Spouse and Dependent Children will become effective on the date on which they become eligible, provided the Administrator receives an application prior to such date or within 31 days following such date; otherwise, coverage becomes effective on the first day of the month following the acceptance of Evidence of insurability by the Insurer. However, following the Spouse's and Dependent Children's participation in the plan, coverage for any other Dependent Child shall automatically become effective on the date such child meets with the definition of "Dependent Child".

Coverage for a Spouse and Dependent Children can, at no time, become effective before an Insured Employee's Effective Date of Individual Insurance.

If a Dependent, other than a newborn child, is confined at home or in a Health Care Facility on the date his or her insurance would otherwise become effective, the Life Insurance will be postponed until the 8th day after the end of such confinement.

"Health Care Facility": refers to facilities such as:

(a) Hospital of any kind;
(b) a skilled nursing facility;
(c) an alcoholism treatment facility;
(d) a place for treatment of drug or chemical addiction or dependence;
(e) a place for treatment of mental, nervous or emotional disorders or conditions;
(f) a place for custodial care.

2.3 Effective Hour on Effective Date

For the purposes of this policy, the Effective Date of Individual Insurance of will be the given date from 00.01 hour A.M. at the Residence of the Insured Employee.

2.4 Actively at Work

If an Employee is not Actively at Work on the date his or her insurance would otherwise become effective, or on the effective date of an increase in benefits, the insurance or increase will become effective on the date he or she returns to being Actively at Work.

3 - Change in Coverage of an Insured Person

If an occurrence takes place affecting the class of insurance or benefit amount of an Insured Person, the Policyholder agrees to notify the Administrator, in writing, within 31 days.

If there is a benefit increase or a change in the class of insurance, then the revised coverage will become effective on the first day of the month following the date the Administrator receives notice from the Policyholder. If the notice of revised coverage is not received within the allotted time then Evidence of Insurability will be required and the revised coverage will become effective on the first day of the month following the acceptance of Evidence of insurability by the Insurer.

If there is an increase in coverage and an Insured Employee is not Actively at Work on the date when his or her class of insurance or coverage would normally be revised, the revised coverage will become effective on or after the first day of the month when the Insured Employee returns to being Actively at Work.

If there is a benefit decreases, then the revised coverage will become effective from the first day of the month following the date of the change.

4 - Termination of Individual Insurance

4.1 Employee

The insurance of an Insured Employee will terminate on the earliest of:

(a) the date of the policy terminates;

(b) the date the participating group/association terminates;

(c) the last day of the Month in which the Insured Employee ceases to be eligible for insurance;

(d) the premium due date required for a Insured Employee in accordance with the conditions of this policy if such premiums are not paid to the Insurer prior to the expiration date of the Grace Period;

(e) the premium due date following the date the Insured Employee ceases to be Actively at Work because leave of absence, lay-off, maternity leave, disability, resignation, or dismissal, except as provided under section 5 - Continuation of Individual Coverage or section 6 - Waiver of Premium;

(f) the date on which the Waiver of Premium terminates, with respect to a benefit for which the premium is being waived under Section 6 - Waiver of Premium, unless the Insured Employee has resumed payment of the premium as an Employee;

(g) the date on which the Insured Person collects, or allows to be collected, as a result of false claims or misrepresentations originating from the Insured Person or a third party, benefit payments which are not provided by the policy, irrespective of the compulsory character of the coverage and of any other recourse which could be exercised by the Insurer.

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

(i) the date the Insured Person ceases to be covered by a Provincial Health insurance plan;

(j) the date of the Insured Employee's death;

(k) the date they reach Age 65.

4.2 Dependents

The insurance of an Insured Spouse or Insured Dependent Child will terminate on the earliest of:

(a) the date the Insured Employee's insurance ceases;

(b) the date the Insured Employee ceases to be in a class of Employees eligible for Dependent insurance;

(c) the date the Dependent no longer qualifies as a Dependent.

4.3 Multiple Covered Critical Illness Conditions Termination

The Critical Illness benefit is payable only once by the Insurer under this policy during the lifetime of an Insured Employee. Coverage D: Employee Mandatory Critical Illness Insurance for that Insured Employee then terminates, regardless of the number of Critical Illnesses that may be diagnosed. Coverage under remaining sections A, B, C, E and F will continue as long as the Insured Employee maintains all other eligibility requirements for this policy.

5 - Continuation of Individual Coverage

5.1 Continuation of Coverage

(a) An Insured Employee who ceases to be Actively at Work as a result of Sickness or Injury may continue to be insured while disabled until the earlier of Age 65, or until his or her employment in a class of Employees eligible for insurance terminates, or until a period of two years from the date of disability has occurred, provided that the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way.

(b) An Insured Employee who is no longer Actively at Work because of unpaid leave may continue to be insured during such leave until the earlier of Age 65, or until a period of six months from the beginning of the unpaid leave has occurred, provided the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way and within 31 days of the start of such leave the Policyholder informs the Administrator of the date such leave is due to end. For the purposes of this provision, suspension cases are treated in the same way as unpaid leave.

(c) An Insured Employee who ceases to be eligible for insurance on account of a temporary lay-off may continue to be insured until the earlier of Age 65, or until a period of six months from the date of layoff has occurred, provided that the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way:

  (1) the disability income benefits, if they are provided in the policy, will terminate on the day of the lay-off and will be reinstated on the day of the return to work in the capacity for which they are made eligible for insurance;

  (2) the other benefits continue to apply in the same manner as if there had not been a temporary lay-off;

  (3) the total premium is payable for the month during which the temporary lay-off begins; the total premium for the month, reduced by the part applicable to the disability income benefits, when included in the policy, is payable during the other month while the absence from work resulting from a temporary lay-off is continued. However, if the lay-off does not persist for at least seven consecutive days, the total premium for the month is payable for the month of the lay-off and for the month of return to work.

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

(e) The Policyholder must forward to the Administrator each month a list showing the name and the policy number of Insured Employees who are on unpaid leave, suspended and laid-off and of Insured Employees who are returning to work, specifying the date in each case.

5.2 Reinstatement of Individual Coverage

Wherever used throughout this policy, “Reinstatement” refers to this section.

(a) An Employee who has not continued to be insured for any reason under the provisions of items (a), (b) or (c) in section 5.1 Continuation of Coverage and who returns to work within the six months following the start of disability, unpaid leave, or temporary lay-off may be insured again without having to satisfy the applicable Waiting Period;

(b) An Employee whose coverage was continued under the provisions of items (a), (b) or (c) in section 5.1 Continuation of Coverage and whose coverage was subsequently discontinued for any reason prior to returning to work and prior to the expiry of the maximum period available for Continuation of Coverage, will be terminated from coverage at the end of the month in which their coverage was discontinued. If the Employee returns to work within the six months following the start of disability, unpaid leave or temporary lay-off, the Employee may be insured again without having to satisfy the applicable Waiting Period.

Reinstatement is only available to Employees who are under Age 65.

6 - Waiver of Premium

6.1 Description of Disability Waiver of Premium

An Insured Person's insurance coverage (under Coverage A: Employee Mandatory Life Insurance, Coverage B: Dependent Mandatory Life Insurance, Coverage C: Employee Mandatory Accidental Death or Dismemberment Insurance and Coverage D: Employee Mandatory Critical Illness Insurance) will be continued without premium payment for one year from the date proof of Total Disability satisfactory to the Insurer has been received if:

(a) the Insured Employee becomes Totally Disabled while insured under the policy and while under Age 65; and

(b) the Insured Employee remains Totally Disabled for at least six months or such longer period as defined in the Certificate; and

(c) such proof is given to the Insurer after the Insured Employee has been Totally Disabled for six months; and

(d) such proof is given to the Insurer no later than 12 months after the last date for which insurance premium for the Insured Employee was paid.

An Insured Person's insurance coverage will be continued without premium payment for further periods of one year if:

(a) the Insured Employee remains Totally Disabled; and

(b) proof of such Total Disability is given to the Insurer during the three-month period prior to each anniversary of the date of the original proof.

6.2 Requirements

Total Disability of an Insured Employee requires:

(a) the regular attendance by a licensed Physician other than the Insured Employee or Immediate Family Member; and

(b) that Total Disability be caused by an accidental bodily Injury which occurs, or a Disease which first manifests, after the Effective Date of Individual Insurance but before Age 65; and

(c) that the accidental bodily Injury or Disease prevents the Insured Employee from engaging in every gainful occupation for which he or she is, or may become, reasonably qualified because of education, training or experience.

The Insurer, at its own expense, will have the right to examine any Insured Employee whose Total Disability allows for an Insured Person’s Premium Payments to be waived as often as may reasonably be required. A Physician of the Insurer’s choice will examine the Insured Employee.

6.3 Recurrence of Disability

Successive periods of Total Disability will be considered as one period of Total Disability for Waiver of Premium if the disability results from the same, or a related, cause and occurs within six months of the Waiver of Premium being terminated. The six continuous months qualifying period will be waived.

If the same disability occurs more than six months after the termination of the Waiver of Premium, the disability will be considered a separate disability and the Insured Employee will be required to remain Totally Disabled for six continuous months.

If two disabilities are due to unrelated causes and are separated by a return to work of a minimum of one day, then the disabilities are considered separate disabilities and the Insured Employee will be required to remain Totally Disabled for six continuous months.

6.4 Notice of Recovery or Death

An Insured Employee shall give immediate notice to the Insurer when he or she recovers from the Total Disability.

If the Insured Employee dies, the Insurer must be given written notice of death and proof that the Insured Employee was continuously disabled until death.

The Insurer must receive this notice and proof within one year of the Insured Employee's death. If this notice and proof is not sent, the Insurer will not be responsible for any payment because of death.

6.5 Termination of the Waiver of Premium Benefit

The insurance under this Waiver of Premium benefit will cease on the earliest of:

(a) the date an Insured Employee is no longer Totally Disabled;

(b) the end of the last year for which proof of Total Disability was received by the Insurer;

(c) the date an Insured Person refuses to be examined as set forth above;

(d) the date an Insured Employee is Age 65; or

(e) the date this policy or the Certificate terminates (not applicable for Life Insurance benefits extended under Waiver of Premium).

7 - Claims

7.1 Beneficiary

This policy contains a provision removing or restricting the right of the group Insured Person to designate persons to whom or for whose benefit insurance money is to be payable.

(a) The Insured Employee's beneficiary, for any amount of insurance payable at his or her death and subject to applicable law, will be the Insured Employee's estate.

(b) The Insured Employee will be considered the beneficiary for all other indemnities payable, including those payable for the Insured Spouse and/or Insured Dependent Children.

7.2 Notice and Proof of Claim

An Insured Person, the Insured Person's representative, or a Beneficiary entitled to make a claim must:

(a) give written notice of claim to the Insurer no later than 30 days after an Accident, Injury, or Illness that has caused a loss and for which expenses are incurred. Claims notices may be sent to the Insurer via fax, email, Canada Post or in-person at the Insurer's Administrative Office; and

(b) within 90 days from the date a claim arises under the contract:

(1) furnish satisfactory proof to the Insurer as is possible in the circumstances providing evidence of the claim and the cause; and

(2) any other information the Insurer may reasonably require to establish the validity of the claim.

An Insured Person, his or her representative, or a Beneficiary entitled to make a claim shall provide proof of claim within 12 months from the date a claim arises due to Travel Emergency Medical expenses, and will furnish proof satisfactory (may require original of receipts) to the Insurer of:

(a) detailed statements showing the services rendered and the fees charged for each service;

(b) copies of the allowance and payment made under the Provincial Government health plan;

(c) proof of the Insured Person's date of birth.

All claims are payable in legal currency of Canada to the Insured Employee or, in the case of an amount of insurance payable upon the death of the Insured Employee, to his or her appointed Beneficiary.

However, all claims respecting an unpaid account covered by an accident and sickness insurance benefit may be paid at the option of the Insurer, to the provider of the services for which the claim was submitted.

7.3 Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim. If the claimant has not received the forms within that time he or she may submit proof of claim in the form of a written statement with the details that gave rise to the claim.

7.4 Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by this condition does not invalidate the claim if the notice or proof is given or furnished as soon as possible, and no later than one year from the date of death, or the date a claim arises under this policy, if it is shown that it was not possible to give notice or furnish proof within the time prescribed.

7.5 Reserving Rights

As a condition precedent to recovery of insurance money under this policy the Insurer reserves the right to:

(a) examine the full details regarding the claim;
(b) require an Insured Person to undergo a medical examination;
(c) examine an Insured Person when and so often as it reasonably required while the claim is pending;
(d) require an autopsy to be performed on an Insured Person in the event of death, unless prohibited by law or religious belief;
(e) disallow the claim based on information developed from the attending Physician's report, medical examination, payroll records, or other sources of pertinent data.

7.6 Fraudulent Claims

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

7.7 Limitation of Action

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (Alberta and B.C.).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in *The Insurance Act* (Manitoba).

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002* (Ontario).

Otherwise, in Quebec every action must be brought within three years after the date evidence is furnished, and in all other provinces within one year from the date of loss, or such longer period as may be required under the law applicable in such province.

7.8 Subrogation

The Insurer is subrogated in all the rights of Insured Persons against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this policy up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the Insured Person sign, if applicable, an act of subrogation in its favor at the time of paying any benefits.

7.9 Recovering Overpayments

Whenever payments have been made for allowable expenses in a total amount that exceeds the maximum payment necessary, the Insurer has the right to recover by any available legal means, such benefit overpayments from any person to who or for whom payments were made or from an Insurance company or other organization.

7.10 Coordination of Coverage

Reimbursement of expenses under this policy are only payable on the excess amount of expenses after deducting the amounts which are payable to an Insured Person from any other individual or group insurance contract with a similar benefit, or any other third party or government health insurance plan. The benefits mentioned in this policy are provided as last payor coverages.

7.11 Settlement Options

A lump sum payment of any amount payable under one or several Life Insurance benefits provided under this policy, may, at the request of the Insured Employee or of the Beneficiary, be replaced by a method of payment mutually agreed upon by the Insured Employee or the Beneficiary and the Insurer such as a deposit bearing interest, guaranteed annuity, immediate or deferred life annuity.

7.12 Extension of Coverage under Previous Insurer

When a group insurance policy covering the Employees eligible for the present insurance, in effect immediately before the coming into force of this policy includes an extension of coverage, any amount payable under a benefit of this policy shall be reduced by the amount of any payment of benefits that the previous insurer is liable to make under such extension of coverage respecting a similar benefit.

8 - Premiums

All premiums are payable in advance and according to an agreed period, at the Administrative Office of the Insurer, in legal currency of Canada.

The grace period for payment of premiums is 60 days. The insurance shall remain in force during such period provided that the premiums are paid before the expiration date of the grace period, otherwise, the policy will be void retroactively to the due date of such premiums.

The amount of the premiums payable under this policy shall be the sum of the individual amounts payable for each Insured Employee.

The premium required for each Insured Employee does not vary during a contractual period, unless there is a change in the type of coverage or class of insurance. However, the Insurer reserves the right to change premium rates, during the contractual period when the amount or level of benefits payable or when the costs incurred by the Insurer under this policy are affected by a change or an addition to the tax systems, social security systems, a statute or a rule passed in regard to such laws or systems. Notice of such a change of premiums must be served in writing at least 30 days prior to its effective date.

The monthly premium payable for each Insured Employee will be determined in accordance with the table of costs established by the Insurer and on file with the Administrator.

The amount of the premium received by the Insurer for an Insured Employee will determine his or her class of insurance and will establish if his or her Dependents are covered.

9 - Contract

9.1 Administration

The Insurer will deal solely with the Policyholder or Administrator who will be deemed the representative of each participating group/association. Any action taken by the Policyholder or Administrator will be binding on the participating Insured Person(s) of the group/association.

9.2 Clerical or Mechanical Errors

If a clerical or mechanical error by the Policyholder, Administrator or by the Insurer results in a person being incorrectly classified under the policy, then such person will be classified according to the true facts.

9.3 Conformity to Legislation

If this policy does not conform to legislation that governs it, it is considered automatically amended to comply with the minimum requirements of that legislation.

9.4 Currency

All payments under the policy, either to or by the Insurer, will be made in the lawful money of Canada.

9.5 Entire Contract

The application, this policy, any document attached to this policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

9.6 Insurance Data

The Administrator will give the Insurer all of the data that is needed to calculate the premium and all other data that is reasonably required. Failure of the Administrator to give this data will not void or continue an Employee's insurance.

The Insurer has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. The Insurer also has this right until all rights and obligations under the policy are finally determined.

9.7 Insured Right of Access

As required by your provincial legislation, or if you reside in Alberta or B.C., the Insured Person and any claimant may request a copy of the Insured Person's application, any written evidence of insurability and the Group Policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

9.8 Material Facts

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

9.9 Misrepresentation and Incontestability

The policy will be void and the Insurer's liability will be limited to the return of any premiums paid if incomplete, inaccurate, untrue or incorrect information was submitted to the Insurer at any time and a claim arises under the policy during the first two years from the Effective Date of Individual Insurance or two years from most recent date of Reinstatement. Misrepresentations relating to a later application for additional coverage or an increased insurance amount will void the relevant change.

9.10 Misstatement of Age

If the Age of an Insured Person has been misstated, the corrected Age and facts will be used to determine whether insurance is in force under the policy and in what amount, and an equitable adjustment of premium will be made.

9.11 Non-Participating

This policy does not share in the Insurer's surplus earnings.

9.12 Replacement

This policy is considered a replacement policy if it replaces previous group coverage providing similar insurance benefits that the Employer terminated less than 31 days prior to the effective date of the Member Client under this policy as stated on the Member Client's Certificate.

If this policy is replacing previous group coverage, the Insurer will insure an Employee (and his or her Dependents) who:

(a) is insured under the previous policy at the date of termination, and whose coverage terminated solely because the policy terminated; and

(b) is Actively at Work on the effective date of the Member Client under this policy as stated on the Member Client's Certificate; and

(c) is a member of a class of eligible Employees.

While such Employee is not Actively at Work, each Employee and Dependent will be insured for the lesser of:

(a) the amount of coverage that they will become eligible for under this policy; and

(b) the amount of coverage that were insured for under the previous policy.

However, no benefits will be payable under this policy for which benefits are payable under the previous policy.

9.13 Renewal of Contract

This contract will be automatically renewed, unless a written notice to the contrary is given by either of the parties, according to the advance renewal notice, at least 60 days before the expiration date of the Renewal Date.

9.14 Responsibility of the Policyholder

The Policyholder agrees to forward to the Administrator the application forms of the eligible Employees applying for insurance, together with the data required to establish their class of insurance;

Upon the Insurer's request, the Policyholder also agrees to furnish the Insurer with the list of all persons eligible for insurance, whether insured or not, together with the data required to establish their class of insurance;

In the case of a collective and temporary cessation of work, the Policyholder shall provide the Administrator, without delay, with a list of the Insured Employees affected and the start date of the collective and temporary cessation of work.

9.15 Termination by the Group/Association

The participating group/association may terminate this insurance by advance written notice delivered to the Insurer at least 30 days prior to the termination date.

9.16 Termination by the Insurer

The Insurer may terminate the policy by advance written notice delivered to the Policyholder at least 30 days prior to the termination date.

9.17 Termination by the Policyholder

The Policyholder may terminate the policy on any premium due date by giving the Insurer written notice 30 days before that date.

9.18 Waiver

The Insurer will be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the Insurer.

Coverage A: Employee Mandatory Life Insurance

A1 - Description of Coverage

Upon death of an Insured Employee, the Insurer will pay to the Beneficiary the amount of Life Insurance for which the Insured Employee was covered as shown in the Schedule.

A2 - Amount of Life Insurance

The amount of Life Insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Employee belongs and, if applicable, the Additional Insurance protection chosen by the Insured Employee. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The amount of Life Insurance for a disabled Insured Employee whose coverage is extended under section 5.1 Continuation of Coverage or section 6 - Waiver of Premium is equal to the amount in force at the onset of the disability and is not changed while the coverage is extended under those sections except with regard to the reductions specified in the Schedule, if applicable.

A3 - Evidence of Insurability

Additional Insurance protection for the Insured Employee is subject to the acceptance of Evidence of insurability deemed satisfactory by the Insurer.

If an Insured Employee, in the judgment of the Insurer, constitutes a higher risk, the Insurer may, at its discretion, either refuse the application for Additional Insurance or accept it subject to the payment of premiums in addition to those stipulated for this benefit.

A4 - Final Expense

The Insurer may pay up to $1,000 in addition to the Life Insurance benefits to a person who incurs an expense during the Insured Employee's last illness, death or burial. The payment will count as a valid payment under the policy.

A5 - Employees Life Insurance Exclusions

A5.1 Pre-existing exclusion

This exclusion applies to Insured Employees who are insured for mandatory Life Insurance coverage within a group comprised of four or less Employees.

No Life Insurance benefit is payable if, 24 months immediately prior to the Effective Date of Individual Insurance, the Insured Employee was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to the Insured Employees death, unless the death of the Insured Employee occurs later than 24 consecutive months from the Effective Date of Individual Insurance or date of most recent Reinstatement of coverage under this policy.

If this policy directly replaces one with another Insurer providing similar benefits, an Insured Employee who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this policy came into force.

An Insured Employee who has not satisfied the time period of pre-existing conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Conditions Exclusion, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this policy came into force.

Coverage B: Dependent Mandatory Life Insurance

B1 - Description of Coverage

Upon death of an Insured Spouse or Insured Dependent Child, the Insurer will pay to an Insured Employee the amount of Life Insurance for which the Insured Dependent was covered as shown in the Schedule.

B2 - Amount of Life Insurance

The amount of Life Insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Dependents belongs and, if applicable, the Additional Insurance protection chosen by the Insured Employee. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The amount of life insurance for an Insured Dependent whose coverage is extended under section 5.1 Continuation of Coverage or section 6 - Waiver of Premium due to disability of the Insured Employee is equal to the amount in force at the onset of disability and is not changed while the coverage is extended under those sections. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

B3 - Evidence of Insurability

Additional Insurance Benefit Amounts for an Insured Spouse or Insured Dependent Child is subject to the acceptance of Evidence of insurability deemed satisfactory by the Insurer.

If an Insured Spouse or Insured Dependent Child, in the judgment of the Insurer, constitutes a higher risk, the Insurer may, at its discretion, either refuse the application or accept it subject to the payment of premiums in addition to those stipulated for this benefit.

B4 - Final Expense

The Insurer may pay up to $1,000 in addition to the Life Insurance benefits to a person who incurs an expense during a Spouse or Dependent Child's last illness, death or burial. The payment will count as a valid payment under the policy.

B5 - Dependents Mandatory Life Insurance Exclusion

B5.1 Pre-existing exclusion

This exclusion applies to an Insured Spouse or Insured Dependent Child who is insured for mandatory Life Insurance coverage within a group comprised of four or less Employees.

No Life Insurance benefit shall be payable if, 24 months immediately prior to the Insured Dependent's Effective Date of Individual Insurance, the Insured Dependent was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to the Insured Dependent's death unless the death of the Insured Dependent occurs later than 24 consecutive months from the Effective Date of Individual Insurance or date of most recent Reinstatement of coverage under this policy.

If this policy directly replaces one with another Insurer providing similar benefits, an Insured Dependent who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this policy came into force.

An Insured Dependent who has not satisfied the time period of pre-existing conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Conditions Exclusion, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this policy came into force.

Coverage C: Employee Mandatory Accidental Death or Dismemberment Insurance

C1 - Description of Coverage

If an Insured Employee suffers an Injury, the Insurer will pay those losses as listed in section C5 – Benefits, on condition that the Insured Employee was covered by this benefit at the time of the Accident responsible for the Injury.

C2 - Aircraft Coverage

Insurance provided under this Employee Mandatory Accidental Death or Dismemberment Insurance includes Injury sustained by an Insured Employee while and in consequence of:

(a) riding as a passenger, in or on any aircraft operated on a regular, special or chartered flight by a domestic or international scheduled air carrier, licensed by the Department of Transport of Canada or the governmental authority having jurisdiction over such air carrier in the country of its registry; or

(b) riding as a passenger, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country; or

(c) boarding or alighting from or being struck by any aircraft.

Subject to items (a) and (b), this policy excludes Injury sustained while and in consequence of:

(d) riding as a pilot, operator or member of the crew in or on any aircraft; or

(e) riding as a passenger, in or on any aircraft owned, operated, or leased by or on behalf of the Policyholder.

C3 - Exposure and Disappearance

If, by reason of an Accident covered by this policy, an Insured Employee is unavoidably exposed to the elements and as the result of such exposure, suffers a loss for which indemnity is otherwise payable under this Employee Mandatory Accidental Death or Dismemberment Insurance, such loss will be covered under the terms of this policy.

If the body of an Insured Employee is not found within one year after the date of his or her disappearance, and the disappearance is a result of the sinking or wrecking of the conveyance in which the Insured Employee was riding at the time of the Accident, and under such circumstances as would otherwise be covered under this policy, it will be presumed the Insured Employee suffered a Loss of Life resulting from Injury caused by an Accident at the time of such sinking or wrecking.

C4 - Amount of Accidental Death or Dismemberment Insurance

The amount of Accidental Death or Dismemberment insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Employee belongs and, if applicable, the Additional Insurance protection chosen by the Insured Employee. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The benefit is calculated by applying the benefit percentage shown in Section C5.1 Specific Loss Accident Indemnity to the Benefit Amount of insurance. For multiple losses, the percentages are added together but the benefit cannot exceed 100% of the Benefit Amount of insurance for all losses relating to the same Accident.

No benefit is paid for losses resulting from an Accident occurring prior to the Effective Date of Individual Insurance.

C5 - Benefits

C5.1 Specific Loss Accident Indemnity

When Injury results in any of the following losses within 365 days after the date of an Accident, the Insurer will pay:

For Loss of:	% of Benefit Amount
Life	100%
Sight in Both Eyes	100%
Speech and Hearing in Both Ears	100%
One Hand and Sight in One Eye	100%
One Foot and Sight in One Eye	100%
Sight in One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	40%
All Toes on One Foot	33.33%

For Loss or Loss of Use of:	% of Benefit Amount
Both Hands	100%
Both Feet	100%
One Hand and One Foot	100%
One Arm	80%
One Leg	80%
One Hand	75%
One Foot	75%
Thumb and Index Finger or at Least Four Fingers on One Hand	40%

For Paralysis of:	% of Benefit Amount
Both Upper and Lower Limbs (Quadriplegia)	200%
Both Lower Limbs (Paraplegia)	200%
Upper and Lower Limbs on One Side of Body (Hemiplegia)	200%

"Loss of Life" *means* the death of an Insured Employee.

"Loss" of:

(a) **hand or foot** *means* complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

(b) **arm or leg** *means* complete severance through or above the elbow or knee joint;

(c) **thumb** *means* the complete severance of one entire phalanx of the thumb;

(d) **finger** *means* the complete severance of two entire phalanges of the finger;

(e) **toe** *means* the complete severance of one entire phalanx of the big toe and all phalanges of the other toes;

(f) **sight** *means* Irreversible and complete loss of sight in one or both eyes.

"Loss of Speech" *means* complete and Irreversible loss of the ability to utter intelligible sounds.

"Loss of Hearing" *means* complete and Irreversible loss of hearing.

"Paralysis" *means* the loss of ability to move all or part of the body.

"Quadriplegia" *means* the permanent Paralysis and functional loss of use of both upper and lower limbs.

"Paraplegia" *means* the permanent Paralysis and functional loss of use of both lower limbs.

"Hemiplegia" *means* the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Loss of Use" *means* total and irreversible loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section for all Losses sustained by any one Insured Employee as the result of any one Accident will not exceed the following:

(a) the Benefit Amount (with the exception of Quadriplegia, Paraplegia and Hemiplegia); or

(b) with respect to Quadriplegia, Paraplegia and Hemiplegia:

(1) 200% of the Benefit Amount; or

(2) the Benefit Amount if Loss of Life occurs within 90 days after the date of the Accident.

Indemnity payable for all Losses under this section will not exceed, in the aggregate, 200% of the Benefit Amount as the result of the same Accident.

C5.2 Cosmetic Disfigurement Benefit

When, as a direct result of suffering a loss under the circumstances described in section C1 - Description of Coverage and section C2 - Aircraft Coverage, an Insured Employee suffers cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement Benefit, provided that such burn is classified as a third-degree burn.

The amount of benefit payable under this section is based on the percentage of the Benefit Amount, as shown in the Cosmetic Burn Schedule below, which is determined by the Area Classification Factor times the percentage of body surface actually burned.

The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Schedule, is based on 100% of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.

If an Insured Employee suffers burns to more than one body part as a result of any one Accident, benefits payable for all such burns will not exceed 100% of the Benefit Amount.

Cosmetic Burn Schedule

Body Part	Area Classification Factor
Face, Neck, Head	11
Hand & Forearm (Right)	5
Hand & Forearm (Left)	5
Upper Arm (Right)	3
Upper Arm (Left)	3
Torso (Front)	2
Torso (Back)	2
Thigh (Right)	1
Thigh (Left)	1
Lower Leg - below knee (Right)	3
Lower Leg - below knee (Left)	3

Body Part	Maximum Allowable % for Body Surface Burned
Face, Neck, Head	9.0%
Hand & Forearm (Right)	4.5%
Hand & Forearm (Left)	4.5%
Upper Arm (Right)	4.5%
Upper Arm (Left)	4.5%
Torso (Front)	18.0%
Torso (Back)	18.0%
Thigh (Right)	9.0%
Thigh (Left)	9.0%
Lower Leg - below knee (Right)	9.0%
Lower Leg - below knee (Left)	9.0%

Body Part	Maximum % of Benefit Amount Payable
Face, Neck, Head	99.9%
Hand & Forearm (Right)	22.5%
Hand & Forearm (Left)	22.5%
Upper Arm (Right)	13.5%
Upper Arm (Left)	13.5%
Torso (Front)	36.0%
Torso (Back)	36.0%
Thigh (Right)	9.0%
Thigh (Left)	9.0%
Lower Leg - below knee (Right)	27.0%
Lower Leg - below knee (Left)	27.0%

In the event benefits are payable under this section and section C5.1 Specific Loss Accident Indemnity or section C5.10 Permanent Total Disability Indemnity, the total benefits payable will not exceed 100% of the Benefit Amount (or 200% for Paralysis).

C5.3 Day-Care Benefit

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee, and indemnity for such Loss becomes payable in accordance with the terms of this Employee Mandatory Accidental Death or Dismemberment Insurance, the Insurer will pay the lesser of the following amounts for any Dependent Child who, on the date of or within 365 days of the Insured Employee's death, is enrolled in a legally licensed Day-Care Centre:

(a) 5% of the Insured Employee's Benefit Amount; or
(b) $5,000 for each year (up to four consecutive years) such child remains enrolled in a legally licensed Day-Care Centre.

The total maximum payable under this section in combination with the Day-Care Benefit maximum provided under any other policy issued by the Insurer will not exceed $5,000 per year.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled in a legally licensed Day-Care Centre.

In the event an Insured Employee's Dependent Child satisfies the above requirements, this benefit will be payable to the surviving Spouse if the Spouse has custody of the child, or to the child's guardian legally appointed to manage the person of the child.

If none of the Insured Employee's Dependent Children satisfy the above requirements or the requirements as shown under section C5.5 Education Benefit, the Insurer will pay to the Insured Employee's Beneficiary the lesser of the following amounts:

(a) 5% of the Insured Employee's Benefit Amount; or
(b) $2,500 under one of the policies issued by the Insurer.

The following definitions are applicable only to this benefit:

"Day-Care Centre" *means* a facility, which is run according to the law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will not include a Hospital, the child's home or care provided during normal school hours while the Dependent Child is attending grades one through twelve.

"Dependent Child" as used above *means* a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Employee. The child must be under 13 years of Age and dependent upon the Insured Employee for maintenance and support.

C5.4 Education Benefit

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee and indemnity for such Loss becomes payable in accordance with the terms of this Employee Mandatory Accidental Death or Dismemberment Insurance, the Insurer will pay the lesser of the following amounts for any Dependent Child who, on the date of or within 365 days of the Insured Employee's death, is enrolled as a full-time student in any Institution for Higher Learning:

(a) 5% of the Insured Employee's Specific Loss Accident Indemnity Benefit Amount; or
(b) $5,000 for each year (up to four consecutive years) such child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section in combination with the Education Benefit maximum provided under any other policy issued by the Insurer will not exceed $5,000 per year.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning.

In the event an Insured Employee's Dependent Child satisfies the requirements indicated above, such child will be deemed the Beneficiary with respect to the benefits payable under this provision. If none of the Insured Employee's Dependent Children satisfy the above requirements or the requirements as shown under Section C5.6 Day Care Benefit, the Insurer will pay to the Insured Employee's beneficiary the lesser of the following amounts:

(a) 5% of the Insured Employee's Specific Loss Accident Indemnity Benefit Amount; or

(b) $2,500 under one of the policies issued by the Insurer.

The following definitions are applicable only to this benefit:

"Institution for Higher Learning" is limited to universities, colleges, CEGEPs and trade schools.

"Dependent Child" as used above *means* a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Employee. The child is unmarried, under 25 years of Age [26 year of Age in the province of Quebec] and dependent upon the Insured Employee for maintenance and support.

C5.5 Family Transportation Expense

When, by reason of Injury, an Insured Person sustains a Loss payable under Section C5.1 Specific Loss Accident Indemnity of this Employee Mandatory Accidental Death or Dismemberment Insurance, an Insured Employee is confined as an inpatient in a Hospital located more than 150 kilometres from his or her normal place of Residence and such Insured Employee is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable expenses actually incurred by any Immediate Family Member(s) or a family representative for Accommodation and transportation by the most direct route from the normal place of residence of the Immediate Family Member(s) or family representative to the confined Insured Employee and return to the normal place of residence of such Immediate Family Member(s) or family representative, not to exceed in the aggregate the amount of $15,000 for all such expenses as the result of any one Accident. Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

"Accommodation" *means* lodging near the Hospital where the Insured Employee is confined.

The above benefit will only be payable under one of the policies issued to the Policyholder by the Insurer.

C5.6 Home Alteration and/or Vehicle Modification Expense

If, by reason of Injury, an Insured Employee sustains:

(a) the Loss of Both Feet or Legs; or

(b) the Loss of Use of Both Feet or Legs; or

(c) becomes Quadriplegic, Paraplegic or Hemiplegic; and

for which indemnity is payable in accordance with the terms of this policy, and subsequently requires the use of a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses incurred within three years of the date of Loss for:

(a) the cost of alterations to the Insured Employee's principal Residence to make it accessible; and/or

(b) the cost of modifications to one motor vehicle utilized by the Insured Employee, when such modifications are approved by licensing authorities, where required, to adapt it to the needs of the Insured Employee.

Payment by the Insurer for the total of all expenses incurred by or for any Insured Employee will not exceed the maximum as stated in the Schedule as the result of any one Accident. The amount payable under this section will be coordinated with any amount paid or payable under any other insurance plan providing the same or similar benefit.

C5.7 Hospital Indemnity

A Daily Benefit will be payable to the Insured Employee when the Insured Employee is in a Hospital and under the Regular Care and Attendance of a Physician, but only if such Period of Hospitalization is necessary for the treatment of an Injury which results in a Loss payable under section C5.1 Specific Loss Accident Indemnity of this Employee Mandatory Accidental Death or Dismemberment Insurance. Such Daily Benefit will be paid from the first Day of Hospitalization, but in no event for more than 365 days per Accident.

Notwithstanding anything contained to the contrary in this policy, a Period of Hospitalization which becomes necessary for the treatment of an Injury other than for a specific Loss will be covered in accordance with the terms of this section provided such Period of Hospitalization commences:

(a) within 365 days of the date of the Accident causing such Injury; and

(b) while insurance under this policy is in force as to that Insured Employee.

Such Daily Benefit will be paid from the fifth Day of Hospitalization.

Only one Period of Hospitalization will be payable for all Injuries sustained by the Insured Employee as the result of the same Accident.

"Daily Benefit" *means* one-thirtieth of 1% of the Insured Employee's Benefit Amount, to a maximum monthly benefit of $2,500, which maximum is in combination with the Hospital Indemnity maximum provided under any other policy issued to the Policyholder by the Insurer.

"Period of Hospitalization" *means* a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less than 90 consecutive days and all such confinements occur within 730 days of the date of the Accident.

"Day of Hospitalization" *means* a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day's room and board is charged.

C5.8 Identification Expense

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee and the police or similar governmental authority requires identification of the Insured Employee's body, the Insurer will reimburse one Immediate Family Member's or a family representative's expenses incurred for transportation to the location of the Insured Employee's body and return to his or her normal place of Residence by the most direct route and for lodging and board, up to a maximum of $10,000. If transportation is by any motor vehicle not for hire then the reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled. The Insured Employee's body must be located more than 150 kilometres from the Immediate Family Member's residence.

The benefit is payable under only one of the policies issued to the Policyholder by the Insurer.

C5.9 Occupational Training Expense

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee and indemnity for such Loss becomes payable in accordance with the terms of this Employee Mandatory Accidental Death or Dismemberment Insurance, the Insurer will pay the reasonable and necessary expenses actually incurred, within 3 years from the date of such Loss, by the Spouse of the Insured Employee who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he or she would not otherwise have sufficient qualifications, not to exceed in the aggregate the Benefit amount as stated in the Schedule for all such expenses. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

In the event the Insured Employee's Spouse satisfies the requirements indicated above, such Spouse will be deemed the Beneficiary with respect to the benefits payable under this provision.

The benefit is payable under only one of the policies issued to the Policyholder by the Insurer.

C5.10 Permanent Total Disability Indemnity

When, as the result of an Injury, an Insured Employee becomes Totally Disabled within 365 days of the date of the Accident, then the Insurer will pay in one sum, provided such disability has continued for a period of 12 consecutive months and is total and permanent at the end of this period, the Benefit Amount, less any other amount paid or payable under section C5.1 Specific Loss Accident Indemnity of this policy as the result of the same Accident.

C5.11 Rehabilitation Expense

In the event an Insured Employee sustains an Injury which results in a Loss payable under Section C5.1 Specific Loss Accident Indemnity of this Employee Mandatory Accidental Death or Dismemberment Insurance, and such Injury requires that the Insured Employee participate in a rehabilitation program in order to be qualified to engage in an occupation in which he or she would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expenses actually incurred, within three years from the date of Loss, by the Insured Employee for such program.

Payment by the Insurer for the total of all expenses incurred by any Insured Employee will not exceed the Benefit amount as stated in the Schedule as the result of any one Accident. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

The benefit is payable under only one of the policies issued to the Policyholder by the Insurer.

C5.12 Workplace Modification and Accommodation Expense

In the event an Insured Employee sustains an Injury which results in a Loss payable under Section C5.1 Specific Loss Accident Indemnity of this Employee Mandatory Accidental Death or Dismemberment Insurance, and such Insured Employee requires special adaptive equipment and/or workplace modification in order to reasonably accommodate his or her return to active full-time work with the Policyholder, the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder provided:

(a) the Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of such Insured Employee;

(b) the Policyholder acknowledges in writing that the performance of the essential duties of such Insured Employee's job may be altered;

(c) the proposed special adaptive equipment and/or workplace modification must have prior written approval by the Insurer;

(d) the Insurer has the right to examine the Insured Employee to evaluate the appropriateness of the proposed modifications.

The benefit will be paid to the Policyholder upon the Insured Employee's return to active full-time work with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder will not exceed $5,000 as a result of any one Accident.

The benefit is payable under only one of the policies issued to the Policyholder by the Insurer.

C5.13 Repatriation Expense

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee more than 50 kilometres from the Insured Employee's normal place of Residence, and indemnity for such Loss becomes payable in accordance with the terms of this Employee Mandatory Accidental Death or Dismemberment Insurance, then the Insurer will pay the reasonable and customary expenses actually incurred for the transportation of the body of the deceased Insured Employee to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of Residence of the deceased, including charges for the preparation of the body for such transportation. Payment by the Insurer will not exceed in the aggregate the amount of $15,000 for all such expenses.

The benefit is payable under only one of the policies issued to the Policyholder by the Insurer.

C5.14 Seat Belt Benefit

In the event an Insured Employee sustains an Injury which results in a Loss payable under Section C5.1 Specific Loss Accident Indemnity of this Employee Mandatory Accidental Death or Dismemberment Insurance, the Insurer will pay an additional sum equal to 10% of the applicable amount payable under Section C5.1 Specific Loss Accident Indemnity, subject to a maximum of $25,000, which maximum is in combination with the Seat Belt Benefit maximum provided under any other policy issued to the Policyholder by the Insurer, if at the time of the Accident, the Insured Employee was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt.

The driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him or her to operate such Motorized Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the Accident. “Intoxicated” and “under the influence of drugs” are as defined by the local jurisdiction where the Accident occurs.

Due proof of Seat Belt use must be provided as part of the written Proof of Loss.

“Motorized Vehicle” *means* a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

“Seat Belt” *means* those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

C6 - Aggregate Limit of Indemnity

The Insurer's aggregate limit of indemnity for all losses arising out of any one Accident, for which coverage is provided under this policy, is as stated in the Schedule. In the event said limit of indemnity for any one Accident is insufficient to pay the full amount of indemnity for each Insured Employee, then the amount payable for each Insured Employee will be in the proportion that the limit of indemnity for any one Accident bears to the total amount of insurance that would have been payable, except for such limit of indemnity.

This section only applies to losses payable under section C5.1 Specific Loss Accident Indemnity and section C5.10 Permanent Total Disability Indemnity.

C7 - Employee Accidental Death or Dismemberment Insurance Exclusions

This policy does not cover any Loss, fatal or non-fatal, caused or contributed to by:

(a) suicide or intentionally self-inflicted Injury while sane or insane;

(b) war or civil war, whether declared or undeclared;

(c) participation in a riot, insurrection, civil commotion or disturbance;

(d) perpetration or attempted perpetration by the Insured Employee of a crime or his or her participation in a crime;

(e) active full-time, part-time or temporary service in the armed forces of any country;

(f) riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in section C2 - Aircraft Coverage;

(g) medical treatment or Surgery, except if the medical treatment or Surgery was needed because of an Accident.

Coverage D: Employee Mandatory Critical Illness Insurance

D1 - Definitions Specific to the Employee Critical Illness Insurance

“Critical Illness” *means* an illness, disorder or Surgery which is specifically covered and defined herein and which is not specifically excluded. See section D5 - Critical Illness Conditions - Defined for definitions of critical illness conditions.

“Date of Diagnosis” *means* the date on which a Specialist first diagnosed the Insured Employee with one of the covered Critical Illness conditions. The date of diagnosis must be after the Effective Date of Individual Insurance or date of most recent Reinstatement and while the policy and group/association is in force.

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

“Irreversible” *means* the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve undue risk to the Insured Employee’s health.

“Life Support” *means* an Insured Employee is under the Regular Care and Attendance of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

“Specialist” *means* a Physician registered and licensed to practice in Canada whose practice is limited to the branch of medicine relating to the applicable Critical Illness condition. The Specialist must be a person other than the Insured Employee or a relative or a business associate of either.

“Surgery” *means* that an Insured Employee undergoes surgery performed on the written advice of a Physician. The surgery must be performed by a Physician, in Canada, the United States, or in such other jurisdiction as the Insurer may approve. Surgery will include the medical procedure for transplanting bone marrow.

“Survival Period” *means* the period starting on the Date of Diagnosis of the Critical Illness condition and ending 30 days following the Date of Diagnosis of the Critical Illness condition, except where modified elsewhere under the policy. The survival period does not include the number of days on Life Support. The Insured Employee must be alive at the end of the survival period and must not have experienced Irreversible cessation of all functions of the brain. The premium is still payable when due during a survival period.

D2 - Description of Coverage

In accordance with the provisions of this policy, the Insurer will pay the Benefit Amount for Critical Illness to the Beneficiary, if the Insured Employee is diagnosed by a Specialist with a covered Critical Illness condition or undergoes a covered Critical Illness Surgery as defined in section D5 – Critical Illness Conditions – Defined.

The Insured Employee must survive the Survival Period and the Diagnosis must be made on or after the Effective Date of Individual Insurance or the date of their most recent Reinstatement and while this policy and the group/association is in force.

D3 - Amount of Critical Illness Insurance

The amount of Critical Illness Insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Employee belongs and, if applicable, the Additional Insurance protection chosen by the Insured Employee. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The amount of Critical Illness Insurance for a disabled Insured Employee whose coverage is extended under section 5.1 Continuation of Coverage or section 6 - Waiver of Premium is equal to the amount in force at the onset of disability and is not changed while the coverage is extended under those sections except with regard to the reductions specified in the Schedule, if applicable.

D4 - Covered Critical Illness Conditions

The following Critical Illness conditions are provided in this policy. Refer to section D5 – Critical Illness Conditions - Defined for definitions.

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

D5 - Critical Illness Conditions – Defined

D5.1 Alzheimer's Disease

"Alzheimer's Disease" *means* a definite Diagnosis of a progressive degenerative Disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The Diagnosis of Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

D5.2 Aortic Surgery

"Aortic Surgery" *means* 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. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery outlined above. The Surgery must be determined to be medically necessary by a Specialist.

D5.3 Aplastic Anemia

"Aplastic Anemia" *means* a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in Anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

(a) marrow stimulating agents;

(b) immunosuppressive agents;

(c) bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

D5.4 Bacterial Meningitis

"Bacterial Meningitis" *means* a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the Date of Diagnosis. The Diagnosis of Bacterial Meningitis must be made by a Specialist.

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

D5.5 Benign Brain Tumour

"Benign Brain Tumour" *means* a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion: No benefit will be payable under this condition if:

Within the first 90 days following the later of:

(a) the Effective Date of Individual Insurance; or

(b) the effective date of last Reinstatement;

the Insured Person has any of the following:

(a) signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made; or

(b) a Diagnosis of Benign Brain Tumour.

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

D5.6 Blindness

"Blindness" *means* a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

(a) the corrected visual acuity being 20/200 or less in both eyes; or

(b) the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

D5.7 Cancer (Life-Threatening)

"Cancer (Life-Threatening)" *means* a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

(a) carcinoma in situ; or

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

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

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

Moratorium Period Exclusion: No benefit will be payable under this condition if within the first 90 days following the later of:

(a) the Effective Date of Individual Insurance; or

(b) the effective date of last Reinstatement;

the Insured Person has any of the following:

(a) signs, symptoms or investigations, that lead to a diagnosis of Cancer (covered or excluded under the policy), regardless of when the diagnosis is made;

(b) a Diagnosis of Cancer (covered or excluded under the policy).

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

D5.8 Coma

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

Exclusion: No benefit will be payable under this condition for:

(a) a medically induced Coma; or

(b) a Coma which results directly from alcohol or drug use; or

(c) a Diagnosis of brain death.

D5.9 Coronary Artery Bypass Surgery

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

D5.10 Deafness

"Deafness" *means* a definite Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The Diagnosis of Deafness must be made by a Specialist.

D5.11 Heart Attack

"Heart Attack" *means* a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

(a) Heart Attack symptoms;

(b) new electrocardiogram (ECG) changes consistent with a Heart Attack; or

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

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

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

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

D5.12 Heart Valve Replacement

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

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

D5.13 Kidney Failure

"Kidney Failure" *means* a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of Kidney Failure must be made by a Specialist.

D5.14 Loss of Independent Existence

"Loss of Independent Existence" *means* a definite Diagnosis of:

(a) a total inability to perform, by oneself, at least two of the following six Activities of Daily Living; or

(b) Cognitive Impairment, as defined below;

for a continuous period of at least 90 days with no reasonable chance of recovery.

The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

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

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

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

D5.15 Loss of Limbs

"Loss of Limbs" *means* a definite Diagnosis of the complete severance of two or more limbs, at or above the wrist or ankle joint, as the result of an Accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

D5.16 Loss of Speech

"Loss of Speech" *means* a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical Injury or Disease, for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

D5.17 Major Organ Failure on Waiting List

"Major Organ Failure on Waiting List" *means* a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person's enrolment in the transplant centre. The Diagnosis of the Major Organ Failure must be made by a Specialist.

D5.18 Major Organ Transplant

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

D5.19 Motor Neuron Disease

"Motor Neuron Disease" *means* a definite 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 conditions. The Diagnosis of Motor Neuron Disease must be made by a Specialist.

D5.20 Multiple Sclerosis

"Multiple Sclerosis" *means* a definite Diagnosis of at least one of the following:

(a) two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or

(b) well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or

(c) a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

D5.21 Occupational HIV Infection

"Occupational HIV Infection" *means* a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental Injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental Injury leading to the infection must have occurred after the later of the Effective Date of Individual Insurance, or the effective date of last Reinstatement.

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

(a) the accidental Injury must be reported to the insurer within 14 days of the accidental injury; and

(b) a serum HIV test must be taken within 14 days of the accidental Injury and the result must be negative; and

(c) a serum HIV test must be taken between 90 days and 180 days after the accidental Injury and the result must be positive; and

(d) all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and

(e) the accidental Injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

(a) the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or

(b) a licensed cure for HIV infection has become available prior to the accidental Injury; or

(c) HIV infection has occurred as a result of non-accidental Injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

D5.22 Paralysis

"Paralysis" *means* a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or Disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

D5.23 Parkinson's Disease

"Parkinson's Disease" *means* a definite Diagnosis of primary idiopathic Parkinson's Disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses). The Diagnosis of Parkinson's Disease must be made by a Specialist.

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

D5.24 Severe Burns

"Severe Burns" *means* a definite Diagnosis of third-degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

D5.25 Stroke

"Stroke" *means* a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:

(a) acute onset of new neurological symptoms; and

(b) new objective neurological deficits on clinical examination;

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

The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

(a) Transient Ischemic Attacks; or

(b) Intracerebral vascular events due to trauma; or

(c) Lacunar infarcts which do not meet the definition of Stroke as described above.

D6 - Employee Mandatory Critical Illness Exclusions

No Critical Illness Benefit Amount shall be due or payable if an Insured Employee's medical condition (listed in section D4 – Covered Critical Illness Conditions and defined in section D5 – Critical Illness Conditions - Defined) results directly or indirectly from any of the following:

(a) intentionally self-inflicted Injury while sane or insane;

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

(c) if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care or services including diagnostic measure as prescribed by his or her attending Physician.

In addition to the above exclusions, the Critical Illness benefit will not be payable for any Cancer that manifests itself prior to the Effective Date of Individual Insurance under this policy when the same Cancer either recurs or metastasizes after such effective date.

D6.1 Pre-existing Conditions exclusion

No Critical Illness benefit shall be payable if, 24 months immediately prior to the Effective Date of Individual Insurance, the Insured Person was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to a Diagnosis of, or treatment for, a Critical Illness condition unless the Diagnosis of the Critical Illness condition occurs later than 24 consecutive months from the Effective Date of Individual Insurance, or date of most recent Reinstatement of coverage under this policy.

If this policy directly replaces one with another Insurer providing similar benefits, an Insured Person who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the Benefit Amount and Critical Illnesses covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within 31 days prior to the date this policy came into force.

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

Coverage E: Travel Emergency Medical

E1 - Description of Coverage

In accordance with the provisions of this policy, the Insurer will pay to the beneficiary all eligible benefits up to the maximum amounts insured only if the service(s) were required as a result of Emergency Illness or Injury which occurred while the Insured Person was on a Trip and which required immediate medical services.

Coverage is limited to a maximum of 60 days per Trip commencing with the date of departure from the Insured Person's province of Residence. If the Insured Person is hospitalized on the 60th day, benefits will be extended until the date of discharge.

E2 - Amount of Travel Emergency Medical

The total amount payable for reimbursement of all expenses, which an Insured Person has incurred as the result of Injuries caused by Accident or as the result of Illness, will not exceed the lifetime maximum as stated in the Schedule.

E3 – Benefits and Eligible Expenses

Charges for eligible services shown below will be reimbursed based on usual, reasonable and customary charges in the area where they were received, less the amount payable by an Insured Person's Provincial Government health plan and/or any other insurance plan providing similar coverages.

E3.1 Allianz Assistance Travel Protection Coverage

E3.2 Ambulance

(a) Land ambulance to the nearest qualified medical facility;

(b) Air ambulance (including a medical attendant when necessary) that is Medically Necessary in order for the Insured Person to travel to his or her province of Residence, and if he or she cannot travel by any other means of transportation.

E3.3 Anesthetist

Expenses for the services of a licensed anesthetist when recommended by a Physician.

E3.4 Appliances and Durable Equipment

(a) artificial limbs, eyes or other prosthetic appliances, subject to the maximum stated in the Schedule, per calendar year;

(b) rental of a wheelchair, an iron lung and other durable medical equipment for temporary therapeutic treatment, subject to the maximum stated in the Schedule, per Accident or Illness.

E3.5 Drug Therapy

Charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician. This excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a 30 day supply.

E3.6 Emergency Dental Treatment Expense

When an Injury to whole and sound teeth is caused by a force or blow external to the mouth, and the Injury requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon, then the Insurer will pay the reasonable and necessary expenses incurred by the Insured Person. The total amount of payments made will not exceed the maximum as shown in the Schedule as a result of any one Accident.

The following conditions apply:

(a) the legally qualified dentist or oral surgeon cannot ordinarily reside in the Insured Person's Residence and cannot be an Immediate Family Member of the Insured Person; and
(b) the treatment, replacement or x-rays must be performed within 30 days from the date of the Injury;
(c) any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the Insured Person's province of Residence;

Capped or crowned teeth will, for the purposes of this policy, be considered whole and sound.

E3.7 Family Transportation

Transportation for an Immediate Family Member to the bedside of the Insured Person including round trip economy Airfare by the most direct route from the Insured Person's province of Residence, and up to $150 per day for a maximum of five days accommodation will be paid for that Immediate Family Member to:

(a) be with the Insured Person confined in Hospital; or

(b) to identify the deceased prior to release of the body.

With respect to clause (a): in order to qualify for benefits the Insured Person must eventually be an in-patient for at least seven days outside of his or her province of Residence, plus the written verification of the attending Physician that the situation was serious enough to have required the visit.

E3.8 Hospital

Hospital services and accommodation up to and including semi-private accommodation level in a Hospital, subject to a maximum duration of 12 Months.

E3.9 Hotel Convalescence Expense

If, as a result of Injury or Illness, an attending Physician certifies in writing that an Insured Person, due to his or her medical condition, is prohibited from resuming any travel following discharge from the Hospital where he or she was confined for a period of not less than seven days, then the Insurer will pay the reasonable and necessary expenses actually incurred for board and Accommodation, subject to the maximum stated in the Schedule, per Accident or Illness.

"Accommodation" *as used above means* commercial lodging in the vicinity of the Hospital where the Insured Person is confined.

E3.10 Meals and Accommodation

Meals and accommodation subject to the maximum stated in the Schedule, ($150.00 per day for 10 days) will be reimbursed for the extra costs of commercial accommodation and meals incurred by the Insured Person when the Insured Person remains with a Travelling Companion or Dependent, when the Trip is delayed or interrupted due to an Illness or Injury to a Travelling Companion or Dependent. The Illness or Injury must be verified in writing by the attending Physician and the expenses for meals and accommodations must be supported with original receipts from commercial organizations.

E3.11 Medical/Surgical Services

Medical/surgical services rendered by a legally qualified Physician or surgeon.

E3.12 Nursing Care

Expenses for the services of a Nurse ordered or prescribed by a Physician, provided the Nurse does not ordinarily reside in the Insured Person's Residence, subject to the maximum stated in the Schedule, per Accident or Illness.

E3.13 Other Medical Supplies and Services

(a) blood plasma, whole blood or oxygen, including the administration thereof;

(b) x-rays and laboratory examinations which are required for diagnostic purposes;

(c) rental or purchase of casts, cervical collars, crutches, trusses, splints and braces (except dental braces and splints);

E3.14 Paramedical

Expenses for the services of any of the following practitioners, provided such practitioner is duly licensed or duly registered where required in the province of practice and does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member, subject to the maximum stated in the Schedule, per specialty, per Accident, or Illness (such services do not require the recommendation of a Physician except as indicated below):

(a) chiropractor

(b) osteopath

(c) chiropodist or podiatrist

(d) massage therapist, on the recommendation of a Physician

(e) speech therapist

(f) psychologist

Expenses for diagnostic x-rays and laboratory tests ordered by a chiropractor, osteopath, chiropodist or podiatrist will be allowed as expenses under the services of such practitioners, subject to a maximum of 1 x-ray per practitioner, for each Insured Person, per Accident or Illness.

E3.15 Physiotherapy

Expenses charged for the services of a duly licensed or duly registered physiotherapist for physiotherapy treatment ordered or prescribed by a Physician, provided such physiotherapist does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member, subject to the maximum stated in the Schedule, per Accident or Illness.

E3.16 Return of Remains

Return of a deceased Insured Person, subject to the maximum stated in the Schedule, including expenses incurred toward the cost of preparation (including cremation) and homeward transportation, when death is caused by Illness or Injury. The Insured Person’s remains will be returned to the point of departure in the Insured Person’s province of Residence. Benefits include the cost of a burial coffin.

E3.17 Vehicle Return

Cost of returning the Insured Person’s vehicle, either private or rental, to the Insured Person’s Residence or nearest appropriate vehicle rental agency when the Insured Person is unable to due to Illness or Injury, subject to the maximum stated in the Schedule. Requires original receipts for costs incurred, i.e., gasoline, accommodation, Airfares.

E4 - Travel Emergency Medical Limitations

The following limitations to the coverage provided under **Coverage E: Travel Emergency Medical** will apply:

(a) coverage for each Trip begins when an Insured Person leaves the border of his or her province of Residence or if travelling by Aircraft, when such Aircraft takes off in his or her province of Residence, provided insurance is in force with respect to such Insured Person in accordance with section 2 - Effective Date of Individual Insurance;

(b) coverage for each Trip terminates when an Insured Person crosses the border of his or her province of Residence when returning from a Trip or, if travelling by Aircraft, when such Aircraft lands in his or her province of Residence or 60 days following the date of departure from his or her province of Residence, whichever is earlier;

(c) all expenses must be incurred on a non-elective Emergency basis outside an Insured Person's province of Residence and are in excess of expenses under any individual, group or government sponsored hospital or medical reimbursement plan;

(d) in consultation with the attending Physician, the Insurer reserves the right to transfer an Insured Person to another Hospital or to return an Insured Person to his or her province of Residence for necessary treatment. In the event the Insured Person refuses to comply, the Insurer will no longer be liable for further expenses incurred, which are relating to the condition causing the treatment, after the proposed transfer date;

(e) Allianz Assistance must be notified within 48 hours of an Emergency, or when reasonably possible, following an Emergency. Claims may be reduced if contact is not made with Allianz Assistance within 48 hours of admission to Hospital.

E5 - Travel Emergency Medical Exclusions

Coverage E: Travel Emergency Medical does not cover loss, fatal or non-fatal, caused or contributed to, by or resulting from:

(a) intentionally self-inflicted Injury while sane or self-inflicted Injury while insane;

(b) declared or undeclared war or any acts thereof;

(c) perpetration of acts of terrorism;

(d) participation in a riot, insurrection or civil commotion;

(e) active full-time, part-time or temporary service in the armed forces of any county;

(f) pregnancy, or childbirth, except complications thereof which will be treated as any other Sickness;

(g) a Trip undertaken by the Insured Person for the purpose of obtaining medical treatment, assessment or consultation;

(h) participation in any professional athletics;

(i) participation in acrobatic, stunt or ultra-light flying, mountaineering, hang gliding, scuba diving, any racing or speed contests.

Coverage E: Travel Emergency Medical does not cover any of the following supplies or services or costs thereof:

(a) expenses covered under any government hospital, medical, dental or health care insurance plan, whether payable or not, or expenses for which insurance is prohibited by law;

(b) medical examinations for the use of a third party;

(c) cosmetic surgery and dental services other than those required as a result of an Accident;

(d) oral contraceptives and patent medicines;

(e) charges for experimental drugs not approved by the governing authority having jurisdiction over the matter in the country where such drugs are prescribed and dispensed;

(f) charges for any experimental medical treatments;

(g) services for which no charge would ordinarily be made if there was no insurance coverage;

(h) expenses incurred for treatment or surgery which medically could be delayed until the Insured Person has returned to his or her province of Residence;

(i) medical expenses for treatment or surgery which the Insured Person elects to have rendered or performed outside his or her province of Residence, following Emergency treatment for a diagnosis of a medical condition which (on medical evidence) would not prevent the Insured Person from returning to his or her province of Residence prior to such treatment or surgery.

Travel Emergency Medical Pre Existing Exclusion

This exclusion applies to Insured Persons who are insured under this policy within a Member Client comprised of four or less Insured Employees.

Coverage E: Travel Emergency Medical does not cover loss (fatal or non-fatal) or expenses caused by, or resulting from, any condition for which the Insured Person received medical advice, consultation or treatment within six Months prior to the commencement of a Trip, with the exception of a Chronic Condition which is under treatment and Stabilized by the regular use of prescribed medication.

"Chronic Condition" *means* a Disease or disorder which has existed for a minimum of six Months.

"Stabilized" *means* there has not been a change in the medical condition requiring medical or psychiatric intervention for a minimum of six Months.

Coverage F: Excess Medical

F1 - Description of Coverage

In accordance with the provisions of this policy, the Insurer will reimburse the reasonable and necessary charges for services or supplies received by the Insured Person within two years following the date the initial deductible under this plan is satisfied for such Eligible Expenses if an Insured Person requires medical or surgical treatment and incurs Eligible Expenses as described in Section F3 – Benefits and Eligible Expense as a result of Injury or Illness.

F2 - Amount of Excess Medical

The total amount payable for reimbursement of all expenses, which an Insured Person has incurred as the result of all Injuries caused any one Accident, or as the result of any one Illness, will not exceed the all expense maximum per calendar year and the lifetime maximums as stated in the Schedule.

F3 - Benefits and Eligible Expenses

F3.1 Ambulance

Expenses for a licensed ground ambulance service or, when recommended by a Physician, by any other conveyance licensed to carry passengers for hire, including air ambulance, to or from the nearest Hospital which is equipped to provide the required treatment subject to the maximum stated in the Schedule, per Accident or Illness.

F3.2 Dental Injury

When an Injury to whole and sound teeth is caused by a force or blow external to the mouth, and the Injury requires treatment, replacement or x-rays by a legally qualified dentist or oral surgeon, then the Insurer will pay the reasonable and necessary expenses incurred by the Insured Person. The total amount of payments made will not exceed the maximum as shown in the Schedule as a result of any one Accident.

The following conditions apply:

(a) the legally qualified dentist or oral surgeon cannot ordinarily reside in the Insured Person's Residence and cannot be an Immediate Family Member of the Insured Person; and
(b) the treatment, replacement or x-rays must be performed within 30 days from the date of the Injury;
(c) any payments made under this section will be in accordance with the current Fee Guide for General Practitioners published by the Dental Association in the Insured Person's province of Residence;

Capped or crowned teeth will, for the purposes of this policy, be considered whole and sound.

F3.3 Drug Therapy

Charges for prescription drugs, sera and vaccines, obtainable only upon a written prescription by a Physician or legally qualified dentist and dispensed by a registered pharmacist or Physician, but excluding any charges made for the administration of injectable drugs, sera and vaccines, subject to a dispensing maximum of a 30 day supply and subject to the maximum stated in the Schedule, per calendar year, per Accident or Illness.

F3.4 Durable Equipment

Expenses for rental of a wheelchair, an iron lung and other durable equipment for temporary therapeutic treatment, not to exceed the purchase price prevailing at the time rental became necessary, subject to the maximum stated in the Schedule, per Accident or Illness.

F3.5 Nursing Care

Expenses for the services of a Nurse ordered or prescribed by a Physician, provided the Nurse does not ordinarily reside in the Insured Person's Residence, subject to the maximum stated in the Schedule, per Accident or Illness.

F3.6 Paramedical

Expenses for the services of any of the following licensed practitioners, provided such practitioner does not ordinarily reside in the Insured Person's Residence and is not an Immediate Family Member up to $50 per treatment, subject to the maximum stated in the Schedule, per calendar year (such services do not require the recommendation of a Physician except as indicated below):

(a) chiropractor;
(b) osteopath;
(c) chiropodist or podiatrist;
(d) licensed masseur, on the recommendation of a Physician;
(e) speech therapist;
(f) licensed psychologist.

Expenses for diagnostic x-rays and laboratory tests ordered by a chiropractor, osteopath, chiropodist or podiatrist will be allowed as expenses under the services of such practitioners, subject to a maximum of one x-ray per practitioner for each Insured Person in any 1 calendar year.

F3.7 Semi-Private Room Costs

Hospital charges for the difference between the public ward allowance under the Insured Person's Provincial Hospital plan and the semi-private accommodation charge (private accommodation if recommended by a Physician), subject to a maximum duration of 12 Months, and subject to the maximum stated in the Schedule, per calendar year, per Accident or Illness.

F4 - Deductible

There is a deductible per calendar year in the amount stated in the Schedule. The deductible amount applies to all eligible expenses stated in Section F3 – Benefits and Eligible Expenses as a result of Injury or Illness.

Reimbursement of insured expenses commences following satisfaction of the deductible amount, if any.

F5 - Recurrent Injury, Sickness or Disease

If an Injury or Illness causes an Insured Person to incur eligible expenses, following which a continuous period of six or more Months elapses, and during which time the same Injury or Illness does not cause the Insured Person to incur any eligible expenses and does not require any treatment of the Insured Person by a Physician, then the Insured Person will be deemed to have recovered from the Injury or Illness at the end of the period of six or more Months.

Thereafter, a subsequent recurrence of the Injury or Illness, which causes the Insured Person to incur eligible expenses will be deemed to be a different Injury or Illness to which the full maximum limit of indemnity will be applicable without any reduction or variation by reason of eligible expenses incurred as a result of the Injury or Illness from which the Insured Person was deemed to have recovered.

F6 - Exclusions, Limitations, and Special Provisions

Coverage F: Excess Medical does not cover any charges for Injury or Illness caused directly or indirectly, in whole or in part by any of the following:

(a) intentionally self-inflicted Injury while sane or insane;

(b) declared or undeclared war or any acts thereof;

(c) perpetration of acts of terrorism;

(d) participation in a riot, insurrection or civil commotion;

(e) active full-time, part-time or temporary service in the armed forces of any county;

(f) any treatment, surgery, care service, examination or device which:

 (1) is not Medically Necessary;

 (2) is provided or required for cosmetic purposes;

 (3) is conducted as an experiment;

 (4) is provided or required for non-curative reasons; or

 (5) exceeds what is ordinarily provided or required by current therapeutic practice;

(g) any treatment related to or provided for drug addiction;

(h) while the Insured Person is committing or attempting to commit an assault, battery or criminal offence, whether or not the Insured Person has been charged with a criminal offence;

(i) operating a motorized vehicle where the Insured Person:

 (1) was found to have a blood alcohol level in excess of 80 milligrams of alcohol per 100 milliliters of blood; or

 (2) has been convicted of an alcohol-related offence such as driving while impaired; or

 (3) has refused to take a breathalyser test;

(j) if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care or services including diagnostic measure as prescribed by their attending Physician.

Coverage F: Excess Medical does not cover any of the following supplies or services or costs thereof:

(a) expenses incurred outside of Canada;

(b) therapeutic or elective abortion;

(c) services or supplies associated with:

 (1) erectile dysfunction;

 (2) the diagnosis or treatment of infertility;

 (3) contraception;

(d) homeopathic preparations, unless federal or provincial legislation requires a prescription for their sale;

(e) drugs which do not legally require a prescription and pharmaceutical supplies which are either experimental or not approved by the Canadian government or Provincial government regulatory body in the Insured Person's province of Residence.

Exclusion for pre-existing condition(s)

This exclusion applies to Insured Persons who are insured under this policy within a Member Client comprised of four or less Insured Employees.

Benefits are not payable as a result of any pre-existing condition unless Excess Medical costs commence after the Insured Person has been continuously insured for 24 Months after the Effective Date of Individual Insurance or the date of their last Reinstatement.

Pre-existing conditions means any Injury, Illness, nervous disorder or any symptom or other condition for which medical advice, consultation, investigation, diagnosis or treatment, including medication, was required or recommended by a Physician, or for which a reasonable person would have sought treatment or advice, during the 24 Month period prior to the Effective Date of Individual Insurance.

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