



Insurance Policy Package

RBC[®] Critical Illness Insurance Term 75

Policy Owner: Sample Contract

Insured Person: Sample Contract

Policy number: SMYJOR02

Coverage date: September 1, 2026

RBC Life Insurance Company agrees to pay benefits as described in this policy.

Please read this policy document carefully. It is a legal document between RBC Life Insurance Company and the policy owner.

The policy owner will have 10 days after receiving this policy to review it and confirm that it is right for them.

Within this 10-day period, the policy owner can cancel the policy and receive a full refund of the premium payment. The policy will be cancelled as of the **policy date**.

This policy contains a provision removing or restricting the right of the policy owner to designate persons to whom or for whose benefit insurance money is to be payable. This restriction applies if this policy includes a return of premium on death benefit rider and the policy owner lives in a province or territory that does not have **sickness beneficiary laws**.

Only the policy owner can act on this policy. The policy owner may name a new owner by submitting a written request to us. The change of ownership will occur once it is recorded by us. The new owner must accept the policy terms and decisions made before the change in ownership. If the early assistance benefit has been paid before the change in ownership, the new owner will not receive this benefit. The insured person named in this policy cannot be changed.

The policy owner and the insured person are two distinct roles. Often, they are the same person. In this document, the use of "you" and "your" will refer only to the insured person.

Words or phrases shown in **bold italics** in this document are defined in Section 7.0 - Definitions.



Policy Schedule

The Insured

Insured Person:	Sample Contract
Date of birth:	May 10, 1990
Issue Age:	36
Smoking status:	Non-Smoker

The Policy

Plan type:	Coverage to age 75, level premiums to age 75, non-cancellable
Critical illness benefit amount:	\$1,000,000.00
Early assistance benefit amount:	\$50,000.00
Policy number:	SMYJOR02
Policy date:	September 1, 2026
Coverage date:	September 1, 2026
Policy Owner:	Sample Contract
Expiry date:	September 1, 2065

The Premium Payments

Monthly premium payment for the illness benefit:	\$919.17
Frequency of payments:	Monthly
Premium payment due date:	1 of the month
Payment method:	Pre-authorized Cheque

Modifications to this Policy

Amendment:	None
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Riders included in this policy



Policy Schedule

Summary of Premium Payments

Policy Anniversary Date	Critical Illness Benefit Amount	Age at Anniversary Date	Total Monthly Premium payment
September 1, 2026	\$1,000,000.00	36	\$919.17
September 1, 2027	\$1,000,000.00	37	\$919.17
September 1, 2028	\$1,000,000.00	38	\$919.17
September 1, 2029	\$1,000,000.00	39	\$919.17
September 1, 2030	\$1,000,000.00	40	\$919.17
September 1, 2031	\$1,000,000.00	41	\$919.17
September 1, 2032	\$1,000,000.00	42	\$919.17
September 1, 2033	\$1,000,000.00	43	\$919.17
September 1, 2034	\$1,000,000.00	44	\$919.17
September 1, 2035	\$1,000,000.00	45	\$919.17
September 1, 2036	\$1,000,000.00	46	\$919.17
September 1, 2037	\$1,000,000.00	47	\$919.17
September 1, 2038	\$1,000,000.00	48	\$919.17
September 1, 2039	\$1,000,000.00	49	\$919.17
September 1, 2040	\$1,000,000.00	50	\$919.17
September 1, 2041	\$1,000,000.00	51	\$919.17
September 1, 2042	\$1,000,000.00	52	\$919.17
September 1, 2043	\$1,000,000.00	53	\$919.17
September 1, 2044	\$1,000,000.00	54	\$919.17
September 1, 2045	\$1,000,000.00	55	\$919.17
September 1, 2046	\$1,000,000.00	56	\$919.17
September 1, 2047	\$1,000,000.00	57	\$919.17
September 1, 2048	\$1,000,000.00	58	\$919.17
September 1, 2049	\$1,000,000.00	59	\$919.17
September 1, 2050	\$1,000,000.00	60	\$919.17
September 1, 2051	\$1,000,000.00	61	\$919.17
September 1, 2052	\$1,000,000.00	62	\$919.17
September 1, 2053	\$1,000,000.00	63	\$919.17
September 1, 2054	\$1,000,000.00	64	\$919.17
September 1, 2055	\$1,000,000.00	65	\$919.17



Policy Schedule

Policy Anniversary Date	Critical Illness Benefit Amount	Age at Anniversary Date	Total Monthly Premium payment
September 1, 2056	\$1,000,000.00	66	\$919.17
September 1, 2057	\$1,000,000.00	67	\$919.17
September 1, 2058	\$1,000,000.00	68	\$919.17
September 1, 2059	\$1,000,000.00	69	\$919.17
September 1, 2060	\$1,000,000.00	70	\$919.17
September 1, 2061	\$1,000,000.00	71	\$919.17
September 1, 2062	\$1,000,000.00	72	\$919.17
September 1, 2063	\$1,000,000.00	73	\$919.17
September 1, 2064	\$1,000,000.00	74	\$919.17
September 1, 2065	\$1,000,000.00	75	\$0.00

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1.0 The Illness Benefit

Introduction

In this policy, the **illness benefit** refers to:

- The critical illness benefit; or
- The early assistance benefit

Details on each of these are described below.

1.1 The Critical Illness Benefit

How to qualify for the critical illness benefit.

To qualify for the critical illness benefit, all of the following must be true:

- This policy is **in effect**;
- You have been **diagnosed** with a critical illness **covered condition** as defined in Section 2.1, or you require a medical procedure or surgery that is a critical illness **covered condition**;
- The **diagnosis** was made, or the medical procedure or surgery was completed, after the later of the **coverage date** or last reinstatement date;
- After the **diagnosis** was made or the medical procedure or surgery was completed, for select **covered conditions**, you have continued to live without the assistance of life support for the number of days in the applicable **survival period**. The **survival period** for each **covered condition** is defined in Section 2.1;
- You have completed the **qualifying period** for select **covered conditions**, which is a set number of days after the **diagnosis** required to confirm that the **covered condition** is permanent, persists, or demonstrates progressive deterioration in function. The **qualifying period** for each **covered condition** is defined in Section 2.1;
- During the **symptom-free period** for select **covered conditions**, you were not diagnosed with an illness identified in the applicable symptom-free period exclusion, or have signs, symptoms, treatments or medical investigations that eventually lead to the diagnosis of an illness identified in that symptom-free period exclusion. The **symptom-free period** and symptom-free period exclusion for each of these **covered conditions** are defined in Section 2.1;
- You meet the critical illness outside of Canada requirements (as described in Section 3.1 - How to make a claim) if you are outside of Canada when you are **diagnosed** with a critical illness **covered condition**, or you require a medical procedure or surgery that is a critical illness **covered condition**.

The critical illness benefit amount is shown in the Policy Schedule.

The critical illness benefit will be paid only once, even if you experience more than one critical illness. Once the critical illness benefit is paid, the coverage ends and the policy, including any riders, will end.



Are there situations when the critical illness benefit will not be paid?

We won't pay the critical illness benefit if we determine that:

- Based on the medical information provided, you were incorrectly diagnosed, and the correct diagnosis is not a critical illness **covered condition** as defined in Section 2.1;
- You do not fully meet the Definition and Diagnosis requirements of the **covered condition** as defined in Section 2.1; or
- The claim for the critical illness benefit falls under any of the exclusions in Section 3.2.

Who receives the critical illness benefit payment?

The critical illness benefit will be paid to the policy owner unless the policy owner has designated a **beneficiary** or **recipient**.

If the policy owner is not living at the time of the claim, and has not designated a **beneficiary** or **recipient**, the critical illness benefit will be paid to the policy owner's estate.

If the policy owner has designated a **beneficiary**, the critical illness benefit will be paid to the **beneficiary**.

If the policy owner has designated a **recipient**, and the policy owner is living at the time of the claim, the critical illness benefit will be paid to the **recipient**. If the policy owner is not living at the time of the claim, the critical illness benefit will be paid to the policy owner's estate.

The benefit amount will be paid in Canadian dollars.



1.2 The Early Assistance Benefit

How to qualify for the early assistance benefit.

To qualify for the early assistance benefit, all of the following must be true:

- This policy is **in effect**;
- You are **diagnosed** with an early assistance **covered condition** as defined in Section 2.2, or you require a medical procedure or surgery that is an early assistance **covered condition**;
- The **diagnosis** was made, or the medical procedure or surgery was completed, after the later of the **coverage date** or last reinstatement date;
- After the **diagnosis** was made or the medical procedure or surgery was completed, for select **covered conditions** you have continued to live without the assistance of life support for the number of days in the applicable **survival period**. The **survival period** for each **covered condition** is defined in Section 2.2;
- During the **symptom-free period** for select **covered conditions**, you were not diagnosed with an illness identified in the applicable symptom-free period exclusion or have signs, symptoms, treatments or medical investigations that eventually lead to the diagnosis of an illness identified in that symptom-free period exclusion. The **symptom-free period** and symptom-free period exclusion for each of these **covered conditions** are defined in Section 2.2;
- The early assistance benefit has not already been paid for this policy or any of the policies that were converted to or exchanged for this policy; and
- You meet the critical illness outside of Canada requirements (as described in Section 3.1 - How to make a claim) if you are outside of Canada when you are **diagnosed** with an early assistance **covered condition** or require a medical procedure or surgery that is an early assistance **covered condition**.

The early assistance benefit amount is 20% of the critical illness benefit amount to a maximum of \$50,000. If there are any other RBC Insurance critical illness policies covering the insured person, the maximum total early assistance benefit amount we will pay is \$50,000.

The early assistance benefit will be paid only once, even if you experience more than one early assistance **covered condition**. Once the early assistance benefit is paid, no further claims for this benefit will be accepted.

Payment of the early assistance benefit does not reduce the critical illness benefit amount that was approved when this policy was purchased.

This policy will remain **in effect** after the payment of the early assistance benefit.

Are there situations when the early assistance benefit may not be paid?

We won't pay the early assistance benefit if we determine that:

- Based on the medical information provided, you were incorrectly diagnosed, and the correct diagnosis is not an early assistance **covered condition** as defined in Section 2.2;
- You do not fully meet the Definition and Diagnosis requirements of the early assistance **covered condition** as defined in Section 2.2; or
- The claim for the early assistance benefit falls under any of the exclusions in Section 3.2.



Who receives the early assistance benefit payment?

The early assistance benefit will be paid to the policy owner unless the policy owner has designated a **beneficiary** or **recipient**.

If the policy owner is not living at the time of the claim, and has not designated a **beneficiary** or **recipient**, the critical illness benefit will be paid to the policy owner's estate.

If the policy owner has designated a **beneficiary**, the critical illness benefit will be paid to the **beneficiary**.

If the policy owner has designated a **recipient**, and the policy owner is living at the time of the claim, the critical illness benefit will be paid to the **recipient**. If the policy owner is not living at the time of the claim, the critical illness benefit will be paid to the policy owner's estate.

The benefit amount will be paid in Canadian dollars.

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2.0 Covered Conditions

Introduction

The **covered conditions** included in this policy are adapted from the Canadian Life & Health Insurance Association Reference Document Critical Illness Benchmark Definitions, December 2024. Some **covered conditions** have specific exclusions, which are shown in the **covered condition**.

Qualifying period, survival period, and symptom-free period are stated for each **covered condition**, if required.

Qualifying period

Some **covered conditions** must be permanent, persistent or demonstrate progressive deterioration in function to qualify for the **illness benefit**. The **qualifying period** is a set number of days after the **diagnosis** required to confirm that the condition is permanent, persists, or demonstrates progressive deterioration in function.

Survival period

For some **covered conditions**, you must continue living, without the assistance of life support, for a minimum number of days before you will qualify for the **illness benefit**. A **survival period** begins on the day you are **diagnosed** with a **covered condition**, or the day you undergo a medical procedure or surgery that is a **covered condition**.

Symptom-free period

For some **covered conditions**, a **symptom-free period** is needed to establish your good health. A **symptom-free period** is a set number of days, after the later of the **coverage date** or last reinstatement date of the policy, during which you must not have been diagnosed with an illness identified in the applicable symptom-free period exclusion or have signs, symptoms, treatments or medical investigations that eventually lead to the diagnosis of an illness identified in that symptom-free period exclusion.

2.1 Critical Illness Covered Conditions

Cancer

Life-threatening cancer

Definition

The uncontrolled growth of malignant cells and invasion of tissue confirmed by histopathological report.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

90 days

Diagnosis requirements

The **diagnosis** of life-threatening cancer must be made by a **specialist** and must be confirmed by a histopathological report.

Condition specific exclusions

While most cancers are covered by this policy, the following cancers are not covered as life-threatening cancer:

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness that is not ulcerated nor has spread to lymph nodes or other organs;
- Any non-melanoma skin cancer, without lymph node or distant metastases. This includes lymphoma which is confined to the skin;
- Prostate cancer unless described as AJCC T2 or higher and/or Gleason grade 7 or higher;
- Thyroid cancer, unless described as AJCC T2 or higher, or has spread to lymph nodes or other organs;
- Chronic lymphocytic leukemia classified as Rai stage 0;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Neuroendocrine tumours classified as AJCC Stage 1;
- Cancers described as carcinoma in situ, Tis or Ta; or
- Any pituitary neuroendocrine tumour (PitNET) unless you have undergone surgery, radiation treatment or embolization, or the PitNET has caused new, irreversible, objective neurological deficits on clinical examination. The new neurological deficits must be detectable and measurable by a **specialist** and must be corroborated by diagnostic imaging. Headache, fatigue or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

Staging or classification refers to the most current (as of date of **diagnosis**) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

Tumours (neoplasms) that are classified as uncertain malignant potential, borderline, or that are not classified as cancer (malignant) are not covered under life-threatening cancer. Classification is based on the most current WHO Classification of Tumours series, also known as the ICD-O (International Classification of Diseases for Oncology), published by the International Agency for Research on Cancer (IARC).

An early assistance benefit may be payable for some early-stage cancers (see Section 2.2).

**Symptom-free period exclusion**

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of life-threatening cancer at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase “any cancer” means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

Heart Conditions

Severe heart attack (acute myocardial infarction)**Definition**

A definite **diagnosis** of death of heart muscle due to obstruction of blood flow.

Qualifying period	Survival period	Symptom-free period
Not required	30 days	Not required

Diagnosis requirements

Heart attack symptoms, accompanied by a rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- New electrocardiographic (ECG) changes consistent with an acute myocardial infarction;
- New diagnostic imaging changes consistent with an acute myocardial infarction; or
- Development of new pathological Q waves on ECG after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

The **diagnosis** of severe heart attack (acute myocardial infarction) must be made by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition if:

- ECG changes are suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina are diagnosed; or
- Elevated cardiac biomarkers and/or symptoms are due to medical procedures or diagnoses other than acute myocardial infarction.

Survival period exclusion

No **illness benefit** will be paid unless you continue living, without the assistance of life support, for 30 days after the day you are **diagnosed** with a severe heart attack (acute myocardial infarction).

**Coronary artery bypass surgery****Definition**

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

Qualifying period

Not required

Survival period

30 days

Symptom-free period

Not required

Diagnosis requirements

The surgery must be determined to be medically necessary by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Survival period exclusion

No **illness benefit** will be paid unless you continue living, without the assistance of life support, for 30 days after the day you undergo coronary artery bypass surgery.

Aortic surgery**Definition**

The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

Qualifying period

Not required

Survival period

30 days

Symptom-free period

Not required

Diagnosis requirements

The surgery must be determined to be medically necessary by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition for:

- Angioplasty;
- Heart valve replacement;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Survival period exclusion

No **illness benefit** will be paid unless you continue living, without the assistance of life support, for 30 days after the day you undergo aortic surgery.

**Heart valve replacement or repair****Definition**

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Qualifying period

Not required

Survival period

30 days

Symptom-free period

Not required

Diagnosis requirements

The surgery must be determined to be medically necessary by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures, or
- Non-surgical procedures.

Survival period exclusion

No **illness benefit** will be paid unless you continue living, without the assistance of life support, for 30 days after the day you undergo heart valve replacement or repair surgery.

Stroke**Stroke (resulting in severe neurological deficits)****Definition**

The death of brain tissue, due to an inadequate blood supply or hemorrhage, with:

- Acute onset of new neurological symptoms; and
- New objective neurological deficits on clinical examination.

Qualifying period

More than
30 days

Survival period

30 days

Symptom-free period

Not required

Diagnosis requirements

The new symptoms and deficits must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of **diagnosis**.

The neurological deficits must be detectable and measurable by a **specialist**. Examples of neurological deficits are measurable weakness in a limb, impaired speech, and measurable changes in cognition. Headache or fatigue will not be considered a neurological deficit.

The **diagnosis** of stroke (resulting in severe neurological deficits) must be made by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition for:

- Transient ischemic attacks (TIA);
- Trauma causing damage to intracerebral blood vessels;
- Disorders of the blood vessels of the inner ear; or
- Death of the optic nerve or retina unless there is total loss of vision of that eye.

**Survival period exclusion**

No **illness benefit** will be paid unless you continue living, without the assistance of life support, for 30 days after the day you are **diagnosed** with a stroke (resulting in severe neurological deficits).

Organ Failure

Kidney failure**Definition**

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.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of kidney failure must be made by a **specialist**.

Condition specific exclusions

None.

Major organ failure on waiting list**Definition**

A definite **diagnosis** of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

To qualify under major organ failure on waiting list, you must be enrolled to receive an organ transplant in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery.

The **diagnosis** of the major organ failure must be made by a **specialist**.

Condition specific exclusions

None.

**Major organ transplant****Definition**

A definite **diagnosis** of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

To qualify under major organ transplant, you must receive bone marrow, a heart, a lung, a liver, or a kidney by undergoing a transplantation procedure.

The **diagnosis** of the major organ failure must be made by a **specialist**.

Condition specific exclusions

None.

Neurology**Multiple sclerosis****Definition**

The **diagnosis** of multiple sclerosis as defined by the consensus diagnostic criteria for multiple sclerosis in use in Canada at the time of **diagnosis**.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

365 days

Diagnosis requirements

The **diagnosis** of multiple sclerosis must be made by a neurologist.

Condition specific exclusions

No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome; or
- Suspected multiple sclerosis or probable multiple sclerosis.

Symptom-free period exclusion

If, within the 365 days following the later of the **coverage date** or last reinstatement date,

- you are **diagnosed** with multiple sclerosis, or
- you have signs, symptoms, treatments or medical investigations that eventually lead to a **diagnosis** of multiple sclerosis,

then this policy will not cover multiple sclerosis, and we will not pay an **illness benefit** for any **diagnosis** of multiple sclerosis at any time.

**Parkinson's disease and specified atypical Parkinsonian disorders****Definition**

Parkinson's disease means a definite **diagnosis** of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders means a definite **diagnosis** of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

Qualifying period	Survival period	Symptom-free period
At least 365 days	Not required	365 days

Diagnosis requirements

You must exhibit objective signs of progressive deterioration in function for at least 365 days, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

The **diagnosis** of Parkinson's disease or a specified atypical Parkinsonian disorder must be made by a neurologist.

Condition specific exclusions

No benefit will be payable under Parkinson's disease and specified atypical Parkinsonian disorders for any other type of Parkinsonism.

Symptom-free period exclusion

If, within the 365 days following the later of the **coverage date** or last reinstatement date,

- you are **diagnosed** with Parkinson's disease or specified atypical Parkinsonian disorder, or
- you have signs, symptoms, treatments or medical investigations that eventually lead to a **diagnosis** of Parkinson's disease or specified atypical Parkinsonian disorder,

then this policy will not cover Parkinson's disease or specified atypical Parkinsonian disorder, and we will not pay an **illness benefit** for any **diagnosis** of Parkinson's disease or specified atypical Parkinsonian disorder at any time.

Dementia, including Alzheimer's disease**Definition**

A definite **diagnosis** of dementia, which must be characterized by a progressive deterioration of memory.

Qualifying period	Survival period	Symptom-free period
At least 180 days	Not required	Not required

Diagnosis requirements

You must exhibit progressive deterioration in at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.



You must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 180-day period.

The **diagnosis** of dementia must be made by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

Motor neuron disease

Definition

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.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of motor neuron disease must be made by a **specialist**.

Condition specific exclusions

None.

Benign brain tumour

Definition

A definite **diagnosis** of a non-malignant tumour originating in the cranial vault from the brain, meninges, or cranial nerves.

Qualifying period

More than
30 days

Survival period

Not required

Symptom-free period

90 days

Diagnosis requirements

You must have undergone surgery, radiation treatment or embolization, or the tumour must have caused new irreversible objective neurological deficits on clinical examination.

The new neurological deficits must be detectable and measurable by a **specialist** and must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of **diagnosis**. Headache, fatigue, or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

The **diagnosis** of benign brain tumour must be made by a **specialist**.

**Condition specific exclusions**

No benefit will be payable under this condition for:

- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- you are **diagnosed** with benign brain tumour, or
- you have signs, symptoms, treatments or medical investigations that eventually lead to a **diagnosis** of benign brain tumour,

then this policy will not cover benign brain tumour, and we will not pay an **illness benefit** for any **diagnosis** of benign brain tumour at any time.

**Traumatic
brain injury****Definition**

A definite **diagnosis** of new damage to brain tissue caused by an external traumatic head injury resulting in newly developed significant neurological deficit.

Qualifying period	Survival period	Symptom-free period
More than 180 days	Not required	Not required

Diagnosis requirements

Newly developed significant neurological deficit that:

- Results from an external trauma severe enough to have prompted you to seek a medical consultation in less than 7 days after the occurrence of the trauma;
- Is present and verifiable on clinical examination;
- Is corroborated by abnormal magnetic resonance (MR) and/or computed tomography (CT) brain imaging studies, that confirm brain trauma; and
- Persists for more than 180 consecutive days following the date of **diagnosis**.

The **diagnosis** of traumatic brain injury must be made by a **specialist**.

A new neurological deficit must be detectable by a **specialist**. Neurological deficits include:

- measurable loss of hearing;
- objective loss of sensation;
- paralysis;
- localized weakness;
- dysarthria (difficulty with pronunciation);
- dysphasia (difficulty with speech)
- dysphagia (difficulty in swallowing);
- measurable visual impairment;
- impaired gait (difficulty walking);
- difficulty with balance;
- lack of coordination;
- new onset seizures undergoing treatment; or
- measurable changes in neuro-cognitive function.

**Condition specific exclusions**

No benefit will be payable under this condition if a neurological deficit is not detectable. Headache and fatigue will not be considered neurological deficits.

Other Covered Conditions

Coma**Definition**

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 3 days (72 hours), and for which period the Glasgow coma score must be 6 or less.

Qualifying period	Survival period	Symptom-free period
At least 3 days (72 hours)	Not required	Not required

Diagnosis requirements

The **diagnosis** of coma must be made by a **specialist**.

Condition specific exclusions

No benefit will be payable under this condition for:

- A medically induced coma;
- A coma which results directly from alcohol or drug use; or,
- A **diagnosis** of brain death.

Blindness**Definition**

A definite **diagnosis** of the total and irreversible loss of vision in both eyes, evidenced by:

- The corrected visual acuity being 20/200 or less in both eyes; or,
- The field of vision being less than 20 degrees in both eyes.

Qualifying period	Survival period	Symptom-free period
Not required	Not required	Not required

Diagnosis requirements

The **diagnosis** of blindness must be made by a **specialist**.

Condition specific exclusions

None.

**Deafness****Definition**

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.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of deafness must be made by a **specialist**.

Condition specific exclusions

None.

Loss of limbs**Definition**

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.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of loss of limbs must be made by a **specialist**.

Condition specific exclusions

None.

Loss of speech**Definition**

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.

Qualifying period

At least
180 days

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of loss of speech must be made by a **specialist**.

Condition specific exclusions

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

**Paralysis****Definition**

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.

Qualifying period

At least
90 days

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of paralysis must be made by a **specialist**.

Condition specific exclusions

None.

Severe burns**Definition**

A definite **diagnosis** of third-degree or full thickness burns over at least 18% of the body surface.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The **diagnosis** of severe burns must be made by a **specialist**.

Condition specific exclusions

None.

Aplastic anemia**Definition**

A definite **diagnosis** of a chronic persistent bone marrow failure.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

Confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The **diagnosis** of aplastic anemia must be made by a **specialist**.

Condition specific exclusions

None.

**Bacterial meningitis****Definition**

A definite **diagnosis** of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria.

Qualifying period

At least
90 days

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The bacterial meningitis must result in objective neurological deficits persisting for at least 90 days from the date of **diagnosis**.

The neurological deficits must be detectable and measurable by a **specialist**. Examples of neurological deficits are measurable weakness in a limb, impaired speech, and measurable changes in cognition. Headache or fatigue will not be considered a neurological deficit.

The **diagnosis** of bacterial meningitis must be made by a **specialist**.

Condition specific exclusions

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

Occupational HIV infection**Definition**

A definite **diagnosis** of infection with human immunodeficiency virus (HIV) resulting from accidental injury during your normal occupation, which exposed you to HIV contaminated body fluids.

Qualifying period

Refer to the Diagnosis
requirements

Survival period

Not required

Symptom-free period

Not required

Diagnosis requirements

The accidental injury leading to the infection must have occurred after the later of the **coverage date** or last reinstatement date of the policy.

Payment under this condition requires satisfaction of all the following:

- The accidental injury must be reported to the insurer within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The **diagnosis** of occupational HIV infection must be made by a **specialist**.

**Condition specific exclusions**

No benefit will be payable under this condition if:

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

Loss of independent existence**Definition**

A definite **diagnosis** of the total inability, due to disease or injury, to perform independently (without help), with or without the aid of assistive devices:

- at least 2 of the 5 activities of daily living listed in Diagnosis requirements;
- for a continuous period of at least 90 days; and
- and with no reasonable chance of recovery.

Qualifying period	Survival period	Symptom-free period
At least 90 days	Not required	Refer to the specific exclusions

Diagnosis requirements

The **diagnosis** must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

The activities of daily living are:

- Bathing: washing oneself in a bathtub, shower or by sponge bath;
- Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances, self-grooming, nail and oral care;
- Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring: being able to stand from a sitting position, as well as getting in and out of bed. The ability to walk independently from one location to another, getting on and off the toilet and maintaining personal hygiene; and
- Feeding: consuming food or drink that already have been prepared and made available.

Condition specific exclusions

None.

Symptom-free period exclusion

If your loss of independent existence is caused or contributed to by a **covered condition** that has a **symptom-free period** and during that **symptom-free period**,

- you were **diagnosed** with that **covered condition**, or
- you had signs, symptoms, treatments or medical investigations that eventually led to a **diagnosis** of that **covered condition**,

then this policy will not cover your loss of independence, and we will not pay an **illness benefit** for your loss of independence at any time.



2.2 Early Assistance Covered Conditions

Coronary angioplasty

Definition

The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

Qualifying period	Survival period	Symptom-free period
Not required	30 days	Not required

Diagnosis requirements

The procedure must be determined to be medically necessary by a **specialist**.

Condition specific exclusions

None.

Survival period exclusion

No **illness benefit** will be paid unless you continue living, without the assistance of life support, for 30 days after the day you undergo coronary angioplasty.

Early-Stage Cancers

Early-stage breast cancer

Definition

Early-stage breast cancer means carcinoma in situ of the breast as confirmed by biopsy.

Qualifying period	Survival period	Symptom-free period
Not required	Not required	90 days

Diagnosis requirements

The **diagnosis** of early-stage breast cancer (carcinoma in-situ) must be made by a **specialist**.

Condition specific exclusions

None.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage breast cancer at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase "any cancer" means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

**Early-stage blood cancer (chronic lymphocytic leukemia)****Definition**

Early-stage blood cancer means chronic lymphocytic leukemia classified as Rai stage 0, as confirmed by appropriate blood tests.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

90 days

Diagnosis requirements

The **diagnosis** of early-stage blood cancer (chronic lymphocytic leukemia) must be made by a **specialist**.

Staging or classification refers to the most current (as of date of **diagnosis**) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

Condition specific exclusions

None.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage blood cancer (chronic lymphocytic leukemia) at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase "any cancer" means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

Early-stage prostate cancer**Definition**

Early-stage prostate cancer means prostate cancer that is either T1A, T1B, or T1C if Gleason grade is 6 or lower, without lymph node or distant metastasis as confirmed by biopsy.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

90 days

Diagnosis requirements

The **diagnosis** of early-stage prostate cancer must be made by a **specialist**.

Condition specific exclusions

None.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,



then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage prostate cancer at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase “any cancer” means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

Early-stage thyroid cancer

Definition

Early-stage thyroid cancer means papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis, as confirmed by biopsy.

Qualifying period	Survival period	Symptom-free period
Not required	Not required	90 days

Diagnosis requirements

The **diagnosis** of early-stage thyroid cancer must be made by a **specialist**.

Condition specific exclusions

None.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last claim statement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage thyroid cancer at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase “any cancer” means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

Early-stage intestinal cancer

Definition

Early-stage intestinal cancer means malignant gastrointestinal stromal tumours (GIST) classified as AJCC stage 1, as confirmed by biopsy.

Qualifying period	Survival period	Symptom-free period
Not required	Not required	90 days

Diagnosis requirements

The **diagnosis** of early-stage intestinal cancer (gastrointestinal stromal tumors) must be made by a **specialist**.

Staging or classification refers to the most current (as of date of **diagnosis**) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

Condition specific exclusions

None.

**Symptom-free period exclusion**

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage intestinal cancer at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase “any cancer” means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

Early-stage neuroendocrine tumours**Definition**

Early-stage neuroendocrine tumours means neuroendocrine tumours classified as AJCC stage 1, excluding pituitary neuroendocrine tumours, as confirmed by biopsy.

Qualifying period	Survival period	Symptom-free period
Not required	Not required	90 days

Diagnosis requirements

The **diagnosis** of early-stage neuroendocrine tumours must be made by a **specialist** and confirmed by pathological examination of the tissue.

Staging or classification refers to the most current (as of date of **diagnosis**) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

Condition specific exclusions

None.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage neuroendocrine tumours at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase “any cancer” means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

**Early-stage skin cancer (melanoma)****Definition**

Early-stage skin cancer (melanoma) is malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis as confirmed by biopsy.

Qualifying period

Not required

Survival period

Not required

Symptom-free period

90 days

Diagnosis requirements

The **diagnosis** of early-stage skin cancer (melanoma) must be made by a **specialist**.

Condition specific exclusions

None.

Symptom-free period exclusion

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of early-stage skin cancer (melanoma) at any time, whether the diagnosis is for the same type of cancer or not.

For this exclusion, the phrase "any cancer" means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.



3.0 Making a Claim for an Illness Benefit

Introduction

This section explains what you need to know when making a claim. It also includes an explanation of certain situations when we won't pay the benefits of this policy.

3.1 How to make a claim

What information is required to make a claim for an illness benefit?

A claim for an **illness benefit** may be submitted if you are **diagnosed** with a **covered condition** as defined in Section 2.0, or you require a medical procedure or surgery that is a **covered condition**.

Before reviewing a claim for an **illness benefit**, we will require:

- Fully completed benefit claim forms. We will request information about you, your health, and other information we consider related to your claim;
- Documentation of your **diagnosis**, or confirmation you have completed a medical procedure or surgery. A medical **specialist** must verify the **diagnosis** or necessity of the medical procedure or surgery. The requirements for each **covered condition** are defined in Section 2.0;
- Authorization for us to contact other sources to get information that we consider related to your claim. These sources may include present and past medical **specialists** and other health care practitioners; and
- A conversation with one of our claims professionals to confirm the information and review expectations.

If the date of **diagnosis**, medical procedure or surgery is within 2 years of the later of the **coverage date** or last reinstatement date, we will review information from other sources to confirm that the contract is valid. Refer to Section 6.1 - General Provisions for details.

Will a medical exam be required?

We may ask you to attend and participate in any examinations or assessments by a medical **specialist** or health care practitioner that we choose.

When to make a claim for an illness benefit.

Contact us within 30 days of receiving the **diagnosis** of a **covered condition** as defined in Section 2.0 or having a medical procedure or surgery that is a **covered condition**.

Within 15 days of the first contact, we will provide claim forms and specific instructions on how to submit the benefit claim.



The fully completed benefit claim forms must be submitted to us within 90 days of when you received the **diagnosis**, or you had a medical procedure or surgery that is a **covered condition**. The claim for benefits will be closed after 90 days if this information is not received.

Is there a time after which it is too late to make a claim for an illness benefit?

If it is not reasonably possible to notify us and provide the completed benefit claim forms within the time limits described above, we may still consider a claim for an **illness benefit**. If there is a reasonable explanation for the late submission, we will review the claim if it is submitted within 1 year of when you received the **diagnosis** or you had a medical procedure or surgery that is a **covered condition**.

A claim for an **illness benefit** will not be valid if more than 1 year has passed since you received the **diagnosis** or had a medical procedure or surgery that is a **covered condition**.

Will premium payments stop after I'm approved to receive an illness benefit?

The premium payments for the policy must continue while a claim for an **illness benefit** is being processed.

If you are approved for the critical illness benefit (Section 1.1), the policy coverage will end, and the policy owner will not need to make any further premium payments. We will also refund the policy owner any premium payments that were made while the claim was being processed.

If you are approved for the early assistance benefit (Section 1.2), there will be no changes to the premium payments. Premium payments must continue to keep the policy **in effect**.

When will an illness benefit be paid?

After the requirements to qualify for the benefit have been met and the claim has been approved, we will pay within 60 days.

What if the benefit claim is not approved?

If the benefit claim is not approved, the policy owner may request an appeal of the claim decision or take legal 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 (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario), or in other applicable legislation in the policy owner's province of residence. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.



What if the critical illness occurs outside of Canada?

If you are outside of Canada when you are **diagnosed** with a **covered condition** as defined in Section 2.0, or you require a medical procedure or surgery that is a **covered condition**, we will pay an **illness benefit** when all the following are true:

- All other requirements in this policy are met; and
- Your complete medical records are made available to us and based on these records we are satisfied that:
 - The same **diagnosis** would have been made if the **covered condition** occurred in Canada;
 - Immediate treatment of the **covered condition** would have been recommended under Canadian standards; and
 - The same treatment or specific surgical procedure would have been advised if the **covered condition** occurred in Canada.

Proof / épreuve



3.2 Exclusions

There are certain situations when we won't pay the benefits of this policy. This will happen if a condition specific exclusion, a survival period exclusion, a symptom-free period exclusion, a named exclusion, or a general exclusion applies to the situation.

What are the condition specific exclusions?

Some **covered conditions** have one or more condition specific exclusions which are shown in the applicable **covered condition** (see Section 2.0). No **illness benefit** will be paid if a condition specific exclusion applies to your **covered condition**.

What are the survival period exclusions?

Some **covered conditions** have a **survival period** which is shown in the applicable **covered condition** (see Section 2.0). If the applicable **covered condition** has a **survival period**, no **illness benefit** will be paid unless you continue living, without the assistance of life support, until the end of the **survival period**.

What are the symptom-free period exclusions?

Some **covered conditions** require a **symptom-free period** which is shown in the applicable **covered condition** (see Section 2.0). The symptom-free period exclusions for those **covered conditions** are:

Life-threatening cancer or Early-stage cancer

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- a physician determines that you have any cancer, or
- you have signs, symptoms, treatments or medical investigations that eventually lead a physician to determine you have any cancer,

then this policy will not cover any cancer, and we will not pay an **illness benefit** for any **diagnosis** of life-threatening cancer or any early-stage cancer at any time, whether the **diagnosis** is for the same type of cancer or not.

For this exclusion, the phrase "any cancer" means any type of cancer including life-threatening cancer, any early-stage cancer that is a **covered condition**, and any type of cancer that is not a **covered condition**.

Benign brain tumour

If, within the 90 days following the later of the **coverage date** or last reinstatement date,

- you are **diagnosed** with benign brain tumour, or
- you have signs, symptoms, treatments or medical investigations that eventually lead to a **diagnosis** of benign brain tumour,

then this policy will not cover benign brain tumour, and we will not pay an **illness benefit** for any **diagnosis** of benign brain tumour at any time.

**Multiple sclerosis**

If, within the 365 days following the later of the **coverage date** or last reinstatement date,

- you are **diagnosed** with multiple sclerosis, or
- you have signs, symptoms, treatments or medical investigations that eventually lead to a **diagnosis** of multiple sclerosis,

then this policy will not cover multiple sclerosis, and we will not pay an **illness benefit** for any **diagnosis** of multiple sclerosis at any time.

Parkinson's disease and specified atypical Parkinsonian disorders

If, within the 365 days following the later of the **coverage date** or last reinstatement date,

- you are **diagnosed** with Parkinson's disease or specified atypical Parkinsonian disorder, or
- you have signs, symptoms, treatments or medical investigations that eventually lead to a **diagnosis** of Parkinson's disease or specified atypical Parkinsonian disorder,

then this policy will not cover Parkinson's disease and specified atypical Parkinsonian disorders, and we will not pay an **illness benefit** for any **diagnosis** of Parkinson's disease and specified atypical Parkinsonian disorders at any time.

Loss of independent existence

If your loss of independent existence is caused or contributed to by a **covered condition** that has a **symptom-free period** and during that **symptom-free period**,

- you were **diagnosed** with that **covered condition**, or
- you had signs, symptoms, treatments or medical investigations that eventually led to a **diagnosis** of that **covered condition**,

then this policy will not cover your loss of independence, and we will not pay an **illness benefit** for your loss of independence at any time.

What is a named exclusion?

We may have modified this policy to exclude claims related to your personal risk factors such as health conditions or lifestyle activities that are specific to you. If we did, these exclusions are shown in a policy amendment.

We will not pay an **illness benefit** for any **covered condition** that is caused or contributed to by any risk factor that we have excluded in a named exclusion.

What are the general exclusions?

We will not pay an **illness benefit** for any **covered condition** that is caused or contributed to by:

- Your use or abuse of any substance or intoxicant, including hallucinogens, or narcotics; or any prescription or non-prescription drug that is inconsistent with the directions of the prescribing medical **specialist** or drug manufacturer;
- Your operation of any motorized land, air or watercraft while your blood alcohol level exceeds 80mg of alcohol per 100ml of blood or while you are under the influence of any drug;
- Your suicide, attempted suicide or intentionally self-inflicted injury;
- Any injury you sustain while you are committing or attempting to commit a **criminal offence**, regardless of whether you are charged or not; or
- Your combat activities or deliberate presence in the conflict zone of any war (whether declared or undeclared) or armed conflict, including while acting in a non-combat capacity.



4.0 Paying for the Policy

What are the premium payments?

The premium payments are shown on the Policy Schedule.

The first payment is a requirement for the policy to become **effective** (See Section 6.1 - When will the policy become effective?). If the **policy date** is earlier than the **coverage date**, this first payment must include all premium payments between the **policy date** and the **coverage date**.

All other payments must be made according to the frequency of payments for the policy to remain **in effect**. Frequency of payments is shown on the Policy Schedule – The Premium Payments.

Premium payments may be made monthly or annually. Your premium payment due date is shown on the Policy Schedule – The Premium Payments. All payments must be in Canadian dollars.

No premium payments are required once the policy ends (see Section 5.0 - Ending the Policy).

What happens if a premium payment is missed?

If we do not receive a premium payment, the policy will remain **in effect** for 31 days from the premium payment due date of the missed payment.

If we do not receive the missed payment, and any additional fees if appropriate, within that 31-day grace period, coverage will end, and the policy will lapse.



5.0 Ending the Policy

When does this policy end?

This policy, including any amendments or riders, will end on the earliest of:

- The date when the critical illness benefit is paid;
- The **expiry date** shown in the Policy Schedule.
 - If you are completing a **survival period** or **qualifying period** on the **expiry date**, the policy will end the day after the **survival period** or **qualifying period** ends;
- The date of your death;
- The date we receive the cancellation request from policy owner;
- The date that is 31 days after the premium payment due date if a premium payment remains unpaid (see Section 4.0 - Paying for the Policy);

Can the policy owner cancel this policy?

The policy owner may cancel the policy at any time by letting us know in writing. This notice must include the policy number and the signature of the policy owner.

All amendments, riders, and waivers associated with the policy will be cancelled at the same time as the policy.

The policy will end on the date we receive the cancellation request. We will refund the unused portion of an annual payment.

Can the policy owner change the benefit amount for this policy?

The policy owner may reduce the critical illness benefit amount of the policy at any time by letting us know in writing. This notice must include the policy number, the new critical illness benefit amount, and the signature of the policy owner.

The new critical illness benefit amount must be at least the minimum we require for the policy and less than the original benefit amount.

The critical illness benefit amount cannot be increased.



Can this policy be reinstated after it has lapsed because of a missed premium payment?

If we receive the full outstanding payment within 60 days of the missed premium payment due date, we will automatically reinstate the policy. Updated personal, health, or financial information will not be required to reinstate the policy.

If more than 60 days have passed since the missed premium payment due date, the policy owner may apply to have this policy reinstated. Updated personal, health, or financial information for the insured person will be required as part of the reinstatement application. If the completed application and the full outstanding payment are received within 2 years of the missed premium payment due date, we will review the application and:

- We may reinstate this policy with no changes to coverage or premium payment; or
- If we do not reinstate this policy, then we will refund the outstanding payment received.

If more than 2 years have passed since the missed premium payment due date, we will not reinstate this policy. If this policy includes a Return of Premium on Surrender rider, we will not reinstate this policy if more than 60 days have passed since the missed premium payment due date.

Can this policy be reinstated after it has been cancelled by the policy owner?

If the policy was cancelled by the policy owner, the policy owner may apply to have this policy reinstated. Updated personal, health, or financial information for the insured person will be required as part of the reinstatement application. If the completed application and the full outstanding payment are received within 2 years of the cancellation date, we will review the application and:

- We may reinstate the policy with no changes to coverage or premium payment; or
- If we do not reinstate the policy, we will refund the outstanding payment received.

If this policy includes a Return of Premium on Surrender rider or more than 2 years have passed since the cancellation date, we will not reinstate this policy.

Reinstatement of the Policy.

Once the policy has been reinstated, we will send the policy owner a letter. This letter will include the reinstatement date.

All other terms of the policy will be the same as before the policy lapsed or was cancelled.

All amendments and riders to this policy will be reinstated as of the reinstatement date.



6.0 Additional information about this Policy

Introduction

This section contains general provisions, which explain legal rights and requirements not already covered in this policy's other provisions, and statutory conditions, which are required by Canadian insurance law.

6.1 General Provisions

When will the policy become effective?

In Quebec, this policy will become **effective** and begin to provide coverage on the **coverage date**, (as shown on the Policy Schedule) when all the following are true:

- The first premium payment is made; and
- We have accepted the application without modification.

In all provinces other than Quebec, and in Quebec if we accept the application with modification, this policy will become **effective** and begin to provide coverage on the **coverage date**, (as shown on the Policy Schedule) when all the following are true:

- The first premium payment is made;
- The policy documentation has been delivered to the policy owner;
- The information provided in the application materials including the application, the tele-interview and other required questionnaires, is still accurate and up to date as of the date the policy was delivered; and
- The policy owner and insured person:
 - Have reviewed the information they provided in the application materials including the application, the tele-interview and other required questionnaires, and have reported any inaccuracies or changes to us; and
 - Have signed and returned any amendments, addendums and exclusions contained in the delivery package.

If we accept premium payments and later discover that any of the above was not true, we may void the policy, which means the policy will be cancelled and treated as if it never existed.

When we will challenge the validity of the policy.

The validity of this policy depends on full and honest disclosure in the application materials including the application, tele-interview, and other required questionnaires. We reserve the right to challenge the validity of this policy if an important fact was incorrectly stated, misrepresented, or not disclosed in the application materials. An important fact is a piece of information that would have led us to decline the policy, increase the premium payments, reduce benefits, or exclude coverage for specific risks or medical conditions.

If any important fact was incorrectly stated, misrepresented, or not disclosed in the application materials, we will:

- Void the policy if the policy is within 2 years of the later of the **coverage date** or the last reinstatement date; and
- Deny a claim for benefits if you are **diagnosed** with a **covered condition** or have a medical procedure or surgery that is a **covered condition** within 2 years of the later of the **coverage date** or the last reinstatement date. In this case, we will also void the policy.



If we void the policy, we will refund the premium payments made after the later of the **policy date** or the last reinstatement date.

If any important fact was fraudulently misstated, misrepresented, or not disclosed in the application materials, we will cancel the policy and deny a claim for benefits at any time. If we cancel the policy in this case, we will not refund the premium payments made.

Misstatement of date of birth or sex.

If your date of birth or sex provided in your application was incorrect, the **illness benefit** amounts will be revised. The new amounts will be what we would have approved for the same premium payments if the correct information had been provided in the application.

If the date of birth shown in the Policy Schedule is incorrect, a new Policy Schedule with the correct information will be issued.

Alignment with provincial or territorial statutes.

On the policy's **coverage date**, this policy will meet the minimum requirements of the laws in the province or territory where the policy owner lives. If this is not true, the policy will be assumed to be amended to meet the minimum requirements as they existed on that date.

Proof / épreuve



6.2 Statutory Conditions

The 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.

Copy of application.

We shall, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

Material facts.

No statement made by the policy owner or the person insured 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 or electronic statements or answers furnished as evidence of insurability.

Notice and proof of claim.

Please refer to "When to make a claim for an illness benefit." in Section 3.1 - How to make a claim.

Failure to give notice or proof.

Please refer to "Is there a time after which it is too late to make a claim for an illness benefit?" in Section 3.1 - How to make a claim.

Insurer to furnish forms for proof of claim.

Please refer to "When to make a claim for an illness benefit." in Section 3.1 - How to make a claim.

Rights of examination.

Please refer to "Will a medical exam be required?" in Section 3.1 - How to make a claim.

When money payable.

Please refer to "When will an illness benefit be paid?" in Section 3.1 - How to make a claim.



7.0 Definitions

Introduction

Words or phrases shown in ***bold italics*** in this document are defined below.

Word or Phrase	Definition
<i>Beneficiary</i>	The person or persons the policy owner designates to receive a benefit under this policy or any attached rider, if the policy owner lives in a province or territory that has <i>sickness beneficiary laws</i> . The policy owner may designate different <i>beneficiaries</i> for different benefits. When the policy owner dies, the designation of the <i>beneficiary</i> remains valid, and any benefit will be paid to the <i>beneficiary</i> .
<i>Coverage date</i>	This is the date that the coverage of this policy begin. The <i>coverage date</i> is stated on the Policy Schedule.
<i>Covered condition</i>	The illness, injury, surgery, medical procedure or loss of function that is defined in Section 2.0 of this contract.
<i>Criminal offence</i>	Any action that would be a violation of the Criminal Code or the Controlled Drug and Substances Act, whether or not the action occurred in Canada.
<i>Diagnosis or diagnosed</i>	The determination by a medical <i>specialist</i> that you have a <i>covered condition</i> based on the Definition, Diagnosis requirements and Condition specific exclusions included in Section 2.0 of this contract.
<i>Effective / In effect</i>	The policy is active and provides coverage. Conditions that must be met for the policy to become <i>effective</i> are described in Section 6.1 - General Provisions
<i>Expiry date</i>	The date of the policy anniversary that is closest to your 75 th birthday.



<i>Illness benefit</i>	Either the critical illness benefit or the early assistance benefit as described in Section 1.0 of this contract.
<i>Policy date</i>	This date is used to determine the policy anniversary and the premium payment due dates. Premium payment amounts are calculated using your age on the birthday nearest the <i>policy date</i> . The <i>policy date</i> is stated on the Policy Schedule.
<i>Recipient</i>	The person or persons the policy owner designates to receive a benefit under this policy or any attached rider, if the policy owner lives in a province or territory that does not have <i>sickness beneficiary laws</i> . The policy owner may designate different <i>recipients</i> for different benefits. The policy owner may not designate a <i>recipient</i> for a return of premium on death benefit if the policy owner is also the insured person. When the policy owner dies, the designation of the <i>recipient</i> is no longer valid, and any benefit will be paid to the policy owner's estate.
<i>Qualifying period</i>	Some conditions must be permanent, persistent or demonstrate progressive deterioration in function to qualify for the <i>illness benefit</i> . The <i>qualifying period</i> is a set number of days after the <i>diagnosis</i> required to confirm that the condition is permanent, persists, or demonstrates progressive deterioration in function.
<i>Sickness beneficiary laws</i>	Insurance laws that let a policy owner designate a <i>beneficiary</i> for sickness insurance money. These laws provide specific rights and protections to policy owners and <i>beneficiaries</i> . Not all provinces and territories have these laws.
<i>Specialist</i>	A licensed physician who has specific medical training relating to the <i>covered condition</i> for which the <i>illness benefit</i> is being claimed. This person cannot be you or the policy owner, or a relative or a business associate of yours or the policy owner.
<i>Survival Period</i>	For some conditions, you must continue living, without the assistance of life support, for a minimum number of days before you will qualify for the <i>illness benefit</i> . A <i>survival period</i> begins on the day you are <i>diagnosed</i> with a <i>covered condition</i> , or the day you undergo a medical procedure or surgery that is a <i>covered condition</i> .
<i>Symptom-free period</i>	A set number of days, after the later of the <i>coverage date</i> or last reinstatement date of the policy, during which you must not have been diagnosed with an illness identified in the applicable symptom-free period exclusion or have signs, symptoms, treatments or medical investigations that eventually lead to the diagnosis of an illness identified in that symptom-free period exclusion.