Your group insurance plan

CITY OF LEDUC

Policy No. 644459

Regular Municipal Employees

Desjardins
Insurance
Life • Health • Retirement

Your Group Insurance

CITY OF LEDUC

Policy No. 644459

Regular Municipal Employees

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on April 1, 2020. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.

Use of masculine is intended to include both women and men.

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BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:	Mandatory
Eligibility Requirements	
Number of hours worked per week:	A minimum of 20 hours per week for permanent or temporary full-time employees to December 1, 2014 and effective January 1, 2015 a minimum of 17.5 hours per week. A minimum of 20 hours per week for permanent or temporary part-time employees to December 1, 2014 and effective January 1, 2015 a minimum of 17.5 hours per week .
Eligibility of Temporary Employees:	Temporary Employees work term must be equal to or greater than 2 years to be eligible for insurance under the policy.
Eligibility Period:	Nil

Waiver of Premium

Benefits for which premiums are waived in the event of Total Disability:	• Basic Participant Life Insurance Benefit • Participant Accidental Death and Dismemberment Benefit • Participant Optional Life Insurance Benefit • Spouse Optional Life Insurance Benefit • Participant Optional Critical Illness Benefit (Enhanced Plan) • Spouse Optional Critical Illness Benefit (Enhanced Plan) • Participant Long Term Disability Benefit
Beginning of Waiver of Premium:	At the end of the Elimination Period of the Participant Long Term Disability Benefit.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Amount of Insurance:	* 2 times annual Earnings, rounded to the next higher $1,000, if not already a multiple, up to a maximum of $500,000.
Non-Evidence Maximum of Insurability:	$500,000
*** Reduction of Amount:**	On the 70th birthday of the Participant, the amount applicable to the Participant will be reduced to 10% of the amount applicable to the Participant immediately before his 70th birthday, to a minimum of $10,000.

Benefit Termination

Age Limit:	Retirement

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Amount of Insurance: Amount is equal to the Basic Participant Life Insurance Benefit amount.

Benefit Termination

Age Limit: Age 70 of the Participant, or retirement whichever occurs first.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance: Any multiple of $10,000 with a minimum of $10,000 and a maximum of $300,000.

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

SPOUSE OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance: Any multiple of $10,000 with a minimum of $10,000 and a maximum of $300,000.

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

Optional Life Rates per $1,000

Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
<25	0.052	0.081	0.027	0.045
25 - 29	0.052	0.081	0.027	0.045
30 - 34	0.053	0.090	0.027	0.067
35 - 39	0.068	0.117	0.045	0.081
40 - 44	0.106	0.198	0.072	0.135
45 - 49	0.179	0.333	0.117	0.225
50 - 54	0.305	0.558	0.200	0.360
55 - 59	0.509	0.882	0.315	0.567
60 - 64	0.784	1.332	0.491	0.837
65 - 69	1.422	2.610	0.882	1.620

PARTICIPANT OPTIONAL CRITICAL ILLNESS BENEFIT (ENHANCED PLAN)

Amount of Insurance:	Any multiple of $10,000 with a minimum of $10,000 and a maximum of $150,000.
Non-Evidence Maximum of Insurability:	The first $10,000 of Optional Critical Illness Benefit is available without evidence of insurability if the application for this coverage is made within 31 days of becoming eligible. Any amount in excess of this $10,000 applied for within the same 31 day period will require evidence of insurability. All amounts of coverage applied for after 31 days of the date of becoming eligible will require evidence of insurability.

Benefit Termination

Age Limit:	Age 70 of the Participant, or retirement whichever occurs first.

SPOUSE OPTIONAL CRITICAL ILLNESS BENEFIT (ENHANCED PLAN)

Amount of Insurance:	Any multiple of $10,000 with a minimum of $10,000 and a maximum of $150,000.
Non-Evidence Maximum of Insurability:	The first $10,000 of Optional Critical Illness Benefit is available without evidence of insurability if the application for this coverage is made within 31 days of becoming eligible. Any amount in excess of this $10,000 applied for within the same 31 day period will require evidence of insurability. All amounts of coverage applied for after 31 days of the date of becoming eligible will require evidence of insurability.

Benefit Termination

Age Limit:	Age 70 of the Participant, or retirement whichever occurs first.

Optional Critical Illness Rates per $1,000

Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
<25	0.096	0.112	0.091	0.108
25 - 29	0.096	0.112	0.091	0.108
30 - 34	0.117	0.148	0.130	0.174
35 - 39	0.136	0.192	0.159	0.247
40 - 44	0.188	0.313	0.211	0.386
45 - 49	0.312	0.615	0.295	0.599
50 - 54	0.506	1.134	0.397	0.842
55 - 59	0.834	1.997	0.561	1.159
60 - 64	1.421	3.338	0.831	1.574
65 - 69	2.349	5.010	1.291	2.169

PARTICIPANT LONG TERM DISABILITY BENEFIT

Percentage and Maximum of Benefit:	66 2/3% of monthly Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $10,000.
Non-Evidence Maximum of Insurability:	$6,500
Elimination Period:	120 calendar days
Maximum Benefit Period:	To age 65
Taxability of Benefits:	Non-taxable

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

1) is under 21 years of Age, and for whom the Participant or the Spouse of the Participant has legal guardianship or had legal guardianship until he reached the Age of majority; or

2) has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant would have legal guardianship if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would have legal guardianship of him as if he were a minor.

   It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration.

For an Employee whose pay is derived in whole or in part from commissions or dividends, Earnings means the average regular rate of pay of an Employee paid by the Employer including commissions and dividends as shown on the income taxation slips of the Employee for the previous two calendar years. If employed less than two years but more than one, Earnings will be averaged over the length of time employed. If employed less than one year, Earnings will be the regular rate of pay of the Employee as reported by the Employer.

Employee means a person who is domiciled in Canada and who is

1) employed by the Employer on a permanent full-time or part-time basis for not less than the number of hours specified in the Benefit Schedule,

2) employed by the Employer on a temporary full-time or part-time basis for not less than the number of hours specified in the Benefit Schedule,

3) an Elected Official of the Policyholder.

However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any companies listed on the application of the Policyholder for the policy or specified in the Benefit Schedule.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

1) is legally married to or living in a civil union with the Participant; or

2) has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or

3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

1) the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or

2) the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days after the date of his eligibility.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

1) the date on which the insurance of a Participant first becomes effective under the policy,

2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible,

4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

WAIVER OF PREMIUM

1) For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

   a) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

   b) the date on which the Participant ceases to be Totally Disabled,

   c) for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

   d) the date on which the Participant attains Age 65 or retires, if earlier,

   e) in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or the policy terminates except for the Basic Participant Life Insurance Benefit, the Participant Optional Life Insurance Benefit, the Spouse Optional Life Insurance Benefit and the Participant Long Term Disability Benefit.

2) Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

3) A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

4) In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

   a) the Participant became Totally Disabled while insured under this Benefit,

   b) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

   c) the Participant dies within 12 months from the onset of his Total Disability,

   d) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

   e) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.

5) To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

   In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

1) the date the Participant no longer qualifies as an Employee, as defined in the policy,

2) the date the Participant ceases to belong to a class of Participants eligible for insurance,

3) the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

4) the end of the period for which required premiums were paid on behalf of the Participant,

5) the date the Participant retires,

6) the date the Participant ceases to be Actively At Work,

7) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

1) the date the insurance of the Participant terminates,

2) the date the Participant no longer has any Dependents,

3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

4) the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

BENEFICIARY

With regard to life insurance only and subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, the death benefit is paid as follows:

1) in the event of the Spouse's death:

   to the Spouse's legal heirs;

2) in the event of the death of the Participant's Dependent Child:

   a) to the Spouse, if alive, or

   b) if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;

3) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

1) the maximum amount applicable in the province of residence of the Participant; or

2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DEFINITIONS

As used in this Benefit

Elements means a natural disaster such as an earthquake, storm, flooding, landslide or any other disaster of the same nature.

Hemiplegia means the total, irrecoverable and permanent paralysis of upper and lower limbs on the same side of the body.

Loss of Arm means the complete severance through or above the elbow.

Loss of Finger means the complete severance of two entire phalanges of one finger.

Loss of Foot means the complete severance through or above the ankle joint but below the knee joint.

Loss of Hand means the complete severance through or above the wrist but below the elbow joint.

Loss of Hearing, Sight or Speech means the total and irrecoverable loss of hearing, sight or speech that is certified by a licensed Physician of recognized standing and certified by the Royal College of Physicians and Surgeons of Canada or the Professional Corporation of Physicians of Quebec.

Loss of Leg means the complete severance through or above the knee joint.

Loss of Thumb means the complete severance of one entire phalanx of the thumb.

Loss of Toe means the complete severance of one entire phalanx of the big toe, and all phalanges of the other toes.

Loss of Use means the total and irrecoverable loss of use of a limb following a continuous period of complete disablement of such limb of not less than 12 months.

Motor Vehicle means a passenger car, station wagon, minivan or multipurpose vehicle similar to a jeep or a pickup truck.

Paraplegia means the total, irrecoverable and permanent paralysis of both lower limbs.

Quadriplegia means the total, irrecoverable and permanent paralysis of both upper and lower limbs.

Seat Belt means the straps that are part of the occupant restraint system.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant suffered one of the specified losses below within 365 days of an Accident causing bodily injuries; and

2) the loss was the direct result of the Accident, independent of any other cause; and

3) the Accident occurred while the Participant was insured under this Benefit;

the Insurer will pay the amount applicable to any such loss in accordance with the following Schedule of Losses and other applicable policy provisions.

SCHEDULE OF LOSSES

The amount payable shown below is a percentage of the amount specified in the Benefit Schedule.

Loss of	Amount Payable
Life	100%
Hearing in Both Ears and Speech	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
Hearing in Both Ears or Speech	67%
Sight of One Eye	67%
One Hand or One Foot	67%
Thumb and Index Finger of the Same Hand	33%
At least Four Fingers of the Same Hand	33%
Hearing in One Ear	25%
All Toes of One Foot	25%

Loss of Use of	Amount Payable
Both Arms or Both Hands	100%
Both Legs or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Thumb and Index Finger of the Same Hand	33%
Hemiplegia, Paraplegia, Quadriplegia	200%

DISAPPEARANCE

If a Participant, while insured under this Benefit, disappears as a result of an Accident involving the sinking or disappearance of a conveyance in which he was riding and if his body is not found within 365 days of such Accident, it will be presumed, unless there is evidence to the contrary, that the Participant suffered a loss of life as a result of a bodily injury caused by the Accident.

EXPOSURE

If a Participant, while insured under this Benefit, suffers a loss due to unavoidable exposure to the Elements, the loss will be deemed to result from an Accident.

REHABILITATION

If a Participant, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount is payable under this Benefit, the Insurer will pay the reasonable and necessary training expenses actually incurred, up to a maximum of $10,000, provided that:

1) the Participant requires such training because of the loss, in order to qualify for employment in an occupation in which he would not have been engaged except for such loss; and

2) such expenses are incurred within 2 years of the date of the Accident.

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION

If a Participant, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount of insurance is payable under this Benefit, and, as a result of such loss, is confined in a Hospital located more than 150 kilometres from his normal place of residence as an in-patient under the regular care of a Physician (other than himself), the Insurer will pay the reasonable expenses incurred by members of his Immediate Family for hotel accommodation and transportation by the most direct route to the Hospital, up to a lifetime maximum of $1,500 for all these expenses.

REPATRIATION

If a Participant, while insured under this Benefit, dies as a result of an Accident that occurs 100 kilometres or more from his normal place of residence and an amount is payable for a loss of life under this Benefit, the Insurer will pay all customary and reasonable expenses incurred for preparation of the body for burial or cremation and transportation of the body to the Participant's place of residence in Canada, up to a maximum of $10,000.

SEAT BELT

If a Participant, while insured under this Benefit, is injured in a car Accident and suffers a loss for which an amount of insurance is payable under this Benefit, the amount payable will be increased by 10% if the Participant was wearing a Seat Belt, provided that

1) the loss occurs while the Participant is a passenger or the driver of a private Motor Vehicle;

2) the Seat Belt was properly fastened; and

3) verification of the use of the Seat Belt is specified in the official Accident report or is certified by the investigator.

HOME OR VEHICLE CONVERSION

If a Participant, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount is payable under this Benefit and then requires (for the same reason that entitled him to that Benefit payment) a wheelchair, the Insurer will pay, upon presentation of proof of payment,

1) the initial costs of converting his home so that it is wheelchair-accessible; and

2) the initial costs of converting a Motor Vehicle belonging to him so that he can access this vehicle and drive it;

subject to one conversion for each of the eligible expenses described in paragraph 1) and 2) above and up to a maximum of $10,000 for all these expenses.

This Benefit only applies if

1) the modifications made to the home are done by one or more people experienced in this field and who are recommended by a licensed organization that offers support and assistance to wheelchair users; and

2) the modifications made to the vehicle are done by one or more people experienced in this field and who are authorized by the provincial motor vehicle office in the Participant's province of residence.

SPECIAL EDUCATION

If the Dependents of a Participant are insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay a Special Education benefit for each Dependent Child who, on the date of the Accident, was insured under the policy and was enrolled as a full-time student in an institution of higher learning above the secondary school level, or was in a secondary school and subsequently enrols as a full-time student in an institution of higher learning within 365 days of the death of such Participant.

Under this Benefit, reimbursement will be made for all reasonable and necessary expenses incurred for tuition and related costs, up to 2% of the amount for which the Participant was insured under this Benefit on the date of his death and an overall maximum of $5,000 for each year, for a maximum of 4 years, provided that the Dependent Child who is eligible for this Special Education benefit continues his education on a full-time basis in an institution of higher learning, without any interruption longer than the normal school vacation.

SPOUSAL RETRAINING

If the Spouse of a Participant is insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay all reasonable and necessary expenses that are actually incurred by the Spouse who takes part in a formal occupational training program, up to $10,000, provided that

1) the Spouse requires such training in order to become specifically qualified for active employment in an occupation for which the Spouse would not otherwise have sufficient qualifications; and

2) such expenses are incurred within 2 years of the date of the Accident.

EXCLUSIONS AND RESTRICTIONS

1) No payment will be made for a loss resulting directly or indirectly, solely or partly from any of the following:

   a) suicide or intentionally self-inflicted injury, while sane or insane;

   b) an Illness that does not result from an Accident but that appears at the time of the Accident;

   c) dental or medical treatment, a surgical procedure or the administration of anaesthesia;

   d) war, whether the war be declared or not, service in the armed forces of any country or participation in a riot, insurrection or civil commotion;

   e) travel or flight aboard any aircraft except solely as a passenger (and not as a pilot or crew member) in an aircraft that

      i) has a certificate of airworthiness or flight permit issued under the Aeronautics Act (Canada) or under the laws of the country where the aircraft is registered, and all the conditions under which the certificate or permit was issued have been complied with; and

      ii) is used for the sole purpose of transportation and not for aviation training or practice, or for experimental or test purposes;

   f) committing, or attempting to commit a criminal offence.

2) The Insurer will not pay the sum insured in the event of an Accident if such Accident leads to the loss as a result of the Participant driving a Motor Vehicle while under the influence of drugs or while his blood alcohol level exceeds the limits set by the Criminal Code of Canada.

3) Under the REHABILITATION, SPECIAL EDUCATION and SPOUSAL RETRAINING provisions, no payment will be made for room and board or other ordinary travelling, clothing or living expenses.

4) For multiple losses to the same limb due to any one Accident, only one loss, corresponding to the most significant loss, will be paid. For all losses due to any one Accident, the aggregate amount payable will not exceed 100% of the Amount of Insurance specified in the Benefit Schedule, except in the case of Hemiplegia, Paraplegia and Quadriplegia, where the total amount payable will not exceed 200% of the Amount of Insurance specified in the Benefit Schedule.

RESTRICTIONS RELATED TO THE WEARING OF A SEAT BELT

To be eligible for the additional amount payable to a Participant who is injured in a car Accident, as specified under the SEAT BELT provision of this Benefit, the driver of the Motor Vehicle must have a valid driver's licence for the type of vehicle he is authorized to drive and must not, at the time of the Accident, be under the influence of drugs, except in the case of medication prescribed by a Physician and taken following the directions for use. Moreover, the driver's blood alcohol level must not exceed the limit set under the Criminal Code of Canada, nor the impaired driving limits established by the local authorities in the area where the Accident occurs.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a death claim.

Any other claim must be submitted to the Insurer within 30 days of the Accident and written proof within 90 days of such Accident.

In the case of a disappearance, as specified under the DISAPPEARANCE provision of this Benefit, the Insurer will pay the claim on presentation of a declaratory judgment of death.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Participant Optional Life Insurance.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Optional Life Insurance Benefit is payable in respect of a Participant who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer’s liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Optional Life Insurance of a Participant aged 65 or younger terminates under any of the conditions specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit and not solely the Participant's request, the Participant will be entitled to convert that insurance to an individual policy, without evidence of insurability.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit will apply to any individual policy available under this Benefit except that the maximum amount that may be converted under this Benefit will be the maximum specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit, minus the amount of any Basic Participant Life Insurance that may be converted.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Optional Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

SPOUSE OPTIONAL LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Spouse applying for any amount of Spouse Optional Life Insurance.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent Spouse died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Spouse in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Spouse Optional Life Insurance Benefit is payable in respect of a Spouse who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer's liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

SPOUSE CONVERSION PRIVILEGE

If the Optional Life Insurance of a Spouse age 65 or younger terminates for any reason other than at the Participant's request, the Participant, or the Spouse in the event of the death of such Participant, may convert this insurance to an individual policy, without evidence of insurability.

The amount of life insurance that may be converted for the Spouse must be at least the amount applicable in the province of residence of the Participant, without exceeding the amount of Spouse Optional Life Insurance in force for the Spouse on the conversion date.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Spouse under this Benefit;

2) The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

3) The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

4) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Spouse's Age at nearest birthday and the class of risk to which the Spouse belongs;

5) If the amount of Spouse Optional Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Spouse may convert;

6) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Spouse under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Spouse dies within 31 days of the termination of his insurance under this Benefit, the amount of Spouse Optional Life Insurance payable will be the amount that the Participant or the Spouse, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT OPTIONAL CRITICAL ILLNESS BENEFIT (ENHANCED PLAN)

DEFINITIONS

Wherever used in this Benefit:

Diagnosis means, as established by a Specialist using tests or other diagnostic methods, the definite presence in the Participant of a Critical Illness or Certain Illness. Surgeries specifically identified in this Benefit are also considered as Diagnoses.

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 an undue risk to the Insured Person's health.

Pre-existing Condition means, within the 24-month period preceding the date of the Insured Person's Commencement of insurance or effective date of last reinstatement of insurance, the existence of

1) a condition or symptom(s) for which medical expenses were incurred, treatment was received, drugs or medicine was prescribed or a Physician or healthcare practitioner was consulted; or

2) a condition or symptom(s) for which an ordinarily prudent person would seek diagnosis, care or treatment.

Specialist means a licensed Physician practising in Canada who has achieved certification as a specialist through the completion of certifying examinations in the applicable jurisdiction. The Specialist must be certified in the specific area of medicine relevant to the Diagnosis for which a claim is being made. In the absence or unavailability of a Specialist, the Diagnosis or the necessity of a Surgery may be established by a qualified Physician practising in Canada, as approved by the Insurer. The Specialist must not be the Insured Person, a relative or business associate of the Insured Person.

Surgery means medically necessary surgery performed on the Participant in accordance with the written advice of a Specialist. The surgery must be performed by a Physician in Canada.

Survival Period, except where otherwise indicated, means the 30 days following the date of Diagnosis or 30 days following the date of Surgery, at the end of which the Participant is alive and has not experienced Irreversible cessation of all functions of the brain. The Survival Period does not include the number of days for which the Participant is on life support. For the purposes of this Benefit, life support means the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support, including but not limited to cases where Irreversible cessation of all functions of the brain has occurred.

For those Critical Illnesses which are subject to a qualifying period, the Survival Period runs concurrently with the qualifying period of the Critical Illness.

Total Disability or Totally Disabled means a state of incapacity as defined in the DEFINITIONS for the Basic Participant Life Insurance Benefit.

Critical Illness means any one of the following conditions, as it is defined in this section:

1) Alzheimer's Disease
2) Aortic Surgery
3) Aplastic Anaemia
4) Bacterial Meningitis
5) Benign Brain Tumour
6) Blindness
7) Cancer (life-threatening)
8) Coma
9) Coronary Artery Bypass Surgery
10) Deafness
11) Dilated Cardiomyopathy
12) Fulminant Viral Hepatitis
13) Heart Attack
14) Heart Valve Replacement
15) Kidney Failure
16) Liver Failure of Advanced Stage
17) Loss of Independent Existence
18) Loss of Limbs
19) Loss of Speech
20) Major Organ Failure on Waiting List
21) Major Organ Transplant
22) Motor Neuron Disease
23) Multiple Sclerosis
24) Muscular Dystrophy
25) Occupational HIV Infection
26) Paralysis
27) Parkinson's Disease
28) Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)
29) Progressive Systemic Sclerosis
30) Severe Burns
31) Stroke (cerebrovascular accident)

Alzheimer's Disease means a definite Diagnosis of a progressive degenerative disease of the brain. The Participant must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision.

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

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.

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

1) marrow stimulating agents;

2) immunosuppressive agents;

3) bone marrow transplantation.

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.

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

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).

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

2) **Exclusion Period**: No benefit will be paid under this condition if, within the first 90 days following the later of:

    a) the date of Commencement of Insurance;

    b) the effective date of last reinstatement of insurance under this Benefit;

    the Participant had any of the following:

    a) signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, without regard to the eligibility of the diagnosis under the policy or when the diagnosis is made;

b) a diagnosis of benign brain tumour, without regard to the eligibility of the diagnosis under the policy.

The medical information described above must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Benign Brain Tumour, or for any Critical Illness caused by any benign brain tumour or its treatment.

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

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

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

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.

1) **Exclusions**: No benefit will be payable under this condition for the following non-life-threatening cancers

   a) carcinoma *in situ*;

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

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

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

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

   a) the date of Commencement of insurance;

   b) the effective date of last reinstatement of insurance under this Benefit;

   the Participant has any of the following:

   a) signs, symptoms or investigations, that lead to a diagnosis of cancer without regard to the eligibility of the diagnosis under the policy or when the diagnosis is made;

   b) a diagnosis of cancer without regard to the eligibility of the diagnosis under the policy.

This medical information as described above must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for cancer, or for any Certain Illness or Critical Illness caused by any cancer or its treatment.

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.

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

1) a medically induced coma;

2) a coma which results directly from alcohol or drug use;

3) a diagnosis of brain death.

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).

Exclusion: No benefit will be payable under this condition for non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

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.

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

> For the purpose of this Benefit, NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

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

Fulminant Viral Hepatitis means a definite Diagnosis of a submassive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

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

2) necrosis involving entire lobules, leaving only a collapsed reticular framework (available histology to be included);

3) rapidly deteriorating liver function tests;

4) deepening jaundice.

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

1) chronic hepatitis;

2) liver failure caused by alcohol, toxins and/or drugs.

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

1) heart attack symptoms;

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

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

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

1) 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

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

Heart Valve Replacement means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve.

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

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.

Liver Failure of Advanced Stage means a definite Diagnosis of liver failure due to cirrhosis and resulting in all of the following:

1) permanent jaundice;

2) ascites;

3) encephalopathy.

Exclusion: No benefit will be payable under this condition for liver disease secondary to alcohol or drug use.

Loss of Independent Existence means a definite Diagnosis of:

1) a total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living, or

2) Cognitive Impairment, as defined below,

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

Activities of Daily Living are:

1) Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

2) Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.

3) Toileting – the ability to get on and off the toilet and maintain personal hygiene.

4) 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.

5) Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.

6) Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

For the purpose of this Benefit, 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 8 hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

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

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.

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.

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

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 Participant must become enrolled as the recipient in a recognized transplant centre in Canada or in 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 of the Insured Person's enrolment in the transplant centre.

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 Participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

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.

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

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

2) well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,

3) 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.

Muscular Dystrophy means a definite Diagnosis of hereditary muscle disorders in which, slow, progressive deterioration occurs, leading to increasing weakness and disability. Diagnosis must be supported by DNA analysis, electromyography and muscle biopsy.

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 date of Commencement of Insurance, or the effective date of last reinstatement of insurance.

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

1) the accidental injury must be reported to the Insurer within 14 days of the accidental injury;

2) a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

3) a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

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

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

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

1) the Participant has elected not to take any available licensed vaccine offering protection against HIV; or

2) a licensed cure for HIV infection has become available prior to the accidental injury; or

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

Paralysis means 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.

Parkinson's Disease means a definite Diagnosis of idiopathic and degenerative Parkinson's disease diagnosed by a duly qualified neurologist. The Diagnosis must be based on two or more of the following symptoms:

1) rigidity;

2) tremors;

3) bradykinesia.

Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization), resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment – 39th Edition) states the following about Class IV: "*Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest*."

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

Progressive Systemic Sclerosis means a definite Diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by biopsy and serological evidence.

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

1) localized scleroderma (linear scleroderma or morphea);

2) eosinophilic fasciitis; or

3) CREST syndrome.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

Stroke (cerebrovascular accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hæmorrhage, or embolism from an extra-cranial source, with:

1) acute onset of new neurological symptoms; and

2) 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.

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

1) transient ischæmic attacks;

2) intracerebral vascular events due to trauma;

3) lacunar infarctions which do not meet the definition of Stroke as described above.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant as specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability.

PAYMENT OF BENEFIT

Payment for the Diagnosis of a Critical Illness or Certain Illness is conditional to prior reception of proof of claim satisfactory to the Insurer, confirming that

1) a Specialist has established the Diagnosis; and

2) the Participant survived after the Diagnosis and the conditions of survival under the Survival Period definition have been met.

COVERAGE FOR CRITICAL ILLNESSES

If the Participant receives the Diagnosis of a Critical Illness as such illness is defined in this Benefit, the Insurer will pay the Amount of Insurance specified in the Benefit Schedule.

However, if this Diagnosis was established after any Diagnosis of a Certain Illness or previous Critical Illness, for which benefit has been paid, benefit for this subsequent Diagnosis may only be claimed under the MULTIPLE OCCURRENCE COVERAGE section.

PARTIAL BENEFIT IN CASE OF CERTAIN ILLNESSES

If the Participant receives the Diagnosis of one of the illnesses eligible under this section as defined hereunder, the Insurer will pay a benefit equal to 10% of the Amount of Insurance specified in the Benefit Schedule up to $25,000.

Only the Diagnosis of one of the following Certain Illnesses is eligible under this section. Certain Illness means:

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

2) Ductal carcinoma *in situ* of the breast which means the Diagnosis of non-invasive breast cancer originating in the ducts of the breast. The Diagnosis must be confirmed by biopsy.

3) Stage A (T1a or T1b) prostate cancer which means the Diagnosis of a clinically unapparent malignant localized tumour in the prostate that is neither palpable nor visible by imaging. The Diagnosis must be confirmed by pathological examination of prostate tissue.

4) Stage 1A malignant melanoma which means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis must be confirmed by biopsy.

Exclusion Period for Certain Illnesses described in 2), 3) and 4) above:

No benefit will be payable under the condition if the Diagnosis has been established within the first 90 days following the later of the date of Commencement of insurance or the effective date of last reinstatement of insurance under this Benefit.

If the Participant has previously received a Diagnosis for a Critical Illness for which benefit has been paid, a claim may only be made under the MULTIPLE OCCURRENCE COVERAGE section.

Only one benefit may be paid in the Participant's lifetime under this section.

CANCER RECURRENCE BENEFIT

The Insurer will pay the Amount of Insurance specified in the Benefit Schedule if the Participant receives a Cancer (life-threatening) Diagnosis subsequent to receiving a previous cancer diagnosis if:

1) more than 60 months have passed since the previous cancer diagnosis; and

2) no treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventative medications and follow up visits to the Physician).

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

MULTIPLE OCCURRENCE COVERAGE

1) If the Participant has received the Diagnosis for a Certain or Critical Illness for which benefit has been paid and subsequently receives a Diagnosis for an eligible Critical Illness, the Insurer will pay the Amount of Insurance specified in the Benefit Schedule.

   For the benefit to be paid, the Diagnosis must be established at least 90 days after the date of the most recent claim settlement payment made for the Diagnosis of a Certain or Critical Illness.

   However, when the Participant has received the Diagnosis of a Certain Illness for which benefit has been paid, and the following Diagnosis received by this Participant is a Critical Illness Diagnosis which was made less than 90 days after the most recent payment made for the settlement of said benefit, the Insurer will pay a benefit equivalent to the Amount of Insurance specified in the Benefit Schedule less the amount paid for the Diagnosis of the Certain Illness.

2) If the Participant has received a Diagnosis of a Critical Illness for which benefit has been paid, and subsequently receives the Diagnosis of a Certain Illness, the Insurer will pay a benefit equal to 10% of the Amount of Insurance specified in the Benefit Schedule up to $25,000.

   For the benefit to be paid, the Diagnosis must be established at least 90 days after the date of the most recent claim settlement payment made for the Diagnosis of a Critical Illness.

Payment of any benefit under this section is subject to the restrictions specified in the RE-ENTRY EXCLUSIONS section.

RE-ENTRY EXCLUSIONS

If the Participant receives a benefit for the Diagnosis of a Certain or Critical Illness, insurance will automatically continue provided payment of premium is continued. The Participant can claim a subsequent benefit for another eligible Critical Illness, subject to the following restrictions:

1) Following an Alzheimer's Disease claim, the Participant cannot claim for Alzheimer's Disease or Loss of Independent Existence.

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

3) Following an Aplastic Anemia claim, the Participant cannot claim for Aplastic Anemia, Cancer (life-threatening), Ductal carcinoma in situ of the breast, Loss of Independent Existence, Stage A (T1a or T1b) prostate cancer or Stage 1A malignant melanoma.

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

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

6) Following a Blindness claim, the Participant cannot claim for Blindness or Loss of Independent Existence.

7) Following a Cancer (life-threatening) claim, the Participant cannot claim for Aplastic Anemia, Cancer (life-threatening) unless all the requirements in the CANCER RECURRENCE BENEFIT section have been met, for Ductal carcinoma *in situ* of the breast, Loss of Independent Existence, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage.

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

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

10) Following a Deafness claim, the Participant cannot claim for Deafness or Loss of Independent Existence.

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

12) Following a Fulminant Viral Hepatitis claim, the Participant cannot claim for Cancer (life-threatening), Ductal carcinoma *in situ* of the breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage.

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

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

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

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

17) Following a Loss of Independent Existence claim, the Participant can no longer claim. Insurance under this Benefit terminates.

18) Following a Loss of Limbs claim, the Participant cannot claim for Loss of Independent Existence or Loss of Limbs.

19) Following a Loss of Speech claim, the Participant cannot claim for Loss of Independent Existence or Loss of Speech.

20) Following a Major Organ Failure on Waiting List claim, the Participant cannot claim for Aplastic Anemia, Cancer (life-threatening), Coma, Ductal carcinoma *in situ* of the breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

21) Following a Major Organ Transplant claim, the Participant cannot claim for Aplastic Anemia, Cancer (life-threatening), Coma, Ductal carcinoma *in situ* of the breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

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

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

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

25) Following an Occupational HIV Infection claim, the Participant cannot claim for Blindness, Cancer (life-threatening), Coma, Deafness, Ductal carcinoma *in situ* of the breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

26) Following a Paralysis claim, the Participant cannot claim for Coma, Loss of Independent Existence, Loss of Speech or Paralysis.

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

28) Following a Primary Pulmonary Hypertension claim, the Participant cannot claim for Aortic Surgery, Coma, Coronary angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, or Stroke.

29) Following a Progressive Systemic Sclerosis claim, the Participant cannot claim for Progressive Systemic Sclerosis, Aortic Surgery, Blindness, Coma, Coronary angioplasty, Coronary Artery Bypass Surgery, Cancer (life-threatening), Ductal carcinoma *in situ* of the breast, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Multiple Sclerosis, Paralysis, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer Stroke, Major Organ Failure on Waiting List or Major Organ Transplant.

30) Following a Severe Burns claim, the Participant cannot claim for Loss of Independent Existence, Paralysis or Severe Burns.

31) Following a Stroke (cerebrovascular accident) claim, the Participant cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

No benefit is payable for:

1) any Certain or Critical Illness resulting directly or indirectly from any of the following:

   a) intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane;

   b) war, whether war be declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

   c) committing, or attempting to commit a criminal offence;

   d) alcohol abuse;

   e) the use of any medication, narcotic, intoxicant or any other harmful substance, except when taken as prescribed or recommended by a Physician.

2) any cancer that manifests itself prior to the date of Commencement of insurance when the same cancer either recurs or metastasizes after the date of Commencement of insurance, unless all the requirements in the CANCER RECURRENCE BENEFIT section have been met;

3) any Certain or Critical Illness resulting directly or indirectly from a Pre-existing Condition.

   This Pre-existing Condition exclusion applies only to amounts equal to or below the Non-Evidence Maximum of Insurability indicated in the Benefit Schedule.

   However, if the Participant has been continuously insured for more than 24 months or has submitted evidence of insurability satisfactory to the Insurer for an amount in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability, this Pre-existing Condition exclusion will not apply to any amount of coverage..

   If this Critical Illness Benefit directly replaces a comparable benefit under the Policyholder's previous group insurance policy, a Participant who has satisfied a period of time for the pre-existing conditions limitations or exclusions under that previous coverage will be deemed to have satisfied the same period of time for the Pre-existing Condition exclusion under this Benefit.

GEOGRAPHIC LIMITATIONS

If a Certain or Critical Illness is diagnosed outside Canada following an Accident or Illness, the Insurer will only assess the claim once the Participant, having returned to Canada, has obtained a medical assessment of the diagnosis made previously.

BENEFIT TERMINATION

This Benefit terminates on the earliest of the following dates:

1) the date the Participant attains the Age Limit specified in the Benefit Schedule;

2) the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

3) the date on which the Insurer pays the amount applicable to Loss of Independent Existence under this Benefit.

CONVERSION PRIVILEGE

If a Participant loses coverage under this Benefit due to:

1) termination of the Participant's employment;

2) cessation of eligibility for insurance under the policy;

3) cessation of a period of Total Disability after which the Participant did not return to work for the policyholder,

and has not reached Age 65, then he may make a written application to the Insurer to convert his coverage within 31 days of cessation or termination. The Insurer will, without evidence of insurability, issue to the Participant an individual critical illness policy of a type offered by the Insurer for such conversions, on the 31st days following the cessation or termination. This privilege does not apply where loss of coverage is due to termination of the policy or benefit.

The amount of insurance that may be converted cannot exceed the Participant's Amount of Insurance in effect on the date of cessation or termination or a total aggregate of $200,000 for all Critical Illness coverage conversions with the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

The Insurer will pay a benefit if the Participant receives the Diagnosis of a Certain or Critical Illness within 31 days of the termination of the Participant's insurance. The Amount of Insurance from which the benefit is calculated is that which the Participant could have converted under this benefit.

NOTICE AND PROOF OF CLAIM

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of a Certain or Critical Illness and of the eligibility for benefits at the time Diagnosis was made.

A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

The Insurer reserves the right to verify the Diagnosis with the attending Specialist(s) and to require any Participant for whom a claim has been submitted to be examined at the Insurer's expense.

SPOUSE OPTIONAL CRITICAL ILLNESS BENEFIT (ENHANCED PLAN)

DEFINITIONS

Wherever used in this Benefit:

Diagnosis means, as established by a Specialist using tests or other diagnostic methods, the definite presence in the Insured Person of a Critical Illness or Certain Illness. Surgeries specifically identified in this Benefit are also considered as Diagnoses.

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 an undue risk to the Insured Person's health.

Pre-existing Condition means, within the 24-month period preceding the date of the Insured Person's Commencement of insurance or effective date of last reinstatement of insurance, the existence of

1) a condition or symptom(s) for which medical expenses were incurred, treatment was received, drugs or medicine was prescribed or a Physician or healthcare practitioner was consulted; or

2) a condition or symptom(s) for which an ordinarily prudent person would seek diagnosis, care or treatment.

Specialist means a licensed Physician practising in Canada who has achieved certification as a specialist through the completion of certifying examinations in the applicable jurisdiction. The Specialist must be certified in the specific area of medicine relevant to the Diagnosis for which a claim is being made. In the absence or unavailability of a Specialist, the Diagnosis or the necessity of a Surgery may be established by a qualified Physician practising in Canada, as approved by the Insurer. The Specialist must not be the Insured Person, a relative or business associate of the Insured Person.

Surgery means medically necessary surgery performed on the Insured Person in accordance with the written advice of a Specialist. The surgery must be performed by a Physician in Canada.

Survival Period, except where otherwise indicated, means the 30 days following the date of Diagnosis or 30 days following the date of Surgery, at the end of which the Insured Person is alive and has not experienced Irreversible cessation of all functions of the brain. The Survival Period does not include the number of days for which the Insured Person is on life support. For the purposes of this Benefit, life support means the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support, including but not limited to cases where Irreversible cessation of all functions of the brain has occurred.

For those Critical Illnesses which are subject to a qualifying period, the Survival Period runs concurrently with the qualifying period of the Critical Illness.

Critical Illness means any one of the following conditions, as it is defined in this section:

1) Alzheimer's Disease
2) Aortic Surgery
3) Aplastic Anaemia
4) Bacterial Meningitis
5) Benign Brain Tumour
6) Blindness
7) Cancer (life-threatening)
8) Coma
9) Coronary Artery Bypass Surgery
10) Deafness
11) Dilated Cardiomyopathy
12) Fulminant Viral Hepatitis
13) Heart Attack
14) Heart Valve Replacement
15) Kidney Failure
16) Liver Failure of Advanced Stage
17) Loss of Independent Existence
18) Loss of Limbs
19) Loss of Speech
20) Major Organ Failure on Waiting List
21) Major Organ Transplant
22) Motor Neuron Disease
23) Multiple Sclerosis
24) Muscular Dystrophy
25) Occupational HIV Infection
26) Paralysis
27) Parkinson's Disease
28) Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)
29) Progressive Systemic Sclerosis
30) Severe Burns
31) Stroke (cerebrovascular accident)

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 judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision.

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

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.

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

1) marrow stimulating agents;

2) immunosuppressive agents;

3) bone marrow transplantation.

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.

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

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).

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

2) **Exclusion Period**: No benefit will be paid under this condition if, within the first 90 days following the later of:

    a) the date of Commencement of Insurance;

    b) the effective date of last reinstatement of insurance under this Benefit;

    the Insured Person had any of the following:

    a) signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, without regard to the eligibility of the diagnosis under the policy or when the diagnosis is made;

b) a diagnosis of benign brain tumour, without regard to the eligibility of the diagnosis under the policy.

The medical information described above must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Benign Brain Tumour, or for any Critical Illness caused by any benign brain tumour or its treatment.

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

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

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

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.

1) **Exclusions**: No benefit will be payable under this condition for the following non-life-threatening cancers

   a) carcinoma *in situ*;

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

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

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

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

   a) the date of Commencement of insurance;

   b) the effective date of last reinstatement of insurance under this Benefit;

   the Insured Person has any of the following:

   a) signs, symptoms or investigations, that lead to a diagnosis of cancer without regard to the eligibility of the diagnosis under the policy or when the diagnosis is made;

   b) a diagnosis of cancer without regard to the eligibility of the diagnosis under the policy.

This medical information as described above must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for cancer, or for any Certain Illness or Critical Illness caused by any cancer or its treatment.

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.

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

1) a medically induced coma;

2) a coma which results directly from alcohol or drug use;

3) a diagnosis of brain death.

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).

Exclusion: No benefit will be payable under this condition for non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

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.

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

For the purpose of this Benefit, NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

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

Fulminant Viral Hepatitis means a definite Diagnosis of a submassive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

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

2) necrosis involving entire lobules, leaving only a collapsed reticular framework (available histology to be included);

3) rapidly deteriorating liver function tests;

4) deepening jaundice.

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

1) chronic hepatitis;

2) liver failure caused by alcohol, toxins and/or drugs.

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

1) heart attack symptoms;

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

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

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

1) 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

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

Heart Valve Replacement means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve.

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

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.

Liver Failure of Advanced Stage means a definite Diagnosis of liver failure due to cirrhosis and resulting in all of the following:

1) permanent jaundice;

2) ascites;

3) encephalopathy.

Exclusion: No benefit will be payable under this condition for liver disease secondary to alcohol or drug use.

Loss of Independent Existence means a definite Diagnosis of:

1) a total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living, or

2) Cognitive Impairment, as defined below,

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

Activities of Daily Living are:

1) Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

2) Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.

3) Toileting – the ability to get on and off the toilet and maintain personal hygiene.

4) 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.

5) Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.

6) Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

For the purpose of this Benefit, 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 8 hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

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

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.

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.

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

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 in 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 of the Insured Person's enrolment in the transplant centre.

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.

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.

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

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

2) well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,

3) 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.

Muscular Dystrophy means a definite Diagnosis of hereditary muscle disorders in which, slow, progressive deterioration occurs, leading to increasing weakness and disability. Diagnosis must be supported by DNA analysis, electromyography and muscle biopsy.

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 date of Commencement of Insurance, or the effective date of last reinstatement of insurance.

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

1) the accidental injury must be reported to the Insurer within 14 days of the accidental injury;

2) a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

3) a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

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

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

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

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

2) a licensed cure for HIV infection has become available prior to the accidental injury; or

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

Paralysis means 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.

Parkinson's Disease means a definite Diagnosis of idiopathic and degenerative Parkinson's disease diagnosed by a duly qualified neurologist. The Diagnosis must be based on two or more of the following symptoms:

1) rigidity;

2) tremors;

3) bradykinesia.

Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization), resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment – 39th Edition) states the following about Class IV: "*Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest*."

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

Progressive Systemic Sclerosis means a definite Diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by biopsy and serological evidence.

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

1) localized scleroderma (linear scleroderma or morphea);

2) eosinophilic fasciitis; or

3) CREST syndrome.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

Stroke (cerebrovascular accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hæmorrhage, or embolism from an extra-cranial source, with:

1) acute onset of new neurological symptoms; and

2) 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.

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

1) transient ischæmic attacks;

2) intracerebral vascular events due to trauma;

3) lacunar infarctions which do not meet the definition of Stroke as described above.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Spouse as specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability.

PAYMENT OF BENEFIT

Payment for the Diagnosis of a Certain Illness or Critical Illness is conditional to prior reception of proof of claim satisfactory to the Insurer confirming that:

1) a Specialist has established the Diagnosis; and

2) the Spouse survived after the Diagnosis and that the conditions of survival under the Survival Period definition have been met.

COVERAGE FOR CRITICAL ILLNESSES

If the Spouse receives the Diagnosis of a Critical Illness as such illness is defined in this Benefit, the Insurer will pay the Amount of Insurance specified in the Benefit Schedule.

However, if this Diagnosis was established after any of a Certain Illness or previous Critical Illness, for which benefit has been paid, benefit for this subsequent Diagnosis may only be claimed under the MULTIPLE OCCURRENCE COVERAGE section.

PARTIAL BENEFIT IN CASE OF CERTAIN ILLNESSES

If the Spouse receives the Diagnosis of one of the illnesses eligible under this section as defined hereunder, the Insurer will pay a benefit equal to 10% of the Amount of Insurance specified in the Benefit Schedule up to $25,000.

Only the Diagnosis of one of the following Certain Illnesses is eligible under this section. Certain Illness means:

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

2) Ductal carcinoma *in situ* of the breast which means the Diagnosis of non-invasive breast cancer originating in the ducts of the breast. The Diagnosis must be confirmed by biopsy.

3) Stage A (T1a or T1b) prostate cancer which means the Diagnosis of a clinically unapparent malignant tumour localized in the prostate that is neither palpable nor visible by imaging. The Diagnosis must be confirmed by pathological examination of prostate tissue.

4) Stage 1A malignant melanoma which means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis must be confirmed by biopsy.

Exclusion Period for Certain Illnesses described in 2), 3) and 4) above:

No benefit will be payable under the condition if the Diagnosis has been established within the first 90 days following the later of the date of Commencement of insurance or the effective date of last reinstatement of insurance under this Benefit.

If the Spouse has previously received a Diagnosis for a Critical Illness for which benefit has been paid, a claim may only be made under the MULTIPLE OCCURRENCE COVERAGE section.

Only one benefit may be paid in the Spouse's lifetime under this section.

CANCER RECURRENCE BENEFIT

The Insurer will pay the Amount of Insurance specified in the Benefit Schedule if the Spouse receives a Cancer (life-threatening) Diagnosis subsequent to receiving a previous cancer diagnosis if:

1) more than 60 months have passed since the previous cancer diagnosis; and

2) no treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventative medications and follow up visits to the Physician).

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

MULTIPLE OCCURRENCE COVERAGE

1) If the Spouse has received the Diagnosis for a Certain or Critical Illness for which benefit has been paid and subsequently receives a Diagnosis for an eligible Critical Illness, the Insurer will pay the Amount of Insurance specified in the Benefit Schedule.

   For the benefit to be paid, the Diagnosis must be established at least 90 days after the date of the most recent claim settlement payment made for the Diagnosis of a Certain or Critical Illness.

   However, when the Spouse has received the Diagnosis of a Certain Illness for which benefit has been paid, and the following Diagnosis received by this Spouse is a Critical Illness Diagnosis which was made less than 90 days after the most recent payment made for the settlement of said benefit, the Insurer will pay a benefit equivalent to the Amount of Insurance specified in the Benefit Schedule less the amount paid for the Diagnosis of the Certain Illness.

2) If the Spouse has received a Diagnosis of a Critical Illness for which benefit has been paid, and subsequently receives the Diagnosis of a Certain Illness, the Insurer will pay a benefit equal to 10% of the Amount of Insurance specified in the Benefit Schedule up to $25,000.

For the benefit to be paid, the Diagnosis must be established at least 90 days after the date of the most recent claim settlement payment made for the Diagnosis of a Critical Illness.

Payment of any benefit under this section is subject to the restrictions specified in the RE-ENTRY EXCLUSIONS section.

RE-ENTRY EXCLUSIONS

If the Spouse receives a benefit for the Diagnosis of a Certain or Critical Illness, insurance will automatically continue provided payment of premium is continued. The Spouse can claim a subsequent benefit for another eligible Critical Illness, subject to the following restrictions:

1) Following an Alzheimer's Disease claim, the Spouse cannot claim for Alzheimer's Disease or Loss of Independent Existence.

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

3) Following an Aplastic Anemia claim, the Spouse cannot claim for Aplastic Anemia, Cancer (life-threatening), Ductal carcinoma *in situ* of the breast, Loss of Independent Existence, Stage A (T1a or T1b) prostate cancer or Stage 1A malignant melanoma.

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

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

6) Following a Blindness claim, the Spouse cannot claim for Blindness or Loss of Independent Existence.

7) Following a Cancer (life-threatening) claim, the Spouse cannot claim for Aplastic Anemia, Cancer (life-threatening) unless all the requirements in the CANCER RECURRENCE BENEFIT section have been met, for Ductal carcinoma *in situ* of the breast, Loss of Independent Existence, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage.

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

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

10) Following a Deafness claim, the Spouse cannot claim for Deafness or Loss of Independent Existence.

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

12) Following a Fulminant Viral Hepatitis claim, the Spouse cannot claim for Cancer (life-threatening), Ductal carcinoma *in situ* of the breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage.

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

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

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

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

17) Following a Loss of Independent Existence claim, the Spouse can no longer claim. Insurance under this Benefit terminates.

18) Following a Loss of Limbs claim, the Spouse cannot claim for Loss of Independent Existence or Loss of Limbs.

19) Following a Loss of Speech claim, the Spouse cannot claim for Loss of Independent Existence or Loss of Speech.

20) Following a Major Organ Failure on Waiting List claim, the Spouse cannot claim for Aplastic Anemia, Cancer (life-threatening), Coma, Ductal carcinoma *in situ* of the breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

21) Following a Major Organ Transplant claim, the Spouse cannot claim for Aplastic Anemia, Cancer (life-threatening), Coma, Ductal carcinoma *in situ* of the breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

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

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

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

25) Following an Occupational HIV Infection claim, the Spouse cannot claim for Blindness, Cancer (life-threatening), Coma, Deafness, Ductal carcinoma *in situ* of the breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

26) Following a Paralysis claim, the Spouse cannot claim for Coma, Loss of Independent Existence, Loss of Speech or Paralysis.

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

28) Following a Primary Pulmonary Hypertension claim, the Spouse cannot claim for Aortic Surgery, Coma, Coronary angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, or Stroke.

29) Following a Progressive Systemic Sclerosis claim, the Participant cannot claim for Progressive Systemic Sclerosis, Aortic Surgery, Blindness, Coma, Coronary angioplasty, Coronary Artery Bypass Surgery, Cancer (life-threatening), Ductal carcinoma *in situ* of the breast, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Multiple Sclerosis, Paralysis, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer Stroke, Major Organ Failure on Waiting List or Major Organ Transplant.

30) Following a Severe Burns claim, the Spouse cannot claim for Loss of Independent Existence, Paralysis or Severe Burns.

31) Following a Stroke (cerebrovascular accident) claim, the Spouse cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

No benefit is payable for:

1) any Certain or Critical Illness resulting directly or indirectly from any of the following:

   a) intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane;

   b) war, whether war be declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

   c) committing, or attempting to commit a criminal offence;

   d) alcohol abuse;

   e) the use of any medication, narcotic, intoxicant or any other harmful substance, except when taken as prescribed or recommended by a Physician.

2) any cancer that manifests itself prior to the date of Commencement of insurance when the same cancer either recurs or metastasizes after the date of Commencement of insurance, unless all the requirements in the CANCER RECURRENCE BENEFIT section have been met;

3) any Certain or Critical Illness resulting directly or indirectly from a Pre-existing Condition.

   This Pre-existing Condition exclusion applies only to amounts equal to or below the Non-Evidence Maximum of Insurability indicated in the Benefit Schedule.

   However, if the Spouse has been continuously insured for more than 24 months or has submitted evidence of insurability satisfactory to the Insurer for an amount in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability, this Pre-existing Condition exclusion will not apply to any amount of coverage.

   If this Critical Illness Benefit directly replaces a comparable benefit under the Policyholder's previous group insurance policy, a Spouse who has satisfied a period of time for the pre-existing conditions limitations or exclusions under that previous coverage will be deemed to have satisfied the same period of time for the Pre-existing Condition exclusion under this Benefit.

GEOGRAPHIC LIMITATIONS

If a Certain or Critical Illness is diagnosed outside Canada following an Accident or Illness, the Insurer will only assess the claim once the Spouse, having returned to Canada, has obtained a medical assessment of the diagnosis made previously.

BENEFIT TERMINATION

This Benefit terminates on the earliest of the following dates:

1) the date the Participant attains the Age Limit specified in the Benefit Schedule;

2) the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision;

3) the date on which the Insurer pays the amount applicable to Loss of Independent Existence under this benefit.

4) the date of cessation of insurance due to the Participant's death.

CONVERSION PRIVILEGE

If a Spouse loses coverage under this Benefit due to:

1) termination of the Participant's employment;

2) cessation of eligibility for insurance under the policy;

3) cessation of a period of Total Disability after which the Participant did not return to work for the policyholder;

4) cessation of insurance due Participant's death;

and has not reached Age 65, then he may make a written application to the Insurer to convert Spouse coverage within 31 days of cessation or termination. The Insurer will, without evidence of insurability, issue to the Spouse an individual critical illness policy of a type offered by the Insurer for such conversions, on the 31st day following the cessation or termination. This privilege does not apply where loss of coverage is due to termination of the policy or benefit.

The amount of insurance that may be converted cannot exceed the Spouse's Amount of Insurance in effect on the date of cessation or termination or a total aggregate of $200,000 for all Critical Illness coverage conversions with the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

The Insurer will pay a benefit if the Spouse of the Participant receives the Diagnosis of a Certain or Critical Illness within 31 days of the termination of the Participant's insurance. The Amount of Insurance from which the benefit is calculated is that which the Spouse could have converted under this benefit.

NOTICE AND PROOF OF CLAIM

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of the relevant Certain or Critical Illness and of eligibility for benefits at the time Diagnosis was made.

A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

The Insurer reserves the right to verify the Diagnosis with the attending Specialist(s) and to require any Insured Person for whom a claim has been submitted to be examined at the Insurer's expense.

PARTICIPANT LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Net Monthly Earnings means the monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled means

1) during the Elimination Period and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered Totally Disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and

2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

1) the end of Elimination Period;

2) the scheduled date of return to work.

The amount of Long Term Disability Benefit payable will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to the initial date of Total Disability.

Long Term Disability Benefits are payable at the end of each month following the completion of the Elimination Period.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Direct Offset

Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and

b) any disability benefit the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding

i) benefits payable on behalf of his Dependents; and

ii) any increase in benefits due solely to cost-of-living, after benefit payments commence; and

c) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis;

d) any disability benefit payable by a private pension plan.

2) Indirect Offset

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

a) 85% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

b) 85% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Participant from all sources, whether he receives or is eligible to receive this income, will include all of the following:

a) any Long Term Disability payments under this Benefit;

b) any monthly Earnings or payments from the Employer;

c) any disability benefits payable under the Quebec Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

d) any disability benefits payable under the Canada Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

e) any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;

f) any disability benefits payable under any other group or association insurance plan;

g) any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;

h) any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

3) In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

4) Limitations

No benefits are payable for a period of Total Disability

a) during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;

b) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a total disability occurring during this period;

c) during a Parental or Family-related Leave taken by a Participant, as provided for under provincial or federal legislation, for Total Disability occurring during this period;

d) during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;

e) during the imprisonment of the Participant due to conviction of an offence;

f) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of Total Disability beginning during the first 12 months of coverage of a Participant, if such Total Disability was directly or indirectly the result of an Illness or Accident that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.

However, if the policy has been in force for less than 12 months, and the Participant has been covered under a comparable benefit under the Employer's previous group insurance policy, for any period of time immediately prior to the Effective Date of the policy, that period of time will apply in determination of the 12 month coverage period.

5) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

a) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

b) committing, or attempting to commit a criminal offence;

c) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Participant was insured under this Benefit;

d) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

e) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

1) 4 consecutive weeks of active full-time employment during the Elimination Period; or

2) 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

1) co-ordination of access to health care services;

2) support program for returning to work;

3) negotiations for a gradual return to work,

4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

1) the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;

2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

4) if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity

B = Monthly Earnings of the Participant immediately prior to the commencement of Total Disability

C = Long Term Disability Benefits otherwise payable under this Benefit

5) while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

1) the date the Participant ceases to be Totally Disabled;

2) the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

3) the date set by the Insurer the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;

4) the date payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;

5) the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

6) the date the Participant attains the Age Limit specified in the Benefit Schedule.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

If a Participant is not Totally Disabled on the date this Benefit terminates but was receiving Long Term Disability Benefits under this Benefit less than 6 months prior to such date, such Participant will be eligible to a resumption of Long Term Disability Benefits if he again becomes Totally Disabled from the same or related causes prior to

1) 90 days after the termination of this Benefit; or

2) 180 days after the last day he was Totally Disabled.

The reinstated Long Term Disability Benefits will be equal to those which the Participant was previously eligible to receive and will continue for the remainder of the Maximum Benefit Period.

BENEFIT EXTENSION IN THE EVENT OF PARTICIPANT'S DEATH

If a Totally Disabled Participant dies while Long Term Disability Benefits are payable, the Insurer will pay a survivor benefit to the Participant's Spouse. The amount of the survivor benefit will be a lump sum payment equal to 3 times the Participant's monthly Long Term Disability Benefit.

In the absence of an eligible surviving Spouse, benefit payments will be made to the Participant's Dependent Child (or children in equal shares) under age 21.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

YOU SHOULD KNOW

GENERAL INQUIRIES

To obtain any other information, visit the "Contact us" section of Desjardins Financial Security's website at **www.desjardinslifeinsurance.com**.

BENEFICIARY

This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits:

Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits.

ACCESS TO THE POLICY

Upon request to Desjardins Financial Security, the Participant may obtain a copy of his application, his insurability report and the policy.

HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they've been wronged or wants us to take corrective action he can file a complaint with the Dispute Resolution Officer at Desjardins Financial Security. The role of the Officer is to evaluate the merit of the decisions and practices of the company when one of its customers believes he has not received the service to which he was entitled.

There are 3 ways to reach the Dispute Resolution Officer

In writing, at the following address:

Dispute Resolution Officer

Desjardins Financial Security

200, rue des Commandeurs

Lévis (Québec) G6V 6R2

By e-mail at: disputeofficer@dfs.ca

By phone at: 1 877 838-8185

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the "Contact us" section of Desjardins Financial Security's website at **www.desjardinslifeinsurance.com**.

Our commitment to you

We will always be here to answer your questions. You can rely on our knowledgeable team to deliver outstanding service and process your claims efficiently. We are here to help you stay healthy and to give you advice and financial support when you need them most.

desjardinslifeinsurance.com

Proud supporter of

Canadian Cancer Society

itsmylife.cancer.ca

Proud supporter of

breakthroughfund.ca

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.
200, rue des Commandeurs
Lévis (QC) G6V 6R2 / 1-866-647-5013

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