HUGO

TERM CRITICAL ILLNESS (25) INSURANCE

Schedule of Benefits

Your contract is composed of this policy, the application, the insurability questionnaire and any policy rider or notice of change annexed to this policy.

Please read your contract carefully, including this policy, the application and insurability questionnaire and validate the answers given therein. If the answers do not reflect your statement or are inaccurate, you must notify the Insurer accordingly within thirty (30) days following the delivery of the policy. Failure to notify the Insurer of any inaccuracy or erroneous statement can render the contract void.

Subject to the provisions and riders of the policy, the Insurer will pay the benefits listed below when a covered event occurs.

Should the Insurer receive a request to cancel the contract or a stop-payment order on any premium due, all obligations of the Insurer under the contract terminate immediately as of the date such is received.

Description of Coverage(s)	Benefit(s)	Modal Premium

Part A – Definitions

When used in this *Policy*, the terms listed below mean:

Accident (or Accidental): an event that occurs while the *Policy* is in force and whose cause is external, violent, sudden, fortuitous and beyond the *Insured*'s control. If an *Accident* results in a loss that first appears over ninety (90) days after the *Accident*, that loss is considered to be the result of *Sickness*.

Activities of Daily Living: the series of actions that a person performs daily for the purpose of eating, dressing, transferring, bathing, toileting and continence:

- **eating:** the ability to consume food that has been prepared and served, with or without the use of adaptive utensils;
- **dressing:** the ability to put on or remove necessary clothing, including orthotics, artificial limbs or other surgical prostheses;
- **transferring:** the ability to transfer oneself in some manner from a bed, a chair or a wheelchair, with or without the use of ancillary equipment;
- **bathing:** the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the use of equipment;
- **toileting:** the ability to get to and from the toilet and maintain personal hygiene;
- **continence:** the ability to manage bowel and bladder function with or without protective undergarments so that a reasonable level of hygiene is maintained.

Beneficiary: a natural or legal person designated by the *Policyowner* in any written notice filed with the *Insurer* as being entitled to receive benefits under this *Policy*.

Care of a Physician: regular and personal care that is provided by a *Physician* and that, based on current medical standards, is appropriate for the condition underlying the *Insured*'s *Disability*.

Disability (or Disabled): the *Insured*'s state of *Total Disability*, due to a condition resulting from an *Accident* or *Sickness*.

Injury: bodily I*njury* resulting directly or indirectly from an *Accident* sustained by the *Insured* and independently of any *Sickness* or other cause, while this *Policy* is in force.

Insurance age: age of the Insured at the last anniversary of the *Policy*.

Insured/Policyowner: the person who owns this *Policy*.

Insurer: Humania Assurance Inc., whose head office is located at 1555 Girouard Street West, Saint-Hyacinthe, Quebec, J2S 2Z6.

Non-Life-Threatening Cancer:

- stage A (T1a or T1b) prostate cancer; or
- stage 1A malignant melanoma as defined by the TNM classification (no more than one (1.0) millimetre thick, without ulceration and without invasion at Clark's Level IV or V); or
- ductal breast carcinoma in situ (requires confirmation through biopsy).

Non-Smoker: a person who has not used tobacco in any form whatsoever, including nicotine substitutes, nicotine products, marijuana or hashish, in the twelve (12) months before signing the application for insurance or reinstatement.

Person Insured: the person designated as such in the application.

Physician: any person legally authorized to practice medicine in Canada within the scope of his or her medical degree (M.D.), and who does not have a family or business relationship with the *Insured* or the *Policyowner*.

Policy: the present contract, the application for this *Policy*, any application for reinstatement and any written request for change to the contract.

Risk Class: the characteristics of the *Insured* that determine the premium rate for a coverage. Risk Classes are based on the *Insured*'s gender, age, tobacco use and health.

Sickness: a deterioration of health or a disorder of the body confirmed by a *Physician*, that is not caused by an *Injury,* and whose first symptoms appear while this *Policy* is in force.

Specialist Physician: a *Physician* who holds a specialised medical degree relevant to the covered Critical Illness for which a benefit is requested.

Survival Period: a period of thirty (30) days, unless stipulated otherwise in the definition of the covered Illness, during which the Insured must survive after the date at which a covered Illness is diagnosed, in order for the benefit amount to be payable.

Total Disability (or Totally Disabled): For a *Insured* who holds remunerative *Work* at the start of the *Disability*, it is the state of an *Insured* who, as a result of an *Accident* or a *Sickness*, is unable, during the *Waiting Period* and for a period of up to twenty-four (24) months immediately following the *Waiting Period*, to perform the main duties of his or her *Work* when the *Disability* begins and who, during that period, does not hold other employment, and is under the continuous and appropriate treatment and *Care of a Physician*.

Thereafter, it is the state of an *Insured* who, as a result of an *Accident* or a *Sickness*, is unable to perform any remunerative *Work* that he or she is reasonably qualified to perform based on his or her education, training or experience and who remains under the continuous and appropriate treatment and *Care of a Physician*.

For an *Insured* who is without *Work* at the start of the *Disability*, it is the state of a *Insured* who, as a result of an *Accident* or a *Sickness*, is unable to perform any remunerative *Work* that he or she is reasonably qualified to perform based on his or her education, training or experience and who remains under the continuous and appropriate treatment and *Care of a Physician*.

Waiting Period: a period, expressed in number of days, during which no benefit is payable. The *Waiting Period* begins on the date of the first medical consultation related to the *Disability* after the onset of that *Disability.*

Work: means the gainful or remunerative occupation(s), employment or *Work* performed by the *Insured* when the *Disability* begins.

Part B – Critical Illness Coverage
25 Illness
Renewable to age 75, Convertible to age 60

Benefits

While the coverage is in force, the Insurer will pay:

The Critical Illness benefit indicated in the Schedule of Benefits if a Critical Illness covered by this Policy occurs, less any amount paid under the terms of this Policy for a Non-Life-Threatening Cancer.

However, this benefit is payable only if the Person Insured is still living after a period of thirty (30) days following the date of diagnosis or after the period specified for that diagnosed covered Illness, excluding the number of days during which the person is on artificial life support.

The benefit amount payable by the Insurer for a Non-Life Threatening Cancer is equal to ten percent (10%) of the Critical Illness Amount insured indicated in the Schedule of Benefits, subject to a maximum of ten thousand dollars ($10,000). This benefit is payable only once while the coverage is in force, and shall be deducted from any other benefit payable under this condition.

Payment Conditions

The benefit is payable only for the first manifestation of a Critical Illness.

Critical Illness benefits are not cumulative. As such, the Insurer's liability is limited to a single benefit under this coverage, that is, the benefit that entitles the Insured to the highest amount. However, an exception applies with respect to the benefit for Non-Life-Threatening Cancer.

Diagnosis in Canada
The diagnosis of a Critical Illness must be made by a Specialist Physician licensed to practice in Canada and must be confirmed by customary modern investigation techniques appropriate to that Illness at the time of claim.

Diagnosis outside Canada
When a Critical Illness is diagnosed outside Canada by a Specialist Physician exercising in a jurisdiction deemed acceptable by the Insurer, the benefit is paid provided all the following conditions are met:

a) the Insurer has received all medical records;

b) based on the medical records received, the Insurer is certain that:

   i) the same diagnosis would have been made had the Critical Illness or Accident been diagnosed by a duly licensed Specialist Physician practicing in Canada; and

   ii) the same treatment would have been prescribed in accordance with Canadian standards; and

   iii) the same treatment, including any necessary surgery, would have been prescribed had the treatment been administered in Canada.

The Insurer may require the Person Insured to undergo one or more independent medical examinations with a Physician of the Insurer's choice. In the case of elective surgery, the required medical examination must be performed prior to the surgery.

Exclusions

In addition to the exclusions stipulated in the General Provisions, no amount is payable if the Illness or Accident results directly or indirectly from an undeclared Illness that is diagnosed, or from undeclared signs or symptoms that are known or are being investigated, before the date at which the coverage is issued.

No benefit is payable for any Cancer or Benign Brain Tumour, for the entire duration of the coverage, if the date of diagnosis for any Cancer whether covered or excluded under this coverage or Benign Brain Tumour, occurs within ninety (90) days of the coverage's effective date or reinstatement, or if the date at which signs or symptoms appear or at which medical consultations or tests leading to a diagnosis of any Cancer whether covered or excluded under this coverage or Benign Brain Tumour, are conducted within ninety (90) days of the coverage's effective date or reinstatement.

Disclosure Obligation
Any diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Premium

The Schedule of Premiums included in this Policy determines the premium payable at every renewal period.

The renewal of premiums indicated in the Schedule of Premiums is guaranteed provided the premium is paid within the required period.

Conversion Privilege

While the Critical Illness coverage under this Policy is in force and prior to the policy anniversary immediately following the Person Insured's sixtieth (60th) birthday, the Insured may request that such coverage be converted without evidence of the Person Insured's insurability, to a new permanent Critical Illness insurance policy with similar benefits as designated by the Insurer on this date. The converted benefit cannot exceed the benefit indicated in the Schedule of Benefits.

The premium for the new policy shall be based on:

- the Person Insured's Insurance Age at the time of conversion;
- the premium rates in use at the date of conversion; and
- the Risk Class of this coverage.

If this coverage is issued with an extra premium or with limitations and exclusions, the converted coverage will also be issued subject to the same conditions.

If, at the time of conversion, this coverage includes the Waiver of Premium Coverage, the new policy will also include a Waiver of Premium Coverage, provided the Insured's premiums are not waived at the time of conversion.

Limitation

If the conversion occurs while the Insured's premiums are waived, the new policy will not include that coverage and the Insured will be required to pay the premiums.

Termination of Coverage

In addition to the terms of the General Provisions, this coverage terminates at the earliest of the following dates:

- the date a written request to this effect is received from the Insured or the date stipulated in that request, if later than the date of receipt by the Insurer;
- the date when a Critical Illness benefit is paid under this coverage, with the exception for any benefit paid for Non-Life-Threatening Cancer;
- the date at which the entire coverage is converted;
- the date of termination of this coverage, as indicated in the Schedule of Benefits;
- the date the Person Insured dies.

Critical Illness Coverage

For the purposes of this Policy, you are covered for the following 25 Critical Illnesses, as defined hereunder:

Alzheimer's Disease *is defined as:*

A definitive clinical diagnosis, by a Specialist Physician, of Alzheimer's disease, which is a progressive degenerative disease of the brain. The Person Insured must present signs of significant loss of intellectual capacity impairing memory and judgment and resulting in significantly reduced mental and social functioning, such that the Person Insured requires continuous daily supervision. All other dementing organic brain disorders or psychiatric Illnesses are excluded.

Aortic Surgery *is defined as:*

Surgery to correct a condition of the aorta requiring surgical replacement of the affected artery with a graft. "Aorta" or "aortic" refers to the thoracic and abdominal aorta, excluding its branches.

Autism *is defined as:*

An organic abnormality in brain development, characterized by the inability to develop a language of communication or other forms of social communication. The diagnosis must be confirmed by a Specialist Physician before the Person Insured's third (3rd) birthday.

Benign Brain Tumour *is defined as:*

A non-malignant tumour of the brain or meninges. The histological nature of the tumour must be confirmed by an examination of tissues through biopsy or surgical excision. Tumours of the bony cranium and pituitary microadenomas of less than ten (10) millimetres in diameter are excluded.

Moratorium period: No benefit is payable for any Cancer or Benign Brain Tumour when the earliest of the following dates occurs within ninety (90) days of this coverage's effective date or reinstatement:

- the date of diagnosis for any Cancer, whether covered or excluded, or for Benign Brain Tumour; or
- the date at which any early signs or symptoms for any Cancer, whether covered or excluded, or for Benign Brain Tumour appear; or
- the date at which the Person Insured has any medical consultation or test leading to the diagnosis of any Cancer, whether covered or excluded, or of Benign Brain Tumour.

However, these exclusions do not result in termination of the coverage. The Person Insured remains insured against the other covered Illnesses.

Disclosure Obligation: Any diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Blindness *is defined as:*

Total and irrecoverable loss of sight in both (2) eyes, confirmed by an ophthalmologist, with a corrected visual acuity of twenty over two hundred (20/200) or less in each eye, or a field of vision of less than twenty (20) degrees in both (2) eyes.

Burns *are defined as:*

Third-degree burns over at least twenty percent (20%) of the body surface.

Cancer *is defined as:*

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

The following forms of cancer are excluded:

- carcinoma in situ;
- stage 1A malignant melanoma as defined by the TNM classification (no more than one (1.0) millimetre thick, without ulceration and without invasion at Clark's Level IV or V);
- any non-melanoma skin cancer that has not become metastatic (spread to adjacent organs);
- stage A (T1a or T1b) prostate cancer.

Moratorium period: No benefit is payable for any Cancer when the earliest of the following dates occurs within ninety (90) days of this coverage's effective date or reinstatement:

- the date of diagnosis for any Cancer, whether covered or excluded; or
- the date at which any early signs or symptoms for any Cancer, whether covered or excluded, appear; or
- the date at which the Person Insured has any medical consultation or test leading to the diagnosis of any Cancer, whether covered or excluded.

However, these exclusions do not result in termination of the coverage. The Person Insured remains insured against the other covered Illnesses.

Disclosure Obligation: Any diagnosis of Cancer (whether covered or excluded under this coverage) or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Coma *is defined as:*

A state of unconsciousness without reaction to external stimuli or response to internal needs for a continuous period of four (4) days. The Glasgow Coma Scale must continuously indicate four (4) or less during the four (4) days.

Exclusions:

- a medically induced coma;
- a coma resulting directly from alcohol or drug use.

Coronary Surgery (coronary artery bypass surgery) *is defined as:*

Heart surgery that uses a coronary artery bypass to correct the narrowing or obstruction of at least one coronary artery. Non-surgical procedures such as angioplasty and laser relief of obstruction are not covered.

Cystic Fibrosis *is defined as:*

A final diagnosis of cystic fibrosis made before the Person Insured reaches the age of eighteen (18), as evidenced by chronic lung disease and pancreatic failure.

Deafness *is defined as:*

Total and irrecoverable loss of hearing in both (2) ears, with a hearing threshold of ninety (90) decibels or greater, within a speech threshold of five hundred (500) to three thousand (3,000) cycles per second.

Heart Attack (myocardial infarction) *is defined as:*

Necrosis of a portion of the cardiac muscle resulting from inadequate blood supply, as evidenced by:

- recent electrocardiographic (ECG) changes indicative of a myocardial infarction; and
- elevation of cardiac biochemical markers to levels considered diagnostic for infarction.

Heart Attack during an angioplasty is covered provided new Q-wave changes on the electrocardiogram are diagnosed in addition to the elevation of cardiac markers.

Heart Attack does not include incidental discovery of ECG changes suggestive of a past symptomless myocardial infarction or a past myocardial infarction without a corroborating medical event.

Heart Valve Replacement *is defined as:*

Replacement of any heart valve with a natural valve, a valve made of animal tissue, or a mechanical valve. Heart valve repair is specifically excluded.

Kidney Failure *is defined as:*

End stage of the chronic, irreversible failure of both (2) kidneys, requiring treatment through regular dialysis, peritoneal dialysis or kidney transplant.

Loss of Autonomy *is defined as:*

A definitive diagnosis, by a Specialist Physician, for a continuous period of ninety (90) days, confirming the Person Insured's complete and permanent inability to perform, on his or her own, at least two (2) of the six (6) Activities of Daily Living listed in that definition, without reasonable likelihood of recovery, or confirming a **Cognitive Impairment** as defined below.

Cognitive Impairment *is defined as:*

Mental deterioration and loss of mental capacity resulting in a deterioration of memory, orientation and the faculty of reason, which are measurable and due to an objective organic cause, diagnosed by a Specialist Physician. The degree of cognitive impairment must be serious enough to warrant continuous daily supervision.

The finding of cognitive impairment must be based on clinical data and standardized assessments, validating the impairment. Any mental or nervous disorder without a demonstrable organic cause is not covered.

Loss of Limbs *is defined as:*

Irreversible severance of two (2) or more limbs above the wrist or ankle joint, resulting from an Accident or a medically necessary amputation. A loss resulting directly from drug or alcohol use is excluded.

Loss of Speech *is defined as:*

The total and irrecoverable loss of the faculty of speech, resulting from an Injury or a physical and persistent Illness for a continuous period of at least one hundred and eighty (180) days. Any psychiatric cause is specifically excluded.

Major Organ Failure on Waiting List *is defined as:*

The diagnosis of irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. Transplantation must be medically necessary.

To qualify under Major Organ Failure on Waiting List, the Person Insured must be an eligible recipient, as part of an approved government program for organ or bone marrow transplant in Canada or in the United States, for one (1) or more organs or of bone marrow, as specified in this clause.

With respect to the Survival Period, the date of diagnosis is the date at which the Person Insured's registration with the transplant program takes effect.

Major Organ Transplant *is defined as:*

The diagnosis of irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. Transplantation must be medically necessary.

To qualify under Major Organ Transplant, the Person Insured must undergo surgery to receive transplantation of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. For the purposes of this coverage, "Major Organ Transplant" is limited to the organs specified in this paragraph.

Motor Neuron Disease *is defined as:*

A definitive diagnosis of one of the following diseases: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, spinal muscular atrophy, progressive bulbar palsy or pseudobulbar palsy. For the purposes of this coverage, "Motor Neuron Disease" is limited to the diseases specified above.

Multiple Sclerosis *is defined as:*

A definitive diagnosis, by a neurologist, of multiple sclerosis, characterized by well-defined neurological abnormalities that persist for a continuous period of at least six (6) months or with two (2) separate episodes, documented with clinical facts. The disseminated demyelinating lesions must be confirmed by magnetic resonance imaging (MRI) or by a medical imaging technique customarily used to diagnose multiple sclerosis.

Occupational HIV *is defined as:*

A diagnosis of infection by the human immunodeficiency virus (HIV), resulting from Accidental Injury in the course of the Person Insured performing the regular duties of his or her Occupation, which exposes him or her to body fluids contaminated with HIV.

The benefit will be payable provided all of the following criteria are met:

a) the Accidental Injury must be reported to the Insurer within fourteen (14) days of the Accidental event;
b) a test for HIV must be performed within fourteen (14) days of the Accidental Injury and the result must be negative;
c) a test for HIV must be performed between ninety (90) and one hundred and eighty (180) days after the Accidental Injury and the result must be positive;
d) all HIV tests must be conducted by a laboratory approved by the Insurer;
e) the Accidental Injury must be reported, investigated and documented in accordance with Canadian labour standards.

No benefit will be payable if:

a) the Person Insured refuses a vaccine that is approved and available and that offers protection from HIV;
b) an approved preventive or curative treatment for HIV infection becomes available before the Accidental Injury;
c) the HIV infection was contracted otherwise than as the result of Accidental Injury (including, but not limited to, sexual transmission or the use of intravenous drugs).

Paralysis *is defined as:*

Complete and permanent loss of use of two (2) or more limbs during a continuous period of ninety (90) days following the event giving rise to the loss, without any sign of improvement during that period. Any psychiatric cause is specifically excluded.

Parkinson's Disease *is defined as:*

A definitive clinical diagnosis, by a Specialist Physician, of primary idiopathic Parkinson's disease, which is characterized by at least two (2) of the following clinical features: muscle rigidity, tremor or bradykinesia (abnormal slowing of movement, slowing of physical and mental reactions). The Person Insured must require substantial physical help from another adult to perform two (2) or more of the following six (6) Activities of Daily Living: bathing, dressing, toileting, continence, transferring or eating, as specified in the definitions. Any other type of parkinsonism is specifically excluded.

Stroke *is defined as:*

A cerebrovascular accident that produces neurological sequelae that last over thirty (30) days and are caused by thrombosis, hemorrhage or extracranial embolism. There must be evidence of objective, measurable neurological deficit. Transient ischemic attacks (TIAs) are specifically excluded.

Part B – Critical Illness Coverage
25 Illness
Coverage to age 75, Convertible to age 60

Benefits

While the coverage is in force, the Insurer will pay:

The Critical Illness benefit indicated in the Schedule of Benefits if a Critical Illness covered by this Policy occurs, less any amount paid under the terms of this Policy for a Non-Life-Threatening Cancer.

However, this benefit is payable only if the Person Insured is still living after a period of thirty (30) days following the date of diagnosis or after the period specified for that diagnosed covered Illness, excluding the number of days during which the person is on artificial life support.

The benefit amount payable by the Insurer for a Non-Life Threatening Cancer is equal to ten percent (10%) of the Critical Illness Amount insured indicated in the Schedule of Benefits, subject to a maximum of ten thousand dollars ($10,000). This benefit is payable only once while the coverage is in force, and shall be deducted from any other benefit payable under this condition.

Payment Conditions

The benefit is payable only for the first manifestation of a Critical Illness.

Critical Illness benefits are not cumulative. As such, the Insurer's liability is limited to a single benefit under this coverage, that is, the benefit that entitles the Insured to the highest amount. However, an exception applies with respect to the benefit for Non-Life-Threatening Cancer.

Diagnosis in Canada
The diagnosis of a Critical Illness must be made by a Specialist Physician licensed to practice in Canada and must be confirmed by customary modern investigation techniques appropriate to that Illness at the time of claim.

Diagnosis outside Canada
When a Critical Illness is diagnosed outside Canada by a Specialist Physician exercising in a jurisdiction deemed acceptable by the Insurer, the benefit is paid provided all the following conditions are met:

a) the Insurer has received all medical records;

b) based on the medical records received, the Insurer is certain that:

   i) the same diagnosis would have been made had the Critical Illness or Accident been diagnosed by a duly licensed Specialist Physician practicing in Canada; and

   ii) the same treatment would have been prescribed in accordance with Canadian standards; and

   iii) the same treatment, including any necessary surgery, would have been prescribed had the treatment been administered in Canada.

The Insurer may require the Person Insured to undergo one or more independent medical examinations with a Physician of the Insurer's choice. In the case of elective surgery, the required medical examination must be performed prior to the surgery.

Exclusions

In addition to the exclusions stipulated in the General Provisions, no amount is payable if the Illness or Accident results directly or indirectly from an undeclared Illness that is diagnosed, or from undeclared signs or symptoms that are known or are being investigated, before the date at which the coverage is issued.

No benefit is payable for any Cancer or Benign Brain Tumour, for the entire duration of the coverage, if the date of diagnosis for any Cancer whether covered or excluded under this coverage or Benign Brain Tumour, occurs within ninety (90) days of the coverage's effective date or reinstatement, or if the date at which signs or symptoms appear or at which medical consultations or tests leading to a diagnosis of any Cancer whether covered or excluded under this coverage or Benign Brain Tumour, are conducted within ninety (90) days of the coverage's effective date or reinstatement.

Disclosure Obligation
Any diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Premium

The premium for this coverage is indicated in the Schedule of Benefits. The premium is fixed and payable until the date of termination of the Policy.

Conversion Privilege

While the Critical Illness coverage under this Policy is in force and prior to the policy anniversary immediately following the Person Insured's sixtieth (60^{th}) birthday, the Insured may request that such coverage be converted without evidence of the Person Insured's insurability, to a new permanent Critical Illness insurance policy with similar benefits as designated by the Insurer on this date. The converted benefit cannot exceed the benefit indicated in the Schedule of Benefits.

The premium for the new policy shall be based on:

- the Person Insured's Insurance Age at the time of conversion;
- the premium rates in use at the date of conversion; and
- the Risk Class of this coverage.

If this coverage is issued with an extra premium or with limitations and exclusions, the converted coverage will also be issued subject to the same conditions.

If, at the time of conversion, this coverage includes the Waiver of Premium Coverage, the new policy will also include a Waiver of Premium Coverage, provided the Insured's premiums are not waived at the time of conversion.

Limitation

If the conversion occurs while the Insured's premiums are waived, the new policy will not include that coverage and the Insured will be required to pay the premiums.

Termination of Coverage

In addition to the terms of the General Provisions, this coverage terminates at the earliest of the following dates:

- the date a written request to this effect is received from the Insured or the date stipulated in that request, if later than the date of receipt by the Insurer;
- the date when a Critical Illness benefit is paid under this coverage, with the exception for any benefit paid for Non-Life-Threatening Cancer;
- the date at which the entire coverage is converted;
- the date of termination of this coverage, as indicated in the Schedule of Benefits;
- the date the Person Insured dies.

Critical Illness Coverage

For the purposes of this Policy, you are covered for the following 25 Critical Illnesses, as defined hereunder:

Alzheimer's Disease *is defined as:*

A definitive clinical diagnosis, by a Specialist `Physician`, of Alzheimer's disease, which is a progressive degenerative disease of the brain. The Person Insured must present signs of significant loss of intellectual capacity impairing memory and judgment and resulting in significantly reduced mental and social functioning, such that the Person Insured requires continuous daily supervision. All other dementing organic brain disorders or psychiatric Illnesses are excluded.

Aortic Surgery *is defined as:*

Surgery to correct a condition of the aorta requiring surgical replacement of the affected artery with a graft. "Aorta" or "aortic" refers to the thoracic and abdominal aorta, excluding its branches.

Autism *is defined as:*

An organic abnormality in brain development, characterized by the inability to develop a language of communication or other forms of social communication. The diagnosis must be confirmed by a Specialist `Physician` before the Person Insured's third (3rd) birthday.

Benign Brain Tumour *is defined as:*

A non-malignant tumour of the brain or meninges. The histological nature of the tumour must be confirmed by an examination of tissues through biopsy or surgical excision. Tumours of the bony cranium and pituitary microadenomas of less than ten (10) millimetres in diameter are excluded.

Moratorium period: No benefit is payable for any Cancer or Benign Brain Tumour when the earliest of the following dates occurs within ninety (90) days of this coverage's effective date or reinstatement:

- the date of diagnosis for any Cancer, whether covered or excluded, or for Benign Brain Tumour; or
- the date at which any early signs or symptoms for any Cancer, whether covered or excluded, or for Benign Brain Tumour appear; or
- the date at which the Person Insured has any medical consultation or test leading to the diagnosis of any Cancer, whether covered or excluded, or of Benign Brain Tumour.

However, these exclusions do not result in termination of the coverage. The Person Insured remains insured against the other covered Illnesses.

Disclosure Obligation: Any diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Blindness *is defined as:*

Total and irrecoverable loss of sight in both (2) eyes, confirmed by an ophthalmologist, with a corrected visual acuity of twenty over two hundred (20/200) or less in each eye, or a field of vision of less than twenty (20) degrees in both (2) eyes.

Burns *are defined as:*

Third-degree burns over at least twenty percent (20%) of the body surface.

Cancer *is defined as:*

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

The following forms of cancer are excluded:

- carcinoma in situ;
- stage 1A malignant melanoma as defined by the TNM classification (no more than one (1.0) millimetre thick, without ulceration and without invasion at Clark's Level IV or V);
- any non-melanoma skin cancer that has not become metastatic (spread to adjacent organs);
- stage A (T1a or T1b) prostate cancer.

Moratorium period: No benefit is payable for any Cancer when the earliest of the following dates occurs within ninety (90) days of this coverage's effective date or reinstatement:

- the date of diagnosis for any Cancer, whether covered or excluded; or
- the date at which any early signs or symptoms for any Cancer, whether covered or excluded, appear; or
- the date at which the Person Insured has any medical consultation or test leading to the diagnosis of any Cancer, whether covered or excluded.

However, these exclusions do not result in termination of the coverage. The Person Insured remains insured against the other covered Illnesses.

Disclosure Obligation: Any diagnosis of Cancer (whether covered or excluded under this coverage) or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Coma *is defined as:*

A state of unconsciousness without reaction to external stimuli or response to internal needs for a continuous period of four (4) days. The Glasgow Coma Scale must continuously indicate four (4) or less during the four (4) days.

Exclusions:

- a medically induced coma;
- a coma resulting directly from alcohol or drug use.

Coronary Surgery (coronary artery bypass surgery) *is defined as:*

Heart surgery that uses a coronary artery bypass to correct the narrowing or obstruction of at least one coronary artery. Non-surgical procedures such as angioplasty and laser relief of obstruction are not covered.

Cystic Fibrosis *is defined as:*

A final diagnosis of cystic fibrosis made before the Person Insured reaches the age of eighteen (18), as evidenced by chronic lung disease and pancreatic failure.

Deafness *is defined as:*

Total and irrecoverable loss of hearing in both (2) ears, with a hearing threshold of ninety (90) decibels or greater, within a speech threshold of five hundred (500) to three thousand (3,000) cycles per second.

Heart Attack (myocardial infarction) *is defined as:*

Necrosis of a portion of the cardiac muscle resulting from inadequate blood supply, as evidenced by:

- recent electrocardiographic (ECG) changes indicative of a myocardial infarction; and
- elevation of cardiac biochemical markers to levels considered diagnostic for infarction.

Heart Attack during an angioplasty is covered provided new Q-wave changes on the electrocardiogram are diagnosed in addition to the elevation of cardiac markers.

Heart Attack does not include incidental discovery of ECG changes suggestive of a past symptomless myocardial infarction or a past myocardial infarction without a corroborating medical event.

Heart Valve Replacement *is defined as:*

Replacement of any heart valve with a natural valve, a valve made of animal tissue, or a mechanical valve. Heart valve repair is specifically excluded.

Kidney Failure *is defined as:*

End stage of the chronic, irreversible failure of both (2) kidneys, requiring treatment through regular dialysis, peritoneal dialysis or kidney transplant.

Loss of Autonomy *is defined as:*

A definitive diagnosis, by a Specialist `Physician`, for a continuous period of ninety (90) days, confirming the Person Insured's complete and permanent inability to perform, on his or her own, at least two (2) of the six (6) Activities of Daily Living listed in that definition, without reasonable likelihood of recovery, or confirming a **Cognitive Impairment** as defined below.

Cognitive Impairment *is defined as:*

Mental deterioration and loss of mental capacity resulting in a deterioration of memory, orientation and the faculty of reason, which are measurable and due to an objective organic cause, diagnosed by a Specialist `Physician`. The degree of cognitive impairment must be serious enough to warrant continuous daily supervision.

The finding of cognitive impairment must be based on clinical data and standardized assessments, validating the impairment. Any mental or nervous disorder without a demonstrable organic cause is not covered.

Loss of Limbs *is defined as:*

Irreversible severance of two (2) or more limbs above the wrist or ankle joint, resulting from an Accident or a medically necessary amputation. A loss resulting directly from drug or alcohol use is excluded.

Loss of Speech *is defined as:*

The total and irrecoverable loss of the faculty of speech, resulting from an Injury or a physical and persistent Illness for a continuous period of at least one hundred and eighty (180) days. Any psychiatric cause is specifically excluded.

Major Organ Failure on Waiting List *is defined as:*

The diagnosis of irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. Transplantation must be medically necessary.

To qualify under Major Organ Failure on Waiting List, the Person Insured must be an eligible recipient, as part of an approved government program for organ or bone marrow transplant in Canada or in the United States, for one (1) or more organs or of bone marrow, as specified in this clause.

With respect to the Survival Period, the date of diagnosis is the date at which the Person Insured's registration with the transplant program takes effect.

Major Organ Transplant *is defined as:*

The diagnosis of irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. Transplantation must be medically necessary.

To qualify under Major Organ Transplant, the Person Insured must undergo surgery to receive transplantation of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. For the purposes of this coverage, "Major Organ Transplant" is limited to the organs specified in this paragraph.

Motor Neuron Disease *is defined as:*

A definitive diagnosis of one of the following diseases: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, spinal muscular atrophy, progressive bulbar palsy or pseudobulbar palsy. For the purposes of this coverage, "Motor Neuron Disease" is limited to the diseases specified above.

Multiple Sclerosis *is defined as:*

A definitive diagnosis, by a neurologist, of multiple sclerosis, characterized by well-defined neurological abnormalities that persist for a continuous period of at least six (6) months or with two (2) separate episodes, documented with clinical facts. The disseminated demyelinating lesions must be confirmed by magnetic resonance imaging (MRI) or by a medical imaging technique customarily used to diagnose multiple sclerosis.

Occupational HIV *is defined as:*

A diagnosis of infection by the human immunodeficiency virus (HIV), resulting from Accidental Injury in the course of the Person Insured performing the regular duties of his or her Occupation, which exposes him or her to body fluids contaminated with HIV.

The benefit will be payable provided all of the following criteria are met:

a) the Accidental Injury must be reported to the Insurer within fourteen (14) days of the Accidental event;
b) a test for HIV must be performed within fourteen (14) days of the Accidental Injury and the result must be negative;
c) a test for HIV must be performed between ninety (90) and one hundred and eighty (180) days after the Accidental Injury and the result must be positive;
d) all HIV tests must be conducted by a laboratory approved by the Insurer;
e) the Accidental Injury must be reported, investigated and documented in accordance with Canadian labour standards.

No benefit will be payable if:

a) the Person Insured refuses a vaccine that is approved and available and that offers protection from HIV;
b) an approved preventive or curative treatment for HIV infection becomes available before the Accidental Injury;
c) the HIV infection was contracted otherwise than as the result of Accidental Injury (including, but not limited to, sexual transmission or the use of intravenous drugs).

Paralysis *is defined as:*

Complete and permanent loss of use of two (2) or more limbs during a continuous period of ninety (90) days following the event giving rise to the loss, without any sign of improvement during that period. Any psychiatric cause is specifically excluded.

Parkinson's Disease *is defined as:*

A definitive clinical diagnosis, by a Specialist `Physician`, of primary idiopathic Parkinson's disease, which is characterized by at least two (2) of the following clinical features: muscle rigidity, tremor or bradykinesia (abnormal slowing of movement, slowing of physical and mental reactions). The Person Insured must require substantial physical help from another adult to perform two (2) or more of the following six (6) Activities of Daily Living: bathing, dressing, toileting, continence, transferring or eating, as specified in the definitions. Any other type of parkinsonism is specifically excluded.

Stroke *is defined as:*

A cerebrovascular accident that produces neurological sequelae that last over thirty (30) days and are caused by thrombosis, hemorrhage or extracranial embolism. There must be evidence of objective, measurable neurological deficit. Transient ischemic attacks (TIAs) are specifically excluded.

Part B – Waiver of Premium Coverage in case of Total Disability of the Insured

Benefit

While this Waiver of Premium coverage is in force, the *Insurer* will waive the premiums under this *Policy* until the *Policy* anniversary following the *Person Insured*'s sixty-fifth (65th) birthday, as long as the following requirements are satisfied:

- the *Person Insured* has been *Totally Disabled* for a period of six (6) consecutive months;
- the *Person Insured*'s *Total Disability* is caused by a *Sickness* or an *Accident* that occurred while this Waiver of Premium coverage was in force; and
- the *Person Insured* remains *Totally Disabled*.

After the *Insurer* is satisfied that the *Person Insured* is entitled to have premiums waived under this *Policy* pursuant to this Waiver of Premium coverage, any premiums due under this *Policy* during the six (6) months *Waiting Period* will be waived retroactively.

Termination of coverage

In addition to the terms of this *Policy*'s General Provisions, this Waiver of Premium coverage terminates at the earliest of the following dates:

- the date a written request from the *Insured* is received by the *Insurer* stating that he wishes to terminate this Waiver of Premium coverage or the date stipulated in that request if such date is later than the date of receipt by the *Insurer;*
- the *Policy* anniversary following the *Person Insured*'s sixty-fifth (65^{th}) birthday; or
- the date on which the *Person Insured* dies.

General provisions

The definitions, limitations and exclusions of this Waiver of Premium coverage apply in addition to those indicated in this *Policy*'s General Provisions.

Part C – General Provisions

Effective date

This Policy takes effect on the date the Insurer approves the application, provided the application is approved without change, the first premium has been paid, and no change has occurred in the Person Insured's insurability since signing the application.

Premiums

The premium of each coverage is indicated in the Schedule of Benefits.

Method of payment

The premium is payable monthly by pre-authorized debit or yearly, at the choice of the Insured. Where a cheque or other bill of exchange or a promissory note or other written promise to pay is given for the whole or part of a premium and payment is not made according to its tenor, the premium or part thereof shall be deemed never to have been paid.

Exclusions

The following exclusions apply to the Waiver of Premium and the Accidental Death and Dismemberment benefits if those coverages are part of this Policy.

No Critical Illness, Waiver of Premium or Accidental Death and Dismemberment benefits will be payable that result from:

- attempted suicide or intentionally self-inflicted Injury or dismemberment, whether the Person Insured is sane or insane;
- the Person Insured's participation in the commission or attempted commission of an unlawful act or crime, driving a motor vehicle or piloting a boat while under the influence of narcotics or while his or her blood alcohol concentration exceeded the legal limit;
- drug addiction, alcohol abuse or the use of hallucinogens, drugs or narcotics;
- service, whether or not as a combatant, with armed forces engaged in surveillance, training, peacekeeping, insurrection, war (whether or not declared) or any related act, or the Insured's participation in a popular uprising.

No Waiver of Premium or Accidental Death and Dismemberment benefits will be payable that result from:

- injury sustained during a flight, except if the Person Insured is a passenger on an aircraft operated by a common carrier;
- cosmetic surgery or elective surgery, and any resulting complication;
- experimental treatments and treatments involving the application of new procedures or new treatments that are not yet standard practice.

No Waiver of Premium benefit will be payable for:

- any period during which the Person Insured is entitled to paid leave under an agreement between the Person Insured and his or her employer;

- pregnancy, childbirth, miscarriage or any resulting condition, except in the case of a pathologic complication;

- any period during which the Person Insured is incarcerated in a penitentiary or a government detention facility.

Age

For the purposes of this Policy, the Person Insured's age is the age attained at his or her last birthday preceding or coincident with the issuance of coverage. If, mistakenly or otherwise, the age used to calculate the premium is incorrect, any amount payable by the Insurer at the time of a claim will be adjusted to reflect the correct age at the date on which the Person Insured became insured.

Duty to disclose

The Person Insured, the Insured and the Beneficiary are required to cooperate fully with the Insurer and shall disclose to the Insurer in any application, on a medical examination, if any, and in any written statements or answers furnished as evidence of insurability, every fact within the person's knowledge that is material to the insurance and is not so disclosed by the other. The Person Insured, the Insured and the Beneficiary shall also sign any form or other document allowing the Insurer to obtain any information it deems relevant.

Subject to the provisions dealing with incontestability and age, failure to disclose or a misrepresentation of such a fact renders a contract voidable by the Insurer.

Incontestability

In the absence of fraud, the Insurer cannot cancel or reduce a coverage that has been in force for two (2) years or that was reinstated over two (2) years previous because of misrepresentation or concealment with respect to risk.

However, this rule does not apply to a claim for a covered critical illness whose first signs and symptoms appear before the coverage has been in effect for two (2) years with respect to the person for whom the claim is made.

Misrepresentation concerning smoking habits

If the premium for this Policy is based on statements in the application for insurance or reinstatement to the effect that the Person Insured does not use of tobacco in any form whatsoever, including nicotine substitutes, nicotine products, marijuana or hashish, and those statements are in fact false, they will be considered fraudulent and this Policy will be void from the effective date.

Accordingly, any claim paid by the Insurer must be reimbursed.

Policy and Coverage termination

Unless stipulated otherwise in a given coverage, this Policy and its coverages terminate at the earliest of the following dates:

- the date a written request to this effect is received from the Insured or the date stipulated in that request, if later than the date of receipt by the Insurer;

- the date when a Critical Illness benefit is paid under this coverage;
- the date at which the entire coverage is converted;
- the date of termination of this coverage, as indicated in the Schedule of Benefits;
- the date the Person Insured dies.

Reinstatement

If this Policy terminates because the premium was not paid, it may be reinstated within ninety (90) days the date of termination provided the Insured requests that it be reinstated, establishes the Person Insured's insurability to the Insurer's satisfaction and pays any outstanding premiums. The periods related to incontestability, the suicide and the moratorium period apply again as of the date of the last reinstatement.

Change of Beneficiary

Subject to applicable law, the Insured may at any time designate or change a Beneficiary or revoke a Beneficiary. For a change of Beneficiary to be recognized, the Insurer must receive written notice of that change. The Insurer bears no responsibility with respect to the validity of a Beneficiary designation or any change of Beneficiary.

Payment under the policy

Death benefits, critical Illness benefits and refund of premium benefits will be paid to the Beneficiary designated in the application or in any other document subsequently submitted to the Insurer by the Insured. Any other benefit shall be paid to the Person Insured or to the Insured if the Person Insured is a minor.

Reimbursement

No cheque in reimbursement of premiums will be issued for amounts of less than twenty dollars ($20).

Legal currency

Any payment under the provisions of this Policy will be made in the legal currency of Canada.

Right to cancel

The Insured may cancel this Policy within fifteen (15) days of the date of its receipt or within sixty (60) days after the date the Policy is issued, provided the Insured, returns the Policy accompanied by a written cancellation request. Any premium paid for the Policy will then be refunded.

Compliance with law

Any provision of the Policy that, at the effective date, does not comply with legislation of the province or territory in which the Policy was issued is amended so as to meet the minimum requirements of such legislation.

General provisions

The exclusions, limitations and General Provisions apply to the Policy as well as to all coverages when they are relevant.

Some coverages contain exclusions and limitations specific to those coverages. These exclusions and limitations apply in addition to the exclusions and limitations of the General Provisions.