Your Insurance Policy

Evolution Jr. Critical Illness

By Specialty Life insurance

HUMANIA ASSURANCE MD®

SLi SPECIALTY LIFE INSURANCE

SLI-EJCI025POL-0122EN

RIGHT TO EXAMINE AND RETURN POLICY WITHIN TEN DAYS

The Owner may, at any time within ten days after receipt of this Policy, return it to Specialty Life insurance or the advisor through whom it was purchased for cancellation. This Policy will be considered void as of the Effective Date if it is returned within those ten days, and any Premium paid will be refunded to the Owner.

Signed for Humania Assurance Inc. at Saint-Hyacinthe, Quebec, on the Issue Date.

Marc Peliel
President and
Chief Executive Officer

Luc Bergeron
Vice-president, Finance
and Treasurer

Welcome!

Ms. Test Client
123 Any Street,
Any City, ON L1L2L3

Congratulations on taking this important step to protect your loved ones, and thank you for letting Specialty Life help.

We have partnered with Humania Assurance Inc. to help individuals like you find the insurance products that best meet your lifestyle and financial needs. Our commitment is to helping you protect your family.

Please note that your insurance policy becomes effective as of the policy date and in accordance with the conditions set out in your policy contract. Before you put your policy away in a safe place, please take a few moments to review the policy and to verify the accuracy of all the personal information.

If you notice any incorrect information or errors in your policy, please contact us at 1.855.966.3580 or at the address provided at the bottom of this letter, as a single incorrect response or other misstatement could render your insurance contract invalid.

In accordance with the “Right to Examine and Return the Policy Within Ten Days,” if we do not hear back from you within ten days of the effective date of the policy, we will presume that you confirm the accuracy of all the content of your contract.

Thank you for your trust in Specialty Life and for choosing to do business with us. You can always rely on our team to provide professional, attentive service and to look after your insurance needs. We will be delighted to answer any questions you may have.

Sincerely,

Specialty Life

About Humania Assurance Inc.

Humania Assurance Inc. is a mutual insurance company that has been developing insurance solutions focused on the needs of Canadians for more than 80 years. It offers innovative web-based insurance coverage to simplify and speed up the process at a competitive price. Our mission: MAKE INSURANCE ACCESSIBLE.

Schedule of Benefits and Premiums

Contract Information

Policy Number:	SL0000000	Province of Issue:	
Policy Effective Date:	00-00-2020	Owner:	
Policy Termination Date:	00-00-2044	Beneficiary(s):	(100%)
Insured:	(name of the child)		

Summary of Insurance Coverage

Type of Policy: *Evolution Jr. Critical Illness* is a Temporary health insurance Policy. The premium paying period for the policy ends at the policy anniversary following the Life Insured's Age 25. Premiums are guaranteed not to change, unless there is a change to the information you provided in your Application.

Coverage Details

Life Insured:	
Sex:	
Issue Age:	
Class and Risk:	
Sum Insured:	$00,000
Premium paying period:	Until the insured's 25th birthday

Premium Details

Premium Frequency:	Monthly
Monthly Premium:	$00.00
This premium includes the policy fee:	*$5.00*

Premium Due Dates

In your application for insurance, you advised us that you wish to pay the premium Monthly. The First premium is due no later than 2020-07-01.

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**
The following coverages have the same effective date of February 2, 2020.		
Temporary Term Critical Illness insurance to age 25, renewable up to age 25	$	$00.00
Policy fees		$5.00
Premium payable on the 1st of each month		$00.00

This policy is guaranteed to be renewable up to age 25 as provided for in the policy, if it is maintained in force by payment of the premiums.

Signing Authority Signature: 

Signing Authority Print Name: Valérie Le Roux

Renewal Premium Schedule

Modal Premium on Renewal for the sum insured of:$00,000

Renewal Date (mm-yyyy)	Modal Premium (*)

(*) Monthly Premium

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Part A - Definitions

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

Activities of Daily Living:

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

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

Covered Critical Illnesses: list of critical illnesses found in Part B of this Policy. Each Covered Critical Illnesses is defined and their definitions, exclusions and limitations must be met for a benefit to become payable.

Family member: the Person Insured's mother, father, spouse, or child, biological or legally recognized.

Hospital: an institution recognized as an acute care hospital centre under legislation in the Person Insured's province of residence, excluding a long-term care unit or beds used for convalescents or chronically sick patients.
Hospital does not mean: a clinic, a health care centre, or a facility that provides mainly rehabilitative or nursing care, even if that facility is part of a Hospital or is associated with a Hospit.

Hospitalization (or Hospitalized): a stay of at least eighteen (18) hours in a Hospital as an in-patient.

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

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

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

Life Insured: The person designated as such in the application.

Owner: the person who owns this Policy.

Partial Payout Critical Illness: a Covered Critical Illness where the benefit payable is 15% of the critical illness coverage chosen.The partial amount is shown in the Schedule of Benefits of the Policy. The benefit amount is only paid once and is deducted from any other critical illness benefit payable by the Insurer. The list of Partial Payout Critical Illnesses can be found in Part B of this Policy.

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 Life Insured or the Owner.

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

Reasonable expenses: means expenses or fees calculated according to the standard schedule of fees in force in the Person Insured's province of residence.

Risk Class: the characteristics of the Life Insured that determine the premium rate for a coverage. Risk Classes are based on the Life 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: a Physician who holds a license and has specialized medical training related to the Covered Critical Illness for which a claim has been submitted.

Student: a person, under age 25, enrolled as a full-time student and who regularly attends day classes at a teaching institution, recognized as such by the Ministry of Education of the person's province of residence and holding the required permits.

Survival Period: period starting on the date of diagnosis of a Covered Critical Illness and ending thirty (30) days later. The Survival Period does not include the number of days on Life Support. The Person Insured must be alive at the end of the Survival Period and must not have experienced irreversible cessation of all functions of the brain.

Total Disability (or Totally Disabled): means a state of incapacity such that the Person Insured is prevented from engaging in any occupation, remunerative or not.

Part B - Benefits - Temporary Critical Illness Life Insurance to age 25, Renewable to age 25

Benefits

While the coverage is in force, the Insurer will pay, when of the following events occurs, the Critical Illness benefit indicated in the Schedule of Benefits if a Critical Illness covered by this Policy occur.

However, this benefit is payable only if the 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 fifteen percent (15%) of the Critical Illness Amount insured indicated in the Schedule of Benefits. This benefit is payable only once while the coverage is in force, and shall be deducted from any other benefit payable under this policy.

If the Insured is covered by more than one Insurance coverage issued by the Insurer, the maximum benefit is then limited to $50,000 for all of these coverages.

For Guaranteed Issue only: For the first two years from the Effective Date of the policy the Critical Illness benefit is equal to the total Premiums paid; plus simple interest, at a rate of 3 percent per annum, on the Premiums paid to the the date of diagnosis of a critical illness covered by this policy.

If the Insured is covered by more than one Insurance coverage issued by the Insurer, the maximum benefit is then limited to $12,500 for all of these coverages.

Payment Conditions

If the Insured suffered from a covered Critical Illness prior to the effective date of this coverage, no benefit will be payable for that category of Critical Illness. No Critical Illness benefit is payable when the Illness results from the Insured's intentional use of a drug or medication not prescribed by a Physician or other health professional or if the Insured has used a drug or medication prescribed by a Physician, a Specialist or an health professional not used as directed.

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 or United States 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 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 Summary of Coverages. The premium is guaranteed for the duration of the coverage.

Termination of coverage

The premium for this coverage is indicated in the Summary of Coverages. The premium is guaranteed for the duration of the coverage.

- The date a written request from the Owner is received by the Insurer, stating that he wishes to terminate this critical illness Insurance coverage, or the date stipulated in that request, if such date is later than the date of receipt by the Insurer;
- The date when a Critical Illness or Life insurance benefit becomes payable under this coverage, with the exception for any benefit paid for a Partial Payout Critical Illness;
- The date of termination of the policy, as indicated in the Schedule of Benefits;
- The date the Person Insured dies.

General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The Policy's General Provisions govern this coverage when they are relevant and compatible with the terms of this coverage.

Definitions

For the purposes of this Policy, the Life Insured is covered for the following Critical Illnesses, as defined hereunder:

Critical Illness

List and Definitions of Covered Critical Illness Categories diagnosed by a Physician or a Specialist while the Policy is in effect.

Specialist

A Specialist is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the insurer, a condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the policy owner, the insured, a relative of or business associate of the policy owner or of the insured. Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the policy owner, the insured, a relative of or business associate of the policy owner or of the insured.

Survival Period

Survival Period means the period starting on the Date of Diagnosis of the Critical Condition and ending 30 days later, except where modified elsewhere under the policy. The Survival Period does not include the number of days on Life Support. The Insured Person must be alive and must not have experienced irreversible cessation of all functions of the brain at the end of the Survival Period. For those CI conditions which have a qualifying period, for example, 90 days for Bacterial Meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Life Support means the Insured Person is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Please note that certain terms, such as, but not limited to, Irreversible and Surgery, as used in the definitions below, should be defined in the contract.

Alternative wording or terms may be required in the CI definitions based on the words or terms used elsewhere in the member company's contracts.

For example:
"Insured Person" could be replaced with terms such as "Insured", "plan member", "employee", or "group member".
"Condition" could be replaced with "critical illness" or "critical condition".

Alternative exclusion wording may also be required for group CI contracts.

For example:
"No benefit will be payable under this condition if, within the first 90 days following the later of, the date the person became insured or, for an increase in coverage, the effective date of the increase, the Insured Person has any of the following".

For the purposes of this Policy, you are covered for the following 31 Critical Illnesses, as defined hereunder:

Acquired brain injury: is defined as a diagnosis of new damage to brain tissue caused by traumatic injury, anoxia or encephalitis, resulting in signs and symptoms of neurological impairment that:

- Are present and verifiable on clinical examination or neuro-psychological testing;
- Are corroborated by imaging studies of the brain such as Magnetic Resonance Imaging (MRI) or Computerized Tomography (CT) showing changes that are consistent in character, location and timing with the new damage; and
- Persist for more than one hundred and eighty (180) days following the date of diagnosis.
- The diagnosis of acquired brain injury must be made in writing by a Specialist.

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

- an abnormality seen on brain or other scans without definite related clinical impairment; or
- neurological signs occurring without symptoms of abnormality.

Aortic Surgery: is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under this condition for:
- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Aplastic Anemia: Is defined as a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

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

The diagnosis of aplastic anemia must be made in writing by a Specialist.

Autism: an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication. The diagnosis of autism must be made in writing by a Specialist.

Limitation: the diagnosis of Autism must be made before the Person Insured's third (3rd) birthday for this benefit to be payable.

Bacterial Meningitis: is defined as a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

Benign Brain Tumour: is defined as 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 insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits. The diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:
- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the policy, or the date of the last reinstatement of the policy, the Insured Person has any of the following:
- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any benign brain tumour (covered or not covered under the policy), regardless of when the diagnosis is made; or
- A diagnosis of any benign brain tumour (covered or not covered under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any benign brain tumour or its treatment.

Blindness: definite diagnosis of the total and irreversible loss of vision in both (2) eyes, evidenced by:

- The corrected visual acuity being twenty over two hundred (20/200) or less in both (2) eyes; or
- The field of vision being less than twenty (20) degrees in both (2) eyes.

The diagnosis of blindness must be made in writing by a Specialist.

Cancer: Formal diagnosis of a malignant tumour. The tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of healthy tissues. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma. The diagnosis of cancer must be made by a Specialist and confirmed by a pathology report.

For the purposes of this Policy:

"T1a or T1b prostate cancer" refers to a tumour that is not clinically apparent or palpable by rectal examination and was incidentally detected in a prostate tissue collection.

- "AJCC stage 1 gastrointestinal stromal tumours [GISTs]" refers to:
- Stomach and/or omentum GISTs with a tumour diameter of less than or equal to 10 cm, with a maximum of 5 mitoses per 5 mm2, or 50 per HPF; or
- Small intestine, esophagus, colon and rectum, mesentery and peritoneum GISTs, with a tumour diameter of less than or equal to 5 cm, with a maximum of 5 mitoses per 5 mm2, or 50 per HPF.
- The terms "Tis," "Ta," "T1a," "T1b," "T1" and "AJCC Stage 1" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual (8th Edition, 2018).
- The term "Rai Stage 0" is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia (Blood 46:219, 1975).

Exclusions: No benefit will be payable under this condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;
- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or ∂ Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-day exclusion period: no benefit will be payable for cancer if, within 90 days of the effective date of the contract or the effective date of the most recent reinstatement of the contract if that date is later, the Insured:

- Showed signs or symptoms, or underwent investigations, that directly or indirectly led to a diagnosis of cancer (whether or not covered by this contract), regardless of the date on which the diagnosis is made; or
- Was diagnosed with cancer (covered or excluded under the contract). Medical information regarding the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be provided to the Insurer within six (6) months of the date of diagnosis. If this information is not provided within the prescribed time, the Insurer may deny a claim for cancer, or for any Critical Illness caused by a cancer or its treatment.

Cancer (Non Life Threatening): The following benefit will be payable under the definition of non life threatening cancer for the following conditions:

- **Stage A (T1a or T1b) prostate cancer:** Stage A (T1a or T1b) prostate cancer must be confirmed by pathological examination of prostate tissue
- **Ductal carcinoma in situ of the breast (stage A):** Ductal carcinoma in situ of the breast is a non-invasive cancer and must be confirmed by biopsy.
- **Stage 1A malignant melanoma:** Stage 1A malignant melanoma is a melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion.

90-day exclusion period: no benefit will be payable for cancer if, within 90 days of the effective date of the contract or the effective date of the most recent reinstatement of the contract if that date is later, the Insured:

- Showed signs or symptoms, or underwent investigations, that directly or indirectly led to a diagnosis of cancer(whether or not covered by this contract), regardless of the date on which the diagnosis is made; or
- Was diagnosed with cancer (covered or excluded under the contract). Medical information regarding the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be provided to the Insurer within six (6) months of the date of diagnosis. If this information is not provided within the prescribed time, the Insurer may deny a claim for cancer, or for any Critical Illness caused by a cancer or its treatment.

Cerebral palsy: is defined as a diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements. The diagnosis of cerebral palsy must be confirmed in writing by a Specialist.

Coma: is defined as a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:
- A medically induced coma;
- A coma which results directly from alcohol or drug use; or,
- A diagnosis of brain death.

Coronary Artery Bypass Surgery: is defined as the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under the definition of Coronary artery bypass surgery for the following conditions:
- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Covered heart conditions if open heart surgery is performed: these heart conditions are covered only if open heart surgery is performed to correct at least one of them:

- Aortic stenosis;
- Atrial septal defect;
- Discrete subvalvular aortic stenosis;
- Pulmonary stenosis;
- Ventricular septal defect.

The surgery must be:

- Recommended to be medically necessary by a Specialist;
- Supported by cardiac imaging acceptable to us; and
- Performed by a Specialist.

Exclusions: Procedures not covered by this definition are:

- Percutaneous atrial septal defect closure; and
- Trans-catheter procedures which include balloon valvuloplasty.

Cystic fibrosis: is defined as a diagnosis of cystic fibrosis where the Life Insured has chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made in in writing by a Specialist.

Deafness: is defined as a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of Deafness must be made by a Specialist.

Heart surgery (coronary artery bypass): Heart surgery (coronary artery bypass surgery) is defined as: Heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical procedures such as angioplasty and the use of lasers to unblock the arteries are not covered.

Heart attack (myocardial infarction): Heart attack (myocardial infarction): a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

- A rise and fall of biochemical markers to levels that confirm the diagnostic of myocardial infarction, with a least one of the following:
- Heart attack symptoms;
- Recent electrocardiogram (ECG) changes consistent with a heart attack;
- Development of new pathological Q-waves on the electrocardiogram (ECG) following an intra-arterial cardiac procedure, including, but not limited to, coronary angiography and/or coronary angioplasty.

The diagnosis of a heart attack must be made by a Specialist.

Exclusions: no benefit will be payable under the definition of HEARTH ATTACK (MYOCARDIAL INFARCTION) for the following conditions:
- Electrocardiogram (ECG) changes suggesting a prior myocardial infarction;
- Other acute coronary syndromes such as angina pectoris and unstable angina; or
- Elevated biochemical cardiac markers and/or symptoms resulting from medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair: surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusions: no benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure: is defined as a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made in writing by a Specialist.

Loss of Independent Existence: is defined as a definite diagnosis of the total inability, due to disease or injury, to perform independently:
- With or without the aid of assistive devices;
- At least 3 of 6 Activities of Daily Living listed below;
- For a continuous period of at least 90 days;
- With no reasonable chance of recovery; and
- The diagnosis must be made by a physician and supported by an independent home care assessment made by occupational therapist or equivalent.

Activities of Daily Living are as follows:

- **Bathing:** washing oneself in a bathtub, shower or by sponge bath;
- **Dressing:** putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- **Toileting:** getting on and off the toilet and maintaining personal hygiene;
- **Bladder and bowel continence:** managing your bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- **Transferring:** moving in and out of a bed, chair or wheelchair;
- **Feeding:** consuming food or drink that already have been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs: is defined as adefinite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made in writing by a Specialist.

Loss of Speech: is defined as a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

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

Major Organ Transplant: is defined as 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.

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

Motor Neuron Disease: is define as a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made in writing by a Specialist.

Multiple Sclerosis: is defined as a definite diagnosis of at least one of the following occurring after the later of the effective date, or the date of the last reinstatement of the policy:

- Two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

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

For purposes of the policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:
- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome;
- Neuromyelitis optica spectrum disorders; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion - No benefit will be payable under this condition if, within the first year following the later of the effective date of the policy or the date of the last reinstatement of the policy, the Insured Person has any of the following:
- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the diagnosis is made; or
- A diagnosis of multiple sclerosis (covered or not covered under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

- 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: is defined as diagnosis of muscular dystrophy where the Life Insured has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy or any other testing acceptable to us that confirms the diagnosis. The diagnosis of muscular dystrophy must be made in writing by a Specialist.

Occupational HIV Infection: is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy.

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

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

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

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

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

Paralysis: is defined as a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders: is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

1-Year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if within the first year following the later of, the effective date of the policy or the date of last reinstatement of the policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- A diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.
No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Stroke (Cerebrovascular accident with persistent neurological deficits): (A formal diagnosis of an acute cerebrovascular event (CVA) caused by intracranial thrombosis, hemorrhage or embolism, with:

- Acute onset of new neurological symptoms; and
- New objective neurological deficits on clinical examination that persist on an ongoing basis for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of stroke (cerebrovascular accident) must be made by a Specialist.

For Policy purposes, neurological deficits must be detectable by a Specialist and may include, but are not limited to, measurable hearing loss, measurable vision loss, measurable decline in neurocognitive function, objective loss of sensitivity, paralysis, localized weakness, dysarthria (difficulty pronouncing), dysphasia (difficulty speaking), dysphagia (difficulty swallowing), abnormal gait (difficulty walking), loss of balance, a lack of coordination or onset of seizures that are being treated. Headaches and fatigue shall not be considered neurological deficits.

Exclusions: no benefit will be payable under the definition of stroke (cerebrovascular accident) for the following conditions:
- Transient ischemic attack;
- Intracerebral vascular events due to trauma;
- Ischemic disorder of the vestibular system;
- Tissue death of the optic nerve or retina without the complete loss of sight of the affected eye; or
- Lacunar infarcts which do not meet the definition of stroke (cerebrovascular accident) as described above.

Severe Burns: is defined as a definite diagnosis of third-degree burns over at least twenty percent (20%) of the body surface. The diagnosis of severe burns must be made in writing by a Specialist.

Type 1 diabetes mellitus: is defined as a diagnosis where the Life Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three (3) months. The diagnosis of Type 1 diabetes mellitus must be made in writing by a Specialist.

Select Exclusions

Pre-existing conditions exclusion

If the Life Insured suffers from a covered illness during the first twenty-four (24) months following the contract start date, or last reinstatement date, the Life Insured is required to notify Specialty Life Insurance of the situation and SLi will review the Life Insured's file:

- If the Life Insured's covered illness does not result from a pre-existing condition, the applicable benefit may be paid to the Life Insured;
- If Life Insured's covered illness results directly or indirectly from, or is related in any way to, the Life Insured's pre-existing condition, the applicable benefit may not be paid. Coverage and other benefits under the policy provisions may be continued.

What is a pre-existing condition?

Pre-existing condition: an illness or condition for which, during the twenty-four (24) months preceding the contract start date, or last reinstatement date:

- The Life Insured was diagnosed or was treated, hospitalized or attended to by a physician or other health professional; or
- The Life Insured was advised to seek treatment or consult a physician or other health professional; or
- The Life Insured received a prescription or took medication; or
- The Life Insured showed signs or symptoms or underwent tests or investigations.

Exclusions of previous critical illnesses
In addition, no benefit is payable for a critical illness if it results from:

- Directly or indirectly, an illness that is diagnosed, or signs or symptoms that are known to exist, or an investigation that is not reported, prior to the contract start date, or last reinstatement date.

Part C - General Provisions

Contract

This Policy is issued by the Insurer based on the application for insurance, a copy of which is attached, as well as on any document subsequently submitted to reinstate or change the Policy. No representative is authorized to change this Policy or to render null any of its provisions.

Any change to the Policy or its riders must be signed by an officer of the Insurer.

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 Life Insured's insurability since the application for insurance or reinstatement was signed.

Premiums

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

Method of payment

Premium is payable monthly by automatic pre-authorized withdrawals. A premium paid by cheque or pre-authorized withdrawal is only considered paid if the payment is honored.

A grace period of thirty (30) days is granted for payment of each premium except the first. If the premium remains unpaid after the grace period, this Policy lapses and all insurance coverage terminates.

The Insurer will deduct outstanding premiums from any amount payable.

Exclusions

No Critical Illness, fracture, injury, Accidental Death, Dismemberment or total loss of use 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, illicit drugs or narcotics, or abuse of prescription drugs;
- 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 Person Insured's participation in a popular uprising.

No fracture, injury, Accidental Death, Dismemberment or total loss of use benefit will be payable that result from:

- injury sustained during a flight, except if the Person Insured is a passenger on a regularly scheduled flight;
- 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;
- participating in a sport for which the Person Insured receives monetary reward or compensation.

Age

For the purposes of this Policy, the Life Insured's age is the age attained at his or her nearest birthday when a coverage is issued. If, mistakenly or otherwise, the age used to calculate the premium is incorrect, any amount payable by the Insurer will be adjusted to reflect the correct age.

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 provision 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.

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 when a Critical Illness benefit is paid under this coverage;
- The date of termination of this Policy, as indicated in the Schedule of Benefits;
- The date a written request from the Owner is received by the Insurer stating that he wishes to terminate this policy or the date stipulated in that request, if such date is later than the date of receipt by the Insurer;
- The date the grace period for premium payment expires;
- The date of the Policy anniversary nearest to the Life Insured's twenty-fifth (25th) birthday;
- The date the Life Insured dies.

Reinstatement

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

When the Policy is reinstated within ninety (90) days of the date of cancellation, no proof of insurability is required.

Change of beneficiary

Subject to applicable law, the Owner may at any time designate or change or revoke a Beneficiary designation that is not an irrevocable Beneficiary designation. 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.

Legal currency

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

Right to cancel

The Owner may cancel this Policy within fifteen (15) days of the date it was received by the Owner or within sixty (60) days after the date the Policy is issued to the Owner, whichever is earlier, provided he or she notifies the Insurer in writing of such cancellation in which case any premium paid for the Policy will 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.

Notice and proof of claim

All claims must be made in writing and submitted to the Insurer within thirty (30) days of the date of the Accident, Sickness or Disability rise to a claim under this Policy.

In the event of the Life Insured's death, the Insurer may, if permitted under applicable law, require an autopsy and any failure to satisfy that request will give the Insurer grounds to refuse payment of the benefit.

The Life Insured, the Owner and the Beneficiary are required to cooperate fully with the Insurer by providing all the information it may require and by signing any form or other document allowing the Insurer to obtain any information it deems relevant.

The Owner or any person entitled to submit a claim must provide the Insurer with all the documents it may require within ninety (90) days of the date of the Accident, Sickness or Disability giving rise to a claim.

In the event of a failure to give notice or provide proof within the stipulated periods, the Life Insured, the Owner or the Beneficiary, as applicable, shall not be entitled to receive benefits, with respect to the claim in question, for the period prior to the date on which the Insurer actually receives that proof.

The Owner must notify the Insurer of any change of address for the purpose of facilitating correspondence and the transmission of any document.

Payment under the policy

Death benefits will be paid to the Beneficiary designated in the application or in any other document subsequently submitted to the Insurer by the Owner.

If the Owner has not designated a Beneficiary, the death benefit will be payable to the Owner or the Owner's estate.

Reimbursement

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