Specialty Life
Critical Illness Insurance Policy

Underwritten by:
Chubb Life Insurance Company of Canada

CHUBB®

SLI-CIPO-1022EN

Policy Schedule

Policy Number	«POLICY»
Insured Person	«FORMALNAME»
Address of the Insured Person	«ADDR3», «ADD4R» «CITY» «PROVINCE» «POSTCODE»
Date of Birth	«DOB»
Insured Persons Gender	«SEX»
Insured's Smoking Status on Date of Application	«SMOKER / NON-SMOKER»
Effective Date	«EFFECTIVE DATE»
Expiry Date	The Premium Due Date following the date you turn age 75
Benefit Amount	$
Principal Sum Amount	$«BASEPREMIUM» «BILLFREQ» Premium cannot be increased for any one single policy but are subject to change by Class Grouping.
Premium Due Date	«EFFDATE»
Beneficiary	The beneficiary of any payable benefits for dependent children (where Dependent Child coverage is in force) will be the Insured Person
Child Rider Benefit Amount	Not Applicable
List of Dependent Children	Not Applicable

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Insuring Agreement

In consideration of the application for insurance, copy included herein, and of the payment of premiums when due as outlined in the policy schedule, we have issued this policy to you. We agree to pay the benefits described in this policy, subject to all of its terms, conditions and limitations.

This policy goes into effect on the effective date shown in the policy schedule, on the condition that the information provided in the application for insurance remains true and complete on such effective date and also at the time that you accept delivery of this policy, and provided the initial premium is paid when due.

In this policy, "you" or "your" means the Insured Person, and "we", "us" or "our" means Chubb Life Insurance Company of Canada ("Chubb Life".)

To help you understand the insurance terms used in this policy, refer to the explanations described under the "Terms used in this policy" section and your policy schedule.

It is important that you read your entire policy carefully so you understand how this insurance works and so that you can evaluate if it suits your needs. If additional information about this insurance is required, please contact the Administrator at 1-844.335.5588 weekdays from 8:00 a.m. to 5:00 p.m. Eastern Standard Time ("EST").

A. Andrew Hollenberg, President
Chubb Life Insurance Company of Canada
199 Bay Street, 24th Floor, Toronto, Ontario, M5L 1E2

Right to Examine Policy for 30 Days

You are allowed 30 days from the date you receive this policy to review it and to return it to us if you do not find it satisfactory. If you return it to us within this 30 day period, the policy will be cancelled as if it had never been in effect and any premium paid will be refunded to you. To cancel your policy, send your request in writing to: Specialty Life Insurance, 8000 Jane Street, Tower A, Suite 101, Concord, Ontario L4K - 5B8

When Will This Insurance Coverage Start?

Subject to the terms and conditions of this policy, the insurance coverage under this policy begins on the effective date subject to on the effective date subject to the following conditions:

- The information provided by you in the application for insurance remains true and complete on the effective date;
- The information provided by you in the application remains true and complete at the time that you accept delivery of this policy; and
- You pay the first premium when due.

If all of these conditions are not met, this policy does not come into effect.

When Will This Insurance Coverage End?

The insurance coverage under this policy ends on the earliest of the following dates:

- The date the insured person named in the policy schedule dies;
- The effective date of your request to cancel this policy. Refer to the section entitled “Cancellation by you”;
- The end of the grace period if the premium remains unpaid. Refer to the section entitled “Grace period”; or
- The expiration date as set out in the policy schedule.

What Benefits Are Provided By This Insurance Coverage?

This policy provides the following insurance coverage:

1. The date the insured person named in the policy schedule dies;
2. The effective date of your request to cancel this policy. Refer to the section entitled “Cancellation by you”;
3. The end of the grace period if the premium remains unpaid. Refer to the section entitled “Grace period”; or
4. The expiration date as set out in the policy schedule.

1. Payment of the Benefit Amount for an Insured Condition

We will pay the benefit amount set out in the policy schedule, if you are diagnosed with an insured condition. We will not pay the benefit amount for any insured condition you were diagnosed with before the effective date of this policy.

We will only pay the benefit amount once while this policy is in force. This means we will not pay more than one benefit amount whether you are diagnosed with, suffer or undergo more than one insured condition, except as outlined under the Second Event Benefit. Coverage under this policy will terminate after payment of this benefit.

You must survive a period of 30 days following the date you are diagnosed with an insured condition, unless otherwise indicated in the description of the insured condition.

There are certain limitations and exclusions that apply: please see the “When we will not pay” section of this policy.

2. Payment of the Benefit Amount for a Child Insured Condition (if applicable)

In addition to the insured conditions, we will pay the benefit amount set out in the policy schedule, if a dependent child is diagnosed with a child insured condition. We will not pay the benefit amount for any child insured condition that the dependent child was diagnosed with before the effective date of this policy.

We will only pay the benefit amount once while this policy is in force. This means we will not pay more than one benefit amount whether the dependent child is diagnosed with, suffers or undergoes more than one child insured condition.

There are certain limitations and exclusions that apply: please see the “When we will not pay” section of this policy.

3. Payment of a Portion of the Benefit Amount for Additional Benefit Conditions

We will pay a percentage of the benefit amount set out in the policy schedule if you are diagnosed with one of the additional benefits conditions. We will not pay for any additional benefit condition you were diagnosed with before the effective date of this policy.

We will only pay for an additional benefit condition once while this policy is in force. This means we will not pay more than once for any additional benefit condition.

You must survive a period of 30 days following the date you are diagnosed with an additional benefit condition, unless otherwise indicated in the description of the additional benefit condition.

If we pay for an additional benefit condition, a benefit amount payable upon diagnosis of an insured condition or for a second event benefit will be reduced by the payment we made for the additional benefit condition.

There are certain limitations and exclusions that apply: please see the "When we will not pay" section of this policy.

Additional Benefit Condition Amounts:

a. We will pay you 20% of the benefit amount up to a maximum of $20,000 if you are diagnosed with DCIS.

b. We will pay you 20% of the benefit amount up to a maximum of $20,000 if you require treatment for early prostate cancer.

c. We will pay you 25% of the benefit amount if you are diagnosed with loss of independence.

4. Payment of a Second Event Benefit

We will pay the benefit amount set out in the policy schedule if you are diagnosed with a second insured condition provided:

a. We have paid the benefit amount for the first insured condition of cancer or a cardiovascular condition (including heartattack, stroke, coronary artery bypass, undergoes aorta surgery or heart valve replacement);

b. Your treating doctor declares that you are fully recovered from the first insured condition and you are not actively receiving treatment; and

c. You have returned to work or your regular activities for a period of at least 90 days from your last treatment for the firstinsured condition;

then you are diagnosed with a second insured condition of cancer or a cardiovascular condition (including heart attack, stroke, coronary artery bypass, undergoes aorta surgery or heart valve replacement).

The second event benefit will only be paid if:

- You survive at least 30 days after the diagnosis of the second insured condition; and
- The first insured condition and the second insured condition do not fall into the same category of insured conditions. This means, for example, if your first insured condition was cancer, we will not pay the second event benefit for a cancer diagnosis but will pay for a cardiovascular condition (including heart attack, stroke, coronary artery bypass, undergoes aorta surgery or heart valve replacement) diagnosis.

The second event benefit is payable only once. Payment of the second event benefit will represent full and final discharge of all claims under the second event benefit. Following payment of the second event benefit, coverage under this policy will terminate.

Additional benefit conditions are not eligible for payment for a second event benefit.

When We Will Not Pay

We will not pay any benefit amount for insured conditions, child insured conditions or additional benefit conditions caused, directly or indirectly, by or contributed to by any of the following:

- Suicide or any intentionally self-inflicted injury, while sane or insane;
- Declared or undeclared war, or any act of war, terrorism, riot or insurrection, or service in the armed forces of any country, government or international organization;
- For injury or sickness, other than one of the insured conditions, child insured conditions or additional benefit conditions, even though such injury or sickness may have been complicated by the insured condition, child insured condition or additional benefit condition;
- A complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS related complex;
- Committing or attempting to commit a criminal offence, or while in prison; or
- The misuse of medication, or the abuse of drugs or intoxicants, or from having a blood alcohol level of 80 milligrams of alcohol in 100 millilitres of blood.

Pre-existing Condition Exclusion: (APPLIED TO COVERAGE $50,000 AND UNDER)

We will not pay any benefit amount for insured conditions, additional benefit conditions caused, directly or indirectly, by or resulting from a pre-existing condition.

90 Day Cancer Exclusion:

We will not pay any benefit amount for cancer, early stage prostate cancer treatment or DCIS for a period of 90 days from the later of:

a. The effective date, or;

b. The date of the last reinstatement of the policy.

During this 90 day period, there will be no insurance coverage for DCIS or cancer or early prostate cancer treatment:

- If the insured person is diagnosed with DCIS or any type of cancer; or
- If the insured person has any symptoms or medical problems which result in an investigation that leads to a diagnosis of cancer, DCIS or early stage prostate cancer treatment.

In the event of any such diagnosis, this policy will remain in force but cancer will be a pre-existing condition and will not be considered an insured condition, child insured condition or additional benefit condition for the insured person, except for a subsequent diagnosis of an unrelated cancer.

Misrepresentation

If you have incorrectly stated, misrepresented or failed to disclose a material fact in your application for insurance, including in any written, telephonic or electronic statements provided as evidence of insurability, we may contest the validity of this policy. This means we can declare the policy void from the beginning.

However, except in the case of fraud, we will not challenge the validity of this policy after it has been in effect continuously for 2 years from the later of the effective date or the date the policy was last reinstated.

If there is evidence of fraud, we can declare the policy void, and will refund premium at any time. Fraud includes, but is not limited to, a material misrepresentation of your smoking habits. It also includes any other misrepresentation about, or failure to disclose, information that is important to our decision to issue this policy at the premium rate we applied at the time the policy was issued.

When Your Date of Birth or Gender is Misstated

If your date of birth or gender has been stated incorrectly in the application of insurance, we will adjust the amount of benefits payable to the amount or total amount that would have been provided in exchange for the same premium you are paying using the correct age or gender. However, if we could not have issued this policy because the correct age does not meet our age requirements, we will declare this policy void and return all premiums paid to you.

Premiums

The premium you must pay to keep this policy in force is shown in the policy schedule. The premium due date is the premium due date reflected on the policy schedule page. The premium rate is based on the insured person's class grouping and death benefit amount selected by you.

Premiums are due to us and must be paid on the premium due date reflected in the Policy Schedule, subject to the Grace period section below.

Change of Premium

We may increase or decrease your premium. We will only change your premium if a change is being made to all insured person's in the same class grouping. No one individual insured person will ever be singled out for a premium rate change.

At least 45 days prior written notice of any change in premium will be given to you. We can only change your premium once in any 12-month period.

Premiums will increase as you get older. You will enter a new premium rate level every 5 years starting at age 25. If you applied just before you are entering a new rate level; we will guarantee the rate you purchased at for the first year.

Grace Period

A grace period of 30 days from the premium due date will be granted to you for the payment of the premium. During such grace period, coverage under this policy shall continue in force, but you will be liable to us for the payment of the premium that accrues during such period. If you do not pay the overdue premium and any premium falling due within the grace period, this policy and the coverage will automatically end without notice to the Insured person or any other person. If your policy ends this way, it is called a lapse.

Reinstating Your Policy

If your policy ended because it lapsed due to non-payment of premium, you may apply to have it put back into effect if the insured person is alive. This process is called reinstatement.

The policy may be reinstated:

- Within thirty-one days of the end of the grace period, by paying to us all overdue premiums, provided that the insured person is alive at the time such payment is received by us; or
- Within two years of the date of lapse, by providing to us a written request for reinstatement, payment of all overdue premiums and evidence of insurability that we consider satisfactory.

If this policy is reinstated, the 2 year period for contesting the validity of this policy and any limitations and exclusions begin anew from the date of reinstatement, as set out in the sections entitled “When we will not pay” and “Misrepresentation”.

Beneficiary

All benefit payments, including benefits payable for any insured dependent child covered under this policy are paid directly to you.

If you are deceased at the time that a benefit is paid by us, we will pay benefits to the beneficiary you named, as set out in the policy schedule. If you make changes, we pay the beneficiary named in your latest written change request you provide to us. You can make a change at any time before your death. If the beneficiary designation is irrevocable, you cannot change it without the beneficiary’s consent. If there is no beneficiary entitled that survives you, we will make the benefit payment to your estate.

Making a Claim

To make a claim, the person making the claim will need to contact the Administrator at the toll free telephone number shown below. The Administrator will then send the claimant the appropriate forms to be completed. The person making the claim must complete the forms and give us the information required to assess the claim.

Doctors may charge a fee to complete certain forms. The person making the claim is responsible for any fees for this information.

The completed claim forms and supporting information must be sent to the Administrator at the following address:

Speciality Life Insurance
8000 Jane Street, Tower A, Suite 101
Concord, Ontario L4K 3W4

Toll-Free Number 1-844.335.5588

This policy must be in effect on the date of diagnosis. You must send the completed claim form and supporting documentation within one year of the date a claim arises under this policy.

For further information about claims, refer to the section of this policy entitled *“Statutory Conditions.”*

Cancelling Your Policy

Cancellation by You – You may cancel this policy at any time by giving written notice to the Administrator at their address shown on the last page of this policy. The effective date of your request to cancel this policy will be the date we receive your cancellation notice. If you cancel your policy within 30 days from the date you receive this policy, any premium paid will be refunded to you. If you cancel your policy any time after this, any premium paid after we receive notice of your cancellation will be refunded to you on a pro-rated basis (if premium has been paid annually).

Non-Cancellable by Us – We cannot cancel your policy before the expiry date. However, in certain circumstances of misrepresentation or non-disclosure, we may declare the policy void. Refer to the sections entitled "Misrepresentation" and "When your date of birth or gender is misstated".

Automatic Termination – Your coverage under this policy will automatically terminate immediately and without notice or further action by us, on the earliest of:

1. The premium due date following your 75th birthday;
2. The date the required premium is not paid when due after expiry of the grace period; or
3. The date of the insured person's death.

Other Important Information

Currency – All references to dollars in this policy mean Canadian dollars.

Non-Participating Insurance – This policy is not participating. This means that you do not share in the distribution of any of our profits or surpluses under this policy.

Cash Value – This policy has no cash value.

Assignment – Your rights or benefits under this policy may not be assigned.

Notices – Any official notices to us, like cancellation notices, must be in writing and be delivered or sent by mail to us at our address shown. Notices from you or a claimant should include this policy number and your name and address.

Exclusion - This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

Legal Actions – Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act, Limitations Act, 2002 or other applicable legislation in your province of residence.

Statutory Conditions

1. The Contract

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

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

2. Material Facts

No statement made by you at the time of application for the contract may be used in defense of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

3. Notice and Proof of Claim

a. You or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, must
   i. Give written notice of claim;
      1. By delivery of the notice, or by sending it by registered mail, to the head office or chief agency of ours in the province, or
      2. By delivery of the notice to an authorized agent of ours in the province, not later than 30 days after the date a claim arises under the contract on account of an accident, sickness or disability,

   ii. Within 90 days after the date a claim arises under this policy, furnish to us such proof as is reasonably possible in the circumstances of;
      1. The event causing such claim;
      2. The right of the claimant to receive payment;
      3. The claimant's age; and
      4. If relevant, the beneficiary's age, and

   iii. If so required by us, furnish a satisfactory certificate as to the cause or nature of the accident or sickness for which claim is made under the contract.

b. Failure to give notice of claim or furnish proof of claim within the time required by this condition does not invalidate the claim if:
   i. The notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or furnish the proof in the time required by this condition, or
   ii. In the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice orproof is given or furnished no later than one year after the date a court makes the declaration.

4. Forms for Proof of Claim

We must furnish forms for proof of claim within 15 days after receiving notice of claim, but if the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident or sickness giving rise to the claim.

5. Rights of Examination

As a condition precedent to recovery of insurance money under the contract,

a. The claimant must give Us an opportunity to examine the person of the person insured when and as often as it reasonably requires while a claim is pending, and

b. In the case of death of the person insured, We may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies.

6. When Money is Payable

All money payable under the contract, must be paid by us within 60 days after it has received proof of claim.

Protecting Your Personal Information

At Chubb, We are committed to protecting Our customers' privacy. Chubb's policy is to limit access to customer information to those who need it to serve customers' insurance needs and to maintain and improve customer service. The information provided by customers is required by us, Our reinsurers and authorized administrators to assess customers' entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-ordinating coverage with other insurers. For these purposes, We, Our reinsurers and authorized administrators consult existing insurance files about customers, collect additional information about and from customers, and where required, collect information from and exchange information with, third parties. We do not disclose customer information to third parties other than Our agents and brokers, except as necessary to conduct business, e.g., processing claims or as required by law. We advise customers that, in some instances, employees, service providers, agents, reinsurers, and any of their providers, of Chubb may be located in jurisdictions outside Canada and that customers' personal information may thus be subject to the laws of those foreign jurisdictions.

The Privacy Officer; Chubb Insurance Company of Canada, 199 Bay Street, 25th Floor, Toronto, Ontario, M5L 1E2. For more information on privacy at Chubb, visit Chubb.com/ca

Complaint Procedures

If an Insured has a complaint or inquiry about any aspect of this insurance coverage, please call 1-877-534-3655 between 8:00 a.m. and 8:00 p.m. (ET), Monday to Friday.

If for some reason the Insured is not satisfied with the resolution to their complaint or inquiry, the Insured may communicate their complaint or inquiry in writing to Our complaints officer:

Chubb Insurance Company of Canada
199 Bay Street, Suite 2500
P.O. Box 139 Commerce Court Postal Station
Toronto, ON M5L 1E2
Email: complaintscanada@chubb.com

If the Insured is still not satisfied with the resolution to their complaint or inquiry, the Insured may communicate their complaint or inquiry in writing to:

OmbudService for Life & Health Insurance (OLHI)
20 Addelaide St. East, Suite 802, P.O. Box 29
Toronto, Ontario M5C 2T6

Terms Used in This Policy

Some words that are used in this policy have very specific meanings that are introduced in the text, set out in the policy schedule or defined below.

"Accident" means a sudden, unforeseen and unintentional event, which causes injury.

"Activities of daily living" means the following activities:

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

"Additional benefit conditions" means DCIS, the early stage prostate cancer treatment and loss of independence. For a complete description of these additional benefit conditions, refer to the section of this policy entitled "Description of Additional Benefit Conditions".

"Administrator" means Insurance Supermarket Inc., based at 8000 Jane Street, Tower A, Suite 101, Concord, Ontario, L4K 5B8. TEL: Toll-Free 1-888-818-1720. The "Administrator" is responsible for sales, marketing and claims administration.

"AIDS" means Acquired Immune Deficiency Syndrome.

"Beneficiary" means the person or persons you name in writing to receive the death benefit in the event of your death.

"Benefit amount" means the amount we will pay to you pursuant to the terms of this policy and as set out on the policy schedule.

"Child insured conditions" means cerebral palsy, cystic fibrosis, Down's syndrome, and muscular dystrophy. For a complete description of these child insured conditions, refer to the section of this policy entitled *"Description of Child Insured Conditions"*.

"Class grouping" means a group of insured persons by occupation, age, gender and/or province or territory of residence.

"Dependent child" means either your natural child, adopted child or step-child. Your dependent child must be:

a. Under 21 years of age, unmarried and dependent onyou for support, and who is not engaged in gainful employment more than 25 hours per week; or

b. Under 26 years of age, unmarried and in attendance at a post-secondary school, dependent on you forsupport, and who is not engaged in gainfulemployment more than 25 hours per week; or

c. By reason of mental or physical illness, is incapable ofself-sustaining employment and is considered a dependent child within the terms of the Income Tax Act (Canada).

If a dependent child is insured under this policy, his or her name will be set out on the policy schedule as an insured dependent child.

"Doctor" means a licensed doctor recognized by the College of Physicians and Surgeons in the province or country in which the treatment is rendered. The doctor must be someone other than a member of your immediate family.

"Effective date" means the date coverage begins as set out under "Effective Date" in the policy schedule.

"Immediate family" includes your spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in- law or daughter-in-law.

"Injury" means bodily injury resulting directly and independently of all other causes from an accident, which is caused by external, violent and visible means and sustained while you are covered under this policy. Injury must result within a 365 day period after the date of the accident.

"Insured" means the person who applied for this policy and whose name appears as the "Insured Person" on the policy schedule, as well as the listed "Insured Dependent Child" on the policy schedule.

"Insured condition" means Alzheimer's disease, motor neuron disease, aorta surgery, benign brain tumour, blindness, cancer, coma, coronary artery bypass surgery, deafness, dismemberment, heart attack, heart valve replacement, loss of speech, major organ failure, major organ transplant, multiple sclerosis, occupational HIV, paralysis, Parkinson's disease, severe burns and stroke. For a complete description of these insured conditions, refer to the section of this policy entitled *"Description of Insured Conditions"*.

"Mental or nervous disease or disorder" means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, without demonstrable organic disease.

"Policy" is this policy document for the insurance coverage on the life of the Insured Person named on the Policy Schedule. This policy includes any amendment or endorsement that we attach to this document.

"Policy schedule" means the policy schedule which is attached to and forms a part of this policy.

"Premium due date" means the effective date for the initial premium due, and the first day of each and every month thereafter.

"Pre-existing Condition" means an injury or sickness for which you received treatment or advice or a diagnosis, or for which treatment was required or recommended by a doctor during the 24 months immediately before the effective date, or last reinstatement date, of the policy. A pre-existing condition includes a condition that directly or indirectly causes the insured condition, child insured condition or additional benefit condition to occur within the first 24 months from the effective date, or last reinstatement date, of the policy.

"Sickness" means an illness, disease, or physical condition which first manifested itself on or after the effective date.

"Specialist" means a doctor whose practice is limited to the particular branch of medicine or surgery required to diagnose or perform surgery upon the specified insured conditions or additional benefits conditions.

"Treatment or advice" means consultation, care or service provided by a doctor. Treatment or advice includes but is not limited to diagnostic measures and prescribed drugs.

Description of Insured Conditions

Alzheimer's disease: The diagnosis that you have Alzheimer's disease, which is a definite diagnosis of a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that you exhibit the loss of intellectual capacity resulting in impairment of your memory and judgment, which results in a significant reduction in your mental and social functioning, such that you require permanent daily personal supervision for the activities of daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this insured condition definition. A doctor who is certified as either a neurologist or a psychiatrist must confirm diagnosis in writing.

Aorta surgery: Surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The aorta surgery must be performed on the prior written advice of a doctor certified as a cardiovascular surgeon. Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

Benign brain tumour: A benign neoplasm in the brain or meninges with histologic confirmation. Cysts, granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

Blindness: The total and irrecoverable loss of sight in both your eyes due to injury or sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A doctor certified in ophthalmology must clinically confirm the diagnosis in writing.

Cancer: A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes leukemia, Hodgkin's disease and invasive melanoma but does not include:

- Carcinoma in situ;
- Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of human immunodeficiency virus (HIV);
- Skin cancer or melanoma that is not invasive and hasnot exceeded .75 millimetres in depth;
- Prostate cancer diagnosed as T1N0 M0 or equivalent staging; or
- A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date.

A doctor certified as an oncologist must confirm diagnosis in writing.

Coma: When you have been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A doctor who is certified as a neurologist must confirm diagnosis in writing.

Coronary artery bypass surgery: When surgery is performed by a doctor who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be an insured condition.

Deafness: The diagnosis of permanent loss of hearing in both of your ears, with an auditory threshold of more than 90 decibels in each ear. A doctor, who is certified as an otolaryngologist must confirm diagnosis in writing.

Dismemberment: A definite diagnosis of the complete severance of two or more of your limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist, who must confirm the diagnosis in writing.

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

a. Heart attack symptoms;
b. New electrocardiogram (ECG) changes consistent with a heart attack; or
c. Development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

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

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

a. Elevated biochemical cardiac markers with a:
   i. Troponin Level of less than 1;
   ii. CK-Mb Level of less than 4; or

b. ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Heart Valve Replacement – The undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a cardiologist.

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

Loss of Speech: The 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, who must confirm the diagnosis in writing.

Major Organ Failure: the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded), both lungs, both kidneys, or bone marrow, in which the affected organ is unresponsive to any treatment and for which you are medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

Major Organ Transplant: 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, you 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, who must confirm the diagnosis in writing.

Motor Neuron Disease - 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.

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

Multiple Sclerosis: The unequivocal written diagnosis by a doctor who is certified as a neurologist confirming at least one of the following:

1. Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
2. Well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination;
3. Or a single attack, confirmed by repeated MRI imagingof the nervous system, which shows multiple lesionsof demyelination which have developed at intervals atleast one month apart.

Occupational HIV Infection: A definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of your normal occupation, which exposed you to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date or latest reinstatement of this policy.

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

a. The accidental injury must be reported to us within 14days 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 and180 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 State of America;
e. The accidental injury must be 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, who must confirm the diagnosis in writing.

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

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

Paralysis: The total and irrecoverable loss of function of 2 or more limbs through neurological damage due to injury or sickness, provided such loss of function continually lasts for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to us to be permanent. A doctor certified as a neurologist must confirm diagnosis in writing.

Parkinson's Disease: The unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform 3 of the 6 Activities of Daily Living without assistance.

Diagnosis should show signs of progressive impairment and must be confirmed in writing by a doctor who is certified as a neurologist.

Severe Burns: If you have third degree burns covering at least 20% of the surface area of your body. A doctor who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.

Stroke: When you have suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the stroke, confirmed in writing by a doctor who is certified as a neurologist.

Description of Additional Benefit Conditions

DCIS is the diagnosis by a doctor of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A doctor certified as an oncologist must confirm the diagnosis in writing.

Early stage prostate cancer (T1a or T1b) treatment: Early Stage Prostate Cancer Treatment is the treatment for Early Stage Prostate Cancer (T1a or T1b). The diagnosis must be made by an oncologist. No benefit will be payable unless the oncologist has recommended one of the following treatments:

- Prostate surgery;
- Radiation therapy;
- Chemotherapy; or
- Hormone therapy.

a. being totally and permanently unable to perform, by oneself, at least 2 of the 6 activities of daily living or,

b. having a cognitive impairment.

Cognitive impairment is a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which is measurable and results from demonstrable organic cause as diagnosed by a doctor. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight continuous hours of daily supervision.

Exclusion: A mental or nervous disease or disorder is not included as a cognitive impairment.

Description of Child Insured Conditions

Cerebral Palsy: a definite diagnosis of definite cerebral palsy, a non-progressive neurological defect characterized by spasticity and uncoordinated movements. A doctor who is certified as a neurologist must confirm the diagnosis in writing.

Cystic Fibrosis: a definite diagnosis of cystic fibrosis which is a hereditary disorder affecting the exocrine glands, resulting in chronic lung disease and pancreatic insufficiency. A doctor who is specialized in medical genetics must confirm the diagnosis in writing.

Down 's syndrome: a definite diagnosis of Down's syndrome supported by chromosomal evidence of Trisomy 21. A doctor who is specialized in medical genetics must confirm the diagnosis in writing.

Muscular Dystrophy: a definite diagnosis of muscular dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscular biopsy. A doctor who is certified as a neurologist must confirm the diagnosis in writing.

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