Winflex Multi-Coverage Insurance

Master Policy # WIN1003

WESTERN LIFE ASSURANCE COMPANY

Administrative Office: 717 Portage Avenue, 4th Floor, Winnipeg MB R3G 0M8
Mailing Address: P.O. Box 3300, Winnipeg MB R3C 5S2
Toll Free: 888-647-5433 Ph: 204-784-6900

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INSURING AGREEMENT

Western Life Assurance Company hereby contracts with

Name and Address of Policyholder:

Participating Member Clients of the Policy Administrator
800 650 West Georgia Street
Vancouver, BC V6B 4N8

"Participating Member Client" *means* clients who are participating in the Administrators Benefit Programs.

Master Policy Effective Date: February 1, 2013 at 12:01 A.M. standard time at the head office address of the Policyholder as stated above.

It continues in force for the period for which premium has been paid.

Renewal Date: February 1, 2014 and each February 1 thereafter, subject to the terms of this policy.

Premiums Due: Payment is due on the first (1st) of each month and a period of sixty (60) days is allowed for the payment of every premium starting on the premium due date.

Western Life Assurance Company (hereinafter called the "Insurer") agrees with the Policyholder named above (hereinafter called the "Policyholder") to insure eligible persons specified herein (hereinafter individually called the "Insured Employee") and their eligible spouses, if any, (hereinafter individually called the "Insured Spouse") and promises to pay for the benefits specified in this policy; to the extent herein limited and provided.

This agreement is made in consideration of the Policyholder's payment of the required premium.

Signed by Western Life Assurance Company at its Administrative Office in Winnipeg, Manitoba, Canada on the Master Policy Effective Date.

Vice President, Finance

President and CEO

SCHEDULE

1. **Eligible Employee Class:** all permanent Employees under the age of seventy (70) working a minimum average of twenty-four (24) hours per week who have satisfied their Employer's Waiting Period.

   Waiting Period: as shown on the Certificate of Insurance issued by the Administrator.

2. **Benefit Amounts:**

		Option 1	Option 2
Coverage A:	Employee and Spouse Mandatory Life Insurance		
	Employee	$ 25,000	$ 25,000
	Spouse	$ 10,000	N/A
Coverage B:	Employee and Spouse Mandatory Accidental Death or Dismemberment Insurance		
	Employee	$ 25,000	$ 25,000
	Spouse	$ 10,000	N/A
Coverage C:	Employee and Spouse Mandatory Critical Illness Insurance		
	Employee	$ 25,000	$ 25,000
	Spouse	$ 10,000	N/A

3. **Non-Evidence Benefit Maximums:** as shown on the Certificate of Insurance issued by the Administrator.

Coverage A:	Employee and Spouse Mandatory Life Insurance	$ 25,000
Coverage B:	Employee and Spouse Mandatory Accidental Death or Dismemberment Insurance	$ 25,000
Coverage C:	Employee and Spouse Mandatory Critical Illness Insurance	$ 25,000

4. **Aggregate Limit of Indemnity:** $3,000,000

5. **Grace Period for Premium Payment:** Sixty (60) days

GENERAL POLICY DEFINITIONS

The male pronoun will be construed as the feminine when the person is a female.

"Accident" *means* a single sudden and unexpected event, which:

a) occurs at an identifiable time and place;

b) causes unexpected bodily Injury at the time it occurs; and

c) arises from an external source to the Insured Person.

"Actively at Work" *means* an Employee capable of working and present at the place of work to carry out normal duties in accordance with the Employee's regular work schedule, on vacation or on a leave approved by the Employer.

"Additional Insurance" *means* the Benefit Amount exceeding the non-evidence benefit maximums of each benefit.

"Administrator" *means* Winflex Health Solutions Inc.

"Age" *means* the attained age of the Insured Person (last birthday).

"Benefit Amount" *means* the insurance benefits provided in the policy and is the amount of insurance issued as shown on the Schedule.

"Certificate" *means* the Certificate of Insurance issued to clients by the Administrator which outlines the Benefit Amount applicable to the identified client.

"Disease" *means* any unhealthy condition of the body or any part thereof.

"Employee" *means* any wage-earner who works on a regular basis for the Employer.

"Employer" *means* the Policyholder or any employer whose Employees or a category of Employees are represented by the Policyholder of this policy.

"Evidence" *means* evidence deemed satisfactory by the Insurer to confirm a particular state or condition.

"Hospital" *means* an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physicians available at all times and which continuously provides twenty-four (24) hour nursing service by graduate registered Nurses. It provides organized facilities for diagnostics and Surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care. For the purposes of this definition, Physicians and Nurses will not exclude an Immediate Family Member.

"Immediate Family Member" *means* a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), Spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

"Insured Person" *means* collectively, an Insured Employee or Insured Spouse eligible for insurance under a particular provision of this policy, unless otherwise stated in this policy.

"Nurse" *means* a graduate registered nurse (R.N.) or nurse who is licensed to practice nursing services by a governmental agency having jurisdiction over such licensing. Nurse is neither the Insured Person himself nor an Immediate Family Member.

"Physician" *means* a doctor of medicine (other than the Insured Person or an Immediate Family Member) who is licensed to practice medicine by:

a) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

b) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Regular Care and Attendance" *means* observation and treatment to the extent necessary under existing standards of medical practice for the condition requiring such treatment, disability, or causing Hospital confinement.

"Residence" *means* both the dwelling in Canada of which an Insured Person is an occupant and the premises on which it is situated.

"Sickness" *means* an impairment of normal physiological function and includes illness and infections.

"Spouse" *means* an individual residing in Canada and covered by a Provincial Health insurance plan under the age of seventy (70):

a) to whom the Insured Employee is legally married, or

b) with whom the Insured Employee has continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before a loss is incurred under the policy.

Only one (1) individual will qualify as a Spouse. If the Insured Employee is legally married but is also cohabiting with an individual as described under item (b) above, the Insured Employee may elect in writing which one of the individuals will qualify as a Spouse under the policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Employee is legally married.

GENERAL POLICY PROVISIONS

SECTION 1 - ELIGIBILITY FOR INSURANCE

1.1 Eligibility

Employees of the Employer belonging to the Eligible Employee class of insurance outlined in the Schedule shall be eligible for insurance from the date outlined in Section 2 – Effective Date of Individual Insurance, provided they are Actively at Work at such date.

The Employee's Spouse shall be eligible for insurance on the same date as the Employee himself or on a subsequent date on which they become a Spouse of the Employee.

Employees not Actively at Work on the date on which they would otherwise be eligible for insurance shall become eligible for insurance on the first (1^{st}) day of the month following the date of their return to work in the capacity for which they are made eligible for insurance.

Insured Persons must be full-time residents of Canada and be covered under their Provincial Government Health care plans.

In the event that two (2) Insured Employees are Spouses and are eligible for insurance under this policy, one (1) of the two (2) may choose to be insured as an Insured Spouse of the other in which case they will not be considered to be an Insured Employee or both may choose to be covered as an Insured Employee in which case neither will be eligible as a Spouse.

Notwithstanding preceding paragraphs, Employees in the service of the Employer on the Master Policy Effective Date whose coverage under another group insurance policy terminates on such date shall be eligible for insurance on the date on which the present policy shall come into force.

1.2 Participation in the Insurance Plan

For Employees and Spouses eligible for an Employer's mandatory insurance, participation in the insurance plan is mandatory.

SECTION 2 - EFFECTIVE DATE OF INDIVIDUAL INSURANCE

2.1 Employee's Insurance

Mandatory Insurance

The Employee's insurance shall become effective on the date he becomes eligible provided an application has been received by the Administrator before such date or within the thirty-one (31) days thereafter, otherwise, coverage becomes effective on the first (1st) day of the month following acceptance of Evidence of insurability by the Insurer.

2.2 Spouse's Insurance

Mandatory Insurance

Coverage for the Spouse shall become effective on the date on which they become eligible, provided the Administrator receives an application prior to such date or within thirty-one (31) days following such date; otherwise, coverage becomes effective on the first (1st) day of the month following the acceptance of Evidence of insurability by the Insurer.

Coverage for the Spouse can, at no time, become effective before the Insured Employee's Effective Date of Individual Insurance.

2.3 Actively at Work

If an Employee is not Actively at Work on the date his insurance would otherwise become effective or on the effective date of an increase in benefits, the insurance or increase will become effective on the date he returns to being Actively at Work.

2.4 Effective Hour on Effective Date

For the purposes of this policy, the Effective Date of Individual Insurance shall be the given date from 00:01 hour A.M. at the Residence of the Insured Employee.

SECTION 3 - CHANGE IN COVERAGE OF AN INSURED PERSON

Whenever an occurrence takes place affecting the class of insurance or revising the coverage of an Insured Person, the Policyholder agrees to notify the Administrator, in writing, within thirty-one (31) days.

In case of an increase of coverage, the new class of insurance or the revised coverage shall become effective from the first (1st) day of the month following the date on which the Administrator receives the notice from the Policyholder. If such notice is not received within the prescribed period, Evidence of insurability shall be required and the revised coverage shall become effective on the first (1st) day of the month following the acceptance of Evidence of insurability by the Insurer.

In the case of an increase of coverage and in the event that an Insured Employee is not Actively at Work in the service of his Employer on the date on which his class of insurance or his coverage would normally be revised, the revised coverage shall not become effective before the first (1st) day of the month following the effective date of his return to work in the capacity for which they are made eligible for insurance.

In the case of a decrease of coverage, the new class of insurance or the revised coverage shall become effective from the first (1st) day of the month following the date of the occurrence affecting the class of insurance or the coverage.

SECTION 4 - TERMINATION OF INDIVIDUAL INSURANCE

The insurance of an Insured Employee and of his Insured Spouse shall terminate on the earliest of:

a) the date the policy terminates;

b) the date the participating group/association terminates;

c) the last day of the month in which the Insured Employee ceases to be eligible for insurance or chooses to terminate their coverage;

d) the premium due date required for an Insured Employee in accordance with the conditions of this policy if such premiums are not paid to the Insurer prior to the expiration date of the Grace Period;

e) the premium due date following the date the Insured Employee ceases to be Actively at Work on account of leave of absence, lay-off, maternity leave, disability, resignation, or dismissal, except as provided under Section 5 - Continuation of Individual Coverage or Section 6 - Waiver of Premium;

f) the date on which the Waiver of Premium terminates, with respect to a benefit for which the premium is being waived under Section 6 - Waiver of Premium, unless the Insured Employee has resumed payment of the premium as an Employee;

g) the date on which the Insured Person collects or allows to be collected, as a result of false claims or misrepresentations originating from the Insured Person or a third party, benefit payments which are not provided by the policy, irrespective of the compulsory character of the coverage and of any other recourse which could be exercised by the Insurer;

h) the date the Insured Person ceases to be a Canadian resident;

i) the date the Insured Person ceases to be covered by a Provincial Health insurance plan; or

j) the date of the Insured Employee's death.

In addition to the above, and with respect to Coverage A: Employee and Spouse Mandatory Life Insurance, Coverage B: Employee and Spouse Mandatory Accidental Death or Dismemberment Insurance and Coverage C: Employee and Spouse Mandatory Critical Illness Insurance the insurance of an Insured Spouse coverage shall also terminate on the last day of the month in which the Insured Spouse ceases to be eligible for insurance.

Multiple Covered Critical Illness Conditions Termination

Coverage C: Employee and Spouse Mandatory Critical Illness Insurance is payable only once by the Insurer during the lifetime of the Insured Employee or Insured Spouse and coverage for that Insured Employee or Insured Spouse then terminates, regardless of the number of Critical Illnesses that may be diagnosed.

SECTION 5 - CONTINUATION OF INDIVIDUAL COVERAGE

5.1 Continuation of Coverage

a) An Insured Employee who ceases to be Actively at Work as a result of Sickness or injury may continue to be insured while disabled until the earlier of age sixty-five (65) or until his employment in a class of Employees eligible for insurance terminates, provided that the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way;

b) An Insured Employee who is no longer Actively at Work because of unpaid leave may continue to be insured during such leave until the earlier of age sixty-five (65) or a maximum period of twenty-four (24) months on unpaid leave provided the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way and within thirty-one (31) days of the start of such leave the Policyholder informs the Administrator of the date such leave is due to end;

c) An Insured Employee who would cease to be eligible for insurance on account of a temporary lay-off may continue to be insured during such lay-off until the earlier of age sixty five (65) or a maximum period of four (4) months on lay-off provided that the Policyholder pays to the Insurer the premium for such Insured Employee in the usual way;

   i) benefits continue to apply in the same manner as if there had not been a temporary lay-off;

   ii) the total premium is payable for the month during which the temporary lay-off begins; the total premium for the month, is payable during the other months while the absence from work resulting from a temporary lay-off is continued. However, if the lay-off does not persist for at least seven (7) consecutive days, the total premium for the month is payable for the month of the lay-off and for the month of return to work.

d) An Employee who does not continue to be insured for any reason under the provisions of items (a), (b) or (c) above at the very beginning of his unpaid leave or of his lay-off cannot do so thereafter;

e) The Policyholder must forward to the Administrator each month a list showing the name and the policy number of Insured Employees who are on unpaid leave, suspended and laid-off and of Insured Employees who are returning to work, specifying the date in each case.

5.2 Reinstatement of Individual Coverage

Wherever used throughout this policy, “Reinstatement” shall refer to this section.

a) The Employee who has not continued to be insured for any reason under the provisions of items (a), (b) or (c) in Section 5.1 Continuation of Coverage and who returns to work within the six (6) months following the start of his disability, unpaid leave or temporary lay-off may be insured again without having to satisfy his applicable Waiting Period;

b) An Employee whose coverage was continued under the provisions of items (a), (b) or (c) in Section 5.1 Continuation of Coverage and whose coverage was subsequently discontinued for any reason prior to returning to work and prior to the expiry of the maximum period available for Continuation of Coverage, will be terminated from coverage at the end of the month in which their coverage was discontinued. If the Employee returns to work within the six (6) months following the start of his disability, unpaid leave or temporary lay-off, the Employee may be insured again without having to satisfy his applicable Waiting Period.

SECTION 6 - WAIVER OF PREMIUM

6.1 Description of Disability Waiver of Premium

An Insured Person's insurance coverage will be continued without Premium Payment for one (1) year from the date proof of Total Disability satisfactory to the Insurer has been received if:

a) the Insured Employee becomes Totally Disabled while insured under the policy and while under age sixty-five (65); and

b) the Insured Employee remains Totally Disabled for at least six (6) months or such longer period as defined in the Certificate; and

c) such proof is given to the Insurer after the Insured Employee has been Totally Disabled for six (6) months; and

d) such proof is given to the Insurer no later than twelve (12) months after the last date for which insurance premium for the Insured Employee was paid.

An Insured Person's insurance coverage will be continued without premium payment for further periods of one (1) year if:

a) the Insured Employee remains Totally Disabled; and

b) proof of such Total Disability is given to the Insurer during the three (3) month period prior to each anniversary of the date of the original proof.

6.2 Requirements

Total Disability of the Insured Employee requires:

a) the regular attendance by a licensed Physician other than the Insured Person or Immediate Family Member; and

b) that Total Disability be caused by bodily injury resulting from an Accident occurring or Disease which first manifests after the Effective Date of Individual Insurance, but before age sixty-five (65); and

c) the accidental bodily injury or Disease prevents the Insured Employee from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience.

The Insurer, at its own expense, will have the right to examine any Insured Employee whose Total Disability allows for an Insured Person’s Premium Payments to be waived as often as may reasonably be required. A Physician of the Insurer’s choice will examine the Insured Employee.

6.3 Termination of the Waiver of Premium Benefit

The insurance under this Waiver of Premium benefit will cease on the earliest of:

a) the date the Insured Employee is no longer Totally Disabled;

b) the end of the last year for which proof of Total Disability was received by the Insurer;

c) the date the Insured Employee refuses to be examined as set forth above;

d) the date the Insured Employee is age sixty-five (65); or

e) the date this policy or the Certificate terminates (not applicable for Life Insurance benefits extended under Waiver of Premium).

SECTION 7 - CLAIMS

7.1 Beneficiary

a) The Insured Employee may, for any amount of insurance payable at his death and subject to applicable law, designate a beneficiary or change a designated beneficiary at any time by a written declaration filed with the Administrator.

b) The Insured Employee will be considered the beneficiary for all indemnities payable other than those listed in (a) above, including those payable for the Insured Spouse.

c) On the Effective Date of Individual Insurance the beneficiary is the executor or administrator of the estate of the Insured Employee or his heirs, unless the Insured Employee forwards a written declaration to the Administrator designating a beneficiary. Any designation or change in beneficiary shall be effective on the date the Insured Employee's written declaration is received at the office of the Administrator.

d) If, at the Insured Employee's death, there is no designated beneficiary, benefit payments shall be made to the executors or administrators of the estate of the Insured Employee, or his heirs.

e) If more than one (1) beneficiary is designated with no indication of their respective interests, they shall share equally in the benefit payments.

f) The rights of a beneficiary who predeceases the Insured Employee shall revert to the Insured Employee.

7.2 Notice and Proof of Claim

The Insured Person or an Insured Person's representative or a Beneficiary entitled to make a claim, shall:

a) give written notice of claim to the Insurer, not later than thirty (30) days from the date a claim arises under the contract

   i) by delivery thereof, or by sending it by mail to the Insurer's Administrative Office; or

   ii) by delivery thereof to the Insurer's authorized agent in the province.

b) within ninety (90) days from the date a claim arises under the contract

   i) furnish satisfactory proof to the Insurer as is reasonably possible, in the circumstances, providing evidence of the claim and the cause; and,

   ii) any other information the Insurer may reasonably require to establish the validity of the claim.

7.3 Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim. Where the claimant has not received the forms within that time the claimant may submit his proof of claim in the form of a written statement giving rise to the claim.

7.4 Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by this condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one (1) year from the date of death or the date a claim arises under the contract if it is shown that it was not reasonably possible to give notice or furnish proof within the time prescribed.

7.5 Reserving Rights

As a condition precedent to recovery of insurance money under this contract the Insurer reserves the right to:

a) examine the full details regarding the claim;

b) require the Insured Person to undergo a medical examination at the Insurer's expense;

c) examine the Insured Person when and so often as it reasonably required while the claim hereunder is pending;

d) require an autopsy to be performed on the Insured Person in the event of death, unless prohibited by law or religious belief; and

e) disallow the claim based on information developed from the attending Physician's report, medical examination, payroll records, or other sources of pertinent data.

7.6 Fraudulent Claims

Any claim for benefits under the policy which is based on false or incorrect information on an application, claim form or other documents required to verify benefits will result in the benefits being denied or the liability assumed by the Beneficiary if the benefit has already been provided or performed.

7.7 Limitation of Action

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (Alberta and B.C.).

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* (Manitoba).

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 *Limitations Act, 2002* (Ontario).

Otherwise, in Quebec every action must be brought within three (3) years after the date evidence is furnished, and in all other provinces within one (1) year from the date of loss or such longer period as may be required under the law applicable in such province.

7.8 Subrogation

The Insurer is subrogated in all the rights of Insured Persons against the third party liable for the damage that has given rise to an entitlement to payment of benefits under this policy up to the limitation of amounts paid by the Insurer.

The Insurer may, in the exercise of its right of subrogation and if it deems that a third party is liable, require that the Insured Person sign, if applicable, an act of subrogation in its favor at the time of paying any benefits.

7.9 Settlement Options

A lump sum payment of any amount payable under one (1) or several Life Insurance benefits provided under this policy, may, at the request of the Insured Employee or of the Beneficiary, be replaced by a method of payment mutually agreed upon by the Insured Employee or the Beneficiary and the Insurer such as a deposit bearing interest, guaranteed annuity, immediate or deferred life annuity.

7.10 Extension of Coverage under Previous Insurer

When a group insurance policy covering the Employees eligible for the present insurance, in effect immediately before the coming into force of this policy includes an extension of coverage, any amount payable under a benefit of this policy shall be reduced by the amount of any payment of benefits that the previous insurer is liable to make under such extension of coverage respecting a similar benefit.

SECTION 8 - PREMIUMS

All premiums shall be payable in advance and according to an agreed period, at the Administrative Office of the Insurer, in legal currency of Canada.

The Grace Period for payment of premiums is sixty (60) days. The insurance shall remain in force during such period provided that the premiums are paid before the expiration date of the Grace Period, otherwise, the policy shall be void retroactively to the due date of such premiums.

The amount of the premiums payable under this policy shall be the sum of the individual amounts payable for each Insured Employee.

The premium required for each Insured Employee does not vary during a contractual period, unless there is a change in the type of coverage or class of insurance. However, the Insurer reserves the right to change premium rates, during the contractual period when the amount or level of benefits payable or when the costs incurred by the Insurer under this policy are affected by a change or an addition to the tax systems, social security systems, a statute or a rule passed in regard to such laws or systems. Notice of such a change of premiums must be served in writing at least thirty-one (31) days prior to its effective date.

The monthly premium payable for each Insured Employee shall be determined in accordance with the Administrators “Group Insurance Master Applications”.

The amount of the premium actually received by the Insurer for an Insured Employee shall determine his class of insurance.

SECTION 9 - CONTRACT

9.1 Administration

The Insurer will deal solely with the Policyholder or Administrator who will be deemed the representative of each participating group/association. Any action taken by the Policyholder or Administrator will be binding on the participating Insured Person(s) of the group/association.

9.2 Clerical or Mechanical Errors

If a clerical or mechanical error by the Policyholder, Administrator or by the Insurer results in a person being incorrectly classified under the policy, then such person will be classified according to the true facts.

9.3 Conformity to Legislation

If this policy does not conform to legislation that governs it, it is considered automatically amended to comply with the minimum requirements of that legislation.

9.4 Currency

All payments under the policy, either to or by the Insurer, will be made in the lawful money of Canada.

9.5 Entire Contract

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

9.6 Insurance Data

The Administrator will give the Insurer all of the data that is needed to calculate the premium and all other data that is reasonably required. Failure of the Administrator to give this data will not void or continue an Employee’s insurance.

The Insurer has the right to examine the Policyholder’s records relative to these benefits at any reasonable time while the policy is in effect. The Insurer also has this right until all rights and obligations under the policy are finally determined.

9.7 Material Facts

No statement made by the Insured Person at the time of application for this contract shall be used in defense of a claim under or to avoid this contract unless it is contained in the application or any other written statement or answers furnished as Evidence of insurability.

9.8 Misrepresentation and Incontestability

The policy will be void and the Insurer's liability will be limited to the return of any premiums paid if incomplete, inaccurate, untrue or wrong information was submitted to the Insurer at any time and a claim arises under the policy during the first two (2) years from the Effective Date of Individual Insurance or two (2) years from most recent date of Reinstatement.

9.9 Misstatement of Age

If the age of an Insured Person has been misstated, the corrected age and facts will be used to determine whether insurance is in force under the policy and in what amount, and an equitable adjustment of premium will be made.

9.10 Non-Participating

This policy does not share in the Insurer's surplus earnings.

9.11 Renewal of Contract

This contract shall be automatically renewed, unless a written notice to the contrary is given by either of the parties, according to the advance renewal notice, at least sixty (60) days before the expiration date of the Renewal Date.

9.12 Responsibility of the Policyholder

The Policyholder agrees to forward to the Administrator the application forms of the eligible Employees applying for insurance, together with the data required to establish their class of insurance;

Upon the Insurer's request, the Policyholder also agrees to furnish the Insurer with the list of all persons eligible for insurance, whether actually insured or not, together with the data required to establish their class of insurance;

In the case of a collective and temporary cessation of work, the Policyholder shall provide the Administrator, without delay, with a list of the Insured Employees affected and the start date of the collective and temporary cessation of work.

9.13 Termination by the Group/Association

The participating group/association may terminate this insurance by advance written notice delivered to the Insurer at least thirty-one (31) days prior to the termination date.

9.14 Termination by the Insurer

The Insurer may terminate the policy by advance written notice delivered to the Policyholder at least thirty-one (31) days prior to the termination date.

9.15 Termination by the Policyholder

The Policyholder may terminate the policy on any premium due date by giving the Insurer written notice thirty-one (31) days before that date.

9.16 Waiver

The Insurer 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 the Insurer.

COVERAGE A: EMPLOYEE AND SPOUSE MANDATORY LIFE INSURANCE

SECTION A1 - DESCRIPTION OF COVERAGE

In accordance with the provisions of this policy, the Insurer will pay to the Beneficiary, following the death of an Insured Person covered by this benefit, the amount of Life Insurance for which the Insured Person is insured for provided the Insured Person was covered by this benefit at the time of his death.

SECTION A2 - AMOUNT OF LIFE INSURANCE

The amount of Life Insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Employee belongs and, if applicable, the Additional Insurance protection chosen by the Insured Employee. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The amount of life insurance for an Insured Person whose coverage is extended under Section 5.1 Continuation of Coverage or Section 6 - Waiver of Premium due to disability of the Insured Employee is equal to the amount in force at the onset of the Insured Employee's disability and is not changed while the coverage is extended under those sections except with regard to the reductions specified in the Schedule, if applicable.

SECTION A3 - EVIDENCE OF INSURABILITY

Additional Insurance protection for the Insured Person is subject to the acceptance of Evidence of insurability deemed satisfactory by the Insurer.

If an Insured Person, in the judgment of the Insurer, constitutes a higher risk, the Insurer may, at its discretion, either refuse the application for additional insurance or accept it subject to the payment of premiums in addition to those stipulated for this benefit.

SECTION A4 - EMPLOYEE AND SPOUSE LIFE INSURANCE EXCLUSIONS

A4.1 Suicide

If an Insured Person commits suicide, whether sane or insane, and has been insured for less than twenty-four (24) months by the Life Insurance protection or the previous Life Insurance protection which was replaced by this policy, the Insurer will refund the premiums collected for this Insured Person for Life Insurance coverage in lieu of paying the Life Insurance benefit.

If an Insured Person increases his amount of Life Insurance, the twenty-four (24) month period outlined above begins to run once again from the date the increase in amount of Life Insurance takes effect, but only for the increase of such amount.

A4.2 Pre-existing Exclusion

This exclusion applies to Insured Employees who are insured for mandatory Life Insurance coverage within a group comprised of four (4) or less Employees.

No Life Insurance benefit shall be payable if, twenty-four (24) months immediately prior to the Effective Date of Individual Insurance, the Insured Person was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to the Insured Person's death, unless the death of the Insured Person occurs later than twenty-four (24) consecutive months from the Effective Date of Individual Insurance or date of most recent Reinstatement of coverage under this policy.

If this policy directly replaces one with another Insurer providing similar benefits, an Insured Person who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

An Insured Person who has not satisfied the time period of pre-existing conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Conditions Exclusion, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

SECTION A5 - EARLY PAYMENT PRIVILEGE

When the protection of a Insured Employee is prolonged without payment of the premiums in accordance with the provisions provided in Section 5 - Waiver of Premium of the present benefit and the Insured Employee's life expectancy is no more than twelve (12) months, the Insured Employee is entitled, if a written request is sent to the Insurer's Administrative Office, to receive Living Benefits equal to the lesser of fifty thousand ($50,000) dollars or twenty five per cent (25%) of the Life Insurance amount for which the Insured Employee is insured for; in the latter case, the amount of Life Insurance used in the calculation is established by immediately considering all reductions of coverage provided in the Schedule, if applicable, that should take place during the twenty-four (24) month period following the date of the request by the Insured Employee.

The Insured Employee who wishes continue to be insured for any reason under this privilege must provide to the Insurer proof showing:

a) that the Insured Employee's life expectancy is not more than twelve (12) months of the date of the Insured Employee's request, and if necessary;

b) acceptance from the Insured Employee's Beneficiary if the latter is other than the executors or administrators of the estate of the Insured Employee or his heirs.

At the time of the Insured Employee's death, the amount otherwise payable for the Insurer to the Beneficiary is reduced by the amount paid in Living Benefits to the Insured Employee in accordance with the present privilege.

COVERAGE B: EMPLOYEE AND SPOUSE MANDATORY ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE

SECTION B1 - DESCRIPTION OF COVERAGE

In accordance with the provisions of this policy, the Insurer will pay, should the Insured Person suffer an Injury, those losses as listed in Section B5 - Benefits provided the Insured Person was covered by this benefit at the time of the Accident.

"Injury" as used in this benefit *means* bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

SECTION B2 - AIRCRAFT COVERAGE

Insurance provided under this Employee and Spouse Mandatory Accidental Death or Dismemberment Insurance includes Injury sustained by an Insured Person while and in consequence of:

a) riding as a passenger, in or on any aircraft operated on a regular, special or chartered flight by a domestic or international scheduled air carrier, licensed by the Department of Transport of Canada or the governmental authority having jurisdiction over such air carrier in the country of its registry; or

b) riding as a passenger, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country; or

c) boarding or alighting from or being struck by any aircraft.

Notwithstanding (a) and (b) above, this policy excludes Injury sustained while and in consequence of:

a) riding as a pilot, operator or member of the crew in or on any aircraft; or

b) riding as a passenger, in or on any aircraft owned, operated, or leased by or on behalf of the Policyholder.

SECTION B3 - EXPOSURE AND DISAPPEARANCE

If, by reason of an Accident covered by this policy, an Insured Person is unavoidably exposed to the elements and as the result of such exposure, suffers a loss for which indemnity is otherwise payable under this Employee and Spouse Mandatory Accidental Death or Dismemberment Insurance, such loss will be covered under the terms of this policy.

If the Insured Person is not found within one (1) year after the date of the disappearance, sinking or wrecking of the conveyance in which the Insured Person was riding at the time of the Accident and under such circumstances as would otherwise be covered hereunder, it will be presumed the Insured Person suffered a Loss of Life resulting from Injury caused by an Accident at the time of such disappearance, sinking or wrecking.

SECTION B4 - AMOUNT OF ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE

The amount of Accidental Death or Dismemberment Insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Employee belongs and, if applicable, the Additional Insurance protection chosen by the Insured Employee. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The amount of Accidental Death or Dismemberment insurance for an Insured Person whose coverage is extended under Section 5.1 Continuation of Coverage or Section 6 - Waiver of Premium due to disability of the Insured Employee is equal to the amount in force at the onset of his disability and is not changed while the coverage is extended under those sections. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The benefit is calculated by applying the benefit percentage shown in Section B5.1 Specific Loss Accident Indemnity to the Benefit Amount of insurance. For multiple losses, the percentages are added together but the benefit cannot exceed one hundred per cent (100%) of the Benefit Amount of insurance for all losses relating to the same Accident.

No benefit is paid for losses resulting from an Accident occurring prior to the Effective Date of Individual Insurance.

SECTION B5 - BENEFITS

B5.1 Specific Loss Accident Indemnity

When Injury results in any of the following losses within three hundred and sixty five (365) days after the date of the Accident, the Insurer will pay:

For Loss of:	% of Benefit Amount
Life	100%
Entire Sight of Both Eyes	100%
Speech and Hearing in Both Ears	100%
One Hand and the Entire Sight of One Eye	100%
One Foot And the Entire Sight of One Eye	100%
Entire Sight of One Eye	75%
Speech	75%
Hearing in Both Ears	75%
Hearing in One Ear	40%
All Toes of One Foot	33.33%

For Loss or Loss of Use of:	% of Benefit Amount
Both Hands	100%
Both Feet	100%
One Hand and One Foot	100%
One Arm	80%
One Leg	80%
One Hand	75%
One Foot	75%
Thumb and Index Finger or at Least Four Fingers of One Hand	40%

For Paralysis of:	% of Benefit Amount
Both Upper and Lower Limbs (Quadriplegia)	200%
Both Lower Limbs (Paraplegia)	200%
Upper and Lower Limbs of One Side of Body (Hemiplegia)	200%

"Loss of Life" *means* the death of the Insured Person.

"Loss" as above used with reference to:

a) **hand or foot** *means* complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

b) **arm or leg** *means* complete severance through or above the elbow or knee joint;

c) **thumb** *means* the complete severance of one (1) entire phalanx of the thumb;

d) **finger** *means* the complete severance of two (2) entire phalanges of the finger;

e) **toe** *means* the complete severance of one (1) entire phalanx of the big toe and all phalanges of the other toes;

f) **eye** *means* the irrecoverable loss of the entire sight thereof.

"Loss of Speech" *means* complete and irrecoverable loss of the ability to utter intelligible sounds.

"Loss of Hearing" *means* complete and irrecoverable loss of hearing.

"Paralysis" *means* the loss of ability to move all or part of the body.

"Quadriplegia" *means* the permanent Paralysis and functional loss of use of both upper and lower limbs.

"Paraplegia" *means* the permanent Paralysis and functional loss of use of both lower limbs.

"Hemiplegia" *means* the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Loss of Use" *means* the total and irrecoverable loss of use, provided the loss is continuous for twelve (12) consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section for all Losses sustained by any one (1) Insured Person as the result of any one (1) Accident will not exceed the following:

a) with the exception of Quadriplegia, Paraplegia and Hemiplegia, the Benefit Amount.

b) with respect to Quadriplegia, Paraplegia and Hemiplegia, two hundred per cent (200%) of the Benefit Amount, or the Benefit Amount if Loss of Life occurs within ninety (90) days after the date of the Accident.

In no event will indemnity payable for all Losses under this section exceed, in the aggregate, two hundred per cent (200%) of the Benefit Amount as the result of the same Accident.

B5.2 Permanent Total Disability Indemnity

When, as the result of an Injury an Insured Employee becomes Totally Disabled within three hundred and sixty five (365) days of the date of the Accident the Insurer will pay in one (1) sum, provided such disability has continued for a period of twelve (12) consecutive months and is total and permanent at the end of this period, the Benefit Amount, less any other amount paid or payable under Section B5.1 Specific Loss Accident Indemnity of this policy as the result of the same Accident.

"Totally Disabled" as used above *means* the Insured Employee is prevented from engaging in each and every occupation or employment for compensation or profit for which he is or may become reasonably qualified by reason of his education, training or experience.

B5.3 Cosmetic Disfigurement Benefit

When, as a direct result of suffering a loss under the circumstances described in Section B1 - Description of Coverage and Section B2 - Aircraft Coverage, an Insured Person suffers cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement Benefit, provided that such burn is classified as a third (3rd) degree burn.

The amount of benefit payable under this section is based on the percentage of the Benefit Amount, as shown in the Cosmetic Burn Schedule below, which is determined by the Area Classification Factor times the percentage of body surface actually burned.

The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Schedule, is based on one hundred per cent (100%) of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.

If an Insured Person suffers burns to more than one (1) body part as a result of any one (1) Accident, benefits payable for all such burns will not exceed one hundred per cent (100%) of the Benefit Amount.

Cosmetic Burn Schedule

Body Part	Area Classification Factor
Face, Neck, Head	11
Hand & Forearm (Right)	5
Hand & Forearm (Left)	5
Upper Arm (Right)	3
Upper Arm (Left)	3
Torso (Front)	2
Torso (Back)	2
Thigh (Right)	1
Thigh (Left)	1
Lower Leg - below knee (Right)	3
Lower Leg - below knee (Left)	3

Body Part	Maximum Allowable % for Body Surface Burned
Face, Neck, Head	9.0%
Hand & Forearm (Right)	4.5%
Hand & Forearm (Left)	4.5%
Upper Arm (Right)	4.5%
Upper Arm (Left)	4.5%
Torso (Front)	18.0%
Torso (Back)	18.0%
Thigh (Right)	9.0%
Thigh (Left)	9.0%
Lower Leg - below knee (Right)	9.0%
Lower Leg - below knee (Left)	9.0%

Body Part	Maximum % of Benefit Amount Payable
Face, Neck, Head	99.9%
Hand & Forearm (Right)	22.5%
Hand & Forearm (Left)	22.5%
Upper Arm (Right)	13.5%
Upper Arm (Left)	13.5%
Torso (Front)	36.0%
Torso (Back)	36.0%
Thigh (Right)	9.0%
Thigh (Left)	9.0%
Lower Leg - below knee (Right)	27.0%
Lower Leg - below knee (Left)	27.0%

In the event benefits are payable under this section and Section B5.1 Specific Loss Accident Indemnity or Section B5.2 Permanent Total Disability Indemnity, the total benefits payable will not exceed one hundred per cent (100%) of the Benefit Amount (or two hundred per cent (200%) for Paralysis).

B5.4 Hospital Indemnity

A Daily Benefit will be payable to the Insured Person when the Insured Person is in a Hospital and under the Regular Care and Attendance of a Physician, but only if such Period of Hospitalization is necessary for the treatment of an Injury which results in a Loss payable under Section B5.1 Specific Loss Accident Indemnity of this Employee and Spouse Accidental Death or Dismemberment Insurance. Such Daily Benefit will be paid from the first (1st) Day of Hospitalization, but in no event for more than three hundred and sixty five (365) days per Accident.

Notwithstanding anything contained to the contrary in this policy, a Period of Hospitalization which becomes necessary for the treatment of an Injury other than for a specific Loss will be covered in accordance with the terms of this section provided such Period of Hospitalization commences:

a) within three hundred and sixty five (365) days of the date of the Accident causing such Injury; and

b) while insurance under this policy is in force as to that Insured Person.

Such Daily Benefit will be paid from the fifth (5th) Day of Hospitalization.

Only one (1) Period of Hospitalization will be payable for all Injuries sustained by the Insured Person as the result of the same Accident.

"Daily Benefit" *means* one-thirtieth of one per cent (1/30 of 1%) of the Insured Person's Benefit Amount, to a maximum monthly benefit of two thousand five hundred dollars ($ 2,500), which maximum is in combination with the Hospital Indemnity maximum provided under any other policy issued to the Policyholder by the Insurer.

"Period of Hospitalization" *means* a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less than ninety (90) consecutive days and all such confinements occur within seven hundred and thirty (730) days of the date of the Accident.

"Day of Hospitalization" *means* a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day's room and board is charged.

B5.5 Education Benefit

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee and indemnity for such Loss becomes payable in accordance with the terms of this Employee and Spouse Accidental Death or Dismemberment Insurance, the Insurer will pay the lesser of the following amounts for any Dependent Child who, on the date of or within three hundred and sixty five (365) days of the Insured Employee's death, is enrolled as a full-time student in any Institution for Higher Learning:

a) five per cent (5%) of the Insured Employee's Specific Loss Accident Indemnity Benefit Amount or

b) five thousand dollars ($ 5,000) for each year (up to four (4) consecutive years) such child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section in combination with the Education Benefit maximum provided under any other policy issued by the Insurer will not exceed five thousand dollars ($5,000) per year.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning.

In the event an Insured Employee's Dependent Child satisfies the requirements indicated above, such child will be deemed the Beneficiary with respect to the benefits payable under this provision. If none of the Insured Employee's Dependent Children satisfy the above requirements or the requirements as shown under Section B5.6 Day Care Benefit, the Insurer will pay to the Insured Employee's Beneficiary the lesser of the following amounts:

a) five per cent (5%) of the Insured Employee's Specific Loss Accident Indemnity Benefit Amount or

b) two thousand and five hundred dollars ($ 2,500) under one (1) of the policies issued by the Insurer.

The following definitions are applicable only to this benefit:

"Institution for Higher Learning" is limited to universities, colleges, CEGEPs and trade schools.

"Dependent Child" *means* a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Employee. The child is unmarried, under twenty-five (25) years of age (twenty-six (26) in the province of Quebec) and dependent upon the Insured Employee for maintenance and support.

B5.6 Day-Care Benefit

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee and indemnity for such Loss becomes payable in accordance with the terms of this Employee and Spouse Accidental Death or Dismemberment Insurance, the Insurer will pay the lesser of the following amounts for any Dependent Child who, on the date of or within three hundred and sixty five (365) days of the Insured Employee's death, is enrolled in a legally licensed Day-Care Centre:

a) five per cent (5%) of the Insured Employee's Benefit Amount or

b) five thousand dollars ($ 5,000) for each year (up to four (4) consecutive years) such child remains enrolled in a legally licensed Day-Care Centre.

The total maximum payable under this section in combination with the Day-Care Benefit maximum provided under any other policy issued by the Insurer will not exceed five thousand dollars ($ 5,000) per year.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled in a legally licensed Day-Care Centre.

In the event an Insured Employee's Dependent Child satisfies the above requirements, this benefit will be payable to the surviving Spouse if the Spouse has custody of the child or to the child's guardian legally appointed to manage the person of the child.

If none of the Insured Employee's Dependent Children satisfy the above requirements or the requirements as shown under Section B5.5 Education Benefit, the Insurer will pay to the Insured Employee's Beneficiary the lesser of the following amounts:

a) five per cent (5%) of the Insured Employee's Benefit Amount or

b) two thousand and five hundred dollars ($ 2,500) under one (1) of the policies issued by the Insurer.

The following definitions are applicable only to this benefit:

"Day-Care Centre" *means* a facility, which is run according to the law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will not include a Hospital, the child's home or care provided during normal school hours while the Dependent Child is attending grades one (1) through twelve (12).

"Dependent Child" *means* a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Employee. The child is under thirteen (13) years of age and dependent upon the Insured Employee for maintenance and support.

B5.7 Seat Belt Benefit

In the event an Insured Person sustains an Injury which results in a Loss payable under Section B5.1 Specific Loss Accident Indemnity of this Employee and Spouse Accidental Death or Dismemberment Insurance, the Insurer will pay an additional sum equal to ten per cent (10%) of the applicable amount payable under Section B5.1 Specific Loss Accident Indemnity, subject to a maximum of twenty five thousand dollars ($ 25,000), which maximum is in combination with the Seat Belt Benefit maximum provided under any other policy issued to the Policyholder by the Insurer, if at the time of the Accident, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt.

The driver of the Motorized Vehicle must hold a current and valid driver's license of a rating authorizing him to operate such Motorized Vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the Accident. "Intoxicated" and "under the influence of drugs" are as defined by the local jurisdiction where the Accident occurs.

Due proof of Seat Belt use must be provided as part of the written Proof of Loss.

"Motorized Vehicle" *means* a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

"Seat Belt" *means* those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

B5.8 Occupational Training Expense

In the event a Loss of Life resulting from Injury is sustained by an Insured Employee and indemnity for such Loss becomes payable in accordance with the terms of this Employee and Spouse Accidental Death or Dismemberment Insurance, the Insurer will pay the reasonable and necessary expenses actually incurred, within three (3) years from the date of such Loss, by the Spouse of the Insured Employee who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of fifteen thousand dollars ($ 15,000) for all such expenses. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

In the event the Insured Employee's Spouse satisfies the requirements indicated above, such Spouse will be deemed the Beneficiary with respect to the benefits payable under this provision.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

B5.9 Rehabilitation Expense

In the event an Insured Employee sustains an Injury which results in a Loss payable under Section B5.1 Specific Loss Accident Indemnity of this Employee and Spouse Accidental Death or Dismemberment Insurance, and such Injury requires that the Insured Employee participate in a rehabilitation program in order to be qualified to engage in an occupation in which he would not have engaged except for such Injury, the Insurer will pay the reasonable and necessary expenses actually incurred, within three (3) years from the date of Loss, by the Insured Employee for such program.

Payment by the Insurer for the total of all expenses incurred by any Insured Employee will not exceed fifteen thousand dollars ($ 15,000) as the result of any one (1) Accident. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

B5.10 Home Alteration and/or Vehicle Modification Expense

When, by reason of Injury, an Insured Person sustains the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity is payable in accordance with the terms of this Employee and Spouse Accidental Death or Dismemberment Insurance, and he subsequently requires the use of a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three (3) years of the date of Loss for:

a) the cost of alterations to the Insured Person's principal Residence for the purpose of making it accessible; and/or

b) the cost of modifications to one (1) motor vehicle utilized by the Insured Person, when such modifications are approved by licensing authorities where required for the purpose of adapting it to the needs of the Insured Person.

Payment by the Insurer for the total of all expenses incurred by or for any Insured Person will not exceed a maximum of fifteen thousand dollars ($ 15,000) as the result of any one (1) Accident. The amount payable under this section will be coordinated with any amount paid or payable under any other insurance plan providing the same or similar benefit.

B5.11 Workplace Modification and Accommodation Expense

In the event an Insured Employee sustains an Injury which results in a Loss payable under Section B5.1 Specific Loss Accident Indemnity of this Employee and Spouse Accidental Death or Dismemberment Insurance, and such Insured Employee requires special adaptive equipment and/or workplace modification in order to reasonably accommodate his return to active full-time work with the Policyholder, the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder provided:

a) the Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of such Insured Employee;

b) the Policyholder acknowledges in writing that the performance of the essential duties of such Insured Employee's job may be altered;

c) the proposed special adaptive equipment and/or workplace modification must have prior written approval by the Insurer; and

d) the Insurer has the right to examine the Insured Employee to evaluate the appropriateness of the proposed modifications.

The benefit will be paid to the Policyholder upon the Insured Employee's return to active full-time work with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder will not exceed five thousand dollars ($ 5,000) as a result of any one (1) Accident.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

B5.12 Repatriation Expense

In the event a Loss of Life resulting from Injury is sustained by an Insured Person more than fifty (50) kilometres from the Insured Person's normal place of Residence and indemnity for such Loss becomes payable in accordance with the terms of this Employees and Spouse Accidental Death or Dismemberment Insurance, the Insurer will pay the reasonable and customary expenses actually incurred for the transportation of the body of the deceased Insured Person to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of Residence of the deceased, including charges for the preparation of the body for such transportation. Payment by the Insurer will not exceed the aggregate amount of fifteen thousand dollars ($ 15,000) for all such expenses.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

B5.13 Identification Expense

In the event a Loss of Life resulting from Injury is sustained by an Insured Person and the police or similar governmental authority requires identification of the Insured Person's body, the Insurer will reimburse one (1) Immediate Family Member's or a family representative's expenses incurred for transportation to the location of the Insured Person's body and return to his normal place of Residence by the most direct route and for lodging and board, up to a maximum of ten thousand dollars ($10,000). If transportation is by any motor vehicle not for hire then the reimbursement of transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled. The Insured Person's body must be located more than one hundred fifty (150) kilometres from the Immediate Family Member's residence.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

B5.14 Family Transportation Expense

When, by reason of Injury, an Insured Person sustains a Loss payable under Section B5.1 Specific Loss Accident Indemnity of this Employee and Spouse Accidental Death or Dismemberment Insurance, an Insured Person is confined as an inpatient in a Hospital located more than one hundred and fifty (150) kilometres from his normal place of Residence and such Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable expenses actually incurred by any Immediate Family Member(s) or a family representative for Accommodation and transportation by the most direct route from the normal place of residence of the Immediate Family Member(s) or family representative to the confined Insured Person and return to the normal place of residence of such Immediate Family Member(s) or family representative, not to exceed in the aggregate the amount of fifteen thousand dollars ($ 15,000) for all such expenses as the result of any one (1) Accident. Payment will not be made for board or other ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of thirty-five cents ($ 0.35) per kilometre travelled.

"Accommodation" *means* lodging in the vicinity of the Hospital where the Insured Person is confined.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

SECTION B6 - AGGREGATE LIMIT OF INDEMNITY

The Insurer's aggregate limit of indemnity for all losses arising out of any one (1) Accident, for which coverage is provided hereunder, is as stated in the Schedule. In the event said limit of indemnity for any one (1) Accident is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person will be in the proportion that the limit of indemnity for any one (1) Accident bears to the total amount of insurance that would have been payable, except for such limit of indemnity.

This section only applies to losses payable under Section B5.1 Specific Loss Accident Indemnity, Section B5.2 Permanent Total Disability Indemnity and B5.3 Cosmetic Disfigurement Benefit.

SECTION B7 - EMPLOYEE AND SPOUSE MANDATORY ACCIDENTAL DEATH OR DISMEMBERMENT INSURANCE EXCLUSIONS

This policy does not cover any Loss, fatal or non-fatal, caused or contributed to by:

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

b) war or civil war, whether declared or undeclared;

c) participation in a riot, insurrection, civil commotion or disturbance;

d) perpetration or attempted perpetration by the Insured Person of a crime or his participation in a crime;

e) active full-time, part-time or temporary service in the armed forces of any country;

f) riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in Section B2 - Aircraft Coverage;

g) medical treatment or Surgery, except if the medical treatment or Surgery was needed because of an Accident.

COVERAGE C: EMPLOYEE AND SPOUSE MANDATORY CRITICAL ILLNESS INSURANCE

SECTION C1 - DEFINITIONS SPECIFIC TO THE EMPLOYEE AND SPOUSE CRITICAL ILLNESS INSURANCE

"Critical Illness" *means* an illness, disorder or Surgery which is specifically covered and defined herein and which is not specifically excluded. See Section C5 - Critical Illness Conditions - Defined for definitions of critical illness conditions.

"Date of Diagnosis" *means* the date on which a Specialist first diagnosed the Insured Person with one (1) of the covered Critical Illness conditions. The date of diagnosis must be after the Effective Date of Individual Insurance or date of most recent Reinstatement and while the policy and group/association is in force.

"Diagnosis" *means* the certified diagnosis of a covered Critical Illness condition by a Specialist. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be diagnosed by a qualified medical Physician practicing in Canada, the United States, or in such other jurisdiction as the Insurer may approve.

"Irreversible" *means* the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve undue risk to the Insured Person's health.

"Life Support" *means* the Insured Person is under the Regular Care and Attendance of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

"Specialist" *means* a Physician registered and licensed to practice in Canada, the United States, or such other jurisdiction as the Insurer may approve whose practice is limited to the particular branch of medicine relating to the applicable Critical Illness condition. The specialist must be a person other than the Insured Person or a relative or a business associate of either.

"Surgery" *means* that the Insured Person actually undergoes surgery performed on the written advice of a Physician. The surgery must be performed by a Physician, in Canada, the United States, or in such other jurisdiction as the Insurer may approve. Surgery will include the medical procedure for transplanting bone marrow.

"Survival Period" *means* the period starting on the Date of Diagnosis of the Critical Illness condition and ending thirty (30) days following the Date of Diagnosis of the Critical Illness condition, 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 at the end of the survival period and must not have experienced Irreversible cessation of all functions of the brain. The premium is still payable when due during a survival period.

SECTION C2 - DESCRIPTION OF COVERAGE

In accordance with the provisions of this policy, the Insurer will pay the Benefit Amount for Critical Illness to the Beneficiary, if the Insured Person is diagnosed by a Specialist with a covered Critical Illness condition or undergoes a covered Critical Illness Surgery as defined in Section C5 - Critical Illness Conditions - Defined.

The Insured Person must survive the Survival Period and the Diagnosis must be made on or after the Effective Date of Individual Insurance or the date of the Insured Person's most recent Reinstatement and while this policy and the group/association is in force.

SECTION C3 - AMOUNT OF CRITICAL ILLNESS INSURANCE

The amount of Critical Illness Insurance is the Benefit Amount shown in the Schedule according to the class of insurance to which the Insured Person belongs and, if applicable, the Additional Insurance protection chosen by the Insured Person. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

The amount of Critical Illness Insurance for an Insured Person whose coverage is extended under Section 5.1 Continuation of Coverage or Section 6 - Waiver of Premium due to disability of the Insured Employee is equal to the amount in force at the onset of the Insured Employee's disability and is not changed while the coverage is extended under those sections. Reduction in Benefit Amounts will apply if stipulated in the Schedule.

SECTION C4 - COVERED CRITICAL ILLNESS CONDITIONS

The following Critical Illness conditions are provided in this policy. Refer to Section C5 - Critical Illness Conditions - Defined for definitions.

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

SECTION C5 - CRITICAL ILLNESS CONDITIONS – DEFINED

C5.1 Alzheimer's Disease

"Alzheimer's Disease" *means* a definite Diagnosis of a progressive degenerative disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of eight (8) hours of daily supervision. The Diagnosis of Alzheimer's Disease must be made by a Specialist.

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

C5.2 Aortic Surgery

"Aortic Surgery" *means* the undergoing of Surgery for Disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery outlined above. The Surgery must be determined to be medically necessary by a Specialist.

C5.3 Aplastic Anemia

"Aplastic Anemia" *means* 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 (1) of the following:

a) marrow stimulating agents;

b) immunosuppressive agents;

c) bone marrow transplantation.

The Diagnosis of Aplastic Anemia must be made by a Specialist.

C5.4 Bacterial Meningitis

"Bacterial Meningitis" *means* a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least ninety (90) days from the Date of Diagnosis. The Diagnosis of Bacterial Meningitis must be made by a Specialist.

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

C5.5 Benign Brain Tumour

"Benign Brain Tumour" *means* a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

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

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

Within the first ninety (90) days following the later of:

a) the Effective Date of Individual Insurance; or

b) the effective date of last Reinstatement;

the Insured Person has any of the following:

a) signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made; or

b) a Diagnosis of Benign Brain Tumour.

This medical information as described above must be reported to the Insurer within six (6) months of the Date of Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Benign Brain Tumour or, any Critical Illness caused by any Benign Brain Tumour or its treatment.

C5.6 Blindness

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

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

b) the field of vision being less than twenty (20) degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

C5.7 Cancer (Life-Threatening)

"Cancer (Life-Threatening)" *means* a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

a) carcinoma in situ, or

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

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

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

Moratorium Period Exclusion: No benefit will be payable under this condition if within the first ninety (90) days following the later of:

a) the Effective Date of Individual Insurance; or

b) the effective date of last Reinstatement;

the Insured Person has any of the following:

a) signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made;

b) a Diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the Insurer within six (6) months of the Date of Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any Cancer or its treatment.

C5.8 Coma

"Coma" *means* a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least ninety-six (96) hours, and for which period the Glasgow coma score must be four (4) or less. The Diagnosis of Coma must be made by a Specialist.

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

a) a medically induced coma; or

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

c) a Diagnosis of brain death.

C5.9 Coronary Artery Bypass Surgery

"Coronary Artery Bypass Surgery" *means* the undergoing of heart Surgery to correct narrowing or blockage of one (1) or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery as outlined above. The Surgery must be determined to be medically necessary by a Specialist.

C5.10 Deafness

"Deafness" *means* a definite Diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of ninety (90) decibels or greater within the speech threshold of five hundred (500) to three thousand (3,000) hertz. The Diagnosis of Deafness must be made by a Specialist.

C5.11 Heart Attack

"Heart Attack" *means* a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) 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.

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

a) elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or

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

C5.12 Heart Valve Replacement

"Heart Valve Replacement" *means* 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 Specialist. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes Surgery as outlined above.

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

C5.13 Kidney Failure

"Kidney Failure" *means* 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 by a Specialist.

C5.14 Loss of Independent Existence

"Loss of Independent Existence" *means* a definite Diagnosis of:

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

b) Cognitive Impairment, as defined below;

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

The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene.
- 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 use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

"Cognitive Impairment" *means* mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight (8) hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

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

C5.15 Loss of Limbs

"Loss of Limbs" *means* a definite Diagnosis of the complete severance of two (2) 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 by a Specialist.

C5.16 Loss of Speech

"Loss of Speech" *means* a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical Injury or Disease, for a period of at least one hundred eighty (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.

C5.17 Major Organ Failure on Waiting List

"Major Organ Failure on Waiting List" *means* a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person's enrolment in the transplant centre. The Diagnosis of the Major Organ Failure must be made by a Specialist.

C5.18 Major Organ Transplant

"Major Organ Transplant" *means* a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. For the purposes of the Survival Period, the Date of Diagnosis is the date the Insured Person undergoes the transplant procedure as outlined above. The Diagnosis of the Major Organ Failure must be made by a Specialist.

C5.19 Motor Neuron Disease

"Motor Neuron Disease" *means* a definite Diagnosis of one (1) 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 by a Specialist.

C5.20 Multiple Sclerosis

"Multiple Sclerosis" *means* a definite Diagnosis of at least one (1) of the following:

a) two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or

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

c) 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 (1) month apart.

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

C5.21 Occupational HIV Infection

"Occupational HIV Infection" *means* a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the Effective Date of Individual Insurance, or the effective date of last Reinstatement.

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

a) The accidental injury must be reported to the insurer within fourteen (14) days of the accidental injury; and

b) A serum HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative; and

c) A serum HIV test must be taken between ninety (90) days and one hundred eighty (180) days after the accidental injury and the result must be positive; and

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and

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

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

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

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

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

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

C5.22 Paralysis

"Paralysis" *means* a definite Diagnosis of the total loss of muscle function of two (2) or more limbs as a result of injury or Disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

C5.23 Parkinson's Disease

"Parkinson's Disease" *means* a definite Diagnosis of primary idiopathic Parkinson's Disease, which is characterized by a minimum of two (2) or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses). The Insured Person must require substantial physical assistance from another adult to perform at least two (2) of the following six (6) Activities of Daily Living. The Diagnosis of Parkinson's Disease must be made by a Specialist.

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene.
- 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 use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

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

C5.24 Severe Burns

"Severe Burns" *means* is defined as "a definite Diagnosis of third-degree burns over at least twenty per cent (20%) of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

C5.25 Stroke

"Stroke" *means* a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

a) acute onset of new neurological symptoms; and

b) new objective neurological deficits on clinical examination;

persisting for more than thirty (30) days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist.

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

a) Transient Ischaemic Attacks; or

b) Intracerebral vascular events due to trauma; or

c) Lacunar infarcts which do not meet the definition of stroke as described above.

SECTION C6 - EMPLOYEE AND SPOUSE MANDATORY CRITICAL ILLNESS EXCLUSIONS

No Critical Illness Benefit Amount shall be due or payable if the Insured Person's medical condition (listed in Section C4 - Covered Critical Illness Conditions and defined in Section C5 - Critical Illness Conditions - Defined) results directly or indirectly from any of the following:

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

b) use of illegal or illicit drugs or substances, or misuse of medication obtained with or without prescription; or

c) if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care or services including diagnostic measures as prescribed by his attending Physician.

In addition to the above exclusions, the Critical Illness benefit will not be payable for any Cancer that manifests itself prior to the Effective Date of Individual Insurance when the same Cancer either recurs or metastasizes after such Effective Date.

C6.1 Pre-Existing Conditions Exclusion

No Critical Illness benefit shall be payable if, twenty-four (24) months immediately prior to the Effective Date of Individual Insurance, the Insured Person was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to a Diagnosis of or treatment for a Critical Illness condition unless the Diagnosis of the Critical Illness condition occurs later than twenty-four (24) consecutive months from the Effective Date of Individual Insurance or date of most recent Reinstatement of coverage under this policy.

If this policy directly replaces one with another Insurer providing similar benefits, an Insured Person who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the Benefit Amount and Critical Illnesses covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

An Insured Person who has not satisfied the time period of pre-existing conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Conditions Exclusion, but only to the extent of the Benefit Amount covered in the prior policy. Any additional Benefit Amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.