Children360 insurance

HUMANIA ASSURANCE MD®

Is your child eligible for Children360?

The policy owner must answer five (5) eligibility questions and ten (10) insurability questions.

Eligibility

To determine a child's eligibility, the policy owner must answer the following questions:

1.	Are you the mother, father or legal guardian of the child to be insured?	**Yes**	No
2.	Does the child to be insured reside with you at least 4 days per month, every month of the year?	**Yes**	No
3.	Was the child born in Canada?	Yes	**No**
3a.	If **Not**: Has the child been a permanent resident of Canada for over two years?	**Yes**	No
4.	Has the child had an application for life insurance or critical illness insurance refused or deferred, or subjected to extra premiums? Or was the child offered insurance with an exclusion?	Yes	**No**

5. BMI Verification

Children aged three (3) years or older must meet the body mass index (BMI) standard as defined by Humania Assurance for the Children360 product. The BMI is not used for children aged two (2) years old or under. But we will ask its weight at birth.

Age	Minimum	Maximum
3	14.15	18.30
4	13.86	17.85
5	13.67	17.91
6	13.56	18.36
7	13.53	19.08

Age	Minimum	Maximum
8	13.58	19.99
9	13.72	21.00
10	13.97	22.15
11	14.53	23.13

Age	Minimum	Maximum
12	14.94	24.15
13	15.46	25.17
14	15.95	25.98
15	16.51	26.77

The body mass index (BMI) is a measure used to define the terms underweight, overweight and obese.
BMI is calculated using the following formula: BMI = weight (kg) / height (m^2).

Insurabililty

To determine a child's insurability, the policy owner must answer **NO to questions six (6) through fifteen (15)**.

6.	Have two (2) or more family members of the child to be insured (mother, father, brother or sister) been diagnosed before the age of sixty (60) with any of the following disorders: heart disease, cerebral vascular accident or stroke, aneurysm, diabetes or cancer?	Yes	**No**
7.	Has any biological family member of the child to be insured (mother, father, brother or sister) ever had or been diagnosed with any of the following disorders: Huntington's disease, polycystic kidney disease, Parkinson's disease, cystic fibrosis, Alzheimer's disease, familial polyposis of the colon, multiple sclerosis, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) or any other hereditary disorders?	Yes	**No**

8.	Has the child to be insured ever had any symptoms of or ever been treated for one of the following conditions: heart trouble or defects, arterial trouble or defects, circulatory problems, cardiac murmur, diabetes, endocrine system disorders, high cholesterol, high blood pressure?	Yes	**No**
9.	Has the child to be insured ever had any symptoms of or been treated for one of the following conditions: cancer, tumours, lymphatic or glandular disorders, leukemia, anaemia, inflammatory disorder, immune deficiency or HIV?	Yes	**No**
10.	Has the child to be insured ever had any symptoms of or been treated for one of the following conditions: deafness, partial or total blindness, pervasive developmental disorder, autism, mental or psychological illnesses, intestinal, renal, rheumatological or neurological disorders, or respiratory problems other than controlled asthma?	Yes	**No**
11.	Does the child have a physical, mental or social growth retardation, a hereditary, familial or congenital condition, a deformity, a movement disorder or has he or she been amputated?	Yes	**No**
12.	Is the child currently being assessed, investigated or treated medically for any condition other than a mild problem such as a cold or flu?	Yes	**No**
13.	Has the child ever taken medication for non-medical reasons, used marijuana or taken drugs?	Yes	**No**
14.	Within the past 2 years, has the child to be insured been hospitalized for observation, care, diagnosis or treatment?	Yes	**No**
15.	Is there a test, consultation, intervention or investigation being planned for the child that has not yet taken place?	Yes	**No**

Children360

POLICY Nº :

EFFECTIVE DATE :

INSURED :

Schedule of Benefits

This *policy*, a copy of the application, and any rider or change notice attached hereto constitute your contract.

Please read your *policy*, the attached copy of the application, and the eligibility and insurability questionnaire carefully and validate the answers given therein. If the answers do not reflect your statement or are inaccurate, please notify the *Insurer* within thirty (30) days following the delivery of the *policy*. Failure to notify the *Insurer* of any inaccuracies or erroneous statements can render the contract void.

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

The *Insurer's* obligations under the contract will terminate immediately upon the *Insurer* receiving a written request from you to cancel the contract or a stop-payment order on any premium due.

Description of Coverages	Benefit(s)	Monthly Premium

Part A – Definitions

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

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

Activities of Daily Living:

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

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

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

Dismemberment or Total Loss of Use:

- **of a hand or a foot:** complete severance at or above the wrist or ankle joint; where there is no severance, total and permanent loss of use of the hand or foot;
- **of an eye:** total and irrecoverable loss of sight in one (1) eye (visual acuity of twenty over two hundred (20/200) or less, or a field of vision of less than twenty (20) degrees);
- **of hearing:** total and irrecoverable loss of hearing in both ears, with a hearing threshold of ninety (90) decibels or over within a speech threshold of five hundred (500) to three thousand (3,000) cycles per second, confirmed by an otolaryngologist who holds a Canadian license to practice and who practices his or her profession in Canada;
- **of a finger or a toe:** complete severance of at least two (2) phalanges of the same finger or same toe.

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

Full-Time Employment: regular, active performance of remunerative work for at least thirty (30) hours per week and at least forty (40) weeks per year.

Hospital: an institution recognized as an acute care hospital centre under legislation in the *Person Insured*'s province of residence, excluding a long-term care unit or beds used for convalescents or chronically sick patients.

Hospital does not mean: a clinic, a health care centre, or a facility that provides mainly rehabilitative or nursing care, even if that facility is part of a Hospital or is associated with a Hospital.

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

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

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

Insured: the person who owns this *Policy*.

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

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

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

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

Policy: the present contract, the application for this *Policy*, any application for reinstatement and any amendment to the contract.

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

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

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

Specialist: a *Physician* who holds a license and has specialized medical training related to the *Covered Critical Illness* for which a claim has been submitted.

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

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

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

Part B – Critical Illness Coverage (37 Illnesses) or Life Insurance Coverage to age 75, Convertible to age 60

Benefit

While the coverage is in effect, the *Insurer* will pay, one of the following two (2) benefits:

1) In the event of the *Person Insured's* diagnosis of a *covered critical illness*, the critical illness benefit shown in the Schedule of Benefits, net of any paid *Partial Payout Critical Illness* benefit, when the following four (4) requirements are met:

   - the critical illness meets the definition of a *covered critical illness*, subject to all its limitations and exclusions;
   - the critical illness does not occur during the moratorium period of the *covered critical illness;*
   - the disclosure obligation of the *covered critical illness* has been met; and
   - the diagnosis of the *covered critical illness* has been made by a *Specialist*.

OR

2) In the event of the *Person Insured's* death, the death benefit indicated in the Schedule of Benefits, net of any paid *Partial Payout Critical Illness* benefit.

The *Partial Payout Critical Illness* benefit is payable only once while the coverage is in force, and shall be deducted from any other benefit payable under this coverage.

Payment Conditions

Critical Illness and death benefits are not cumulative. The *Insurer's* liability is limited to a single critical illness or death benefit under this coverage. The *Partial Payout Critical Illness* benefit is payable only once and is deducted from any other benefit payable under this coverage.

The *Insurer* determines the date of diagnosis when all the relevant information for the claim has been received.

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

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

a) the *Insurer* has received all relevant medical records;

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

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

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

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

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

Restriction

Maximum benefits payable

The total amount of Critical Illnesses benefits payable by the *Insurer* for all Children360 policies issued in respect of a particular *Person Insured* may not exceed fifty thousand dollars ($50,000). In the event that the amount of coverage held in respect of a particular *Person Insured* is greater than fifty thousand dollars ($50,000), the *Insurer* will pay a total benefit of fifty thousand dollars ($50,000) and will refund any premiums paid in respect of any benefits in excess of that amount.

Exclusions

If the *Person Insured* commits suicide within two (2) years of the effective date of coverage or of the most recent reinstatement, whether the *Person Insured* is sane or insane, the *Insurer*'s liability is limited to a refund of the premiums paid for this coverage, without interest.

No benefit will be payable if the definition of *Covered Critical Illness* is not met, including all exclusions and limitations.

Some critical illnesses are subject to a moratorium period (ninety (90) days for Cancer and Benign Brain Tumour; twelve (12) months for Parkinson) and to a duty to disclose diagnosis of such illnesses, covered or not, to the *Insurer* within six (6) months of the date of the diagnosis. Failure to report such information to the *Insurer* within the prescribed period may render the specific critical illness coverage null and void.

Premium

The premium for this coverage is indicated in the Schedule of Benefits. The premium is guaranteed and payable as long as the coverage is in force.

Conversion Privilege

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

The premium for the new policy shall be based on:

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

All additional coverages or benefits will be subject to satisfactory evidence of insurability as determined by the *Insurer*. A request for conversion must be accompanied by the first premium payment.

If the coverage provided under this *policy* is subject to an extra premium, limitations or exclusions, the converted coverage will also be issued subject to the same conditions.

Termination of Coverage

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

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

General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions of the *policy*. The General Provisions of the *policy* apply to this coverage when they are relevant and compatible with its terms.

List and definitions of Covered Critical Illnesses (37 Illnesses)

For the purposes of this Policy, the *Person Insured* is covered for the following 37 Critical Illnesses, as defined hereunder:

Childhood Critical Illnesses

1. **Autism:** an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication.

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

2. **Congenital heart disease:** diagnosis of at least one of the covered heart conditions described below:
   - Coarctation of the aorta
   - Ebstein's anomaly
   - Eisenmenger syndrome
   - Tetralogy of Fallot
   - Transposition of the great vessels

   The diagnosis of the heart condition must be supported by cardiac imaging acceptable to us.

   Limitation: the diagnosis of the heart condition must be confirmed before the twenty-fourth (24th) birthday of the *Person Insured* for this benefit to be payable.

3. **Covered heart conditions if open heart surgery is performed:** these heart conditions are covered only if open heart surgery is performed to correct at least one of them:
   - Aortic stenosis
   - Atrial septal defect
   - Discrete subvalvular aortic stenosis
   - Pulmonary stenosis
   - Ventricular septal defect.

   The surgery must be:
   - recommended by a *Specialist;*
   - supported by cardiac imaging acceptable to us; and
   - performed by a *Specialist*.

   Limitation: the open heart surgery must be performed before the twenty-fourth (24th) birthday of the *Person Insured* for this benefit to be payable.

   Exclusions

   Procedures not covered by this definition are:
   - percutaneous atrial septal defect closure; and
   - trans-catheter procedures which include balloon valvuloplasty.

4. **Type 1 diabetes mellitus:** diagnosis where the *Person Insured* has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three (3) months.

   Limitation: the diagnosis of type 1 diabetes mellitus must be confirmed before the twenty-fourth (24th) birthday of the *Person Insured* for this benefit to be payable.

5. **Muscular dystrophy:** diagnosis of muscular dystrophy where the *Person Insured* has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

   Limitation: the diagnosis of muscular dystrophy must be confirmed before the twenty-fourth (24th) birthday of the *Person Insured* for this benefit to be payable.

6. **Cystic fibrosis:** diagnosis of cystic fibrosis where the *Person Insured* has chronic lung disease and pancreatic insufficiency.

   Limitation: the diagnosis of cystic fibrosis must be confirmed before the twenty-fourth (24th) birthday of the *Person Insured* for this benefit to be payable.

7. **Cerebral palsy:** diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements.

   Limitation: the diagnosis of cerebral palsy must be confirmed before the twenty-fourth (24th) birthday of the *Person Insured* for this benefit to be payable.

Critical Illnesses

8. **Stroke (Cerebrovascular Accident):** definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:
   - acute onset of new neurological symptoms; and
   - 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.

   Exclusion

   No benefit will be payable under this condition for:
   - transient ischaemic attacks;
   - intracerebral vascular events due to trauma; or
   - lacunar infarcts which do not meet the definition of stroke as described above.

9. **Aplastic Anemia:** definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:
   - marrow stimulating agents;
   - immunosuppressive agents; or
   - bone marrow transplantation.

10. **Severe Burns:** definite diagnosis of third-degree burns over at least twenty percent (20%) of the body surface.

11. **Cancer (Life-Threatening):** definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

    Moratorium period

    No benefit will be payable under this condition if, within the first ninety (90) days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the *Person Insured* has any of the following:
    - signs, symptoms or investigations, that lead to a diagnosis of Cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
    - a diagnosis of Cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the *Insurer* within six (6) months of the date of the diagnosis. If this information is not provided within this period, the *Insurer* has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Exclusions

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

12. **Blindness:** definite diagnosis of the total and irreversible loss of vision in both (2) eyes, evidenced by:
    - the corrected visual acuity being twenty over two hundred (20/200) or less in both (2) eyes; or
    - the field of vision being less than twenty (20) degrees in both (2) eyes.

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

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

14. **Coma:** definitive 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.

    Exclusion

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

15. **Heart Attack:** 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 of the following:
    - heart attack symptoms;
    - new electrocardiogram (ECG) changes consistent with a heart attack; or
    - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Exclusion

No benefit will be payable under this condition for:

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

16. **Dementia, including Alzheimer's Disease :** definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:
    - aphasia (a discorder of speech);
    - apraxia (difficulty performing familiar tasks);
    - agnosia (difficulty recognizing objects); or
    - disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

    The *Person Insured* must exhibit:
    - dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of twenty thirty 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
    - evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a six (6) month period.

    Exclusion: no benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

    For purpose of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein Se, McHugh PR, J Psychiatr Res. 1975;12(3):189.

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

    The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy.

    Limitation

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

    Exclusion

    No benefit will be payable under this condition if:

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

18. **Kidney Failure:** 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.

19. **Acquired brain injury:** diagnosis of damage to brain tissue caused by traumatic injury, anoxia or encephalitis, resulting in signs and symptoms of neurological impairment that:

- are present and verifiable on clinical examination or neuro-psychological testing;
- persist for more than one hundred and eighty (180) days following the date of diagnosis; and
- are corroborated by imaging studies of the brain that are consistent with the diagnosis.

Exclusions

No benefit will be payable under this condition for:

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

20. **Parkinson's Disease and Specified Atypical Parkinsonian Disorders**

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

b) **Specified Atypical Parkinsonian Disorders:** definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

Exclusions: no benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Moratorium period

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

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the *Insurer* within six (6) months of the date of the diagnosis. If this information is not provided within this period, the *Insurer* has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

21. **Motor Neuron Disease:** definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

22. **Bacterial Meningitis:** 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.

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

23. **Paralysis:** 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.

24. **Loss of Independent Existence (age 18 and over):** definite diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

    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 assistive devices;
    - dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
    - toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
    - bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
    - transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
    - feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

    Limitation: the Loss of Independent Existence coverage comes into effect when the *Person Insured* reaches age eighteen (18). If the, Loss of Independent Existence occurs prior to age eighteen (18), no Loss of Independent Existence benefit is payable and the Loss of Independent Existence coverage is null and void.

25. **Loss of Speech:** 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.

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

26. **Loss of Limbs:** definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

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

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

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

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

29. **Multiple Sclerosis:** definite diagnosis of at least one of the following:

    - two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
    - well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
    - a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

30. **Deafness:** definite diagnosis of the total and irreversible loss of hearing in both (2) 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.

31. **Major Organ Failure on Waiting List:** definite diagnosis of the irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the *Person Insured* must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the *Person Insured*'s enrolment in the transplant centre.

32. **Major Organ Transplant:** definite diagnosis of the irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the *Person Insured* must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

33. **Benign Brain Tumour:** 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).

    Moratorium Period

    No benefit will be payable under this condition if, within the first ninety (90) days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the *Person Insured* has any of the following:

    - signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
    - a diagnosis of Benign Brain Tumour (covered or excluded under the policy).

    Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the *Insurer* within six (6) months of the date of the diagnosis. If this information is not provided within this period, 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.

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

Partial Payout Critical Illnesses

34. **Coronary Angioplasty:** interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a *Specialist*.

35. **Stage A (T1a or T1b) prostate cancer:** Stage A (T1a or T1b) prostate cancer must be confirmed by pathological examination of prostate tissue.

    Moratorium Period

    No benefit will be payable under this condition if within the first ninety (90) days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the *Person Insured* has any of the following:

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

    Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the *Insurer* within six (6) months of the date of the diagnosis. If this information is not provided within this period, the *Insurer* has the right to deny any claim for Stage A (T1a or T1b) prostate cancer or, any critical illness caused by any Stage A (T1a or T1b) prostate cancer or its treatment.

36. **Ductal carcinoma in situ of the breast (stage A):** Ductal carcinoma in situ of the breast is a non-invasive cancer and must be confirmed by biopsy.

Moratorium Period

No benefit will be payable under this condition if within the first ninety (90) days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the *Person Insured* has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the *Insurer* within six (6) months of the date of the diagnosis. If this information is not provided within this period, the *Insurer* has the right to deny any claim for Ductal carcinoma in situ of the breast (stage A) or, any critical illness caused by any Ductal carcinoma in situ of the breast (stage A) or its treatment.

37. **Stage 1A malignant melanoma:** Stage 1A malignant melanoma is a melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion.

Moratorium Period

No benefit will be payable under this condition if within the first ninety (90) days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the *Person Insured* has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the *Insurer* within six (6) months of the date of the diagnosis. If this information is not provided within this period, the *Insurer* has the right to deny any claim for Stage 1A malignant melanoma or, any critical illness caused by any Stage 1A malignant melanoma or its treatment.

Part B – Option Plus Coverage

This coverage includes the following four (4) benefits.

1) Accident Benefit

While the coverage is in force, the *Insurer* will pay to the *Insured:*

1. In the event of the Accidental death of the *Person Insured*, occurring within ninety (90) days immediately following the *Accident*..... $50,000

2. In the event of *Dismemberment or Total Loss of Use* suffered by the *Person Insured*, resulting from *Injuries* caused by an *Accident:*

   a) of both feet or of both hands $200,000
   b) of one hand and one foot $200,000
   c) of one foot and loss of sight of one eye..... $200,000
   d) of one hand and loss of sight of one eye..... $200,000
   e) of one foot or of one hand $100,000
   f) of sight of one eye..... $25,000
   g) of hearing of one ear $25,000
   h) of two phalanges or more of the same finger or toe $5,000

   Dismemberment or total loss of use benefits are not cumulative and are payable provided that the *Person Insured* is still alive at the end of the period of three hundred sixty five (365) days immediately following the *Accident*.

Only one of the losses described in the preceding paragraphs 1 and 2 will be paid. Moreover, if the *Person Insured* dies within the period of three hundred sixty five (365) days immediately following the *accident*, as result of the *accident*, the *Insurer* will only pay the $50,000 death benefit.

3. In case of a fracture sustained in an *accident:*

   a) of the skull, spine, pelvis or thigh bone $1,000
   b) of a rib, the sternum, larynx, windpipe, shoulder blade, humerus, kneecap, shin bone, fibula..... $200
   c) of any bone not included in the above list $150

   The fracture diagnosis must be supported by x-ray evidence and submitted to the *Insurer* within thirty (30) days of the *accident*.

The benefits in the above paragraph 3 are not cumulative. Only one of the above benefit amounts will be paid and such benefit will only be paid if the *Person Insured* is still living at the end of the thirty-day (30) period immediately following the *accident*. In case of multiple fractures, the *Insurer* will pay the benefit for the fracture providing the highest benefit.

4. In case of *injuries* suffered by the *Person Insured:*

   a) $25 per day while confined to *hospital* from the first to the 365th day;
   b) costs of a private or semi-private room up to a maximum of $55 per day of *hospitalization;*

c) *reasonable expenses*, actually incurred, for the transportation of the *Person Insured* by ambulance or taxi from the place of the *accident* to the nearest *hospital* and from the *hospital* to the *Person Insured's* home, if justified by the *Person Insured's* state of health;

d) fees of a qualified chiropractor, orthophonist, speech therapist, osteopath, podiatrist or psychologist, up to $15 per treatment, subject to a maximum of $240 per policy year;

e) cost of only one x-ray, up to $25;

f) costs of repairing or replacing eye glasses up to $75;

g) if prescribed by a *physician*, up to a lifetime maximum of $10,000:

   i) drugs;

   ii) fees of a physiotherapist, up to $15 per treatment, subject to a maximum of $240 per policy year;

   iii) fees of a nurse or nursing assistant, up to a lifetime maximum of $5,000;

   iv) cost of orthopedic apparatus, splints and trusses;

   v) rental of wheelchair, crutches and hospital-type bed;

   vi) any initial prosthesis, up to a lifetime maximum of $3,000, including hearing aids, but excluding dental prosthesis;

h) cost of medical, surgical and hospital services rendered outside Canada, up to a lifetime maximum of $10,000, in case of emergency care only, provided the *accident* occurs within six (6) months of a temporary stay outside Canada.

The *hospitalization*, the treatments and the services mentioned in the preceding paragraphs must have commenced within thirty (30) days immediately following the *accident*.

i) within two (2) years immediately following the *accident*, fees of a dental surgeon for the treatment or complete or partial replacement of any healthy, natural and sound teeth lost or damaged because of such *accident*, up to $300 per tooth. If a removable prosthesis is used to replace the teeth, the *Insurer* shall pay up to $250 per tooth.

   Notwithstanding the preceding paragraph if, due to the *Person Insured's* age and dental development, treatment has to be postponed beyond the two (2) year period immediately following the *accident*, the *Insurer* shall pay the dental surgeon's fees, up to $150 per tooth and up to $600 maximum per *accident*. Treatment must be recommended by a dental surgeon within the two (2)-year period immediately following the *accident*. No claim under this paragraph will be considered if the same claim has been settled under the terms of the preceding paragraph.

   Fees are based on the schedule of fees of the provincial Association of Dental Surgeons of the province of the dental surgeon's place of practice.

j) $1,500 while the *Person Insured* is a *student* and *totally disabled* for a complete school year immediately following the *accident;*

k) up to $1,000 for tutorial services dispensed to the *Person Insured* while a *student* and confined at home or *hospital*, provided that:

   i) the confinement commences within ninety (90) days immediately following the *accident;*

   ii) the tutorial services are part of the study program of the *student* when the confinement occured; and

   iii) the tutorial services are dispensed by a teacher holding a teaching certificate of the appropriate level and such teacher is not a relative of the *student* nor related to the *Student* by marriage;

l) up to $3,000 for reeducation courses to enable the *Person Insured* while a *student* to secure employment, provided that:

   i) the *accident* is the direct cause of the interruption of the *Person Insured's* studies; and

   ii) the courses are taken within three (3) years immediately following the *accident*.

m) cost of transportation for the *Person Insured* while a *student* or of pre-school age, for a three (3) year period immediately following the *accident*, to undergo treatment in a location situated more than forty (40) kilometers from the *Person Insured's* residence provided that such treatment is medically prescribed and is not available at a closer location.

   In addition to the cost of transportation, up to $50 per day, for the cost of transportation and living expenses of an adult attendant, if required by the physical condition or age of the *Person Insured* while a *student* or of pre-school age.

   The maximum lifetime benefit payable under this coverage is $500;

n) while the *Person Insured* is a *student* aged sixteen (16) or older, and after a waiting period of fifteen (15) days, $150 for each complete week of continuous *Total Disability* between June 1st and September 1st of the year of the *accident*. No amount is payable for the first fifteen (15) days of disability.

The *Insurer* shall only pay for fees and expenses actually incurred up to three (3) years immediately following the *accident*.

Limitation

The *Person Insured* cannot be covered by more than one Accident Benefit offered by Humania Assurance Inc., namely: « Children360 Option Plus Accident Benefit » or « Street-Wise Accident ». Should a situation of multiple coverages arise, the *Insurer* will pay benefits under the greater coverage and all other coverage will be cancelled. The *Insurer's* liability for the cancelled coverage is limited to a refund of premiums paid, without interest. No claim may be considered on cancelled policy or coverage.

Exclusions

1. No benefits are payable under this Accident Benefit coverage:

1.1. if *injuries*, resulting, directly or indirectly in death, *dismemberment, total loss of use* or a need for medical care are:

a) self inflicted *injuries*, whether or not the *Person Insured* is sane or insane;

b) sustained by the *Person Insured* while aboard an aircraft, except as a passenger on a regularly scheduled flight;

c) incurred while participating in a sport for which the *Person Insured* receives monetary reward or compensation;

d) sustained by the *Person Insured* during a riot, a demonstration, an insurrection, a war or any related act;

e) sustained by the *Person Insured* when participating or attempting to participate in an illegal or a criminal act or while driving a motor vehicle or a boat while being under the influence of drugs or when the blood alcohol level exceeds 80 milligrams per 100 millilitres of blood;

f) sustained by the *Person Insured* while under the influence of any drug, hallucinogen or narcotic.

1.2. when death or *injuries* are a direct or indirect result of gas inhalation, poisoning or drug absorption.

1.3. as soon as the *Person Insured* ceases to be a permanent resident of Canada (as defined by the Canada Revenue Agency).

2. Unless the *Person Insured* was *hospitalized*, fees of chiropractors and physiotherapists are excluded if the *injuries* sustained result from the *Person Insured* training for or participating, in any organized league sport.

3. No benefits, under article 4 of the Accident Benefit, are payable:

3.1. for prosthesis and orthotic devices used exclusively to participate in sports or sporting activities or that are not medically necessary for rehabilitation or recovery;

3.2. if the *Person Insured* is covered under a similar insurance plan or under a public plan administered by a governmental agency;

3.3. for costs incured for cosmetic or esthetic purposes.

2) Compassionate Leave Benefit

The *Insurer* will pay to the *Insured* the monthly Compassionate Leave Benefit amount shown in the Schedule of Benefits for a continuous period of unpaid leave of absence of a *family member* falling within the twelve (12) month period starting three (3) months after the date of diagnosis recognized by the *Insurer:*

- when the *Person Insured* is diagnosed with a *covered critical illness* giving rise to a full payout of the Critical Illness benefit; and

- an eligible *family member* takes an unpaid leave of absence from *full-time employment* to care for the *Person Insured* diagnosed with a *covered critical illness*.

The Compassionate Leave Benefit is only payable for:

- the leave of absence of one eligible *family member* of the *Person Insured* as long as the *family member* does not receive any salary, individual, group or governmental wage loss replacement or disability benefit;

- one and only one continuous leave of absence.

If more than one *family member* takes a leave of absence from their *full-time employment*, the *Insurer* will only pay a benefit for the leave maximizing the benefit payable.

Benefit payments begin after receipt of proof of leave of absence for the eligible *family member* acceptable to the *Insurer* and the completion of the three (3) months waiting period immediately following the date of diagnosis recognized by the *Insurer*.

Compassionate Leave Benefit Adjustment

Where necessary, the monthly benefit payable will be adjusted to a daily rate basis of one-thirtieth (1/30) of the monthly benefit for each day of leave of absence from *full-time employment*.

Maximum benefit payable

The total amount of Compassionate Leave Benefit payable by the *Insurer* under this *policy* cannot be greater than twelve (12) times the monthly Compassionate Leave Benefit amount shown in the Schedule of Benefits. This coverage terminates when the maximum benefit has been paid.

3) Hospitalization Benefit

During the fifteen (15) month period following the date of diagnosis recognized by the *Insurer*, when the *Person Insured* is *hospitalized* for a *covered critical illness*, giving rise to a full payout of the Critical Illness benefit, the *Insurer* will pay to the *Insured*, a $200 daily benefit for as long as the *Person Insured* is *hospitalized,* up to a maximum of thirty (30) days.

4) Out-of-Canada Medical Coverage

During the fifteen (15) month period following the date of diagnosis recognized by the *Insurer*, the *Insurer* will reimburse to the *Insured* out-of-Canada medical, surgical or hospital expenses incurred by the *Person Insured* in relation to a *covered critical illness*, giving rise to a full payout of the Critical Illness benefit, to the maximum shown in the Schedule of Benefits.

The treatments must be performed by a *specialist* practicing in a jurisdiction deemed acceptable by the *Insurer* and the benefit shall only be payable upon submission of the claim to the *Insurer* with acceptable proof of the incurred expense.

Premium

The premium for this Option Plus Coverage is indicated in the Schedule of Benefits. The premium is guaranteed and payable as long as this coverage is in force.

Termination of Coverage

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

- the date a written request to this effect is received from the *Insured* or the date stipulated in that request, if later than the date of receipt by the *Insurer;*
- the date of termination of the *policy*, as indicated in the Schedule of Benefits;
- fifteen (15) months after the date of diagnosis recognized by the *Insurer* of a *covered critical illness,* resulting in a full payout of the critical illness benefit;
- the date the *Person Insured* dies.

General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions of the *policy*. The General Provisions of the *policy* apply to this coverage when they are relevant and compatible with its terms.

Part B – Additional Life Insurance Coverage to age 75, Convertible to age 60

Benefit

In the event of the *Person Insured's* death while this coverage is in force, the *Insurer* will pay to the *Beneficiary*, the lump sum death benefit indicated in the Schedule of Benefits, subject to the limitations and exclusions of the *policy*.

When the Critical Illness coverage of the *policy* terminates following the full payout for a *Covered Critical Illness*, the Additional Life Insurance coverage remains in effect and becomes paid-up. The conversion privilege is maintained, in accordance with the **Conversion Privilege** section below, however, once converted, premiums for the new *policy* become payable.

Premium

The premium for this coverage is indicated in the Schedule of Benefits. The premium is guaranteed and payable as long as the coverage is in force or as long as there has not been a full payout for a *Covered Critical Illness*.

Dependence with the Critical Illness Coverage of this policy

This Additional Life Insurance coverage is dependent on the Critical Illness Coverage of this *policy*.

The benefit amount of this coverage must at all times be equal to the benefit amount of the Critical Illness Coverage.

If the Critical Illness Coverage benefit of this *policy* is reduced by the *Insured*, the benefit amount of this coverage will also be reduced by the same amount.

Conversion Privilege

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

The premium for the new *policy* shall be based on:

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

All additional coverages or benefits will be subject to satisfactory evidence of insurability as determined by the *Insurer*. A request for conversion must be accompanied by the first premium payment.

Exclusions

If the *Person Insured* commits suicide within two (2) years of the effective date of coverage or of the most recent reinstatement, whether he or she is sane or insane, the *Insurer's* liability is limited to a refund of the premiums paid for this coverage, without interest.

Termination of Coverage

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

- the date a written request to this effect is received from the *Insured* or the date stipulated in that request, if later than the date of receipt by the *Insurer;*
- the date on which the entire coverage is converted;
- the date of termination of the *policy*, as indicated in the Schedule of Benefits;
- the date the *Person Insured* dies.

General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions of the *policy*. The General Provisions of the *policy* apply to this coverage when they are relevant and compatible with its terms.

Part B – 15-Year and at Age 75 Premium Refund Rider

15-Year Premium Refund Benefit

The *Insurer* will pay to the *Insured*, while the coverage is in effect, a maximum of two (2) premium refund Benefits amounts over the lifetime of the *Policy* when a *15-Year Refund Period* is completed.

The *Insurer* will reimburse seventy-five percent (75%) of the *Refundable Premiums* when a *15-Year Refund Period* is completed, provided this coverage is in effect on the date of completion of such *15-Year Refund Period*.

Premium Refund Benefit at Age 75

When the *Person Insured* reaches the *insurance age* of seventy-five (75), the *Insurer* will pay to the *Insured*, while the coverage is in effect,100% of the premiums paid since the last 15-Year Premium Refund Benefit paid, less any Partial Payout benefits for *Covered Critical Illness* actually paid or payable by the *Insurer*.

Definitions

15-Year Refund Period: the period of fifteen (15) consecutive years of coverage beginning at the effective date of coverage, during which no *Partial Payout Critical Illnesses* benefit or 15-Year Premium Refund Benefit was paid or is payable. If the *Insurer* pays either benefit, a new *15-Year Refund Period* commence on the date of the next premium payment date following the date of payment of such benefit.

Premiums Paid: premiums paid by or on behalf of the *Insured* to the *Insurer*, for all coverages under the *Policy* for which the benefit amount has not been reduced, at the *Insured's* request, by more than twenty-five percent (25%).

If the benefit amount has been reduced by more than twenty-five percent (25%) at the *Insured's* request, the resulting premium shall be considered to have been the premium paid from the start of the *15-Year Refund Period* for the purpose of this rider.

Refundable Premiums: the sum of all *Premiums Paid* to the *Insurer*, since the beginning of the *15-Year Refund Period*, for each coverage in effect at the start of the *Refund Period.*

Termination of Coverage

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

- the date a written request to this effect is received from the *Insured* or the date stipulated in that request, if later than the date of receipt by the *Insurer;*
- the date of diagnosis of a *Covered Critical Illness* giving rise to a full payout of benefits;
- the date of termination of the *Policy*, as indicated in the Schedule of Benefits;
- the date the *Person Insured* dies.

General Provisions

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

Part C – General Provisions

Effective date

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

Premiums

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

Method of payment

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

Exclusions

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

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

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

- injury sustained during a flight, except if the Person Insured is a passenger on a regularly scheduled flight;
- cosmetic surgery or elective surgery, and any resulting complication;
- experimental treatments and treatments involving the application of new procedures or new treatments that are not yet standard practice;
- participating in a sport for which the Person Insured receives monetary reward or compensation.

Age

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

Duty to disclose

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

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

Incontestability

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

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

Policy and Coverage termination

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

- the date a written request to this effect is received from the Insured or the date stipulated in that request, if later than the date of receipt by the Insurer;
- the date when a Critical Illness benefit is paid under this coverage;
- the date on which all of the Policy's convertible coverage have been converted;
- the date of termination of this Policy, as indicated in the Schedule of Benefits;
- the date the Person Insured dies.

Reinstatement

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

Change of Beneficiary

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

Payment under the policy

Death benefits will be paid to the Beneficiary designated in the application or in any other document subsequently submitted to the Insurer by the Insured. Any other benefit payable under the terms of the policy shall be paid to the Insured unless otherwise stipulated in any other document subsequently submitted to the Insurer.

Reimbursement

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

Legal currency

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

Right to cancel

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

Compliance with law

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

General provisions

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

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