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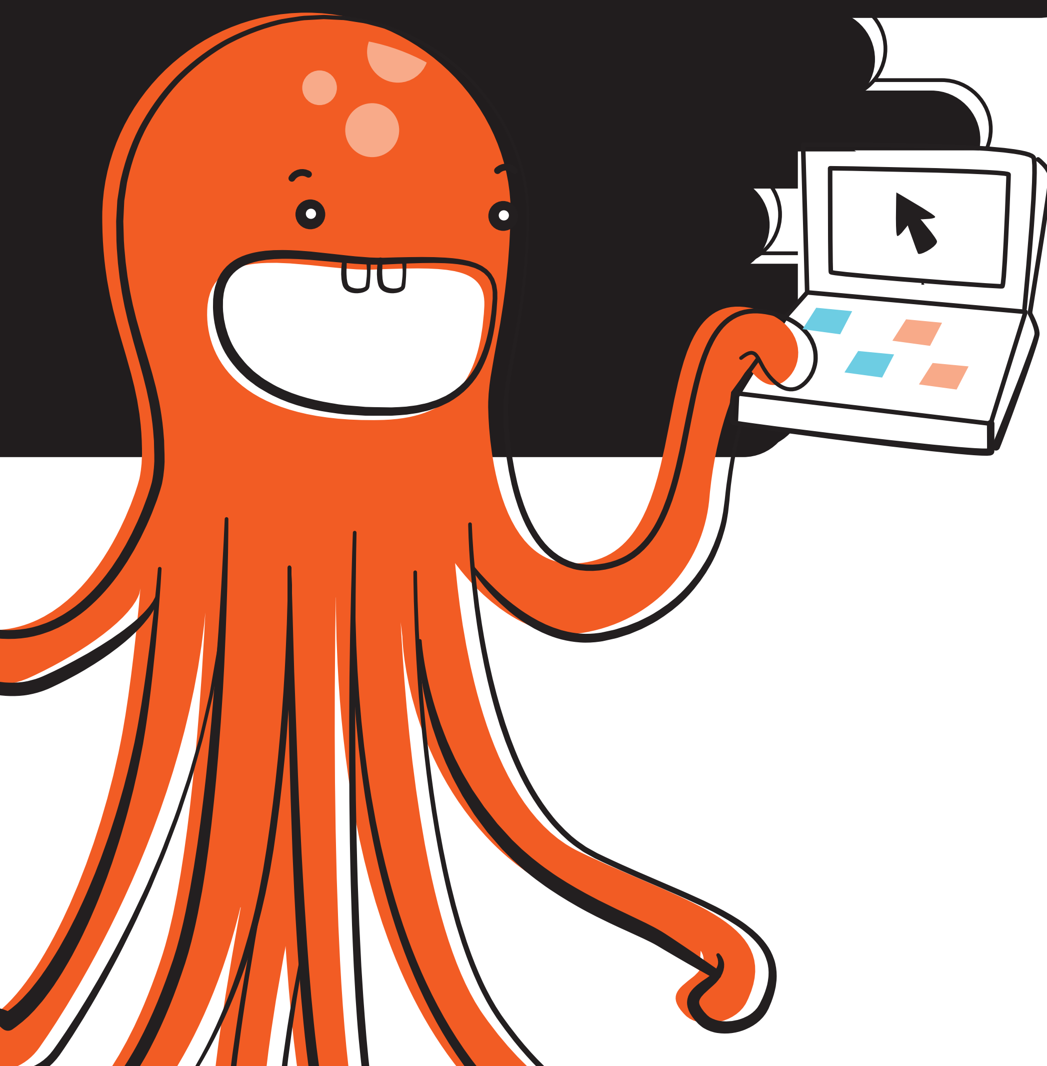
Critical Illness Insurance Policy



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PARACHUTE Complete Critical Illness Insurance Policy

This Policy sets out the critical illness insurance coverage provided to You by Temple Insurance Company. In this Policy, Temple Insurance Company is called "Temple", "We" or "Us".

"You" and "Your" refer to the individual identified as the policyholder in the Summary of Coverage.

It is important that You read this Policy document carefully along with Your Summary of Coverage, which sets out details of Your coverage, including the amount of Your coverage, and whether Your Spouse and Children are covered.

Your Summary of Coverage along with this Policy document are part of Your contract of insurance.

Temple Insurance Company hereby agrees to pay the benefits in accordance with and subject to the provisions of this Policy.

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This Policy is subject to exclusions and limitations, including, without limitation, an exclusion relating to Pre-Existing Conditions and Covered Condition exclusions. **This Policy contains a provision removing or restricting the right of the Insured to designate persons to whom or for whose benefit insurance money is to be payable (not applicable in Quebec).**

Please take the time to review this Policy
Within 10 days of delivery of the Policy and on the condition that no claim has been made, You may cancel for any reason and receive a full refund of any premium You have paid if You provide Us with written Notice of cancellation.

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Article 1

1.1 Schedule of Benefits

Covered Conditions

Refer to Your Summary of Coverage to determine those Covered Conditions for which You are covered or for which coverage is specifically excluded. Also, refer to Article 7 for the precise definitions of the following Covered Conditions.

You and Your Spouse
(100% Face Amount)

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dementia, including Alzheimer's Disease
- Heart Attack
- Heart Valve Replacement or Repair
- 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 Infection
- Paralysis
- Parkinson's Disease and Specified Atypical Parkinsonian Disorders
- Severe Burns
- Stroke

Early Diagnosis Benefit Covered Conditions
(10% Face Amount)

- Coronary Angioplasty
- Cancer (Non-Life-Threatening), being:
  - Ductal Carcinoma in Situ of Breast
  - Stage A (T1a or T1b) Prostate Cancer
  - Stage 1A Malignant Melanoma
  - Early Stage Thyroid Cancer
  - Early Stage Lymphocytic Leukemia
  - Gastrointestinal Stromal Tumour

Child
(100% Face Amount)

- Autism
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Cerebral Palsy
- Coma
- Congenital Heart Disease Requiring Surgery
- Cystic Fibrosis
- Deafness
- Down Syndrome
- Heart Attack
- Kidney Failure
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Multiple Sclerosis
- Muscular Dystrophy
- Paralysis
- Severe Burns
- Stroke
- Type 1 Diabetes Mellitus

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Minimum and Maximum Face Amounts

*The maximum Child Face Amount is $25,000 or 50% of Your Face Amount, rounded to the next $1,000, whichever is the lesser. All eligible Children will be insured for the same Face Amount.

	Units	Minimum	Maximum
You	$5,000.00	$10,000.00	$100,000.00
Spouse	$5,000.00	$10,000.00	$100,000.00
Dependent – Child	$1,000.00	$5,000.00	$25,000.00

Charitable Donation $500

Multiple Event Coverage For You and Your Spouse

Multiple Cancer Benefit For You and Your Spouse

Non-Evidence Maximum $ 30,000.00

Pre-Existing Condition Period 24 months

Pre-Existing Condition Exclusion Period 24 months

Maximum Issue Age 64 years of age

Termination Age 70 years of age

Covered Conditions & Exclusions As indicated in the Covered Conditions, Limitations and Exclusions provision in Article 7.

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Article 2

2.1 Definitions

This article sets out the definitions for words and phrases that have specific meanings when used in this Policy. These words and phrases appear in bold in this Policy. They include the plural as well as the singular.

Accident means an unexpected event involving an external force, causing loss or Injury, independently of any other causes.

Actively at School means you:

1. are a student at an Institute for Higher Learning;
2. satisfy the definition of full-time student at such Institute for Higher Learning; and
3. attend your classes on a regular basis.

You are considered actively at school on any day that is not your regular scheduled school day (e.g. vacation or holiday), provided you were Actively at School on the immediately preceding scheduled school day, and you are not confined to Hospital.

Actively at Work means You perform all the functional and crucial duties of Your occupation for a full workday at:

1. Your employer's place of business;
2. an alternate place approved by Your employer; or
3. a place where Your employer requires You to travel.

You are considered Actively at Work on any day that is not Your regular scheduled workday (e.g. vacation or holiday), provided You were Actively at Work on the preceding scheduled workday and You are not confined to Hospital or otherwise incapacitated from reporting to place of employment for Your employer. If You are on parental leave under a Provincial or Federal program, You are considered Actively at Work.

Application means the form requesting insurance coverage under this Policy submitted by You to Us for approval.

Beneficiary means the individual who is entitled to receive the benefits under this Policy.

Benefit Amount is the dollar amount of coverage that is payable in the event of a Diagnosis of a Covered Condition in accordance with the terms of this Policy, calculated as all or a portion of the Insured Person's Face Amount.

Child means Your natural or adopted child or stepchild who, at the time of Application for insurance, is wholly dependent on You for support and either (i) less than 21 years old, or (ii) less than 26 years old, and in attendance at an accredited school as a full-time student, and is:

1. a Full-Time Resident of Canada;
2. unmarried;
3. not employed on a full-time basis; and
4. not eligible for voluntary critical illness insurance as an employee under a group benefit plan.

We may require written proof of the Child's status as often as We determine is reasonably necessary.

Claim means a formal request to Us for payment of a Benefit Amount under this Policy, along with supporting documents.

Claimant means an individual who makes a Claim for a Benefit Amount under this Policy.

Covered Conditions means the medical conditions or events for which a Benefit Amount may be paid under this Policy.

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Date of Diagnosis means the date on which an Insured Person is first Diagnosed with a given Covered Condition. For the Covered Conditions "Major Organ Failure on Waiting List" and "Kidney Failure", the Date of Diagnosis will be considered to be the date on which the Insured Person was added to a recognized organ waiting list.

The Date of Diagnosis must occur while the Policy is in force.

Dependent or **Eligible Dependent** means Your Child or Children.

Diagnosis or **Diagnosed** means the medical diagnosis (including diagnostic measures) by a Physician of an Insured Person with a Covered Condition.

The Diagnosis must be made according to generally accepted medical classification systems including but not limited to: biopsy, bone scans, CT-scan, hematological tests, MRI or X-rays. Any tests or examinations that must be performed in order to satisfy the Covered Condition requirements must be conducted by a Physician who is not the Insured Person, or a relative of or business associate, or live with the Insured Person.

Effective Date of Coverage means the date and time that coverage becomes effective for an Insured Person or, for an increase in coverage, the date the increase becomes effective as shown on Your Summary of Coverage.

Evidence of Insurability means:

1. the part of your Application containing the statement or medical evidence that serves as proof of Your or Your Dependents' or Spouse's medical, lifestyle and family medical history; and
2. the information about the existence of Grandfathered Coverage supplied by You as part of the Application and used by Us in our decision to issue this Policy.

All Evidence of Insurability must be submitted on forms provided by Us.

Face Amount means the dollar amount of insurance coverage applicable to an Insured Person that is used to determine the Benefit Amount payable for any Claim.

Full-Time Resident of Canada means an individual who is a resident of Canada and who is covered by a Canadian Provincial or Territorial Health Care Insurance Plan.

Grace Period means the number of days in which coverage for an Insured Person under this Policy remains effective although the required premium is late.

Grandfathered Coverage means that an Insured Person was covered by a Prior Policy, the existence of such Prior Policy being part of the Evidence of Insurability and material to Our decision to issue this Policy.

If issued, the Insured Person will be insured under this Policy in an amount equivalent to the Face Amount of the Prior Policy on the Effective Date of Coverage, for all Covered Conditions identified by the Insurer as being common between the Prior Policy and this Policy, subject to the maximum Face Amount available and to the provisions of Transfer of Coverage from the Prior Policy.

Hospital means a facility licensed to provide full-time medical care and treatment under the direction of a full-time staff of licensed Physicians. It does not include a facility that is primarily a nursing home, rest home or facility for treating drug or alcohol abuse.

Injury or **Injuries** means physical harm or damage to an Insured Person's body caused by an Accident.

Institute for Higher Learning means any university, private or community college, CEGEP or trade school in Canada.

Insured or **Insured Person** means You, Your Spouse and Your Dependents who are insured under this Policy. An Insured Person cannot be insured as both the policyholder and as a Spouse or Dependent under one of Our PARACHUTE Critical Illness policies.

Insurer, **We** and **Us** means Temple Insurance Company.

Irreversible means not able to be undone or alterable.

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Life Event means one of the following events:

1. Your marriage (including common-law) or divorce,
2. the birth or adoption of Your Child; or
3. the death of Your Spouse or Child.

For the purposes of this definition, We will consider that Your marriage has occurred on the date:

1. of Your legal marriage;
2. You have been living with another person in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
3. You enter into a civil union as defined by the Civil Code of Quebec; or
4. You register a domestic partnership in Nova Scotia.

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

Medically Necessary means broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a Sickness or Injury.

Multiple Event Categories means the categories of Covered Conditions that are included in the Multiple Event Coverage Benefit.

Non-Evidence Maximum means the maximum Face Amount available under this Policy without requiring You, Your Spouse or Your Dependents to provide satisfactory Evidence of Insurability.

If the requested Face Amount exceeds the Non-Evidence Maximum, the amount in excess of this limit is available only if You, Your Spouse or Your Dependent provide Evidence of Insurability to Us and We approve this excess amount.

Notice means a written communication by an Insured Person or Claimant to Us, or vice versa.

Notice of Claim means the initial written Notice given to Us that a Claimant is making a Claim under this Policy, using a form provided by Us.

Physician means a medical doctor who is legally qualified and lawfully entitled to practise medicine and prescribe and administer drugs or perform Surgery, and who is operating in accordance with and within the scope of his or her licence in the jurisdiction where he or she provides such services.

The Physician must not be the Insured Person, a relative of or business associate of the Insured Person, or reside with any such person.

Policy means this insurance contract.

Policy Anniversary means the annual anniversary of the Policy.

Policyholder means You.

Pre-Existing Condition means a condition, whether Diagnosed or not, for which the Insured Person sought medical investigation, medical care or services, Diagnosis, treatment, including diagnostic measures, medication or medical advice, or for which there were symptoms, signs or evidence that should have caused an individual to seek medical care or services, Diagnosis, treatment, including diagnostic measures, medication or medical advice.

Pre-Existing Condition Exclusion Period means the 24-month period immediately following the Pre-Existing Condition Starting Date.

Pre-Existing Condition Period means the 24-month period immediately prior to the Pre-Existing Condition Starting Date.

Pre-Existing Condition Starting Date means:

1. the Effective Date; or
2. in respect of any new Covered Condition or increase in Face Amount, the date of the Policy amendment to (a) add such new Covered Condition, or (b) increase such Face Amount, as applicable.

Prior Policy means a Group Critical Illness policy under which You were insured that terminated within 31 days of Your Effective Date of Coverage.

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Proof of Claim means evidence or documentation submitted to Us by the Claimant or obtained by Us in the course of our investigation of a Claim.

Provincial or Territorial Health Care Insurance Plan means any plan that provides hospital, medical or dental benefits established by the government in the Insured Person's province or territory of primary residence.

Schedule of Benefits summarizes the benefit features available to You, Your Spouse and Your Dependents according to the terms and conditions of this Policy.

Sickness means the state of being ill, either through disease or malady, but not as the result of an Accident.

Smoker means an individual who, in the 12 months before declaring their smoking status on an Application or Change in Smoking Status form:

1. has used tobacco in any form (with the exception of one large cigar per month), nicotine products, nicotine substitutes, oral and nasal sprays, or smoking cessation products; or
2. has consumed marijuana or hashish more than three times per week.

Specialist means a licensed Physician who has been trained in the specific area of medicine relevant to the Covered Condition for which a Benefit Amount is being Claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by Us, a Covered Condition may be Diagnosed by a qualified Physician practising in Canada or the United States of America.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative of or business associate of the Insured Person, or reside with any such person.

Spouse means an individual who:

1. is a Full-Time Resident of Canada; and
2. satisfies one of the following:
   a. is legally married to You;
   b. has been living with You in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
   c. is in a civil union with You as defined by the Civil Code of Quebec;
   d. is Your registered domestic partner in Nova Scotia; or
   e. is the biological or adoptive father or mother of at least one of Your children.

Only one Spouse is eligible for insurance under this Policy and it is the person who most recently satisfies the definition of Spouse who is eligible to apply for coverage under the Policy.

We may require written proof of the Spouse's status as often as We determine is reasonably necessary.

Summary of Coverage means the insurance document called a "Summary of Coverage", or any replacement of such document, which We issue to You, which summarizes the Benefit Amount You, Your Spouse and Your Dependents have under this Policy. The Summary of Coverage forms part of Your contract of insurance.

Surgery means the treatment of disorders of the body by incision or manipulation with surgical instruments.

Survival Period means the period starting on the Date of Diagnosis and ending 14 days later, except as specifically provided elsewhere under the Policy. The Survival Period does not include the number of days on Life Support. The Insured Person must not have experienced Irreversible cessation of all functions of the brain and must be alive at the end of the Survival Period.

For those conditions which have a qualifying period, for example 90 days for Bacterial Meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Termination Date means the date on which the Insured Person is no longer eligible for coverage or has received the maximum amount payable under his or her Policy.

You and **Your** refer to the individual identified as the policyholder in the Summary of Coverage.

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Article 3

3.1 Benefits Provisions

Your Spouse and Eligible Dependents

When are Your Spouse and Dependents eligible for coverage under this Policy?	Your Spouse and Dependents are eligible for coverage under this Policy on the latest of: 1. the date You are eligible for coverage under this Policy; and 2. the date such Spouse or Dependent first satisfies the definition of Spouse or Child under this Policy.
Who can apply for coverage under the Policy?	You must make Application to add coverage for Your Spouse or Dependents. Your Summary of Coverage will indicate whether You have this coverage.

Payment of Benefit Amount

When is the Benefit Amount payable?

If an Insured Person is first Diagnosed with a Covered Condition while insured under this Policy, We will pay the Benefit Amount for that Covered Condition, subject to the terms and conditions of this Policy.

The Benefit Amount will become payable provided that the following conditions are met:

1. We receive evidence, satisfactory to Us, including but not limited to medical evidence, documenting the Insured Person's Diagnosis;
2. the Diagnosis is made by a Physician, unless the Policy requires that the Diagnosis be made by a Specialist. If the Diagnosis is made outside of Canada, We reserve the right to require the Diagnosis be confirmed by a Physician or Specialist licensed and practising in Canada; and
3. no Policy Exclusions or Limitations apply.

Charitable Donation

What is the Charitable Donation benefit?

When We determine that a Benefit Amount is payable in respect of an Insured Person's first payable Claim under this Policy, the Claimant may designate a Canadian registered charitable organization to receive the one-time Charitable Donation listed on the Schedule of Benefits. We will pay this Charitable Donation to such organization, provided that We may, in our discretion, pay the Charitable Donation to another Canadian registered charity with similar purposes.

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Multiple Event Categories

If an Insured Person experiences multiple Covered Conditions, will the Benefit Amount be paid more than once?

Applicable to You and Your Spouse. This benefit is not available to Children.

If You or Your Spouse receive a Benefit Amount under this Policy, the Insured Person's coverage may remain in force subject to the terms and conditions of the Policy, specifically, the following paragraph, provided that premium is paid in accordance with the Policy.

The Face Amount may be Claimed for up to four Covered Conditions, with one Claim being eligible in each of the Multiple Event Categories listed below. In order to be eligible for this coverage, the subsequent Diagnosis must be made 90 days or more after the date the prior Covered Condition was Diagnosed.

The Multiple Event Categories are:

Category 1	Cancer (Life-Threatening)
Category 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, and Stroke (Cerebrovascular Accident)
Category 3	Blindness, Deafness, Loss of Limbs, Loss of Speech, Occupational HIV, and Severe Burns
Category 4	Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Kidney Failure, Loss of Independent Existence, Motor Neuron Disease, Multiple Sclerosis, Major Organ Transplant, Major Organ Failure on Waiting List, Paralysis, and Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Payment of Early Diagnosis Benefit Covered Conditions will not affect the ability to make a Claim under the Multiple Event Categories.

This benefit is subject to the following limitations:

Once a benefit has become payable, the Insured Person will not be covered under this Policy for another Claim that is:

1. in the opinion of Our chief medical officer, caused by, or contributed to, has spread from or has occurred as a result of the same Covered Condition;
2. in the opinion of Our chief medical officer, directly or indirectly associated with, or is likely to have been caused by, a Covered Condition that the Insured Person has already Claimed under this Policy; or
3. for a Claim for another Covered Condition within the same Multiple Event Category as a Claim that has already been paid under this Policy.

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Early Diagnosis Benefit

What is the Early Diagnosis Benefit?

Applicable to You and Your Spouse. This benefit is not available to Children.

If a You or Your Spouse is Diagnosed with an Early Diagnosis Benefit Covered Condition while insured under this Policy, We will pay the Insured Person the applicable Benefit Amount for that Covered Condition, subject to the terms and conditions of this Policy.

The Benefit Amount for Early Diagnosis Benefit Covered Conditions is 10% of the Face Amount, and is only payable once per Covered Condition per Insured Person.

Multiple Cancer Benefit

If an Insured Person experiences more than one occurrence of Cancer, will the Benefit Amount be paid more than once?

Applicable to You and Your Spouse. This benefit is not available to Children.

If You or Your Spouse receive a Benefit Amount under this Policy as a result of a Cancer (Life-Threatening) Diagnosis, the Insured Person's eligibility to Claim in the future for Cancer (Life-Threatening) is subject to the definition of Multiple Cancer below, provided that no exclusions or limitations apply and premium is paid in accordance with the terms and conditions of this Policy.

Multiple Cancer is defined as a subsequent Diagnosis of the Insured Person with Cancer (Life-Threatening), provided that:

1. the Insured Person has not received any treatment relating directly or indirectly to the previous cancer within the 60-month period prior to the subsequent Diagnosis;
2. the Insured Person does not have any new signs, symptoms or deliberate or incidental findings, during the 60-month period prior to the subsequent Diagnosis, for which they sought medical investigation, consultation to investigate and or diagnose, diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that should have caused an individual to seek the same relating to a Diagnosis of Cancer (Life-Threatening) or Cancer (Non-Life-Threatening); and
3. both the first and subsequent Diagnoses are made while the Insured Person is covered under the Policy and prior to the Termination Date.

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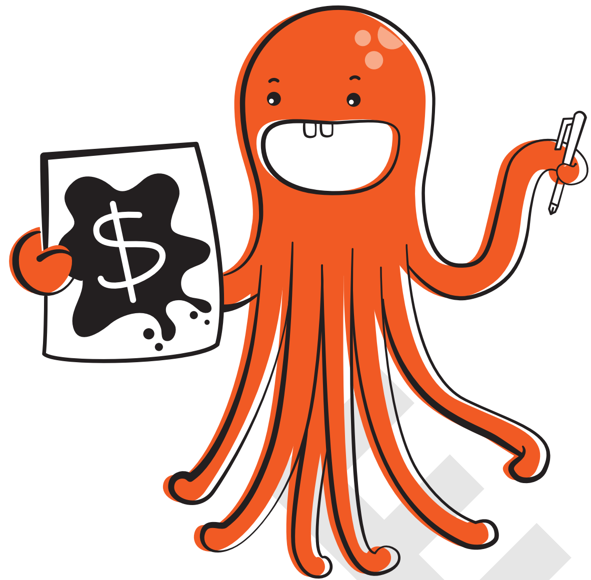

Article 4

4.1 Premium Provisions

Payment of Premiums

What is the premium amount and when are premiums due?

Your first premium is due on or before Your Effective Date of Coverage. Thereafter, premiums are due on the same day of each month while the Policy is in force. The amount of Your premium for the first 12 months, following Your Effective Date of Coverage, including premiums payable for Your Spouse and Dependents, is set out in Your Summary of Coverage.

If You cancel the Policy, Your premium refund will be calculated on a pro-rata basis from the effective date of the cancellation until the next premium due date. Premium adjustments for any other changes to the Policy will be calculated on a pro-rata basis from the effective date of the change until the next Policy Anniversary.

Premium Rates

Can the Insurer change the premium amount?

Your premiums are guaranteed for the first 12 months following your Effective Date of Coverage if You do not make any changes to Your coverage or Your Spouse's or Dependents' coverage. Afterwards, We may change the amount of the premiums on any Policy Anniversary. We will notify You at least 60 days in advance of any increase.

Grace Period

What happens if a premium payment is late?

Other than for payment of the initial premium, which must be paid or Your coverage and that of Your Spouse and Dependents will not come into effect, We will grant a Grace Period of 60 days from the premium due date for the payment of overdue premium. Your coverage and that of Your Spouse and Dependents will remain in force during the Grace Period but will automatically terminate if You do not pay the required premium during the Grace Period.

Reinstatement of an Insured Person's Coverage

Can a terminated Policy be reinstated?

If Your Policy terminates due to non-payment of premium it may not be reinstated.

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Article 5

5.1 Effective Date and Termination of Coverage

Effective Date of Coverage for Insured Persons

When is coverage effective?	Your coverage will be effective on the Effective Date of Coverage set out in the Summary of Coverage. Coverage for Your Spouse and Dependents will be effective on the latest of the following dates: 1. the Effective Date of Coverage set out in the Summary of Coverage; or 2. the date You apply, and are approved, for coverage for Your Spouse or Dependent.

Transfer of Coverage from a Prior Policy

What happens if coverage under this Policy is replacing coverage under a Prior Policy?	If this Policy is replacing Your coverage under a Prior Policy, the Pre-Existing Condition Exclusion Period will be reduced by the time You, Your Spouse and Your Dependents were covered under such Prior Policy, but only with respect to any Grandfathered Coverage. All new Covered Conditions We identify and all increases in Face Amount that are not Grandfathered Coverage will be deemed to be issued on the Effective Date of Coverage.

Renewal of the Policy

Will the Policy be renewed?	This Policy renews on each Policy Anniversary, provided that You are under 70 years of age, and You, Your covered Spouse and Children, if applicable, and are Full-Time Residents of Canada on the Policy Anniversary. In addition, You must confirm Your intention to renew Your coverage by paying to Us the premium due on the Policy Anniversary. We cannot cancel the Policy, other than for non-payment of premium.
When does the Policy terminate?	Your Policy expires on the date You turn 70 and it terminates as specified in the termination provisions. You may terminate this Policy by providing written Notice to Us. Coverage will be terminated as of the date We receive such Notice.

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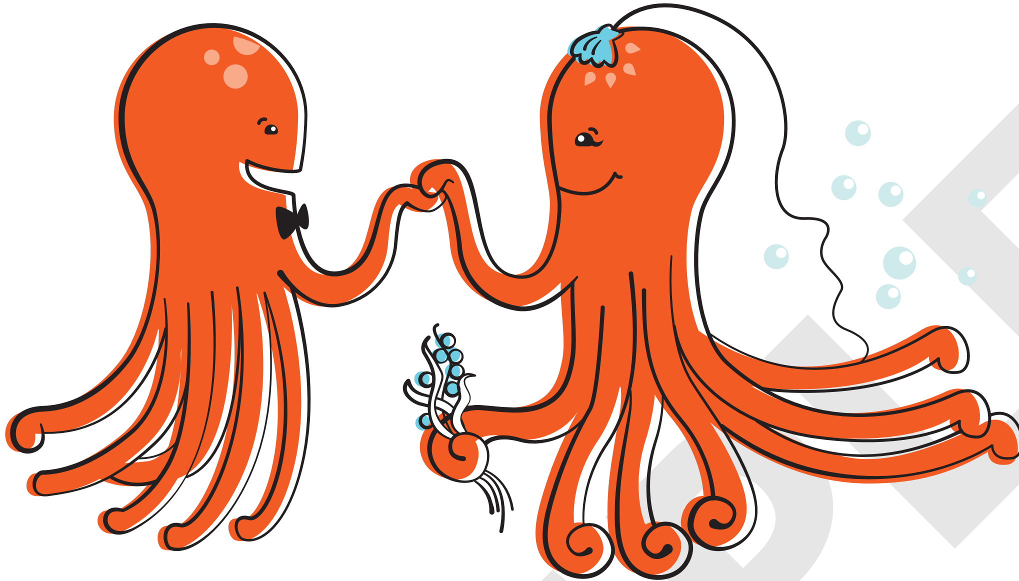

Life Event

Can You request a change to the Face Amount?

You may request an increase in any or all of Your Face Amount, Your Spouse's Face Amount or Your Dependents' Face Amount, within 60 days of the occurrence of a Life Event, provided that You are Actively at School or Actively at Work on the date You request the increase.

If the new Face Amount is less than the Non-Evidence Maximum, Evidence of Insurability is not required. The increase will be effective on the latest of the following dates:

1. the date You apply for the increase; and
2. the date of Your Life Event.

If the new Face Amount is greater than the Non-Evidence Maximum, Evidence of Insurability will be required. The increase will be effective on the latest of the following dates:

1. the date You apply for the increase;
2. the date of Your Life Event; and
3. the date We approve the Evidence of Insurability.

If You do not apply within 60 days of the occurrence of a Life Event, Your coverage remains unchanged. To increase coverage after the 60-day period has passed, Evidence of Insurability will be required.

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Termination of Your Insurance

When does the insurance of the policyholder terminate?

You will cease to be insured on the earliest of the following dates:

1. the date this Policy terminates;
2. the last day for which any required premium has been paid for Your insurance if the Grace Period has expired;
3. any Policy Anniversary upon which You are no longer a Full-Time Resident of Canada;
4. the date You reach the age of 70 years;
5. the date the maximum amount payable under this Policy is paid out; and
6. the date You die.

Termination of a Spouse's Insurance

When does the insurance of the Spouse terminate?

Your Spouse will cease to be insured on the earliest of the following dates:

1. the date this Policy terminates;
2. the date You cease to be an Insured Person;
3. the date We receive Your request to terminate Your Spouse's coverage in writing;
4. the date Your Spouse ceases to be legally married to You, or in a civil union with You as defined by the Civil Code of Quebec, or in registered domestic partnership in Nova Scotia, or has ceased living with You in a role like that of a marriage partner;
5. the last day for which any required premium has been paid for Your Spouse's insurance if the Grace Period has expired;
6. the Policy Anniversary if Your Spouse is no longer a Full-Time Resident of Canada;
7. the date Your Spouse reaches the age of 70 years;
8. the date the maximum amount payable under this Policy has been paid out; and
9. the date Your Spouse dies.

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Termination of a Child's Insurance

When does the Child's insurance terminate?

Your Child will cease to be insured on the earliest of the following dates:

1. the date this Policy terminates;
2. the date You cease to be an Insured Person;
3. the date the Child becomes employed on a full-time basis;
4. the date the Child turns 21, or 26 if in attendance at an accredited school as a full-time student;
5. the date the Child gets married or enters into a civil union as defined by the Civil Code of Quebec or a registered domestic partnership in Nova Scotia, or has been living with another person in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
6. the date the Child becomes eligible for voluntary critical illness insurance as an employee under any group benefit plan;
7. the last day for which any required premium has been paid for Your Child coverage if the Grace Period has expired;
8. the date We receive Your request to terminate Your Child's coverage in writing;
9. the date the Child is paid a Benefit Amount under this Policy; and
10. the date the Child dies.

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Article 6

6.1 Claim Provisions

Notice of Claim

What is required to file a Claim?	Written Notice of Claim must be given to Us within 30 days of the Date of Diagnosis. If such Notice of Claim is not provided within that time, the Claim will not be invalidated if Notice of Claim is given as soon as reasonably possible.

Proof of Claim

What Proof of Claim is required?	The Claimant must submit a Claim for benefits under this Policy using the approved Claim forms provided by Us. We will not pay any Claim until We receive satisfactory proof in writing that such benefits are payable under the terms of this Policy. Written Proof of Claim must be provided to the Us within 90 days of the Date of Diagnosis. Failure to provide such Proof of Claim within this time will not invalidate the Claim if the Proof of Claim is given as soon as reasonably possible, provided the information is sent to Us within one year of Date of Diagnosis. The Claimant will be responsible for expenses incurred for providing Claim information.
Will the Insured Person need to be examined?	We may determine a physical examination of the Insured Person by one or more Physicians is necessary to assist in adjudicating the Claim. We will be responsible for any costs associated with such physical examinations. If the Insured Person refuses to be examined, We may not be able to make a favourable decision in respect of the Claim.

Beneficiary

Who receives the Benefit Amount under this Policy?	Benefits are paid to the Insured Person, provided that benefits with respect to a Child are payable to You. If the Insured Person is no longer living at the time payment is made, these benefits are payable to his or her estate. We do not accept Beneficiary designations for any benefits under this Policy, other than in Quebec.

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Methods of Payment

How is the Benefit Amount Paid?

The Benefit Amount is payable as a lump sum.

Review Procedure

Can a Claimant request that a denial of a Claim be reviewed?

If all or any part of a Claim is denied, the Claimant may request a review of the denial within 6 months after receiving a Notice of denial by writing to Us. The Claimant may submit written comments, documents, records or other information relating to the Claim, and may request free of charge a copy of the Application and any document provided to Us regarding the Insured Person's Evidence of Insurability and this Policy.

We will review the Claim and the Claimant's written submissions, and will notify the Claimant of Our decision within a reasonable time upon receipt of all required information.

Legal Proceedings

When can legal actions be brought against the Insurer?

No legal action may be brought against Us within 60 days after Proof of Claim has been submitted, or after the time limit for bringing such an action set out in applicable legislation has expired.

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, Manitoba and British Columbia), the Limitations Act, 2002 (Ontario), or other applicable provincial legislation.

SAMPLE

Article 7

7.1 Covered Conditions, Limitations and Exclusions

Covered Conditions

What are the Covered Conditions under the Policy?

An Insured Person is only covered for those Covered Conditions set out as applicable to them on the Schedule of Benefits.

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

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

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

1. marrow stimulating agents;
2. immunosuppressive agents;
3. bone marrow transplantation.

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

Autism is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the Diagnosis confirmed by a Specialist before the third birthday of the Child.

Bacterial Meningitis is defined as a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit(s) documented for at least 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.

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Benign Brain Tumour is defined as a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The 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.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Insurer within 6 months of the date of the Diagnosis. If this information is not provided within this period, the 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 Covered Condition if, within the first 90 days following the later of:

1. the Effective Date of Coverage, or
2. the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following:
    a. signs, symptoms, evidence 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
    b. a Diagnosis of benign brain tumour (covered or excluded under the Policy).

Exclusion: No benefit will be payable under this Covered Condition for pituitary adenomas less than 10 mm.

Blindness is defined as a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

1. the corrected visual acuity being 20/200 or less in both eyes; or
2. the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

SAMPLE

Cancer (Life-Threatening) is defined as a 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. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of (i) the Effective Date of Coverage or (ii) the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following:

1. 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
2. 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 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.

Exclusion: No benefit will be payable for the following:

1. lesions described as benign, pre-malignant, uncertain, borderline, noninvasive, carcinoma in-situ (Tis), or tumours classified as Ta;
2. 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;
3. any non-melanoma skin cancer, without lymph node or distant metastasis;
4. prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
5. 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;
6. chronic lymphocytic leukemia classified less than Rai stage 1; or
7. 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.

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Cancer (Non-Life-Threatening) includes:

1. **Ductal Carcinoma in Situ of Breast**, which is defined as the Diagnosis of non-life-threatening ductal carcinoma in situ of the breast, confirmed by biopsy.
2. **Early Stage Lymphocytic Leukemia**, which is defined as the Diagnosis of chronic lymphocytic leukemia classified less than Rai stage 1.
3. **Early Stage Thyroid Cancer**, which is defined as the Diagnosis of 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.
4. **GIST (Gastrointestinal Stromal Tumour)**, which is defined as the Diagnosis of malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.
5. **Stage A (T1a or T1b) Prostate Cancer**, which is defined as the Diagnosis of prostate cancer classified as T1a or T1b, without lymph node or distant metastasis.
6. **Stage 1A Malignant Melanoma**, which is defined as the Diagnosis of 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.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of:

1. the Effective Date of Coverage, or
2. the date of the last reinstatement of coverage, 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; or
   b. a Diagnosis of cancer (covered or excluded under the Policy).

Cerebral Palsy is defined as a definitive Diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

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

Exclusion: No benefit will be payable under this Covered Condition for:

1. a medically induced coma;
2. a coma which results directly from alcohol or drug use; or
3. a Diagnosis of brain death.

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Congenital Heart Disease is defined as any one or more Diagnosis(es) from the following lists of heart conditions that are Covered Condition:

List A

- Atresia of any heart valve
- Coarctation of The Aorta
- Double Inlet Ventricle
- Double Outlet Left Ventricle
- Ebstein's Anomaly
- Eisenmenger Syndrome
- Hypoplastic Left Heart Syndrome
- Hypoplastic Right Ventricle
- Single Ventricle
- Tetralogy of Fallot
- Total Anomalous Pulmonary Venous Connection
- Transposition of The Great Vessels
- Truncus Arteriosus

The Covered Conditions described in List A will be covered commencing from the date of birth. The Diagnosis of any of the Covered Conditions in List A must be made by a Specialist who is a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B

- Aortic Stenosis
- Atrial Septal Defect
- Discrete Subvalvular Aortic Stenosis
- Pulmonary Stenosis
- Ventricular Septal Defect

The Covered Conditions described in List B will be covered only when open heart Surgery is performed for correction of the Covered Condition following the date of birth. The Diagnosis of any of the Covered Conditions in this List B must be made by a Specialist who is a qualified pediatric cardiologist, and supported by appropriate cardiac imaging. The Surgery must be recommended by a Specialist who is a qualified pediatric cardiologist and performed by a Specialist who is a cardiac surgeon in Canada.

List B Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.

General Congenital Heart Disease Exclusion: All other congenital cardiac conditions not specifically described in List A or List B are not Covered Conditions and are excluded.

Coronary Angioplasty is defined as the undergoing of an 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.

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

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

SAMPLE

Cystic Fibrosis is defined as a definitive Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

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

Dementia, including Alzheimer's Disease is defined as a 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:

1. aphasia (a disorder of speech);
2. apraxia (difficulty performing familiar tasks);
3. agnosia (difficulty recognizing objects); or
4. 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 Insured Person must exhibit:

1. dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
2. evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The Diagnosis of Dementia must be made by a Specialist.

For the purposes of the Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, Journal of Psychiatric Research 1975;12(3):189.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

Down Syndrome is defined as a definitive Diagnosis of Down Syndrome, confirmed by a Physician Specialist with expertise in the specialty normally designated to assess and manage Down Syndrome.

SAMPLE

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

1. heart attack symptoms;
2. new electrocardiogram (ECG) changes consistent with a heart attack; or
3. 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 Covered Condition for:

1. elevated cardiac biochemical 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;
2. ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above; or
3. Diagnosis or working Diagnosis of Heart Attack without the supporting cardiac-biochemical markers diagnostic of myocardial infarction and new ECG changes consistent with a heart attack as defined in the Policy.

Heart Valve Replacement or Repair is defined as the undergoing of 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 Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure is defined as a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The Date of Diagnosis is the date of the Insured Person's initiation into the transplant program. The Diagnosis of Kidney Failure must be made by a Specialist.

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Loss of Independent Existence is defined as a definite Diagnosis of the total and permanent inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 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:

1. **bathing** — the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
2. **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;
3. **toileting** — the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
4. **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;
5. **transferring** — the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
6. **feeding** — the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs is defined as a 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. The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech is defined as a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical Injury or Sickness for a period of at least 180 days. The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for all psychiatric-related causes.

Major Organ Failure on Waiting List is defined as a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be Medically Necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person 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 purpose of the Survival Period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant is defined as a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be Medically Necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Diagnosis of the major organ failure must be made by a Specialist.

SAMPLE

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

Multiple Sclerosis is defined as a definite Diagnosis of at least one of the following:

1. two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI), of the nervous system showing multiple lesions of demyelination;
2. well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system showing multiple lesions of demyelination; or
3. 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.

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

Muscular Dystrophy is defined as a definitive Diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Occupational HIV Infection is defined as a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from an Accident causing Injury during the course of the Insured Person's normal occupation which exposed the Insured Person to HIV-contaminated body fluids.

The Injury from Accident leading to the infection must have occurred after the later of the Effective Date of Coverage or the Effective Date of the last reinstatement of the Insured Person's coverage.

Payment under this Covered Condition requires satisfaction of all of the following:

1. the Injury from Accident must be reported to the Insurer within 14 days of the Accident causing the Injury;
2. a serum HIV test must be taken within 14 days of the Injury from Accident and the result must be negative;
3. a serum HIV test must be taken between 90 days and 180 days after the Accidental Injury from Accident and the result must be positive;
4. all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
5. the Injury from Accident must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

SAMPLE

Exclusion: No benefit will be payable under this Covered Condition if:

1. the Insured Person has elected not to take any available licensed vaccine offering protection against HIV;
2. a licensed cure for HIV infection has become available prior to the Injury from Accident; or
3. HIV infection has occurred as a result of any Injury not from Accident including, but not limited to, sexual transmission and intravenous (IV) drug use.

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

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

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

Specified Atypical Parkinsonian Disorders defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist who is a neurologist

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Insurer within 6 months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any Claim for Parkinson's Disease, Specified Atypical Parkinsonian Disorders or any Covered Condition caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of: (i) the Effective Date of the Policy or (ii) the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following:

1. 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
2. a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Exclusion: No benefit will be payable under this Covered Condition for any other type of Parkinsonism.

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Severe Burns is defined as a definite Diagnosis of third-degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) is defined as a definite Diagnosis of an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

1. acute onset of new neurological symptoms, and
2. new objective neurological deficits on clinical examination,

persisting for more than 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 Covered Condition for:

1. transient Ischaemic Attacks;
2. intracerebral vascular events due to trauma; or
3. lacunar infarcts which do not meet the definition of Stroke as described above.

Type 1 Diabetes Mellitus (Juvenile Diabetes) is defined as the Diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a Specialist who is a qualified pediatrician or endocrinologist licensed and practising in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

Pre-Existing Condition Limitation

Will a Benefit Amount be payable for a Pre-Existing Condition?

No Benefit Amount will be payable for a Pre-Existing Condition, whether Diagnosed or not, that existed during the Pre-Existing Condition Period and is Diagnosed during the Pre-Existing Condition Exclusion Period.

SAMPLE

Child Critical Illness Exclusions

What exclusions apply to Child coverage?

1. When a Child is born within ten months of Your Effective Date of Coverage, and is Diagnosed with any Covered Condition within 31 days after their date of birth, no benefit will be payable for such Covered Condition.
2. Any cancer tumour in the presence of the human immunodeficiency virus (HIV).

General Exclusions for All Covered Conditions

What exclusions apply to all coverage?

1. No benefit will be payable if the Pre-Existing Condition Limitation applies.
2. No benefit will be payable for a Covered Condition Diagnosed while the Insured Person is not covered under this Policy.
3. No benefit will be payable if the Survival Period limitations are not satisfied.
4. No benefit will be payable if the Insured Person's condition was either directly or indirectly caused by, contributed to, resulted from or was in any way associated with one or more of the following:
   a. attempted suicide or self-inflicted Injury or Sickness, while sane or not sane;
   b. committing or attempting to commit a criminal offence;
   c. the use of alcohol or any medications or drugs, other than taken as prescribed by a Physician;
   d. insurrection, riot, civil commotion, hostilities of any kind, war (whether declared or not), or active service in the armed forces of any country;
   e. any Accident, Injury or Sickness caused by hazardous activities or sports such as, but not limited to: professional sports, racing, B.A.S.E. jumping, bungee jumping, parachuting, ultra-light flying, hang gliding, scuba diving, rock or mountain climbing, back country or heli-skiing, motocross or extreme sports;
   f. Injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured Person's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of the Injury;
   g. medical care which is not Medically Necessary or which is cosmetic in nature (the donation of an organ or tissue will be considered as Medically Necessary care); or
   h. any specific exclusions relating to any given Covered Condition as set out within the definition for that Covered Condition in this article.
5. No benefit will be payable if the Insured Person fails to seek treatment in order to avoid the Pre-Existing Condition Period limitations or other conditions and restrictions of this Policy.
6. No benefit will be payable if, within 90 days following the later of the Effective Date of Coverage or date of last reinstatement of coverage:
   a. a Diagnosis of Cancer (Life-Threatening) or Cancer (Non-Life-Threatening) is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of cancer (life-threatening) or cancer (non-life-threatening) (covered or excluded under this benefit), regardless of when the Diagnosis is made; or
   b. a Diagnosis of Benign Brain Tumour is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or excluded under this benefit), regardless of when the Diagnosis is made.
7. No benefit will be payable if, within 365 days following the later of the Effective Date of Coverage or date of last reinstatement of coverage, a Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorders is made or the Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is made.

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Article 8

8.1 General Provisions

Entire Contract

What is included in the contract of insurance?	The entire contract of insurance consists of this Policy, the Summary of Coverage, the Application, any documents attached to the Policy when issued and any amendments to the Policy agreed upon in writing after the Policy is issued.

Misstatement of Facts and Clerical Error

What if an Insured Person misstates any information?	If You or any Insured Person misstates any relevant information relating to the Application, the true facts will be used to determine whether or not insurance is in force under this Policy. Where Evidence of Insurability is required, You and each other Insured Person must disclose to Us at the time of Application every fact of which You and they are aware that may be material to the coverage. Premium adjustments or refunds will be made if appropriate.
What if a clerical error is made?	A clerical error is a mistake in writing or copying data that is made by Us. A clerical error will not invalidate insurance that is otherwise in force or continue insurance otherwise terminated under the terms and conditions of the Policy.

Age

What if an Insured Person's age has been misstated?	We have the right to require satisfactory proof of the Insured Person's age before making payment of any Claim. If the age of an Insured Person has been misstated, the Benefit Amount will be adjusted upwards or downwards based on the premium rates and the Insured Person's true age. If You were not eligible for insurance based on Your true age, then Your coverage, and that of Your Spouse and Dependents, if any, will be voided and an equitable adjustment of premiums will be made with You. If Your Spouse has misstated his or her age and is not eligible for insurance based on his or her true age, then Your Spouse's coverage will be voided and an equitable adjustment of premiums will be made with You.

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Contestability of Policy

When is the Policy incontestable?	We will not contest the validity of this Policy or any statement made by an Insured Person, after the Policy has been in force for two years from the Effective Date of Coverage, except for non-payment of premium or fraud.

Currency

Are payments made in Canadian currency?	All payments under this Policy made either to or by Us, will be made in Canadian currency.

Non-Participating Policy

Is this a Participating Policy?	This Policy is non-participating. You are not eligible to share in Our profits or surplus.

Conformity

What if this Policy does not comply with applicable provincial law?	Any provision of this Policy that conflicts with the laws of the province or territory where the Insured Person lives is automatically amended to conform to the minimum requirements of such laws.
Can the benefits under this Policy be assigned?	No Insured Person is permitted to assign his or her rights under this Policy.

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Article 9

9.1 Statutory Conditions

Applicable in all provinces and territories (with the exception of Quebec).

1. The Contract

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

2. 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.

3. Copy of Application

The Insurer shall, upon request, furnish to the Insured or to a Claimant under the contract a copy of the Application.

4. Material Facts

No statement made by the Insured or a person insured at the time of Application for the contract shall be used in defence of a Claim under or to avoid the contract unless it is contained in the Application or any other written statements or answers furnished as Evidence of Insurability.

5. Termination of Insurance

1. The contract may be terminated by the Insured at any time on request.
2. If the contract is terminated by the Insured, the Insurer must refund as soon as practicable the excess of premium actually paid by the Insured over the short rate premium calculated to the date of receipt of the Notice according to the table in use by the Insurer at the time of termination.

6. Notice & Proof of Claim

The insured or a person insured, or a Beneficiary entitled to make a Claim, or the agent of any of them, shall

1. give written Notice of Claim to the Insurer
    a. by delivery of the Notice, or by sending it by registered mail, to the head office or chief agency of the Insurer in the province, or
    b. by delivery of the Notice to an authorized agent of the Insurer in the province, not later than 30 days after the date a Claim arises under the contract on account of an Accident or Sickness,
2. within 90 days after the date a Claim arises under the contract on account of an Accident or Sickness, furnish to the Insurer such proof as is reasonably possible in the circumstances of
    a. the happening of the Accident or the start of the Sickness,
    b. the loss caused by the Accident or Sickness,
    c. the right of the Claimant to receive payment,
    d. the Claimant's age, and
    e. if relevant, the Beneficiary's age, and
3. if so required by the Insurer, furnish a satisfactory certificate as to the cause or nature of the Accident or Sickness for which Claim is made under the contract and, in the case of Sickness, its duration.

Failure to give Notice of Claim or furnish Proof of Claim within the time required by this statutory condition does not invalidate the Claim if

1. the Notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year or, in Saskatchewan, not later than the limitation period set out in The Limitations Act,

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after the date of the Accident or the date a Claim arises under the contract on account of Sickness, and it is shown that it was not reasonably possible to give the Notice or furnish the proof in the time required by this condition, or

2. in the case of the death of the person insured, if a declaration of presumption of death is necessary, the Notice or proof is given or furnished no later than one year or, in Saskatchewan, not later than the limitation period set out in The Limitations Act, after the date a court makes the declaration.

7. Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for Proof of Claim within 15 days after receiving Notice of Claim, but if the Claimant has not received the forms within that time the Claimant may submit his or her Proof of Claim in the form of a written statement of the cause or nature of the Accident or Sickness giving rise to the Claim and of the extent of the loss.

8. Right of Examination

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

1. the Claimant must give the Insurer an opportunity to examine the person of the person insured when and as often as it reasonably requires while the Claim hereunder is pending, and
2. in the case of death of the person insured, the Insurer may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies

9. When Money Payable

All money payable under this contract shall be paid by the Insurer within 60 days after it has received Proof of Claim.

10. Limitation of Actions

Applicable in New Brunswick, Nova Scotia, Newfoundland and PEI only: An action or proceeding against the Insurer for the recovery of a Claim under this contract shall not be commenced more than one year after the date the insurance money became payable or would have become payable if it had been a valid Claim.

Applicable in Yukon, NWT and Nunavut only**:** An action or proceeding against the Insurer for the recovery of a Claim under this contract shall not be commenced more than two years after the date the insurance money became payable or would have become payable if it had been a valid Claim.

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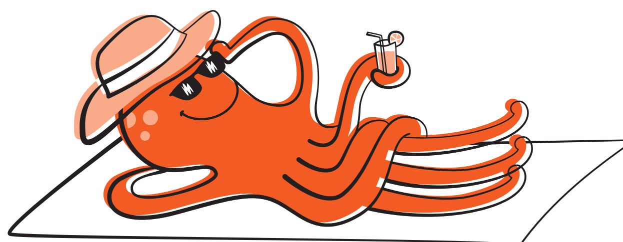
—END OF POLICY—



Article 10

10.1 Privacy Policy

The collection, use, disclosure and retention of personal information in connection with this Policy will be done in accordance with the provisions of applicable privacy legislation and Our Privacy Statement. We collect, use and disclose personal information to process Applications and, if such Applications are approved, to provide and administer the relevant product(s) to the Insured Persons, including investigating and assessing Claims and creating and maintaining Our records.

The Insured Person may exercise certain rights of access and rectification with respect to the information in the Insured Person's file by sending a request in writing to Us. We limit access to personal information in such files to:

1. our employees who have a need to access such information to perform their jobs;
2. people We approve who need such information to perform their duties as they relate to Your Policy;
3. people to whom the Insured Person has granted access; and
4. people authorized by law to access such items.

For questions about Our personal information policies and practises, please contact Us:

Privacy Officer

Temple Insurance Company
390 Bay Street, 22nd Floor
Toronto, Ontario M5H 2Y2

By phone at:
416-364-2851 or
1-877-364-2851 (toll-free)

By email at:
privacyofficer@templeins.com

Or refer to our website:

https://www.munichre.com/temple-insurance/en/general/privacy-statement.html

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