TRANSITION 5
AND TRANSITION 5 SIMPLIFIED ISSUE

YOUR CRITICAL ILLNESS INSURANCE CONTRACT

GENERAL CONDITIONS

Premiums

Premiums for this contract are payable at the Company's Head Office or at one of its offices in legal Canadian tender. The period for premium payments is 31 days, except for the initial premium for each coverage, which is payable on the effective date of this coverage.

Effective Date

- **Contract**

The effective date of the contract is indicated on the Contract Specifications Page. It determines the date of the oldest coverage of this contract and which is always in force.

- **Coverage**

Each coverage has its own effective date indicated on the Contract Specifications Page. The coverage years are determined based on this date. In addition, the 2-year period provided under the title INCONTESTABILITY of this clause begins from this date for each coverage.

Age

"Age" means the age on the birthday closest to the effective date of the coverage.

Incontestability

The statements made in the application or in any other document used in the acceptance of the coverage are considered as being true and incontestable once the coverage has been in force for 2 years, starting on the effective date or the reinstatement date of the coverage, whichever is the most recent, except:

- in the case of misstatement of age;
- in case of fraud;
- if a critical illness is diagnosed within 2 years after the effective date of the coverage or within 2 years of any reinstatement, whichever is the most recent, where false declarations have been made in any document used in the acceptance of the application or the acceptance of the request of reinstatement, or where facts susceptible of influencing the Company's decision have not been declared.

(Continued on reverse)

Reinstatement

Within 2 years following cancellation of the contract due to non-payment of premiums, the contract may be reinstated, subject to the following conditions:

- presentation of evidence of insurability deemed satisfactory by the Company and
- payment of all premiums due, including interest.

Dissociation

With the consent of the applicant, an insured may withdraw from this contract and continue to be insured under an individual contract of the same type that includes the features indicated on the Contract Specifications Page. However, the Company reserves the right to issue a contract it deems to be equivalent. The exercising of this right results in transaction fees that are charged to this contract and policy fees that apply to the new contract.

Premium Loan

Any premiums that are not paid under this contract at the end of the premium payment period are automatically paid by means of a policy loan when the FLEXIBLE RETURN OF PREMIUMS RIDER benefit is available. If the available value is not sufficient to pay the full premium of this contract, the contract remains in effect for a period proportional to the portion of the premium paid.

Policy Loan

Upon written request from the applicant, if a FLEXIBLE RETURN OF PREMIUMS RIDER benefit is available, the Company agrees to loan an amount which, added to any other amount due, any premium due and unpaid plus interest, shall not exceed 95% of the value of the FLEXIBLE RETURN OF PREMIUMS RIDER benefit available under this contract.

The applicable interest rate is determined by the Company from time to time and interest is payable on the anniversary date of the contract. In default of payment, the interest is added to the amount due and accrues interest.

When the amount owed to the Company, including interest, is equal to or greater than the value of the FLEXIBLE RETURN OF PREMIUMS RIDER benefit, this contract shall be terminated without notice.

The value of the policy loan is automatically deducted from any benefit payable under this contract.

Transaction Fees

The Company reserves the right to collect fees for any transactions made, or for any unhonoured cheques.

TRANSITION 5 - T10 R&C

10-YEAR TERM CRITICAL ILLNESS COVERAGE
PREMIUMS GUARANTEED UPON RENEWALS

Benefits

- **Critical Illness Benefit**

When the insured is diagnosed with a critical illness described under the title TERMINOLOGY OF THE COVERED MEDICAL CONDITIONS of the TRANSITION 5 – CRITICAL ILLNESS COVERAGE clause and lives for at least 30 days after the date of the diagnosis or during the specific period of the diagnosed condition, the Company pays, in a single lump-sum payment, to the beneficiary of the critical illness benefit, the face amount indicated on the Contract Specifications Page.

If you have subscribed to a ***Flexible Return of Premiums Rider*** attached to the present coverage and when the amount of that ***Flexible Return of Premiums Rider*** Benefit is higher than the face amount entered on the Contract Specifications Page and the insured is stricken with a Critical Illness, the Company pays to the beneficiary as the Critical Illness Benefit, in a single lump sum the ***Flexible Return of Premiums Rider*** Benefit.

For the diagnosis of the LOSS OF INDEPENDENT EXISTENCE, the maximum face amount payable is $500,000 per insured for all in-force CRITICAL ILLNESS COVERAGE [1] contracts held at the Company. If the face amount in force is above this $500,000, after payment, it will be decreased of $500,000. The adjustments described under the title REDUCTION IN THE CRITICAL ILLNESS COVERAGE of this clause apply, and the protection remains in effect for the remaining amount.

In the event of a diagnosis of one of the following conditions described under the title PREVENTION + BENEFIT of the TRANSITION 5 – CRITICAL ILLNESS COVERAGE clause:

- **coronary angioplasty;**
- **malignant melanoma;**
- **stage A prostate cancer A (T1a or T1b);**
- **ductal carcinoma in situ of the breast;**

the maximum face amount payable is 10% of the face amount entered on the Contract Specifications Page, to a maximum of $50,000 per payment.

Reduction in the Critical Illness Coverage

The premium of the coverage is adjusted for any decrease in insurance, if applicable, depending of the sum insured and the insured's age at issue.

- When the applicant makes a written request to the Company to reduce the TRANSITION 5 - T10 R&C coverage for an insured, or
- when the applicant makes a written request to the Company to partially convert the TRANSITION 5 - T10 R&C coverage, or
- following the payment of the critical illness benefit following the diagnosis of the LOSS OF INDEPENDENT EXISTENCE condition while the face amount is over $500,000.

(Continued on reverse)

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1. **Means any protection whose finality is the payment of a Critical Illness benefit regardless of the name of product or coverage.**

Renewal

On the 10th anniversary of this TRANSITION 5 - T10 R&C coverage, and at the end of each subsequent 10-year period, the Company automatically renews the coverage, without evidence of insurability, for a period of 10 years provided the insured is less than 66 years of age at that time.

On the renewal date, if the insured is 66 years of age or older, but less than 75 years of age, the Company automatically renews the coverage for a period which expires on the insured's 75th birthday.

The renewal premium corresponds to the age of the insured at the beginning of the renewal period, as indicated in this TRANSITION 5 - T10 R&C coverage Renewal Premiums Page.

Conversion

Upon written request from the applicant up to the insured's 65th birthday, the Company agrees to replace the coverage granted under this TRANSITION 5 T10 R&C coverage with a Transition 5 permanent or term to age 75 coverage offered at the insured's attained age for conversion purposes or with any other coverage deemed equivalent by the Company and available at the time of the conversion for a face amount not exceeding the face amount of the TRANSITION 5 T10 R&C coverage indicated on the Contract Specifications Page, without proof of insurability.

The new coverage is issued at the insured's age on his/her nearest birthday at the time of the conversion. It is established according to the rate category indicated on the Contract Specifications Page then in effect. It also contains all other conditions and restrictions of this coverage. However, the Company reserves the right to issue a contract according to a rate category it deems equivalent if the rate category indicated in the Contract Specifications Page is not available. However, if the insured is 14 years of age or under when this coverage is issued, the new coverage is established at the **Smoker rate** unless this coverage was the subject of a change in the tobacco class accepted by the Company. The Company reserves the right to impose exclusions on the new coverage in accordance with the clauses in effect at the time of the conversion.

The new coverage may include the additional benefits that apply to the TRANSITION 5 T10 R&C coverage, including disability benefits, on condition that the definition of disability is identical to the definition in this contract.

For a contract that includes the disability benefits, if the insured or the applicant is disabled, conversion can only take place when the insured reaches age 65 into a Critical illness 5 term to age 75 coverage or into any other coverage deemed equivalent by the Company. In addition, the request for conversion must be made within 31 days after the insured's 65th birthday and if the insured or the applicant remains disabled.

Termination of Coverage

The coverage terminates when the first of the following events occurs:

- on the total payment of the face amount entered on the Contract Specifications Page for one of the medical conditions described under the title TERMINOLOGY OF COVERED MEDICAL CONDITIONS of the TRANSITION 5 – CRITICAL ILLNESS COVERAGE clause;
- on the date the TRANSITION 5 - T10 R&C coverage is converted;
- upon the death of the insured;
- on the insured's 75th birthday;
- on the date this TRANSITION 5 - T10 R&C coverage or the contract is cancelled for any reason;
- on the payment of the FLEXIBLE RETURN OF PREMIUMS RIDER benefit, if applicable.

TRANSITION 5
FLEXIBLE RETURN OF PREMIUMS RIDER

Premiums

This benefit is granted in return for the payment of the premium and according to the terms established on the page of contract specifications. These premiums are payable for the same term as the protection to which it is attached.

Flexible Return of Premiums Benefit

Starting when the insured reaches age 65 or on the 15th anniversary of the coverage to which this rider is attached, the applicant may, on written request, terminate this Critical Illness coverage in order to take advantage of the Flexible Return of Premiums Benefit provided that the Critical Illness benefit has not been fully paid.

Flexible Return of Premiums for Transition T10 et T75	
Âge at issue	**Description of the % of the Flexible Return of Premiums**
0 à 49	100% at the insured's age of 65 and thereafter
50 ans and over	100% at the first of these eventualities : -15th anniversary of the coverage; -at the insured's age of 75.

According to the above table, the amount paid to the beneficiary of the Flexible Return of Premiums Rider benefit equals 100% of the total premiums and extra premiums, as indicated at the ***Composition of the amount of the Flexible Return of Premiums Rider*** section of this Rider, without interests.

When the TRANSITION 5- T75 coverage is issued following the conversion of Critical Illness 5 T10 R&C that contained the Flexible Return of Premiums Rider , the premiums paid since the Critical Illness 5 T10 R& C coverage was issued will also be included in the payment of the Flexible Return of Premiums Benefit, in proportion to the premium related to the converted insurance coverage.

When the TRANSITION 5- T100, T100 Option 10, T100 Option 20 coverage is issued following the conversion of a Critical Illness 5- T10 R&C coverage that contained the Flexible Return of Premiums Rider, only the premiums paid since the issuance of the TRANSITION 5- T100, T100 Option 10, T100 Option 20, coverage will be included in the payment of the Flexible Return of Premiums Benefit.

The paid premiums are adjusted for any decrease in insurance or any partial conversion, as described under the title REDUCTION IN THE CRITICAL ILLNESS COVERAGE of this clause.

Reduction in the Critical Illness Coverage

- When the applicant makes a written request to the Company to reduce the Critical Illness Coverage to which this rider is attached for an insured, or
- when the applicant makes a written request to the Company to partially convert the TRANSITION 5- T10 R&C coverage, or
- following the payment of the critical illness benefit following the diagnosis of the LOSS OF INDEPENDENT EXISTENCE condition while the face amount is over $500,000.

(Continued on reverse)

The paid premiums used to calculate the FLEXIBLE RETURN OF PREMIUMS BENEFIT are adjusted according to the proportion of the premium decrease as described below:

$$\text{Proportion} = \frac{\text{Premium* before the reduction in coverage} - \text{Premium* after the reduction in coverage}}{\text{Premium* before the reduction in coverage}}$$

*The premium amount includes the premium of the coverage and the premium of the Return of Premiums upon Death and Flexible Return of Premiums Riders.

The established proportion cannot be lower than 0.

Adjusted paid premiums after the reduction in coverage = Premiums paid before the reduction in coverage X (1 – Proportion)

Moreover, if a FLEXIBLE RETURN OF PREMIUMS BENEFIT is available when the coverage is reduced excluding:

– the decrease due to the payment of critical illness benefit following the diagnosis of the LOSS OF INDEPENDENT EXISTENCE condition while the face amount is over $500,000.

The Company will pay the following amount to the beneficiary of the Flexible Return of Premiums Benefit:

Amount paid = Value of the Flexible Return of Premiums Benefit X Proportion

Composition of the amount of the Flexible Return of Premiums Rider

Includes:

- Premiums for the Critical Illness Coverage associated with this rider, including premiums waived for a disability;
- Premiums for the ***Return of Premiums Upon Death Rider***, if the rider is in effect upon reimbursement;
- Premiums for the ***Flexible Return of Premiums Rider***, if the rider is in effect upon reimbursement;
- Extra premiums related to this Rider and to the Critical Illness Coverage associated with this rider and the extra premiums of the ***Return of Premiums Upon Death Rider***, if applicable;
- Fees related to the method of payment other than annual;
- Policy fees if they are attached to this coverage.

The premiums for riders and additional benefits not mentioned in this rider are excluded.

Renewal

This section applies in the case this Rider is attached to a Transition 5 – T10 R & C coverage.

On the 10th anniversary of this rider and in this TRANSITION 5 - T10 R&C coverage, and at the end of each subsequent 10-year period, the Company automatically renews the coverages, without evidence of insurability, for a period of 10 years provided the insured is less than 66 years of age at that time.

On the renewal date, if the insured is 66 years of age or older, but less than 75 years of age, the Company automatically renews the coverages for a period which expires on the insured's 75th birthday.

The renewal premium corresponds to the age of the insured at the beginning of the renewal period, as indicated in this TRANSITION 5 - T10 R&C coverage Renewal Premiums Page.

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Reduced Paid-up Insurance

Upon written request from the applicant, on the coverage anniversary, when the ***Flexible Return of Premiums Rider*** benefit is available, the Company agrees to convert this coverage to which the Rider is attached to a reduced paid-up insurance. The reduced benefit amount is determined by the Company based on the amount of the ***Flexible Return of Premiums Rider*** benefit at the time the written request is received and using the rules and premium rates then in use by the Company and applicable to the class of risk in which this coverage was issued.

All riders attached to the converted coverage will be terminated.

Termination of Coverage

The coverage terminates :

On the termination date or the cancellation date of the coverage associated with this choice, for any reason.

TRANSITION - 5 CRITICAL ILLNESS COVERAGE

Critical Illness

« Critical illness » means one of the conditions described under the titles TERMINOLOGY OF THE COVERED MEDICAL CONDITIONS and PREVENTION + BENEFIT of this clause, which is diagnosed while the coverage is in force and the insured lives for at least 30 days after the date of the diagnosis or during the specific period of the diagnosed condition.

Juvenile Critical Illness

« Juvenile Critical illness » means one of the conditions described under the titles TERMINOLOGY OF THE COVERED JUVENILE MEDICAL CONDITIONS and PREVENTION + BENEFIT of this clause, which is diagnosed before the age of 25 years old, while the coverage is in force and the insured lives for at least 30 days after the date of the diagnosis or during the specific period of the diagnosed condition.

Definitions

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

Specialist
A Specialist is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a speciality examining board. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist.

Surgery
Surgery means that the insured undergoes Surgery on the written advice of a specialist.The Surgery must be performed by a physician licensed and practicing medicine in Canada, the United States or in such other jurisdiction as we may approve. Surgery will include the medical procedure for transplanting bone marrow.

Survival Period
Survival Period means the period starting on the date of diagnosis of the Critical Condition and ending 30 days following the date of diagnosis of the Critical Condition, except where modified elsewhere under the policy. The Survival Period does not include the number of days on Life Support*. The Insured Person must be alive at the end of the Survival Period and must not have experienced irreversible cessation of all functions of the brain.

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

Terminology of the Covered Medical Conditions

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

(Continued on reverse)

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

Aortic Surgery

The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Aplastic Anemia

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

- marrow stimulating agents;
- immunosuppressive agents;
- bone marrow transplantation.

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

Bacterial Meningitis

A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit 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.

Benign Brain Tumour

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

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

Moratorium Period Exclusion

No benefit will be payable under this condition if:
Within the first 90 days following the later of:

- the effective date of the policy, or
- the effective date of last reinstatement of the policy,

the Insured Person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour,

regardless of when the diagnosis is made,

- a diagnosis of Benign Brain Tumour.

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any Benign Brain Tumour or its treatment.

Blindness

A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

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

The diagnosis of Blindness must be made by a Specialist.

(Continued on next page)

Cancer (Life-Threatening)

A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of Cancer must be made by a Specialist.

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

- carcinoma in situ, or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion), or
- any non-melanoma skin cancer that has not metastasized, or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion

No benefit will be payable under this condition if:

Within the first 90 days following the later of:

- the effective date of the policy, or
- the effective date of last reinstatement of the policy,

the Insured Person 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,
- a diagnosis of cancer (covered or excluded under the policy).

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Coma

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

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

- a medically induced coma; or,
- a coma which results directly from alcohol or drug use; or,
- a diagnosis of brain death.

Coronary Artery Bypass Surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist.

Deafness

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

Heart Attack

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

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- 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.

(Continued on reverse)

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.

Heart Valve Replacement

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist.

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

Kidney Failure

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

Loss of Independent Existence

A definite diagnosis of:

a) a total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living, or,
b) Cognitive Impairment, as defined below,

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:

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

Cognitive Impairment is defined as “mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of 8 hours of daily supervision.

Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

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

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Loss of Limbs

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

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

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

Major Organ Failure on Waiting List

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 purposes 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

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease

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

Multiple Sclerosis

A 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; *or,*
- well-defined neurological abnormalities lasting more than 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.

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

Occupational HIV Infection

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

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

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

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

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

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

(Continued on reverse)

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

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

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

Paralysis

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

Parkinson's Disease

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

Activities of Daily Living are:

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

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

Severe Burns

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)

A 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 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.

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

- Transient Ischaemic Attacks; or,
- Intracerebral vascular events due to trauma; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.

Terminology of the Covered Juvenile Medical Conditions

Congenital Heart Disease

A diagnosis of the following heart conditions:

i) The following conditions are covered following a 30 day survival period from diagnosis or birth whichever comes later. The diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

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

ii) The following conditions are covered only when open heart surgery is performed for correction of the condition and following a 30 day survival period from diagnosis or birth whichever comes later. The diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada or the U.S.
Pulmonary Stenosis
Aortic Stenosis
Discrete Subvalvular Aortic Stenosis
Ventricular Septal Defect
Atrial Septal Defect

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

All other congenital cardiac conditions are excluded.

Cerebral Palsy

A definitive diagnosis of definite Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Cystic Fibrosis

A definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Muscular Dystrophy

A definitive diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

(Continued on reverse)

Type 1 Diabetes Mellitus

A 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 qualified pediatrician or endocrinologist licensed and practising in Canada or the U.S. and there must be evidence of dependence on insulin for a minimum of three months.

PREVENTION + BENEFIT

The Company can pay a partial benefit when the insured is stricken with one of the following conditions:

Coronary Angioplasty

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;

Malignant Melanoma

Invasive malignant melanoma into the dermis equal to or lower than a depth of 1. mm;

Stage A Prostate Cancer (T1a or T1b)

The diagnosis of stage A (T1a or T1b) prostate cancer;

Ductal Carcinoma in situ of the Breast

The diagnosis of ductal carcinoma in situ of the breast.

Applicable exclusions and restrictions

- **to malignant melanoma,**
- **to stage A prostate cancer A (T1a or T1b), and,**
- **to ductal carcinoma in situ of the breast:**

- -No benefit is payable for a diagnosis of cancer (covered or excluded) made within 90 days after the effective date of the protection or within 90 days of any reinstatement of the protection. In addition, no critical illness benefit is payable if the insured's condition results directly from cancer diagnosed during one of these 90-day periods or treatments of this cancer.

- -No benefit is payable for any sign or symptom that appears within 90 days after the effective date of the protection or within 90 days of any reinstatement of the protection and having motivated a medical consultation or tests leading to a diagnosis of any type of cancer whatsoever (covered or excluded in the contract). In such a case, no cancer benefit is payable for any subsequent diagnosis of cancer. In addition, no critical illness benefit is payable if the insured's condition results directly from any sign or symptom that appears during one of these 90-day periods and having motivated a medical consultation or tests leading to a diagnosis of any type of cancer whatsoever (covered or excluded in the contract).

Conditions of Payment

COVERED MEDICAL CONDITIONS
The benefit is payable:

- if this is the first occurrence of a critical illness, or
- if it is a manifestation of a critical illness for which the insured has received a benefit under the title PREVENTION + BENEFIT of this clause.

PREVENTION + BENEFIT
The benefit is only payable:

- if this is the first occurrence of a critical illness, and,
- only once for all of the medical conditions defined under the title PREVENTION + BENEFIT of this clause.

(Continued on next page)

Conditions of payment

- **Diagnosis in Canada or in the United States of America**

The diagnosis of a critical illness must be made by a Specialist, authorized to practice in Canada or the United States of America and confirmed by modern and usually used investigative techniques relating to this illness at the time settlement is requested. In the absence or unavailability of a Specialist, and as approved by the insurer, a condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.The specialist must not be the insured, the Applicant, a relative of or business associate of the Applicant or of the Insured.

Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the Applicant, the Insured, a relative of or business associate of the Applicant or of the Insured.

- **Diagnosis Outside of Canada and in the United States of America**

If a critical illness is diagnosed outside of Canada and in the United States of America by a Specialist in a jurisdiction deemed acceptable by the Company, the benefit will be payable only if all of the following conditions are satisfied:

- The complete medical records of the life insured are made available to the Company;

- Based on these medical records, the Company is satisfied that:

  - the same diagnosis would have been made if the illness had been diagnosed by a Specialist practicing in Canada;
  - immediate treatment would have been indicated under Canadian standards; and
  - the same treatment, involving the particular surgical procedure, if any, would have been recommended if treatment had taken place in Canada.

The Life Insured must undergo an independent medical examination by a Medical Doctor appointed by the Company, if the Company makes such a request. In the case of elective Surgery, such an examination must be undergone before Surgery occurs.

Exclusions and Restrictions

No benefit for critical illness is paid if the insured's condition :

- results from self-inflicted injuries or an attempt to commit suicide, whether or not the insured was conscious of his actions;

- results from voluntary absorption of medication, drugs, steroids, narcotics or toxic substances, unless taken as prescribed by a licensed physician;

- results from wars, armed conflicts, riots, insurrections or public demonstrations, regardless of whether or not the insured was an active participant;

- results from service in the armed forces, engaged in surveillance, training, peacekeeping duties or war, whether war be declared or not;

- occurs while he or she is committing, attempting to commit or provoking a criminal offence;

- occurs while he or she is driving a vehicle under the influence of narcotics or with a proportion of alcohol in the insured’s blood higher than 80 milligrams per 100 millilitres of blood.

Moreover, no critical illness benefit is paid if the insured's condition corresponds to one of the medical conditions specifically excluded from the illnesses described in the title TERMINOLOGY OF THE COVERED MEDICAL CONDITIONS and in the title PREVENTION + BENEFIT under this clause.