BASIC GROUP CRITICAL ILLNESS INSURANCE, BASIC GROUP TERM LIFE INSURANCE AND BASIC GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

*This Insurance Benefits Summary is designed to outline the benefits for which you are eligible under a Group Policy issued to your employer by Industrial Alliance Insurance and Financial Services Inc. (the **Company**) which is available to you upon request. This Group Policy contains a provision removing or restricting the right of the Insured Person to designate persons to whom or for whose benefit insurance money is payable. In the event of any variation between the group insurance certificate, this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Employee will be governed solely by the Group Policy which may be amended from time to time.*

Benefit Schedule

You are insured for the following coverage amounts under the Group Policy:

- $10,000 of Basic Group Critical Illness Insurance
- $25,000 of Basic Group Term Life Insurance
- $25,000 of Basic Group Accidental Death & Dismemberment Insurance

PLAN DEFINITIONS

Employee means an employee (you) as defined in the Group Policy.

Insured Employee means an Insured Person (you) who is an eligible Employee.

Insured Person means the person who is insured under the Group Policy.

Basic Group Critical Illness Insurance

Covered Condition Benefit

If you are diagnosed by a Specialist with a Covered Condition while your Basic Group Critical Illness Insurance is in force and survive for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay you the Basic Group Critical Illness Insurance Benefit Amount in force (the **Covered Condition Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of your coverage. If you die before the approved Covered Condition Benefit is paid, the Covered Condition Benefit will be paid to your estate. In the event you receive a simultaneous Diagnosis of multiple Covered Conditions, the Company will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (MEC Grouping) shown in the **Multiple Event Coverage Benefit** section, starting with MEC Grouping Group 1.

Cancer Recurrence Benefit

If you receive a Diagnosis of Cancer under the Group Policy, and thereafter you are diagnosed with Cancer again only as described below, the Company will pay you the Benefit Amount in force (the **Cancer Recurrence Benefit**) subject to the terms and conditions of the Group Policy. **Cancer Recurrence** means you receive a subsequent Diagnosis of Cancer, provided that:

a) more than 60 months have passed between the previous Cancer Date of Diagnosis and the date of the subsequent Diagnosis
b) you have not received any treatment relating directly or indirectly to the previous cancer within a continuous 60-month period prior to the subsequent Diagnosis;
c) you do not have any new signs, symptoms or deliberate or incidental findings, during a continuous 60-month period prior to the subsequent Diagnosis, for which you sought medical investigation, consultation to investigate and/or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused an individual to seek the same relating to a Diagnosis of any cancer covered or excluded under the Group Policy; and
d) both the first and subsequent diagnoses are made subsequent to the effective date of your coverage under the Group Policy and prior to the termination date of your coverage under the Group Policy.

Multiple Event Coverage Benefit

If you receive a Covered Condition Benefit under the Group Policy, and thereafter you are diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**MEC Grouping**), the Company will pay you the Basic Group Critical Illness Insurance Benefit Amount in force (the **Multiple Event Coverage Benefit**), subject to the terms and conditions of the Group Policy. You must survive for 30 days following the Date of Diagnosis or such longer survival period as described in certain Covered Conditions to qualify for this benefit. If you die before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to your estate.

MEC Grouping	Covered Condition
Group 1	Cancer
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant

Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

AdvanceCare Benefit

If you are diagnosed by a Specialist with an AdvanceCare Benefit Condition while your Basic Group Critical Illness Insurance is in force, the Company will pay you a benefit equivalent to 10% of your Benefit Amount in force (the **AdvanceCare Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of your coverage. If you die before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to your estate. The AdvanceCare Benefit is a one-time benefit for which the Company will pay for one AdvanceCare Benefit Condition only. Payment of the AdvanceCare Benefit will not affect the amount of benefit payment under a Covered Condition Benefit or a Multiple Event Coverage Benefit. Your Basic Group Critical Illness Insurance will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit providing premiums continue to be paid as required.

Pre-existing Condition Timeframe

A Pre-existing Condition Timeframe of 24 months is applicable to your coverage, commencing with your effective date of coverage.

Administration of the Pre-existing Condition Timeframe will be as outlined in the Group Policy.

Limitations

a) Cancer

You will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Cancer, or have any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Cancer (MEC Grouping 1) will no longer be considered a Covered Condition for you.

b) Benign Brain Tumour

You will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within the first 90 days following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Benign Brain Tumour, or have any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for you.

c) Multiple Sclerosis

You will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Multiple Sclerosis, or have any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for you.

d) Parkinson's Disease and Specified Atypical Parkinsonian Disorders

You will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, or have any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If you continue to satisfy the eligibility provisions for coverage under the Group Policy, Basic Group Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for you.

e) AdvanceCare Benefit

You will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within the first 90 days following the issue date of your Basic Group Critical Illness Insurance coverage, you have a Diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Basic Group Critical Illness Insurance will remain in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for you.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply.

No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

a) a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, Diagnosis or consultation, including consultation to investigate and/or diagnose (where Diagnosis has not yet been made) was received by you or would have been received by a prudent individual within the 24 months immediately preceding the effective date of your coverage. This exclusion applies for the duration of your Pre-existing Condition Timeframe;
b) attempted suicide;
c) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with your employment;
d) taking any drug other than as prescribed by a licensed physician;
e) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of your blood exceeds 80 milligrams;
f) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

In addition, no benefit will be paid if you suffers Blindness, Coma, Deafness, Loss of Limb, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

CRITICAL ILLNESS PLAN DEFINITIONS

AdvanceCare Benefit Conditions are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to you. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

Benefit Amount means the amount of Basic Group Critical Illness Insurance for which an Insured Person is covered, as indicated in the Benefit Schedule.

Covered Conditions with respect to you are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, 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 and Stroke, as defined in the section titled *Definitions of Covered Conditions*.

Date of Diagnosis means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

Diagnosis means the certified Diagnosis of the Insured Person with a Covered Condition, with Cancer Recurrence or with one of the AdvanceCare Benefit Conditions by a Specialist.

Pre-existing Condition Timeframe means a period of 24 months during which your Basic Group Critical Illness Insurance is in force under the Group Policy, commencing with the effective date of coverage.

Specialist means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- Is currently practicing in their area of specialty 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 and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

DEFINITIONS OF COVERED CONDITIONS

Aortic Surgery means 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 condition for

- *Angioplasty;*
- *Intra-arterial procedures;*
- *Percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

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

- Marrow stimulating agents;
- Immunosuppressive agents; or

- Bone marrow transplantation.

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

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the Date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

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

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- *Pituitary adenomas less than 10 mm;*
- *Vascular malformations;*
- *Cholesteatomas; or*
- *Infectious or inflammatory tumours.*

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms, or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or*
- *A Diagnosis of Benign Brain Tumour (covered or not covered under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, 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 means 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.

Cancer means the definite Diagnosis of a malignant tumour. This tumour 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 and must be confirmed by a pathology report.

For purposes of the Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- *Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;*
- *Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;*
- *Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;*
- *Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;*
- *Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;*
- *Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;*
- *Gastro-intestinal stromal tumours classified as AJCC Stage 1;*
- *Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or*
- *Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.*

90-Day Exclusion : No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of any cancer (covered or not covered under the Policy), regardless of when the Diagnosis is made; or*
- *A diagnosis of any cancer (covered or not covered under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or any critical illness caused by any cancer or its treatment.

Coma means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 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 means 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.*

Deafness means 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 means 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:

- Aphasia (a disorder of speech)
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. Inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The Insured Person must exhibit

- 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
- 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, including Alzheimer's Disease must be made by a Specialist.

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

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

Heart Attack (acute myocardial infarction) means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a 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.

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

- *ECG changes suggestive of a prior myocardial infarction;*
- *Other acute coronary syndromes, including angina pectoris and unstable angina; or*
- *Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack*

Heart Valve Replacement or Repair means 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*
- *Inter-arterial procedures, percutaneous trans-catheter procedures; or*
- *Non-surgical procedures.*

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already have been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs means 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 means a definite Diagnosis of the total and irreversible loss of the ability to speak as a 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 means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center 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 means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease means 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 means a definite Diagnosis of at least one of the following:

- Two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI 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.

For purposes of the Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- *Solitary sclerosis;*
- *Clinically isolated syndrome;*
- *Radiologically isolated syndrome;*
- *Neuromyelitis optica spectrum disorders; or*
- *Suspected multiple sclerosis or probable multiple sclerosis.*

1-Year Exclusion - No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last Reinstatement Date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the Diagnosis is made; or*
- *A Diagnosis of multiple sclerosis (covered or not covered under the Policy).*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

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

- The accidental injury must be reported to the Company within 14 days of the accidental injury;

- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- 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 means 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 and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of primary Parkinson's Disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: 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 Parkinson's Disorders are 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.

1-year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

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

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

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Severe Burns means 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 resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism 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 showing changes that are consistent in character, location and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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.*

DEFINITIONS OF ADVANCECARE BENEFIT CONDITIONS

Coronary Angioplasty means 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.

Early Stage Cancer refers to one of the following conditions:

- 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;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastrointestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus ; or
- Ductal Carcinoma in situ of the Breast.

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

CONVERSION PRIVILEGE

If your Basic Group Critical Illness Insurance terminates as a result of ceasing to be eligible for insurance under the Group Policy and the Insured Person has not received a Covered Condition Benefit nor an AdvanceCare Benefit from the Company, the Insured Person may, on or before their 65th birthday and without evidence of insurability, convert your terminated Basic Group Critical Illness Insurance to a separate critical illness policy (the **Converted Coverage)**, issued by the Company subject to all of the following conditions:

a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be $5,000;
b) the maximum amount of insurance under the Converted Coverage will be limited to the lesser amount of $100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;
c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;
d) the Converted Coverage will be of a type then issued by the Company providing term insurance to age 75;
e) the Converted Coverage will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;
f) the premium rates for the Converted Coverage will be those then in effect for such policy;
g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion: and
h) if a special provision, exclusion and/or limitation had been imposed on the Basic Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Coverage.

CLAIMS AT TUGO

As an Insured Person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. **Claims at** TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons at special pricing discounts.

For assistance in accessing this service, please visit www.tugo.com/tms.

Note: Utilization fees may apply.

Basic Group Term Life Insurance

Basic Group Term Life Benefit

This plan provides a lump sum benefit (the **"Basic Group Term Life Benefit"**) in the event of your death, subject to the terms and conditions of the Group Policy.

Benefit Amount

You are insured for the amount of Basic Group Term Life Insurance (the **"Benefit Amount"**) indicated in the Benefit Schedule.

Conversion Privilege

If the Basic Group Term Life Insurance of an Insured Employee terminates as a result of such Insured Person ceasing to be eligible for insurance under the Group Policy, the Insured Person may convert their terminated Basic Group Term Life Insurance to an individual policy for the lesser of $200,000 or the amount of such Insured Person's insurance reduced by any amount for which they may be eligible under any replacing group policy, provided such Insured Person is under age 65 at the date of termination. This may be done without further evidence of health at smoker rates applicable to such Insured Person's age at the time of conversion.

You must apply to the Company in writing, within 31 days of the date your insurance terminates.

Basic Group Accidental Death & Dismemberment ("AD&D") Insurance

You are covered for any injury sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job.

You are insured for the amount of Basic Group Accidental Death & Dismemberment Insurance (the **"Principal Sum"**) indicated in the Benefit Schedule.

Schedule of Losses

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand	40%
Four Fingers of Either Hand	40%
Hearing in One Ear	40%
All Toes of One Foot	33 1/3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Bereavement Benefit ($2,500)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six sessions of grief counselling, by a professional counsellor.

Brain Damage Benefit

If an injury results in brain damage, the Company will pay the Principal Sum, less any amount paid or payable under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident, provided that the insured incurs brain damage within 120 days from the date of the accident, is hospitalized as a result at least 7 of the first 120 days, and a physician determines and the Company is satisfied that the insured has evidence of brain damage for at least 6 consecutive months.

Continuation of Coverage

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability, subject to continued payment of premiums.

Conversion Option

Upon termination of active employment, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of Principal Sum equal to or lower than the amount of Principal Sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

Day Care Benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the Principal Sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

Education Benefit ($10,000)

If an injury results in loss of life, the Company will pay 5% of the Principal Sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

Family Transportation Benefit ($20,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Funeral Expense Benefit ($5,000)

If an injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

Indemnity payable under this part shall be limited to only one policy if this benefit is contained in two or more policies issued by the company.

Home Alteration and Vehicle Modification Benefit ($50,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to the greater of $15,000 or 10% of the Principal Sum to a maximum of $50,000.

Hospital Indemnity Expense Benefit ($2,500)

A daily benefit of 1/30th of 1% of the Principal Sum will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and begins while this insurance is in force, subject to the above-mentioned monthly maximum.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

Identification Benefit ($20,000)

If an injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Parental Care Benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the Principal Sum to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care program, or living in the insured's residence, or receiving support and care provided by the insured.

Psychological Therapy Benefit ($5,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and results in the insured requiring psychological therapy, as prescribed by a physician, the Company will pay the reasonable and necessary expenses actually incurred.

Rehabilitation Benefit ($20,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training within 3 years.

Repatriation Benefit ($20,000)

If an injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

Seat Belt Benefit ($25,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Principal Sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit ($20,000)

If an injury results in loss of life, the Company will reimburse the spouse for the reasonable and necessary expenses actually incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Workplace Modification and Accommodation Benefit ($5,000)

If an injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and requires special adaptive equipment and/or workplace modification for an insured to return to active full-time employment, the Company will pay the reasonable and necessary expenses actually incurred, provided the employer agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such insured; and the employer acknowledges in writing that the performance of the essential duties of such insured's occupation may be altered.

Limited Air Travel Coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the employer.

When Does This Insurance Not Apply?

The policy does not cover loss, fatal or non-fatal, caused by or resulting from:

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the Limited Air Travel Coverage;
- operating a motor vehicle under the influence of any intoxicant or if the blood alcohol concentration is in excess of 80mg of alcohol per 100ml of blood;
- being under the influence or a drug or controlled substance as defined by federal or provincial law, unless administered on the advice of a physician.

GENERAL PROVISIONS

BENEFICIARY

Critical Illness Insurance: The Covered Condition Benefit or AdvanceCare Benefit will be paid to the Insured Person. If the Insured Person dies prior to the Covered Condition Benefit or AdvanceCare Benefit being paid, the Company will pay the benefit to the Insured Person's estate.

Term Life Insurance: In the event of your death, the benefit will be paid to the beneficiary you have designated. If no beneficiary is designated by you, the benefit will be paid to your estate.

Accidental Death & Dismemberment Insurance: In the event of your accidental death, the benefit will be paid to the beneficiary you have designated. All other Accidental Death & Dismemberment Insurance benefits are payable to you, with the exception of indemnities payable under the following parts:

- Bereavement Benefit
- Identification Benefit
- Day Care Benefit
- Parental Care Benefit
- Education Benefit
- Repatriation Benefit
- Family Transportation Benefit
- Spousal Retraining Benefit
- Funeral Expense Benefit
- Workplace Modification and Accommodation Benefit

WAIVER OF PREMIUM DISABILITY BENEFIT – CRITICAL ILLNESS INSURANCE, TERM LIFE INSURANCE & ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

If you are not Actively at Work and have been **Totally Disabled** for six continuous months, your premiums will be waived retroactively to the first day of the month coincident with or next following your date of disability provided **Total Disability** occurs before your 65th birthday.

No premium will be waived if the total disability is caused or contributed to by an injury or sickness intentionally self-inflicted or resulting from an act of war.

With regards to Basic Group Critical Illness Insurance, you will continue to satisfy the Pre-existing Condition Timeframe, if applicable, while premiums are waived and coverage is in force.

Waiver of Premium will cease on the earliest of the following dates:

- The date you cease to be Totally Disabled;
- When you are Totally Disabled prior to age 63, the end of the month following your 65th birthday; or
- When you are Totally Disabled at age 63 or older, premiums will be waived for a maximum of 24 consecutive months.

Total Disability or **Totally Disabled** means disability resulting from injury or sickness which requires the regular care and personal attendance of a registered physician and which totally and continuously disables and prevents you from performing every duty pertaining to your regular occupation during the first 24 months of injury or sickness and thereafter, totally and continuously disables and prevents you from performing any gainful occupation for which you are or may become reasonably fitted by reason of your training, education or experience.

TERMINATION OF YOUR INSURANCE

Your Basic Group Insurance will terminate automatically on the earliest of the following dates:

a) the date of your death;
b) the date on which your employment terminates or changes so that you cease to be eligible for insurance under the Group Policy;
c) when you are under age 65 and reside in Québec, the date on which you are no longer covered under a private drug plan provided by the Policyholder, as required by the Québec Act respecting prescription drug insurance;
d) the end of the month coincident with or next following the date the Company receives written notice from the Policyholder requesting cancellation of the Basic Group Critical Illness Insurance coverage;
e) the date of your 75th birthday;
f) the date on which a leave of absence has expired, and you are not actively at work;
g) when you are not actively at work, as a result of a disability and you are under age 63 when such disability related absence from work commences, your insurance will terminate on the date you attain age 65, unless you return to full-time active employment before age 65;
h) when you are not actively at work as a result of a disability and you are age 63 or older but less than age 75 when such disability related absence from work commences, your insurance will terminate on the date of completion of 24 consecutive months of disability related absence from work unless you return to full-time employment before 24 months of disability have expired.

CLAIMS PROCEDURES

Before paying a benefit under the Group Policy, we will require our claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at: 1.800.266.5667 to obtain the appropriate forms and for details on claims procedures.

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. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims for Basic Group Critical Illness Insurance will be adjudicated according to the definition of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

QUESTIONS? WE'RE HERE TO HELP.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
SpecialMarkets@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

iA Special Markets
Industrial Alliance Insurance and Financial Services Inc.
400-988 Broadway W PO Box 5900
Vancouver, BC V6B 5H6