Sun Critical Illness Insurance - Term 75

- premium payment period: payable to the policy anniversary nearest age 75
  - **Advanced Return of premium of cancellation or expiry**
  - **Return of premium on death**
  - **Owner waiver disability**
  - **Owner waiver death**

Policy number: LI-1234,567-8

Owner: Jim Doe

The following policy wording is provided solely for your convenience and reference. It is incomplete and reflects only some of the general provisions that may be found in some of our insurance policies. We periodically make changes to policy wording and therefore this incomplete sample may not duplicate the wording of any actual issued policy. It is not to be construed or interpreted in any manner as a contract or an offer to contract. The actual policy issued to any given client will govern that relationship.

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Policy summary

In this document, *you* and *your* mean the owner of this policy. *We, us*, *our,* and *the company* mean Sun Life Assurance Company of Canada.

Your policy is issued and underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

It's important that you read your entire policy carefully. It sets out the benefits payable and has exclusions and reductions of coverage. To help you understand insurance terms, refer to the explanations described under the heading, *Insurance terms*.

Plan:	**Sun Critical Illness Insurance - Term 75**
Policy number:	LI-1234,567-9
Policy date:	October 2, 2017
Owner:	Jim Doe born on February 15, 1978 age nearest on the policy date: XX No contingent owner was named on your application. You must tell us in writing if you want to name a contingent owner.
Insured person:	John Doe born on March 1, 2005 age nearest on the policy date: XX

Any critical illness insurance benefit payable is paid to the critical illness benefit payee named on your application, unless you make a change in writing.

Any returnable premium amount payable on cancellation or expiry of this policy is paid to the owner of this policy.

Any returnable premium amount on death is paid to the person named on your application as the return of premium on death beneficiary, unless you make a change in writing.

This is not a participating policy. You are not eligible to receive dividends.

Policy summary (continued)

Sun Critical Illness Insurance - Term 75
Critical illness insurance benefit

Insured person:	John Doe
Benefit amount:	$XXX,XXX The amount we pay for illnesses eligible for full benefit payout (Group 1) and partial benefit payout (Group 2) is described later.
Premium payment period:	Payable to the policy anniversary nearest age 75
Risk classification:	On the policy anniversary nearest the 18th birthday of the insured person, we will classify them as a smoker. If the insured person is a non-smoker at that time, you may apply to have them classified as a non-smoker. If we approve the non-smoker classification as described later, the premium will be lower than under a smoker classification.
Date this policy ends:	October 2, XXXX

Optional benefits

Total disability waiver:	If John Doe is totally disabled, we waive the premiums for this policy.
Date this benefit begins:	October 2, XXXX
Date this benefit ends:	October 2, XXXX
Advanced return of premium with Return of premium on cancellation or expiry:	We automatically pay a portion of the returnable premium amount on October 2, XXXX, and the balance of the returnable premium amount if you cancel this policy on or after October 2, XXXX or when this policy ends, as described later.
Return of premium on death:	We pay the returnable premium amount if the insured person dies while this policy is in effect, as described later.
Owner waiver disability:	If Jim Doe is totally disabled, we waive premiums for this policy.
Date this benefit ends:	October 2, XXXX
Owner waiver death:	If Jim Doe dies, we waive premiums for this policy.
Date this benefit ends:	October 2, XXXX

Schedule of guaranteed premiums

You must pay all premiums for this policy by the premium due date.

Premiums are due annually on October 2nd, starting on October 2, XXXX.
The total initial annual premium for this policy is $XXX.XX.

(1) Critical illness insurance
(2) Total disability waiver
(3) Owner waiver disability
(4) Owner waiver death
(5) Return of premium benefit(s)

Beginning on	(1)	(2)	(3)	(4)	(5)	Annual premium ($)
2 Oct XXXX	XXX.XX	XX.XX	XX.XX	XX.XX	XX.XX	XXX.XX
2 Oct XXXX	XXX.XX	XX.XX	XX.XX	XX.XX	XX.XX	XXX.XX
2 Oct XXXX	policy ends					

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If you change your mind within 10 days

You may send us a written request to cancel your policy within:
- 10 days of receiving it from us, or
- 60 days after the policy is issued, whichever date is earlier.

You are considered to have received your policy 5 days after it's mailed from our office, or on the date your advisor delivers it to you.

When we receive your written request we'll refund any amount paid. This is called rescission.

Your decision to cancel your policy is your personal right. When we receive your request to cancel it, all of our obligations and liabilities under this policy end immediately. The cancellation is binding on you and any person entitled to make a claim under this policy, whether their entitlement is revocable or irrevocable.

To cancel your policy, send your request in writing to:

Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601, Stn. Waterloo
Waterloo ON Canada N2J 4C5

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Contesting the policy

The incontestability provisions set out in the provincial or territorial insurance legislation applicable to this policy apply.

Limit on contesting
We cannot challenge the validity of the policy after it has been in effect continuously for two years from the later of the date it took effect and the date it was last reinstated. If the policy is amended to increase or change a benefit or improve a rating, we cannot challenge the validity of the amendment after it has been in effect continuously for two years from the later of the date the amendment took effect and the date the policy was last reinstated.

Exception to the limit on contesting
We can challenge the validity of the policy or an amendment at any time in cases of fraud or cases involving a disability benefit.

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When a critical illness insurance benefit is payable

We pay a critical illness insurance benefit if this policy is in effect and all requirements for an illness eligible for full benefit payout (Group 1) or partial benefit payout (Group 2) as defined under the heading, *Covered critical illnesses,* are satisfied. If we make a payment, it's paid to the critical illness benefit payee named on your application, unless you make a change in writing.

Before we make a payment, we must verify the insured person's date of birth. If the date of birth on the application is incorrect, we'll adjust the amount we pay to the amount that would have been payable based on the premiums paid and the correct date of birth.

Critical illness payment for illnesses eligible for full benefit payout (Group 1)

If the insured person qualifies for an illness eligible for full benefit payout (Group 1), we make a one-time payment and this policy ends. We determine the critical illness payment amount as of the date the benefit is payable. The amount we pay is:

- the greater of the critical illness insurance benefit amount in effect or the returnable premium amount for *Return of premium on cancellation or expiry*
- **plus** any balance in the withdrawable premium fund
- **minus** any unpaid premiums, including interest.

Critical illness payment for illnesses eligible for partial benefit payout (Group 2)

If the insured person qualifies for an illness eligible for partial benefit payout (Group 2), we make a payment. For each claim, the amount we pay is the lesser of:

- 15% of the critical illness insurance benefit amount on the date the benefit is payable, or
- $50,000.

A maximum of 4 partial benefit payments may be payable, provided each claim is for a different covered Group 2 illness.

The amount we pay is reduced by any unpaid premiums including interest on the date the benefit is payable.

If we make a payment for a partial payout (Group 2) illness, coverage will continue for all full payout (Group 1) illnesses. The critical illness insurance benefit amount and returnable premium amount are not reduced by the amount of the partial payout.

Exclusions (when a critical illness insurance benefit is not payable)

In addition to the exclusions described under the heading, *Covered critical illnesses,* the following describes when we will not make a critical illness insurance benefit payment.

We will not make any payment if the covered critical illness is directly or indirectly caused by or associated with the insured person operating a vehicle while their blood alcohol level is more than 80 milligrams of alcohol per 100 milliliters of blood. A vehicle includes any form of ground, air or marine transportation that can be put into motion by any means, including muscular power. We do not take into account whether or not the vehicle is in motion.

We will not make any payment if the covered critical illness is directly or indirectly caused by or associated with the insured person:

- committing or attempting to commit a criminal offence

- taking or attempting to take their own life, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
- causing themself bodily injury, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
- taking any drug, unless the drug was taken as prescribed by a licensed medical practitioner
- inhaling or ingesting any poisonous substance, whether voluntarily or otherwise, or
- inhaling any type of gas, whether voluntarily or otherwise.

We will not make any payment if the covered critical illness is directly or indirectly caused by or associated with civil disorder or war, whether declared or not.

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Covered critical illnesses

The insured person has coverage for the following illnesses eligible for full benefit payout (Group 1) and partial benefit payout (Group 2). Some covered critical illnesses have a survival period. The insured person must be alive at the end of the survival period to satisfy the requirement for the covered critical illness. For illnesses that do not have a survival period, the insured person must be alive at the time the diagnosis is made. All criteria in the definition of the covered critical illness must be met in order to qualify for benefit payment.

Two covered critical illnesses, benign brain tumour and cancer, have a restriction called the *90 day exclusion period*. Under this exclusion period, you have a responsibility to notify us about those illnesses to ensure other covered critical illnesses are not excluded. This responsibility is described in the definitions for benign brain tumour and cancer.

The covered critical illness Parkinson's disease and specified atypical parkinsonian disorders has a restriction called the *1 year exclusion period*. Under this exclusion period, you have a responsibility to notify us about this illness to ensure other covered critical illnesses are not excluded. This responsibility is described in the definition for Parkinson's disease and specified atypical parkinsonian disorders.

Illnesses eligible for full benefit payout (Group 1)

Acquired brain injury due to external trauma

Acquired brain injury due to external trauma means a definite diagnosis of new damage to brain tissue caused by traumatic head injury resulting in newly developed significant neurological deficit that:

- results from an external trauma severe enough to have prompted the insured to seek a medical consultation in less than a week after the occurrence of said trauma
- is present and verifiable on clinical examination
- is corroborated by abnormal magnetic resonance (MR) and/or computed tomography (CT) brain imaging studies, that confirm brain trauma, and
- persists for more than 180 consecutive days following the date of diagnosis.

The diagnosis of acquired brain injury due to external trauma must be made by a specialist.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:

- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness

- dysarthria (difficulty with pronunciation)
- dysphasia, (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function.

Headache or fatigue will not be considered a neurological deficit.

Exclusion
No benefit will be payable under this condition for:
- an abnormality seen on imaging studies of the brain without corresponding clinical impairment;
- neurological deficit without corresponding imaging study lesions;
- a concussion that does not have abnormal imaging studies.

Aortic surgery
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. The insured person must survive for 30 days following the date of surgery.

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

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

The diagnosis of aplastic anemia must be made by a specialist.

Bacterial meningitis
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 new objective neurological deficits persisting for at least 90 consecutive days from the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:
- measurable loss of hearing

- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia, (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function.

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

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 new 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.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:
- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia, (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function.

Headache or fatigue will not be considered a neurological deficit.

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

90 day exclusion period for benign brain tumour
No benefit will be payable for benign brain tumour if, within the first 90 days following the later of:
- the date the application for this policy was signed
- the policy date, shown on the *Policy summary*, or
- the most recent date this policy was put back into effect (reinstatement),

the 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 excluded under the policy).

Your responsibility to notify us about benign brain tumour
You have a responsibility to notify us about benign brain tumour, regardless of when a diagnosis is made:
- If we are notified within 6 months of the date of the diagnosis and the coverage for benign brain tumour is excluded based on the 90 day exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

To notify us, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Blindness
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
Cancer means a 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 histopathology report or appropriate pathological testing in the case of non solid tumours.

Exclusion
No benefit will be payable for the following:
- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis
- any non-melanoma skin cancer, without lymph node or distant metastasis
- 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 less than Rai stage 1

- gastro-intestinal stromal tumours classified as AJCC Stage 1, or
- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than medication to counteract the effects from hormonal oversecretion by the tumour

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010. For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

90 day exclusion period for cancer
No benefit will be payable for cancer if, within the first 90 days following the later of:
- the date the application for this policy was signed
- the underwriting decision date, but only if shown under the heading, Amendments to this policy
- the policy date, shown on the Policy summary, or
- the most recent date this policy was put back into effect (reinstatement),

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

Your responsibility to notify us about cancer
You have a responsibility to notify us about cancer, regardless of when a diagnosis is made:
- If we are notified within 6 months of the date of the diagnosis and the coverage for cancer is excluded based on the 90 day exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for cancer or any critical illness caused by any cancer or its treatment.

To notify us, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Cerebral palsy
Coverage for this illness ends on the insured person's 24th birthday.

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

The diagnosis of cerebral palsy must be:
- made before the insured person's 24th birthday, and
- made by a specialist.

Coma
Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 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
- a coma which results directly from alcohol or drug use, or
- a diagnosis of brain death.

Congenital heart disease

Coverage for this illness ends on the insured person's 24th birthday.

Congenital heart disease means a definite diagnosis of at least one of the covered heart conditions.

Covered heart conditions
- Coarctation of the aorta
- Ebstein's anomaly
- Eisenmenger syndrome
- Tetralogy of Fallot
- Transposition of the great vessels

The diagnosis of the heart condition must be:
- made before the insured person's 24th birthday
- made by a specialist, and
- supported by cardiac imaging acceptable to us.

The insured person must survive for 30 days following the date of diagnosis.

Congenital heart disease also covers specific conditions described below for which open heart surgery is performed to correct the condition.

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

Procedures not covered by this definition are:
- Percutaneous atrial septal defect closure
- Trans-catheter procedures which include balloon valvuloplasty.

The diagnosis of the heart condition must be made and the surgery:
- recommended by a specialist
- supported by cardiac imaging acceptable to us, and
- performed by a specialist.

The insured person must survive for 30 days following the date of surgery.

Coronary artery bypass surgery
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. The insured person must survive for 30 days following the date of surgery.

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

Cystic fibrosis
Coverage for this illness ends on the insured person's 24th birthday.

Cystic fibrosis means a definite diagnosis of cystic fibrosis where the insured person has chronic lung disease and pancreatic insufficiency.

The diagnosis of cystic fibrosis must be:
- made before the insured person's 24th birthday, and
- made by a specialist.

Deafness
Deafness is defined as a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of deafness must be made by a specialist.

Dementia, including Alzheimer's disease
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 behaviour), 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 must be made by a specialist.

Exclusion
No benefit will be payable under this 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

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 acute myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new pathological Q waves on ECG following coronary angiography and/or angioplasty.

The diagnosis of heart attack (acute myocardial infarction) must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

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 or repair

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. The insured person must survive for 30 days following the date of surgery.

Exclusion

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

Kidney failure

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

The diagnosis of kidney failure must be made by a specialist.

Loss of independent existence

Loss of independent existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

The diagnosis of loss of independent existence must be made by a specialist.

Activities of daily living are:

- Bathing: the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices

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

If the insured person has a loss of independent existence before the policy anniversary nearest their 18th birthday, you must wait to send us a claim for this illness. The earliest you may submit a claim is the policy anniversary nearest the insured person's 18th birthday. The latest you may submit a claim is the policy anniversary nearest the insured person's 19th birthday.

Loss of limbs

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

Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 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

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

The date of diagnosis is the date of the insured person's enrollment in the transplant centre.

The diagnosis of the major organ failure must be made by a specialist.

Major organ transplant

Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The diagnosis of the major organ failure must be made by a specialist.

Motor neuron disease

Motor neuron disease means a definite diagnosis of one of the following conditions and is limited to these conditions:

- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- primary lateral sclerosis
- progressive spinal muscular atrophy
- progressive bulbar palsy, or
- pseudo bulbar palsy.

The diagnosis of motor neuron disease must be made by a specialist.

Multiple sclerosis

Multiple sclerosis means 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
- 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.

Muscular dystrophy

Coverage for this illness ends on the insured person's 24th birthday.

Muscular dystrophy means a definite diagnosis of muscular dystrophy where the insured person has well-defined neurological abnormalities, confirmed by electromyography and either muscle biopsy or other testing acceptable to us that confirms the diagnosis.

The diagnosis of muscular dystrophy must be:

- made before the insured person's 24th birthday, and
- made by a specialist.

Occupational HIV infection

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

The accidental injury leading to the infection must have occurred after the later of:

- the date the application for this policy was signed
- the policy date, shown on the *Policy summary*, or
- the most recent date this policy was put back into effect (reinstatement).

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

- the accidental injury must be reported to us 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

- the accidental injury must have been reported, investigated and documented in accordance with current workplace guidelines for Canada or the United States.

The diagnosis of occupational HIV infection must be made by a specialist.

Exclusion
No benefit is payable under this condition if:
- the insured person has elected not to take any available licensed vaccine offering protection against HIV
- a licensed cure for HIV infection has become available prior to the accidental injury, or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis
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
Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:
- muscular rigidity, or
- rest tremor.

The insured person must exhibit objective signs of progressive deterioration in function for at least 1 year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders means 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 neurologist.

Exclusion
No benefit is payable under this condition for all other types of parkinsonism.

1 year exclusion period for Parkinson's disease and specified atypical parkinsonian disorders
No benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders if, within 1 year following the later of:
- the date the application for this policy was signed
- the policy date, shown on the *Policy summary*, or
- the most recent date this policy was put back into effect (reinstatement),

the 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.

Your responsibility to notify us about Parkinson's disease and specified atypical parkinsonian disorders

You have a responsibility to notify us about Parkinson's disease or specified atypical parkinsonian disorders, regardless of when a diagnosis is made:

- If we are notified within 6 months of the date of the diagnosis and the coverage for Parkinson's disease or specified atypical parkinsonian disorders is excluded based on the 1 year exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

To notify us, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Severe burns

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

Stroke (cerebrovascular accident) resulting in persistent neurological deficits means a definite diagnosis of an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extracranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 consecutive 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 persistent neurological deficits.

The diagnosis of stroke (cerebrovascular accident) must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:

- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia, (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function.

Headache or fatigue will not be considered a neurological deficit.

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

Type 1 diabetes mellitus
Coverage for this illness ends on the insured person's 24th birthday.

Type 1 diabetes mellitus means a definite diagnosis where the insured person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The diagnosis of Type 1 diabetes mellitus must be:
- made before the insured person's 24th birthday, and
- made by a specialist.

Illnesses eligible for partial benefit payout (Group 2)

Cancer

Chronic lymphocytic leukemia (CLL) Rai stage 0
Chronic lymphocytic leukemia (CLL) means a definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL).

The diagnosis of chronic lymphocytic leukemia must be made by a specialist and confirmed by pathological examination of the tissue.

Exclusion
No benefit will be payable under this condition for monoclonal lymphocytosis of undetermined significance (MLUS).

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

Ductal carcinoma in situ of the breast
Ductal carcinoma in situ of the breast is a non-invasive cancer.

The diagnosis of ductal carcinoma in situ of the breast must be made by a specialist and confirmed by pathological examination of the tissue.

Gastrointestinal stromal tumours classified as AJCC Stage 1
The diagnosis of gastrointestinal stromal tumours classified as AJCC Stage 1 must be made by a specialist and confirmed by pathological examination of the tissue.

Grade 1 neuroendocrine tumours (carcinoid)

The diagnosis of grade 1 neuroendocrine tumours (carcinoid) must be made by a specialist and confirmed by pathological examination of the tissue. The grade 1 neuroendocrine tumours (carcinoid) must be confined to the affected organ and treated with surgery alone.

Papillary thyroid cancer or follicular thyroid cancer stage T1

Papillary thyroid cancer or follicular thyroid cancer means a definite diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.

The diagnosis of papillary thyroid cancer or follicular thyroid cancer must be made by a specialist and confirmed by pathological examination of the tissue.

Stage A (T1a or T1b) prostate cancer

The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a specialist and confirmed by pathological examination of the tissue.

Stage 1A malignant melanoma

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

The diagnosis of stage 1A malignant melanoma must be made by a specialist and confirmed by pathological examination of the tissue.

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010. For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

90 day exclusion period for cancer

No benefit will be payable for cancer if, within the first 90 days following the later of:

- the date the application for this policy was signed
- the policy date, shown on the *Policy summary*, or
- the most recent date this policy was put back into effect (reinstatement),

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

Your responsibility to notify us about cancer

You have a responsibility to notify us about cancer, regardless of when a diagnosis is made:

- If we are notified within 6 months of the date of the diagnosis and the coverage for cancer is excluded based on the 90 day exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for cancer or any critical illness caused by any cancer or its treatment.

To notify us, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Coronary angioplasty
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. The insured person must survive for 30 days following the date of the procedure.

E21245A

Making a claim for a critical illness insurance benefit

You may submit a claim if the requirements in this policy are satisfied. To make a claim, you can contact your advisor. Or call us at the toll free phone number shown at the beginning of this policy. We will send the appropriate form to be completed.

What we need
We will use the completed form to help us review the claim. We will also need the claimant to give us access to:
- proof that they have the right to receive the benefit
- proof that the insured person had a covered critical illness while this policy was in effect
- a written diagnosis which describes the condition and the cause of the illness, and
- the insured person's complete medical records.

Physicians may charge a fee to complete certain forms. The person making the claim is responsible for any fee.

When we need it
This policy must be in effect on the date you submit the claim.

If the insured person has a loss of independent existence before the policy anniversary nearest their 18th birthday:
- there's a waiting period before you can submit the claim for the illness.
- the earliest you may submit is the policy anniversary nearest the insured person's 18th birthday
- the latest you may submit is the policy anniversary nearest the insured person's 19th birthday

For all other covered critical illnesses, you must send us the claim within 1 year of the date the insured person has a covered critical illness.

Important information about your diagnosis
The diagnosis and treatment for any covered critical illness must be made by a specialist. The diagnosis must be provided in writing and must:
- include appropriate information to assess the covered critical illness, and
- be prepared and signed by a specialist licensed and practicing in Canada or the United States or another physician acceptable to us.

A specialist is a licensed physician who has been trained in the specific area of medicine relevant to the covered critical illness for which a claim is being submitted. They are also certified by a specialty examining board. If there is no specialist or one isn't available, the diagnosis can come from another qualified physician acceptable to us.

Any physician or specialist who makes the diagnosis or any physician, specialist, health care practitioner or medical professional who provides treatment, tests or examinations for a covered critical illness must not be:

- the owner
- the insured person
- anyone entitled to make a claim under this policy, or
- any relative or business associate of these people.

We may require the insured person to be examined by health care practitioners that we appoint. These may include licensed physicians, physiotherapists, occupational therapists, psychiatrists, psychologists, neurologists or others. We pay the cost of these examinations.

If an illness develops or is diagnosed while outside of Canada or the United States

You may make a claim for a critical illness insurance benefit if a covered critical illness develops or is diagnosed while outside of Canada or the United States.

We will need you to give us all of the information we need to review your claim. If the medical records of the insured person are not in French or English, you must provide the original records. We will also need a translation of the records into either French or English. The translator must not be:

1. the owner
2. the insured person
3. anyone entitled to make a claim under this policy, or
4. any relative or business associate of these people.

The person making the claim is responsible for the cost of the translation.

We will review the medical records we receive. We need to be satisfied that the same diagnosis or treatment would have been made if the illness developed or was diagnosed in Canada.

E21250A

Paying for your policy

Premiums for this policy

We will provide you with the benefits described in this policy if you pay your premium amounts when they're due. Be sure to make your payments to Sun Life Assurance Company of Canada. The *Schedule of guaranteed premiums* describes your premium guarantees. We may not accept cash payments.

If you miss paying a premium when it's due, we will deduct the amount from your withdrawable premium fund. We'll only do this if there's enough money in the fund to cover the missed payment.

Withdrawable premium fund

If you send us more than you owe to keep the policy in effect, we will hold the excess amount in the withdrawable premium fund. We may set a maximum amount that you can have in the fund. You can use this fund to pay premiums at any time.

The amount in your premium fund earns interest daily. The interest is compounded annually. We set the interest rate each day based on short-term interest rates. Interest earned on your premium fund is taxable.

You may withdraw money from your premium fund any time, in line with our minimum withdrawal rules.

We may charge a fee when you make a withdrawal.

If we don't receive your payment

If you don't pay your premium on time, your policy ends 31 days after the premium was due. This means your policy will have lapsed.

Putting your policy back into effect

We will not put this policy back into effect if you cancelled it.

If your policy ended because it lapsed, you can apply to put it back into effect if:

- the insured person is living,
- they haven't had a covered critical illness, and
- they haven't had any signs or symptoms of a covered critical illness. This process is called reinstatement.

If you want to reinstate your policy, you must:

- apply within 2 years of the policy ending
- give us new evidence of insurability that we consider satisfactory, and
- make a payment equal to the reinstatement charge we set.

We'll review your application and let you know if we can reinstate your policy. If we can't reinstate it, we'll reimburse your reinstatement charge.

Reinstating while disabled

We will not put this policy back into effect if you cancelled it. If your policy includes *Owner waiver disability* or *Total disability waiver* and if your policy lapsed while you or the insured person is disabled, you may apply to reinstate it, you won't need to give us new evidence of insurability.

We will consider your application to reinstate the policy if:

- The policy lapsed before you made a disability benefit claim. Or, you made a disability claim but we haven't completed our claim review yet.
- You apply within 1 year of the date the policy lapsed
- The disabled person must have been disabled when the policy lapsed and their disability continued for at least 6 consecutive months
- You must apply before the end date of the disability benefit on the person shown on the *Policy summary*
- You must give us proof, that we consider satisfactory, of the disability and the length of time the person was disabled, and
- The person insured under the critical illness insurance benefit must be alive when you apply. They must also be alive on the date we reinstate your policy.

E21260A

Applying to decrease the critical illness insurance benefit amount

You may apply to decrease the critical illness insurance benefit amount. To keep this policy in effect, any decrease is subject to the minimum limit we set for the critical illness insurance benefit.

E21270A

Applying for non-smoker classification on the insured person

This provision applies if the insured person was age nearest 16 or younger on the date their critical illness insurance benefit took effect.

On the policy anniversary nearest the insured person's 18th birthday, we will classify them as a smoker. If the insured person is a nonsmoker at that time, you may apply to have them classified as a nonsmoker.

If applying before the policy anniversary nearest the 19th birthday
If you apply after the policy anniversary nearest the insured person's 17th birthday and before the policy anniversary nearest their 19th birthday, we require a nonsmoker declaration signed by the insured person and you, the owner.

If applying on or after the policy anniversary nearest the 19th birthday
If you apply on or after the policy anniversary nearest the insured person's 19th birthday, we require new evidence of insurability on the insured person. The application must be signed by the insured person and you, the owner.

If we approve your application, we will classify the insured person as a nonsmoker. The new premium will begin on the policy anniversary nearest the insured person's 18th birthday or on the date we approve your application if you apply after that date. We'll let you know what the new premium will be.

E21275A

Your right to cancel this policy

You may cancel your policy at any time. Your decision to cancel your policy is your personal right. The cancellation is binding on you and any person entitled to make a claim under this policy, whether their entitlement is revocable or irrevocable.

All of our obligations and liabilities under this policy end immediately on the date we receive your request to cancel your policy or on any later date you indicate in your request.

To cancel your policy, send your request in writing to:
Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601, Stn Waterloo
Waterloo ON Canada N2J 4C5

If you apply to cancel your policy within the first 10 days of receiving it from us, we will treat this as a rescission. You can find the full details under the heading, *If you change your mind within 10 days.*

If you apply to cancel your policy after the 10th day of receiving it from us, we'll pay you:
- any amount in the withdrawable premium fund
- **minus** any unpaid premiums including interest.

E21285A

When your policy ends

If your policy hasn't ended for any of the reasons already described, this policy, including any optional benefits, will automatically end on the earlier of:

- the policy end date, shown on the *Policy summary,* or
- the date the insured person dies.

When this policy ends, we will pay you any amount in the withdrawable premium fund.

E21066A

Other information about your policy

Information about our contract with you

Once your policy is in effect, the following documents make up our entire contract with you:

- your application for insurance, including any evidence of insurability, and
- this policy, including any amendments.

All of our obligations to you are contained in the documents described above. Any other document or oral statement does not form part of this contract. This policy or any part of this policy may not be amended or waived except by a written amendment. Two signing officers authorized by Sun Life Assurance Company of Canada must also sign the amendment.

Time limit for recovery of insurance money

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless it starts within the time set out in the Insurance Act, or the provincial or territorial legislation that applies to this policy.

Currency of this policy

All amounts of money in this policy are in Canadian dollars.

Transferring your policy (assignment)

You may be able to transfer your rights under this policy to someone else by assigning the policy. We are not responsible for ensuring that the assignment of your policy is legally valid. If you choose to transfer this policy, send a notice of the assignment to:

Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601, Stn. Waterloo
Waterloo ON Canada N2J 4C5

Insurance terms

The following explanations describe insurance terms that may or may not apply to this policy.

Age
Age means a person's age on their birthday nearest to a particular date. This is known as 'age nearest'. For example, a person's age at the policy date means their age on their birthday nearest to the policy date.

Benefits
We offer a variety of insurance coverages. The critical illness insurance benefit is a coverage that is automatically included in your policy. Other optional benefits may be available. An example of an optional benefit is Total disability waiver.

Contingent owner
The person or persons named in writing to take ownership of this policy if you die before the date the policy ends.

What happens if no contingent owner is named when a policy owner dies?
- If there is only one policy owner on the date of death, then the policy owner's estate becomes the new policy owner.
- If there are two or more policy owners on the date of death, then the deceased policy owner's estate along with the surviving policy owner(s) own the policy.

Critical illness benefit payee
The person or persons named in writing to receive the critical illness insurance benefit.

Evidence of insurability
This may include medical, financial, lifestyle, tobacco usage and family medical history information and other personal history information needed to approve an application for insurance.

Permanent insurance
A type of insurance that provides protection for the insured person's entire lifetime.

Policy date
The policy date is the start date of an insurance policy. Your policy date is shown on the *Policy summary*.

Policy anniversary
The month and day every year that is the same as your policy date.

Policy year
The 12 month period that runs from one policy anniversary to the next policy anniversary.

Term insurance
A type of insurance that provides protection for a limited number of years.

Statutory conditions

1. The contract

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

Copy of application

2) The insurer shall, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

2. Material facts

No statement made by the insured or a person insured at the time of application for this contract shall be used in defence of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

3. Notice and proof of claim

1) The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

a) give written notice of claim to the insurer,

- by delivery thereof, or by sending it by registered mail to the head office or chief agency of the insurer in the province, or
- by delivery thereof to an authorized agent of the insurer in the province,

not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability,

b) within 90 days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the insurer such proof, as is reasonably possible in the circumstances, of:

- the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby
- the right of the claimant to receive payment
- the claimant's age, and
- if relevant, the beneficiary's age, and

c) if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such sickness or disability.

Failure to give notice or proof

2) Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if:

a) the notice or proof is given or furnished as soon as reasonably possible, and in no event later than 1 year from the date of the accident or the date a claim arises under the contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed, or

b) in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than 1 year after the date a court makes the declaration.

4. Insurer to furnish forms for proof of claim

The insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

5. Rights of examination

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

a) the claimant shall afford to the insurer an opportunity to examine the person of the person insured when and so often as it reasonably requires while the claim hereunder is pending, and

b) in the case of death of the person insured, the insurer may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies.

6. When money is payable other than for loss of time

All money payable under this contract, other than benefits for loss of time, shall be paid by the insurer within 60 days after it has received proof of claim.

E21820A

Advanced return of premium with Return of premium on cancellation or expiry

You may be eligible to receive returnable premium payments as described below.

When we pay the advanced return of premium

You do not have to apply – we will automatically pay you an advance of 75 % of the returnable premium amount on the 15th policy anniversary.

The benefit has no value before this date.

Your policy does not end when we make this advanced payment.

The advanced return of premium amount

The advanced returnable premium amount is the total of:

- 75 % all premiums paid
- **minus** any premiums paid for the *Long term care conversion option*
- **minus** any unpaid premiums including interest.

When we pay the return of premium on cancellation or expiry

If you cancel this policy

We will pay you the available returnable premium amount if you cancel this policy at any time on or after the 30th policy anniversary.

The benefit has no value if the policy is cancelled before this date.

If this policy expires

We will pay the available returnable premium amount to you if this policy expires on the policy end date shown on the *Policy summary.*

The returnable premium amount

The returnable premium amount is the total of:

- all premiums paid
- **minus** any advanced return of premium amount we paid
- **minus** any premiums paid for the *Long term care conversion option*
- **minus** any unpaid premiums including interest.

We will also pay you any amount in the withdrawable premium fund on the date the policy ends.

If the insured person qualifies for an illness eligible for full benefit payout (Group 1), at any time, the amount we pay is the greater of:
- the critical illness insurance benefit amount in effect, or
- the returnable premium amount for *Return of premium on cancellation or expiry*

E21880A
Return of premium on death

We will pay either the returnable premium amount or a critical illness insurance benefit, but not both. If we pay the returnable premium amount on death, we will not pay a returnable premium amount for any other benefit in this policy.

When we pay
If the insured person dies, we pay the returnable premium amount on death to the person named on your application as the return of premium on death beneficiary, unless you make a change in writing.

The benefit has no value before this date.

The returnable premium amount
The returnable premium amount on death is the total of:
- all premiums paid
- **minus** any advanced return of premium amount we paid
- **minus** any premiums paid for the *Long term care conversion option*
- **minus** any unpaid premiums including interest.

We will also pay you any amount in the withdrawable premium fund on the date the insured person dies.

Making a claim
To make a claim, contact your advisor or call us at the toll free phone number shown at the beginning of this policy. We will send the appropriate form to be completed.

The person making the claim and completing the form must be the return of premium on death beneficiary. We require proof that the insured person died while this policy was in effect.

E17895A
Owner waiver disability

In this provision, *you* and *owner* mean the owner covered under this benefit. You may qualify to stop paying the premiums for this policy if you become totally disabled while this benefit is in effect. We call this waiving premiums.

The *Policy summary* shows the following information about Owner waiver disability:

- the owner with the benefit, and
- the date the benefit ends.

If you change ownership by transferring your rights under this policy to another person, this benefit ends and the new owner will not qualify to have premiums waived.

The maximum total annual amount we waive for an insured person is $50,000 across all insurance policies issued by us, or for which we have assumed responsibility, on that person.

Qualifying for this benefit

To qualify for this benefit:

- Owner waiver disability must be in effect
- the owner's disability must begin before the benefit end date shown on the *Policy summary*
- the owner's disability must continue for at least 6 consecutive months, and
- we determine that the owner is totally disabled and all requirements for this benefit have been satisfied.

To be considered totally disabled the owner must be:

- under the active, continuous and medically appropriate care of a physician, or other health care practitioner acceptable to us, and
- following the treatment prescribed and any other recommendations made by a physician or health care practitioner.

Disabled while employed

If the owner becomes disabled while employed, we consider them to be totally disabled if, as a result of injury or disease, they are completely unable, during the first 2 years following the date of their disability, to carry on the essential duties of their own occupation.

After the first 2 years, we consider the owner to be totally disabled if they are unable, as a result of injury or disease, to perform the duties of any occupation within their education, training or experience. We do not consider an owner to be totally disabled if they are earning money or profiting from any occupation.

In determining whether or not the owner is able to perform the duties of any occupation, we do not take into account whether a suitable occupation is actually available. In addition, we do not consider whether a suitable occupation would provide earnings comparable to what the owner was paid before becoming totally disabled.

Disabled while unemployed

If the owner becomes disabled while unemployed, and is not earning money or profiting from any occupation, we consider them totally disabled if they are unable, as a result of injury or disease, to perform the duties of any occupation within their education, training or experience.

In determining whether or not the owner is able to perform the duties of any occupation, we do not take into account whether a suitable occupation is actually available. In addition, we do not consider whether a suitable occupation would provide earnings comparable to what the owner was paid before becoming totally disabled.

Disabled while a student

If the owner is a student at the time they become disabled, we consider them to be totally disabled if they are unable, as a result of injury or disease, to:

- attend or participate as a student in an education program during the entire time they are totally disabled, or
- perform the duties of any occupation for earnings or profit within their education, training or experience.

In determining whether or not the owner is able to perform the duties of any occupation, we do not take into account whether a suitable occupation is actually available. In addition, we do not consider whether a suitable occupation would provide earnings comparable to what the owner was paid before becoming totally disabled.

When we start waiving

Premiums must be paid until we give notice that we approved the claim. At that time, we waive premiums starting from the month the owner became totally disabled.

Premiums are waived until the earlier of:

- the date the owner no longer qualifies for this benefit
- the date the policy ends
- the date premiums are no longer payable for this policy, and
- the date the owner dies.

If any premium is paid and later waived, we credit the same amount to the withdrawable premium fund.

When we will not waive (exclusions and reductions of coverage)

We will not waive premiums if the owner's disability begins after the Owner waiver disability benefit end date shown on the *Policy summary*.

We will not waive premiums if the disability is directly or indirectly caused by or associated with the owner operating a vehicle while their blood alcohol level is more than 80 milligrams of alcohol per 100 milliliters of blood. A vehicle includes any form of ground, air or marine transportation that can be put into motion by any means, including muscular power. We do not take into account whether or not the vehicle is in motion.

We will not waive premiums if the disability is directly or indirectly caused by or associated with the owner:

- committing or attempting to commit a criminal offence
- attempting to take their own life, regardless of whether the owner had a mental illness or understood or intended the consequences of their action(s)
- causing themself bodily injury, regardless of whether the owner had a mental illness or understood or intended the consequences of their action(s)
- taking any drug, unless the drug was taken as prescribed by a licensed medical practitioner
- inhaling or ingesting any poisonous substance, whether voluntarily or otherwise, or
- inhaling any type of gas, whether voluntarily or otherwise.

We will not waive premiums if the owner's disability is directly or indirectly caused by or associated with civil disorder or war, whether declared or not.

Making a claim

To make a claim, contact your advisor or call us at the toll free phone number shown at the beginning of this policy. We will send the appropriate form to be completed.

We must receive proof of the owner's disability:

- while the owner is alive
- continuing for at least 6 consecutive months while this benefit is in effect, and
- within 1 year of the date the disability began.

Any initial or ongoing claim for benefits under the disability waiver provision must be supported by written evidence from a physician or other health care practitioner acceptable to us.

If we receive proof of the disability more than 1 year after the disability starts and the owner qualifies for this benefit, we consider the disability to have begun 1 year before the date we received the proof. This means that we will only waive premiums starting from 1 year before the date we received the proof, regardless of when the disability actually started. We will not consider a late claim if you submit it more than 1 year after the end date of this benefit.

You must pay any cost associated with providing proof of disability.

We may also require the owner to authorize us to gather and use additional information from other insurers or government agencies.

Before we approve a claim, the owner's date of birth must be verified.

How to continue to qualify

We continue to waive premiums while the owner:

- continues to be disabled and satisfies our total disability requirements
- is under the continuous care of a licensed physician
- follows a prescribed treatment program for their disability, and
- makes reasonable efforts to use any appropriate rehabilitation program.

From time to time, we will ask for proof, that we consider satisfactory, that the owner is still disabled. You must pay any cost associated with providing this proof.

We may require the owner to be examined by any health care practitioners we appoint. These may be licensed physicians, physiotherapists, occupational therapists, psychiatrists, psychologists or others. We pay the cost of these examinations.

The physicians, specialists or health care practitioners who provide information to us may not be the owner of this policy, any insured person under this policy, anyone entitled to make a claim under this policy, or any relative or business associate of these people.

We may also require the owner to authorize us to gather and use information from other insurers or government agencies.

When we stop waiving

We stop waiving premiums on the date the owner:

- is no longer totally disabled
- is earning money or profiting from any occupation

- takes part in any educational program as a student without our approval
- fails to submit any required proof of disability
- refuses to attend any examinations or rehabilitation programs without a valid medical reason
- fails to meet any other requirements to have premiums waived, or
- dies.

Reoccurrence of a previous disability claim

You may apply to have premiums waived without having to wait another 6 months if there's a reoccurrence of a previous disability claim. We consider the disability to be a reoccurrence of the previous one if:

- we waived premiums for the previous disability
- the disabled owner recovers from their disability and then becomes totally disabled again from the same cause within 6 months from the date we stopped waiving premiums, and
- the owner is totally disabled as described under the heading, *Qualifying for this benefit*.

We waive premiums from the date the disability started again.

When the benefit ends

Owner waiver disability ends on the earliest of:

- the benefit end date, shown on the *Policy summary*
- the date you transfer ownership of this policy to a new owner
- the date you cancel the benefit
- the date the owner dies, or
- the date this policy ends.

E17900A

Owner waiver death

In this provision, *you* and *owner* mean the owner covered under this benefit. If you die while this benefit is in effect, premiums are no longer payable for this policy. We call this waiving premiums.

The *Policy summary* shows the following information about Owner waiver death:

- the owner with the benefit, and
- the date the benefit ends.

If you change ownership by transferring your rights under this policy to another person, this benefit ends and the new owner will not qualify to have premiums waived.

The maximum total annual amount we waive for an insured person is $50,000 across all insurance policies issued by us, or for which we have assumed responsibility, on that person.

When we start waiving

Premiums must be paid until we give notice that we approved the claim. At that time, we waive premiums starting from the month the owner died.

If we approve the claim, we waive premiums until the earlier of:

- premiums are no longer payable for this policy, or
- the date the policy ends.

If any premium is paid and later waived, we credit the same amount to the withdrawable premium fund.

When we will not waive (exclusions and reductions of coverage)

We will not waive premiums if the owner takes their own life, regardless of whether the owner has a mental illness or understands or intends the consequences of their action(s), within 2 years of the later of:

- the date the application for this benefit was signed
- the policy date, shown on the *Policy summary*, or
- the most recent date your policy was put back into effect, if it has been reinstated.

Making a claim

To make a claim, contact your advisor or call us at the toll free phone number shown at the beginning of this policy. We will send the appropriate form to be completed. The person making the claim must give us any information we need to assess the claim, including proof that the owner died while this benefit was in effect.

Before we approve a claim, the owner's date of birth must be verified.

When the benefit ends

Owner waiver death ends on the earliest of:

- the benefit end date, shown on the *Policy summary*
- the date you transfer ownership of this policy to a new owner
- the date you cancel the benefit, or
- the date this policy ends.