SSQ Financial Group

WE THRIVE
ON MUTUAL TRUST

HIGH LINER FOODS INC.

Critical Illness Insurance

Policy 1N400

This Booklet/Certificate is an important document.
Please keep it in a safe place.

Table of Contents

This booklet is an outline of SSQ Insurance Company Inc. Critical Illness Insurance Plan offered to the Employees of HIGH LINER FOODS INC. and their dependents (Spouses and Dependent Children). It is designed to help you learn more about the coverage offered under this Plan. This booklet should be retained for reference.

The Critical Illness Insurance Group Policy no. **1N400**, its endorsements and attached papers, if any, and the entire contract of insurance, all referred to hereafter as the "Policy", sets forth the terms and conditions of the Insurance Plan. All rights and obligations are determined in accordance with the Policy, not this booklet. For exact provisions of coverage offered, please contact your Human Resources department.

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.

NOTICE OF NEW FILE

File and Personal Information

In order to maintain the confidentiality of information concerning the persons it insures, the Insurer opens an insurance file to hold personal information about the application for insurance and any insurance claims made.

With the exception of certain cases provided for under applicable legislation, access to insured persons' files is restricted to those employees, legal agents and service providers who must consult these files for the purpose of contract management, inquiries or underwriting, in addition to reinsurers and any other person you may authorize. The Insurer keeps these insurance files in its offices.

All persons insured with SSQ Insurance Company Inc. have the right to consult the information contained in their file and, if necessary, to have any errors or inaccuracies corrected, free of charge, by making a written request to the attention of the Insurer's Personal Information Protection Officer at the following address: SSQ, Life Insurance Company Inc., 2525 Laurier Boulevard, P.O. Box 10500, Station Sainte-Foy, Quebec QC G1V 4H6. However, the Insurer may charge fees for transcribing, reproducing or sending this information. The person making the request for information will be informed beforehand of the approximate amount that will be charged.

Legal Agents and Service Providers

The Insurer may exchange information of a personal and confidential nature with its reinsurers, legal agents and service providers only for the purpose of allowing them to carry out the tasks they are assigned. The Insurer's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When you enrol in a group insurance plan, and also when you make a claim, you are actually giving your consent that the Insurer and its legal agents and service providers may use your personal information for the above-mentioned purposes. It is understood that not giving this consent would compromise the management of your insurance coverage and the quality of the services the Insurer can offer you.

For more information, consult the SSQ Personal Information Protection Policy available at ssq.ca.

INTRODUCTION

What is Critical Illness Insurance?

Critical Illness Insurance can provide the funds and means to preserve your quality of life, protect personal assets and allow the freedom and flexibility to choose the kind of health care you want.

It is designed to provide a lump sum payment in the event that the individual is diagnosed for the first time with a given covered Critical Illness while the insurance is in force and survives at least 14 days following the diagnosis. Among the many advantages of this coverage, payment of benefits is not limited by your ability to work or even by a full recovery. Should you receive a critical illness diagnosis, the benefit is paid directly to you and you are **free to choose how to use the amount you receive.**

Why is Critical Illness Insurance important?

Research has shown that a significant number of Canadians will face the challenge of a critical illness. Consider the following:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- On average, 3,300 Canadians will be diagnosed with cancer every week.
- There are an estimated 70,000 heart attacks each year in Canada. One heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That's one stroke every 10 minutes.
- 75% of stroke victims survive the initial event.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.

Source: Heart and Stroke Foundation, Canadian Cancer Society and Multiple Sclerosis Society of Canada

Critical illnesses are diagnosed everyday. Although healthy lifestyle choices can help protect against some health risks, a critical illness or condition can strike anyone at any time. Thanks to advances in modern medicine however, Canadians are enjoying longer and healthier lives. As survival rates improve, the need for Critical Illness Insurance, to help provide financial support throughout the recovery process is becoming more and more important.

A Critical Illness Insurance benefit can help you:

- obtain the appropriate care where and when you decide
- cover medical expenses not covered under your provincial health care plan
- focus on your recovery process by funding a leave of absence or time off to take care of a family member
- compensate for reduced family earnings and face increased costs, by using the benefit to pay for:
    - medical bills or private nursing care
    - mortgage payments or rent
    - debt or other financial liabilities
    - child care
    - hired domestic help
    - home or vehicle modifications

What are the advantages of your coverage?

With your Critical Illness Insurance, you benefit from:

- coverage up to $10,000 for you, up to $10,000 for your spouse, and up to $ 25,000 for your dependent children, tax-free, without having to answer any medical questions or provide any evidence of insurability;
- affordable coverage thanks to our competitive group rates;
- premium payments by way of payroll deductions;
- continued protection even if your health has diminished while covered under the Plan – even after having received a critical illness benefit, you and your insured spouse may still be covered under the Insurer's Critical Illness coverage!

GENERAL DEFINITIONS

"Critical Illness" means a deterioration of health or bodily disorder which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

1. Aortic surgery
2. Aplastic anemia
3. Bacterial meningitis
4. Benign brain tumour
5. Blindness
6. Cancer (life-threatening)
7. Coma
8. Coronary angioplasty
9. Coronary artery bypass surgery
10. Crohn's disease requiring surgery
11. Deafness
12. Dementia, including Alzheimer's disease
13. Dilated cardiomyopathy
14. Ductal carcinoma in situ of the breast
15. Fulminant viral hepatitis
16. Heart attack
17. Heart valve replacement or repair
18. Hip replacement surgery
19. Kidney failure
20. Knee replacement surgery
21. Liver failure of advanced stage
22. Loss of independent existence
23. Loss of limbs
24. Loss of speech
25. Major organ failure on waiting list
26. Major organ transplant
27. Motor neuron disease
28. Multiple sclerosis
29. Muscular dystrophy
30. Occupational HIV infection

31. Paralysis
32. Parkinson's disease and specified atypical Parkinsonian disorders
33. Primary pulmonary hypertension
34. Progressive systemic sclerosis
35. Severe burns
36. Severe rheumatoid arthritis
37. Stage 1A malignant melanoma
38. Stage A (T1a or T1b) prostate cancer
39. Stroke
40. Systemic lupus erythematosus

Any Critical Illness or health problem which is not defined in the present document is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"Critical Illness" with respect to an Insured Dependent Child means one of the following illnesses, conditions or surgical operations which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

1. Benign brain tumour
2. Blindness
3. Cancer (life-threatening)
4. Cerebral palsy
5. Coma
6. Congenital heart disease requiring surgery
7. Cystic fibrosis
8. Deafness
9. Down's syndrome
10. Kidney failure
11. Loss of speech
12. Major organ failure on waiting list
13. Major organ transplant
14. Mental deficiency
15. Muscular dystrophy
16. Paralysis

17. Severe burns
18. Spina bifida cystica

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"*Dependent Child*" means a natural child, adopted child, stepchild or child otherwise in a parent-child relationship with the Insured Employee. The child must be unmarried and dependent upon the Insured Employee for maintenance and support, reside in Canada and:

(1) be under 21 years of age; or

(2) be under 25 years of age (26 in the Province of Quebec) and in attendance at an Institution for Higher Learning on a full-time basis; or

(3) no matter his age on the date of the claim, be residing with the Insured Employee or Insured Spouse and be suffering from a severe, incurable and chronic physical or mental disability that began while the child met the conditions indicated in (1) or (2) above in this definition, and have remained continuously disabled since that date; the disability must render the child incapable of pursuing any gainful activity. The Insurer may require medical evidence of such as it seems necessary.

The Dependent Child will be covered from birth provided such child is born alive.

"Diagnosis" or *"Diagnosed"* refers to the determination by a Specialist, using tests or other diagnostic methods, that the Insured Person has a specific illness covered under the Policy. The Diagnosis of any covered illness must be made in Canada or the United States by a Specialist licensed to practice in Canada or the United States. Furthermore, his area of practice must include the area of medicine directly related to the illness in question.

"Employee" means a salaried employee of the Policyholder who is under the age of seventy (70) and resides in Canada, and whose usual place of work is in Canada.

"Institution for Higher Learning" means and is limited to universities, colleges, CEGEPs and professional or vocational schools.

"Insured" means an individual whose coverage under the Policy is in force.

"Insured Employee" means an Employee whose coverage under the plan is in force.

"Irreversible" means a condition of the Insured where the prognosis cannot be improved by medical or surgical treatment at the time of Diagnosis. However, when the prognosis could be improved by medical or surgical treatment but would impose, in the opinion of the Insured's Physician, a risk to the Insured's health that would outweigh the expected benefit(s) of such treatment, the condition is then also considered as Irreversible for the purpose of this definition.

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

"Physician" means an individual who is legally licensed to practice medicine in Canada or the United States and provides treatment within the scope of his licence. The Physician must not ordinarily reside with the Insured. The Physician must not be the Insured, a relative of or business associate of the Insured.

"Pre-existing Condition" means:

- the existence of symptom(s) within a twenty-four (24) month period preceding the Insured's effective date of individual coverage which would cause a reasonably prudent person to seek Diagnosis, care or treatment; or
- an illness or condition for which the Insured, during twenty-four (24) months prior to the effective date of his individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a Physician.

"Principal Sum" means the amount of insurance applicable to the Insured and stated on the Insured Employee's most recently signed individual enrollment card on file with the Policyholder, if any.

"Specialist" means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be Diagnosed by a qualified Physician practising in Canada or the United States. The Specialist must not ordinarily reside with the Insured. The Specialist must not be the Insured, a relative of or business associate of the Insured.

"Spouse" means an individual under the age of seventy (70) who resides in Canada and:

(1) who is legally married to or in a civil union with the Insured Employee; or

(2) with whom the Insured Employee has continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

However, if an individual is the biological or adoptive mother or father of at least one of the children of the Insured Employee and is cohabiting with the Insured Employee, the individual shall be deemed to be a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one (1) year of cohabitation.

Only one (1) individual qualifies as the Spouse of any Insured Employee. If the Insured Employee is legally married or in a civil union but is also cohabiting with an individual as described under Item (b) above, the Insured Employee may elect in writing which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom the Insured Employee is legally married or in a civil union.

"Surgery" means that the Insured undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada or the United States.

"Survival Period" means the fourteen (14) days following the date of Diagnosis or fourteen (14) days following the date of Surgery if applicable, except where otherwise specified under the present document. The Survival Period does not include days on Life Support as defined in this section. The Insured must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain.

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

ENROLMENT

Enrolment in this plan is on a voluntary basis.

ELIGIBILITY

- All active Employees of the Policyholder
- Spouses of all active Employees
- Dependent Children of all active Employees

If an Employee is absent from active work for any reason other than maternity or parental leave or vacation or other paid leave, such Employee will only become eligible upon return to active work. Dependent Children become eligible only when the Employee or Spouse enrols in the plan.

COVERAGE AMOUNTS

Critical Illness Insurance is a voluntary group coverage for you, your Spouse and your Dependent Children.

You have the option to buy an amount of principal sum in units of $ 10,000 up to a maximum of $ 150,000, subject to the terms of premium payment indicated in the "*Coverage Payment*" section.

Your Spouse has option to buy an amount of principal sum in units of $ 10,000 up to a maximum of $ 150,000, subject to the terms of premium payment indicated in the "*Coverage Payment*" section.

You can enroll your Dependent Children for coverage up to $ 25,000 of principal sum, each, without having to provide any evidence of insurability.

With regard to evidence of insurability, you may request an amount of coverage equal or less than the guaranteed issue amount of $ 10,000 and your Spouse may request an amount of coverage equal or less than the guaranteed issue amount of $ 10,000 without having to answer medical questions or having to present evidence of insurability. However, if you or your Spouse wishes to request an amount of coverage greater than the guaranteed issue amount, you and/or your Spousemust submit to the Insurer satisfactory evidence of insurability.

EVIDENCE OF INSURABILITY AND EFFECTIVE DATE OF INSURANCE

Required evidence of insurability

Evidence of insurability to the satisfaction of the Insurer is required when the requested amount exceeds the Guaranteed Issue Amount. It is also required when the request is received by the Policyholder more than thirty-one (31) days after one of the following events:

a. the Effective Date of the Policy;

b. the person's date of eligibility;

c. a Life Event.

Life Events

At the time of any Life Event listed hereafter, the eligible persons may enrol in the plan subject to the provisions of this "Evidence of Insurability and Effective Date of Insurance" section. For the purposes of this insurance, Life Events that give rise to a new eligibility period without evidence of insurability are the following: marriage; civil union; cohabitation for one year; birth or adoption of a first child.

For coverage obtained without evidence of insurability

Coverage as to each eligible Employee or Spouse becomes effective on the latest of the following dates:

a. the Effective Date of the Policy with respect to a request received by the Policyholder on or prior to the Effective Date of the Policy;

b. the date the Employee returns to active full-time work if such Employee is absent from full-time work on the Effective Date of the Policy for any reason other than: vacation or other paid leaves; maternity leaves; parental leaves;

c. the first day of the month coincident with or next following the date of eligibility of the Employee or the Spouse with respect to an Employee or a Spouse who becomes eligible after the Effective Date of the Policy.

Coverage as to each eligible Dependent Child becomes effective on the latest of the following dates:

a. the effective date of the Employee's or Spouse's insurance hereunder;

b. the date the Dependent Child becomes eligible with respect to those who become eligible after the effective date of the Employee's or Spouse's insurance;

c. the date the enrolment of the eligible person is completed.

For coverage that can be obtained only upon approval of evidence of insurability by the Insurer

Coverage as to each eligible person becomes effective on the later between the Effective Date of the Policy and the first day of the month coincident with or next following the date of approval of evidence of insurability, if approved by the Insurer. However, Dependent Children coverage cannot become effective before the Employee's or Spouse's coverage.

DEFINITIONS OF COVERED ILLNESSES

Other illnesses are also covered under this plan. They are defined under section "Complementary Benefit in Case of Certain Illnesses".

"**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 refers to the thoracic and abdominal aorta but not its branches.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; 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 (1) of the following:

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

"**Bacterial meningitis**"

means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least ninety (90) days from the date of Diagnosis.

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

"**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).

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

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of benign brain tumour (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Benign brain tumour or any Critical Illness caused by any benign brain tumour or by 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.

"**Cancer" (life-threatening)**

means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following types of cancer are included: carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Exclusion: No benefit will be payable under this condition for any of the following:

- lesions described as benign, pre-malignant, uncertain, borderline or 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;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than the American Joint Committee on Cancer (AJCC) stage 2.

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or not), regardless of when the Diagnosis was made; or

- a Diagnosis of cancer (covered or not).

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or by its treatment.

References: For the 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. Also for the 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

"**Cerebral palsy**"

means the definite Diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

"**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 ninety six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

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

"**Congenital heart disease requiring surgery**"

means the definite Diagnosis of any serious cardiac malformation present at birth, for which corrective surgery has been performed.

"**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).

Exclusions: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures or non-surgical procedures.

"**Cystic fibrosis**"

means the definite Diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.

"**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.

"**Dementia, including Alzheimer's disease**"

means the 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);
- 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 following is also required:

- dementia of at least moderate severity, which must be evidenced by a Mini 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 six (6) month period.

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

"**Dilated cardiomyopathy**"

means a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of dilated cardiomyopathy must be confirmed by echocardiographic abnormalities demonstrating new abnormal cardiac function with a persistent low ejection fraction (less than 40%) for at least 3 months.

New York Heart Association Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

"**Down's syndrome**"

means the definite Diagnosis of a congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present.

"**Fulminant viral hepatitis**"

means a definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

(a) a rapidly decreasing liver size as confirmed by abdominal ultrasound;
(b) necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
(c) rapidly deteriorating liver function tests;
(d) deepening jaundice.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

"**Heart attack**"

means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:

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

Exclusions: No benefit will be payable under this condition for any of the following:

- 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**"

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.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; 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 or peritoneal dialysis is required, or renal transplantation initiated.

"**Liver failure of advanced stage**"

means a definite Diagnosis of Liver failure due to cirrhosis and resulting in all of the following:
(a) Permanent jaundice;
(b) Ascites;
(c) Encephalopathy.

Exclusion: No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

"**Loss of independent existence**"

means a definite Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

Activities of Daily Living are:

- Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices.
- Dressing - the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances, with or without the aid of assistive devices.
- Toileting - the ability to get on and off the toilet and maintain personal hygiene, with or without the aid of assistive devices.
- Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices.

- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the aid of assistive devices.

"**Loss of limbs**"

means a definite Diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

"**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.

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 or bone marrow, and for which transplant 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. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrollment in the transplant centre.

"**Major organ transplant**"

means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver 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 or bone marrow, and limited to these entities.

Exclusion: No benefit will be payable under this condition for any organ transplant other than those described above.

"**Mental deficiency**"

means the definite Diagnosis of an intellectual deficiency, as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70.

"**Motor neuron disease**"

means a definitive Diagnosis of one (1) 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.

"**Multiple sclerosis**"

means a definite Diagnosis of at least one (1) of the following:
- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or

- well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

"**Muscular dystrophy**"

means a definite Diagnosis of all of the following:
(a) Clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
(b) Characteristic electromyography changes;
(c) Muscle biopsy confirming Diagnosis of muscular dystrophy.

"**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 occur while this coverage is in force.

Payment under this condition also requires satisfaction of all of the following:
(a) The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;
(b) A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;
(c) A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;
(d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;
(e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

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 (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event.

"**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 is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders (SAPD) means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or specified atypical Parkinsonian disorder must be made by a neurologist. In all cases, the Insured Person condition must exhibit objective signs of a 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.

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

In addition, no benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders if one of the following occurred to the Insured Person within the year following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease or atypical Parkinsonian disorders or any other type of Parkinsonism, regardless of when the Diagnosis was made; or
- a Diagnosis of Parkinson's disease, atypical Parkinsonian disorders or any other type of Parkinsonism.

Restriction: This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided during this period, the Insurer has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorder or any Critical Illness caused by Parkinson's disease or Parkinsonian disorders or by their treatments.

"**Primary pulmonary hypertension**" **(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)**

means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment.

The New York Heart Association Classification of Cardiac Impairment (source: *Current Medical Diagnosis and Treatment-39th Edition*) states the following about Class IV:

"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

Exclusion: No benefit will be payable under this condition for any other type of pulmonary arterial hypertension.

"**Progressive systemic sclerosis**"

means a definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological evidence and with biopsy results when available.

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

- Localized scleroderma (linear scleroderma or morphea); or
- Eosinophilic fasciitis; or
- CREST syndrome.

"**Severe burns**"

means a definite Diagnosis of third degree burns over at least 20% of the body surface.

"**Spina bifida cystica**"

means the definite Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

(a) hydrocephalus;
(b) paralysis;
(c) bowel problems; and
(d) bladder problems.

Exclusion: No benefit will be payable under this condition for Spina Bifida Occulta.

"**Stroke**"

means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

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

persisting for more than thirty (30) days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Exclusion: No benefit will be payable under this condition for any of the following:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

COMPLEMENTARY BENEFIT IN CASE OF CERTAIN ILLNESSES (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

In addition to the Critical Illnesses described under section "Definitions of Covered Illnesses", the following illnesses, as defined hereunder, are covered under the Complementary Benefit in Case of Certain Illnesses.

1. Coronary angioplasty
2. Crohn's disease requiring surgery
3. Ductal carcinoma in situ of the breast
4. Hip or knee replacement surgery
5. Severe rheumatoid arthritis
6. Stage A (T1a or T1b) prostate cancer
7. Stage 1A malignant melanoma
8. Systemic lupus erythematosus

"**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.

"**Crohn's disease requiring surgery**"

means the unequivocal Diagnosis of Crohn's disease confirmed by results of typical endoscopy and histopathology findings. Also, the Insured must exhibit intra-abdominal or anal abscesses or fistulas, or intestinal obstruction or perforation, or intractable disease not responding to non-surgical management. In addition, symptoms must have persisted despite optimal non-surgical therapy and a surgical intervention including at least one bowel segment resection must be medically necessary.

"**Ductal carcinoma in situ of the breast**"

means the Diagnosis of this illness, as confirmed by biopsy.

"**Hip or knee replacement surgery**"

means an open Surgery resulting in the total prosthetic replacement of either the hip or the entire knee (known as total knee replacement), subject to the following:

- For hip replacement to qualify under this insurance, the femoral stem must be replaced. Also, this procedure should be performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar).
- For knee replacement to qualify under this insurance, all three compartments of the knee (medial, lateral and patellofemoral) must be replaced.

Exclusions: No benefit will be payable under this condition for arthroscopic treatment of joint surfaces or revision of previous total hip or knee replacements.

"**Severe rheumatoid arthritis**"

means the definite Diagnosis of severe seropositive rheumatoid arthritis, that must involve widespread joint destruction affecting at least 3 large joints (these are shoulders, elbows, hips, knees, and ankles), as well as 3 small joints (these are metacarpophalangeal joints, proximal interphalangeal joints, thumb interphalangeal joints, joints of the wrists and second through fifth metatarsophalangeal joints). The Diagnosis must be confirmed by clinical and radiological evidence of joints destruction and deformity.

"**Stage A (T1a or T1b) prostate cancer**"

means the definite Diagnosis of this illness, as confirmed by pathological examination of prostate tissue.

"**Stage 1A malignant melanoma**"

means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

"**Systemic lupus erythematosus**"

means the definite Diagnosis of systemic lupus erythematosus, that must involve renal system which requires corticosteroid treatment for a continuous period of six (6) months and permanent impairment of kidney function tests that show Glomerular Filtration Rate (GFR) below 30mL/min/1.73m^2. In addition, a positive ANA test must be present.

Exclusions: No benefit will be payable under this condition for any other forms of lupus, such as discoid lupus and those forms with only hematological and joint involvement.

If the Insured Employee or Insured Spouse is Diagnosed with one of the illnesses indicated previously in this section while his coverage is in force and subject to the conditions of the "Survival Period" section and the limitations specified in the "Re-Entry Conditions" section, the Insurer will pay the Insured Employee or the Insured Spouse:

(1) 10% of the Principal Sum, subject to a maximum of $25,000, for the following conditions:
- Coronary angioplasty
- Ductal carcinoma in situ of the breast
- Stage A (T1a or T1b) prostate cancer
- Stage A malignant melanoma

The payment of the Complementary Benefit in Case of Certain Illnesses in group (1) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(2) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
- Crohn's disease requiring surgery
- Severe rheumatoid arthritis
- Systemic lupus erythematosus

The payment of the Complementary Benefit in Case of Certain Illnesses in group (2) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(3) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
- Hip replacement surgery
- Knee replacement surgery

The payment of the Complementary Benefit in Case of Certain Illnesses in group (3) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

CANCER RECURRENCE BENEFIT (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

The Insurer will pay a Principal Sum amount if the Insured Employee or Insured Spouse is Diagnosed a subsequent time with Cancer and that more than sixty (60) months have passed since the previous Cancer Diagnosis and no treatment relating directly or indirectly to Cancer has been received within that sixty (60) month period (treatment does not include preventive medications and follow up visits to the doctor).

The subsequent Diagnosis must be made while coverage is in force.

MULTIPLE EVENT COVERAGE (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

If an Insured Employee or Insured Spouse is Diagnosed with a covered Critical Illness for which the Principal Sum (or 10% of the Principal Sum under the Complementary Benefit in Case of Certain Illnesses) has been paid and is then Diagnosed with another covered Critical Illness, the Insurer will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the Complementary Benefit in Case of Certain Illnesses) subject to the limitations specified in the "Re-Entry Conditions" section.

To give rise to a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made ninety (90) days or more after the date another covered condition was Diagnosed.

SECOND MEDICAL OPINION SERVICE

Any Insured who is Diagnosed with a covered Critical Illness while enrolled in the insurance program is offered access to **AXA Assistance's Second Medical Opinion** program.

This program allows the Insured to obtain a second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the Insured's file to confirm the initial Diagnosis and make recommendations on appropriate treatment.

If you or your insured Spouse or insured Dependent Child have been Diagnosed with a covered Critical Illness, simply call: **1-877-266-6550** in order to benefit from AXA Assistance's Second Medical Opinion program.

RE-ENTRY CONDITIONS (APPLICABLE TO AN INSURED EMPLOYEE AND INSURED SPOUSE)

If a benefit amount has already been received for a covered Critical Illness of an Insured Employee or Insured Spouse, coverage continues for that person, provided payment of premium is continued. Subsequent benefit payments are subject to the "Re-entry Exclusions Appendix" of this insurance.

CONDITIONS FOR PAYMENT

When an Insured is Diagnosed with a covered Critical Illness and the required Survival Period is completed, the Insurer shall pay the Principal Sum, unless otherwise provided under the contract and subject to all of the conditions and limitations of this Policy.

BENEFICIARY

Amounts payable under this Critical Illness benefit will be payable to the Insured Employee or to the Insured Spouse if the latter is the one who is Diagnosed with the Critical Illness.

However, accrued benefits, if any, unpaid at the time of the beneficiary becoming unable to legally receive payment of benefits will be paid to the beneficiary's estates.

With respect to the Insured Dependent Child, the Principal Sum payable in the event of a Critical Illness will be payable to the Insured Employee.

TERMINATION OF COVERAGE

Coverage of an Insured will immediately terminate on the earliest of the following dates:

A) With respect to an Insured Employee:

1. the date the Policy is terminated;
2. the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
3. the premium due date coincident with or following the date the Insured Employee reaches seventy (70) years of age;
4. the premium due date coincident with or following the date the Insured Employee ceases to be an active Employee of the Policyholder on account of leave of absence, lay-off, maternity or parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections:
   - Waiver of Premium
   - Continuation of Coverage during Approved Leaves
   - Extension of Coverage
5. the date the Insured Employee dies;
6. the premium due date coincident with or following the date the Insured Employee gives notice of cancellation to the Policyholder.

B) With respect to an Insured Spouse:

1. the date such person ceases to satisfy the criteria for definition of "Spouse" as presented in the Policy;
2. the premium due date coincident with or following the date the Insured Spouse reaches seventy (70) years of age;
3. the date the Insured Employee's insurance coverage is terminated.

C) With respect to an Insured Dependent Child:

1. the date such person ceases to satisfy the criteria for definition of "Dependent Child" as presented in the Policy;
2. the date the Principal Sum payment has been paid;
3. the date the Insured Employee's insurance coverage is terminated.

CONVERSION OF GROUP COVERAGE TO AN INDIVIDUAL INSURANCE CONTRACT

In the event an Insured Employee's or Insured Spouse's coverage is terminated because:

a. the Insured Employee ceases to be an active Employee of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or

b. the Insured Employee ceases to be an eligible person under the plan; or

c. the period of extension of coverage ends,

the Insured Employee or Insured Spouse who has not yet reached the age of sixty-five (65) may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual Critical Illness policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual Critical Illness policy to the applicant that will consist of 4 illnesses [Cancer (life-threatening), Coronary artery bypass surgery, Heart attack and Stroke].

However, conversion will not be possible if the Policy is terminated at the time of the application. An Insured Employee or Insured Spouse may only convert if he has never received a benefit payment and has never received a payment under the "Complementary Benefit in Case of Certain Illnesses" section in the past.

The amount of insurance that may be converted will not exceed the lesser of:

a. the amount of insurance then in effect on the date of termination; or

b. a total aggregate amount of one hundred thousand dollars ($100,000) for all such conversions by any Insured.

Premiums for such individual Critical Illness policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates in force for the attained age of such Insured at the date of conversion. Premiums will be payable annually in advance and the Critical Illness policy will be issued on an annually renewable basis.

WAIVER OF PREMIUM

The Insurer will waive the Insured Employee's premium in the following circumstances:

A) If the Insured Employee has Life Insurance with waiver of premium provisions or Long Term Disability (LTD) Insurance and becomes totally disabled while covered under both this Critical Illness Insurance and the Life or LTD Insurance:

   From the first day of the month following the date the Insured Employee becomes entitled to waiver of premium under the Life or LTD Insurance.

B) If the Insured Employee has no Life Insurance with waiver of premium provisions and no Long Term Disability (LTD) Insurance and becomes totally disabled while covered under this Critical Illness Insurance:

   From the first day of the month following six (6) consecutive months during which injury or sickness totally disables and prevents this Insured Employee from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience.

Notice of such disability must be submitted to the Insurer within twelve (12) months of the onset of total disability and due proof of disability must be submitted to the Insurer within three (3) months following the date notice was given.

Premiums with respect to the Critical Illness Insurance of the Insured Spouse and Insured Dependent Children, if any, will also be waived whenever the Insured Employee's premiums for Critical Illness Insurance are waived.

Premiums will continue to be waived until the earliest of the following dates:

a. the date the Critical Illness Insurance is terminated;

b. the date the Insured Employee reaches sixty-five (65) years of age;

c. the date the Insured Employee ceases to be totally disabled; or

d. the date the Insured Employee fails to provide proof satisfactory to the Insurer of the continuance of total disability within ninety (90) days of request of such proof or refuses to submit to examination.

The coverage which is continued under this clause will be subject to the terms and provisions of this document in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in this document, in no event will benefits payable for any Diagnosis which occurs while coverage is being continued under this clause exceed the amount of insurance that would have been payable to the Insured at the date of commencement of disability.

The Insurer will have the right to request proof of the continuance of total disability, and may also require the disabled Insured Employee to submit to examination by the Insurer's medical advisor from time to time, as the Insurer may reasonably require.

CONTINUATION OF COVERAGE DURING APPROVED LEAVES

Coverage under the Policy will be continued for an Insured Employee and his Insured Spouse and/or his Insured Dependent Children during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave of the Insured Employee, provided payment of premium is continued.

This continuation of coverage will terminate at 12:01 a.m., Standard Time:

1. with respect to any leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a twelve (12) month period that started on the date such approved leave of absence began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

2. with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a six (6) month period that started on the date such approved temporary lay-off began or on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of six (6) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

3. with respect to strike, on the thirty-first (31st) day following the commencement of the strike, or later if approved by the Policyholder;

4. with respect to any maternity/parental leave approved by the Policyholder, on the date the Insured Employee returns to work in any capacity for the Policyholder or any other employer, including self-employment; and

5. with respect to any disability leave approved by the Policyholder, on the date the Insured Employee reaches seventy (70) years of age, qualifies for a waiver of premium or returns to work in any capacity, whichever is earlier.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable at the date of commencement of the leave of the Insured Employee.

EXTENSION OF COVERAGE

Individual coverage will be continued for a period of up to twelve (12) months for an Insured Employee whose employment has been terminated by the Policyholder, provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement received by the Insured Employee from the Policyholder and payment of premium in accordance with the Master Application is continued. Under such conditions, individual coverage for the Insured with respect to the Insured Spouse and/or Insured Dependent Children will also continue, provided payment of the appropriate premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date the Insured Employee returns to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable at the date of termination of employment.

EXCLUSIONS

No indemnity will be paid if a Critical Illness results directly or indirectly from any one or more of the following causes or situations:

1. Within ninety (90) days following the effective date of the Insured's coverage:
    a. Diagnosis of Cancer is made; or
    b. The Insured has any signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made.
2. Within ninety (90) days following the effective date of the Insured's coverage:
    a. Diagnosis of Benign Brain Tumour is made; or
    b. The Insured has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.
3. The Insured does not satisfy the Survival Period limitations.
4. The Insured suffers a self-inflicted injury, Sickness or Disease, whether the Insured was sane or insane at the time of such infliction.
5. The Insured Person has used illicit drugs, or any drug other than as prescribed, recommended or administered by or in accordance with the instruction of a Physician, whether or not such drugs are available only by prescription.
6. The Insured has any cancer that manifests itself prior to the Insured's effective date of individual coverage when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.
7. The Insured operated a motor vehicle while concentration of alcohol in his blood exceeded the applicable legal limit where the events causing the Critical Illness occurred.
8. The Insured committed or attempted to commit a criminal offense or provoked an assault.
9. The Critical Illness results from an abuse of alcohol.
10. The Insured participated in any riot, war or any civil strife.

11. A Pre-existing Condition, except if the Critical Illness being claimed for is Diagnosed at least twenty-four (24) months after the Insured's effective date of coverage and subject to all other provisions of the "Pre-existing Condition Exclusion" section.

PRE-EXISTING CONDITION EXCLUSION

This Pre-existing Condition Exclusion applies to all portions of the Principal Sum that are obtained without evidence of insurability, as well as all Critical Illnesses newly covered without evidence of insurability.

If the Critical Illness Insurance directly replaces one with the insurer or another insurer providing similar benefits and that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy, an Insured who has satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be deemed to have satisfied the time period under the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

An Insured who has not satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be allowed to apply any amount of time satisfied under the Pre-existing Condition Exclusion of the previous policy toward the satisfaction of the time period requirement of the Pre-existing Condition Exclusion of the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy and provided that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

COVERAGE PAYMENT

Monthly premium

Monthly rates for each $ 1,000 of Principal Sum (provincial taxes not included):

	Premium Rates ($)			
	Male		Female	
AGE	Non-Smoker	Smoker	Non-Smoker	Smoker
15-19	$ 0.106	$ 0.122	$ 0.092	$ 0.106
20-24	$ 0.112	$ 0.128	$ 0.087	$ 0.101
25-29	$ 0.152	$ 0.184	$ 0.144	$ 0.178
30-34	$ 0.163	$ 0.207	$ 0.188	$ 0.254
35-39	$ 0.187	$ 0.269	$ 0.224	$ 0.348
40-44	$ 0.263	$ 0.448	$ 0.288	$ 0.532
45-49	$ 0.439	$ 0.889	$ 0.419	$ 0.872
50-54	$ 0.689	$ 1.587	$ 0.570	$ 1.254
55-59	$ 1.181	$ 2.907	$ 0.772	$ 1.664
60-64	$ 2.012	$ 4.869	$ 1.145	$ 2.270
65	$ 2.676	$ 6.479	$ 1.524	$ 3.021
66	$ 2.943	$ 7.127	$ 1.675	$ 3.322
67	$ 3.238	$ 7.840	$ 1.843	$ 3.654
68	$ 3.562	$ 8.625	$ 2.027	$ 4.019
69	$ 3.918	$ 9.487	$ 2.229	$ 4.420

Monthly rate for each $ 1,000 of Principal Sum for Dependent Children (provincial taxes not included): $ 0.547

To calculate your monthly premium or your Spouse's monthly premium, use the table above to find the unit rate that applies (based on age, gender and smoker status). Multiply the unit rate found by the number of $ 1,000 units of principal sum selected.

To calculate your Dependent Child's monthly premium, multiply the unit rate of $ 0.547 by the number of $ 1,000 units of Principal Sum selected for your Dependent Child.

PREMIUM PAYMENT

Premiums for your coverage, your Spouse's coverage and your Dependent Child's coverage, if applicable, are paid by you, using the means of payroll deductions.

LIMITATION OF CONTRACTUAL LIABILITY

If any amendment made to fiscal legislation, to a government plan, to an insurance plan provided for in employee working conditions or to an employer retirement plan has the effect of increasing liability under this benefit, then the provisions of the contract shall continue to apply as though such amendment had not been made, unless the parties expressly agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to the Insurer by the Policyholder. This additional premium shall be equal to the value of the increase in contractual liability.

AREA OF DIAGNOSIS

Should an Insured claim for a Critical Illness which occurred or was diagnosed outside of Canada or the United States, such Insured may be eligible to receive indemnity under this section upon that person's return to Canada. Prior to determining eligibility, however, the Insurer will have the right to require that the Insured obtain, on his return to Canada, a Diagnosis by a Physician in Canada.

CLAIMS PROVISIONS

Notice of Claim Written notice of Critical Illness on which claim is based must be given to the Insurer within thirty (30) days after the date of the Diagnosis resulting in such Critical Illness. Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled the indemnity under the Policy, as the case may be, to the Insurer at 1200, Papineau Avenue, Suite 460, Montreal (Quebec), H2K 4R5, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose Critical Illness is the basis of such notice. Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Claim Forms The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of Critical Illness. If such forms are not so furnished within fifteen (15) days after the Insurer's receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such Critical Illness upon submitting, within the time fixed in the Policy for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim is made.

Proof of Critical Illness Written proof of Critical Illness must be furnished to the Insurer within ninety (90) days after the date of Diagnosis resulting in such Critical Illness. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Physical Examination and Autopsy The Insurer will have the right and opportunity to confirm the Diagnosis at its own expense by appointing a medical practitioner to examine the Insured whose Critical Illness is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims All indemnities provided in the Policy for Critical Illness will be paid after customary proof of Critical Illness satisfactory to the Insurer has been given in accordance with the requirements of the Policy. All moneys payable under the Policy are payable in the lawful money of Canada.

RE-ENTRY EXCLUSIONS APPENDIX

This appendix provides for all Critical Illnesses that may be included in all of the Insurer's Critical Illness insurance packages so that the policyholder and the participants are informed that these exclusions shall continue to apply even when the policyholder or participant has chosen any new Critical Illness insurance package offered by the Insurer. Please refer to the provisions of the Critical Illness benefit to know what Critical Illnesses and Surgeries are actually covered under your policy.

After benefit has been claimed and adjudicated as payable for an individual other than a child with respect to a first event mentioned in the columns at the right of this schedule, no benefits can be paid for the same individual with respect to subsequent events mentioned on the lines of the left column hereunder, if the cell they have in common is marked with an X. Also, for an event to give rise to benefits, it must be included in the list of Covered Illnesses of the Insured's coverage or under the "Complementary Benefit in Case of Certain Illnesses" section, if any.

After benefit has been claimed and adjudicated as payable for a child with respect to a covered event, no benefits can be paid for the same child with respect to any subsequent event.

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Aortic surgery	Aplastic anemia	Bacterial meningitis	Benign brain tumour	Blindness	Cancer (life threatening)	Coma
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia		X				X	
Bacterial meningitis			X	X			
Benign brain tumour				X			
Blindness			X	X	X		X
Cancer (life threatening)		X				X *	
Coma	X		X	X			X
Coronary angioplasty	X						
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery							
Deafness			X	X			X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast		X				X	
Fulminant viral hepatitis							
Heart attack	X						
Heart valve replacement or repair	X						
Hip replacement surgery							
Kidney failure	X						
Knee replacement surgery							
Liver failure of advanced stage	X					X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech			X	X			X
Major organ failure on waiting list	X						
Major organ transplant	X						
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis			X	X			X
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X				X	
Stage A (T1a or T1B) prostate cancer		X				X	
Stroke	X		X	X			X
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Coronary angioplasty	Coronary artery bypass surgery	Crohn's disease requiring surgery	Deafness	Dementia, including Alzheimer's disease	Dilated cardiomyopathy	Ductal carcinoma in situ of the breast
No claim can be paid for this subsequent event							
Aortic surgery		X				X	
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							
Cancer (life threatening)							
Coma		X				X	
Coronary angioplasty	X	X				X	X
Coronary artery bypass surgery		X				X	
Crohn's disease requiring surgery			X				
Deafness				X			
Dementia, including Alzheimer's disease		X			X	X	
Dilated cardiomyopathy						X	
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis							
Heart attack		X				X	
Heart valve replacement or repair		X				X	
Hip replacement surgery							
Kidney failure		X	X			X	
Knee replacement surgery							
Liver failure of advanced stage		X	X			X	
Loss of independent existence		X	X	X	X	X	
Loss of limbs							
Loss of speech							
Major organ failure on waiting list		X	X			X	
Major organ transplant		X	X			X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis							
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis			X				
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X				X	
Systemic lupus erythematosus			X				

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Fulminant viral hepatitis	Heart attack	Heart valve replacement or repair	Hip replacement surgery	Kidney failure	Knee replacement surgery	Liver failure of advanced stage
No claim can be paid for this subsequent event							
Aortic surgery		X	X				X
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							X
Cancer (life threatening)	X						X
Coma		X	X		X		X
Coronary angioplasty		X	X				X
Coronary artery bypass surgery		X	X				X
Crohn's disease requiring surgery					X		
Deafness							
Dementia, including Alzheimer's disease		X	X				
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis	X						
Heart attack		X	X		X		X
Heart valve replacement or repair		X	X				
Hip replacement surgery				X		X	
Kidney failure		X	X		X		X
Knee replacement surgery				X		X	
Liver failure of advanced stage	X	X	X		X		X
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech							
Major organ failure on waiting list	X	X	X		X		X
Major organ transplant	X	X	X		X		X
Motor neuron disease							
Multiple sclerosis							X
Muscular dystrophy							
Occupational HIV infection							
Paralysis							X
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							X
Severe burns							
Severe rheumatoid arthritis				X	X	X	
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X	X		X		X
Systemic lupus erythematosus					X		

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Loss of independent existence	Loss of limbs	Loss of speech	Major organ failure on waiting list	Major organ transplant	Motor neuron disease	Multiple sclerosis
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia	X			X	X		
Bacterial meningitis	X						
Benign brain tumour	X						
Blindness	X					X	X
Cancer (life threatening)	X			X	X		
Coma	X			X	X	X	X
Coronary angioplasty							
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery	X						
Deafness	X					X	X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy	X						
Ductal carcinoma in situ of the breast				X	X		
Fulminant viral hepatitis	X						
Heart attack	X			X	X	X	
Heart valve replacement or repair	X						
Hip replacement surgery	X						
Kidney failure	X			X	X		X
Knee replacement surgery	X						
Liver failure of advanced stage	X			X	X		
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs	X	X					
Loss of speech	X		X			X	X
Major organ failure on waiting list	X			X	X		
Major organ transplant	X			X	X		
Motor neuron disease	X					X	
Multiple sclerosis	X						X
Muscular dystrophy	X						
Occupational HIV infection	X						
Paralysis	X					X	X
Parkinson's disease and SAPD	X						
Primary pulmonary hypertension	X						
Progressive systemic sclerosis	X						
Severe burns	X						
Severe rheumatoid arthritis	X						
Stage 1A malignant melanoma				X	X		
Stage A (T1a or T1B) prostate cancer				X	X		
Stroke	X			X	X	X	X
Systemic lupus erythematosus	X						

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Muscular dystrophy	Occupational HIV infection	Paralysis	Parkinson's disease and SAPD	Primary pulmonary hypertension	Progressive systemic sclerosis	Severe burns
No claim can be paid for this subsequent event							
Aortic surgery					X		
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness	X	X					
Cancer (life threatening)		X					
Coma	X	X	X	X	X	X	
Coronary angioplasty							
Coronary artery bypass surgery					X		
Crohn's disease requiring surgery							
Deafness	X	X					
Dementia, including Alzheimer's disease							
Dilated cardiomyopathy	X				X		
Ductal carcinoma in situ of the breast		X					
Fulminant viral hepatitis							
Heart attack	X				X	X	
Heart valve replacement or repair	X				X		
Hip replacement surgery							
Kidney failure	X	X			X	X	
Knee replacement surgery							
Liver failure of advanced stage	X	X				X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech	X	X	X	X			
Major organ failure on waiting list	X				X	X	
Major organ transplant	X				X	X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy	X						
Occupational HIV infection		X					
Paralysis	X	X	X	X			X
Parkinson's disease and SAPD				X			
Primary pulmonary hypertension					X		
Progressive systemic sclerosis						X	
Severe burns							X
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X					
Stage A (T1a or T1B) prostate cancer		X					
Stroke	X	X			X	X	
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event				
	Severe rheumatoid arthritis	Stage 1A malignant melanoma	Stage A (T1a or T1B) prostate cancer	Stroke	Systemic lupus erythematosus
No claim can be paid for this subsequent event					
Aortic surgery				X	
Aplastic anemia					
Bacterial meningitis					
Benign brain tumour					
Blindness					
Cancer (life threatening)					
Coma				X	
Coronary angioplasty		X	X	X	
Coronary artery bypass surgery				X	
Crohn's disease requiring surgery	X				X
Deafness					
Dementia, including Alzheimer's disease				X	
Dilated cardiomyopathy					
Ductal carcinoma in situ of the breast		X	X		
Fulminant viral hepatitis					
Heart attack				X	
Heart valve replacement or repair				X	
Hip replacement surgery	X				
Kidney failure	X			X	X
Knee replacement surgery	X				
Liver failure of advanced stage	X			X	X
Loss of independent existence	X			X	X
Loss of limbs					
Loss of speech					
Major organ failure on waiting list	X			X	X
Major organ transplant	X			X	X
Motor neuron disease					
Multiple sclerosis					
Muscular dystrophy					
Occupational HIV infection					
Paralysis					
Parkinson's disease and SAPD					
Primary pulmonary hypertension					X
Progressive systemic sclerosis					
Severe burns					
Severe rheumatoid arthritis	X				X
Stage 1A malignant melanoma		X	X		
Stage A (T1a or T1B) prostate cancer		X	X		
Stroke				X	X
Systemic lupus erythematosus	X				X

* Following a life threatening Cancer claim, the Insured cannot claim again for Cancer, except for plans with a "Cancer Recurrence Benefit" section, when all of its requirements have been met.