CRITICAL ILLNESS BENEFIT:
Definitions & Exclusions

BASIC & VOLUNTARY:
PARTICIPANT AND SPOUSAL
CRITICAL ILLNESS BENEFIT

Definitions

As used in this Benefit:

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

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

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

"Aplastic anemia" 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.

The Diagnosis of aplastic anemia must be made by a Specialist.

"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 90 days from the date of Diagnosis. The Diagnosis of bacterial meningitis must be made by a Specialist.

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

"Benign brain tumour" 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). The Diagnosis of benign brain tumour must be made by a Specialist.

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

Moratorium Period Exclusion

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

- the effective date of the policy; or

- the effective date of last reinstatement of the policy,

the Insured Person has any of the following:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour, regardless of when the Diagnosis is made; or
- a Diagnosis of benign brain tumour.

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, the Insurer has the right to deny any claim for benign brain tumour or, any Critical Illness caused by any benign brain tumour or its treatment.

"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" (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 Diagnosis of cancer must be made by a Specialist.

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

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

Moratorium Period Exclusion

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

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

the Insured Person has any of the following:

- signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the policy), regardless of when the Diagnosis is made; or
- a Diagnosis of cancer (covered or excluded under the policy).

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, the Insurer has the right to deny any claim for cancer or, any Critical Illness caused by any cancer or its treatment.

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

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

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

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

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

"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 made by a Specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least 3 months.

NYHA 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 nonprescription drug use) of dilated cardiomyopathy.

"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.

The Diagnosis of fulminant viral hepatitis must be made by a Specialist.

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.

The Diagnosis of heart attack must be made by a Specialist.

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

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

"Kidney failure" means a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of kidney failure must be made by a Specialist.

"Loss of independent existence" means a definite Diagnosis of:
(a) a total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living; or
(b) Cognitive Impairment, as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery.

The Diagnosis of loss of independent existence must be made by a Specialist.

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

"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. The Diagnosis of loss of limbs must be made by a Specialist.

"Loss of speech" means a definite Diagnosis of the total and Irreversible loss of the ability to speak as 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" 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. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

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

"Motor neuron disease" means a 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,

and limited to these conditions.

The Diagnosis of motor neuron disease must be made by a Specialist.

"Multiple sclerosis" means a definite Diagnosis of at least one (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.

The Diagnosis of multiple sclerosis must be made by a Specialist.

"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.

The Diagnosis of muscular dystrophy must be made by a Specialist.

"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 effective date of the coverage, or the effective date of last reinstatement of the policy.

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

(a) The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;
(b) A serum HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative;
(c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
(d) All HIV tests must be performed by a duly licensed laboratory in Canada or United States;
(e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The Diagnosis of occupational HIV infection must be made by a Specialist.

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

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

"Paralysis" means a definite Diagnosis of the total loss of muscle function of two (2) 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" means a definite Diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of
two (2) or more of the following clinical manifestations:

- muscle rigidity;
- tremor; or
- bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

The Diagnosis of Parkinson's disease must be made by a Specialist.

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

"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 Diagnosis of primary pulmonary hypertension must be made by a Specialist.

The NYHA 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 all other types of pulmonary arterial hypertension.

"Severe burns" mean a definite Diagnosis of third (3rd) degree burns over at least 20% of the body surface. The Diagnosis of severe burns must be made by a Specialist.

"Stroke" (cerebrovascular accident) 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. The Diagnosis of stroke must be made by a Specialist.

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

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma; or

lacunar infarcts which do not meet the definition of stroke as described above.

Payment of benefit

Upon receipt of Proof of Claim satisfactory to the Insurer confirming

1. that a Physician, specialized in the appropriate field and licensed to practise in Canada, has diagnosed a Participant as having one of the illnesses listed in the ELIGIBLE CRITICAL ILLNESS BENEFIT SCHEDULE;
2. that the Participant survived for at least 30 days after the date the diagnosis was made by a licensed Physician;
3. in the event that the Participant has cancer, including benign Brain tumour:
    i. that the medical symptoms or problems that gave rise to the diagnosis of that cancer appeared at least 90 days after coverage took effect or was reinstated, or
    ii. that the cancer was diagnosed by a Physician at least 90 days after coverage took effect or was reinstated.

The Participant may only make one claim for only one Critical Illness under this Benefit.

Eligible critical illness benefit schedule

The amount payable is $10,000.

Restrictions, exclusions and limitations

1. No benefit is payable for any Critical Illness resulting directly or indirectly from any of the following:
    i. intentionally self-inflicted injury, voluntary exposure to an Illness or attempted suicide while sane or insane;
    ii. war, whether war be declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
    iii. committing, or attempting to commit a criminal offence;
    iv. alcohol abuse;
    v. the use of any medication, narcotic, intoxicant or any other harmful substance, except when prescribed or recommended by a Physician.
2. No benefit is payable for the following:
    i. an Illness or pre-existing condition for which the Participant has received care, treatment or services, consulted a Physician or taken medication that was prescribed to him, in the 24 months prior to the effective date of coverage, unless the Illness in question was diagnosed at least 24 months after the effective date of the insurance of the Participant, subject to other applicable provisions of this policy;
    ii. paralysis, paraplegia, hemiplegia or quadriplegia resulting directly or indirectly from the practice of one or more of the following activities: amateur or professional boxing, bungee jumping, cliff diving, mountain climbing, car racing or speed races on land or water, parachuting or underwater activities;
    iii. transient cerebral ischemia;
    iv. all types of parkinsonism other than idiopathic and degenerative Parkinson's disease;

v. non-surgical techniques, such as balloon angioplasty or the correction of an occlusion using laser treatment or any other non-bypass technique;

vi. organic brain syndromes and psychiatric disorders other than Alzheimer's disease.

vii. lesser acute coronary syndromes including unstable angina and acute coronary insufficiency.

Restrictions, exclusions and limitations related to cancer diagnosis

This Benefit does not apply when cancer is diagnosed within 90 days of the effective date of coverage or reinstatement or when the medical symptoms or problems giving rise to the diagnosis of cancer appeared during this initial 90-day period.

In addition, no benefit is payable for the following forms of cancer:

1. early prostate cancer, diagnosed as T1A N0 M0 and T1B N0M0 or equivalent staging;
2. non-invasive cancer in situ;
3. precancerous lesions, benign tumours or polyps;
4. any tumour that develops in a person who is HIV seropositive;
5. any skin cancer other than invasive malignant melanoma greater than 0.75 mm.

Restrictions, exclusions and limitations related to diagnosis of HIV infection

Benefits are payable provided that the following conditions are met:

1. the Insured Person (or the Policyholder) must inform the Insurer of any Accident or injury that could result in HIV infection within 14 days of the event;
2. within 14 days of the Accident or injury, the Insured Person must undergo blood tests confirming that he is HIV seronegative; and
3. an HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
4. the accidental injury must have been reported, investigated and documented in accordance with workplace legislation and regulations.

The Insurer may require that all blood samples taken be provided so they can be analyzed by an independent lab, and may request any other blood test that it deems appropriate.

If an HIV vaccine becomes available, no benefits will be paid to an Insured Person who has an Accident or is injured on the job and who previously refused to be vaccinated. In addition, no benefits will be payable if a cure for HIV became available prior to the Accident or injury giving rise to the claim. HIV infections resulting from any cause not related to the Insured Person's work, such as sexual activity or drug use, are not covered under this Benefit.

Geographic limitations

If an eligible Critical Illness is diagnosed outside Canada following an Accident or Illness, the Insurer will only assess the claim once the Participant, having returned to Canada, has obtained an assessment of the diagnosis made previously and has received medical care.

Notice and proof of claim

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of the relevant Illness and of the Participant's eligibility for benefits at the time the diagnosis was made.

A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

The Insurer reserves the right to verify the diagnosis with the attending Physician(s) and to require any Participant who has submitted a claim to be examined at the Insurer's expense.

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PROOF OF CLAIM RELATED TO AN ACCIDENT OR INJURY THAT MAY RESULT IN HIV INFECTION

A written notice of claim must be submitted to the Insurer within 14 days of the Accident or injury.

The Insured Person (or the Policyholder) must notify the Insurer of the Accident or injury, which will then be investigated and a report produced in accordance with the established procedures for the occupation in question.

CHILDREN CRITICAL ILLNESS BENEFIT

Definitions

As used in this Benefit :

Child means a person who:

1) is under 21 years of Age, and for whom the Participant or the Spouse of the Participant has legal guardianship or had legal guardianship until he reached the Age of majority; or

2) has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant would have legal guardianship if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would have legal guardianship of him as if he were a minor. It is also understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

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

"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). The Diagnosis of benign brain tumour must be made by a Specialist.

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

Moratorium Period Exclusion

No benefit will be payable under this condition if:
Within the first 90 days following the later of:
- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the Insured Person has any of the following:
- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour, regardless of when the Diagnosis is made; or
- a Diagnosis of benign brain tumour.

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, the Insurer has the right to deny any claim for benign brain tumour or, any Critical Illness caused by any benign brain tumour or its treatment.

"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" (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 Diagnosis of cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:
- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion

No benefit will be payable under this condition if:
Within the first 90 days following the later of:
- the effective date of the policy; or
- the effective date of last reinstatement of the policy,

the Insured Person has any of the following:
- signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the policy), regardless of when the Diagnosis is made; or
- a Diagnosis of cancer (covered or excluded under the policy).

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, the Insurer has the right to deny any claim for cancer or, any Critical Illness caused by any cancer or its treatment.

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

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

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

"Heart valve replacement" means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve. The Surgery must be determined to be medically necessary by a Specialist.

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

"Kidney failure" 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 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. The Diagnosis of loss of limbs must be made by a Specialist.

"Loss of speech" means a definite Diagnosis of the total and Irreversible loss of the ability to speak as 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" 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. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

"Major organ transplant" 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.

"Severe burns" mean a definite Diagnosis of third (3^{rd}) degree burns over at least 20% of the body surface. The Diagnosis of severe burns must be made by a Specialist.

"Cerebral palsy" means a chronic disorder, diagnosed by a licensed specialist physician, 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.

"Congenital heart disease requiring surgery" means any serious cardiac malformation present at birth, diagnosed by a licensed specialist physician, for which corrective surgery has been performed.

"Cystic fibrosis" means a genetic disease, diagnosed by a licensed specialist physician, 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.

"Down's syndrome" means a congenital condition, diagnosed by a licensed specialist physician, 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.

"Serious cerebral lesion" means any lesion, diagnosed by a Physician, that is characterized by an invasive development problem or serious intellectual deficiency, that prevents an individual from performing the basic activities of daily living and requires professional specialized services for his treatment, rehabilitation, re-education or schooling on a daily basis.

"Serious mental deficiency" means a deficiency which, when evaluated through standard testing, demonstrates that an individual has an IQ of under 70.

"Spina bifida cystica" means a congenital defect, diagnosed by a licensed specialist physician, 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: hydrocephalus, paralysis, bowel, and bladder problems.

Payment of benefit

Upon receipt of Proof of Claim satisfactory to the Insurer confirming

1. that a Physician, specialized in the appropriate field and licensed to practice in Canada, has diagnosed an Insured Person as having one of the illnesses listed in the ELIGIBLE CRITICAL ILLNESS BENEFIT SCHEDULE;
2. that the Insured Person survived for at least 30 days after the date the diagnosis was made by a Physician;
3. in the event that the Insured Person has cancer:
    i. that the medical symptoms or problems that gave rise to the diagnosis of that cancer appeared at least 90 days after coverage took effect or was reinstated, or
    ii. that the cancer was diagnosed by a licensed Physician at least 90 days after coverage took effect or was reinstated,

The Insured Person may only make one claim for only one Critical Illness under this Benefit.

Eligible critical illness benefit schedule

The amount payable is $5,000.

Restrictions, exclusions and limitations

1. No benefit is payable for any Critical Illness resulting directly or indirectly from any of the following:
    i. intentionally self-inflicted injury, voluntary exposure to an Illness or attempted suicide while sane or insane;
    ii. war, whether war be declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
    iii. committing, or attempting to commit a criminal offence;
    iv. alcohol abuse;
    v. the use of any medication, narcotic, intoxicant or any other harmful substance, except when prescribed or recommended by a Physician.

2. No benefit is payable for the following:
    i. an Illness or pre-existing condition for which the Insured Person received care, treatment or services, consulted a Physician or taken medication that was prescribed to him, in the 24 months prior to the effective date of coverage, unless the Illness in question was diagnosed at least 24 months after the effective date of the insurance of the Insured Person, subject to other applicable provisions of this policy;
    ii. paralysis, paraplegia, hemiplegia or quadriplegia resulting directly or indirectly from the practice of one or more of the following activities: amateur or professional boxing, bungee jumping, cliff diving, mountain climbing, car racing or speed races on land or water, parachuting or underwater activities;
    iii. transient cerebral ischemia;

iv. Spina-bifida occulta;

v. non-surgical techniques, such as balloon angioplasty or the correction of an occlusion using laser treatment or any other non-bypass technique;

Restrictions, exclusions and limitations related to cancer diagnosis

This Benefit does not apply when cancer is diagnosed within 90 days of the effective date of coverage or reinstatement or when the medical symptoms or problems giving rise to the diagnosis of cancer appeared during this initial 90-day period.

In addition, no benefit is payable for the following forms of cancer:

1. early prostate cancer, diagnosed as T1A N0 M0 and T1B N0M0 or equivalent staging;
2. non-invasive cancer in situ;
3. precancerous lesions, benign tumours or polyps;
4. any tumour that develops in a person who is HIV seropositive;
5. any skin cancer other than invasive malignant melanoma greater than 0.75 mm.

The Insurer may require that all blood samples taken be provided so they can be analyzed by an independent lab, and may request any other blood test that it deems appropriate.

Geographic limitations

If an eligible Critical Illness is diagnosed outside Canada following an Accident or Illness, the Insurer will only assess the claim once the Insured Person, having returned to Canada, has obtained an assessment of the diagnosis made previously and has received medical care.

The insurance of an Insured Person terminates the date on which the Insurer pays the amount applicable to one of the eligible Critical Illnesses under this Benefit. No further premium is required.

Notice and proof of claim

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of the relevant Illness and of the Insured Person's eligibility for benefits at the time the diagnosis was made.

A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

PROOF OF CLAIM RELATED TO AN ACCIDENT OR INJURY THAT MAY RESULT IN HIV INFECTION

A written notice of claim must be submitted to the Insurer within 14 days of the Accident or injury.

The Insured Person (or the Policyholder) must notify the Insurer of the Accident or injury, which will then be investigated and a report produced in accordance with the established procedures for the occupation in question.