Manulife

LivingCare

Sample contract

This sample policy contract is provided for your information only.
It is not a valid contract or an offer of insurance.

1 Table of contents

2 Understanding your policy

Your LivingCare policy document is an important part of the legal contract between you and us. We ask that you read it carefully to ensure that it gives you the coverage you applied for.

What if your address changes?

Please advise us of changes in your address so that you can receive information from us about your policy. You can use our address and phone number information (shown in the section called *How does your policy work*? and on your policy statement) to contact us.

How do we use specific terms in this policy?

In this policy, we use many terms in a specific way. Words and phrases that have a specific meaning in the context of your LivingCare insurance policy are defined in the section called *Words and phrases used in this policy document*.

In this policy:

- *You* and *your* refer to the owner(s) of the policy.
- *We*, *us*, and *our* refer to The Manufacturers Life Insurance Company.

How does your policy work?

When you bought this LivingCare policy, we agreed to provide long term care insurance according to the terms of this policy document as long as you pay your premiums.

Here is how your policy works:

- You mail or deliver payments to us, or arrange to transfer payments to us from your bank account. The amount of the payments is shown in the section called *Policy summary*.
- If you do not pay your premiums, you have a 31-day grace period to pay the overdue amount to keep your policy in effect.
- You may have purchased additional insurance coverages and benefits through riders offered with this policy. All of your insurance coverage, including the additional coverage provided by riders, is summarized in the section called *Policy summary*.
- You, or the insured person, or a friend or relative notify us within 30 days of noticing that a person insured under this policy appears to be functionally dependent. Call our customer service centre, which is shown on page 3.1, or email us at CC_987@manulife.com.
- After you contact us, we will do a face-to-face assessment and review other information to determine if the insured person is functionally dependent. We describe how we determine if a person is functionally dependent in the section called *How do we determine if the insured person is functionally dependent?*.
- When we determine that an insured person is functionally dependent, has satisfied the Waiting Period and met all other conditions of this policy, we will pay a Care Benefit as shown in the section called *Policy summary*. Unless you, the owner, have instructed us otherwise, we will pay the Care Benefit to the insured person.
- While the insured person is functionally dependent, we will pay a Care Benefit every month until the coverage ends.

4 LivingCare benefits

What is the Care Benefit?

The Care Benefit is an amount that is payable for each month that the insured person is functionally dependent.

We will pay a Care Benefit when all of these four conditions are met:

1 We determine that the insured person is functionally dependent.
2 The insured person becomes functionally dependent on or after the Coverage Date.
3 The insured person is functionally dependent for a number of days equal to the Waiting Period.
4 The insurance coverage is in effect on the last day of the Waiting Period.

How do we determine if the insured person is functionally dependent?

You, or the insured person, or a friend or relative should notify us within 30 days of noticing that the insured person appears to be functionally dependent. We will arrange for an initial assessment to help us determine if the insured person is functionally dependent.

An initial assessment is a face-to-face evaluation done where the insured person is residing by a Care Advisor appointed by us.

The Care Advisor will assist us in determining:

- the insured person's ability to do the Activities of Daily Living, and/or
- if the insured person has a cognitive impairment.

The Care Advisor will assess any factors that are relevant to the insured person's situation. These may include:

- functional, cognitive, behavioural and emotional well-being
- family support, and
- the safety of their environment.

In their assessment, the Care Advisor will use professionally accepted tests that provide objective measures and produce verifiable results.

We may also require other proof including, but not limited to, hospital or facility records, information from government agencies or medical reports. We may require that the insured person be examined by a health care professional designated by us at our expense.

We will need you and the insured person to co-operate, be available, and to provide the information we need to review and make a decision on the claim. If you or the insured person do not co-operate, we will not proceed with the claim.

When is an insured person functionally dependent?

The insured person is functionally dependent when we determine that, even with the use of medications, assistive devices, appliances, or other aids:

- the insured person cannot do two or more of the Activities of Daily Living without substantial assistance from another person, or
- due to a cognitive impairment, the insured person needs substantial supervision to protect themselves from threats to their health or safety.

To be considered functionally dependent, the insured person must also:

- be under the regular care of a physician
- follow recommended treatments, and
- use assistive devices that are appropriate for the conditions causing them to be functionally dependent.

What are the Activities of Daily Living?

The Activities of Daily Living are specific basic daily tasks that the insured person needs to be able to do to maintain their own health and safety. The Activities of Daily Living are:

Bathing which means washing their body in a bathtub (including getting into or out of the bathtub), or in a shower (including getting into or out of the shower), or by a sponge bath. Bathing does not include the insured person's ability to wash their hair or to reach their back or feet.

Eating which means feeding themselves from a cup, bowl or plate, or by a feeding tube. Eating does not include preparing or serving their meals.

Dressing which means putting on and taking off all necessary items of clothing and any medically necessary braces, surgical appliances or artificial limbs. A "necessary item of clothing" is any item of clothing that can be made, purchased, or purchased and altered and that is reasonable for the insured person's health, comfort and dignity in the environment in which they normally live.

Toileting which means getting to and from, and on and off the toilet, and performing the associated personal hygiene.

Transferring which means moving into or out of a bed, chair or wheelchair.

Maintaining continence which means controlling their bowel and bladder function or, if they cannot maintain control, performing the associated personal hygiene (including the use of incontinence products and caring for a catheter or colostomy bag).

What is substantial assistance?

If an insured person needs substantial assistance to perform the Activities of Daily Living, this means they usually and regularly need either hands-on physical assistance or stand-by assistance from another person.

Substantial assistance means either:

- Hands-on physical assistance from another person or
- Stand-by assistance, which means the presence of another person within arm's reach who will physically intervene to prevent the insured person from being injured. For example, a person providing stand-by assistance would be ready to catch a person who fell while getting into or out of the bathtub or shower, or would be ready to remove food from a person's throat if they choked while eating.

What is substantial supervision?

If an insured person needs substantial supervision, this means they need continual supervision by a responsible adult. This person must be willing and able to take the actions or provide the directions needed to protect the insured person from threats to their health or safety.

What is a cognitive impairment?

A cognitive impairment is a loss of, or deterioration in, intellectual capacity. The insured person's loss or deterioration must meet these three conditions:

1 It must be comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia or the result of severe brain injury.
2 It must be demonstrated by impairment in:
   a short-term or long-term memory
   b orientation as to people, places, or time
   c deductive or abstract reasoning, or
   d judgment as it relates to the insured person's awareness of their own safety and the safety of others.
3 It must be confirmed and measured by clinical evidence and standardized tests.

Exclusion

A cognitive impairment does not include any mental or nervous disorder, including but not limited to anxiety disorders, mood disorders, sleep disorders, pain disorders, personality disorders and psychotic disorders.

What is the Waiting Period?

The insured person must be functionally dependent for a number of days equal to the Waiting Period before they are eligible to receive a Care Benefit. The Waiting Period you selected is shown in the section called *Policy summary*.

When does the Waiting Period start?

The Waiting Period starts on the day of the assessment that leads to our decision that the insured person is functionally dependent. For this reason, we should be notified as soon as possible (and not later than 30 days) after you notice the insured person appears to be functionally dependent.

If we determine that we cannot perform an assessment promptly because of the insured person's health, the Waiting Period will begin on the date of a major health event (such as a stroke, accident, or admittance to a hospital for a prolonged stay). We must have documented medical evidence of that event which we will use to determine if the insured person is functionally dependent.

To satisfy the Waiting Period, the insured person must be functionally dependent for the number of days shown in the section called Policy summary. These days can be either

- consecutive or
- inconsecutive, as long as each day that the insured person is functionally dependent is separated by 180 days or less, and is a result of the same or a related cause.

What is the Waiting Period on subsequent claims?

If we have stopped paying a Care Benefit because the insured person was no longer eligible, and if we determine that the insured person is functionally dependent again:

- less than 180 calendar days after we stopped paying a Care Benefit for the previous period when they were functionally dependent, and
- from the same or related cause as the previous period when they were functionally dependent

then the insured person will not have to satisfy another Waiting Period. We will consider the subsequent period when the insured person is functionally dependent to be a continuation of the previous claim.

If we have stopped paying a Care Benefit because the insured person was no longer eligible, and if we determine that the insured person is functionally dependent again either:

- 180 calendar days or more after we stopped paying a Care Benefit for the previous period when they were functionally dependent, or
- from a new or different cause than the previous period when they were functionally dependent

then the insured person will need to satisfy a new Waiting Period. We will consider the subsequent period when the insured person is functionally dependent to be a new claim.

How do we determine the Care Benefit?

The amount of the Care Benefit depends on the Amount of Insurance, the Benefit Option (both shown in the section called *Policy summary*) and the Care Setting. The two kinds of Care Settings are:

"Not a Facility" Care Setting

We will use "Not a Facility" for the Care Setting if the insured person is functionally dependent and is residing:

- in a private residence
- in a hospital (except in the specific circumstances described below)
- in a facility that is used primarily for acute medical care, training or education, the treatment of alcoholism or chemical dependency or the treatment of mental or nervous disorders, or
- in any location other than a long term care facility as defined in the section called *What is a long term care facility?*.

"Facility" Care Setting

We will use "Facility" for the Care Setting if the insured person is functionally dependent and is residing in a long term care facility as defined in the section called *What is a long term care facility?*. We will require proof that is satisfactory to us that the insured person is residing in a long term care facility.

We will also use "Facility" for the Care Setting if the insured person is functionally dependent and is:

- temporarily staying in a hospital at their own expense because they require care in a long term care facility and are waiting until those arrangements can be made, or
- temporarily staying in a hospital while they are eligible for a Care Benefit at the Care Setting of "Facility".

What is a long term care facility?

A long term care facility means a place of care in Canada or the continental United States (including Alaska) and Hawaii. That place of care must meet these three requirements:

1 Offer services performed by or continually supervised by a physician or registered nurse on-site 24 hours a day. The physician or nurse must be licensed in Canada or the United States.

or

Offer 24-hour on-site staff to provide custodial care to multiple residents, with established procedures for obtaining appropriate aid in the event of a medical emergency.

2 Maintain a daily record of care for each patient.

3 Administer a planned program of observation and treatment that meets existing standards of medical practice for the functional dependence causing the insured person's stay at that place of care.

How are Care Benefits paid?

We will determine the Care Benefit based on the number of days that the insured person was functionally dependent and resided in either the "Facility" or "Not a Facility" Care Setting during that month.

We pay Care Benefits once a month.

Unless you have instructed us otherwise, we pay the Care Benefit to the insured person.

While we are paying a Care Benefit, we have the right to require additional assessments or other proof that the insured person is still functionally dependent, when and as often as we require. We will need you and the insured person to co-operate, be available and provide the information we need to review and make a decision on the claim. If you and the insured person do not co-operate, we will stop paying the Care Benefit.

What is the Benefit Balance?

The Benefit Balance is the amount that remains available to pay a Care Benefit under your insurance coverage. We will show the Benefit Balance for each insurance coverage or each set of Shared insurance coverages on your policy statement.

Benefit Balance for Individual insurance coverage

On the Coverage Date, the Benefit Balance for an Individual insurance coverage is equal to the Amount of Insurance. The Benefit Balance will be reduced by each Care Benefit that we pay after the Coverage Date.

Benefit Balance for Shared insurance coverages

On the Coverage Date, the Benefit Balance for Shared insurance coverages is equal to the Amount of Insurance shared by those coverages. The Benefit Balance will be reduced by each Care Benefit that we pay under either of the Shared insurance coverages.

For example: On the day that an insurance coverage is issued (the Coverage Date), the total Benefit Balance for Shared insurance coverages 9098 (insuring Person A) and 9099 (insuring Person B) is $100,000. This is equal to the Amount of Insurance that shows on both Shared insurance coverages 9098 and 9099. Any Care Benefit paid for Person A and any Care Benefit paid for Person B will be deducted from that Benefit Balance. The maximum amount of Care Benefits we will pay under the Shared insurance coverages 9098 and 9099 will be $100,000 in total.

(The coverage numbers, Amount of Insurance and Benefit Balance in this example are for illustration purposes only. They do not reflect the amounts or insurance coverages that apply to this policy.)

What happens to the Benefit Balance if you make changes to your insurance coverages?

If you make a change that results in a decrease in the Amount of Insurance for an insurance coverage, we will also decrease the Benefit Balance for that coverage. The decrease in the Benefit Balance will be in the same proportion as the decrease in your Amount of Insurance.

What happens when the Benefit Balance is $0?

For an Individual insurance coverage, your insurance coverage ends on the day that the Benefit Balance for that coverage is reduced to $0.

For Shared insurance coverages, both of the Shared insurance coverages will end on the day that the Benefit Balance for those Shared insurance coverages is reduced to $0.

What are Care Support Services?

Care Support Services are also available to you as a benefit of this policy.

While the insured person is functionally dependent, you can use the services of the Care Advisor once every 12 months. The Care Advisor will help you understand the long term care services in your area that could be available for the insured person. The Care Advisor will prepare written recommendations about the type, frequency and duration of long term care services that could benefit the insured person's health and safety.

The Care Advisor can also:

- help you secure recommended care services in your area
- prepare a list of local providers, community programs and health information resources, and explain the costs of any of these services
- review the care the insured person is receiving, and suggest changes or additions that could improve the insured person's health or safety, and
- arrange for necessary changes in the services the insured person is receiving.

We will pay the entire cost of services provided as Care Support Services, but we reserve the right to put reasonable limits on the amount of Care Support Services time available to you and the insured person.

If your policy is expected to terminate within three months because the Benefit Balance will be $0, you can ask us to have the Care Advisor conduct one final review of the care the insured person is receiving and make written recommendations about the services that will be needed.

What services are not Care Support Services?

We will not pay for the costs of other advisors or service providers you may use, or for the cost of any of the services, treatments or assistive devices recommended by the Care Advisor that you choose to implement.

5 Managing your policy

What are premium payments?

The premiums required for your insurance and rider coverages are shown in the section called *Policy summary*.

When can we change premiums?

The premiums shown in the section called *Policy summary* will not change before the fifth coverage anniversary unless you make a change to your coverage.

On and after the fifth coverage anniversary, we can change the premiums for an insurance coverage on each coverage anniversary.

We cannot change the premium for an insurance coverage after the later of these dates:

- the coverage anniversary nearest the insured person's 75th birthday, and
- the 20th anniversary of that coverage

We will only change your premiums to reflect changes in our cost of providing long term care insurance, and only if we change the premiums on all similar insurance coverages with us. This means we cannot single out any insured person's coverage for an increase because of any change in the insured person's health or functional ability. We cannot change any other provisions of this policy without your consent.

How to make payments

You can choose to make payments monthly, quarterly, semi-annually or annually, subject to our administrative rules in effect at the time.

If you pay monthly, you must arrange for us to make automatic monthly withdrawals from a bank account. If you pay quarterly, semi-annually or annually, you can mail or deliver your payments to us at our Canadian head office.

Payments made to us by cheque or electronic transfer must be in Canadian funds, drawn on a Canadian financial institution. Cheques must be made payable to Manulife Financial.

What is a Waiver of Premium on Claim Benefit?

A Waiver of Premium on Claim Benefit is included as part of your policy. For an Individual insurance coverage, we will waive the premium that is needed to keep your policy in effect while an insured person is eligible for a Care Benefit.

For Shared insurance coverages, we will waive the premium that is needed to keep your policy in effect while one or both of the insured people is eligible for a Care Benefit.

If we waive a premium or portion of a premium that you have already paid, we will refund the unused amount to you.

When an insured person satisfies the Waiting Period, we will refund any premiums due and paid during the Waiting Period.

If the insured person is no longer eligible to receive a Care Benefit, you will have to start paying premiums again. We will notify you of the premiums you must pay to keep your policy in effect from the day we stop paying a Care Benefit until the day of your next scheduled premium payment.

What is the Grace Period?

If, by any premium due date, you do not pay the required premium in full, you will have a 31-day Grace Period to make the required payment.

If you do not pay the required premium in full by the end of the Grace Period, your policy will lapse and we will refund to you any partial payment that you made during the Grace Period.

If a Care Benefit becomes payable during the Grace Period, we will pay the Care Benefit.

How to reinstate your lapsed policy

At any time within two years from the last day of the Grace Period, you may apply to reinstate your policy. To reinstate your policy, we must, within those two years, receive your written application for reinstatement and evidence of insurability satisfactory to us. We must also receive payment from you for:

- any amounts that were due on or before the beginning of the Grace Period, plus
- the total of all premiums due from the beginning of the Grace Period to the date of reinstatement, plus
- interest on these amounts at a rate determined by us at that time.

The effective date of the reinstatement of the policy is the date on which we determine these requirements have been met.

When does your coverage end?

Your insurance coverages under this policy have no expiry date. An insurance coverage ends on the earliest of the following dates:

- the monthly processing day that coincides with or next follows the day we receive your written request to cancel that coverage at our Canadian head office
- the day the insured person under the coverage dies (see also the section called *What is the Benefit Balance?* about Shared insurance coverages)
- the day the Benefit Balance for the coverage is reduced to $0, and
- the day your policy ends.

When does your policy end?

Your policy ends on the earliest of the following dates:

- the business day we receive your written request to cancel your policy at our Canadian head office, or
- 31 days after the day the policy enters the Grace Period, if you have not paid the amount needed to keep the policy in effect, or
- the day there is no longer any insurance coverage in effect.

What happens if the insured person dies?

Individual insurance coverage

If the insured person dies, we will cancel the insurance coverage that applies to the insured person as of the date of death.

Shared insurance coverages

If one of the people insured by a Shared insurance coverage dies, we will cancel the insurance coverage that applies to that insured person as of the date of death.

The insurance coverage for the surviving insured person will remain in effect as an Individual insurance coverage. The Benefit Balance that remains on the Shared insurance coverages will become the Benefit Balance for that Individual insurance coverage. The Care Benefit amount will not change.

We will adjust the premiums for the insurance coverage so they are based on:

- the rates for an Individual insurance coverage on the Coverage Date adjusted by any changes that have been determined for those rates since the Coverage Date, and
- the sex and age of the insured person as of the Coverage Date of the original insurance coverage.

What happens to the unused portion of premiums?

We will refund the unused portion, if any, of any premiums paid for the coverage(s) on an insured person during the policy year in which their death occurred.

How to make changes to your coverages

Subject to our administrative rules in effect at the time, you can ask us to change the Amount of Insurance, Waiting Period or Benefit Option for your insurance coverage. You may be able to add or cancel rider coverages subject to our approval and based on our administrative rules in effect at the time you request the change.

How to transfer ownership of your policy

You can transfer ownership of your policy, unless this is prohibited by law.

If you transfer ownership:

- you can only transfer the entire policy, not selected coverages, and
- the effective date of the transfer is the day we receive an original or notarized copy of the transfer at our Canadian head office or at our principal place of business in your province.

We are not responsible for the validity or sufficiency of the transfer of ownership.

How to use your policy as security for a loan

You can use your policy as security for a loan by assigning it to a lender. This type of security is called a collateral assignment or, under the Quebec Civil Code, a hypothec. These rules apply when you assign a policy:

- You can only assign or hypothecate the entire policy, not selected coverages.
- We are bound by the assignment or hypothec when we receive written notice of it at our Canadian head office.
- The lender should send a copy of the assignment or hypothec to us.
- After you have collaterally assigned or hypothecated your policy, you may need the consent of the lender to make changes to your policy. These changes include but are not limited to reducing or cancelling a coverage or cancelling your policy.
- We are not responsible for making sure that any assignment or hypothec is valid or adequate.
- The rights of the lender will take precedence over the rights of any other person claiming a benefit.

How to split your policy

You have the right to split your policy if it insures two people and the relationship of these insured people is changing. When the policy is split, insurance can continue on these insured people under two separate policies. These rights are subject to our administrative rules in effect at the time.

You cannot split the policy if either of the insured people:

- is currently receiving or is eligible to receive a Care Benefit
- has received a Care Benefit in the past 180 days, or
- is in the process of satisfying the Waiting Period.

What happens if you split your policy?

If you split your policy, the total of the benefits in the separated policies will equal the benefits provided in your original policy on the day before the split occurred. The Care Benefit amount will be the same on the separated policies as it was on the original policy.

The separated policies will have the same Policy Date as the original policy, and each coverage on the separated policies will have the same Coverage Date and Coverage Issue Date as it did on the original policy.

Once the policy has been split, the premium we charge for the coverage on each policy will be based on:

- the rates for an Individual insurance coverage on the Coverage Date adjusted by any changes that have been determined for those rates since the Coverage Date, and
- the sex and age of the insured person as of the Coverage Date of the original insurance coverage.

What is our right to contest the contract?

What are our rights at any time?

We have the right at any time to question the validity of your policy or any insurance or rider coverage under it. We can deny any claim if you, or any of the insured people, fraudulently misrepresented a material fact by not disclosing it or stating it incorrectly in any application or on any medical examination or in any other information we have used as evidence of insurability.

A material fact is a fact that, if disclosed, would:

- influence our decision to issue the coverage, or
- affect the conditions under which we would be willing to provide coverage. These conditions could include limiting coverage or charging a higher premium.

In this the section called *What is our right to contest the contract?*, a material fact does not include any statements you or the insured person made about their age or sex.

What are our rights during the Contestability Period?

The Contestability Period for any insurance or rider coverage on your policy is the first two years from these dates:

- the Policy Issue Date,
- the Coverage Issue Date,
- the effective date you made a change that required updated evidence of insurability for that coverage on your policy, and
- the date your policy was last reinstated.

During the Contestability Period (or if you, an insured person under your policy or the insured person's physician notices or becomes aware of any sign, symptom, condition or medical problem during a Contestability Period that leads to functional dependence at any time in the future), we have the right to question the validity of your policy or any insurance or rider coverage under it. We have this right if you or any insured person misrepresented a material fact (whether fraudulently or not) by not disclosing it or stating it incorrectly in any application or on any medical examination or in any information we have used as evidence of insurability.

What will we do if an insured person's age or sex has been stated incorrectly?

If the age or sex of any insured person has been stated incorrectly, any benefit payable on any insurance or rider coverage for that insured person will be increased or decreased to the amount that we would have paid based on:

- the last premium you paid for that coverage, and
- the Amount of Insurance the last premium would have purchased according to this person's correct age or sex.

If we would not have issued the coverage because the correct age does not meet our rules regarding the minimum and maximum age, we can declare the coverage invalid within the period permitted by law.

What currency is used for payments?

All payments to or by us will be in Canadian dollars. Payments made to us by cheque or electronic transfer must be in Canadian funds, drawn on a Canadian financial institution. Cheques must be made payable to Manulife Financial.

What type of policy is LivingCare?

This policy is non-participating. This means that it does not provide the rights of a participating policy, such as eligibility for dividends or the right to vote at our annual meetings.

6 Exclusions and limitations

Exclusions

In this policy document, the United States refers to the continental United States (including Alaska) and Hawaii.

We will not consider the insured person to be functionally dependent and we will not pay any Care Benefits under this policy if the insured person, while sane or insane, becomes functionally dependent because of any of the following:

- intentionally self-inflicted injuries
- committing an act that would be a criminal act according to the laws of Canada, no matter where the act was committed
- operating a motor vehicle while the concentration of alcohol in 100 ml of blood exceeds 80 mg
- the insured person's intentional use or intake of:
  - any prescription drug or narcotic other than as instructed by a physician
  - any drug or narcotic legally available for sale in Canada or the United States without a prescription, in a manner other than as recommended by the manufacturer
  - any drug or narcotic not legally available in Canada or the United States, or
  - any poisonous substance or intoxicant.

The insured person will not be considered functionally dependent while he or she is residing outside Canada and the United States, and we will not pay a Care Benefit while the insured person resides outside Canada and the United States.

Any days when the insured person resides outside Canada and the United States will not be considered days when the person is functionally dependent for the purpose of satisfying the Waiting Period.

7 Statutory conditions

The contract

Your contract includes:

- the application form(s) for your insurance and rider coverages
- any information you or the insured person provided to us for evidence of insurability. This includes but is not limited to:
  a) the medical evidence form(s); and,
  b) the statements and answers you or the insured person gave us
- this LivingCare policy document
- all information you or the insured person provide if you change your insurance or rider coverages or reinstate your policy. This includes but is not limited to:
  a) the application form(s) for those changes or reinstatement
  b) any amendments or endorsements issued to reflect those changes or reinstatement, and
  c) any updated Policy summary pages or any tables of rates or values issued to reflect those changes or reinstatement
- any other amendments or endorsements agreed on in writing by us and signed by our president or one of our vice-presidents after your policy is issued.

Waiver

No agent has the authority to change the contract or waive any of its provisions. We shall not be deemed to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in a written statement signed by us.

Copy of your application

We will provide a copy of your application with your LivingCare policy document.

Material facts

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

Cancellation by owner

If you choose to cancel your policy, your policy ends on the business day we receive your written request to cancel the policy in our principal place of business in your province or at our Canadian head office. We will refund the unused portion, if any, of any premium paid for the coverage(s) on that insured person during the policy year that you request cancellation. If no premium was paid during the policy year you request cancellation, no premium will be refunded.

Notice and proof of claim

You, or the insured person, or a friend or relative must:

- notify us as soon as possible (and not later than 30 days) after noticing that the insured person appears to be functionally dependent. Contact us at 500 King Street N, PO Box 1602 STN Waterloo, Waterloo, ON, N2J 4C6, or email us at CC_987@manulife.com or call us at 1-866-575-0684.
- provide us with information satisfactory to us about the cause or nature of the insured person's functional dependence, the right of the claimant to receive payment, their age and the age of the beneficiary (if relevant). We must receive this information within 90 days of the day you notify us that the insured person may be functionally dependent.

Failure to give notice or proof

If you fail to notify us or provide satisfactory proof to us within the time prescribed in this statutory condition, we will pay a Care Benefit:

- if we determine that the insured person is functionally dependent and has satisfied the Waiting Period, and
- if you notify us as soon as reasonably possible within one year from the date the insured person appeared to be functionally dependent, and
- if we receive proof satisfactory to us that it was not reasonably possible for you to give us notice or provide proof within the time prescribed.

Declaration of presumption of death

If we require a declaration of presumption of death to pay the death benefit, the person making the claim must give us appropriate notice or proof of the claim within one year of the court's declaration. That person can contact us for information on the documents we need to process the claim.

Rights of examination

To verify the insured person's eligibility for benefits, we may require that the insured person be examined when and as often as we reasonably require.

Payment of claim

We will pay all benefits payable under this policy within 60 days after we have received proof of claim.

Limitations of actions

An action or proceeding against us for the recovery of a claim under this policy must begin within one year of the date the insurance money became payable or would have become payable if the claim had been valid.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (or in the Civil Code of Quebec for the province of Quebec).

Provincial variations

If necessary, the provisions described in this LivingCare policy document will be adjusted to meet the minimum requirements of law within your province or territory.

8 Words and phrases used in this policy document

Activities of Daily Living (See the section called *When is an insured person functionally dependent?*)

administrative rules are guidelines we set that establish how and in what circumstances you may exercise certain rights under your policy. When you exercise your policy rights you must do so in accordance with the administrative rules in effect at the time you exercise the right. We may change these guidelines from time to time without notice to you.

Amount of Insurance is the amount of each insurance coverage shown in the section called *Policy summary*.

Benefit Balance (See the section called *What is the Benefit Balance?*)

Care Benefit is the benefit that will be paid when the insured person is functionally dependent and has satisfied the Waiting Period. The Care Benefit amounts are shown in the section called *Policy summary*.

Care Setting is the location where the insured person resides. The Care Setting can be either "Facility" or "Not a Facility". (See the section called *How do we determine the Care Benefit?*)

Care Support Services (See the section called *What are Care Support Services?*)

cognitive impairment (See the section called *When is an insured person functionally dependent?*)

Contestability Period (See the section called *What is our right to contest the contract?*)

coverage provides a benefit under this policy. The word coverage applies to both insurance coverage and rider coverage provided under this policy.

Coverage Date is the day an insurance or rider coverage begins. Coverage years, months and anniversaries are measured from the Coverage Date.

Coverage Issue Date is the day we issue an insurance or rider coverage. If your policy has been reinstated, the Coverage Issue Date in the section called *Policy summary* shows the date the policy was last reinstated.

evidence of insurability is information we require from you and the insured person that allows us to determine whether we can accept your application for insurance, or change or reinstate your insurance.

"Facility" (See the section called *How do we determine the Care Benefit?*)

functionally dependent (See the section called *When is an insured person functionally dependent?*)

Grace Period (See the section called *What is the Grace Period?*)

Individual insurance coverage means an insurance coverage for which the coverage type is "Individual." See also the section called *Policy summary* where we identify the coverage types for your insurance.

insurance coverage is long term care insurance protection provided by this policy. You can have one or more insurance coverages under this policy, each insuring one person and providing a long term care benefit. The Amount of Insurance for each of your coverages is shown in the section called *Policy summary*.

insured person or people is any person or people who we have agreed to insure in this contract. We've listed the insured people in the section called *Policy summary*.

material fact (See the section called *What is our right to contest the contract?*).

Monthly Processing Date is the first day of each policy month. For example, if your Policy Date is April 12, your monthly processing date will be the 12th of each month. We show this day in the section called *Policy summary*.

necessary items of clothing (See the section called *When is an insured person functionally dependent?*)

"Not a Facility" (See the section called *How do we determine the Care Benefit?*)

physician means a person legally licensed to practice medicine in Canada or the United States or other jurisdictions that we may approve. The physician must not be the policy owner, the insured, or a relative or business associate of the owner or any insured person.

policy is this LivingCare policy document and all insurance coverages provided by it.

Policy Anniversary (See Policy Date)

Policy Date is the effective date of the policy. Policy years, months, and anniversaries are measured from the Policy Date.

Policy fee is the amount we charge to administer your policy. It is included in your total premium.

Policy Issue Date is the day we issue the policy as shown in the section called *Policy summary*. If your policy was reinstated, the Policy Issue Date reflects the day the policy was last reinstated.

policy owner is the owner of the policy who holds all rights under the policy, unless these rights are limited by law or by collateral assignment or, under Quebec Civil Code, hypothecation of the policy.

Premium duration is the period of time that premiums are payable for a LivingCare policy as shown in the section called *Policy summary*.

regular care of a physician means consultations with and treatment by a physician which are appropriate in nature and frequency for the condition causing the insured person to be functionally dependent.

riders are optional benefits or coverages you can purchase in addition to your insurance coverage.

rider coverage is additional protection provided by a rider. The benefit provided by each of your rider coverages is shown in the section called *Policy summary*.

Shared insurance coverage means an insurance coverage for which the coverage type is "Shared". See also the section called *Policy summary* where we identify the coverage types for your insurance.

substantial assistance (See the section called *When is an insured person functionally dependent?*)

substantial supervision (See the section called *When is an insured person functionally dependent?*)

Waiting Period (See the section called *What is the Waiting Period?*)

Return of Premium on Death Rider

General information

The Return of Premium on Death rider coverage applies to the associated LivingCare insurance coverage(s) as shown in the section called *Policy summary*. The insured person (or people, for associated LivingCare Shared insurance coverages), Coverage Date, Premium Duration, Benefit Option and Waiting Period must be the same for both the rider and the associated LivingCare insurance coverages.

What is the benefit provided by this rider?

We will pay a Return of Premium on Death Benefit when the last person insured under this rider dies, as long as the rider coverage is in effect on the date of that death. Unless you instruct us otherwise, we will pay the Return of Premium on Death Benefit to you or to your estate.

How is the Return of Premium on Death Benefit calculated?

The Return of Premium on Death Benefit for an associated LivingCare insurance coverage is the *lesser* of A and B:

A	B
• The eligible premiums This is the sum of the premiums you paid for coverages that are in effect or coverages that were Shared and terminated because the first insured person died. These coverages include: • • • • • the Inflation Protection rider on the associated LivingCare insurance coverage.	• The Benefit Balance under the associated LivingCare insurance coverage as of the date of death of the last insured person on this rider.
plus	
• the premiums you paid for the policy fee If more than one Return of Premium on Death rider coverage is terminating because the last insured person died, the premiums you paid for the policy fee will be allocated equally between those coverages. *continued on next page*	

multiplied by
• the Return Percentage shown in the chart below
minus
• the sum of all Care Benefits paid or payable from associated LivingCare insurance coverages that are in effect or coverages that were Shared and terminated because the first insured person died.

Return Percentage

The Return of Premium on Death Benefit will be adjusted by the Return Percentage described below.

If the Return of Premium on Death Benefit is payable by this Coverage Anniversary	...then the Return Percentage is
before the 1st	0%
on or after the 1st but before the 2nd	5%
on or after the 2nd but before the 3rd	10%
on or after the 3rd but before the 4th	15%
on or after the 4th but before the 5th	20%
on or after the 5th but before the 6th	25%
on or after the 6th but before the 7th	30%
on or after the 7th but before the 8th	35%
on or after the 8th but before the 9th	40%
on or after the 9th but before the 10th	45%
on or after the 10th but before the 11th	50%
on or after the 11th but before the 12th	55%
on or after the 12th but before the 13th	60%
on or after the 13th but before the 14th	65%
on or after the 14th but before the 15th	70%
on or after the 15th but before the 16th	75%
on or after the 16th but before the 17th	80%
on or after the 17th but before the 18th	85%
on or after the 18th but before the 19th	90%
on or after the 19th but before the 20th	95%
on or after the 20th	100%

What happens if you change your associated LivingCare insurance coverage?

Refer to the section called *How to make changes to your coverages* for a description of your rights to make changes to your insurance coverage.

What happens to eligible premiums after a decrease in the Amount of Insurance?

If we agree to your request for a decrease in the Amount of Insurance on an associated LivingCare insurance coverage, the Return of Premium on Death Benefit amount for that coverage will also decrease. The amount of eligible premiums will be reduced in proportion to the decrease in the Amount of Insurance on the associated LivingCare insurance coverage(s).

Eligible premiums will include premiums you paid for the following coverages as of the Monthly Processing Day that the Amount of Insurance was reduced:

- this rider coverage
- the Inflation Protection rider coverage(s) in effect on the associated LivingCare insurance coverage(s)
- the associated LivingCare insurance coverage(s) that are in effect

If the associated LivingCare insurance coverages were Shared on the Coverage Date, we will not decrease the eligible premiums paid for an associated LivingCare insurance coverage or its associated Inflation Protection rider coverage if they were terminated because the first insured person died.

If the Amount of Insurance is reduced because you requested an increase to the Benefit Option on the associated LivingCare insurance coverage(s), we will not reduce the eligible premiums you have paid for this rider coverage, or the associated LivingCare insurance coverage, or its associated Inflation Protection rider coverage.

Our administrative rules in effect at the time you request the decrease will apply.

How does a decrease in the Amount of Insurance affect your Benefit Balance?

If we agree to a change that results in a decrease in the Amount of Insurance on an associated LivingCare insurance coverage, the Benefit Balance will also decrease. The decrease in the Benefit Balance will be in the same proportion as the decrease in the Amount of Insurance on the associated LivingCare insurance coverage.

Our administrative rules in effect at the time you request the decrease will apply.

What happens to this rider if you split your policy?

If you split your policy, we will terminate your Return of Premium on Death rider coverage. No Return of Premium on Death Benefit will be payable on the original policy or new policies.

See the section called *How to split your policy* for a description of your right to split your policy.

How to pay for your Return of Premium on Death rider coverage

The premium required for your Return of Premium on Death rider coverage is shown in Section 3. Refer to the section called *What are premium payments* for information on how to make your premium payments.

No further premium will be required for a rider coverage when the rider coverage has been in effect longer than the Premium Duration for the rider.

How may premiums change?

The premiums shown in Section 3 for your Return of Premium on Death rider coverage will not change before the fifth coverage anniversary unless you make a change to your coverage.

On and after the fifth coverage anniversary, we can change the premiums for your rider coverage on each coverage anniversary.

We cannot change the premium for your rider coverage after the later of these dates:

- the coverage anniversary nearest the insured person's 75th birthday or joint attained age 75, and
- the 20th anniversary of that coverage.

We will only change premiums for your Return of Premium on Death rider coverage to reflect changes in our costs of providing return of premium on death coverage and only if we change the premiums on all similar Return of Premium on Death rider coverages. This means we cannot single out your Return of Premium on Death rider coverage for an increase because of any change in the insured person's or people's health or functional ability. We cannot change any other terms of your rider coverage without your consent.

When does this rider coverage end?

A coverage provided by this rider ends on the earliest of:

- the day the last insured person under the rider coverage is no longer an insured person under the associated LivingCare insurance coverage
- the Monthly processing day that coincides with or next follows the day we receive your written request to cancel that rider coverage at our Canadian head office
- the day we cancel or deny insurance or rider coverage on the insured person, as described in section called *Contesting the contract*
- the date that the associated LivingCare insurance coverage is terminated because its Benefit Balance equals $0, or
- the effective date of any Policy Split made to the associated LivingCare Shared insurance coverages.

When does this rider end?

This rider ends on the earliest of:

- the Monthly processing day that coincides with or next follows the day we receive your written request to cancel this rider at our Canadian head office
- the day the last coverage under this rider ends, or
- the day your insurance policy ends See the section called *When does your policy end*.

Inflation Protection Rider

General information

The Inflation Protection Rider coverage applies to an associated LivingCare insurance coverage as shown in the section called *Policy summary*. The insured person (or people, for associated LivingCare Shared insurance coverages), Type of coverage, Premium Duration, Benefit Option and Waiting Period must be the same for both the rider and the associated LivingCare insurance coverage.

What is the benefit provided by this rider?

The Inflation Protection Rider increases the Care Benefit and the remaining Benefit Balance on the associated LivingCare insurance coverage. In the section called *Policy summary*, we show the Inflation Protection Rate for this rider.

How do we apply the Inflation Protection Rate?

If this rider and the associated LivingCare insurance coverage are in effect, the Care Benefit and remaining Benefit Balance for that coverage are increased on each policy anniversary. The increase will be applied whether or not the insured person is functionally dependent. The new Care Benefit and Benefit Balance amounts will be shown on your policy statement.
(*See the section called LivingCare benefits for descriptions of the Care Benefit and Benefit Balance.*)

If the associated LivingCare insurance coverage is Individual

We calculate a new Care Benefit and Benefit Balance on each policy anniversary in this way:

a We determine the Care Benefit for the associated LivingCare Individual insurance coverage on the day before the policy anniversary, and then we increase it by the Inflation Protection Rate.
b We determine the Benefit Balance for the associated LivingCare Individual insurance coverage on the day before the policy anniversary, and then we increase it by the Inflation Protection Rate.

If the associated LivingCare insurance coverage is Shared

We calculate a new Care Benefit and shared Benefit Balance on each policy anniversary in this way:

a We determine the Care Benefit for each associated LivingCare Shared insurance coverage on the day before the policy anniversary, and then we increase the Care Benefit by the Inflation Protection Rate.
b We determine the shared Benefit Balance for the associated LivingCare Shared insurance coverages on the day before the policy anniversary, and then we increase it by the Inflation Protection Rate.

What happens if you change your associated LivingCare coverage?

Refer to the section called *How to make changes to your coverages* for a description of your rights to make changes to your insurance coverage.

If you request a change that results in a decrease in the Amount of Insurance on an associated LivingCare insurance coverage we will determine the Care Benefit and Benefit Balance on the day before we make the change and we will decrease both amounts. The amount of the decrease will be in the same proportion as the decrease in your Amount of Insurance. The Inflation Protection Rate will not change.

What happens if you cancel your Inflation Protection Rider?

If you cancel your Inflation Protection Rider coverage, the Benefit Balance will be reduced to the current Amount of Insurance on the associated LivingCare insurance coverage minus any Care Benefits paid since the Coverage Date. The Care Benefit will also decrease; it will be based on the current Amount of Insurance and Benefit Option on the associated LivingCare insurance coverage.

All inflation protection increases applied to your Benefit Balance and Care Benefit will be void.

What happens to this rider if the policy is split?

If you split your policy, the provisions in Section 5.11 will apply and each new Individual coverage will also be connected to an Inflation Protection Rider.

We will adjust the premiums for the Inflation Protection Rider coverage so they are based on:

- the rates for an Individual Inflation Protection Rider coverage on the Coverage Date plus any changes that have been determined for those rates since the Coverage Date, and
- the sex and age of the insured person as of the Coverage Date of the original Inflation Protection Rider coverage.

What happens to this rider if one of the insured people sharing a coverage dies?

If one of the insured people dies, the provisions in Section 5.7 will apply. If the shared coverage was connected to an Inflation Protection Rider, the new Individual insurance coverage will be connected to an Inflation Protection Rider. The Inflation Protection Rider on the insured person who died will be terminated.

We will adjust the premiums for the Inflation Protection Rider coverage so they are based on:

- the rates for an Individual Inflation Protection Rider coverage on the Coverage Date plus any changes that have been determined for those rates since the Coverage Date, and
- the sex and age of the insured person as of the Coverage Date of the original Inflation Protection Rider coverage.

How to pay for your Inflation Protection Rider coverage

The premiums required for your Inflation Protection Rider coverage are shown in the section called *Policy summary*.

No further premium will be required for a rider coverage when the length of time that the coverage has been in effect exceeds the Premium Duration for the associated LivingCare insurance coverage.

How may premiums change?

The premiums shown in section called *Policy summary* will not change before the fifth coverage anniversary unless you make a change to your coverage.

On and after the fifth coverage anniversary, we can change the premiums for your Inflation Protection Rider coverage on each coverage anniversary.

We cannot change the premium for your rider coverage after the later of these dates:
- the coverage anniversary nearest the insured person's 75th birthday, and
- the 20th anniversary of that coverage.

We will only change premiums for your Inflation Protection Rider coverage to reflect changes in our costs of providing inflation protection coverage, and only if we change the premiums on all similar Inflation Protection Rider coverages. This means we cannot single out any insured person's coverage for an increase because of any change in that person's health or functional ability. We cannot change any other terms of your rider coverage without your consent.

When does a rider coverage end?

A coverage provided by this rider ends on the earliest of:
- the day the insured person under the rider coverage is no longer an insured person under the associated LivingCare insurance coverage,
- the Monthly processing day that coincides with or next follows the day we receive your written request to cancel that rider coverage at our Canadian head office,
- the day we cancel or deny insurance or rider coverage on the insured person, as described in Section 5.12 under the subheading *What is our right to contest the contract*? or
- the date that the associated LivingCare insurance coverage is terminated because its Benefit Balance equals $0.

When does this rider end?

This rider ends on the earliest of:
- the Monthly processing day that coincides with or next follows the day we receive your written request to cancel this rider at our Canadian head office,
- the day the last Inflation Protection Rider coverage under this rider ends, or
- the day your insurance policy ends (See the section called *When does your coverage end?*).