INSURANCE

RIDERS AND ADDITIONAL BENEFITS GUIDE

iA Financial Group

For advisor use only

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INTRODUCTION

Industrial Alliance products are designed to meet the specific needs of your clients. A variety of complementary coverage can therefore be added to each policy in the form of riders or additional benefits to create tailored, comprehensive coverage.

This guide presents all these types of coverage. We've taken care to specify the following for each one:

- Whether it is a rider or an additional benefit
- Which products it is available on
- Details that need to be brought to your attention

GENERAL INFORMATION

- **"Age at issue"** means the age on the birthday closest to the effective coverage date.

- **"Age at which the coverage terminates"** means the age on the policy anniversary date closest to the insured's date of birth.

- **Premium payment period:** Premiums for riders and additional benefits are generally payable until coverage expires, except for those associated with 10-15-20 options, where premiums are payable only during the premium payment period for those options.

RIDERS AND ADDITIONAL BENEFITS OFFERED FOR EACH PRODUCT

	Genesis	EquiBuild	TERM & WHOLE LIFE INSURANCE	Transition	iA PAR Estate & Wealth
RIDERS					
Term Life Insurance	Available	Available	Available	Not available	Available
Disability Credit	Available	Available	Available	Not available	Available
Hospitalization	Available	Not available	Available	Available	Not available
Hospitalization and Home Care	Available	Not available	Available	Available	Not available
Critical Illness	Available	Available	Available	Not available	Available
Child Critical Illness	Available	Available	Available	Available	Available
Child Module	Available	Available	Available	Not available	Available
Child Module PLUS	Available	Not available	Available	Not available	Available
SI	Available	Available	Available	Available	Not available
Paramedical Care in the Event of an Accident	Available	Not available	Available	Available	Not available
ADDITIONAL BENEFITS					
CAD/CID	Available	Available	Not available	Not available	Not available
CADE	Available	Available	Not available	Not available	Not available
AD	Available	Not available	Available	Not available	Available
AD&D	Available	Not available	Available	Not available	Available
WPDis	Not available	Not available	Available	Available	Available
WPIDis	Not available	Not available	Available	Available	Available
WPD	Not available	Not available	Available	Available	Available
AF	Available	Not available	Available	Available	Available
GI	Available	Not available	Available	Not available	Not available

To learn more about the complementary coverage available by product, please refer to the various product guides in the Document Centre of the Advisor Centre.

To find out what riders and additional benefits are available for old products, please refer to the product guides in effect in the Document Centre of the Advisor Centre.

1. TERM LIFE INSURANCE OPTIONS

Products to which the benefit applies:
Genesis, EquiBuild, Term & Whole Life Insurance, iA PAR Estate & Wealth

Type: Rider

The following term insurance options are available as riders. The main features of these options are as follows:

	T10 (R&C), T20 (R&C)	Pick-A-Term T25 and T30
Age at issue	0-70 years	T25: 0-60 years T30: 0-55 years
Minimum face amount	$25,000	$25,000
Renewable insurance[1]	To age 85	Renewable at the end of the term at YRT rates
Convertible insurance	Before age 71	Before age 71

Any additional joint insurance coverage (permanent life or term life) must be the same type as the basic coverage. For example, if the basic coverage is joint first-to-die insurance, the supplemental term life insurance coverage must also be joint first-to-die.

Please note that it is possible to add individual term riders on a joint policy **only on Term & Whole Life Insurance and iA PAR Estate and Wealth products**. It is not possible to add individual term life riders to a Joint Universal Life plan.

In addition, a term life insurance rider can only be underwritten on a EquiBuild policy during mid-term and not at issue.

[1] Renewal premiums are guaranteed and calculated according to the insured's age at renewal. The premiums are established according to the initial risk class (non-preferred, preferred or elite) and according to the initial tobacco status.

2. DISABILITY CREDIT INSURANCE

Products to which the benefit applies:
Genesis, EquiBuild, Term & Whole Life Insurance, iA PAR Estate & Wealth

Type: Rider

Age at issue: 18 to 59 years

Disability credit insurance protection, available as a rider, gives added flexibility to the life insurance products identified above and fulfills a need for additional financial security.

This protection provides the payment of benefits in the event of the insured's disability while covered by this rider. With this additional coverage, clients will be able to meet their financial obligations and maintain their quality of life.

2.1 Definitions used in the description of the disability credit insurance protection

- **Accident**

  An unforeseeable event resulting exclusively from external, sudden, violent and involuntary causes, which occurs independently of any physical or mental illness. This event must occur while this rider is in force and result in an injury, the signs of which must be assessed and documented by a physician.

- **Elimination period**

  A period during which the insured has been disabled and no disability benefits are paid. The duration of the elimination period is 30 days.

- **Disability or disabled**

  For insureds who are employed at the onset of a disability:

  - **For the first 24 months of the disability:** disability is a state of total and continuous incapacity, caused by an illness or an accident, that prevents the insured from performing the duties of his or her principal occupation.
  - **Thereafter:** disability is a state of total and continuous incapacity, caused by an illness or an accident, that prevents the insured from performing any occupation for which he or she is reasonably qualified, regardless of the availability of such employment.

  For insureds who are not employed at the onset of a disability (insureds who are unemployed, in school or retired, for example):

  Disability is a state of total and continuous incapacity, an illness or an accident, that prevents the insured from performing any occupation.

  For all insureds, regardless of their situation:

  The insured's disability must occur while this rider is in force in order for disability benefits to be paid.

- **Waiting period**

  A period during which the insured must be disabled before becoming eligible for disability benefits. The duration of the waiting period is 90 days, followed by the payment of benefits retroactive to the 31st day of the disability, that is, immediately after expiration of the elimination period.

  When the insured's disability is caused by an accident (and disability begins on the date of the accident) or by a hospitalization of a continuous period of at least 72 hours, the duration of the waiting period is 30 days.

2.2 Eligibility for the disability credit insurance protection

- The insured must be actively on the job market upon subscription and work full time for a minimum of 20 hours per week at least 8 months per year.
- The insured must be one of the borrowers listed on the mortgage, loan, line of credit, lease or lease contract.
- The insured must own a life insurance policy in order to add the disability credit insurance protection.
- Insureds required to pay an extra premium on their life insurance policy are not eligible for the disability credit insurance protection.
- It is also possible for an insured to modify the 2-year or 5-year duration option to the Up-to-age-65 duration option upon submission of evidence of insurability.
- Shareholders/owners are eligible for the disability credit insurance protection. However, only shareholders/owners that are active in the company are eligible on commercial loans. Proof of share ownership is required when the disability credit insurance protection is subscribed.

  A maximum monthly benefit of $5,000 is allowed, per insured, for all disability credit insurance protections underwritten with the Company.

2.3 Eligible credits

Most types of personal or commercial credit are eligible for disability credit insurance protection, such as:

- Lines of credit,
- Mortgages and home equity lines of credit,
- Renovation loans,
- Loans on buildings with fewer than 7 units (residential or commercial),
- Student loans,
- Car and boat loans,
- Leases (residential only),
- Vehicle lease contracts.

Loans where the borrower is a company are eligible as long as the insured is the owner of the company.

In addition, only loans, contracts, leases and lines of credit entered into prior to the onset of the insured's disability are eligible.

Eligible credit evidence when making a claim

- Eligible credit evidence is a document from the lending institution indicating the borrowers' names, the credit issue date and the balance of the loan or line of credit. Only loans on which the insured is the borrower are eligible for disability credit insurance protection.
- Eligible credit evidence is mandatory when making a disability credit insurance claim.
- In the case of a lease, a copy of the lease is acceptable as evidence.
- Eligible credit evidence is required at the time of the claim, not at subscription.

2.4 Non-eligible credit

The following forms of credit are not eligible for disability benefits:

- Unnotarized loans between individuals,
- Credit card balances,
- Loans on buildings with 7 units or more (residential or commercial),
- Advances or policy collateral loans on a life insurance policy,
- Consumer proposals,
- Commercial leases,
- Verbal leases.

In addition, loans, contracts, leases and lines of credit entered into the onset of the insured's disability are not eligible.

2.5 Disability benefits duration

The following duration of benefits options are available to the applicant:

- 2 years of benefits for the same disability. A maximum of 60 monthly benefits is paid for the entire duration of protection under this rider.
- 5 years of benefits for the same disability. A maximum of 60 monthly benefits is paid for the entire duration of protection under this rider.
- Until the policy anniversary of the year the insured reaches age 65.

Note that:

- The amount paid for each day of disability is equal to 1/30th of the monthly payable benefit.
- Benefits are payable at the end of each month of disability.

- **Limitations for certain eligible credit types**

  Regardless of the duration of benefits selected by the insured, the following limitations apply based on the eligible credit type concerned:

  For all disabilities of the same insured during the entire duration of protection under this rider:

  - A maximum of 24 monthly benefits is paid for a rental lease.
  - A maximum of 60 monthly benefits is paid for a car or boat loan or a vehicle lease contract.
  - A maximum of 120 monthly benefits is paid for a line of credit. This last limitation does not apply to any portion of a home equity line of credit with a repayment schedule (loan portion).

- **Vehicle lease contracts**

  While disability benefits are being paid, if the lease contract expires and is replaced with a new contract, benefit payment continues without exceeding the maximum of 60 monthly benefits. The amount of these benefits will be the same as those paid under the initial lease contract.

2.6 Disability benefits amount

The monthly disability benefit amount is established at subscription as a fixed dollar amount determined by the applicant.

This amount cannot be less than $300 per insured if the disability credit insurance protection is added at issue of the life insurance policy.

In addition, the monthly benefit amount is equal to the lesser of the following amounts:

- The protection amount selected by the applicant, as written in the contract,
- The amount specified in the “Monthly benefit maximum amount” section below,
- $3,500.

- **Monthly benefit maximum amount**

  - The monthly benefit maximum amount is equal to the amount that appears on the eligible credit evidence at the onset of the insured’s disability and excludes any other amount than the principal and interest.
  - In the case of a line of credit, the monthly benefit maximum amount is equal to the balance of the line of credit at the onset of the insured’s disability, multiplied by the interest rate that appears on the eligible credit evidence at the onset of the disability, plus 0.5%.
  - The monthly benefit is determined at the onset of the insured’s disability and remains fixed throughout the disability period.

- **Joint life insurance policy subscription**
  - Any disability credit insurance rider attached to a life insurance policy is issued on an individual basis.
  - If one of the insureds is required to pay an extra premium, the disability credit insurance protection is still available to all other insureds.
  - The total of monthly disability benefits paid for a loan or line of credit may not exceed 100% of the minimum payment required by the financial institution.
  - When more than one insured has disability credit insurance protection, the monthly benefit maximum amount applies to the total of benefits paid for the same eligible credit, even if more than one insured is simultaneously disabled.

    Example:

    Paul and Kim have a joint Pick-A-Term insurance that covers their mortgage and a disability credit insurance protection for each of them.

    - Question: Can Paul and Kim make a claim if they're both disabled at the same time?
    - Answer: Yes. However, the two benefits amount combined may not exceed 100% of the minimum mortgage payment required by the lending financial institution.

- **Coordination and integration of benefits**
  - The benefits under the disability credit insurance protection are not integrated with other benefits received from private, group or public insurance plans.
  - However, these private or public plans may take into account the benefit paid by a private plan such as the disability credit insurance protection and readjust their benefit accordingly.
  - Benefits for the disability credit insurance protection are not payable if the same eligible credit is covered by another insurance company.

2.7 Rules for recurrence of a disability

- **Same disability diagnosis:**

  It is considered a recurrence when a subsequent disability results from the same cause as a previous disability and occurs within three months of the end of the previous disability for which benefits were paid. Payment of benefits resumes on the date of the recurrence of the disability, for the remaining duration of the benefits chosen by the insured at subscription.

  Conversely, a subsequent disability is considered a new disability if it occurs more than three months after the end of the previous disability, even if this subsequent disability results from the same cause. A new waiting period and elimination period will have to be met by the insured before becoming eligible for disability benefits.

- **Different disability diagnosis:**

  Following the end of a period of disability, if an insured suffers another disability resulting from a different cause than the first disability, the insured becomes eligible for benefits again, regardless of the time elapsed since the end of the previous period of disability. Nonetheless, a new waiting period and elimination period will have to be met by the insured before becoming eligible for disability benefits.

2.8 Premium payments

Disability credit insurance protection premiums are levelled and guaranteed for the duration of coverage.

- **Duration of premium payments**

  - Premiums are payable for the entire duration of the coverage, i.e., until the policy anniversary of the year the insured reaches age 65.
  - Premiums are established per $10 of monthly benefit and vary according to insured's age at subscription, sex and tobacco use.
  - Premiums for the disability credit insurance protection are not modified when the life insurance policy is renewed.

  Waiver of premiums in case of disability is not automatically included, but may be added as an additional benefit.

2.9 Termination of the disability credit insurance protection

The disability credit insurance protection terminates on the first of the following dates:

- **2-year or 5-year duration of benefits:**
  - Date of death of the insured,
  - Cancellation date of the life insurance policy to which the disability credit insurance rider is attached,
  - Date on which all benefits have been paid in accordance with the "Disability benefits duration" section,
  - Date of termination of last eligible credit, or of the line of credit,
  - Date of policy anniversary of the year the insured reaches age 65, whether or not the insured is disabled on that date,
  - Date of cancellation of the disability credit insurance rider.

- **Up-to-age-65 duration of benefits:**
  - Date of death of the insured,
  - Cancellation date of the life insurance policy to which the disability credit insurance rider is attached,
  - Date of termination of last eligible credit, or of the line of credit,
  - Date of policy anniversary of the year the insured reaches age 65, whether or not the insured is disabled on that date,
  - Date of cancellation of the disability credit insurance rider.

Conversion of a term life insurance policy to a whole-life insurance policy also terminates the disability credit insurance protection.

2.10 Beneficiary

The beneficiary of the disability credit insurance protection must be the applicant. This information does not have to be indicated on the application. When the disability credit insurance protection is subscribed by two insureds and they are also the applicants, the disability benefit is paid to both insureds.

When there is only one insured under the disability credit insurance protection but two applicants under the life insurance policy, the disability benefit is also paid to both insureds.

2.11 Change in the amount of coverage

At any time, when the disability credit insurance protection is in force, the insured can request to modify the amount of coverage.

- **Decrease in the level of coverage**

  No evidence of insurability is required to decrease the monthly benefit amount.

- **Increase in the level of coverage**

  Evidence of insurability is required if the insured applies to increase the monthly benefit amount. The existing disability credit insurance rider is cancelled, and a new disability credit insurance rider is issued. Premiums are based on the insured's age at the time of the change.

- **Addition of disability credit insurance protection after subscription**

  The insured may add the disability credit insurance protection at any time after the contract is issued. However, new evidence of insurability is required. Premiums are based on the insured's age at time of addition.

3. ACCIDENTAL DEATH (AD) AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Products to which the benefit applies:
Genesis, Term & Whole Life Insurance, iA PAR Estate & Wealth

Type: Additional benefit

Age at issue: 0 to 60 years

3.1 Accidental Death (AD)

This benefit provides an additional payment of the selected protection, at issue under this benefit, if death results entirely from accidental causes and occurs within 365 days following the date of the accident.

3.2 Accidental Death and Dismemberment (AD&D)

Upon **death**, this benefit provides for the additional payment of the amount of protection, selected at issue under this benefit, if death results entirely from accidental causes and occurs within 365 days following the date of the accident.

In the event of **dismemberment or loss of use**, this benefit provides for the payment of a percentage of the amount of protection, selected at issue under this benefit, if dismemberment or loss of use results entirely from accidental causes and occurs within 365 days following the date of the accident.

The benefit is payable according to the following circumstance:

LOSS[2]	AMOUNT PAYABLE
Of life	100% of the amount of the benefit
Both hands or both feet or sight in both eyes	100% of the amount of the benefit
One hand and one foot	100% of the amount of the benefit
One hand and sight in one eye or one foot and sight in one eye	100% of the amount of the benefit
One hand or one foot or sight in one eye	50% of the amount of the benefit

[2] The loss of one hand or one foot or sight in one eye means the total and irrecoverable loss of use of the hand, the foot or the eye that cannot even be partially recovered with any therapy.

3.3 Common features of the AD and AD&D benefits

3.3.1 Issue rules

Minimum: **$10,000**

Maximum This amount applies for all contracts underwritten at the Company. The lesser between:

- The initial face amount
- $150,000 for an insured between 0 and 25
- $250,000 for an insured aged between 26 and 60

3.3.2 Premiums

The contract holder benefits from a level premium that is guaranteed for the duration of the contract. The age at issue influences the calculation of the premium rates.

Duration of premium payments:

Premiums are payable until age 70. If the benefit is attached to a 10-15-20 option in Genesis or to a L10, L15 Ultra, L20, or L65 in whole life insurance, the premiums are payable for a maximum period of 10, 15, 20, 30 or 65 years, as the case may be. As per the Child Life & Health Duo, premiums are payable for 10 years, regardless of the age of the insured at issue.

3.3.3 Expiry of the benefit

The guarantee applies until either the policy anniversary closest to the insured's 70th birthday, or the guarantee or contract cancellation date, whichever comes first.

3.3.4 Exclusions and restrictions

The benefit has no effect when death results directly or indirectly from one or more of the following causes:

- Suicide
- Poisoning
- Gas inhalation
- Riots, Wars
- Driving a vehicle under the influence of drugs or with a concentration of alcohol of more than 80 mg per 100 ml of blood

Refer to the contract clauses for more details.

4. ACCIDENTAL FRACTURE (AF)

Products to which the benefit applies:
Genesis, Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth

Type: Additional benefit

Age at issue: 0 to 60 years

This benefit provides for the payment of a benefit if the insured suffers a bone fracture resulting from accidental causes.

4.1 Premium

Level premium regardless of the insured's age, sex or tobacco status.

Duration of premium payments

Premiums are payable until age 70. If the benefit is attached to a 10-15-20 option in Genesis or to a L10, L20, or L65 in whole life insurance, premiums are payable for a maximum period of 10, 15, 20, 30 or 65 years, as the case may be. As per the Child Life & Health Duo, premiums are payable for 10 years, regardless of the age of the insured at issue.

4.2 Expiry of the benefit

The guarantee applies either until the contract anniversary closest to the insured's 70th birthday or the termination date of the guarantee or the contract, whichever of these events is the first to occur.

4.3 Table of amounts of the benefits

APPLICABLE TYPE OF FRACTURE	AMOUNT OF THE BENEFIT
Skull	
without permanent neurological deficit [(1)]	$3,500
with permanent neurological deficit [(1)]	$10,000
Spinal column	
without permanent neurological deficit [(1)]	$3,500
with permanent neurological deficit [(1)]	$10,000
Femur	
Neck of femur “femoral neck”	$7,500
Femur (excluding neck of femur “femoral neck”)	$3,500
Pelvis (excluding the Sacrum and Coccyx)	$7,500
Hip	$7,500
Humerus	$1,500
Larynx	$1,500
Fibula	$1,500
Sacrum (excluding the Coccyx)	$1,500
Tibia	$1,500
Trachea	$1,500
Ulna	$1,000
Radius	$1,000
Coccyx	$500
Bone not listed above	$500

*Permanent neurological deficit that has quantifiable repercussions on the insured’s daily activities, such as:

- The inability to assume the same workload as previously, or;
- A major residual physical deficit (for example: paralysis of a facial nerve)

The diagnosis must be confirmed by a neurological exam performed by a neurologist, 30 days after the accident at the latest.

— The fracture must be diagnosed within 30 days following the accident.

— The insured must survive 15 days after the accident that caused the fracture.

— Satisfactory proof must be provided to the Company within 90 days following the date of the accident.

In the event of multiple fractures, the Company will pay a benefit for the fracture that provides the highest amount. In addition, the amount of the benefit is doubled if the insured suffers a fracture while travelling as a paying passenger on a public transportation vehicle.

4.4 Exclusions and restrictions

The benefit has no effect when the fracture results directly or indirectly from the following causes:

- voluntary self-inflicted injuries,
- an accident that occurs during a criminal act in which the insured participated
- an accident that occurs while the insured was driving a vehicle and was under the influence of alcohol of more than 80 mg per 100 ml of blood or drugs
- an accident during a war or conflict

Refer to the contract clauses for more details.

5. HOSPITALIZATION RIDER

Products to which the benefit applies:
Genesis, Term & Whole Life Insurance, Transition

Type: Rider

Age at issue: 0 to 65 years

5.1 Description of the protection

The Hospitalization rider is coverage offered on an individual basis only, which must be added onto basic coverage. However, in case of termination of the contract to which it is attached, this rider may remain in effect. In the event of the main insured's death, the Hospitalization rider remains in effect for the other insureds having this coverage, and policy fees will be added.

The "Hospitalization" rider allows the applicant to receive a lump sum amount of money for each day the insured is hospitalized following an accident or illness. Considering that several unexpected expenses must necessarily be incurred in these situations, clients are very appreciative of this coverage. No hospitalization benefit will be paid for a stay in a long term care health center.

The "Hospitalization" rider also provides for the payment of additional benefits when the insured's condition requires hospitalization in intensive care or for hospitalization outside the province of residence. It also offers the reimbursement of a portion of the ambulance fees and a benefit to help the insured move to a long-term care centre if medically necessary.

To remember: "Hospitalization" rider is non offered in case of extra premiums

5.2 Premiums

- Premiums are payable until the policy anniversary nearest the insured's 80th birthday.
- Guaranteed for the first 5 years.
- No quick payment options.
- The premium rate options are established on the amount of the benefit and will vary according to the age at issue.

The premiums are guaranteed for the 5 years that follow the effective date of the contract. At the end of this period, the Company reserves the right to revise the premiums at any time. Following a revision, they will once again be guaranteed for a period of 5 years.

5.3 Beginning of payments

On the first day of a hospitalization of 24 consecutive hours (emergency stay not included in this period). In the event the insured undergoes day surgery, the duration of hospitalization corresponds to a period of 24 hours of hospitalization.

The benefits are paid:

- at the end of the hospital stay when the hospitalization period is less than seven days;
- every month, according to the proof submitted to the company.

Amount of the benefit:

- Insured's choice of $50, $100, $150 or $200 per day of hospitalization.
- 50% decrease in the protection on the policy anniversary nearest the insured's 70th birthday

5.4 Scope of the coverage

24 hours a day in the event of accident or illness

5.5 Medical requirements

Declaration of insurability only.

5.6 Maximum duration of benefits

36 months per period of hospitalization.

5.7 Termination of the protection

The protection terminates on the policy anniversary nearest the insured's 80th birthday.

5.8 Ambulance fees

- $200 additional lump-sum payment upon proof of transportation by ambulance, considering the insured is eligible for the Hospitalization rider payment.
- Maximum of $1,000/year per insured person.

Transportation by ambulance must have been used in the event of one of the following situations:

- emergency transportation to a hospital equipped to provide the required care following an accident or illness, including transportation between hospitals; or
- transportation from the hospital to the insured's residence, in the event it is required by the insured's medical condition.

5.9 Hospitalization in intensive care

Additional benefit = 4 X daily benefit with a maximum of 30 consecutive days and 90 days/contract/insured

If the insured is hospitalized for intensive care, the applicant insured is entitled to a daily additional benefit equal to 4 times the daily benefit indicated on the page of contract specifications for a duration not exceeding 30 consecutive days per period of hospitalization and for a maximum of 90 days per insured for the period during which the contract is in force.

Intensive care means care provided in a specially designed unit of a hospital, open 24 hours a day, intended for seriously ill or injured persons where patients who require intensive medical care receive treatment that they would not receive in another unit of the hospital.

5.10 Hospitalization outside the province of residence

Additional benefit = 1 X daily benefit with a maximum of 30 consecutive days and 90 days/contract/insured

The insured will receive payment of an additional benefit, following an accident, if he is outside the insured's province of residence, in Canada or the United States. The applicant is entitled to an additional benefit equal to 1 time the daily benefit indicated on the page of contract specifications for the first 30 days of hospitalization.

If the insured is hospitalized for a cause other than accidental, the hospital must be situated more than 50 kilometers from his residence to be admissible for the additional benefit.

The additional benefit for hospitalization outside the province of residence is limited to 90 days per insured for the period during which the contract is in force.

5.11 Integration

The hospitalization benefit is not integrated with other group insurance benefits for which the insured could be eligible and it is not integrated with the provincial group health insurance plan.

5.12 Waiver of premiums

No waiver included automatically. The CAD, CID and the CADE are recommended with GENESIS and the WPD and WPDis are recommended for any other life insurance policies.

5.13 Moving expenses

In the event the insured must be transferred to a home-care centre and long-term care facility following a hospitalization, the company agrees to pay a lump-sum amount of $1,000 to cover the moving expenses. For the lump-sum amount to be payable, the benefit must be in force for at least 12 months. A single lump-sum payment will be made per contract.

No hospitalization benefit will be paid for a stay in a residential or long-term care center. As stipulated in the contract, the insured is no longer covered by this guarantee from the moment he/she leaves the hospital.

5.14 Restrictions and exclusions

No benefit is paid if the hospitalization results from a pre-existing condition, pregnancy or childbirth that occurs within 12 consecutive months after the effective date of the insurance.

There are pre-existing conditions when:

- the injury or bodily injury caused by an accident or illness existed during the 24 months preceding the effective date of this insurance; and for which
- the insured person received a diagnosis or suspected the existence of this affliction, received medical care or surgery, underwent diagnostic tests, received treatments or took medication prescribed by a physician.

The benefit is not valid when paid if the hospitalization or insured's transportation results from cosmetic treatments or surgery, self-inflicted injuries, an attempted suicide, poisoning, the inhalation of any gas, riots, wars, driving a vehicle under the influence of drugs or a certain degree of alcohol in the blood (more than 80mg per 100 ml of blood) or practicing dangerous sports (refer to the contract clauses for more details). The benefit is also invalid in the following cases: voluntarily taking medications, drugs, steroids, narcotics or toxic substances, armed conflicts, insurrections or popular movements, service in the armed forces or criminal acts (refer to the contract clauses for more details).

6. HOSPITALIZATION AND HOME CARE RIDER

Products to which the benefit applies:
Genesis, Term & Whole Life Insurance, Transition

Type: Rider

Age at issue: 16 to 65 years

By subscribing to the Hospitalization and Home Care Rider, the insured benefits from the same coverage as described in the previous "Hospitalization Rider" section. Added to this coverage is Home Care protection, which pays certain costs for care received following a hospitalization.

This rider is offered on a stand-**alone basis only.**

6.1 Premiums

Premiums for this coverage are established according to age and the amount of the benefit. They are guaranteed for five years following the effective date. At the end of this period, the Company can revise the premiums at any time. However, following a revision of premiums, the premiums are once again guaranteed for a five-year period.

6.1.1 Premium payment period

Premiums are payable until the policy anniversary nearest the insured's 80th birthday.

6.2 Termination of the coverage

The coverage terminates on the first of the following events:

- the anniversary of this rider nearest the insured's 80th birthday;
- the date on which this rider or the contract is cancelled for any reason whatsoever;
- the date on which you use the extended insurance or reduced insurance option when they apply.

The following fees are eligible:

- assistance fees to accomplish certain daily activities
- transportation fees for medical consultation
- fees incurred to purchase medical supplies

6.3 Benefit reduction

The daily allowance for hospitalization is reduced by 50% at the contract's anniversary that's the closest to the insured's 70th birthday.

6.4 Assistance fees

The daily indemnity depends on the amount of benefit that appears in the contract for hospitalization ($50, $100, $150 or $200 per day of hospitalization).

Licensed practical nurse or client care attendant

Covers the fees for the services of a client care attendant specializing in home care or a licensed practical nurse, to help the insured accomplish at least two (2) activities of daily living, subject to a maximum of:

Hospitalization	Home care Nurse
$50	$50/day
$100	$60/day
$150	$70/day
$200	$80/day

Friend or parent

Covers the fees for a parent or friend to help the insured accomplish at least two (2) activities of daily living, subject to a maximum of:

Hospitalization	Home care friend or parent
$50	$25/day
$100	$30/day
$150	$35/day
$200	$40/day

6.5 Transportation fees

When a medical consultation is required by a doctor or a specialist, following the insured's hospitalization, the insured's transportation fees for this medical follow up are reimbursed as a lump-sum amount of $15 per trip, to a maximum of $30 per day.

6.6 Fees for medical supplies

When the insured person receives at-home care from a licensed nurse, the fees incurred to purchase the medical supplies required to treat an illness or accident are reimbursed. A lump-sum amount of $150 of eligible fees will be paid.

The fees incurred for care by a home care specialist, a loved one and/or transportation fees are subject to a maximum number of days to incur these fees.

6.7 Number of days of coverage

The total amount of benefit and its duration are based on the number of days of hospitalization:

Maximum period to incur the fees starting on the release date from hospital.

A maximum period is provided to incur home care fees following a hospitalization.

Number of days of hospitalization	Period to incur the fees (days)	Duration of coverage (days)
1 to 3	9	5
4 to 7	14	7
8 to 14	28	14
More	35	21

Example:

An insured is hospitalized for 6 days at $150 per day of hospitalization. The insured will be able to receive a benefit for home care expenses and travel expenses incurred in the 14 days after he is released from hospital, for a total of seven days.

If the insured receives care by a professional or a nurse, the maximum benefit in this case will be:

Travel expenses	7 days x $30/day =	$210
Home care benefit	7 days x $70/day =	$490
	TOTAL	**$700**

To be eligible for home care benefits, the insured person must incur the expenses in Canada and at least 1 hospitalization benefit has to have been paid.

To be eligible for benefits for fees to pay for a licensed practical nurse, a client care attendant specialized in home care, or a loved one, the insured person must be unable to accomplish at least two (2) of the activities of daily living listed below.

Proof of the inability to accomplish the tasks that require the services must be provided to the company, along with the receipt that proves that the service was indeed provided.

Activities of daily living

- bathing
- dressing
- toileting
- bladder and bowel continence
- transferring
- feeding

Refer to the contract for the restrictions and exclusions or for more details.

6.8 End of coverage

On the anniversary of the nearest rider of the 80th anniversary of the insured.

7. PARAMEDICAL CARE IN THE EVENT OF AN ACCIDENT

Products to which this benefit applies:
Genesis, Term & Whole Life Insurance, Transition

Type: Rider

Under the Paramedical Care in Case of Accident Rider, the insured receives several types of benefits to cover the fees resulting from an accident.

This rider is offered on a stand-alone basis only.

Age at issue: 15 days to 65 years

7.1 Premiums

Guaranteed and level, according to age and sex

7.2 Premium payment period

Premiums are payable until the policy anniversary nearest the insured's 75th birthday.

7.3 Hospital and Paramedical Fees Following an Accident

Reimbursement of reasonable fees for services, care and treatment provided following an injury and incurred in the insured's province of residence within 104 weeks following the accident, for:

Supplementary cost for a private or semi-private room during a hospital stay:

- maximum per day: $55
- maximum per accident: $3,300
- maximum per insured: $5,000

Additional fees for other expenses resulting from a hospitalization (television, parking, meals, etc.) during a stay in a hospital:

- maximum per day: $30
- maximum per accident: $1,800
- maximum per insured: $2,700

Therapeutic medication that can only be obtained with a physician's prescription and sold by a pharmacist*:

- maximum per accident: $500
- maximum per insured: $1,500

The following expenses recommended by a physician and required for healing[3]:

- rental of a wheelchair, crutches or other orthopedic equipment or the purchase (but not the replacement) if rental is more expensive or impossible
- purchase (but not the replacement) of a fibreglass cast
  - maximum per insured: $500
  - maximum per insured: $1,500

Restriction — Orthopedic equipment used solely for the purposes of practising sports are not reimbursable.

Purchase (but not the replacement) of a prosthetic device (artificial limbs), other than dentures and hearing aids:

- maximum per insured: $3,000

Purchase (but not the replacement) of a hearing aid:

- maximum per insured: $500

Treatments received from a physiotherapist, chiropractor, occupational therapist, podiatrist, osteopath, audiologist or a speech therapist:

- maximum per visit: $25
- maximum per accident: $500 (for all treatments)
- maximum per insured: $1,500

Out-of-hospital nursing services when recommended by a physician:

- maximum per accident: $2,000
- maximum per insured: $4,000

Transportation expenses within 24 hours of the accident using the most economic means available and taking the insured's state of health into account:

- emergency transportation (ambulance, taxi or private vehicle) from the insured's residence to the nearest doctor's office or hospital that is reasonably equipped to provide the necessary care
- transportation (taxi or private vehicle) from this hospital or doctor's office to the insured's residence
- parking expenses, up to a maximum of $10/day
- transportation using a private vehicle is reimbursed at a rate of $10/trip
  - maximum per accident: $1,000
  - maximum per contract: $2,000

Room and board for the person accompanying the insured during hospitalization following an accident, when the insured is hospitalized more than 50 kilometres from his residence:

- maximum par jour: $100
- maximum per accident: $500
- maximum per insured: $1,500

Costs incurred to repair or replace glasses used to correct vision following an accident:

- maximum per accident: $200
- maximum per insured: $400

The maximum amount payable under the "Hospitalization and Paramedical Expenses Following an Accident" clause is $25,000 per accident.

7.4 Emergency Care Outside the Province of Residence:

Up to a maximum of $10,000 per contract for ambulance transportation, the services of a physician and hospital care (including nursing care, laboratory analyses, X-rays or other diagnostic tests) obtained outside the insured's province of residence following an accident. The Company will pay expenses in excess of those covered under any government or private plan if it was impossible to obtain this care or these services in the insured's province of residence.

7.5 Childcare Expenses

The costs incurred by the applicant for the care of:

- his/her insured child under age 18 who must remain at home following an accident
- his/her other children under age 18 if the applicant must accompany an insured child under age for medical follow-up after an accident
- The childcare provider must be at least 18 years of age and cannot be a member of the insured's immediate family
  - maximum per hour: $10
  - maximum per policy year: $1,000
  - maximum per insured: $3,000

7.6 Reimbursement of Registrations

If the accident required withdrawal from a cultural or sports activity, the Company will reimburse the amount in proportion to elapsed duration of the activity:

- maximum per accident: $500
- maximum per insured: $1,500

7.7 Disability Living Allowance

If an accident is the direct cause of a total and continuous disability, the Company will pay a monthly benefit after a 3-month waiting period, as long as the insured is alive and cannot resume normal activities. However, no payment will be made during the period in which the insured occupies a remunerative position. The disability must occur before the contract anniversary closest to the 60th insured's birthday.

- monthly benefit: $200
- maximum per accident: $2,400
- maximum per insured: $4,800

[3] Non-refundable surplus of fees eligible for a government or private insurance plan.

7.8 Total disability following an accident for insureds under age 25 with student status when the accident occurs

Reorientation costs to obtain other training rendered necessary by the accident. These costs must be incurred within two years following the accident.

- maximum per insured: $3,000

Remedial classes given by a teacher approved by the school board are payable beginning on the 31st day of absence from regular classes.

- maximum per hour: $15
- maximum per insured: $1,500

Return transportation between the home and school

- maximum per day: $20
- maximum per accident: $400
- maximum per insured: $1,200

The insured student must not be able to travel to his/her educational institution using his/her usual method of transportation and the individual who transports the insured must be age 18 or over. Transportation using a private vehicle is reimbursed at the rate of $10 per trip, subject to maximum above.

7.9 Dental Care Expenses per Damaged Tooth Following an Accident

Reasonable expenses incurred as a result of an injury to a whole and sound tooth for X-rays or treatments administered within 260 weeks of the date of the accident.

- maximum per accident: $300
- maximum per insured: $1,200

The Company will also reimburse the replacement or repair cost of a dental prosthesis.

- maximum: $300
- maximum per insured: $1,200

For each insured, the maximum TOTAL amount of benefits for the Paramedical Care in the Event of an Accident (excluding the refurbishing expenses presented below), is $40,000.

7.10 Adaptation following an accident

Reimbursement of the indispensable expenses following an accident to adapt the car and/or primary residence for the insured person who suffers permanent motor impairment.

The overall lifetime maximum is **$25,000** per insured person.

The adaptation expenses must be incurred within twelve months of release from hospital.

Prior evaluation

The principle insured or a family member must send the insurer the following documents:

- estimate of the cost of the work
- copy of the home ownership deed if the insured is the owner or agreement by the owner for the work to proceed if the insured person is not the owner.
- agreement of the municipality for special adjustments.

7.11 Integration

The benefit to adapt the car and/or home is integrated with the benefits that the beneficiary could receive under another private coverage or government plan.

7.12 Claims

This form, along with proof of the nature and extent of the losses must be provided to the satisfaction of the Company no later than 90 days after the accident. Original copies of invoices and receipts must be furnished to the Company within this time limit.

7.13 Limitations and exclusions

Refer to the contract for limitations or exclusions.

8. GUARANTEED INSURABILITY (GI)

Products that offer this complementary coverage:
Genesis, Term & Whole Life Insurance

Type: Additional benefit

Age at issue: 0 to 50 years

Age at the termination of the coverage: 59 years

Number of underwriting rights: 6

Minimum per subscription: $10,000 per underwriting right

Maximum per subscription: Twice the face amount, up to a maximum of $100,000 per underwriting right, for all contracts underwritten with the company on the same life.

Total maximum: $500,000

It is therefore possible to increase the life insurance coverage up to $500,000 without evidence of insurability. Insureds with an extra premium are not eligible for guaranteed insurability.

This benefit offers the applicant the possibility to subscribe to an additional amount of insurance on the life of the insured, WITHOUT EVIDENCE OF INSURABILITY. The new coverage must be permanent life insurance. The applicant can exercise this option within 31 days following each third anniversary of the benefit as long as the insured is under 59 years of age. A maximum of six consecutive or non-consecutive underwriting rights can be exercised.

8.1 Duration of premium payments

Premiums are payable until the last underwriting right is exercised and until the insured reaches age 59. If the benefit is attached to a Genesis 10-15-20 option, or a L10, L20, or L65 in whole life insurance, the premiums are payable for a maximum period of 10, 15 or 20 years, as the case may be. As per the Child Life & Health Duo, premiums are payable for 10 years, regardless of the age of the insured at issue.

For the renewal of T10 (R & C) and T20 (R & C) term insurance, the guaranteed insurability premium remains the same as at issue.

The insurance premium is based on the rates in effect at the attained age according to the same risk class (sex and tobaccos status) as the basic contract to which the guaranteed insurability is added. Preferred rates do not apply to GI, since they are only available starting at a face amount equal to or greater than $500,000.

Upon exercising an underwriting right, the new life insurance requested must be insurance normally issued by the Company, except for any term insurance.

An underwriting right can be exercised before the next underwriting date within 31 days after one of the following events: obtain a college or university degree, a marriage, birth or adoption of a child. However, only one early right is permitted per GI contract for a diploma or marriage.

Guaranteed insurability can be added to any existing contract. However, for the purposes of medical requirements, the amount of risk will be equal to twice the maximum value of the benefit, plus the value of any insurance issued without a medical examination in the last two years.

Example:

Sophia wishes to insure her 16-year-old son Max. She purchases $50,000 in insurance and $100,000 in Guaranteed Insurability.

Max will be able to increase his life insurance coverage six times during the coverage period and so, until age 59. The additional face amount could reach up to $500,000.

Here are the ages at which Maxim will be able to benefit from his GI rights.

Age	19	22	25	28	31	34	37	40	43	46	49	52	55	58

If Max obtains a university degree at age 23, he will be able to exercise the right allocated at age 25 before the age 25 underwriting right. The next underwriting right will therefore be at age 28 and so on.

9. CHILD MODULE

Products that offer this complementary coverage:
Genesis, EquiBuild, Term & Whole Life Insurance, iA PAR Estate & Wealth

Type: Rider

9.1 Issue rules

Age at issue

- Child: 15 days to 20 years
- Insured: 15 to 50 years

For each present and future child, this benefit includes a standard amount of term insurance until the first of the following two events:

- 25th birthday* of the child; or
- 65th birthday* of the insured to whom the module is attached.

Child Module premiums are also payable according to one of the two situations described above. The Child Module can be purchased for an unborn first child. The insurance for children starts from the fifteenth day after birth.

Available face amount: $10,000 to $50,000

9.2 Conversion privilege

Upon written request from the applicant on the 25th birthday of the insured's child or in the 31 days that follow, this insurance is convertible to permanent life insurance, without proof of insurability. The maximum amount of insurance that can be converted, for each child, must not exceed:

- 5 times the face amount
- $250,000

The new coverage is established at the standard smoker rate.

If the child is under age 25 when the main insured reaches age 65, the conversion could be made in the 30 days following the 65th birthday of the main insured.

There will be a waiver of premiums under the life insurance on the children if the insured to which the module is attached dies before age 65[4].

Proof of insurability must be provided for all children born when the Child Module is added to the coverage. A child can be excluded for medical reasons. Living children who are not declared in the application are not covered by the Child Module.

[4] on the policy anniversary nearest the insured's birthday.

10. CHILD MODULE PLUS

Products that offer this complementary coverage:
Genesis, Term & Whole Life Insurance, iA PAR Estate & Wealth

Type: Rider

10.1 Issue rules

Age at issue

- Child: 15 days to 20 years
- Insured: 15 to 50 years

Available face amount: $10,000 to $50,000

Child Module PLUS is a more complete additional benefit that combines, under one single protection, a term life insurance and a protection in case of accidental fracture.

For each present and future child, this benefit includes a standard amount of term insurance until the first of the following two events:

- 25th birthday* of the child; or
- 65th birthday* of the insured to whom the module is attached.

The Child Module PLUS premiums are also payable according to one of the first two events described above. The Child Module can be purchased by a mother who applies for an unborn first child. The insurance for children starts from the fifteenth day after birth.

10.2 Conversion privilege

Upon written request from the applicant on the 25th birthday of the insured's child or in the 31 days that follow, this insurance is convertible to permanent life insurance, without proof of insurability. The maximum amount of insurance that can be converted, for each child, must not exceed:

- 5 times the face amount;
- $250,000

The new coverage is established at the standard smoker rate.

If the child is under age 25 when the main insured reaches age 65, the conversion could be made in the 30 days following the 65th birthday of the main insured.

There will be a waiver of premiums under the life insurance on the children if the insured to which the module is attached dies before age 65 (on the policy anniversary nearest the insured’s birthday).

Proof of insurability must be provided for all children born when the Child Module is added to the coverage. A child can be excluded for medical reasons. Living children who are not declared in the application are not covered by the Child Module.

Accidental fracture coverage is attached to the basic life insurance.

APPLICABLE TYPE OF FRACTURE	AMOUNT OF THE BENEFIT
Skull	
— without permanent neurological deficit[5]	$1,750
— with permanent neurological deficit[12]	$5,000
Spinal column	
— without permanent neurological deficit[12]	$1,750
— with permanent neurological deficit[12]	$5,000
Femur	
— Neck of femur “femoral neck”	$3,750
— Femur (excluding neck of femur “femoral neck”)	$1,750
Pelvis (excluding the Sacrum and Coccyx)	$3,750
Hip	$3,750
Humerus	$750
Larynx	$750
Fibula	$750
Sacrum (excluding the Coccyx)	$750
Tibia	$750
Trachea	$750
Ulna	$500
Radius	$500
Coccyx	$250
Bone not listed above	$250

As with the accidental fracture benefit, in the event of multiple fractures, the Company will pay the benefit for the fracture that provides the highest amount. The insured must survive for 15 days after the accident that caused the fracture.

If the insured takes advantage of his conversion privilege at age 25, the accidental fracture coverage is converted into a regular AF additional benefit.

10.3 Exclusions and restrictions

The benefit has no effect when the fracture results directly or indirectly from the following causes: voluntary self-inflicted injuries, an accident that occurs during a criminal act in which the insured participated, an accident that occurs while the insured was driving a vehicle and was under the influence of alcohol or drugs, an accident during a war or conflict (refer to the contract clauses for more details).

[5] Permanent neurological deficit that has quantifiable repercussions on the insured's daily activities, such as:

- The inability to assume the same workload as previously, or;
- A major residual physical deficit (for example: paralysis of a facial nerve)

The diagnosis must be confirmed by a neurological exam performed by a neurologist, 30 days after the accident at the latest.

11. CONTRIBUTION IN THE EVENT OF THE APPLICANT'S (CAD) DISABILITY, CONTRIBUTION IN THE EVENT OF THE INSURED'S DISABILITY (CID) AND CONTRIBUTION IN THE EVENT OF THE APPLICANT'S DEATH (CADE)

Products that offer this complementary coverage:
Genesis, EquiBuild

Type: Additional benefit

11.1 Definition of total disability

For the insured active on the job market at the onset of disability

- During the first 24 months following the onset of disability:

The insured's total and continuous inability to perform the duties of his main occupation following an injury or illness.

- Subsequently:

The insured's total and continuous in ability to engage in any occupation for which he is reasonably qualified following an injury or illness, regardless of the availability of employment.

- For the insured who is unemployed at the onset of disability

The insured's total and continuous in ability to engage in any occupation for which he is reasonably qualified following an injury or illness, regardless of the availability of employment.

11.2 Contribution in the Event of the Applicant's Disability - CAD

Under this benefit, in the event of the applicant's disability (CAD), the company pays the monthly contribution to the accumulation fund. Disability must occur before age 60 and the first payment is made four months after the onset of disability.

The contribution paid under this benefit cannot exceed 200% of the minimum premium (including the premium of the 10-15-20 options and additional benefits, if applicable).

11.2.1 Issue rules

Age at issue: 18 to 55 years.
For any existing contract or for any new issue. As soon as one applicant subscribes to the CAD, the other one is obligated to subscribe.

11.2.2 Waiting period

A continuous period of six months must elapse from the first date of total disability of the insured (CID) before the company begins to pay benefits retroactively to the date of the starting date of the disability.

11.2.3 Duration of premium payments

Premiums are payable until the policy anniversary nearest the applicant's 60th birthday (or insured's 60th birthday in the case of CID). If a 10-, 15- or 20-year option is selected, the premiums are payable according to the duration of the selected option, without exceeding the policy anniversary nearest the applicant's 60th birthday (or insured's 60th birthday in the case of CID). If there are several different options on the contract, the duration of premium payments corresponds to the longest option period up to the policy anniversary nearest the applicant's 60th birthday (or insured's 60th birthday in the case of CID).

11.2.4 Duration of contributions

Contributions are paid to the accumulation fund until the applicant (or the insured in case of a CID) turns 100. If a 10-, 15- or 20-year option is selected, contributions are paid based on the duration of the selected option. If there are several different options on the contract, the duration of contribution payments corresponds to the longest option period without exceeding the applicant's age of 100 (or insured's age in the case of a CID).

If an option is selected and in addition, the contract includes a rider or an additional life insurance coverage, contributions will be paid until the latter of the following events:

- The premium payment period is over
- The applicant turns 100 (or the insured turns 100 in the case of the CID)

11.2.5 Rules for recurring disabilities

Recurring disabilities are covered. If the insured recovers and returns to work following a disability, then suffers a relapse associated with the same cause or a related cause within three months of the recovery, the disability will continue as though it had never been interrupted for the waiver period. A new waiting period will not be applied.

11.2.6 Rules for more than one disability period

More than one disability is covered. If, after being disabled, an insured recovers completely and then becomes disabled again due to a different cause that is related or not to the first disability, this new disability will be covered, subject to a new waiting period.

11.3 Contribution in the Event of the Insured's Disability – CID (the applicant is a company)

The CID additional benefit is used in business insurance (when the applicant is a company). It is then mandatory for all insureds and covers the entire premium of the contract.

Under this benefit, in the event of the insured's disability (CID), the company makes the monthly contribution to the accumulation fund. Disability must occur before age 60 and the first payment is made four months after the onset of the disability.

The contribution paid under this benefit cannot exceed 200% of the minimum premium including the premium of the 10-15-20 options and additional benefits.

Age at issue, waiting period, rules for recurring disabilities and rules for more than one disability period and identical to section 11.2.

11.4 Contribution in the Event of the Applicant's Death (CADE)

Under this benefit, in the event of the applicant's death (CADE), the company makes the monthly contribution to the accumulation fund. Death must occur before age 65 and the first payment is made on the monthly policy anniversary that follows the reception of proof of death.

The contribution paid under this benefit cannot exceed 200% of the minimum premium including the premium of the 10-15-20 options and additional benefits, if applicable.

11.4.1 Issue rules

Age at issue: 18 to 55 years

This benefit is offered to applicants between 18 and 55 years of age for any existing contract or for any new issue and medical requirements are required.

11.4.2 Duration of premium payments

Premiums are payable until the applicant reaches age 65. If the 10-15-20 option is selected, the premiums are payable according to the duration of the selected coverage, without exceeding age 65. If there are several different options on the contract, the duration of premium payments corresponds to the longest option period, without exceeding age 65.

11.4.3 Duration of contributions

Monthly contributions will stop on the monthly anniversary of the policy following the date on which the deceased applicant would have turned 100.

12. WAIVER OF PREMIUMS IN THE EVENT OF THE APPLICANT'S DEATH (WPD) AND IN THE EVENT OF THE APPLICANT'S (WPDIS) OR INSURED'S (WPIDIS) DISABILITY

12.1 Waiver of premiums in the event of the applicant's death (WPD)

Products to which the benefit applies:
Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth

Type: Additional benefit

Age at issue: 18 to 55 years
For any existing contract or new issue.

This benefit provides for the insured's (or insureds') premium payments to be waived if the applicant dies **before age 65**. The premium payments will be waived until the benefit period chosen by the applicant expires. **The WPD is not available when the applicant is the only insured on the policy. For iA PAR, the WPD doesn't cover the contributions to the additional deposit option.**

12.1.1 Premium payment period

The premiums are payable for the benefit period without exceeding the applicant's 65th birthday. Upon the renewal of a term coverage option, the amount of the WPD premium varies according to changes in the core product's premium.

12.1.2 Premium waiver period

The premium payment will be waived if the applicant dies before age 65 and before the benefit expires.

The premiums will be waived during the remaining premium payment period for life insurance coverage.

Example:

An applicant subscribes to the WPD at age 50 on an L20 protection. Nine years later, at age 59, the applicant dies. The premiums for the policy will be waived for the following 11 years (until age 70).

12.2 Waiver of Premiums in the Event of the Applicant's (WPDis) or Insured's (WPIDis) Disability

Products to which the benefit applies:
Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth

Type: Additional benefit

Age at issue: 18 to 55 years

For any existing contract or new issue.
The WPDis and WPIDis provide for the waiver of premium payments if the applicant (WPDis) or the insured (WPIDis) becomes totally disabled before age 60, and if this disability lasts longer than six months. The premiums are waived for the disability period chosen without exceeding the benefit period chosen by the applicant**. For iA PAR, the WPDis and WPDis doesn't cover the contributions to the additional deposit option.**

The WPIDis is only offered when the applicant is a company and there is only one insured on the contract.

12.2.1 Definition of total disability

For the insured active on the job market at the onset of disability

- During the first 24 months following the onset of disability:

The insured's total and continuous inability to perform the duties of his main occupation following an accident or injury.

- Subsequently:

The insured's total and continuous in ability to engage in any occupation for which he is reasonably qualified following an accident or injury, regardless of the availability of employment.

- For the insured who is unemployed at the onset of disability

The insured's total and continuous in ability to engage in any occupation for which he is reasonably qualified following an accident or injury, regardless of the availability of employment.

12.2.2 Waiting period

A continuous 6-month period must elapse from the date the applicant's (WPDis) or insured's (WPIDis) total disability begins before the company begins to waive the premiums for this contract retroactive to the date the disability began.

12.2.3 Premium payment period

The premiums are payable for the benefit period without exceeding the insured's 60th birthday. If a quick payment option is selected such L10, L20, Child Life & Health Duo, the contributions are payable according to the duration of the option of the selected coverage, without exceeding age 60. Upon the renewal of a term coverage option, the amount of the WPDis and WPIDis premium varies according to changes in the core product's premium.

12.2.4 Premium waiver period

Premium payments will be waived if the applicant (WPDis) or insured (WPIDis) becomes totally disabled before age 60. The waiver will continue for the premium payment period of the life insurance protection or until the end of the disability.

Example:

An applicant subscribes to the WPDis at age 50 on an L20 protection. Nine years later, at age 59, the applicant becomes totally disabled. If his disability lasts at least six months, the premium payment will be waived for the following 11 years (to age 70) or until the end of the disability period if it is shorter. The premiums due and paid during the six months waiting period will also be reimbursed.

12.2.5 Rules for recurring disabilities

Recurring disabilities are covered. If the insured recovers and returns to work following a disability, then suffers a relapse associated with the same cause or a related cause within three months of the recovery, the disability will continue as though it had never been interrupted for the waiver period. A new waiting period will not be applied.

12.2.6 Rules for more than one disability period

More than one disability is covered. If, after being disabled, an insured recovers completely and then becomes disabled again due to a different cause that is related or not to the first disability, this new disability will be covered, subject to a new waiting period.

13. SUPPLEMENTARY INCOME (SI)

Products to which the benefit applies:
Genesis, EquiBuild, Term & Whole Life Insurance, Transition

Type: Additional benefit

Age at issue: 18 to 60 years

Supplementary Income is meant primarily for self-employed workers, professionals and small and medium-sized business owners who do not have group insurance, as well as people who have Disability Credit rider that only covers a portion of their income.

Supplementary Income provides for the payment of a monthly income in the event of the insured's total disability following an accident or illness, according to the type of protection chosen by the client. Disability must occur before age 65.

By subscribing to the supplementary income benefit, the client benefits from level and guaranteed premiums for the duration of the coverage. The premiums are established according to the amount of the monthly benefit, the age at issue, sex and tobacco use (no preferred rates), and are payable to age 65.

Elimination period: 1 month

Waiting period: 2 months after the elimination period (retroactive). So 3 months after the onset of disability, the client will receive its first payment which covers months 2 and 3.

Type of protection (offered on an individual basis only)

- Accident (only)
- Accident and illness

13.1 Definition of total disability

For the insured active on the job market at the onset of disability

- During the first 24 months following the onset of disability:

The insured's total and continuous inability to perform the duties of his main occupation following an accident or injury.

- Subsequently:

The insured's total and continuous in ability to engage in any occupation for which he is reasonably qualified following an accident or injury, regardless of the availability of employment.

- For the insured who is unemployed at the onset of disability

The insured's total and continuous in ability to engage in any occupation for which he is reasonably qualified following an accident or injury, regardless of the availability of employment.

13.2 Monthly benefit

- Minimum: $100
- Maximum: $2,000

13.3 Disability benefit payment period

- Two years, without exceeding age 65 (SI 2)
- To age 65 (SI 65)

13.4 Beneficiary

The monthly income from the supplementary income is automatically paid to the policyholder.

13.5 Waiver of premiums

- Premiums not waived
- When the applicant is also the insured for the Supplementary Income rider, it is strongly recommended to also subscribe to the Contribution in the Event of the Applicant's Disability (CAD) or Waiver of Premiums in the Event of the Applicant's Disability (WPDis).

13.6 Proof of income

- Strongly recommended upon subscription, since the benefit could be reduced if, at the outset, the client was over-insured in comparison to his income.
- Required when a claim request is made (for the two years preceding the onset of the disability).

13.7 Decrease in income

- **After the contract is issued:** The company must be informed. The amounts of protection and premiums will be reduced.
- **When the claim request is made:** After it has received the proof of income, the company will reimburse the excess premiums for a maximum period of 12 months.

13.8 Rules in the event of relapse

If the insured recovers and returns to work after a period of disability and suffers a relapse related to the same cause that led to the disability or a related cause within the three-month period following his recovery, the disability will continue as if it had never been interrupted for the remaining duration of the disability benefit payment period, without the application of a new waiting period.

13.9 Gradual or part-time return

For a gradual or part-time return to work, 50% of the monthly annuity is paid during a maximum period of 2 months.

13.10 Integration of benefits

The monthly SI income is integrated. If the insured receives Disability Credit rider benefits under other plans (private public and group plans), the supplementary income benefit payable by the company will be reduced in order that the total disability benefits received by the insured not exceed 100% of his average net monthly income for the two years preceding the onset of total disability. The first four months risk being the most affected by the integration.

13.11 Eligibility criteria

Employment conditions:

- Have earned a gross annual average income equal to or greater than $9,000 in the last two years.
- Be actively at work when the insurance is purchased.
- Work full-time, i.e., 20 hours/week, 9 months +/year; if less than 9 months but more than 6 months, only the two-year accident coverage is available.
- Work at his job (or the same type of employment) for at least one year except for graduated students (CEGEP or university) if they work in a profession related to their field of study.

Note - The job must be the insured's primary source of income and must represent a minimum of 75% of his total annual income.

The medical requirements applicable to the supplementary income are found in the F13-166A Requirements Table. Risks that have an extra premium attached to them are not eligible.

13.12 Underwriting

Medical and financial requirements may be requested in addition to life and critical illness requirements.

- Proof of income not mandatory, but strongly recommended.
- Declaration of insurability F1A
- Telephone interview if SI to age 65, accident and illness with a monthly benefit of $1,000 or more (telephone interview is only required if no paramedical exam or telephone interview is required for the life insurance)
- Other Q6A questionnaire for SI

13.13 Change after the contract is issued

Accident and illness	➔	Accident	Without proof of insurability, premiums according to age upon issue
SI 65	➔	SI 2	
Accident	➔	Accident and illness	With proof of insurability, premiums according to age reached
SI 2	➔	SI 65	

13.14 Exclusions and restrictions

No benefit is paid if the insured's disability results from cosmetic surgery or treatments, self-inflicted injuries, attempted suicide, poisoning, inhalation of any gas, voluntarily taking medication, drugs, steroids, narcotics or toxic substances, war, armed conflicts, riots, insurrections or popular movements, service in the armed forces, a criminal act, driving a vehicle under the influence of drugs or with a certain level of alcohol in the blood, practising dangerous sports (refer to the contract for more specifications).

In addition, no benefit is paid if the insured works at any remunerated employment, returns to school or receives benefits from a government organization to perfect his training or update previous training, if the work stoppage results from preventive leave, maternity leave or parental leave, if the insured refuses to submit to adequate medical treatment, if the insured is not under the continuous care of a physician or the insured has not completed the applicable waiting period (please refer to the contract for more details).

13.15 Termination of the protection

The protection terminates on the first of the following dates or on the first of the following events:

- the policy anniversary nearest the insured's 65th birthday;
- the date on which the rider is cancelled[6] or lapses;
- the cancellation or lapse date of the protection on which the SI was purchased (unless a prior basic protection is still in force);
- on the insured's death.

[6] It is important to note that when the Supplementary Income rider is attached to a **Transition** policy, the rider can remain in-force after the policy has been cancelled or the critical illness benefit has been paid.

14. CRITICAL ILLNESS

Products to which the benefit applies:
Genesis, EquiBuild, Term & Whole Life Insurance, iA PAR Estate & Wealth

Type: Rider

Age[7] at issue:

T10 (R&C):	0–64 years
T20 (R&C):	0–54 years
T25 (R&C):	0–49 years
T75:	0–65 years
T100:	0–65 years

The Critical Illness Rider is insurance coverage that guarantees payment of a lump-sum amount if the insured is alive at the time of diagnosis of any of the diseases or conditions covered. For some diseases, the insured must be alive 30 days after the diagnosis.

The Critical Illness Rider comes in two versions: Critical Illness Coverage – 25 Illnesses and Critical Illness Coverage – 4 Illnesses. Both versions offer the same features.

The Critical Illness Coverage – 4 Illnesses version offers term options decreasing to 50% for the mortgage market, among other benefits. The acceptance process (medical opinions) is also faster and the eight medical questions have been simplified to open the product up to more people.

14.1 Products available

The Critical Illness Rider is offered on an individual basis only and without return of premiums option. The types of coverage offered for both 25 Illnesses and 4 Illnesses versions are the following:

- T10, T20 and T25 (R&C) – 10-, 20- and 25-year term coverage.
- T75 – Coverage until the insured turns 75.
- T100 – Permanent coverage. T100 coverage is paid up when the insured turns 100. After that, no premium is required.

14.2 Face amount option

14.2.1 Levelled face amount

The face amount is fixed for the duration.

14.2.2 Decreasing to 50%

Available only on Critical Illness Rider – 4 Illnesses coverage (T10, T20, T25)

The face amount decreases once a year, on the annual anniversary of the coverage, to imitate a mortgage decrease. The initial face amount can be higher than the balance of the loan or credit line when the protection is established. For a decreasing to 50% face amount, the face amount decreases to reach 50% of the initial face amount and then remains level.

[7] Note that the age means the age on the birthday closest to the effective coverage date.

The decrease is calculated like a mortgage amortization calendar, at an 8% interest rate. A calendar showing the decrease in the face amount attached to each new contract. The face amount cannot be changed from decreasing to level during the term.

Within the 13-month period after the Critical Illness Rider is issued, the type of face amount can be changed from one to another, i.e. decreasing to level or level to decreasing. When the face amount is changed from decreasing to level, the established face amount will correspond to the current face amount when the change is made. Afterward, this type of change can no longer be made.

Note – The face amount doesn't have to correspond exactly to the balance of the loan or credit line and no proof of loan is required at rider issue or when a claim is made.

14.3 Renewal

- Critical Illness Rider, 4 Illnesses and 25 Illnesses coverages – T10, T20 and T25 (R&C) – Renewable up until the insured turns 75.
- Critical Illness Rider, 4 Illnesses coverage, decreasing to 50% – T10, T20 and T25 (R&C) – Renewable up until the insured turns 75. The face amount will be equal to 50% of the initial face amount and will be level.

The renewal premiums are guaranteed at issue and calculated using the attained age of the insured at the time of renewal.

14.4 Conversion option

- Critical Illness Rider, 4 Illnesses and 25 Illnesses coverages – T10, T20 and T25 (R&C) – Can be converted to permanent coverage until the insured turns 65 for T75 and T100. No evidence of insurability is required at the time of conversion.
- Critical Illness Rider, 4 Illnesses coverage, decreasing to 50% – T10, T20 and T25 (R&C) – Can be converted to permanent coverage until the insured turns 65 for T75 and T100. The face amount will be equal to the face amount at the time of conversion. No evidence of insurability is required at the time of conversion.

Conversion is permitted on a same-generation product only.

14.5 Termination of the Contract

The insurance terminates when the first of the following events occurs:

- The last protection terminates
- The critical illness benefit is paid
- The last insured dies
- The policy expires
- We cancel this policy within legal guidelines

14.6 Riders

Please note that premium refund riders are not available with the Critical Illness Rider. When the Critical Illness Rider is converted within the policy containing this rider, adding the Flexible Return of Premiums (FRP) or Return of Premiums upon Death (RPD) rider is not permitted.

Example:

- Paul has a whole life insurance policy that includes a Critical Illness T10 rider.
- Paul wants to convert his T10 rider to a T75 and add a Return of Premiums upon Death rider.
- Paul cannot add the Return of Premiums upon Death rider within his whole life Insurance policy.

In other words, you can't add a rider to a rider. When critical illness coverage is in a rider, the rider can be converted and a Return of Premiums upon Death rider can be added under the following terms and conditions:

- Policy: A new Transition policy is issued.
- Evidence of insurability: No evidence of insurability is required.
- Issue date: The issue date of the new policy is the conversion date.

14.7 Covered illnesses and conditions covered

	Covered illnesses and conditions covered	Critical Illness Rider – 25 Illnesses	Critical Illness Rider – 4 Illnesses
Adult	Aortic Surgery	Covered	Not covered
	Aplastic anemia	Covered	Not covered
	Bacterial Meningitis	Covered	Not covered
	Benign Brain Tumour	Covered	Not covered
	Blindness	Covered	Not covered
	Cancer (Life-Threatening)	Covered	Covered
	Coma	Covered	Not covered
	Coronary Artery Bypass Surgery	Covered	Covered
	Deafness	Covered	Not covered
	Dementia, including Alzheimer's Disease	Covered	Not covered
	Heart Attack	Covered	Covered
	Heart Valve Replacement or Repair	Covered	Not covered
	Kidney Failure	Covered	Not covered
	Loss of Independent Existence	Covered	Not covered
	Loss of Limbs	Covered	Not covered
	Loss of Speech	Covered	Not covered
	Major Organ Failure on Waiting List	Covered	Not covered
	Major Organ Transplant	Covered	Not covered
	Motor Neuron Disease	Covered	Not covered
	Multiple Sclerosis	Covered	Not covered
	Occupational HIV Infection	Covered	Not covered
	Paralysis	Covered	Not covered
	Parkinson's Disease and Specified Atypical Parkinsonian Disorders	Covered	Not covered
	Severe Burns	Covered	Not covered
	Stroke (Cerebrovascular Accident)	Covered	Covered
Children	Cerebral paralysis	Covered	Covered
	Congenital heart disease	Covered	Covered
	Cystic fibrosis	Covered	Covered
	Muscular dystrophy	Covered	Covered
	Type 1 diabetes mellitus	Covered	Covered

14.8 Prevention + Benefit

The Prevention + benefit pays a partial benefit equal to 15% of the face amount, up to $50,000, if the insured is diagnosed with one of the following six diseases:

- Coronary angioplasty
- Cancers detected in early stages:
  - Gastrointestinal stromal tumours (GIST) and neuroendocrine tumours (classified less than AJCC Stage 2)
  - Stage 1 malignant melanoma
  - Stage A prostate cancer (T1a or T1b)
  - Ductal carcinoma in situ of the breast
  - Papillary or follicular thyroid cancer stage T1
  - Rai Stage 0 chronic lymphocytic leukemia (CLL)

The Prevention + benefit can be paid up to **four times** for all the illnesses above (once per illness) for the entire term of the Critical Illness Rider. The insured can therefore receive up to a total of $200,000 with the Prevention + benefit. The rider continues under the same conditions after the benefit is paid and the face amount is not reduced by the amount paid.

14.9 Face amount

Minimum initial face amount:		$10,000
Maximum initial face amount:	0 to 17 years: 18 ears+:	$500,000 $2,500,000

14.10 Premiums

Insurance premiums are based on the face amount, age, sex and smoking status of each insured person at the time the Critical Illness Rider is issued. Preferred rates are not available for this rider. Premiums are guaranteed for all coverages.

Premiums are set according to the following four rate bands:

Band	Amount of insurance ($)
1	$10,000 to $49,999
2	$50,000 to $99,999
3	$100,000 to $199,999
4	$200,000 to $2,500,000

14.11 Benefit payment

The benefit is paid to the designated beneficiary if the insured meets the conditions of survival of a critical illness covered by the Critical Illness Rider. The payment of the critical illness benefit does not terminate the life insurance coverage (if applicable).

14.12 Taxation

The Critical Illness rider benefit is not taxable. If the beneficiary of the benefit is an employee, the premiums paid by the company may be tax deductible. Moreover, the benefit paid to a company is not part of the capital dividend account.

The following table summarizes the tax implications for various options available.

SUMMARY OF TAX IMPLICATIONS OF CRITICAL ILLNESS RIDER

	Individual		**Business**	
Policyholder	Individual	Business	Business	Business
Benefit beneficiary	Individual	Individual (as a shareholder)	Individual (as an employee)	Business
Premiums	Non-deductible	Non-deductible	Deductible	Non-deductible
Benefit	Non-taxable	Non-taxable	Non-taxable	Non-taxable
Other tax implications	None	Taxable benefit for the shareholder equal to the premiums	Taxable benefit for the employee equal to the premiums	Is not part of the capital dividend account

15. CHILD CRITICAL ILLNESS/TRANSITION CHILD

Products to which the benefit applies:
Child Critical Illness:
Genesis, EquiBuild, Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth

Transition - Child:
Transition

Type: Rider

Age at issue:

- Child: 0 to 20 years
- Insured: 15 to 50 years

Every child who is named on the critical illness insurance application or is born or legally adopted after the effective date of the policy is automatically covered under the Transition 6.0 Child Rider, with no evidence of insurability required, except:

- If they are expressly excluded as confirmed by an amendment to the policy
- If they are born or legally adopted between the date, the critical illness insurance application is signed and the effective date of this rider

Under the Child Critical Illness Rider, for every present and future child, the face amount is paid if the child respects the conditions of survival of one of the Critical Illness and covered conditions (see covered illnesses and conditions in section 14.7) or one of the juvenile illnesses listed below:

- Type 1 diabetes mellitus
- Muscular dystrophy
- Cystic fibrosis
- Congenital heart disease
- Cerebral palsy
- Down syndrome

15.1 Face amount (per child)

Minimum:	$2,000
Maximum:	$20,000

15.2 Termination date

Critical Illness term coverage for a child ends when the first of the following events occurs:

- The Critical Illness benefit is paid;
- The last child turns 25;
- The last child dies;
- The anniversary of the policy this rider is attached to is reached or the insured turns 65;
- The coverage this rider is attached to ends;

- This rider is terminated;
- The policy ends.

15.3 Paid-up insurance

If the insured to whom the rider is attached dies or receives a Critical Illness benefit before the end of the Child Critical Illness Rider and the Transition 6.0 Child Rider, the insurance under this rider is paid-up until the youngest child has reached age 25.

15.4 Conversion privilege

Upon written request from the applicant, on the 25th birthday of the insured's child or during a 31 days period following the 25th birthday of the insured's child, the company replaces the coverage granted into Transition individual coverage or, if applicable, any other available product the company deems equivalent when the conversion takes place:

- without evidence of insurability;
- for the same face amount; and
- according to a smoker premium (satisfactory evidence of insurability is required to obtain the non-smoker status).

16. COMPLEMENTARY COVERAGE AVAILABLE FOR JOINT INSURANCE

	Basic joint insurance			Additional benefit	
Additional benefit	**First death**	**Last death**	**Last death paid up on the first death**	**On an individual basis only**	**Products offering this coverage**
Disability Credit	Available	Available	Available	Available	Genesis, Term & Whole Life Insurance, EquiBuild(6), iA PAR Estate & Wealth(6)
AD(1)	Available	Not available	Not available	Not available	Genesis, Term & Whole Life Insurance
AD&D(1)	Available	Not available	Not available	Not available	Genesis, Term & Whole Life Insurance
SI	Available	Available	Not available	Available	Genesis, Term & Whole Life Insurance, Transition, EquiBuild(6)
AF(1)	Available	Not available	Not available	Not available	Genesis, Term & Whole Life Insurance, Transition
GI/MGI	**Not available**				
Hospitalization	Available	Available	Not available	Available	Genesis, Term & Whole Life Insurance, Transition
Hospitalization and Home Care	Available	Available	Not available	Available	Genesis, Term & Whole Life Insurance, Transition
Paramedical Care in the Event of an Accident	Available	Available	Not available	Available	Genesis, Term & Whole Life Insurance, Transition
CAD(2) / CID(3)	Available	Available	Available	Not available	Genesis, EquiBuild(6)
CADE(2)		Available	Available	Not available	Genesis, EquiBuild(6)
WPDis(4)	Available	Available	Available	Not available	Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth(6)
WPIDis	Not available	Not available	Not available	Available	Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth(6)
WPD(4)	Available	Available	Available	Not available	Term & Whole Life Insurance, Transition, iA PAR Estate & Wealth(6)
Child Module(5)	Available	Available	Not available	Not available	Genesis, Term & Whole Life Insurance, EquiBuild(6), iA PAR Estate & Wealth(6)
Child Module Plus	Available	Available	Not available	Not available	Genesis, Term & Whole Life Insurance, iA PAR Estate & Wealth(6)
Critical Illness	Available	Available	Not available	Available	Genesis, Term & Whole Life Insurance, EquiBuild(6), iA PAR Estate & Wealth(6)
Child Critical Illness(5)	Available	Available	Not available	Not available	Genesis, Term & Whole Life Insurance, EquiBuild(6), Transition(6), iA PAR Estate & Wealth(6)
Term Life	Available	Available	Not available	Not available	Term & Whole Life Insurance
T10(R&C) / T20(R&C)	Available	Available	Not available	Not available	Genesis, EquiBuild(6), iA PAR Estate & Wealth(6)
Pick-A-Term T25 and T30	Not available	Not available	Not available	Available	Genesis, EquiBuild(6), iA PAR Estate & Wealth(6)

(1) AD, AD&D and AF coverages end at age 70, based on the age of the oldest insured.

(2) CAD/CADE coverages may also apply to more than one applicant and, in such case, must be taken out by all the applicants. The premium is equal to the sum of each applicant's individual premiums.

(3) CID coverage applies to business contracts and must be taken out by all insureds **on an individual basis**. The premium is equal to the sum of each applicant's individual premiums.

(4) WPDis and WPD may also apply for two applicants, provided that both are insurable. In such case, an individual premium is calculated for each applicant. Furthermore, as soon as one of the applicants takes out WPDis, the other must also do so.

(5) Child Module and Child Critical Illness coverages end when the oldest insured turns 65.

Note: When **more than two lives** are covered under joint insurance, only the following complementary coverages are available:

- In Genesis: CAD, CADE
- In Term & Whole Life Insurance: WPDis, WPD, Disability Credit Rider, Term

(6) The only types of coverage available for EquiBuild and iA PAR Estate & Wealth are the following: individual and joint-last-to-die.

17. APPENDIX I – DEFINITIONS OF CRITICAL ILLNESSES AND CONDITIONS

You will find here below definitions for each of the 25 critical Illnesses and conditions covered by the contract.

A survival period applies for certain Critical Illnesses covered. When no survival period applies to a covered critical illness, the insured must be alive at the time the illness is diagnosed.

The following critical illnesses and conditions are covered under this policy:

Aortic Surgery

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

Exclusion from this definition:

No Critical Illness Benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures. A 30-day survival period applies.

Aplastic Anemia

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

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

The diagnosis of Aplastic Anemia must be made by a specialist.

Bacterial Meningitis

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 from this definition:

No Critical Illness Benefit will be payable for viral meningitis.

Benign Brain Tumour

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 from this definition:

No Critical Illness Benefit will be payable if, within the first 90 days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the life insured has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for Benign Brain Tumour or, any Critical Illness caused by any Benign Brain Tumour or its treatment. No Critical Illness Benefit will be payable for pituitary adenomas less than 10 mm.

Blindness

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)

A definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a specialist.

Exclusion from this definition:

No Critical Illness 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 date of last reinstatement of the policy, the life insured 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).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for cancer or, any Critical Illness caused by any cancer or its treatment.

No Critical Illness Benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

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

Coma

A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of Coma must be made by a specialist.

Exclusion from this definition:

No Critical Illness Benefit will be payable 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

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist. A 30-day survival period applies.

Exclusion from this definition:

No Critical Illness Benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness

A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of Deafness must be made by a specialist.

Dementia, including Alzheimer's Disease

A definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate,
- sequence, monitor, and stop complex behaviour), which is affecting daily life.

The life insured must exhibit:

- dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The diagnosis of Dementia must be made by specialist.

Exclusion from this definition:

No Critical Illness Benefit will be payable for affective or schizophrenic disorders, or delirium.

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

Heart Attack

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 of the following:

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

The diagnosis of Heart Attack must be made by a specialist. A 30-day survival period applies.

Exclusion from this definition:

No Critical Illness Benefit will be payable 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 does not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist. A 30-day survival period applies.

Exclusion from this definition:

No Critical Illness Benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure

A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a specialist.

Loss of Independent Existence

A definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a specialist.

Activities of daily living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs

A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a specialist.

Loss of Speech

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 from this definition:

No Critical Illness Benefit will be payable for all psychiatric related causes.

Major Organ Failure on Waiting List

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 life insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. The date of diagnosis is the date of the life insured's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Major Organ Transplant

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 life insured 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

A definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo-bulbar palsy, and limited to these conditions. The diagnosis of Motor Neuron disease must be made by a specialist.

Multiple Sclerosis

A definite diagnosis of at least one of the following:

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

The diagnosis of Multiple Sclerosis must be made by a specialist.

Occupational HIV Infection

A definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the life insured'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 policy, or the effective date of last reinstatement of the policy. The Critical Illness Benefit is payable if all of the following conditions are satisfied:

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

The diagnosis of Occupational HIV Infection must be made by a specialist.

Exclusion from this definition:

No Critical Illness Benefit will be payable if:

- The life insured 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

A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Parkinson's Disease is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The life insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

Exclusion from this definition:

No Critical Illness Benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the life insured has any of the following:

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

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

No Critical Illness Benefit will be payable for any other type of Parkinsonism.

Severe Burns

A definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a specialist.

Stroke (Cerebrovascular Accident)

A definite diagnosis of an acute cerebrovascular event caused by intracranial 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 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. A 30-day survival period applies.

Exclusion from this definition:

No Critical Illness Benefit will be payable 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.

18. APPENDIX II – DEFINITIONS OF JUVENILE CRITICAL ILLNESSES AND CONDITIONS

A survival period applies for certain Juvenile Critical Illness covered. When no survival period applies to a Juvenile Critical Illness covered, the insured must be alive at the time the diagnosis is made. The diagnosis of a Juvenile Critical Illness and condition must be made before the life insured's 25th birthday.

The following juvenile critical illnesses and conditions are covered under this policy:

Cerebral Palsy

A definitive diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements. The diagnosis of Cerebral Palsy must be made by a specialist.

Congenital Heart Disease

A definite diagnosis of Congenital Heart Disease listed below, made by a specialist and supported by appropriate cardiac imaging. For the purposes of the survival period, the date of the diagnosis is the latter of the end date of the survival period and the end date of the 30-day period following the birth of the life insured. A 30-day survival period applies.

- The following Congenital Heart Diseases are covered:

  - Transposition of the great vessels
  - Atresia of any heart valve
  - Coarctation of the aorta
  - Single ventricle
  - Hypoplastic left heart syndrome
  - Double outlet left ventricle
  - Total anomalous pulmonary venous connection
  - Truncus arteriosus
  - Tetralogy of Fallot
  - Eisenmenger syndrome
  - Double inlet ventricle
  - Hypoplastic right ventricle
  - Ebstein's anomaly

- The following Congenital Heart Diseases are covered if open-heart surgery is determined medically necessary by a specialist.
  - Pulmonary stenosis
  - Aortic stenosis
  - Discrete subvalvular aortic stenosis
  - Ventricular septal defect
  - Atrial septal defect

<u>Exclusion from this definition:</u>

No Critical Illness Benefit is payable if the Congenital Heart Disease is not listed in items above and for techniques such as valvuloplasty and percutaneous interauricular communication closure.

Cystic Fibrosis

A definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency and high levels of chlorine in sweat (60 mmol/L or higher). The diagnosis of Cystic Fibrosis must be made by a specialist.

Muscular Dystrophy

A definitive diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy. The diagnosis of Muscular Dystrophy must be made by a specialist.

Type 1 Diabetes Mellitus

A definite diagnosis of Type 1 Diabetes Mellitus, characterized by an absolute deficiency of insulin secretion and continued dependence on exogenous insulin for survival. Diagnosis must be made by a specialist practising in Canada or the United States of America. In addition, there must be proof that there has been insulin dependence for a minimum of three months.

The following illness is covered by the Child Critical Illness rider only

Down's Syndrome: a definite diagnosis of a genetic condition characterized by mental retardation and specific physical characteristics.

19. APPENDIX III – PREVENTION +

A survival period applies for certain Critical Illnesses covered under the Prevention + benefit. When no survival period applies to a covered Critical Illness, the insured must be alive at the time the diagnosis is made. The following critical illnesses and conditions are covered under the Prevention + Benefit:

Coronary angioplasty

The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist. A 30-day survival period applies.

Ductal carcinoma in situ of the breast

A definite diagnosis of ductal carcinoma in situ of the breast, confirmed by biopsy. The diagnosis must be made by a specialist.

Gastrointestinal stromal tumours (GIST) and neuroendocrine tumours (classified less than AJCC Stage 2)

A definite diagnosis of malignant gastrointestinal stromal tumours (GIST) and malignant neuroendocrine tumours, classified less than AJCC Stage 2. The diagnosis must be made by a specialist and confirmed by biopsy.

Stage 1 malignant melanoma

A definite diagnosis of stage 1A or 1B malignant melanoma not ulcerated into the dermis equal to or lower than a depth of one millimetre confirmed by biopsy. The diagnosis must be made by a specialist.

Exclusion from this definition

No Prevention + Benefit will be payable under this Critical Illness for any malignant melanoma in situ.

Stage A (T1a or T1b) prostate cancer

A definite diagnosis of stage A (T1a or T1b) prostate cancer, confirmed by biopsy. The diagnosis must be made by a specialist.

Rai stage 0 chronic lymphocytic leukemia (CLL)

A definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL) confirmed by appropriate blood tests. The diagnosis must be made by a specialist.

For the purposes of the policy, the term Rai staging is to be applied as set out in Rai, K.R., Sawitsky, A., Cronkite, E.P., Chanana, A.D., Levy, R.N. & Pasternack, B.S (1975). Clinical staging of chronic lymphocytic leukemia. Blood, Volume 46, p. 219.

Exclusion from this definition:

No Prevention + Benefit will be payable under this Critical Illness for any monoclonal lymphocytosis of undetermined significance (MLUS).

Papillary or follicular thyroid cancer stage T1

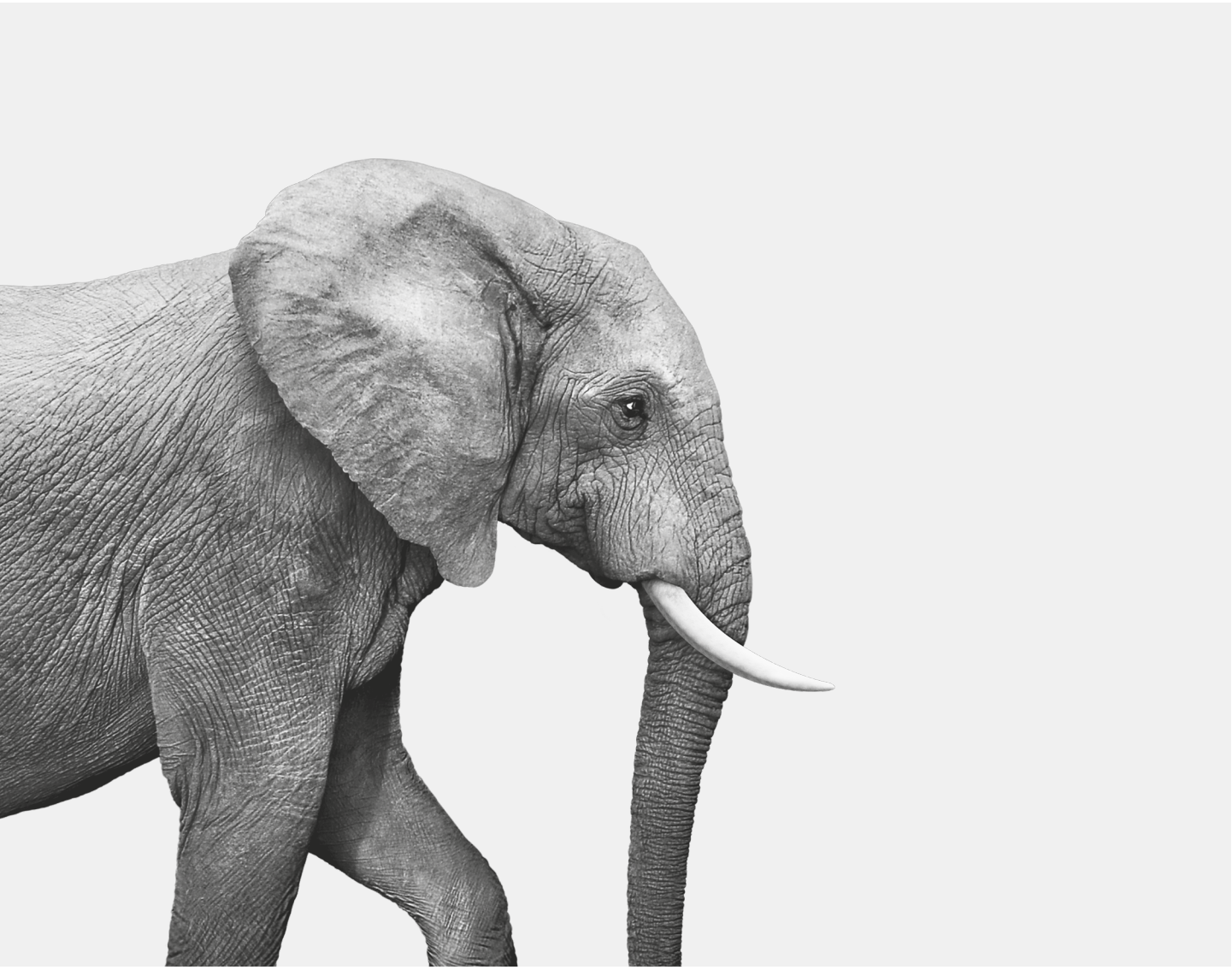
A definite diagnosis of papillary or follicular thyroid cancer or both, that is less than or equal to two centimetres in greatest diameter and classified as T1, without lymph node or distant metastasis, confirmed by a biopsy. The diagnosis must be made by a specialist.

Exclusions and Restrictions applicable to Prevention + Benefit

Subject to any other exclusions and restrictions under this policy, no Prevention + Benefit is payable to the diagnosis of any of the cancers described in provision 5.2.1 (Terminology of Critical Illnesses covered under Prevention + Benefit) if, within the first 90 days following the latter of the effective date of the policy and the date of last reinstatement of the policy, the Insured has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within six months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for cancer or any Critical Illness caused by any cancer or its treatment.



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