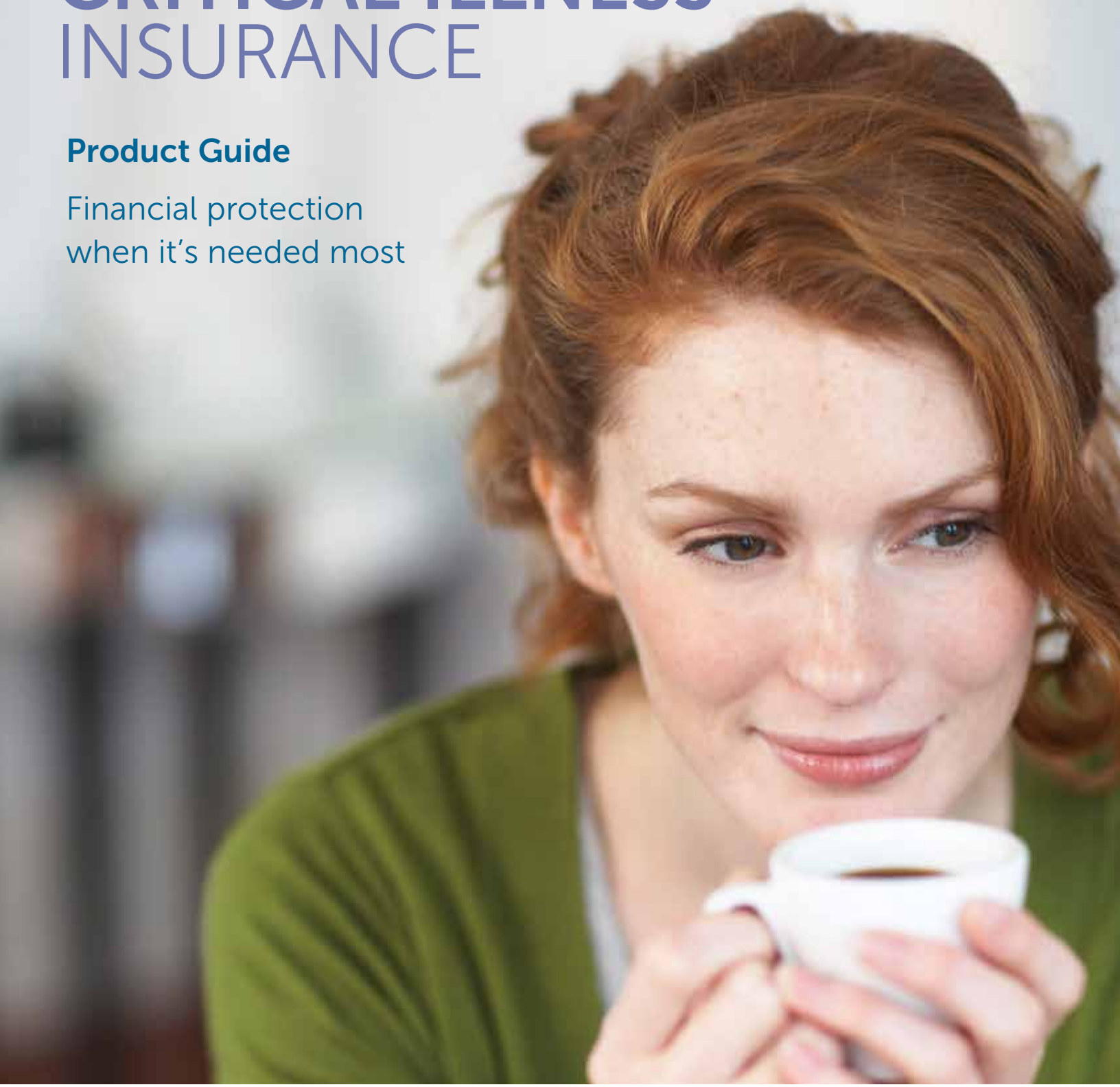
GROUP **CRITICAL ILLNESS** INSURANCE

Product Guide

Financial protection
when it's needed most



Empire Life®

VALUABLE PROTECTION... WHEN EMPLOYEES NEED IT MOST

A serious illness can be frightening enough without worrying about money. Yet most employees would find it financially challenging were they suddenly forced to take time off work. Would their spouse need to take time off too, for caregiving? What about travel for treatment (including accommodation, meals and parking)? Would they need medication or medical supplies not covered by the health plan?

The odds of surviving a critical illness have never been better, but the road to recovery can be surprisingly costly. Not everyone has enough savings to draw on. Disability benefits certainly help but may not be enough.

Group Critical Illness insurance can help bridge the gap between disability benefits and unexpected medical costs. It provides financial protection when it's needed most, so employees can focus on their recovery. And it's fast becoming an essential component in competitive benefit plans—in fact, the CI market has doubled since 2010 according to a recent study[1] —providing value for both employees and employers.

For employees:

- A non-taxable lump sum that's not dependent on recovery or return to work
- No limitations on the funds
- Financial protection when it's needed most, stabilizing household finances and helping to pay unexpected medical costs

For employers:

- Helps demonstrate that employee health and wellbeing is a priority
- Can keep productivity as high as possible by supporting employees before, during, and after diagnosis
- Keeps benefits competitive

[1] Munich Re 2014

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CUSTOMERS CAN PROTECT THEIR EMPLOYEES... THEIR WAY

The medical breakthroughs helping people survive major illnesses are also making critical illness insurance more relevant and appealing than ever before. With three product options to choose from, customers can add the type and level of protection that fits their needs.

The strength of our portfolio

The Empire Life Group CI portfolio of products offers lots of flexibility thanks to the following market-leading features:

1. Coverage of 31 health conditions with our Traditional and Enhanced CI. The four conditions covered by Vital Assist CI provide solid protection against the conditions that make up close to 90%of CI claims[1]. But the trend is towards covering more, and with our Traditional and Enhanced CI, Empire Life delivers.
2. Coverage for groups with as few as three people (when CI is taken, there must be a minimum of three people in the group or class).
3. Face amount options up to $250,000 (and as much as $500,000 when combined with employee-paid Optional CI).
4. Partial, multiple, and cancer recurrence benefits, available with Enhanced CI, let customers add an extra layer of protection for all employees or just selected classes. And when customers add optional CI to their plan, even if they take Vital Assist CI or Traditional CI, employees can always add this extra layer themselves.
5. Our complementary Health Concierge Service, provided by MedExtra Inc., plays a vital role helping employees and their families through a difficult time. The Health Concierge Service can accelerate the diagnosis, help establish the best treatment plan, answer questions, be the liaison between hospital medical staff and the employee and family. It also provides emotional support throughout the journey. Far more than a medical second opinion service, the Health Concierge Service provides six types of assistance that can make all the difference.
6. With waiver of premium, we suspend all benefit premiums for CI (including for spouse and any dependants) for employees who become disabled. At the same time, we maintain their benefit coverage. The definition of disability will depend on whether Life or LTD benefits is in place.
7. For new customers, our combined medical underwriting form means that employees complete one streamlined form for life insurance, LTD, and CI coverage.

[1]Munich Re 2014

The Empire Life Group CI Portfolio

	Vital Assist CI **Simplified coverage**	**Traditional CI** **Complete coverage**	**Enhanced CI** **Multiple event coverage**
Covered conditions	4 for employee	31 for employee/ spouse 15 for dependent children	31 for employee/ spouse 15 for dependent children
Eligibility	Employees	Employee/spousal/ dependant coverage available	Employee/spousal/ dependant coverage available
Optional CI	Optional employee/ spousal/ dependant CI available (Traditional or Enhanced CI)	Optional employee/ spousal/ dependant CI available (Traditional or Enhanced CI)	Optional employee/ spousal/ dependant CI available (Traditional or Enhanced CI)
Group/class size	3 and up	3 and up	3 and up
Coverage amounts	$10,000/$20,000/$30,000*	$10,000-$250,000 employee (units of $1,000) $10,000-$25,000 spouse (units of $1,000)** $5,000 dependent children (flat amount)	
Optional CI coverage amounts	$10,000-$250,000 employee (units of $1,000) $10,000-$250,000 spouse (units of $1,000) $5,000-$25,000 dependent children (units of $1,000)		
Payout features	Lump sum and medical expense benefit	One time benefit	Partial/multiple/cancer recurrence benefits***
Pre-existing condition exclusions	No pre-ex	Pre-ex 24/24 Pre-ex 12/12 (option for 50+ groups) Pre-ex 0/0 (option for 200+ groups)	Pre-ex 24/24 Pre-ex 12/12 (option for 50+ groups) Pre-ex 0/0 (option for 200+ groups)
Medical underwriting	None	May apply	May apply
Waiver of premium	No	Yes	Yes
Portability	No	No	No
Conversion	No	No	No
Termination age	Employee age 65	Employee age 70 for mandatory coverage, 65 for optional coverage	Employee age 70 for mandatory coverage, 65 for optional coverage
Reduction schedule	Does not apply	Coverage reduces by 50% when employee turns 65 for mandatory employee and spousal coverage No reduction for mandatory dependant coverage or for optional coverage	

* $5,000, $15,000, or $25,000 lump sum + $5,000 medical expense benefit
** Group/class must have 5 lives for coverage over $10,000
***Does not apply to dependent children

COVERED CONDITIONS

Here is a listing of medical conditions covered by each of our three product options. Vital Assist CI covers the 4 most prevalent conditions. Traditional CI and Enhanced CI cover 31 conditions—the 4 most prevalent plus 27 other conditions, and 15 conditions for dependent children.

	Vital Assist CI Simplified coverage	Traditional CI Complete coverage	Enhanced CI Multiple event coverage
Aortic surgery		•	•
Aplastic anemia		•	•
Bacterial meningitis		•	•
Benign brain tumour		•	•
Blindness		•	•
Cancer (life-threatening)	•	•	•
Cardiomyopathy		•	•
Coma		•	•
Coronary artery bypass surgery	•	•	•
Deafness		•	•
Dementia, including Alzheimer's disease		•	•
End-stage liver failure		•	•
Fulminant viral hepatitis		•	•
Heart attack	•	•	•
Heart valve replacement or repair		•	•
Kidney failure		•	•
Loss of independent existence		•	•
Loss of limbs		•	•
Loss of speech		•	•
Major organ failure on waiting list		•	•
Major organ transplant		•	•
Motor neuron disease		•	•
Multiple sclerosis		•	•
Occupational HIV infection		•	•
Paralysis		•	•
Parkinson's disease and specified atypical Parkinsonian disorders		•	•
Primary pulmonary arterial hypertension		•	•
Progressive systemic sclerosis (scleroderma)		•	•
Severe burns		•	•
Stroke (cerebrovascular accident)	•	•	•

Customers can add protection for employees' spouses and dependent children when they choose Traditional CI and Enhanced CI. Spousal coverage includes the 31 conditions above. The table below lists the conditions covered for dependent children.

	Traditional CI Complete coverage	Enhanced CI Multiple event coverage
Benign brain tumour	•	•
Blindness	•	•
Cancer (life-threatening)	•	•
Cerebral palsy	•	•
Congenital heart disease	•	•
Cystic fibrosis	•	•
Deafness	•	•
Down's syndrome	•	•
Kidney failure	•	•
Major organ failure, on waiting list	•	•
Major organ transplant	•	•
Muscular dystrophy	•	•
Paralysis	•	•
Spina bifida cystica	•	•
Type 1 diabetes mellitus	•	•

OUR NEW VITAL ASSIST CI

Our Vital Assist Health Benefit has been improved, renamed Vital Assist CI, and is now part of our CI portfolio. Like Traditional and Enhanced CI, Vital Assist CI:

- can cover groups/classes with as few as three employees
- is based on CLHIA 2013 CI benchmark definitions
- includes a demographic rate basis
- can have optional Traditional or optional Enhanced CI added, for extra coverage
- provides access to our complementary Health Concierge Service

The rest of Vital Assist features are not changing.

Vital Assist CI provides valuable financial protection without breaking the budget. It's a simplified and affordable solution:

- $10,000, $20,000, $30,000 in benefits ($5,000, $15,000, or $25,000 lump sum plus a $5,000 medical expense benefit to cover eligible out-of-pocket medical expenses incurred by employees and their insured dependants within 12 months of the date the employee meets the eligibility requirements)
- No medical underwriting, except for late enrollees
- No one is excluded at time of claim due to a pre-existing medical condition
- Coverage of the top four conditions—cancer, heart attack, stroke, and coronary artery bypass surgery—accounts for close to 90% of CI claims[1]
- With three levels of coverage, customers can choose the total benefit amount that meets their needs
- Medical expense benefit encourages employees to focus on their health and recovery

To be eligible for reimbursement, a medical expense must be listed in the Canada Revenue Agency (CRA) inventory of eligible medical expenses AND must not be an excluded item under the terms of the group benefits contract.

Vital Assist is payable when an insured employee is diagnosed with one of the four covered conditions and within 60 days of the date of diagnosis stays in hospital as an in-patient for 72 consecutive hours OR is absent from work for two consecutive weeks as a result of the covered condition and as supported by written proof from the attending physician.

[1]Munich Re 2014

PARTIAL, MULTIPLE, CANCER RECURRENCE BENEFITS

Customers who select Enhanced CI give employees extra protection with partial benefits, multiple event coverage and cancer recurrence benefits. Partial/multiple/cancer recurrence benefits do not apply to dependent children.

Partial benefits

Some health conditions, while serious, are not generally considered life threatening thanks to advances in medicine. At the same time, an individual diagnosed with one of the following conditions may need to take time off work and may incur unforeseen costs. The following illnesses are eligible for a payout of 10% of the coverage amount:

1. Coronary Angioplasty
2. Ductal Breast Carcinoma in situ
3. Early Stage Chronic Lymphocytic Leukemia
4. Early Stage Malignant Melanoma
5. Early Stage Prostate Cancer
6. Early Stage Thyroid Cancer

The partial benefit is payable one time. Partial benefits do not count towards any subsequent full payouts. It is possible to receive a partial benefit and then two full benefits. It is not, however, possible to receive two full benefits and then a partial benefit.

Examples

Suzanne is diagnosed with ductal breast carcinoma in situ

Is it one of the six conditions covered by partial benefits?	**Yes**
Has she received any payout in the past?	**No**
Is she eligible for a partial payout?	**Yes**

Richard is diagnosed with early stage prostate cancer

Is it one of the six conditions covered by partial benefits?	**Yes**
Has he received any payout in the past? He had a heart attack and received a full payout last year	**Yes**
Is he eligible for a partial payout?	**Yes**

Melanie is diagnosed with early stage malignant melanoma

Is it one of the six conditions covered by partial benefits?	**Yes**
Has she received any payout in the past? She had a heart attack and received a full payout and she had a benign brain tumour and received a full payout	**Yes**
Is she now eligible for a partial payout?	**No**

Simon is diagnosed with early stage thyroid cancer

Is it one of the six conditions covered by partial benefits?	**Yes**
Has he received any payout in the past? He was diagnosed with Loss of Independent Existence and received the full payout	**Yes**
Is he now eligible for a partial payout? Loss of Independent Existence triggers full payout and termination of coverage	**No**

Multiple benefits

Since more and more people survive critical illnesses and are able to return to work, multiple event coverage protects individuals in the event of a second illness. Here's how it works: Illnesses are classed into one of four groups. Individuals who are diagnosed with an illness in group 1 and paid the principal sum can receive a second full payout if they are later diagnosed with another critical illness in a different group. The exception is Loss of Independent Existence, which once diagnosed triggers termination of the benefit and precludes any further payment.

Group 1	Group 2	Group 3	Group 4
Aplastic anemia Benign brain tumour Cancer (life threatening) End stage liver failure Fulminant viral hepatitis Kidney failure Major organ transplant Major organ failure on waiting list Occupational HIV infection Progressive systemic sclerosis (Scleroderma) Primary pulmonary arterial hypertension	Aortic surgery Cardiomyopathy Coronary artery bypass surgery Heart valve replacement or repair Heart attack Stroke (cerebrovascular accident)	Bacterial meningitis Blindness Coma Deafness Dementia including Alzheimer's disease Loss of limbs Loss of speech Motor neuron disease Multiple sclerosis Paralysis Parkinson's Disease and specified atypical Parkinsonian disorders Severe burns	Loss of independent existence

Cancer recurrence benefits

Individuals diagnosed with life threatening cancer a second time can receive a second full payout if they have no medical care related to cancer for five years after the first cancer (aside from routine screening and prevention). It does not have to be a different cancer to qualify for payout. An intervening partial payout will restart the five year waiting period. Some conditions apply. For example, an employee who has received a full payout for cancer and a full payout for a heart attack will have their CI benefit terminate and they will not be eligible for a third payout.

Examples

Alexa has a heart attack and later has a second heart attack. She receives a **full payout for the first heart attack** and **no payout for the second—one payout per covered condition**

Doug has cancer and five years later has another cancer. He receives **two full payouts. Cancer is the exception to the rule about one payout per covered condition**

Phil has cancer and receives a **full payout**. Two years later he has early stage prostate cancer and receives a **partial payout**. If he later has another cancer, **it needs to occur five years after his partial benefit is paid, in order to receive another full payout**

SELECTING THE RIGHT CI PRODUCT FOR YOUR CUSTOMER

Every customer has their own way of looking at employee benefits. Our critical illness portfolio gives customers lots of choice and flexibility, so they can add the type and amount of coverage that's right for their business. Wondering which product might be best suited to a particular customer? We've matched our products to three customer profiles.

Approach to employee benefits?	Which option fits best?
• Values protection and wants benefits to protect employees against major risks • Benefits are reasonably priced • Spends dollars wisely • Core protection and enough left to offer some less essential benefits employees value	Vital Assist CI Simplified Coverage • Coverage is easy to understand and easy to administer • Simplified eligibility • Easier on the budget
• Benefits need to be comparable to companies they compete with • Benchmarks plan to make sure it's same or better • Offers a good mix of benefits: core protection plus other less essential benefits employees value	Traditional CI Complete Coverage • With coverage from $10,000 to $250,000, this product gives lots of flexibility to set the right level of protection • Aligns with what competitors are offering, which makes it easy for prospective employees to do a comparison and see the value
• Benefits need to be superior to companies they compete with • Wants a high degree of protection for employees and their families • Knows over the long haul someone can get sick more than once • Talented employees are hard to come by, so loyalty is key	Enhanced CI Multiple Event Coverage • Protecting employees should they be seriously ill more than once is what really makes this product stand out • This is robust coverage for robust benefit plans

With each product option, customers can select Optional coverage, which allows employees to purchase additional CI coverage. Employees get the benefit of group pricing; customers provide the opportunity.

UNDERWRITING GUIDELINES

- 100% participation is required for all employee classes taking Critical Illness
- Employee CI is a prerequisite for spousal and/or dependant CI, as well as for Optional CI
- Optional spousal CI can be offered even if mandatory spousal CI is not selected
- The level of Optional CI can differ from the level of the mandatory coverage. For example, mandatory coverage can be Enhanced CI and Optional CI could be Traditional. Coverage is determined at the class level (not at the certificate level)

Grandfathering

- At time of claim, we will count time served with the previous carrier when it comes to pre-existing condition exclusions. For example, at time of claim, if an employee had CI for six months with the previous carrier, our pre-ex would be reduced to 18 months for that employee.

  - the exception to this is for additional covered conditions. For example, if the previous policy covered 22 conditions and Empire Life covers 31 conditions, the nine additional conditions would be subject to our 24 month pre-ex. This will is particularly important for groups moving from Vital Assist Health Benefit to either Traditional or Enhanced CI.

- This same rule applies to increases in face amounts for groups transitioning to Empire Life with fewer than 50 employees covered for CI. For example, if the existing CI is for $10,000 and a customer wishes to increase coverage to $30,000, the additional $20,000 will be subject to our 24 month pre-ex. The other $10,000 would be subject to whatever pre-ex had already been served at the previous carrier.
- This logic also applies to amendments of CI amounts down the road, only it will be based on the amount of the increase, not the number of lives. Any increase greater than $10,000 will be subject to starting the pre-ex on the difference.

HEALTH CONCIERGE SERVICE

Being diagnosed with a life threatening condition can be like suddenly landing in hostile foreign territory. Feelings of fear, loss and dislocation can be intense. At times like this, everyone needs an expert guide. The Health Concierge Service can help.

Delivered by MedExtra Inc., the Health Concierge Service is a made in Canada solution designed to supplement the Canadian healthcare system. It bridges the gap between the care a seriously ill person is looking for and what our healthcare system is currently structured to provide. The MedExtra team of experienced doctors and nurses deliver medical, tactical, and emotional support— before, during and after diagnosis.

Assistance throughout the journey is key—and it's one of the factors that make the Health Concierge Service much more than a medical second opinion service. The MedExtra team can help:

- accelerate the diagnosis
- facilitate state-of-the-art treatment and follow up
- facilitate a smooth return-to-work
- provide clarity
- provide continuity of care, and
- provide emotional support

A critical illness can take weeks—even months—to diagnose. Waiting for appointments with specialists, for testing, and for test results can be extremely stressful for individuals and their families. The Health Concierge Service provides support, information, and guidance to accelerate the definitive diagnosis of a covered condition. These pre-diagnosis services can include:

- Identifying the right tests to arrive at a diagnosis
- Coordinating with treating physicians to obtain test requisitions
- Arranging diagnostic tests and advanced testing
- Obtaining and discussing test results
- Creating a Medical Action Plan
- Providing ongoing psycho-social and emotional support throughout the entire process

Once a diagnosis is made, many questions and uncertainty can arise. The MedExtra Remote Second Opinion allows each case to be thoroughly reviewed by top specialists in Canada, at US Centres of Excellence, or worldwide to confirm diagnosis and suggest the most up-to-date treatment plan.

Knowing the Health Concierge Service is there from the first suspicion that something is wrong, through to diagnosis, treatment and beyond, is invaluable. From the moment the call is made to the Health Concierge Service, each individual has a dedicated Care Manager who guides them every step of the way, throughout their journey into the world of advanced medicine. The MedExtra brand of customer service results in personalized, attentive, empathetic, and detail oriented care.

Services are available to employees with covered and non-covered conditions. For employees with non-covered conditions, MedExtra staff can provide Care Management and information about the employee's specific condition at no charge. Additional services including medical second opinion are available at a significantly lower cost than would be charged were group pricing not in place.

Empire Life is delighted to provide access to this market-leading service to everyone covered by one of our Group CI products.

COMMUNICATION

As an advisor, you have an important role to play in helping customers understand the rules governing critical illness insurance. Here are a few points that are especially important for customers to understand:

- CI is meant to cover life threatening conditions.
- For clarity, fairness and transparency, Empire Life has adopted the CLHIA benchmark definitions for our covered conditions, where they exist.
- Rules governing pre-existing conditions are designed to protect the benefit against anti-selection and can have an impact on the approval of claims.
- Multiple, partial, cancer recurrence benefits provided in Enhanced CI protect employees in the event of a second critical illness. Conditions apply, and are illustrated in the examples.
- Covered conditions and the definitions for covered conditions may differ from one carrier to the next.
- When moving benefits, the new carrier needs to count time served towards pre-existing condition exclusions.

Plan administrators have an important role to play in helping employees understand their CI benefit. Effective communication is key to avoiding confusion and disappointment. The Empire Life Group CI Employee Communication Kit contains materials that can make communication easy.

COVERED CONDITIONS

Empire Life and most other carriers are using CLHIA definitions for covered conditions where they exist.

The following 31 health conditions are covered under Traditional and Enhanced CI. Vital Assist CI covers the top 4 conditions: cancer (life-threatening), heart attack, coronary artery bypass surgery, and stroke (cerebrovascular accident).

"Critical Illness" means an illness or Surgery which is specifically covered and defined in this Provision and which is not specifically excluded. Critical Illness means any one of the following conditions defined hereunder:

"Aortic Surgery" is defined as 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: No CI Benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

"Aplastic Anemia" is defined as 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" is defined as a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the Date of Diagnosis. The Diagnosis of Bacterial Meningitis must be made by a Specialist.

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

"Benign Brain Tumour" is defined as a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No CI Benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the Person Insured's insurance, or the date of last reinstatement of the Person Insured's insurance, the Person 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 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 CI Benefit will be payable under this condition for pituitary adenomas less than 10 mm.

"Blindness" is defined as 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)" is defined as 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, but are not limited to, carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No CI Benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the Person Insured's insurance, or the date of last reinstatement of the Person Insured's insurance, the Person 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 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 CI Benefit will be payable for the following:

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

"Cardiomyopathy" is defined as the unequivocal Diagnosis by a Consultant Cardiologist of Cardiomyopathy causing permanent impaired left ventricular function. This must result in severe physical limitation of activity to the degree of at least class III of the New York Heart Association Classification. This degree of limitation must be permanent and must be sustained over at least three (3) months while on optimal medical therapy.

Exclusion: Cardiomyopathy directly related to alcohol or drug misuse is excluded.

New York Heart Association Classification:

Class I. Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.

Class II. Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

Class III. Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.

Class IV. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases.

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

Exclusion: No CI Benefit will be payable under this condition for:

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

"Coronary Artery Bypass Surgery" is defined as 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.

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

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

"Dementia", including Alzheimer's Disease is defined as 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 Person 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 a Specialist.

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

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

"End-stage Liver Failure" is defined as the permanent and Irreversible failure of liver function that has resulted in Stage B or Stage C Child-Pugh classification liver failure as certified by a Specialist, where all three of the following are present:

1. permanent jaundice;
2. ascites; and
3. hepatic encephalopathy.

Exclusion: Liver failure secondary to drug or alcohol abuse is excluded.

"Fulminant Viral Hepatitis" is defined as a sub-massive to massive necrosis of the liver caused by any virus, leading precipitously to liver failure.

This Diagnosis must be supported by all of the following:

- rapid decreasing of liver size;
- necrosis involving entire lobules, leaving only a collapsed reticular framework;
- rapid deterioration of liver function tests;
- deepening jaundice; and
- hepatic encephalopathy.

Hepatitis infection or carrier status alone, does not meet this definition.

"Heart Attack" is defined as 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.

Exclusion: No CI Benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

"Heart Valve Replacement or Repair" is defined as 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.

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

"Kidney Failure" is defined as a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

"Loss of Independent Existence" is defined as 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" is defined as 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" is defined as a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

The diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No CI Benefit will be payable under this condition for all psychiatric related causes.

"Major Organ Failure on Waiting List" is defined as 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 Person Insured must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant Surgery.

For the purposes of the Survival Period, the Date of Diagnosis is the date of the Person Insured's enrolment in the transplant center.

The Diagnosis of the major organ failure must be made by a Specialist.

"Major Organ Transplant" is defined as 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 Person 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" is defined as 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" is defined as 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.

"Muscular Dystrophy" is defined as a genetic muscle disorder causing motor dysfunction. A Specialist must make the definite Diagnosis of Muscular Dystrophy based on clinically accepted tests at the time of claim. The disease must cause permanent muscle weakness evident on physical examination.

"Occupational HIV Infection" is defined as a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Person 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 Person Insured's insurance, or the effective date of last reinstatement of the Person Insured's insurance.

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

1. The accidental injury must be reported to the Company within 14 days of the accidental injury;
2. A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
3. A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
4. All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
5. 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: No CI Benefit will be payable under this condition if:

- The Person 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" is defined as 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' 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 Person 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.

Exclusions: No CI 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 Person Insured's insurance, or the date of last reinstatement of the Person Insured's insurance, the Person 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 CI Benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

"Primary Pulmonary Arterial Hypertension" means a primary and unexplained increase in pulmonary artery pressure causing signs of right heart strain and failure. There must be permanent Irreversible physical impairment to the degree of at least Class III of the New York Heart Association Classification of cardiac impairment while on optimal medical treatment.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, diseases of the left side of the heart and congenital heart disease are specifically excluded.

The Diagnosis of primary pulmonary hypertension needs to be made by a Specialist and needs to be supported by data provided at cardiac catherisation.

The Diagnosis must be supported by all three (3) of the following criteria:

1. Mean pulmonary artery pressure > 40 mmHg;
2. Pulmonary vascular resistance > 3 (mmHg/L)/min; and
3. Normal pulmonary wedge pressure < 15 mmHg.

New York Heart Classification:

Class I. Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.

Class II. Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

Class III. Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.

Class IV. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort increases.

"Progressive Systemic Sclerosis (Scleroderma)" is defined as a systemic connective tissue disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. A Specialist must make the definite Diagnosis of Progressive Systemic Sclerosis. This Diagnosis must be supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following are excluded:

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

"Severe Burns" is defined as 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)" is defined as a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No CI Benefit will be payable under this condition for:

- Transient Ischaemic Attacks; or,
- Intracerebral vascular events due to trauma; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.

PARTIAL BENEFIT

"Non Life-Threatening Critical Illness" means any one of the following conditions, as it is defined below:

"Coronary Angioplasty" is defined as 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.

"Ductal Breast Carcinoma In-situ" is defined as the presence of malignant breast cancer cells that remain within the cell group from which they arose, where cancer cells do not penetrate the basement membrane nor invade the surrounding tissues. The Diagnosis of ductal breast carcinoma in-situ must be confirmed with a valid pathology report by a certified pathologist and it must be classified as "Tis" according to the AJCC 7th Edition TNM staging method or FIGO Stage 0 of the Federation Internationale de Gynaecologie et d'Obstetrique staging system.

Exclusion: Lobular breast carcinoma in-situ is excluded.

"Early Stage Chronic Lymphocytic Leukemia" is defined as a malignant proliferation of lymphocyte white blood cells. The Diagnosis of chronic lymphocytic leukemia must be made by an approved Specialist. The chronic lymphocytic leukemia must be classified as Rai stage 0 where there is an increase in blood lymphocytes but there is no enlargement of lymph nodes, liver or spleen, and there is no anemia or thrombocytopenia.

Exclusion: No CI Benefit will be payable for monoclonal B-cell lymphocytosis (MBL), lymphoma, or other causes of lymphocytosis.

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.

"Early Stage Malignant Melanoma" is defined as an invasive malignant melanoma of the skin that is less than or equal to 1.0 mm in Breslow thickness, and is non-ulcerated and there is no spread to lymph nodes or distant metastases. There must be uncontrolled growth and spread of malignant melanoma cells that invade past the epidermis into the dermis of the skin. The Diagnosis must be confirmed with a valid pathology report and a report from an approved Specialist.

Exclusion: No CI Benefit will be payable for melanoma in-situ.

"Early Stage Prostate Cancer" is defined as an invasive malignant prostate cancer that is characterized by the uncontrolled growth and spread of malignant prostate cancer cells that invade the prostate gland. The cancer must be confined to the prostate gland with no spread to lymph nodes or distant metastases, and classified as stage T1a or T1b by the AJCC 2010 Seventh Edition TNM Classification. The Diagnosis must be confirmed with a valid pathology report and a report from an approved Specialist.

Exclusion: No CI Benefit will be payable for any grade of Prostatic Intra-epithelial neoplasia (PIN) or prostate cancer in-situ.

"Early Stage Thyroid Cancer" is defined as invasive malignant papillary or follicular thyroid cancer that is characterized by the uncontrolled growth and spread of malignant thyroid cancer cells that invade the thyroid gland. The cancer must be confined to the thyroid gland with no spread to lymph nodes or distant metastases. The thyroid cancer must be 2.0 cm or less in greatest diameter in size and classified as stage T1 by the AJCC 2010 Seventh Edition TNM Classification. The Diagnosis must be confirmed with a valid pathology report and a report from an approved Specialist.

Exclusion: No CI Benefit will be payable for benign thyroid nodules.

DEPENDANT CI

"Critical Illness" for the Dependant CI Benefit means any one of the following conditions, as it is defined in this section:

"Benign Brain Tumour" is defined as a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No CI Benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the Person Insured's insurance, or the date of last reinstatement of the Person Insured's insurance, the Person 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 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 CI Benefit will be payable under this condition for pituitary adenomas less than 10 mm.

"Blindness" is defined as 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)" is defined as 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, but are not limited to, carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No CI Benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the Person Insured's insurance, or the date of last reinstatement of the Person Insured's insurance, the Person 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 Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for cancer or, any covered Critical Illness caused by any cancer or its treatment.

No CI Benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; 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.

"Cerebral Palsy" is defined as a non-progressive neurological disorder affecting the developing brain. A Specialist must make the definite Diagnosis of Cerebral Palsy before the Person Insured reaches the age of 5. The disease must have caused permanent motor deficits with muscle dysfunction and activity limitation.

"Congenital Heart Disease" is defined as a definite Diagnosis of at least one of the following nine (9) conditions made by a Specialist licensed and practising in Canada or by another Physician acceptable to the Company. The Diagnosis must be supported by cardiac imaging acceptable to the Company.

1. Coarctation of The Aorta
2. Ebstein's Anomaly
3. Eisenmenger Syndrome
4. Tetralogy of Fallot
5. Transposition of The Great Vessels
6. Truncus Arteriosus
7. Total Anomalous Pulmonary Venous Connection
8. Pulmonary Valve Atresia
9. Tricuspid Valve Atresia

The following five (5) congenital heart conditions are also covered under this definition but only if open heart surgery is performed to correct the congenital cardiac impairment.

1. Aortic Stenosis
2. Subvalvular Aortic Stenosis
3. Atrial Septal Defect
4. Ventricular Septal Defect
5. Pulmonary Stenosis

Percutaneous trans-catheter procedures and balloon valvuloplasty are not considered as forms of open heart surgery under this definition.

All other congenital conditions are excluded.

"Cystic Fibrosis" is defined as a genetic disorder characterized by abnormal transport of chloride and sodium causing organ dysfunction. A Specialist must make the definite Diagnosis of Cystic Fibrosis based on clinically accepted tests at the time of the claim. The disease must cause ongoing symptoms indicating involvement of the lungs, pancreas, liver or intestines.

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

The Diagnosis of Deafness must be made by a Specialist.

"Down's Syndrome" is defined as an unequivocal Diagnosis of Down's Syndrome made by a Specialist and supported by chromosomal evidence of Trisomy 21.

"Kidney Failure" is defined as a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

"Major Organ Failure on Waiting List" is defined as 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 Person Insured must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant Surgery.

For the purposes of the Survival Period, the Date of Diagnosis is the date of the Person Insured's enrolment in the transplant center.

The Diagnosis of the major organ failure must be made by a Specialist.

"Major Organ Transplant" is defined as 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 Person 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.

"Muscular Dystrophy" is defined as a genetic muscle disorder causing motor dysfunction. A Specialist must make the definite Diagnosis of Muscular Dystrophy based on clinically accepted tests at the time of claim. The disease must cause permanent muscle weakness evident on physical examination.

"Paralysis" is defined as 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.

"Spina Bifida Cystica" is defined as the definite Diagnosis of a myelomeningocele which is a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin. All of the following must be present to some degree:

- Hydrocephalus;
- Paralysis;
- Bowel dysfunction; and
- Bladder dysfunction

The Diagnosis of Spina Bifida Cystica must be made by a Specialist.

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

"Type 1 Diabetes Mellitus" is defined as a definite Diagnosis of Type 1 Diabetes Mellitus where the Person Insured has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The Diagnosis of Type 1 Diabetes Mellitus must be made by a Specialist.

Exclusion: Type 2 Diabetes Mellitus is excluded even if the disease is being treated with insulin.

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[1] *The Globe and Mail Report on Business*, June 2014, based on revenue
[2] As at May 19, 2015

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