Critical Illness Insurance

Living Benefit Plans

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BMO Insurance

Critical Illness at a Glance

What is Critical Illness Insurance?

Critical Illness Insurance offers a lump sum, tax-free benefit upon a medical diagnosis of a covered condition (e.g. cancer, heart attack, and stroke).

What is the need?

With today's medical advances, a healthy individual stands a better chance of surviving a critical illness now more than ever. However, there are immediate financial consequences that a critical illness insurance benefit can help offset.

Recovering Physical Health

First and foremost, you want your client to survive the critical illness and get better. Many expenses can be incurred, some of which may not be covered under provincial health care plans or through a private disability program, such as:

- medication (cancer drugs)
- hospital upgrades
- homecare expenses
- out-of-country care
- home renovations
- vehicle conversions

Maintaining Financial Health

You want to protect your client's and his family's lifestyle. Your client or your client's spouse will need time away from work during the recovery period:

Income supplements:

- cover your loss of income
- cover your spouse's income
- mortgage payments
- other debt
- children's education expenses
- business continuity expenses

Lump sum requirements:

- pay off mortgages, loan or other debt
- vacation for you and your family
- funds for early retirement

Check out our **Critical Illness Calculator** and see how much critical illness insurance your client may need.

Client Profile in Canada

Who is purchasing CI?

- average age is around 37
- approx. half of sales are to females (48%)
- 92% of sales are to non-smokers
- 11% of sales are to juveniles

Source: Munich Re: 2014 Individual Insurance Survey

Some stats

Cancer

- Nearly 1 in 2 Canadians (45% of men and 43% of women) is expected to develop cancer during their lifetime
- Lung, breast, colorectal and prostate cancer are the most commonly diagnosed types of cancer in Canada (excluding non-melanoma skin cancer)
- Prostate cancer accounts for one-fifth (20%) of all new cancer cases in men
- Breast cancer accounts for one-quarter (25%) of all new cancer cases in women
- The 5-year survival rate after diagnosis of cancer is 63%

Source: Cancer Statistics at a Glance, from cancer.ca on October 11, 2021 (2021)

Heart attack

- There are an estimated 63,200 heart attacks each year in Canada
- There are 34.6 million visits each year to a physician for the management of cardiovascular disease
- 1.6 million Canadians are now living with the effects of cardiovascular disease
- 90% of Canadians over age 20 have at least one risk factor[1] for heart disease

Sources: University of Ottawa Heart Institute, 2021 and statistics from canada.ca – Heart disease in Canada: Highlights from the Canadian Chronic Disease Surveillance System accessed October 11, 2021

[1] Risk factors include smoking, alcohol, physical inactivity, obesity, high blood pressure, high blood cholesterol and diabetes.

Stroke

- More than 62,000 strokes occur in Canada each year
- 80% of victims of a stroke will survive
- 405,000 Canadians are living with the effects of stroke

Sources: 2018 Stroke Report, Heart and Stroke Foundation and statistics from www.heartandstroke.com accessed on October 11, 2021

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Underwriting Tips

Application

- Ask your client in advance of the application to write down all significant illnesses including dates and treatment provided. This will facilitate the ordering of proper requirements by the underwriter when they initially review your client's application. It will also facilitate consistent information provided to the nurse during the paramedical exam and may reduce the need for an Attending Physician's statement.
- More often than not your client will have seen many other physicians other than their Family Doctor. Ask them to list the names of all doctors seen in order to avoid having the underwriter order multiple reports later in the underwriting process.
- Ensure your client discloses any hospitalizations or hospital Emergency room visits.
- Ensure your client discloses any limitations of their activity.
- Ensure your client is truthful in disclosing all smoking habits. We consider cigarettes, cigarillos, e-cigarettes, chewing tobacco, pipes, betel nut, snuff, shisha, water pipes, marijuana, hashish or nicotine cessation products at smoker rates.
- Ensure that your client is aware of their family history; the nature of the illness, the approximate age of diagnosis as well as date of death if applicable.

NOTE: This does not apply for individuals who were adopted.

Medical Examination

- When the paramedical nurse arrives for the appointment be sure to advise your client to have all of their medications available or write them down in advance of the appointment.
- The nurse will take your client's blood pressure 3 times and take their height and weight.
- If a blood profile is required, advise your client to fast for 12 hours and avoid alcohol and caffeine during this time.
- If an ECG is required ensure that your client is having the exam in a place where they are able to lie down flat and that they are wearing a top that can be easily opened to allow for proper lead placement. This is important as ECG results can be deemed abnormal where an underlying condition does not exist. This could result in a retest, decline for further evaluation by their doctor or an additional Attending Physician Statement.
- Advise your client to get a good night's sleep before the exam, and drink several glasses of water on the day of the appointment. This helps in specimen collection for both blood and urine samples.
- If your client has a tendency towards high blood pressure, we recommend that they schedule their appointment for a time of day when they are most relaxed, avoiding stress, caffeine and nicotine as these can temporarily raise your blood pressure and heart rate.
- Remind your clients that the nurse is not authorized to answer any questions regarding the insurance coverage applied for.

Pre-Screening Checklist

Do not submit applications where the following medical histories are present as they will be declined:

- Kidney failure
- Polycystic Kidney disease
- Cystic Fibrosis
- Type 1 diabetes
- Multiple Sclerosis
- Huntington's disease
- Lou Gehrig's disease
- Coronary Artery disease
- Stroke or TIA
- any heart valve disorders
- chronic liver disease including Cirrhosis and Hepatitis
- invasive cancers
- Dementia or Alzheimer's disease
- AIDS or HIV
- uncontrolled high blood pressure or cholesterol
- Parkinson's disease or any other neuro degenerative disorder
- Permanent Paralysis
- chronic respiratory disorders such as COPD
- Any issues that warrant further investigation either via consultation with a specialist or diagnostic testing that has not yet been completed and results are unknown.

Please note that this is only a checklist of conditions that would definitely result in an application being declined for critical illness coverage. There may be other conditions that could result in a decline for your client.

If any member of the proposed insured's immediate family (i.e. siblings and parents) has had one of the above conditions, the policy may be rated or in some cases, declined.

Family History

Family history plays an important role in the underwriting assessment as it may indicate an increased risk for disease and clinical screening. Important factors considered when assessing family history are:

- nature of disease
- date of diagnosis and death if applicable
- age and gender of the proposed insured and family members
- How many family members have been affected by single or linked diseases?

Remember that life insurance and critical illness insurance are assessed differently. Life insurance is a benefit paid on death while critical illness is paid on the diagnosis of a covered condition. As a result, whether your client applies for a critical illness standalone product or rider, there is an increased number of Attending Physician Statements ordered as we are assessing the increased incidence rate of a diagnosed covered condition versus death from a disease.

Most critical illness insurance claims are denied due to non-disclosure and/or not meeting the definition for the covered condition. Please remind your clients that a critical illness insurance policy is a contract of good faith and they are required to disclose all material information to the insurance company. Failure to do so could result in rescinded contracts and claims denial.

Continued

Product Features at a Glance

BMO Life Assurance Company (BMO Insurance) offers five (5) critical illness insurance policies marketed as Living Benefit Plans

Plan Name	Plan Type	Target Market
Living Benefit 10	Renewable and Convertible Term	Ideal for low cost mortgage protection
Living Benefit 20		
Living Benefit 75	Level term to age 75	Money back for retirement and ideal for key person
Living Benefit 100	Level term to age 100	Key person, Buy-sell, with a quick pay option
15-Pay Living Benefit 100		

Renewable and Convertible Term

Feature	Living Benefit 10	Living Benefit 20
Issue ages	18 to 65 (Age at nearest birthday)	18 to 55 (Age at nearest birthday)
Coverage period	To age 75	
Minimum coverage amount	$25,000	
Maximum coverage amount	$2,000,000	
Coverage option	Single life only (No joint or multi-coverage options available on Living Benefit plans)	
Rate bands	• Band 1 – $25,000 – $99,999 • Band 2 – $100,000 – $249,999 • Band 3 – $250,000 – $499,999 • Band 4 – $500,000 – $2,000,000	
Premiums	The initial term premiums and subsequent term renewal premiums are guaranteed at issue using the attained insurance age of the insured.	
Policy fee (Annual)	$50.00	
Multi-policy fee discount	• The multi-policy discount is available for multiple applications of term, whole life and living benefits plans submitted to our Head Office within 60 days of the initial application. For personally owned policies the policy owner/lives insured must be an individual purchasing multiple plans or family members applying for multiple plans at the same time. In the case of corporate owned policies, the lives insured must have an established business relationship. • The policy fee on the first policy will be the full policy fee, which will be reduced by $25 for the second and subsequent associated policies. • Please refer to the Multi-Policy Discount document (809E) for details.	
Available riders	• Return of Premium on Death (ROPD) – Returns the sum of the eligible premiums paid from the policy effective date to the date of death • Supplemental benefits: - Children's Term Rider - Accidental Death Benefit Rider - Waiver of Premium Rider	
Living Benefit 10 and 20 riders	Living Benefit 10 and 20 riders can be added to: • Life Dimensions plans, Wealth Dimensions plans • Term 10, Term 15, Term 20, Term 25, Term 30 plans • Term 100 • BMO Insurance Whole Life	
When CI coverage ends	Coverage terminates on the earliest of: • the date the contract is cancelled • the date of death of the insured • payment of the critical illness benefit • the date the contract lapsed as a result of any unpaid premiums after the grace period has expired • the date the insured reaches attained insurance age 75	

Continued

Level term to age 75

Feature	Living Benefit 75
Issue ages	18 to 65 (Age at nearest birthday)
Coverage period	To age 75
Minimum coverage amount	$25,000
Maximum coverage amount	$2,000,000
Coverage option	Single life only (No joint or multi-coverage options available on Living Benefit plans)
Rate bands	• Band 1 – $25,000 – $99,999 • Band 2 – $100,000 – $249,999 • Band 3 – $250,000 – $499,999 • Band 4 – $500,000 – $2,000,000
Premiums	Level premium is guaranteed at issue using the attained insurance age of the insured for the duration of the policy.
Policy fee (Annual)	$50.00
Multi-policy fee discount	• The multi-policy discount is available for multiple applications of term, whole life and living benefits plans submitted to our Head Office within 60 days of the initial application. For personally owned policies the policy owner/lives insured must be an individual purchasing multiple plans or family members applying for multiple plans at the same time. In the case of corporate owned policies, the lives insured must have an established business relationship. • The policy fee on the first policy will be the full policy fee, which will be reduced by $25 for the second and subsequent associated policies. • Please refer to the Multi-Policy Discount document (809E) for details.
Available riders	• Return of Premium (see page 8 for full details): - Return of Premium on Death (ROPD) – Returns the sum of the eligible premiums paid from the policy effective date to the date of death - Return of Premium on Surrender (ROP15) – 100% of the eligible premium becomes available on or after the 15th policy anniversary - Return of Premium on Surrender (ROP65) – 100% of the eligible premium becomes available on or after the insured's attained age 65 - Return of Premium on Expiry (ROPX) – 100% of the eligible premium becomes available on the insured's attained age 75 (Expiry) • Supplemental benefits - Children's Term Rider - Accidental Death Benefit Rider - Waiver of Premium Rider
Living Benefit 75 rider	Living Benefit 75 rider can be added to: • Life Dimensions plans, Wealth Dimensions plans • Term 100 • BMO Insurance Whole Life
When CI coverage ends	Coverage terminates on the earliest of: • the date the contract is cancelled • the date of death of the insured • payment of the critical illness benefit • the date the contract lapsed as a result of any unpaid premiums after the grace period has expired • payment of the Return of Premium on Surrender benefit rider if fully surrendered • the date the insured reaches attained insurance age 75

Continued

Level term to age 100

Feature	Living Benefit 100	15-Pay Living Benefit 100
Issue ages	18 to 65 (Age at nearest birthday)	
Coverage period	To age 100	
Minimum coverage amount	$25,000	
Maximum coverage amount	$2,000,000	
Coverage option	Single life only (No joint or multi-coverage options available on Living Benefit plans)	
Rate bands	• Band 1 – $25,000 – $99,999 • Band 2 – $100,000 – $249,999 • Band 3 – $250,000 – $499,999 • Band 4 – $500,000 – $2,000,000	
Premiums	Level premium is guaranteed at issue using the attained insurance age of the insured for the duration of the policy.	Level premium is guaranteed at issue using the attained insurance age of the insured for 15 years at which time the policy is fully paid up.
Policy fee (Annual)	$50.00	
Multi-policy fee discount	• The multi-policy discount is available for multiple applications of term, whole life and living benefits plans submitted to our Head Office within 60 days of the initial application. For personally owned policies the policy owner/lives insured must be an individual purchasing multiple plans or family members applying for multiple plans at the same time. In the case of corporate owned policies, the lives insured must have an established business relationship. • The policy fee on the first policy will be the full policy fee, which will be reduced by $25 for the second and subsequent associated policies. • Please refer to the Multi-Policy Discount document (809E) for details.	
Available riders	• Return of Premium (see page 8 for full details): - Return of Premium on Death (ROPD) – Returns the sum of the eligible premiums1 paid from the policy effective date to the date of death - Return of Premium on Surrender (ROP15) – 100% of the eligible premium1 becomes available on or after the 15th policy anniversary - Return of Premium on Surrender (ROP20) – 100% of the eligible premium1 becomes available on or after the 20th policy anniversary • Supplemental benefits: - Children's Term Rider - Accidental Death Benefit Rider - Waiver of Premium Rider	• Return of Premium (see page 8 for full details): - Return of Premium on Death (ROPD) – Returns the sum of the eligible premiums paid from the policy effective date to the date of death - Return of Premium on Surrender (ROP15) – 100% of the eligible premium becomes available on or after the 15th policy anniversary • Supplemental benefits: - Waiver of Premium Rider
Living Benefit 100 rider	Living Benefit 100 rider can be added to: • Life Dimensions, Life Dimensions (Low Fees), Wealth Dimensions • Term 100 • BMO Insurance Whole Life • 15-Pay Living Benefit 100 is not available as a rider	
When CI coverage ends	Coverage terminates on the earliest of: • the date the contract is cancelled • the date of death of the insured • payment of the critical illness benefit • the date the contract lapsed as a result of any unpaid premiums after the grace period has expired. • payment of the Return of Premium on Surrender benefit rider if fully surrendered. • the date the insured reaches attained insurance age 100	

Continued

Policy Benefits

Depending on the policy, there are up to four (4) policy benefits.

Refer to the following table to determine the available benefits.

Benefit	Plan				
	LB10	LB20	LB75	LB100	15LB100
Critical Illness Benefit	Yes	Yes	Yes	Yes	Yes
Critical Care Assist Benefit	Yes	Yes	Yes	Yes	Yes
Early Discovery Benefit	Yes	Yes	Yes	Yes	Yes
Maturity Benefit	No	No	No	Yes	Yes

Critical Illness Benefit

The Critical Illness Benefit (sum insured) is paid to the Policy Owner on the first diagnosis of a critical illness covered condition and the completion of the thirty (30) day survival period if applicable.

For certain critical illness covered conditions, the Critical Illness Benefit is subject to exclusions.

No benefit is payable for Benign Brain Tumour or Cancer (Life-Threatening) if, within the first 90 days following the later of,

- the Policy Date of the Policy, or
- 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 Benign Brain Tumour or Cancer (Life-Threatening) (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of Benign Brain Tumour or Cancer (Life-Threatening) (covered or excluded under the Policy)

No benefit is payable for Parkinson's Disease and Specified Atypical Parkinsonian Disorders, within the first year following the later of,

- the Policy Date of the Policy, or
- 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 Parkinson's Disease and Specified Atypical Parkinsonian Disorders (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders (covered or excluded under the Policy)

The sum insured is payable only once for the occurrence of a critical illness, subject to the terms, conditions and other provisions of the policy.

If the Critical Illness Benefit is paid then the policy terminates. The Critical Illness Benefit is not payable for the occurrence of any other illness, disorder or surgery and is not payable as a result of the death of the Insured.

Assistance Services

BMO Insurance•**HealthAdvocate**™ Plan

Innovative and comprehensive assistance services[2] designed exclusively for eligible BMO Insurance policyholders – Plan Members. Every Living Benefit policy includes – at no additional cost – the **BMO Insurance Health Advocate** Plan. This program includes access to medical information and services as well as personal assistance programs.

Medical Information and Advisory Services

This component of the **BMO Insurance Health Advocate** Plan offers your clients unlimited access to medical information and services from Teladoc Medical Experts®† – a leader when it comes to delivering world class medical advice and support. These services include:

- **Expert Medical Opinion**
  Teladoc Medical Experts will conduct an in-depth analysis of medical records and re-test pathology to establish or confirm a diagnosis and treatment plan. They will receive a comprehensive medical summary from Teladoc Medical Experts with his or her recommendation(s) that your client can share with their doctor.
- **Find a Doctor**
  Teladoc Medical Experts will conduct a customized search guided by your criteria and geographic preference and recommend top-rated Canadian physicians that specialize in a medical condition.[3] They will also contact the specialists to ensure they are accepting new patients.
- **Care Finder**
  Should your client need treatment outside of Canada, Teladoc Medical Experts will locate specialists or facilities outside of Canada for their treatment/condition-specific needs.[3]
- **Personal Health Navigator**
  Teladoc Medical Experts will help your clients navigate the Canadian health care system by providing them with medical information and resources, one-on-one support, and customized health coaching for a wide range of health related concerns – not only for a serious illness or condition. One simple phone call connects your client to a Teladoc Medical Experts Member Advocate, who can provide them with the information they need to make informed healthcare decisions.

! Your clients and their immediate family members, including their spouse and children, have access to these services any time. In addition, once every three years their extended family members, including their parents, their siblings and their spouse's parents and siblings, get to access these services for FREE,[4] without compromising your access.

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Personal Assistance Services
This component of the **BMO Insurance Health Advocate Plan** offers your clients personal assistance services provided by TELUS Health (Canada) Ltd., one of Canada's leading providers of these programs and includes:

- **Health Coaching** – Health Coaches are Registered and Occupational Health Nurses who offer practical and personalized support for a variety of health conditions and health risks. Health coaches can assist your clients by answering questions, work with them to create a risk reduction action plan and to motivate them to reach their goals.
- **Dependent Care Consultation Services** – Dependent Care Consultants provide personalized, caring advice as well as resources and community referrals for questions and concerns related to childcare, elder care and family related issues. From prenatal care, parenting advice, and assistance with securing daycare to gathering information related to home care services, seniors' accommodations, caregiver support groups and palliative care options, a Dependent Care Consultant partners with your clients to find answers to their unique needs.
- **Nutrition Support** – Diet can strongly affect mood, energy levels and overall health. Your clients can connect with a registered dietician to assist them with establishing and maintaining a healthy, well-balanced diet, to focus on disease prevention and disease management, and get support with weight management and to support them with achieving their nutrition related goals.
- **Professional Counselling Support Services** – Caring professional counsellors are dedicated to supporting your clients through the issues that may be impacting their lives. 24/7 access to confidential, short-term clinical support is available, at no cost to them. This virtual counselling service can support your clients and their immediate dependents with concerns related to mental health, grief and loss, addictions, relationships and life changing events.
- **Online Health and Wellness Resources** – Your clients can find answers fast, with the online wellbeing resources library including hundreds of articles, toolkits, audio recordings, wellness assessments, behavioral change programs and more. They can navigate wellbeing content, produced by industry experts, on topics related to family, health, life, money and work.

®† Teladoc Medical Experts, Expert Medical Opinion, Find a Doctor, Care Finder and Personal Health Navigator are service marks or registered trademarks of Teladoc Health, Inc.

[2] BMO Insurance reserves the right to change the service provider, the nature of services or cancel access to these services at any time without notice, unless otherwise stated

[3] Expenses associated with medical treatment, travel and lodging relating to these services are the responsibility of the member.

[4] BMO Insurance offers the services on a referral basis only and will not charge you for the services provided. LIfeWorks and Teladoc Health, Inc. will not charge you for the services they provide. You may, however, incur additional costs for services or for providers that may be referred to you by LifeWorks or Teladoc Medical Experts. These additional charges are incurred at your sole discretion and BMO Insurance will not be liable for their payment.

Early Discovery Benefit

The Early Discovery Benefit is paid to the owner on the first diagnosis of early discovery covered condition, completes the Survival Period applicable to the early Discovery Covered Condition and meets all the other terms of the policy.

The Early Discovery Benefit Amount payable is the lesser of:

a. 15% of the Sum Insured on the date of diagnosis, or;

b. $50,000.00.

A maximum of four Early Discovery Benefits may be payable under this Policy and any other policy resulting from a conversion of this Policy, provided each claim is for a different Early Discovery Covered Condition.

Any payment of the Early Discovery Benefit Amount will not reduce the policy premiums or reduce the Critical Illness Benefit. The Early Discovery Benefit Covered Conditions are subject to exclusions that are listed on page 20.

Maturity Benefit (for Living Benefit 100 plans only)

Providing no Critical Illness Benefit has been paid, the in force Critical Illness Benefit (less any amount paid under the Early Discovery Benefit) will automatically be paid to the Policy Owner upon the Life Insured reaching attained Age 100.

Termination of Contract

A policy will terminate on the earliest of:

- payment of the Critical Illness Benefit
- date of death of the Life Insured
- expiry date of the contract
- date the policy lapsed as a result of any unpaid premiums after the expiration of the grace period
- date the company receives the Policy Owner's request in writing to cancel the policy

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Return of Premium (ROP) Benefit Riders

The Living Benefit plans offer a wide range of return of premium benefit rider options.

Plan	Living Benefit 10	Living Benefit 20	Living Benefit 75	Living Benefit 100	15-Pay Living Benefit 100
Return of Premium options available	ROPD	ROPD	ROPD	ROPD	ROPD
			100% ROPS starting at year 15 OR	100% ROPS starting at year 15 OR	100% ROPS starting at year 15
			100% ROPS starting at Age 65 OR	100% ROPS starting at year 20	
			100% ROPX at Age 75		

ROPD – Return of Premium on Death
ROPS – Return of Premium on Surrender
ROPX – Return of Premium on Expiry

Issue Ages

ROP Name	Minimum Issue Age	Maximum Issue Age
Return of Premium on Death (ROPD)	18	LB10, LB75, LB100 & 15LB100 = 65 LB20 = 55
Return of Premium on Surrender (ROPS)		
ROPS15	18	65
ROPS20	18	65
ROPS65	18	50
Return of Premium on Expiry (ROPX)	18	60

Return of Premium on Death (ROPD) Benefit Rider

The ROPD benefit will return the sum of the annual base premiums from the policy effective date to the date of death of the insured. No return of premium on death benefit is payable if the critical illness benefit has been paid.

Annual Base Premium includes:

For purposes of the ROPD benefit rider, the annual base premium includes the policy's annual premium, modal loading, policy fee, medical extras, plus any ROP rider premium if elected.

Annual Base Premium does not include:

Excluded are any premiums paid for Waiver of Premium, Child Term Rider and Accidental Death Benefit if elected.

A change to non-smoker rate and change in rating will impact the ROP refund.

Calculating ROPD

Male 40, non smoker example

$100,000 LB75 critical illness benefit, Including ROPD and Wavier of Premium
Premiums are paid monthly
Monthly Premium (including policy fee) for CI benefit = $107.91
Monthly premium for ROPD = $3.24
Monthly premium for Waiver of Premium = $5.15
Client dies at age 70 (30 years exactly)
Total Monthly Premium = $116.30

ROPD Calculation

[((Sum of all Monthly Premiums for CI benefit + Sum of all Monthly Premiums for ROPD))] × 30 years = ROPD benefit

[(($107.91 × 12) + ($3.24 × 12)) × 30 years] = $40,014

Return of Premium on Expiry (ROPX) Benefit Rider

If there has been no reduction in the critical illness benefit, the ROPX benefit is equal to the annual base premiums paid from the policy effective date to the expiry date.

If there has been a reduction in the critical illness benefit prior to the expiry date, the ROPX benefit is equal to the annual base premiums paid from the policy effective date to the expiry date on the reduced sum insured (reduced critical illness benefit).

Annual Base Premium includes:

For purposes of the ROPX benefit rider, the annual base premium includes the policy's annual premium, modal loading, policy fee, medical extras, plus any ROP rider premium if elected.

Annual Base Premium does not include:

Excluded are any premiums paid for Waiver of Premium, Child Term Rider and Accidental Death Benefit if elected.

A change to non-smoker rate and change in rating will impact the ROP refund.

Continued

Calculating ROPX

Male 40, non smoker

$100,000 LB75 critical illness benefit, Including ROPD and ROPX	75,000 LB75 critical illness benefit Including ROPD and ROPX
Total annual premium for the CI benefit = $1199	Total annual premium for the CI benefit = $1023.50
Total annual premium for the ROPD = $36	Total annual premium for the ROPD = $33.75
Total annual premium for the ROPX = $440	Total annual premium for the ROPX = $363.75
Total annual premium = $1,675	Total annual premium = $1,421

Example 1

Client has purchased a $100,000 CI benefit.

Full CI benefit stays in-force until expiry date at attained age 75.

i. $100,000 stays in force until expiry (Age 75)

ROPX Benefit (at expiry) = Annual Base Premium (on $100,000 sum insured, immediately prior to expiry) × 35 years (from Policy Effective Date to Option Election Date)

= $1,675 × 35 years = $58,625

Example 2

Client has purchased a $100,000 CI benefit.

CI benefit (sum insured) is reduced by $25,000 (the partial surrender) at the end of the 10th policy year and then the policy expires at age 75.

i. Surrender $25,000 at the end of the 10th policy year.
Sum insured after the partial surrender = $75,000

ROPX Benefit (year 10) = $0

The policy owner is not entitled to receive a Return of Premium on Expiry Benefit for full or partial surrenders that occur prior to the expiry of the contract (Age 75)

ii. Remaining $75,000 stays in force until expiry (Age 75)

ROPX Benefit (at expiry) = Annual Base Premium (on $75,000 sum insured, immediately prior to expiry) × 35 years (from Policy Effective Date to Option Election Date)

= $1,421 × 35 years = $49,735

Return of Premium on Surrender (ROPS)

ROPS15

On or after the 15th policy anniversary, the owner may elect to surrender the policy or surrender a portion of the policy and receive a return of premium on surrender benefit. The date this right is exercised is called the option election date.

ROPS20

On or after the 20th policy anniversary, the owner may elect to surrender the policy or surrender a portion of the policy and receive a return of premium on surrender benefit. The date this right is exercised is called the option election date.

ROPS65

On or after the insured's attained age 65, the owner may elect to surrender the policy or surrender a portion of the policy and receive a return of premium on surrender benefit. The date this right is exercised is called the option election date.

The return of premium on surrender benefit is equal to the sum of the annual base premiums paid on the surrendered critical illness benefit from the policy effective date to the option election date.

The return of premium on surrender benefit is not limited to the critical illness benefit (sum insured).

Annual Base premium includes:

For purposes of the ROPS benefit riders, the annual base premium includes the policy's annual premium, modal loading, policy fee, medical extras, plus any ROP rider premium if elected.

Annual Base Premium does not include:

Excluded are any premiums paid for Waiver of Premium, Child Term Rider and Accidental Death Benefit if elected.

A change to non-smoker rate and change in rating will impact the ROP refund.

Return of Premium on Surrender Benefit Formula

For full or partial surrenders prior to the 15th policy anniversary (ROPS15), prior to the 20th policy anniversary (ROPS20) and prior to the insured's attained age 65 (ROPS65) the policy owner is not entitled to receive a Return of Premium on Surrender Benefit, and therefore no benefit will be paid.

For full or partial surrenders on or after the 15th policy anniversary (ROPS15), on or after the 20th policy anniversary (ROPS20) and on or after the insured's attained age 65 (ROPS65), the policy owner is entitled to receive a return of premium on surrender benefit equal to the annual base premiums paid on the surrendered critical illness benefit from the policy effective date to the option election date.

Mathematically applied:

ROPS Benefit = A – B, where:

A = annual base premiums paid on the critical illness benefit, immediately prior to the surrender, from the policy effective date to the option election date

B = annual base premiums paid on the critical illness benefit, immediately after the surrender, from the policy effective date to the option election date

Continued

Calculating ROPS

Male 40, non smoker examples

$100,000 LB100 critical illness benefit, Including ROPD and ROPS15	**$75,000 LB100 critical illness benefit, Including ROPD and ROPS15**
Total annual premium for the CI benefit = $1,119	Total annual premium for the CI benefit = $1,023.50
Total annual premium for the ROPD = $36	Total annual premium for the ROPD = $33.75
Total annual premium for the ROPS15 = $833	Total annual premium for the ROPS15 = $719.25
Total annual premium = $2,068	Total annual premium = $1,776.50
$50,000 LB100 critical illness benefit, Including ROPD and ROPS15	**$25,000 LB100 critical illness benefit, Including ROPD and ROPS15**
Total annual premium for the CI benefit = $699.00	Total annual premium for the CI benefit = $374.50
Total annual premium for the ROPD = $22.50	Total annual premium for the ROPD = $11.25
Total annual premium for the ROPS15 = $479.50	Total annual premium for the ROPS15 = $239.75
Total annual premium = $1,201.00	Total annual premium = $625.50

Example 1

Full surrender in policy year 10

i. Surrender the full $100,000 sum insured at the end of the 10th policy year

ROPS Benefit = $0.

The policy owner is not entitled to receive a Return of Premium on Surrender Benefit for any full or partial surrender(s) that occur prior to the 15th policy anniversary.

Example 2

Full surrender immediately after policy anniversary 15

i. Surrender the full $100,000 sum insured immediately after the 15th policy anniversary

ROPS Benefit (year 15) = A – B = $31,020 - $0 = $31,020, where:

A = Annual Base Premium (on $100,000 sum insured, immediately prior to surrender) × 15 years (from Policy Effective Date to Option Election Date) = $2,068 × 15 years = $31,020

B = Annual Base Premium (on $0 sum insured, immediately after surrender) × 15 years (from Policy Effective Date to Option Election Date) = $0 × 15 years = $0

Example 3

Reduce CI sum insured by $25,000 at the end of the 10th policy year and then surrender the policy immediately after the 15th policy anniversary

i. Surrender $25,000 at the end of the 10th policy year. Sum insured after the partial surrender = $75,000

ROPS Benefit (year 10) = $0

The policy owner is not entitled to receive a Return of Premium on Surrender Benefit for any full or partial surrender(s) that occur prior to the 15th policy anniversary.

ii. Surrender the remaining $75,000 immediately after the 15th policy anniversary

ROPS Benefit (year 15) = A – B = $26,647.50 - $0 = $26,647.50, where:

A = Annual Base Premium (on $75,000 sum insured, immediately prior to surrender) × 15 years (from Policy Effective Date to Option Election Date) = $1,776.50 × 15 = $26,647.50

B = Annual Base Premium (on $0 sum insured, immediately after surrender) × 15 years (from Policy Effective Date to Option Election Date) = $0 × 15 years = $0

Example 4

Reduce CI sum insured (partial surrender) $25,000 at the end of the 10th policy year.

i. Reduce CI sum insured (partial surrender) $25,000 at the end of the 10th policy year. Sum insured after the partial surrender = $75,000

ROPS Benefit (year 10) = $0.

The policy owner is not entitled to receive a Return of Premium on Surrender Benefit for any full or partial surrender(s) that occurs prior to the 15th policy anniversary.

Reduce sum insured (partial surrender) $50,000 immediately after the 15th policy anniversary, and then

ii. Reduce CI sum insured (partial surrender) $50,000 at the end of the 15th policy year. Sum insured after the partial surrender = $25,000

ROPS Benefit (year 15) = A – B = $26,647.50 - $9,382.50 = $17,265.00, where:

A = Annual Base Premium (on $75,000 sum insured, immediately prior to surrender) × 15 years (from Policy Effective Date to Option Election Date) = $1,776.50 × 15 years = $26,647.50

B = Annual Base Premium (on $25,000 sum insured, immediately after surrender) × 15 years (from Policy Effective Date to Option Election Date) = $625.50 × 15 years = $9,382.50

Surrender the policy immediately after the 25th policy anniversary.

iii. Fully surrender the remaining $25,000 immediately after the 25th policy anniversary

ROPS Benefit (year 25) = A – B = $15,637.50 - $0 = $15,637.50, where:

A = Annual Base Premium (on $25,000 sum insured, immediately prior to surrender) × 25 years (from Policy Effective Date to Option Election Date) = $625.50 × 25 years = $15,637.50

B = Annual Base Premium (on $0 sum insured, immediately after surrender) × 25 years (from Policy Effective Date to Option Election Date) = $0 × 25 years = $0

Continued

Conversion Options

Conversion of a Term Critical Illness (CI) Policy or Rider to a Level Premium Critical Illness Policy

A renewable and convertible term critical illness policy may be converted to a level premium term critical illness policy of the same generation subject to the following conditions:

- The policy must be in force at the time of the conversion.
- The Policy Owner must apply for the conversion up to the Insured's attained Age 60.
- The conversion policy will provide coverage for the same Covered Conditions as covered in the original policy.
- The sum insured (critical illness benefit) of the conversion policy must be equal to or less than the sum insured of the converting policy. If the policy is partially converted, the sum insured of each of the conversion policy and the original policy must be more than the minimum coverage amount for each plan.
- The conversion policy will be issued at the attained age of the insured as of the date of conversion. The premiums on the conversion policy at time of issue will also be based on the original substandard rating, if any.
- The new premium must not be less than the minimum required by the Company for the mode of payment selected.
- The policy date of the conversion policy will be the conversion date.

If the Early Discovery Benefit amount has been paid under the original policy, the conversion policy will not include the Early Discovery Benefit as this benefit is payable only once.

When a policyholder is converting from a renewable convertible term CI policy to a level premium term critical illness policy, they may also add a Return of Premium on Death or Surrender Benefit rider of the same generation to the conversion policy without evidence of insurability.

Requirements

- Request for Term Conversion to a Permanent Plan, form 639E.
- First initial premium – cheque or special withdrawal instructions.
- Premium Change Request Form, form 164E for a new payor otherwise submit a void cheque.
- If you request to add a Return of Premium on Death Benefit rider, Return of Premium on Surrender Benefit rider or a Return of Premium on Expiry Benefit rider to the conversion policy, you will need to complete either the Direction to Pay for Critical Illness Policies, form 630E or Beneficiary Designations for Critical Illness Policies, form 626E.

Items to Remember

- Verify the conversion period, expiry dates and eligibility based on your client's attained age.
- Verify the minimum coverage amounts.
- Client may request the addition of Return of Premium Benefit rider (e.g. ROPD, ROPS, ROPX) from the same generation as the converted policy to the conversion policy without evidence of insurability.
- Do not run a current quote/illustration for policies issued prior to November 2, 2015 (Wave 32). Please contact New Business at Insurance.IndividualNewBusiness@BMO.com for a conversion quote.
- Any request involving underwriting such as non-smoker changes, reconsideration of rating, increase in coverage, etc., please refer to the Underwriting Guidelines for requirements.

Covered Conditions

Critical Illness Covered Conditions

Living Benefit plans cover the following 25 conditions

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dementia, including Alzheimer's Disease
- 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
- Severe Burns
- Stroke

The Life Insured must be alive at the end of the survival period (when applicable) in order for the critical illness benefit to be paid. The survival period means the period starting on the date of diagnosis of the critical illness and ending 30 consecutive days following the diagnosis of the critical illness. The survival period does not include the number of days on life support. The Life Insured must be alive at the end of the survival period and not be on life support.

Continued

Aortic Surgery

Definition
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 and must be performed by a Specialist.

The Life Insured must satisfy the Survival Period.

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

Interpretation
The aorta is the large artery that carries blood from the heart through the chest and into the abdomen. Surgical replacement of diseased portions of the aorta with a graft is covered by this policy. All non-surgical procedures on the aorta are excluded from coverage.

Aplastic Anemia

Definition
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.

Interpretation
Aplastic anemia means failure of the bone marrow to produce red blood cells, some types of white blood cells and the platelets required for normal blood clotting. This results in anemia and an increased risk of infection and abnormal bleeding. Aplastic anemia can appear quickly or slowly at any age and treatment requires a blood transfusion, medication and stem-cell transplantation

Bacterial Meningitis

Definition
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 benefit will be payable under this condition for viral meningitis.

Interpretation
Bacterial meningitis is an infection of the membranes surrounding the brain and spinal cord. A number of different bacteria can cause meningitis and it is treated in hospital with antibiotics. Bacterial meningitis severe enough to cause neurological deficits (e.g., deafness) persisting for at least 90 days is a covered condition.

Meningitis caused by a viral infection is a much less serious condition and is not covered by this policy.

Benign Brain Tumour

Definition
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.

Exclusions:
No benefit will be payable under this condition if, within the first 90 days following the later of, the Policy Issue Date of the Policy, or 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 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 benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Interpretation
Benign brain tumours may arise inside the skull but outside the brain or inside the normal spaces within the brain itself. Typically they are slow growing and don't invade brain tissue but they may cause serious problems due to space limitations inside the skull or by obstructing the normal flow of fluid within the brain. No benefit is payable unless surgical or radiation treatment is necessary or the tumour causes a permanent neurological deficit.

Benign tumours of the pituitary gland less than 10 mm in diameter are usually treated with medication and are not covered by this policy.

Malignant brain tumours and malignant tumours originating elsewhere in the body that have spread to the brain are covered under Cancer (Life-Threatening).

Continued

Blindness

Definition
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.

Interpretation
Blindness may be caused by injury or disease of the eye, the optic nerve, the optic pathways within the brain and the visual cortex itself. The Canadian definition of legal blindness is the definition used in this policy and both eyes must be permanently affected.

Cancer (Life-Threatening)

Definition
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 carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a Specialist.

Exclusions:
No benefit will be payable under this condition if, within the first 90 days following the later of, the Policy Issue Date of the Policy, or 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 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 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.

Interpretation
The policy definition of Cancer (Life-Threatening) covers most types of malignant tumours including the several types of cancer, lymphomas, leukemias and melanomas.

The main exclusions are those cancers generally considered non-life-threatening and readily treatable, benign, premalignant or borderline malignant and any carcinoma in-situ, i.e., non-invasive cancer.

Coma

Definition
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 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

Coma means an unrousable mental state in which there is no meaningful response to environmental stimuli such as speech or pain. The level of coma is measured by the Glasgow Coma Scale and no benefit will be payable unless the coma is level 4 or less and continuous for at least 96 hours.

Interpretation
Exclusions: medically induced coma, coma due to alcohol or drug use and coma due to brain death.

Continued

Coronary Artery Bypass Surgery

Definition
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. The Life Insured must satisfy the Survival Period.

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

Interpretation
The coronary arteries supply the heart muscle with the blood it needs to work. Coronary artery disease may cause localised narrowing of these arteries and restrict the heart's blood supply. Coronary artery bypass surgery uses grafts made from the patient's own veins or arteries to bypass such narrowings and restore the blood supply and such surgery is covered under this policy.

All non-surgical methods of dilating coronary artery narrowings such as with catheters introduced through the skin into arm or leg arteries (angioplasty) are excluded from this definition.

Deafness

Definition
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. The Life Insured must satisfy the Survival Period.

Interpretation
Deafness may be caused by injury or disease. A hearing threshold of 90 decibels or greater means profound deafness and both ears must be affected.

Dementia, including Alzheimer's Disease

Definition
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 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 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.

Interpretation
Dementia is an acquired, progressive impairment of cognitive function such as memory, language, orientation in time and place and abstract thought. The presence and progression of dementia can be assessed by standardised tests such as the Mini Mental State Exam and must be at least moderately severe.

Impairment of cognitive function due acute delirium or to psychiatric illness such as schizophrenia is excluded.

Heart Attack

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. The Life Insured must satisfy the Survival Period.

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

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

Continued

Heart Attack (cont'd)

Interpretation
A heart attack (myocardial infarct) means that a portion of heart muscle has insufficient blood supply to meet its needs for long enough to cause that portion of muscle to die. The commonest cause is obstruction of a coronary artery by coronary artery disease and /or a blood clot. The dying muscle releases chemicals (cardiac enzymes) which can be detected by blood tests and also causes new changes in the electrocardiogram (ECG) and a heart attack diagnosis is made by these test results. The dead muscle is replaced by scar tissue over time.

Catheter interventions in the coronary arteries can also cause a rise in cardiac enzymes but unless there are also new ECG changes diagnostic of a heart attack, such a rise is not accepted as evidence of a heart attack and therefore excluded. Also excluded from coverage is the incidental finding on an ECG that an unrecognised heart attack has occurred at some time in the past.

Heart Valve Replacement or Repair

Definition
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. The Life Insured must satisfy the Survival Period.

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

Interpretation
The four heart valves (tricuspid, pulmonary, mitral, aortic) control the flow of blood into and out of the main right and left pumping chambers (ventricles) of the heart. Valves that leak can be surgically repaired in some instances but may need to be replaced and all valves that are too narrowed need to be surgically replaced by mechanical or tissue valves. All such surgery is covered by this policy.

Non-surgical procedures on heart valves are excluded from coverage.

Kidney Failure

Definition
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.

Interpretation
Severe, chronic and irreversible kidney failure must be managed by regular peritoneal dialysis, hemodialysis or by kidney transplantation and all such management of kidney failure is covered by this policy.

Loss of Independent Existence

Definition
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

Interpretation
The list of daily activities that we all need to do for ourselves in order to live independently are: bathing, dressing, toileting, control of bowels and bladder, getting in and out of a bed, chair or wheelchair by ourselves or with assistive devices, and feeding ourselves. The loss of the ability to do two or more of these activities without help from another person for at least 90 days and with no reasonable chance of recovery as confirmed by a Specialist physician constitutes Loss of Independent Existence as defined by this policy.

Loss of Limbs

Definition
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.

Interpretation
Whether by accidental injury or deliberate amputation because of disease, the Loss of Limbs means the loss by complete severance of two or more limbs at or above the wrist or ankle joint.

Continued

Loss of Speech

Definition
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 benefit will be payable under this condition for all psychiatric related causes.

Interpretation
Loss of Speech means the total and permanent loss of the ability to express thoughts and ideas by vocal sounds and may result from injury or disease to the brain or larynx.

Loss of Speech secondary to psychiatric illness is excluded from coverage.

Major Organ Failure on Waiting List

Definition
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 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. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

Interpretation
The diagnosis by a specialist of the irreversible failure of the heart, both lungs, the liver, both kidneys or the bone marrow may be managed by the replacement of the failed organ with one obtained from a donor. Enrollment as a recipient on the waiting list for a transplant at a recognised transplant centre in Canada or the United States of America qualifies the policy holder for this benefit.

For Survival Period purposes, the Date of Diagnosis is the date of enrollment on the transplantation waiting list.

Major Organ Transplant

Definition
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 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.

Interpretation
Irreversible failure of the heart, both lungs, the liver, both kidneys and the bone marrow may be managed by replacement of the failed organ with one obtained from a donor. Undergoing surgery that results in the failed listed organ being replaced by a transplanted organ is a covered condition.

Motor Neuron Disease

Definition
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.

Interpretation
Motor Neuron Disease may present in several different ways and a definite diagnosis of any of the listed clinical presentations by a specialist is a covered condition.

Multiple Sclerosis

Definition
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.

Interpretation
Multiple sclerosis is a chronic inflammatory disease of the brain and/or spinal cord which may present in several different ways and a definite diagnosis by a specialist of any of the listed clinical presentations is a covered condition.

Continued

Occupational HIV Infection

Definition
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 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 Policy Issue Date, or the effective date of last reinstatement of the Policy.

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

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

- The 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.

Interpretation
Infection with the human immunodeficiency virus (HIV) may result from exposure of those whose occupations (ambulance crew, nurses, medical lab technicians, dentists, physicians, police officers, etc.) may expose them to the blood or bodily fluids of people already infected with HIV. Prompt reporting of such work exposure is required to ensure that subsequent HIV infection is the result of such exposure and thus rule out HIV infections resulting from drug abuse or sexual transmission.

Paralysis

Definition
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.

Interpretation
The total loss of muscle function (Paralysis) of 2 or more limbs must persist for at least 90 days following the injury or disease causing the paralysis in order to eliminate temporary paralysis.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Definition
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 Insured Person 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: No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders Exclusion Period
No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the Policy Issue, or 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 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.

Continued

Parkinson's Disease and Specified Atypical Parkinsonian Disorders (cont'd)

Interpretation
Primary Parkinson's disease is the second most common neuro-degenerative disorder after Alzheimer's disease and its incidence in the population rises with age. Progressive slowing of movement and muscular rigidity and / or resting tremor are needed for diagnosis and lead to impairment of the activities of daily living. Progressive deterioration of function for at least one year in spite of appropriate medical treatment by a neurologist is a covered condition.

Specified Atypical Parkinsonian Disorders as defined are also covered conditions but Parkinson's Disease and Specified Atypical Parkinsonian Disorders due to any other cause such as medications are excluded from this coverage.

Symptoms of Parkinson's Disease or Specified Atypical covered Parkinsonian Disorders will not be considered a Payable benefit if such Symptoms occurred within the first year of policy issue regardless when the diagnosis is made.

Severe Burns

Definition
Severe Burns is defined as 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.

Interpretation
Third degree burns destroy the full thickness of the skin and for Severe Burns as defined, at least 20% of the total body surface area must be burned to this degree.

Stroke (Cerebrovascular Accident)

Definition
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. The Life Insured must satisfy the Survival Period.

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

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

Interpretation
Interruption of the blood flow in an artery supplying blood to an area of the brain results in the death (infarction) of that area which may cause a clinical Stroke. The interruption in flow may be caused by blood clotting in a diseased artery, by a blood clot originating elsewhere (usually in the heart) that is carried into a brain artery by the blood flow or by bleeding from rupture of a brain artery. Depending on the area of the brain involved, new clinical symptoms and signs such as limb weakness or paralysis and impairment of sensation, speech or vision may occur which are termed neurological deficits. Confirmation of brain infarction on brain imaging studies and of neurological deficits persisting for more that 30 days from the onset of the Stroke event confirmed by a specialist are required to make a Stroke diagnosis covered by this policy.

Stroke events causing neurological deficits that persist for less than 30 days and events caused by trauma, not by vascular disease, are excluded from coverage.

Early Discovery Covered Conditions

Living Benefit plans cover the following 7 conditions

- Coronary Angioplasty
- early Breast Cancer
- early Prostate Cancer
- early Skin Cancer
- early Stage Blood Cancer
- early Stage Intestinal Cancer
- early Thyroid Cancer

The insured must be alive at the end of the survival period in order for the early discovery benefit to be paid. The survival period means the period starting on the date of diagnosis of the early discovery and ending 30 consecutive days following the diagnosis of the early discovery. The survival period does not include the number of days on life support. The insured must be alive at the end of the survival period and not be on life support.

Coronary Angioplasty

Definition
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. The Life Insured must satisfy the Survival Period.

Early Breast Cancer

Definition
Early Breast Cancer is defined as ductal carcinoma in situ of the breast as confirmed by a biopsy and diagnosed by a Specialist.

Continued

Early Prostate Cancer

Definition
Early Prostate Cancer is defined as prostate cancer that is either T1A or T1B, without lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.

Early Skin Cancer

Definition
Early Skin Cancer is defined as malignant melanoma skin cancer that is less than or equal to 1.0 mm thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.

Early Stage Blood Cancer

Definition
Early Stage Blood Cancer is defined as chronic lymphocytic leukemia classified less than Rai stage 1, confirmed by appropriate blood tests and diagnosed by a Specialist.

Early Stage Intestinal Cancer

Definition
Early Stage Intestinal Cancer is defined as malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2, as confirmed by biopsy and diagnosed by a Specialist.

Early Thyroid Cancer

Definition
Early Thyroid Cancer is defined as 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, as confirmed by biopsy and diagnosed by a Specialist.

Early Discovery Covered Conditions Terms

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.

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.

Early Discovery Covered Conditions Exclusions

No benefit will be payable under the Early Discovery Benefit if:

Within the first 90 days following the later of:

- the Policy Issue Date of the Policy, or;
- the effective date of last reinstatement of the Policy;

the Insured has any of the following:

- Signs, symptoms or investigations that lead to a diagnosis of an Early Discovery Covered Condition, regardless of when the diagnosis is made;
- A diagnosis of an Early Discovery Covered Condition.

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for an Early Discovery Covered Condition or, any critical illness caused by an Early Discovery Covered Condition or its treatment.

The Early Discovery Benefit is payable only once for the occurrence of any Early Discovery Covered Condition. If this Policy is the result of a conversion where under the original Policy or Rider the Early Discovery Benefit Amount has already been paid, the Early Discovery Benefit will not be payable on this Policy.

We will not pay for the same Early Discovery Covered Condition more than once. Any payment of the Early Discovery Benefit Amount will not reduce the Policy Premiums or reduce the Critical Illness Benefit.

Early Discovery Covered Conditions Interpretation

The early discovery of some conditions that are excluded by policy definition from the list of critical illness covered conditions above may be covered by the Early Discovery Covered Conditions clause.

Under this clause, some cancers that are generally considered non life-threatening such as ductal breast cancer in-situ, early prostate cancer, early skin cancer and chronic lymphocytic leukemia may be covered and also some types of uncommon early intestinal cancers and some early thyroid cancers.

Localised coronary artery narrowings that are not surgically bypassed but are stretched open (coronary angioplasty) by a balloon on the end of a catheter introduced through an arm or leg artery are covered under this clause.

Continued

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