Critical Assist® Resource Guide

Critical Assist® IV

About This Guide

Navigating the Guide

To navigate through this guide, use the links in the bookmarks section on the left. Depending on your computer settings, those links may not be visible when this guide is opened. If they are not visible, click on the Bookmarks icon on the left side of the screen. You may then click on the links in this pane to navigate to any of the guide topics.

Please Note: Co-operators Life Insurance Company will be hereinafter referred to in this document as “The Company”, “We” or “Us”.

Disclaimer of Liability

While every effort is made to ensure the information contained within this document is accurate and complete, We assume no legal liability or responsibility for any errors or omissions. Where the information differs from the insurance policy wording, the terms of the policy will always apply.

TABLE OF CONTENTS

Introduction

The Critical Assist Product Guide provides comprehensive information about this line of products:

- Critical Assist® (CA):
  - CA 10
  - CA 25
  - CA 75
  - CA 20-Pay

- Critical Assist® – Head Start (CA – Head Start):
  - CA – Head Start 10
  - CA – Head Start 25
  - CA – Head Start 75
  - CA – Head Start 20-Pay

Note: Where the information varies, the resource guide differentiates with headings indicating the product name.

Product Overview

This product line is appropriate for clients looking for a measure of financial security if struck by a critical illness.

The benefit can be used to offset uninsured medical expenses, provide home renovations for wheelchair accessibility, provide nursing care, help with ongoing responsibilities, mortgage loan payments, etc. However, there are no restrictions on how the benefit can be used.

Unlike many creditor products, the coverage is on an individual, fully underwritten basis. Therefore, coverage cannot be cancelled, premium rates are guaranteed and significant underwriting is done at time of issue. The benefit is paid to the owner, not the creditor.

Critical Assist (CA)

- The CA product provides coverage for 29 diseases/conditions, four of which qualify for an Early Assist payment.

Critical Assist – Head Start (CA – Head Start)

- The CA – Head Start product provides a benefit for an insured child who suffers one of 36 defined Covered Conditions, four of which qualify for an Early Assist payment. Coverage includes seven childhood and 29 adult conditions. Coverage for the childhood conditions begins at the policy date. Coverage for two of the childhood conditions ends just before an insured child's third birthday with coverage for the remaining five ending when the child turns Insurance Age 18. Except for LOIE, coverage for the adult conditions begins on the policy date and ends at Insurance Age 75. Coverage for LOIE begins at Insurance Age 18. In the event of either a full payment or an Early Assist payment, the benefit is paid to the Policyowner, who may be a parent or grandparent.

All Critical Assist products feature the Best Doctors® program. This innovative, world leading service provides information about care options and ways to access it when clients need it most – at time of claim. Refer to the Best Doctors section of this Guide for complete details on this program.

Overview of Features

Availability

The CA and CA – Head Start plans are available to persons who:

- meet the health qualifications; and
- meet the age qualifications for each plan.

The Illustration system, E-App and LIFE Pages provide Pre-Screening Questionnaires.

Availability as a Rider on Life Coverages: CA

- CA 10 and CA 25 are available as a rider on Universal Life Suites, Infinity Term and Versatile Term policies.
- Refer to the corresponding base Resource Guides for details.

Number of Lives

- CA and CA – Head Start are available on a Single Life basis only.

Policy Ownership

- The Policyowner may be one or more individuals. Joint ownership must be indicated on the E-Apps system.
- All owners must authorize any policy changes.
- Once an insured child turns 18, ownership of the CA – Head Start policy may be transferred to that child, who then becomes the Policyowner and assumes responsibility for paying all premiums.

Issue Ages

CA 10	Insurance Ages 18 – 65 years
CA 25	Insurance Ages 18 – 50 years
CA 75	Insurance Ages 18 – 65 years
CA 20-Pay	Insurance Ages 18 – 50 years
CA – Head Start 10	Insurance Ages 30 days – 17 years
CA - Head Start 25	Insurance Ages 30 days – 17 years
CA – Head Start 75	Insurance Ages 30 days – 17 years
CA – Head Start 20-Pay	Insurance Ages 30 days – 17 years

Coverage Amount: CA

- Minimum: $25,000
- Maximum: $2,000,000. Amounts above $2,000,000 require Head Office approval.

Coverage Amount: CA – Head Start

- Minimum: $25,000
- Maximum: $250,000 including any other CA – Head Start policies issued by us on the child

Coverage Period

Refer to the Expiry/Coverage Period section in this Guide for information about coverage period.

Covered Conditions

1. Aortic Surgery
2. Aplastic Anemia
3. Bacterial Meningitis
4. Benign Brain Tumour
5. Blindness
6. Cancer (Life-threatening)
7. Coma
8. Coronary Artery Bypass Surgery
9. Deafness
10. Dementia, including Alzheimer's Disease
11. Heart Attack
12. Heart Valve Replacement or Repair
13. Kidney Failure
14. Loss of Independent Existence
15. Loss of Limbs
16. Loss of Speech
17. Major Organ Failure on Waiting List
18. Major Organ Transplant
19. Motor Neuron Disease
20. Multiple Sclerosis
21. Occupational HIV Infection
22. Paralysis
23. Parkinson's Disease and Specified Atypical Parkinsonian Disorders
24. Severe Burns
25. Stroke (Cerebrovascular Accident)

Additional Covered Childhood Conditions under CA – Head Start

1. Autism
2. Cerebral Palsy
3. Congenital Heart Disease
4. Cystic Fibrosis
5. Type 1 Diabetes Mellitus
6. Muscular Dystrophy
7. Rett Syndrome

Refer to the Covered Conditions sections in this guide for Benchmark definitions of each condition.

Early Assist Covered Conditions

1. Coronary Angioplasty
2. Non-Life-threatening Cancers (3)

Refer to Early Assist Covered Conditions Sections in this guide for Benchmark definitions of each condition.

Benefit Period

One single, lump sum payment is made upon confirmed diagnosis of one of the Covered Conditions.

Beneficiary
Critical illness benefit payments (full payout or Early Assist) will always be paid to the Policyowner, unless assigned or subject to a garnishee. Benefit payments for Premium Payback at Expiry (PPE) or Premium Payback at Surrender (PPS) coverages are always paid to the Policyowner. Because of regulations governing accident and sickness insurance, the Policyowner cannot name a beneficiary for critical illness benefits. The Policyowner can name a beneficiary for the Premium Payback at Death (PPD) benefit.

Premiums
Premium rates are calculated based on incidence rates – specifically the probability of contracting one of the given conditions. The premium structures available are:

- Level for 10 years and renewable at attained age rate for successive 10-year periods to expiry (age 75)
- Level for initial 25-year period, renewable at attained age rate for successive 20-year periods to expiry (age 75)
- Level to age 75
- Level and paid-up after 20 years with coverage to age 75

Premium Mode

- Annual
- Semi-annual
- Monthly Pre-Authorized Debit (PAD)

Policy Fee
The policy fee added to the total modal premium is:

Annual	$35.00
Semi-annual	$18.20
Monthly Pre-Authorized Debit (PAD)	$3.15

Modal Factor

Semi-annual	0.52
Monthly Pre-Authorized Debit (PAD)	0.09

Premium Rate Bands: CA

Band 1	$25,000 to $99,999
Band 2	$100,000 to $249,999
Band 3	$250,000 to $2,000,000

Premium Rate Bands: CA – Head Start

Band 1	$25,000 to $149,999
Band 2	$150,000 to $250,000

Premium Rate Classes: CA
There are two premium rate classes:

- Smoker
- Non-Smoker

Premium Rate Classes: CA – Head Start
There is only one premium rate class for these plans:

- Regular – applies to all lives to be insured and varies by age and gender only

Other Features

- Premium Deposit Fund (PDF)
- Premium Payback at Death (PPD)
- Conversion Privileges
- Best Doctors program[1.]
- Counselling Benefit

Optional Riders and Other Benefits: CA

- Premium Payback at Expiry (PPE)[2.] - Available only on Level to 75 and Level 20-Pay with Coverage to Age 75 plans
- Premium Payback at Surrender (PPS)[3.] - Available only on Level to 75 and Level 20-Pay with Coverage to Age 75 plans
- Disability Premium Waiver (DPW)
- Premium Payback at Expiry Disability Premium Waiver (PPE DPW)
- Premium Payback at Surrender Disability Premium Waiver (PPS DPW)

Optional Riders and Other Benefits: CA – Head Start

- Premium Payback at Expiry (PPE)[2.] - Available only on Level to 75 and Level 20-Pay with Coverage to Age 75 plans
- Premium Payback at Surrender (PPS)[3.] - Available only on Level to 75 and Level 20-Pay with Coverage to Age 75 plans
- Automatic Waiver of Premium (AWP)
- Premium Payback at Expiry Automatic Waiver of Premium (PPE AWP)
- Premium Payback at Surrender Automatic Waiver of Premium (PPS AWP)

[1] Refer to the Best Doctors section at the end of this Product Guide for information about this program.
[2] If PPE is selected, PPS is not available.
[3] If PPS is selected, PPE is not available (coverage is included with PPS).

Other Features

Premium Deposit Fund

- Clients can prepay their premiums. Any amount over the annual premium would go into the Premium Deposit Fund (PDF). Premium payments are deducted annually from the PDF. Any shortfall of the annual premium over the PDF will have to be paid in cash by the owner. The interest earned on funds in the PDF will be taxable. The PDF interest rate is not guaranteed and is subject to change at any time. The rate is published on LIFE Pages.

Premium Payback at Death (PPD)

- If the Person Insured dies while the Critical Assist policy is in-force, or during the days of grace and no benefit has been paid (excluding a claim for a partial payout under one of the specified partial coverage conditions, which does not reduce or eliminate the PPD amount payable), We will pay to the beneficiary the following Premium Payback at Death benefit:
    - The premiums, without interest, that have been paid for the Critical Assist coverage (including the Premium Payback at Expiry premiums or Premium Payback at Surrender premiums) from the coverage effective date to the date of death, less any indebtedness (overdue premium and accrued interest) owed to Us by the Policyowner.
    - No Disability Premium Waiver benefit premium will be refunded.
    - The rated portion of the premium is returned on CA policies.
- This is an embedded benefit automatically issued with a CA policy in all cases.
- We will require proof of death acceptable to Us, which must be provided at the cost of the claimant.

Conversion Privileges

- Policyowners may convert 10-year and 25-year term policies for Level to Age 75 or Level 20-Pay with Coverage to Age 75 policies. We are then offering for purposes of conversion, without evidence of insurability.
- The premiums charged for the new insurance will be subject to the current rules governing rate classes and will be based on the Life Insured's attained age nearest birthday at the date of conversion.
- Available at any time prior to the policy anniversary nearest the Life Insured's 50th birthday.
- PPS or PPE can be added at this time, but premium payments prior to the conversion are not included in the PPS or PPE benefit.
- DPW/AWP can be added at this time, subject to the rules governing them, with evidence of insurability.
- The face amount of the policy taken can be less than or equal to the face amount of the original policy.
- Partial conversions will be allowed; however, the face amount remaining on the original policy must satisfy the minimum face amount.
- Any substandard rating will continue to apply.

Note: The Benign Brain Tumour/Cancer/ Parkinson's Disease exclusion period would not re-start due to the conversion.

Counselling Benefit

- Available on all CA and CA – Head Start policies (non-contractually).

- Upon diagnosis of a Covered Condition, the Policyowner will receive access to up to three hours of over the phone counselling to be used by themselves or their family members.
- The Policyowner will receive notice and access to this benefit at the time of claim.

Riders and Other Benefits

Premium Payback at Expiry (PPE)

General

- This optional benefit, available only on Level to Age 75 and Level 20-Pay with Coverage to Age 75 plans, returns the premiums paid (excluding the DPW or AWP premium, without interest and less any indebtedness) upon expiry of the base plan.

Availability

- Available on CA and CA – Head Start.
- Available only at time of policy issue – it cannot be added to a policy after issue.
- Available to persons who are from Insurance Age 30 days to Insurance Age 65.
- The PPE benefit is available on standard and rated Level to Age 75 and Level 20-Pay with Coverage to Age 75 plans.
- Not available if the Premium Payback at Surrender (PPS) has been selected, since coverage for PPE is included within PPS.
- The premium payment length of the PPE benefit must correspond to the premium payment length of the base coverage it is attached to.
- If a client selects DPW on the CA base plan, DPW must also be selected on the PPE Rider.
- If a client selects AWP on the CA – Head Start base plan, AWP must also be selected on the PPE Rider.

Increases

- Increases are not allowed on this benefit. To increase the base plan, another policy must be purchased.
- The second or subsequent policy is not required to have this benefit or vice versa.

Decreases

- If the Policyowner decreases the sum insured of the base Critical Assist policy at any time, the PPE benefit will be calculated as if the lowest sum insured had been in effect since the policy issue date.
- No base or PPE premium will be refunded for the portion of coverage that was surrendered.

Benefit Payable – Upon Expiry of the Critical Assist Plan

- If on the expiry date, the Person Insured has not made a claim for a Critical Assist benefit under the policy (excluding a claim for a partial payout under one of the specified partial coverage conditions, which does not reduce or eliminate the PPE amount payable) and this additional benefit remains in effect, We will pay to the Policyowner, without interest:
    - The sum of premiums for the base policy (including the PPE premium and the rated portion of the base and PPE premiums) that have been paid from the policy date to the expiry date, less any indebtedness owed to Us by the Policyowner.
    - No Disability Premium Waiver or Automatic Waiver of Premium Benefit premiums will be refunded.

- We will automatically pay the benefit upon expiry. The Policyowner is not required to make a claim.
- If the Policyowner decreases the sum insured on the Critical Assist policy at any time, the PPE benefit will be calculated as if the lowest sum insured for the contract had been in effect since the policy issue date.

Benefit Payable - Upon Covered Illness of the Person Insured

- If the Critical Assist policy terminates as a result of a critical illness benefit being paid, no PPE benefit is payable.

Benefit Payable - Upon Death of the Person Insured

- If the Critical Assist policy terminates as a result of death of the Person Insured, no PPE benefit is payable.
- A PPD benefit will be paid.

Expiry/Coverage Period

- This benefit terminates at the earlier of:
  - the benefit anniversary date nearest the Person Insured's 75th birthday;
  - the lapse, surrender or termination of the Critical Assist policy to which this additional benefit is attached; or
  - upon receipt of a written request from the Policyowner to cancel this benefit.

Reinstatement

- A Critical Assist policy can be reinstated within three years of lapse.
- However, reinstatement retaining the original effective date is only available if the policy has been lapsed 90 days or less.
- The policy can be reinstated without evidence if all arrears are received within 90 days of the premium due date.
- To reinstate after 90 days (but within three years) of lapse, We require:
  - completion of an application;
  - evidence of acceptable risk; and
  - payment of all indebtedness plus interest and applicable sales tax, since the date of lapse.

Premium Payback at Surrender (PPS)

General

- This optional benefit, available only on Level to Age 75 and Level 20-Pay with Coverage to Age 75 plans, returns the premiums paid (excluding DPW premium or AWP premium, without interest and less any indebtedness), on the date the option is exercised by the Policyowner. The option exercise date must be within the period specified below.
- The PPS benefit on a CA policy is available to the Policyowner if the policy has been in-force for 15 years or more.
- The PPS benefit on a CA – Head Start policy is available to the Policyowner from the later of the Insured Person's Insurance Age of 18 or policy year 15.
- The PPS benefit also includes an option, at the time of surrender, to purchase a reduced paid-up policy (in effect, fully pay up the premiums on a policy with reduced insurance value).

Availability

- Available on CA and CA – Head Start.
- Available only at time of policy issue – it cannot be added to a policy after issue.
- Available to persons who are from Insurance Age 30 days to Insurance Age 59.
- The PPS benefit is available only on standard and rated Level to Age 75 and Level 20-Pay with Coverage to Age 75 plans.
- Not available if Premium Payback at Expiry (PPE) has been selected.
- The premium payment length of the PPS benefit must correspond to the premium payment length of the base coverage it is attached to.
- If a client selects DPW on the CA base plan, DPW must also be selected on the PPS Rider.
- If a client selects AWP on the CA - Head Start base plan, AWP must also be selected on the PPS Rider.

Increases

- Increases are not allowed on this benefit. To increase the base plan, another policy must be purchased.
- The second or subsequent policy is not required to have this benefit or vice versa.

Decreases

- If the Policyowner decreases the sum insured of the base Critical Assist policy at any time, the PPS benefit will be calculated as if the lowest sum insured had been in effect since the policy issue date.
- No base or PPS premium will be refunded for the portion of coverage that was surrendered.

Benefit Payable – Upon Expiry of the Critical Assist Plan

- If on the expiry date, the Person Insured has not made a claim for a Critical Assist Benefit under the policy (excluding a claim for a partial payout under one of the specified partial coverage conditions, which does not reduce or eliminate the PPS amount payable) and this additional benefit remains in effect, We will pay to the Policyowner, without interest for:
    - The sum of premiums for the base policy (including the PPS premium and the rated portion of the base and PPS premiums) that have been paid from the policy date to the expiry date, less any indebtedness owed to Us by the Policyowner.
    - No Disability Premium Waiver or Automatic Waiver of Premium Benefit premiums will be refunded.
    - We will automatically pay the benefit upon expiry. The Policyowner is not required to make a claim.
- If the Policyowner decreases the sum insured on the Critical Assist policy at any time, the PPS benefit will be calculated as if the lowest sum insured for the contract had been in effect since the policy issue date.

Benefit Payable – Upon Surrender of the Critical Assist Plan

- In policy years 0 to 14, the benefit terminates, without value, upon termination of the policy to which the additional benefit is attached.
- For adult policies in-force for 15 years or more, the client can apply for the PPS return of premium benefit. Payment of the benefit terminates the policy (including the PPS Benefit) and the policy cannot be reinstated.
- For children's plans, from the later of the Insured Person's Insurance Age 18 or from policy year 15 or more, the Policyowner can apply for the PPS benefit. Payment of the benefit terminates the policy (including PPS Benefit) and the policy cannot be reinstated.
- If on the date of termination, the Person Insured or Policyowner has not made any claim for a benefit under the policy and this additional benefit remains in effect, We will pay to the Policyowner, without interest, the sum of premiums for the base policy (including the PPS premium and the rated portion of the base and PPS premiums) that have been paid from the policy date to the termination date, less any indebtedness owed to Us by the Policyowner.
- No Disability Premium Waiver Benefit or Automatic Waiver of Premium Benefit premiums will be refunded.
- If the Policyowner decreases the sum insured of the base Critical Assist policy at any time, the PPS benefit will be calculated as if the lowest sum insured had been in effect since the policy issue date.

Benefit Payable - Upon Covered Illness of the Person Insured

- If the Critical Assist policy terminates as a result of a critical illness benefit being paid, no PPS benefit is payable.

Benefit Payable - Upon Death of the Person Insured

- If the Critical Assist policy terminates as a result of death of the Person Insured, no PPS benefit is payable.
- A PPD benefit will be paid.

Reduced Paid-Up Status

- At the time of applying for the PPS Benefit, the Policyowner can choose to take the cash payment provided by this benefit or take a reduced paid-up Critical Assist policy (excluding Waiver of Premium or any other rider, if elected).
- The contract includes a Reduced Paid-Up (RPU) clause stating that the amount of the RPU will be “as determined by The Company”.
- If RPU is selected, the PPD, PPS and DPW/AWP Rider benefits will be discontinued.
- There is no possibility of reinstatement.
- If the PPS benefit is on a CA 20-Pay policy, the Reduced Paid-Up option is only available until policy year 20, at which time the policy will be in paid-up status.

Expiry/Coverage Period

- Coverage from this benefit will cease at the earliest of:
    - expiry at Insurance Age 75. We will automatically pay 100% of the benefit to a maximum of the Face Amount upon expiry. The Policyowner is not required to make a claim.
    - the lapse or termination of the policy prior to the 15th policy anniversary for adult plans.
    - the lapse or termination of the policy prior to the 15th policy anniversary or before the child reaches Insurance Age 18 for children’s plans.
    - payment of this benefit to the Policyowner.
    - the changing of the policy to Reduced Paid-Up Critical Assist.
    - upon receipt of a written request from the Policyowner to cancel this benefit.

Reinstatement

- A Critical Assist policy can be reinstated within three years of lapse.
- However, reinstatement retaining the original effective date is only available if the policy has been lapsed 90 days or less.
- The policy can be reinstated without evidence if all arrears are received within 90 days of the premium due date.
- To reinstate after 90 days (but within three years) of lapse, We require:
    - completion of an application;
    - evidence of acceptable risk; and
    - payment of all indebtedness plus interest since the date of lapse.

Disability Premium Waiver (DPW): CA

General

- This optional benefit waives premiums on the Critical Assist base plan and on DPW after the Person Insured has been totally disabled for six consecutive months.
- All premiums falling due on the policy while the Person Insured is totally disabled will be waived. This includes the premium for the base plan as well as the premiums for the PPE or PPS benefits (if applicable) and the premiums for DPW coverages. The rated portion of the premiums on any rated policies is also waived (if applicable).
- The Person Insured must become totally disabled while this provision is in-force.
- All premiums are payable until the DPW claim is approved. Any premium paid and later waived will be refunded.
- We will not waive any premium that fell due more than one year before the written notice of claim is received by Us.

Availability

- Available on CA.
- Available at issue only.
- The DPW benefit is available to persons who meet:
    - The health qualifications; and
    - are from Insurance Age 18 years to Insurance Age 55.
- The premium payment length of the DPW benefit must correspond to the premium payment length of the base coverage it is attached to.

Expiry/Coverage Period

- The DPW benefit terminates at the earlier of:
    - the benefit anniversary date nearest the Person Insured's 60th birthday;[4]
    - the lapse, surrender or termination of the policy to which this additional benefit is attached; or
    - upon receipt of a written request from the Policyowner to cancel this coverage.

Automatic Exclusions

- Premiums will not be waived if total disability results directly or indirectly from, or is associated with:
    - self-inflicted injuries while sane or insane;
    - civil disorder, war or act of war whether declared or not;
    - aircraft accident unless the Person Insured was traveling as a passenger having no duties on, or relating to, the aircraft for flight; or
    - service in the armed forces of any country, combination of countries, or international organization at war, whether war is declared or not.

[4] *Unless the Person Insured is on DPW claim.*

Notice and Proof of Claim

- A written notice of claim must be received by The Company prior to the expiry date of this provision. This must be done during the lifetime of the Person Insured and during continuance of total disability.
- The proof of total disability must be received by The Company within 60 days of the written notice of claim. Otherwise, the notice of claim will be re-dated to exactly 60 days before the proof of claim was received, regardless of original date of submission.
- No claim will be allowed if the notice and proof of claim have not been given within one year after the expiry date of this benefit.

Proof of Continuance of Total Disability

- Proof of continuance of total disability will be required at least annually during the duration of any total disability.

Automatic Waiver of Premium on Owner's Death and Disability (AWP): CA – Head Start

General

- This optional benefit provides that on the death of the owner of a CA – Head Start policy while this benefit is in-force, the premiums on the base policy and the AWP Benefit falling due after such death and prior to the policy anniversary nearest the child's 21st birthday will be waived.
- In addition to waiving premiums upon the death of the Policyowner of a CA – Head Start policy, the benefit will also waive premiums after the Policyowner has become totally disabled for six consecutive months.
- Disability coverage terminates at the earlier of the policy anniversary nearest the child's 21st birthday or the Policyowner's 60th birthday. The death coverage portion of this benefit continues to the policy anniversary nearest the child's 21st birthday, regardless of Policyowner age.
    - At age 21, children may purchase DPW coverage for themselves and underwriting would be required.
- The inclusion of the benefit is subject to satisfactory evidence of the insurability of the Policyowner.
- We may request medical evidence to determine eligibility.

Availability

- Available on CA – Head Start.
- Available at issue only.
- Available to persons who meet:
    - The health qualifications; and
    - are Insurance Age 18 to Insurance Age 55.
- The premium payment length of the AWP benefit must correspond to the premium payment length of the base coverage it is attached to.

Premiums

- Premiums are payable for the same term as the basic plan or until the policy anniversary nearest the child's 21st birthday, whichever is the shorter term.
- If the disability coverage of an AWP on Owner's Death and Disability benefit expires (when Policyowner turns Insurance Age 60) while the death coverage is still active, the premiums for this benefit will remain unchanged.

Expiry/Coverage Period

- The AWP benefit terminates at the earlier of:
    - the policy anniversary nearest the child's 21st birthday;
    - the lapse, surrender or termination of the policy to which this additional benefit is attached; or
    - upon receipt of a written request from the Policyowner to cancel this coverage.
- The disability coverage portion of the AWP on Owner's Death and Disability benefit will terminate at the policy anniversary nearest the Policyowner's 60th birthday if still active, unless the Policyowner is on AWP claim at that time.

Automatic Exclusions

- Premiums will not be waived if total disability results directly or indirectly from, or is associated with:
    - self-inflicted injuries while sane or insane;
    - civil disorder, war or act of war whether declared or not;
    - aircraft accident unless the Person Insured was traveling as a passenger having no duties on, or relating to, the aircraft for flight; or
    - service in the armed forces of any country, combination of countries, or international organization at war, whether war is declared or not.

Notice and Proof of Claim

- A written notice of claim must be received by The Company prior to the expiry date of this provision. This must be done during the lifetime of the Person Insured and during continuance of total disability.
- The proof of total disability must be received by The Company within 60 days of the written notice of claim. Otherwise, the notice of claim will be re-dated to exactly 60 days before the proof of claim was received, regardless of original date of submission.
- No claim will be allowed if the notice and proof of claim have not been given within one year after the expiry date of this benefit.

Proof of Continuance of Total Disability

- Proof of continuance of total disability may be required at least annually during the duration of any total disability.

Premium Payback at Expiry Disability Premium Waiver (PPE DPW): CA

General

- This optional benefit, available on the Premium Payback at Expiry (PPE) Benefit, waives PPE and PPE DPW premiums after the insured has become totally disabled for six consecutive months.

Availability

- Available on CA.
- Available on Level to 75 and Level 20-Pay with Coverage to Age 75 plans where the PPE Benefit has been selected.
- PPE DPW is available at issue only.
- Available to persons who are from Insurance Age 18 to Insurance Age 55.
- The premium payment length of the PPE DPW benefit must correspond to the premium payment length of the base coverage it is attached to.
- If the client selects DPW on the base plan and has selected the PPE optional benefit, PPE DPW must also be selected.

Expiry/Coverage Period

- The PPE DPW Benefit expires on the earlier of:
    - the benefit anniversary date nearest the insured's 60th birthday;
    - the lapse, surrender, or termination of the policy to which this additional benefit is attached; or
    - upon receipt of a written request from the Policyowner to cancel this benefit.

Benefit Payments

- This benefit waives the PPE and PPE DPW premiums in accordance with the same definitions as the Critical Assist DPW Benefit.

Premium Payback at Expiry Automatic Waiver of Premium on Owner's Death and Disability (PPE AWP): CA - Head Start

General

- Policyowners may purchase an optional benefit that waives premiums for the PPE and PPE AWP Benefits.
- PPE AWP providers that on the death of the owner of a CA – Head Start policy while this benefit is in-force, the premiums for the PPE and PPE AWP benefit falling due after such death and prior to the policy anniversary nearest the child's 21st birthday will be waived.
- In addition to waiving premiums upon the death of the Policyowner of a CA – Head Start policy, the benefit will also waive premiums after the Policyowner has become totally disabled for six consecutive months.
- Disability coverage terminates at the earlier of the policy anniversary nearest the child's 21st birthday or the Policyowner's 60th birthday. The death coverage portion of this benefit continues to the policy anniversary nearest the child's 21st birthday, regardless of Policyowner age.
    - At age 21, children may purchase PPE DPW coverage themselves. Underwriting would be required.
- The inclusion of this benefit is subject to satisfactory evidence of the insurability of the Policyowner.
- We may request medical evidence to determine eligibility.

Availability

- Available on CA - Head Start.
- Available on Level to 75 and Level 20-Pay with Coverage to Age 75 plans where the PPE Benefit has been selected.
- PPE AWP is available at issue only.
- Available to persons who are from Insurance Age 18 to Insurance Age 55.
- The premium payment length of the PPE AWP benefit must correspond to the premium payment length of the base coverage it is attached to.
- If the client selects AWP on the base plan and has selected the PPE optional benefit, PPE AWP must be selected.

Expiry/Coverage Period

- The PPE AWP benefit terminates at the earlier of:
    - The policy anniversary nearest the child's 21st birthday;
    - The lapse, surrender or termination of the policy to which this additional benefit is attached; or
    - Upon receipt of a written request from the Policyowner to cancel this coverage.
- The disability coverage portion of the PPE AWP on Owner's Death and Disability benefit will terminate at the policy anniversary nearest the Policyowner's 60th birthday. If still active, unless the Policyowner is on AWP claim at the time.

Benefit Payments

- This benefit waives the PPE and PPE AWP premiums in accordance with the same definitions as the CA – Head Start AWP Benefit.

Premium Payback at Surrender Disability Premium Waiver (PPS DPW): CA

General

- This optional benefit, available on the Premium Payback at Surrender rider, waives PPS and PPS DPW premiums after the insured has become totally disabled for six consecutive months.

Availability

- Available on CA.
- Available on Level to 75 and Level 20-Pay with Coverage to Age 75 plans where the PPS Benefit has been selected.
- PPS DPW is available at issue only.
- Available to persons who are from Insurance Age 18 to Insurance Age 55.
- The premium payment length of the PPS DPW benefit must correspond to the premium payment length of the base coverage it is attached to.
- If the client selects DPW on the base plan and has selected the PPS optional benefit, PPS DPW must be selected.

Expiry/Coverage Period

- The PPS DPW benefit expires on the earlier of:
  - the benefit anniversary date nearest the insured's 60th birthday;[5]
  - the lapse, surrender, or termination of the policy to which this additional benefit is attached; or
  - upon receipt of a written request from the Policyowner to cancel this benefit.

Benefit Payments

- This benefit waives the PPS and PPS DPW premiums in accordance with the same definitions as the Critical Assist DPW Benefit.

[5] *Unless the Policyowner is on DPW claim.*

Premium Payback at Surrender Automatic Waiver of Premium on Owner's Death and Disability (PPS AWP): CA - Head Start

General

- Policyowners may purchase an optional benefit that waives premiums for the PPS and the PPS AWP Benefits.
- PPS AWP provides that on the death of the owner of a CA – Head Start policy while this benefit is in-force, the premiums for PPS and PPS AWP falling due after such death and prior to the policy anniversary nearest the child's 21st birthday will be waived.
- In addition to waiving premiums upon the death of the Policyowner for a CA – Head Start policy, the benefit will also waive premiums for PPS and PPS AWP after the Policyowner has become totally disabled for six consecutive months.
- Disability coverage terminates at the earlier of the policy anniversary nearest the child's 21st birthday or the Policyowner's 60th birthday. The death coverage portion of this benefit continues to the policy anniversary nearest the child's 21st birthday, regardless of Policyowner age.
    - At age 21, children may purchase PPS DPW coverage for themselves. Underwriting would be required.
- The inclusion of this benefit is subject to satisfactory evidence of the insurability of the Policyowner.
- We may request medical evidence to determine eligibility.

Availability

- Available on CA - Head Start.
- Available on Level to 75 and Level 20-Pay with Coverage to Age 75 plans where the PPS Benefit has been selected.
- PPS AWP is available at issue only.
- Available to persons who are from Insurance Age 18 to Insurance Age 55.
- The premium payment length of the PPS AWP benefit must correspond to the premium payment length of the base coverage it is attached to.
- If the client selects AWP on the base plan and has selected the PPS optional benefit, PPS AWP must be selected.

Expiry/Coverage Period

- The PPS AWP benefit terminates at the earlier of:
    - the policy anniversary nearest the child's 21st birthday;
    - the lapse, surrender or termination of the policy to which this additional benefit is attached; or
    - upon receipt of a written request from the Policyowner to cancel this coverage.
- The disability coverage portion of the PPS AWP on Owner's Death and Disability benefit will terminate at the policy anniversary nearest the Policyowner's 60th birthday if still active, unless the Policyowner is on AWP claim at the time.

Benefit Payments

- This benefit waives the PPS and PPS AWP premiums in accordance with the same definitions as the Critical Assist – Head Start AWP benefit.

Benefits Payable Upon Illness

Once a claim is approved, the Full Payout Benefit or Early Assist Benefit is payable to the Policyowner after all the following conditions have been satisfied:

- The Person Insured is diagnosed with a Covered Condition in accordance with the Covered Conditions section or an Early Assist Condition in accordance with the Early Assist Covered Conditions section;
- the policy is in effect on the date of diagnosis of the Covered Condition or Early Assist Covered Condition;
- the Person Insured survives the survival period or such longer qualifying period as is described in the Covered Condition or Early Assist Condition;
- the Person Insured has not experienced irreversible cessation of all functions of the brain; and
- the Person Insured has satisfied the criteria for the Covered Condition or Early Assist Condition.

Benefit and Payment

- Subject to the terms of the policy, the amount payable after the diagnosis of the Person Insured with a Covered Condition will be the face amount of the policy in-force at that time (including any amounts payable under any additional benefits or riders), less any indebtedness.
- Payment of the full benefit terminates the policy.
- The benefit payment will be made to the Policyowner after We receive satisfactory proof of entitlement.
- Only one benefit will be paid on each Person Insured on a policy.

Early Assist Benefit and Payment

- Subject to the terms of the policy, the amount payable after the diagnosis of the Person Insured with an Early Assist Covered Condition will be the lesser of:
    - 10% of the face amount of the policy in-force at that time, or
    - $50,000.
- Payment of an Early Assist Benefit will not reduce the face amount of the CA/CA – Head Start benefit, not reduce the premium and not terminate the policy.
- The Early Assist Benefit payment will be made to the Policyowner after We receive satisfactory proof of entitlement.
- Only one Early Assist Benefit will be paid on each Person Insured on a policy.
- No Early Assist Benefit shall be paid if the Person Insured refuses or fails to attend any Medical Assessment required by Us to adjudicate the claim.

Automatic Exclusions

No full payout or Early Assist Benefit for any Critical Assist product shall be paid in any of the following circumstances:

- in the event the policy has lapsed, for any Covered Condition or Early Assist Condition for which the Person Insured has experienced any symptoms of, has undergone any tests or medical consultations for or which is diagnosed between the end of the days of grace and the date the policy is reinstated;
- when a Covered Condition or Early Assist Condition results directly or indirectly from:
    - an intentional, self-inflicted injury regardless of mental state;
    - committing, attempting or provoking an assault or criminal offence;
    - civil disorder, war or act of war, or service in the armed forces of any country, combination of countries, or international organization at war, whether war is declared or not;
    - the intentional taking of any poison, alcohol, drug, narcotic or sedative except as prescribed by a Medical Practitioner;
    - medical care which is not medically necessary or which is of a cosmetic nature. The donation of an organ or tissue will be considered as necessary medical care;
    - the Person Insured sustaining injuries resulting directly or indirectly from a vehicle[6.] accident if the Person Insured was driving the vehicle involved in the accident and had:
        - alcohol in their blood in excess of 80 milligrams of alcohol per 100 millilitres of blood; or
        - their judgment impaired by the use or intake of alcohol or any drug, intoxicant, narcotic or poisonous substance except as prescribed and administered by a Medical Practitioner.

[6] *"Vehicle" means a vehicle that is drawn, propelled, or driven by any means other than muscular power and without limiting the generality of the foregoing, specifically includes a boat and a snowmobile.*

Claims Requirements

A Person Insured must submit a claim for the Critical Assist benefit on the appropriate claim forms.

- The form is to be completed by the Person Insured and the Person Insured's Medical Practitioner(s) or Specialist(s).
- In the case of a CA – Head Start claim, the Policyowner will complete and sign the claim form on behalf of the insured child. At Insurance Age 18, ownership of a CA - Head Start policy may be transferred to the insured child, who would then complete the claim form in the event of a claim. If the policy is not transferred to the child, the Policyowner will always be responsible for signing and submitting a completed claim form.
- Any expenses incurred by the Person Insured or the Policyowner to prove the claim will be the responsibility of the Person Insured. We may request additional information prior to making a decision.

Proof of the Covered Condition must be received by Us within 120 days of the onset of the Covered Condition. Failure to furnish proof within this time shall invalidate any claim unless it is shown to have been impossible to furnish the proof within this time frame and that the proof was furnished as soon as was reasonably possible (and in any event within 12 months after diagnosis of the Covered Condition).

If the policyowner is unable to make a claim (e.g., is in a coma), if there is a duly appointed Enduring Power of Attorney specifically dealing with insurance policies and thereby authorizing the Power of Attorney to make such a request, then it can be made. Otherwise any party appointed guardian of the Person Insured by the courts can submit the claim.

Independent Assessments

The Critical Assist contract calls for the Person Insured to undergo independent assessments, as may be deemed necessary by Us, by a Specialist or Medical Practitioner of our choice in order to allow Us to adjudicate a claim. Any independent assessment required in connection with this provision will be at The Company's expense.

No Critical Assist benefit or Early Assist Benefit shall be paid if the Person Insured refuses or fails to attend any medical assessment required by Us to adjudicate the claim.

Expiry/Coverage Period

Coverage for all Critical Assist products will automatically terminate on the earliest of the following:

- 31 days after the due date of any premium which remains unpaid for this policy;
- the policy expiry date (policy anniversary nearest the 75th birthday of the Person Insured);[7]
- upon a written request from the Policyowner to cancel this policy;
- the date of death of the Person Insured;
- the date of payment of a full payout critical illness benefit under this coverage; or
- if within the first 90 days following the later of:
    - the effective date of the policy; or
    - the effective date of last reinstatement of the policy,

  the 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).

If the cause for termination is due to the diagnosis, or symptoms leading to the diagnosis, of Cancer within the first 90 days as outlined above, We will refund to the Owner the premiums that have been paid for the coverage from the policy date to the date the coverage is terminated.

[7] *Coverage for each CA – Head Start condition terminates in accordance with the contract definition for that condition.*

Issue and Underwriting Criteria

Some important aspects to keep in mind about the “living benefits” provided by Critical Assist products are:

- Underwriting and claims handling have different characteristics and the same Person Insured may have different results under a Critical Assist policy and a life insurance policy written at the same time, including ratings or declines.
- In general, family history has greater importance with Critical Assist than with life insurance.

For detailed information about Underwriting, refer to the Field Risk Selection Guide.

Non-Acceptable Risks

Do not submit an application if the client has or has had any of the following conditions/diagnoses/or situations:

- AIDS, a positive HIV test or AIDS related disease
- Alcohol or drug abuse within three years
    - Polydrug use or history of cross-addiction will not be considered until complete abstinent for a minimum of seven years.
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)
- Cancer[8].
- Cirrhosis of liver
- Criminal Charges, Incarceration, Probation
- Cystic Fibrosis
- Diabetes other than adult onset
- Down Syndrome
- Heart disease, including heart attack, angina, valvular surgery, coronary bypass surgery or angioplasty
- Huntington's Chorea
- Motor Neuron Disease
- Multiple Sclerosis
- Organ transplant
- Parkinson's disease
- Permanent Paralysis
- Polycystic Kidney Disease under age 35
- Premature Infants with birth weight under 4 lbs
- Respiratory disorders requiring supplementation oxygen
- Stroke or Transient Ischemic Attack (TIA)
- Systemic Lupus Erythematosus (SLE)
- Three or more family members with a history of one or more of the critical illness conditions covered, occurring before age 65
- Currently on disability
- Driver's license currently suspended or driving with an interlock device
- Has any symptoms or complaints for which he/she has not consulted a physician or received treatment

[8] *Applicants with certain cancers, including skin cancers other than melanoma or certain early stage cancers, may be eligible for coverage. Please consult your underwriter.*

- Active severe infection such as T.B., Kidney infection, etc. (generally will not consider until cured)
- Surgery recommended or contemplated (generally will not consider until the client released from hospital and back to work on a full-time basis – also see Cancer and heart surgery above)
- Major hospitalization - contact the Underwriting Department (in general, case should not be written until the client fully recovered and back to work on a full-time basis)
- Pregnancy - generally not considered if any problems in past pregnancies, or if any problems with the present pregnancy (problems could include toxemia, diabetes or elevated blood pressure)
    - Cannot consider until three months after delivery

Note: There are other impairments/situations where critical illness coverage will not be available. For questionable risks, please call an underwriter to discuss before taking an application. Please also refer to the Field Risk Selection Guide for more information on Non-Acceptable Risks.

Pre-Screening Questionnaire

The purpose of the Pre-screening Questionnaire is to gauge a client's eligibility for an insurance product prior to completing and uploading a formal application. By completing the questionnaire, an Advisor can determine the type of product the client might qualify for, which is a pro-active way of managing client expectations. Even if the client feels that they do not qualify for a particular product, the Pre-screening Questionnaire may show that the client could qualify for a different product. The online Pre-screening Questionnaire is located on LIFE Pages, E-App or in the illustration system.

Ratings

CA

- All Proposed Insureds are subject to health, occupation, avocational and professional sport, aviation and military ratings.
- Health ratings are subject to a maximum of 250% (+150%).

CA – Head Start

- No ratings apply.
- Only standard applicants will be issued coverage.

Exclusions

These plans are subject to exclusions, with no corresponding reduction in premium.

Insurable Interest

Since Premium Payback at Death (PPD) allows for a beneficiary, "insurable interest" needs to be established on the part of the beneficiary.

Replacements

At this time, there are no provincial regulations requiring disclosure forms when Critical Assist coverage is replacing life or critical illness coverage. As a matter of principle, We do not recommend replacements.

However, if proceeding, a prudent Advisor conscious of E&O concerns should discuss the number of illnesses covered in each critical illness plan and the fact that the definitions may be different, there are moratoriums which recommence with a new issue, etc.

Backdating/Age Conversion

Because of impacts on the survival/qualifying period, backdating, for any purpose, is not allowed.

Temporary Insurance Agreement

The Temporary Insurance Agreement (TIA) is not to be issued and no premium is to be accepted if:

- any Proposed Insured (or parent or grandparent on behalf of a minor in the case of a CA - Head Start application) answers yes to any of the questions on the Temporary Insurance application;
- the Advisor has reason to believe any Proposed Insured is not in good health; or
- the total amount of CA coverage applied for with Us on any Proposed Insured exceeds $1,000,000.

In this situation, no temporary insurance will be in effect. The premium will be requested when the policy has been approved. In the event a Temporary Insurance Agreement is issued in error, the payment received will be refunded and the TIA coverage cancelled.

The maximum amount of insurance on the Life Insured is limited to the lesser of the amount of insurance applied for under the application or $500,000.

In addition to the usual limitations, no benefits will be paid under the TIA if the person is diagnosed with Cancer or with any other Covered Condition as would be defined in the policy applied for and death occurs from the Covered Condition within 30 days of diagnosis.

Financial Underwriting

With appropriate documentation to justify the amount, most clients would be eligible for $100,000 of critical illness coverage.

Note: The following limits are subject to the overall maximum of $2,000,000 ($250,000 for CA – Head Start).

Income Replacement

Employed clients who become critically ill will need some form of income continuance to replace their lost wages during disability and recuperation. The maximum issue limits are as follows:

Age 18-55:	ten times earned income
Age 56-60:	five times earned income
Age 61 & up:	three times earned income

Non-Income Earning Clients

Spouse
Non-income earning spouses will be eligible for critical illness coverage based on family earned income and the critical illness coverage in place on the primary wage earner. The amount of critical illness coverage is limited to the lesser of the following:

- $250,000;
- three times the wage earner's income; or
- the amount of critical illness insurance in-force on the wage earner.[9.]

Students
Most students will be eligible for a total line of $100,000 of critical illness coverage. Clients who are studying or have recently graduated from professional programs such as dentistry, medicine, MBA, etc., may qualify for higher amounts.

Dividend/Pension Income

Since income is unearned and will continue in the event of sickness or disability, a critical illness may not have the same dire impact on lifestyle and cash flow as it would have for someone who is salaried or self-employed and may experience an interruption in earnings. Therefore, it is not appropriate to apply multiples of income to dividend or pension earnings to determine the appropriate amount of critical illness coverage to be offered.

The client's overall debt load in relationship to income should be taken into consideration. Where there is substantial unearned income, over and above daily cost of living expenses, there will be less need for critical illness coverage.

Documentation as to how the amount of critical illness applied for was arrived at must be provided with the application.

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[9] *If the primary wage earner does not have any critical illness coverage in place, We require a full explanation before considering any coverage on the non-income earning spouse.*

Mortgage

Clients who have critical illness income replacement coverage may also want to obtain enough critical illness insurance to reduce or pay off their mortgage in the event of severe illness. This is applicable where the repayment period is for five or more year's duration and the coverage is taken out on the primary wage earner.

Over insurance

A speculative hazard may exist in those cases where the amount of personal insurance, both applied for and in-force, are out of proportion to the client's income/net worth.

The maximum amount of individual critical illness coverage in-force with all companies cannot exceed $2,000,000 on a per life basis.

Other Possible Speculation Situations

- A sudden interest at age 60 in a large amount of coverage after a lifetime of disinterest.
- An elderly wealthy applicant who lists no attending physicians or medical history.
- An application for creditor coverage long after the loan was granted.
- Key person coverage requested on only one of several key persons.
- Multiple applications to different companies to avoid special medical studies.

Financial Underwriting Hints - General

Submit a cover memo with the application providing the following information:

- Explain the purpose of the insurance amount requested.
- Include the Person to be Insured's income and source of all income, along with a net worth and what it is comprised of.
- Explain how the insurance amount was arrived at or provide a copy of the Needs Analysis.
- Explain the purpose(s) of all in-force critical illness insurance coverages.
- A Personal Financial Questionnaire must be completed if the total of existing and pending critical illness coverage with all companies exceeds $500,000 on a per life basis and may be requested in other situations to determine net worth.
- Include any special information such as:
    - the importance of the client in the community, as a reference;
    - future inheritance; and
    - any additional information important to the case or significant to the financial status of the individual, but not captured elsewhere.
- The amount of in-force coverage plus that applied for must be justified. The majority of cases should be financially justified based upon the information referenced above. However, additional documentation[10.] may be necessary if:
    - the documentation requested above is not provided;
    - very large insurance amounts are requested or already in-force;
    - the total insurance amount cannot be justified; or
    - contradictory or negative financial information is developed.

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[10] *The additional documentation referred to could be one or more of: Buy/Sell Agreement; Income Tax Returns; Loan Agreements; Sales Projections; Financial Statements; and Personal Financial Questionnaire (see above).*

Financial Underwriting Hints Specific to Critical Assist – Head Start

- Parents should have life, critical illness or disability coverage in-force or pending.
- All minor children in the family should be applying for Critical Assist – Head Start of generally the same amount of insurance. Adult siblings where parents are choosing not to provide coverage can be excluded. If an adult sibling is being left out, it should be indicated in the cover memo.
- For coverage amounts greater than $150,000, parents should have at least the same amount of critical illness coverage as that being applied for on the child. For situations where the parent is uninsurable, this should be documented in the cover memo. If no critical illness coverage is in-force, parents should have significant life coverage and extensive group or health benefits. Parents must also demonstrate that they have a comfortable financial standing.
- Grandparents may apply for Critical Assist – Head Start coverage on their grandchildren. However, they must provide the reason they are applying on the child and they must apply for all their grandchildren that qualify.

Please refer to the Field Risk Selection Guide for more information on Risk Selection Criteria, Financial Underwriting Requirements, Insurance on Dependants and Consumer Reports.

Policy Changes

Increases in Coverage Amounts

No increases are allowed. The client may purchase an additional Critical Assist policy, subject to the then current minimums and maximums by means of completing an application for a new CA/CA - Head Start policy (refer to the Minimum and Maximum Benefit Amounts section of this Guide).

Decreases in Coverage Amounts

The Policyowner may decrease the coverage amount once per calendar year, subject to the then current minimums (refer to the Minimum and Maximum Benefit Amounts section of this Guide), without incurring a service fee. Any additional changes to coverage amounts shall be subject to a service fee as determined by Us at the time of the change.

If the policy has a PPE or PPS Benefit, the benefit will not automatically terminate, but the PPE or PPS benefit will be calculated as if the policy had been issued at its lowest coverage amount.

Change in Rate Class/Rating Review

Change from Smoker (Regular) to Non-Smoker

- A change to the Non-Smoker rate class will be effective as of the current date, but the original policy age and date will be retained.
- This will necessitate the following requirements:
    - Sections 1, 3, 4, 5, 6 and 7 of LSR005; and
    - A Urine Test for sum insureds over $100,000.
- The client must meet our current Non-Smoker definition (i.e., not used of any form of tobacco, nicotine product or nicotine substitute (including e-cigarettes or vaping) other than 12 or fewer cigars within 12 months prior to the date of the application).
- The Underwriting Department will review the evidence received and additional medical evidence may be required to assess the risk.
- In general, if the mortality risk has increased (i.e., client is now ratable), changing to Non-Smoker rates will not be to the client's advantage and is therefore not available.
- The change to a Non-Smoker rate will not result in any refund or credit for the higher Smoker rates paid up to the effective date of the change.
- Existing in-force or other pending critical illness coverage with Us and other companies may modify underwriting requirements.
- Disclosure forms are not required for this change.
- A child insured under CA – Head Start may apply for Non-Smoker rates at Insurance Age 18 (with underwriting) with the change effective at the current age and date. However, it may not be in the insured's best interests to accept the Non-Smoker rate since it may be higher than the existing regular rate that was given when the insured was at a younger age.

Rating Reviews

- There is a minimum one year waiting period.
- Sections 1, 3, 4, 5, 6 and 7 of the Application for Policy Change and/or Reinstatement of Life/Health Insurance Form (LSR005) must be completed.
- The Underwriting Department will review the evidence received and additional medical evidence may be required to assess the risk.
- Any change to the rating will be effective as of the current date, but the original policy age and date will be retained.
- Existing in-force or other pending critical illness coverage with Us and other companies may modify underwriting requirements.
- Disclosure forms are not required for this change to this product.

Reinstatements

- A Critical Assist policy can be reinstated within three years of lapse. The policy can be reinstated without evidence if all arrears are received within 90 days of the premium due date.
- To reinstate after 90 days (but within three years) of lapse, We require:
    - completion of an application;
    - evidence of acceptable risk; and
    - payment of all indebtedness plus interest since the date of lapse.
- We pay for the cost of evidence for the first reinstatement – the client pays the cost for subsequent reinstatements and will not be reimbursed.

Note: The 90-day period exclusion on Cancer starts again on the reinstatement date.

Assignments

Assignments are allowed on the base plans for CA and CA – Head Start.

Taxation

There is no official Canada Revenue Agency (CRA) ruling yet on the tax treatment of critical illness benefits. The current industry consensus is:

For adult plans:

- If the Critical Assist premium is paid by the Person Insured, the benefit is treated as non-taxable to the Person Insured as the recipient.
- If the Critical Assist premium is not paid by the Person Insured and it is:
    - paid by a corporation, the benefit is likely taxable to the Policyowner as the recipient.
    - paid by an individual, the benefit is possibly taxable to the Policyowner as the recipient.

For children's plans:

- If the Critical Assist premium is paid by the Policyowner and the Policyowner is the parent or grandparent of the insured child, the benefit is treated as non-taxable to the Policyowner as the recipient.
- If the ownership of the Critical Assist policy has been transferred to the insured child (only possible after the insured child reaches Insurance Age 18), the benefit is treated as non-taxable to the person insured.
- If the Critical Assist premium is not paid by the Policyowner and it is:
    - paid by a corporation (which cannot be a Policyowner), the benefit is likely taxable to the Policyowner as the recipient.
    - paid by an individual other than the Policyowner, the benefit is possibly taxable to the Policyowner as the recipient. Such a situation could occur if a relative wanted to pay the policy premiums for a child as a gift.

Advisor Licensing

An accident & sickness license is required to sell this product.

Assuris Coverage

Assuris considers critical illness insurance to be a “protection” benefit and this type of benefit is fully covered by Assuris up to $60,000. For amounts in excess of $60,000, Assuris covers 85% of the promised protection benefit (but not less than $60,000).

For information about policy benefits and rules concerning combining coverages, Advisors and clients should refer to Assuris publications or the Assuris website at www.assuris.ca.

Group Conversions

When employees of most of our Group Critical Illness plans terminate employment, their conversion privilege provides that they may convert to a regular premium individual Critical Assist plan without evidence of insurability, provided that the application is made within 31 days of termination of employment.

To convert Group Critical Illness, complete a Group Life Application through E-app with your client, within the grace period, and collect the initial modal premium. The regular premium amount will be based on the client's non-smoker/smoker status, as determined by the answer to the tobacco usage question within the E-app.

Individual plans available on a Group Critical Illness conversion are:

- Critical Assist 10 Year Renewable to Insurance Age 75;
- Critical Assist 25 Year with 20 Year Renewals to Insurance Age 75;
- Critical Assist Level to Insurance Age 75; and
- Critical Assist Level 20-Pay with Coverage to Insurance Age 75.

Special notes

- Conversion is subject to the issue age regulations of each individual plan;
- PPE and PPS can be added to the conversion without underwriting;
- DPW is not allowed on group conversion and
- Conversion is only allowed on the employee. The spouse's coverage cannot be converted

Amount Eligible for Conversion

Due to the termination of an employee's insurance, the sum insured will be limited to the lesser of:

- $25,000 (for groups up to 35 lives) or $50,000 (for groups with more than 35 lives); or
- The full amount of insurance at the time of termination when the right to convert is exercised, less the full amount of insurance for which the employee is eligible under a new Group Critical Illness contract.

Minimum Sum Insured Acceptable on a Group Conversion

If the sum insured available for conversion under the Group policy is less than the individual plan minimum, the lesser amount will be allowed. However, an extra $35 policy fee will apply. Minimum amount is $5,000.

Covered Conditions – Critical Assist

Critical Assist policies cover 29 specified conditions. Of these, 25 conditions qualify for one full payout of the insurance amount upon submission and approval of a claim. The remaining four conditions qualify for one Early Assist partial payout upon submission and approval of a claim.

Refer also to the Automatic Exclusions section of this guide under Issues and Underwriting.

The following definitions follow the “benchmark” definitions developed by the Canadian Insurance industry. The “benchmark” definitions are reviewed and updated by the CLHIA (Canadian Life and Health Insurance Association) periodically to maintain currency with medical advancements and other product developments.

Both the “plain language” and “contractual” definitions of the Covered Conditions are provided below. The “plain language” definitions are for reference only. All claims will be adjudicated on the basis of the contractual definitions.

The coverage period for all conditions except Loss of Independent Existence is from the Policy Date to Insurance Age 75. The coverage period for Loss of Independent Existence is from Insurance Age 18 to Insurance Age 75.

Aortic Surgery

Plain Language Definition
The Aorta is the large blood vessel leading from the heart that supplies branch arteries leading to various organs. If it becomes diseased, it weakens and can rupture. When this happens, it must be surgically replaced with a graft. The benefit is paid 30 days after the surgery occurs, as long as the policy is in effect when the surgery occurs and at the time of payment.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Date of Diagnosis
The date the Person Insured undergoes the surgery for the Covered Condition.

Survival Period
30 days

Aplastic Anemia

Plain Language Definition
This condition occurs when there is a chronic and persistent bone marrow failure.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Bacterial Meningitis

Plain Language Definition
Bacterial Meningitis is a serious infection of the fluid in the spinal cord or surrounding the brain.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered Condition for viral meningitis.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
90 days

Benign Brain Tumour

Plain Language Definition
A Benign Brain Tumour is a non-cancerous growth in the brain or its protective membranes (meninges). The person must develop the Benign Brain Tumour after the policy is in effect.

No benefit is payable for this condition if a Benign Brain Tumour is diagnosed, or if there are any symptoms that lead to the diagnosis of a Benign Brain Tumour within 90 days of the policy being issued or reinstated. This condition would be excluded from the contract and the policy would remain in effect.

Contractual Wording
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 Critical Assist Benefit will be payable under this Covered Condition for pituitary adenomas less than 10 mm.

No Critical Assist benefit will be payable under this Covered Condition if:
Within the first 90 days following the later of:

- the effective date of the Policy, or
- the effective date of last Reinstatement of the Policy,

the 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 Us within six months of the Date of Diagnosis. If this information is not provided within this period, the Person Insured's coverage will terminate and We will refund to the Owner the premiums that have been paid for the coverage from the Policy Date to the date the coverage is terminated.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Blindness

Plain Language Definition
Blindness is the total and irreversible loss of vision in both eyes. The loss of vision must occur after the policy is in-force.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Cancer (Life-threatening)

Plain Language Definition
Cancer is a type of abnormal or malignant (cancerous) cell growth that spreads throughout the body destroying healthy tissue. Some cancers are not considered life-threatening and are not covered under this benefit. However, if a cancer spreads to surrounding tissue or organs, or progresses, the critical illness benefit will be paid if the condition is not excluded.

No benefit is payable under the policy if cancer is diagnosed, or if there are any symptoms that lead to the diagnosis of Cancer within 90 days of the policy being issued or reinstated. The policy will be terminated and premiums will be refunded.

Contractual 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 and sarcoma. The Diagnosis of Cancer must be made by a Specialist.

Exclusion
No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0mm 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 2.0cm 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 this 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 this 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.

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

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

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 Us within six months of the Date of Diagnosis. If this information is not provided within this period, the Person Insured's coverage will terminate and We will refund to the Owner the premiums that have been paid for the coverage from the Policy Date to the date the coverage is terminated.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by Independent Assessment.

Survival Period
30 days

Coma

Plain Language Definition
A Coma is an unconscious state from which a person cannot be roused or awakened, even with intense external stimulation. For benefits to be paid, the coma state must occur after the policy is in-force; it must continue for a continuous period of four days; the person must require life support systems; and the coma must not be drug or alcohol induced.

Contractual Wording
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 four or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion
No Critical Assist benefit will be payable under this Covered Condition for:

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

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coronary Artery Bypass Surgery

Plain Language Definition
Coronary Artery Bypass surgery is open-heart surgery to correct the narrowing or blockage of one or more coronary arteries. Only Coronary Artery Bypass surgery is covered. No other procedures to improve blood flow to the heart are covered.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Date of Diagnosis
The date the Person Insured undergoes the surgery for the Covered Condition.

Survival Period
30 days

Deafness

Plain Language Definition
Deafness is the total and irreversible loss of hearing in each ear. The loss of hearing must occur after the policy is in-force.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Dementia, including Alzheimer's Disease

Plain Language Definition
Dementia is a progressive, degenerative and irreversible disease of the brain that will eventually erode a person's memory and some areas of cognitive function that affect their daily life, including speech ability, ability to perform familiar tasks or recognizing objects and ability to think and control complex behaviours. Dementia as a result of affective or schizophrenic disorders, or delirium is not covered under the policy.

Contractual Wording
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 six months period.

The Diagnosis of Dementia must be made by a Specialist.

Exclusion
No Critical Assist benefit will be payable under this Covered 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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Heart Attack

Plain Language Definition
When a heart attack occurs, part of the heart muscle dies because there is a shortage of blood to the heart. A heart attack is an acute event that can be detected by an ECG (Electrocardiogram) and other diagnostic tests.

It is possible to have had a silent heart attack and not know about it. The chance finding of a silent heart attack through an ECG is not covered under a critical illness policy. The benefit will be paid when the insured is diagnosed as having suffered a Heart Attack (not a silent heart attack), as long as the insured survives the heart attack by 30 days.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered 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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Heart Valve Replacement or Repair

Plain Language Definition
When a heart valve is damaged beyond repair, it must be surgically replaced by a new valve, either natural or man-made. This condition also covers the surgical repair of defects or abnormalities of the heart valve.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Date of Diagnosis
The date the Person Insured undergoes the surgery for the Covered Condition.

Survival Period
30 days

Kidney Failure

Plain Language Definition
This diagnosis requires a permanent loss of function of both kidneys. The insured must have regular dialysis treatment or a kidney transplant and the kidney failure diagnosis or kidney transplant must occur while the policy is in effect.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Loss of Independent Existence

Contractual Wording
Loss of Independent Existence is defined as a definite Diagnosis of the total inability to perform, by oneself, at least two of the following six 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.

Date of Eligibility
Eligibility under the policy means the complete fulfillment of the condition as described above. The Date of Eligibility and all requirements, must occur while the policy is in-force and the Coverage Period is in effect.

Survival Period
30 days

Loss of Limbs

Plain Language Definition
Two or more limbs are cut off above the wrist or ankle joint, as a result of an accident, injury or illness, after the policy is in-force.

Contractual Wording
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.

Date of Diagnosis
The date the limbs are severed.

Survival Period
30 days

Loss of Speech

Plain Language Definition
Total, permanent and irreversible loss of speech, due to a physical injury or disease that occurs after the policy is in-force and that has lasted for at least 180 days. A loss of speech from a psychiatric cause is not covered.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered Condition for all psychiatric related causes.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Major Organ Failure on Waiting List

Plain Language Definition
In certain conditions, any of the heart, lungs, liver, kidneys or bone marrow can become injured or diseased sufficiently, such that the person needs an organ transplant. This benefit will be paid 30 days after the insured is enrolled in a recognized transplant program, as long as the policy is in effect at those times.

Contractual Wording
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 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 Person Insured's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Date of Diagnosis
The date the Person Insured is enrolled in the transplant centre.

Survival Period
30 days

Major Organ Transplant

Plain Language Definition
In certain conditions, any of the heart, lungs, liver, kidneys or bone marrow can become injured or diseased sufficiently, such that the person needs an organ transplant.

This benefit will be paid 30 days after the insured undergoes transplant surgery as a recipient, as long as the policy is in effect at those times.

Contractual Wording
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.

Date of Diagnosis
The date the Person Insured undergoes the surgery for the Covered Condition.

Survival Period
30 days

Motor Neuron Disease

Plain Language Definition
Motor Neuron Disease is a progressive disorder that affects the central nervous system and causes muscles to weaken and deteriorate. The most common form is ALS or Amyotrophic Lateral Sclerosis, better known as Lou Gehrig's Disease.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Multiple Sclerosis

Plain Language Definition
Multiple Sclerosis (MS) is a progressive brain and spinal cord disease with multiple and varied neurological symptoms and signs. For this reason, MS can be difficult to diagnose and usually takes a number of tests before it is confirmed. Symptoms and diagnosis must occur after the policy comes into effect.

Contractual Wording
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;
- well-defined neurological abnormalities lasting more than six 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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Occupational HIV Infection

Plain Language Definition
The HIV (AIDS virus) infection must be caused by an accidental exposure to HIV- contaminated blood or bodily fluids, in the course of performing a job or occupation. To give reasonable assurances that the HIV infection was caused by an accidental exposure at work, certain reporting requirements and medical lab testing requirements must be met.

Non-accidental injury (including, but not limited to, sexual transmission or intravenous drug use) is specifically excluded.

Contractual Wording
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 Policy, 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;
- An 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 Critical Assist benefit will be payable under this Covered Condition if:

- The Person Insured has elected not to take any available licensed vaccine offering protection against HIV;
- 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 or intravenous (IV) drug use.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Paralysis

Plain Language Definition
Paralysis is the complete and permanent loss of voluntary movement in at least two limbs, whether caused by an accident, illness or disease, which must occur after the policy is in-force. All psychiatric-related causes are specifically excluded.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Plain Language Definition
Parkinson's Disease is a progressive, degenerative disease of the central nervous system that is characterized by rigid muscles, a tremor and slow movements. Atypical Parkinsonian Disorders refers to conditions that have similar symptoms to Parkinson's Disease, but are caused by different parts of the brain than classic Parkinson's Disease. Three specific atypical Parkinsonian disorders are covered.

No benefit is payable for this condition if Parkinson's Disease and Specified Atypical Parkinsonian Disorders is diagnosed, or if there are any symptoms that lead to the diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders within the first year of the policy being issued or reinstated. This condition would be excluded from the contract and the policy would remain in effect.

Contractual Wording
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 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.

Exclusion
No Critical Assist benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

No Critical Assist benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if:

- Within the first year following the later of:
  - the effective date of the Policy, or
  - the effective date of the last Reinstatement of the Policy

  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 Us within six months of the Date of Diagnosis. If this information is not provided within this period, the Person Insured's coverage will terminate and We will refund to the Owner the premiums that have been paid for the coverage from the Policy Date to the date the coverage is terminated.

Date of Diagnosis
The date this Covered Condition is first identified by a Neurologist, subject to verification by an Independent Assessment.

Survival Period
30 days

Severe Burns

Plain Language Definition
Only third-degree burns are covered under the policy. They are the most serious type of burn, involving all layers of the skin. Coverage is provided if the individual has third-degree burns covering at least 20% of the body and the burns occur after the policy is in-force.

Contractual Wording
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.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Stroke (Cerebrovascular Accident)

Plain Language Definition
A stroke occurs when there is permanent damage to an area of the brain due to any of the following events:

- There is bleeding into the brain (a haemorrhage);
- An artery supplying the brain becomes blocked by a blood clot (a thrombosis); or
- A blood clot from another part of the body is carried to the brain and blocks an artery in the brain (an embolus). Transient Ischemic Attacks (TIAs) are not covered.

Contractual Wording
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 Critical Assist benefit will be payable under this Covered Condition for:

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

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Covered Conditions – Critical Assist – Head Start

CA – Head Start policies cover 36 specified conditions. Of these, 32 conditions qualify for one full payout of the insurance amount upon submission and approval of a claim. The remaining four conditions qualify for one Early Assist partial payout upon submission and approval of a claim.

Refer also to the Automatic Exclusions section of this Guide.

The childhood definitions that follow are not “benchmark” definitions, since the insurance industry has not determined standards to date. The adult definitions follow the “benchmark” definitions developed by the Canadian Life Insurance industry and can be found above.

For any Covered Condition, coverage starts and continues for the coverage period listed for that condition.

Note that CA – Head Start covers the 25 conditions listed and defined above as well as the following seven childhood conditions.

Autism

Contractual Wording
Autism is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the Diagnosis confirmed by a Specialist at least one day prior to the third birthday of the insured.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coverage Period
From the Policy Date to one day prior to the third birthday of the Insured.

Cerebral Palsy

Contractual Wording
Cerebral Palsy is defined as a definitive Diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coverage Period
From the Policy Date to Insurance Age 18.

Congenital Heart Disease

Contractual Wording
Congenital Heart Disease is defined as a Diagnosis of one or more of the following heart conditions made by a qualified Cardiologist and supported by appropriate cardiac imaging:

- Total Anomalous Pulmonary Venous Connection
- Transposition of The Great Vessels
- Atresia of any heart valve
- Coarctation of The Aorta
- Single Ventricle
- Hypoplastic Left Heart Syndrome
- Double Outlet Left Ventricle
- Truncus Arteriosus
- Tetralogy of Fallot
- Eisenmenger Syndrome
- Double Inlet Ventricle
- Hypoplastic Right Ventricle
- Ebstein's Anomaly

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

The following conditions are covered only when open heart surgery is performed for correction of the condition and following a 30-day survival period from diagnosis:

- Pulmonary Stenosis
- Aortic Stenosis
- Discrete Subvalvular Aortic Stenosis
- Ventricular Septal Defect
- Atrial Septal Defect

The Diagnosis must be made by a qualified Pediatric Cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified Pediatric Cardiologist and performed by a Cardiac Surgeon in Canada or the U.S.A.

Exclusion
Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded. All other congenital cardiac conditions are excluded.

Date of Diagnosis
The date the Person Insured undergoes the surgery for the Covered Condition.

Survival Period
30 days

Coverage Period
From the Policy Date to Insurance Age 18.

Cystic Fibrosis

Contractual Wording
Cystic Fibrosis is defined as a definitive Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coverage Period
From the Policy Date to Insurance Age 18.

Type 1 Diabetes Mellitus

Contractual Wording
Type 1 Diabetes Mellitus is defined as a Diagnosis of Type 1 Diabetes Mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a qualified Pediatrician or Endocrinologist licensed and practising in Canada or the U.S.A. and there must be evidence of dependence on insulin for a minimum of three months.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coverage Period
From the Policy Date to Insurance Age 18.

Muscular Dystrophy

Contractual Wording
Muscular Dystrophy is defined as a definitive Diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coverage Period
From the Policy Date to Insurance Age 18.

Rett Syndrome

Contractual Wording
Rett Syndrome is defined as a genetic disorder of the central nervous system that is characterized by a retardation of the cephalic growth after the age of six months, the loss of use of the hands and a communication disorder associated with severe psychomotor retardation. The Diagnosis must be confirmed by a Specialist at least one day prior to the third birthday of the Insured.

Date of Diagnosis
The date this Covered Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Coverage Period
From the Policy Date to one day prior to the third birthday of the Insured.

Early Assist Covered Conditions

Both the “plain language” and “contractual” definitions of the Early Assist Covered Conditions are provided below. The “plain language” definitions are for reference only. All claims will be adjudicated on the basis of the contractual definitions.

Only one Early Assist Benefit can be paid to each Person Insured under this Policy.

No Early Assist Benefit shall be paid if the Person Insured refuses or fails to attend any Medical Assessment required by Us to adjudicate the claim.

Coronary Angioplasty

Plain Language Definition
Coronary Angioplasty is a procedure to unblock or widen a coronary artery that supplies blood to the heart to allow uninterrupted blood flow.

Upon an approved claim, partial payout of the insurance amount will be made to the Person Insured.

Contractual Wording
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.

Date of Diagnosis
The date the Person Insured undergoes surgery.

Survival Period
30 days

Non-Life-threatening Cancers (3)

Plain Language Definition
Ductal carcinoma in Situ of the breast (DCIS); Stage A Prostate Cancer and Stage 1A Malignant Melanoma – these cancers are a type of abnormal or malignant (cancerous) cell growth that spreads throughout the body destroying healthy tissue.

Contractual Wording

- Ductal carcinoma in situ of the breast (DCIS) requires confirmation by biopsy.
- Stage T1a or T1b (stage A) prostate cancer.
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness).

Exclusion
No Early Assist Benefit will be payable under these Early Assist Conditions if:

- Within the first 90 days following the later of:
  - the effective date of the Policy, or
  - the effective date of last Reinstatement of the Policy,

  the 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,
  - 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 Us within six months of the Date of Diagnosis. If this information is not provided within this period, the Person Insured's coverage will terminate and We will refund to the Owner the premiums that have been paid for the coverage from the Policy Date to the date the coverage is terminated.

Date of Diagnosis
The date this Early Assist Condition is first identified by a Specialist, subject to verification by an Independent Assessment.

Survival Period
30 days

Definitions

Definition of Totally Disabled

“Totally Disabled” means that disability is caused by accident or sickness while this provision is in-force, lasts continuously for six or more consecutive months and prevents the Person Insured from working for wages or profit in any occupation.

Definition of Specialist

“Specialist” means a medical practitioner who is trained in the specific area of medicine relevant to the Covered Condition or Early Assist Condition for which the Critical Assist Benefit or Early Assist Benefit is being claimed and who is duly licensed, certified or registered to practice that profession in the Province or Territory in Canada or State in the United States of America (or any other jurisdiction We may approve) in which the person is practicing. Specialist includes, but is not limited to, Cardiologist, Neurologist, Nephrologists, Oncologist, Ophthalmologist, Burn Specialist and Internist.

In the absence or unavailability of a Specialist and as approved by Us, a Covered Condition or Early Assist Condition may be Diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

Licensed, certified or registered means licensed, certified or registered to practice the profession by the appropriate authority of the Province or Territory in Canada or State in the United States of America (or any other jurisdiction We may approve) in which care or services are rendered, or where no such authority exists, having a certificate of competency from the professional body which establishes standards of competency and conduct for such profession.

The Specialist cannot be the Owner, the Person Insured, a relative of or business associate of the Owner or of the Person Insured.

Best Doctors®

The reason We developed our critical illness insurance product was to help our clients deal with the consequences of a serious illness. We do this firstly by assisting them financially through a claim benefit – in a lump sum format. One other important client need in a "living benefit" situation is information about care options and ways to access it.

We have provided access to an innovative, world-leading service called Best Doctors® to clients with a Critical Assist or Critical Assist – Head Start plan.

Key Points

Key points to keep in mind regarding this plan are that Best Doctors:

- Provides information and assists with access – the client is required to pay any expenses involved in receiving medical care.
- Is available to the spouse and dependent children of the Policyholder.
- Is a confidential, multi-lingual service independent of our claims process. Best Doctors can internally support multiple languages and provide translation services for any others.
- Is not a medical help line for all medical concerns.
- Services are available to those insured under a CA or CA – Head Start policy.
- Services are available regardless of claim and can be utilized for any condition, covered or not.
- Services are no**t** included contractually, but rather on a "best efforts" basis. We are not involved with or responsible for any Best Doctors services. The service can be cancelled at any time without notice.

While the cost of the Best Doctors service is covered by Us, all costs of obtaining health care are the responsibility of the client.

Conditions Covered by Best Doctors Services

Any and all medical conditions qualify for access to these services. No claim is necessary.

Overview

Best Doctors is a world leader in connecting people with the best medical care. Using its renowned database of over 50,000 doctors recognized as the best by top specialists in over 450 specialties and subspecialties, Best Doctors provides rapid access to the best medical knowledge and peace of mind to thousands of people around the world faced with a serious illness. Best Doctors services are available worldwide, serving more than 40 million lives.

Key Services

- Ensure the right diagnosis and treatment with InterConsultation®
- Find an expert in your condition with FindBestDoc®
- Find an international specialist right for you with FindBestCare®
- Navigate the health care system with Best Doctors 360°®

Key Advantages for Clients

Best Doctors provides the following services, at no cost to clients:

- Answers to medical questions without having to leave home.
- Peace of mind that their diagnoses are accurate and they are receiving the correct treatment.
- Recommendations from world-leading doctors.
- Ongoing support to help clients make informed health care decisions.
- Immediate access to a unique database of 50,000 doctors who have been deemed as the best in their specialties by their peers (note that clients retain the right to choose their doctor).
- Navigation of the often confusing, restrictive health care system.
- Wellness support and recommendations.

Accurately diagnosing and applying the most appropriate treatment regimen can significantly improve the overall care, recovery time and outcomes for patients. Best Doctors checks in with the member even after the case is completed.

Key Sales Advantages for Advisors

Branding Opportunities:
A proven brand that will help differentiate Us from other competing insurance products, Best Doctors is a recognized global brand, providing your clients with confidence and security.

Fulfillment:
While the critical illness and disability income products you are providing will meet the financial needs your clients, Best Doctors will meet the medical needs. By offering Best Doctors services, We will be going beyond providing just a claim cheque.

Top Line Sales:
Best Doctors will provide an innovative service that adds value to our critical illness and disability insurance products, giving you a new way to promote health insurance and further strengthen your multi-line client relationships.

Retention:
Integrating Best Doctors as part of health policies can help increase retention, as the suite of services of Best Doctors are unavailable outside an insurance plan.

Best Doctors Program in Detail

Best Doctors developed a suite of services aligned with consumer driven objectives that:

- Ensure the member has the correct diagnosis and treatment plan.
- Find expert physicians in members' conditions.
- Support the member throughout the entire process.
- Best Doctors has developed its solutions through four key services:

InterConsultation® – Ensure the Right Diagnosis and Treatment
Members get an expert opinion on medical conditions through analysis of their medical records and history.

InterConsultation is more than just a second opinion; it is a confidential, patented process that complements the care members receive from their own physicians by providing a second expert review, bringing greater certainty to their diagnoses and treatment plans. Best Doctors medical specialists perform an in-depth analysis of members' medical data, including diagnostic imaging, test results and pathology samples. Best Doctors then provides a report with a detailed summary of the expert's recommendations, which the client and their treating physician may wish to consider. The process is completely confidential and provided at no additional cost to the member, but the client must meet their own costs of any private medical treatment.

The patient and the doctor have access to information on the latest tests and technologies, as well as the opinions of world-class doctors. With a detailed turnaround of results, this second opinion can reduce potentially serious complications from a misdiagnosis and help the patient's local treating physician determine the proper course of action.

FindBestDoc® – Find an Expert in Your Condition
Members have access to leading specialists and general practitioners in Canada best suited to their medical needs and locations.

This is a service that puts knowledge in the hands of the client. Members will have access to a Member Advocate (Registered Nurse) who supports the member. From a database of 50,000 specialists, Best Doctors will recommend up to three doctors whose skill and experience are most suited to treat the condition, taking into account the member's unique medical history, geographic location and preferences. Every recommendation is based solely on quality and expertise. Once again, remember that the client must cover the cost of any private medical treatment.

Best Doctors' database is developed using a comprehensive, peer-review methodology. Best Doctors does not accept financial compensation, nor does it compensate physicians for inclusion in the network to maintain the quality and integrity of the database.

FindBestCare® – Find an International Specialist Right for You
Members get access to the best specialists in any condition, selected from Best Doctors' global database of over 50,000 physicians.

If a member is leaving the country and needs a specialist outside of Canada, Best Doctors can identify one through their FindBestCare service.[11] They will coordinate a search of their global database of over 50,000 physicians in more than 450 specialties and subspecialties to find the expert(s) best suited to the member's needs.

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[11] *Best Doctors does not make referrals or appointments for members or arrange or cover the cost of travel or lodging.*

Best Doctors 360º® – Navigate the Health Care System
Members get customized information and resources based on their medical conditions and locations.

Best Doctors 360° helps members take control of their health by arming them with the right information, so they can make well-informed decisions on a wide variety of health topics. Best Doctors provide tools and resources for members who are facing medical uncertainty, whether their condition is simple or complex. These resources include condition-specific website links and articles, physician biographies and contact information for specialists and facilities who can assist with a variety of medical needs.

Best Doctors also offers advice and wellness support, such as; assistance finding support groups for depression, research and help in finding care and residency for elderly parents, finding groups or associations for diabetes and assistance in formulating questions members need to ask their physicians.

How the InterConsultation Process Works

The Policyowner receives a Best Doctors certificate when the policy is issued and the Life Insured has access to Best Doctors for any medical condition. At that point:

1. The Life Insured calls the toll-free number indicated on the certificate.

2. Best Doctors will verify eligibility with Us.

3. A Member Advocate is assigned to the Life Insured's case and contacts him/her to conduct a full intake and gather a complete medical history.

4. The Member Advocate will designate a team to collect all relevant medical records, imaging studies and pathology samples after the signing of a medical records release. Pathology samples may be retested at one of their centres of excellence. These costs are covered by Best Doctors.

5. Best Doctors will create a comprehensive case summary with the information provided and select and world leading expert in the member's condition.

6. The expert will perform an in-depth analysis and provide their recommendation(s) in a detailed, confidential report.

7. They stay in regular contact with the member, so they feel supported throughout the process. They then share the report with them and, with permission, treating physicians.

Frequently Asked Questions

Is Best Doctors offered by other insurance companies?
Yes. Best Doctors is offered by a number of insurance companies of all sizes.

Are We encouraging Canadians to bypass the public health care system for treatment in the U.S.A.?
Absolutely not—more than 90% of Best Doctors cases are treated locally and resolved through the patients' treating physicians.

Does Best Doctors arrange for clients to see a doctor faster than those waiting to see the same doctor on their own?
No. Our clients will not have better access to Canadian doctors, but will have better access to information to tell them which doctors in Canada and around the world have the highest level of skill and expertise – as rated by their peers – for treating their condition. In other words, clients will not jump the queue, but can be assured that they are in the right queue for their particular illness.

Does a client need to return the benefit to Us if a second opinion reveals an inaccurate diagnosis?
We will not ask for the benefit to be repaid regardless of the outcome of Best Doctors findings once the claim is approved and paid. We are no longer directly involved in the case after that point. All subsequent communication involving medical diagnosis and treatment remains confidential between the client and Best Doctors.

Can client family members use Best Doctors services?
The services are available to the Lives Insured as well as their spouse and dependent children.

Can one purchase Best Doctors services without MDI or CA/CA – Head Start insurance?
No. Best Doctors isn't offered as a stand-alone service.

Do the Best Doctors services terminate due to payout of a Covered Condition on my policy?
No. Best Doctors services remain available for up to three months following a benefit payment on your policy.

About Best Doctors

Best Doctors identifies and solves the most complex, critical and costly problems in health care by combining data analytics and top clinical talent with our highly personal methodology across a global network. Best Doctors helps members take control of their health. Through their various services, Best Doctors complements the care members receive from their own physicians, providing expert medical advice so they can make the best possible medical decisions.

Created in 1989, Best Doctors vision was shaped by its founders, professors of medicine at Harvard Medical School, who spent many years caring for patients committed to surviving life-threatening illnesses. Together, they realized that patients with difficult illnesses often lacked guidance and support to successfully access the best medical care without restrictions. Globally, Best Doctors serves over 40 million lives through large insurers, employers, affinity groups, governments and financial groups.

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