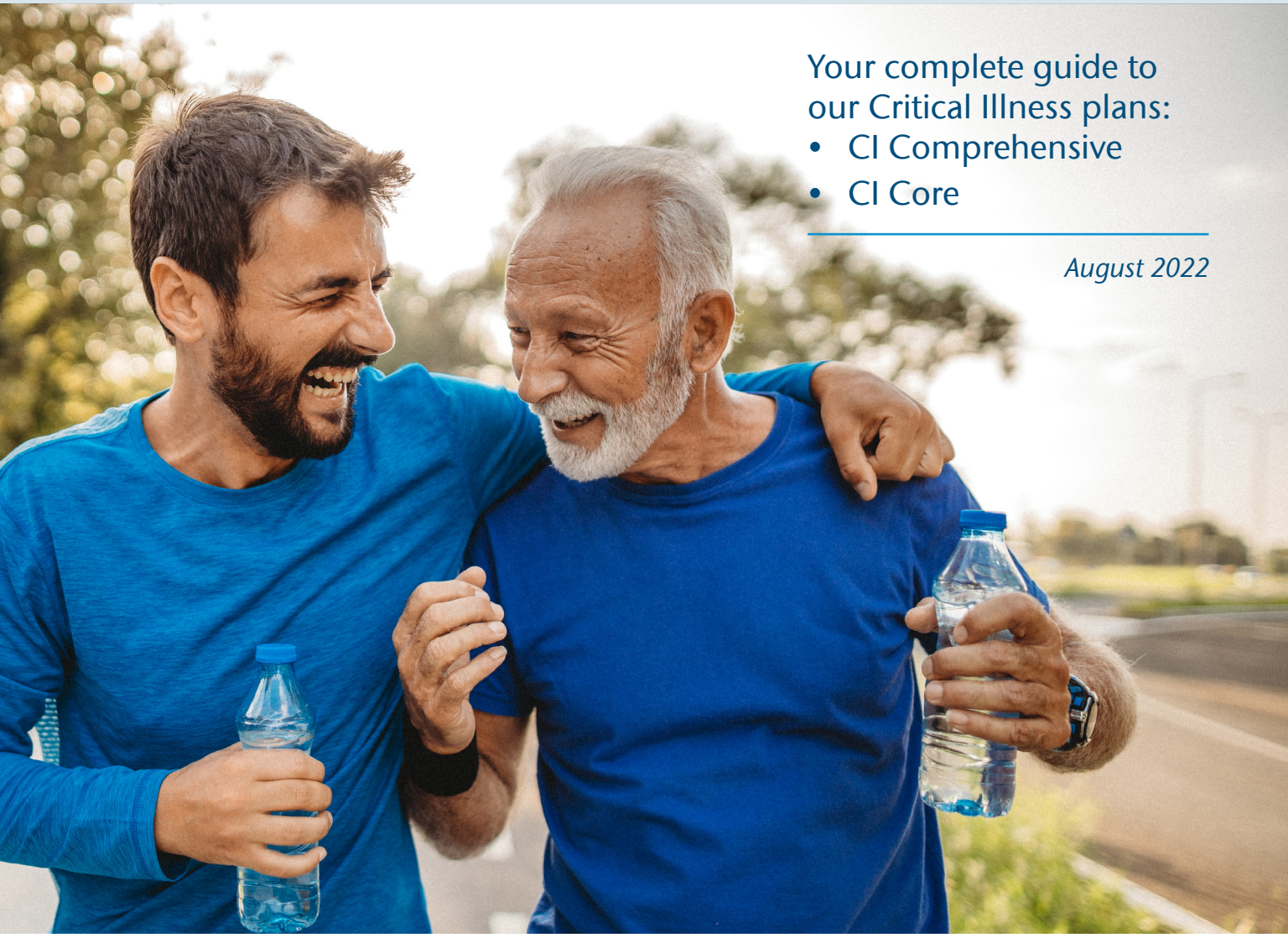
Comprehensive & Core

CRITICAL ILLNESS



Your complete guide to our Critical Illness plans:

- CI Comprehensive
- CI Core

August 2022

Wawanesa Life®

CRITICAL ILLNESS At a Glance

	Critical Illness Comprehensive	Critical Illness Core
Underwriting	Fully Underwritten	8 Qualifying Questions
Plan Types	Critical Illness Term 10 Critical Illness Term to Age 75 Critical Illness Term to Age 75 with Return of Premium on Expiry (ROPX)	
Issue Age (Age Last)	18-60	
Maturity Date	Anniversary following age 75	
Policy Fee	None	
Company Minimum Annual Premium	$ 50	
Face Amount	$ 10,000 - $ 1,000,000	$ 10,000 - $ 100,000
Premium Payment Method	Monthly: Pre-Authorized Debit (PAD) / Electronic Funds Transfer (EFT) Semi-Annual: Cheque Annual: Cheque, PAD/EFT, Credit Card (Visa, Mastercard)	
Premium Bands	$10,000 - $ 99,999 $100,000 - $ 249,999 $250,000 - $ 499,999 $500,000 - $ 999,999 $1,000,000	$10,000 - $ 99,999 $100,000
Riders	Child Critical Illness Rider Disability Waiver of Premium Benefit	Child Critical Illness Rider
Exchangeable	Yes, Term 10 may be exchanged to Term to age 75 or Term to age 75 with Return of Premium on Expiry prior to the policy anniversary immediately following the insured person's 60th birthday.	
Return of Premium on Death Benefit	Included	

	Critical Illness Comprehensive	Critical Illness Core
Covered Conditions	**26 Covered Conditions:** 1. Acquired Brain Injury 2. Aortic Surgery 3. Aplastic Anemia 4. Bacterial Meningitis 5. Benign Brain Tumour 6. Blindness 7. Cancer 8. Coma 9. Coronary Artery Bypass Surgery 10. Deafness 11. Dementia, including Alzheimer's Disease 12. Heart Attack 13. Heart Valve Replacement or Repair 14. Kidney Failure 15. Loss of Independent Existence 16. Loss of Limbs 17. Loss of Speech 18. Major Organ Failure on Waiting List 19. Major Organ Transplant 20. Motor Neuron Disease 21. Multiple Sclerosis 22. Occupational HIV Infection 23. Paralysis 24. Parkinson's Disease and Specified Atypical Parkinsonian Disorders 25. Severe Burns 26. Stroke	**4 Covered Conditions:** 1. Cancer 2. Coronary Artery Bypass Surgery 3. Heart Attack 4. Stroke
Early Diagnosed Benefit: Covered Conditions	1. Coronary Angioplasty 2. Chronic lymphocytic leukemia (CLL) Rai stage 0 3. Ductal carcinoma in situ of the breast 4. Gastrointestinal stromal tumours classified as AJCC Stage 1 5. Grade 1 neuroendocrine tumours (carcinoid) 6. Papillary thyroid cancer or follicular thyroid cancer stage T1 7. Stage T1a or T1b prostate cancer 8. Early stage malignant melanoma	N/A

WAWANESA LIFE'S CRITICAL ILLNESS PLANS

Wawanesa Life offers two Critical Illness products, each with the following three plan types:

Critical Illness **Comprehensive**

Plan types available:
• Critical Illness Term 10
• Critical Illness Term 75
• Critical Illness Term to Age 75 with Return of Premium on Expiry

Critical Illness **Core**

Plan types available:
• Critical Illness Term 10
• Critical Illness Term 75
• Critical Illness Term to Age 75 with Return of Premium on Expiry

Critical Illness coverage provides a lump sum living benefit to the policy owner of the plan on of one of the covered conditions provided the insured meets the definition of the covered condition. No waiting period is applicable unless specified under the specific covered condition. The critical illness benefit is only payable once and the policy then terminates, regardless of the number of critical illnesses that may be Diagnosed.

Critical Illness Comprehensive is our fully underwritten CI product with 26 covered conditions.

Critical Illness Core is our simplified underwritten CI product with 4 covered conditions. CI Core offers a quick and easy application process with only 8 Qualifying Questions.

Each Critical Illness product offers three different plan types:

Term 10 is renewable and exchangeable. The plan renews every 10 years until the policy anniversary following age 75 at which time the plan matures. The sum insured is level, and all premiums are guaranteed. Premiums increase at each renewal.

Term to Age 75 provides a level amount of critical illness insurance until the policy anniversary following age 75 of the insured at which time the insurance terminates. Premiums are guaranteed at issue.

Term to Age 75 with Return of Premium on Expiry provides a level amount of critical illness insurance until the policy anniversary following age 75 of the insured at which time the insurance terminates. Premiums are guaranteed at issue. Upon maturity of the policy on the anniversary following age 75, a Return of Premium on Expiry is payable.

RETURN OF PREMIUM ON DEATH BENEFIT

The Return of Premium on Death Benefit is included on all Critical Illness - Comprehensive and Critical Illness - Core policies. If no claim for a Critical Illness Benefit (except for Early Diagnosed Benefit) was made under the policy, the sum of the premiums paid for the base policy as well as the Disability Waiver of Premium Rider, if applicable will be payable to the beneficiary.

EXCHANGE OPTION

Term 10 policies may be exchanged to Term to Age 75 or Term to Age 75 with Return of Premium on Expiry at any time prior to the policy anniversary immediately following the Insured Person's 60th birthday without evidence of insurability as long as the policy is in force.

CRITICAL ILLNESS: CORE & COMPREHENSIVE DEFINITIONS

Cancer

Cancer is defined as the definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as prognostic AJCC Stage 1 means:
    - » Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF; or
    - » Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm^2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and prognostic AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions: No benefit will be payable under this condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumours classified as Tis or Ta;
- Malignant melanoma of skin 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. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- 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 dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as prognostic AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- Thymomas confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-Day Exclusion: 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 the last reinstatement of the policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the policy), regardless of when the diagnosis is made; or
- A diagnosis of any cancer (covered or not covered under the policy).

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

Waiting Period:

- There is no waiting period for this condition.

Coronary Artery Bypass Surgery

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.

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

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Waiting Period:

- The 30 days following the date of the surgery.

Heart Attack

Heart Attack is defined as a definite diagnosis of death of heart muscle due to obstruction of blood flow, that results in:

A rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- Heart attack symptoms;
- New electrocardiographic (ECG) changes consistent with a heart attack;
- Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

The diagnosis of heart attack (acute myocardial infarction) must be made by a Specialist.

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

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Waiting Period:

- The 30 days following the date of the diagnosis.

Stroke

Stroke is defined as a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism, with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination, persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of Stroke must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision , measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- Transient Ischaemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischaemic disorders of the vestibular system;
- Death of tissue of the optic nerve or retina without total loss of vision of that eye; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.

Waiting Period:

- Until the date the criteria above in Stroke has been met.

CRITICAL ILLNESS: COMPREHENSIVE ONLY DEFINITIONS

Acquired Brain Injury

Acquired Brain Injury is defined as a definite diagnosis of new damage to brain tissue caused by traumatic injury, anoxia or encephalitis, resulting in signs and symptoms of neurological impairment that:

- are present and verifiable on clinical examination or neuro-psychological testing;
- are corroborated by imaging studies of the brain such as Magnetic Resonance Imaging (MRI) or Computerized Tomography (CT) showing changes that are consistent in character, location and timing with the new damage; and
- persist for more than 180 days following the date of diagnosis.

The diagnosis of Acquired Brain Injury must be made by a Specialist.

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

- an abnormality seen on brain or other scans without definite related clinical impairment;
- post-concussion syndrome;
- neurologic symptoms occurring without clinical impairment on physical examinations

Waiting Period:

- There is no waiting period for this condition.

Aortic Surgery

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.

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

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Waiting Period:

- The 30 days following the date of the surgery.

Aplastic Anemia

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; or
- Bone marrow transplantation.

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

Waiting Period:

- There is no waiting period for this condition.

Bacterial Meningitis

Bacterial Meningitis is defined as a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

The diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for viral meningitis.

Waiting Period:

- Until the date the criteria above in Section 5.4 Bacterial Meningitis has been met.

Benign Brain Tumour

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 Insured Person must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion: 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 the last reinstatement of the policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any benign brain tumour (covered or not covered under the policy), regardless of when the diagnosis is made; or
- A diagnosis of any benign brain tumour (covered or not covered under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any benign brain tumour or its treatment.

Waiting Period:

- There is no waiting period for this condition.

Blindness

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.

Waiting Period:

- There is no waiting period for this condition.

Coma

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

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

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

Waiting Period:

- Until the date the criteria above in Section 5.8 Coma has been met.

Deafness

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.

Waiting Period:

- There is no waiting period for this condition.

Dementia, including Alzheimer's Disease

Dementia, including Alzheimer's Disease is defined as a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

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

The Insured Person must exhibit:

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

The diagnosis of Dementia must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

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

Waiting Period:

- There is no waiting period for this condition.

Heart Valve Replacement or Repair

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.

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

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Waiting Period:

- The 30 days following the date of the surgery.

Kidney Failure

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.

Waiting Period:

- There is no waiting period for this condition.

Loss of Independent Existence

Loss of Independent Existence is defined as a definite diagnosis of the total inability, due to disease or injury, to perform independently:

- with or without the aid of assistive devices;
- at least 3 of 6 Activities of Daily Living listed below;
- for a continuous period of at least 90 days;
- with no reasonable chance of recovery; and
- The diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

- **Bathing:** washing oneself in a bathtub, shower or by sponge bath;
- **Dressing:** putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- **Toileting:** getting on and off the toilet and maintaining personal hygiene;
- **Bladder and bowel continence:** managing bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- **Transferring:** moving in and out of a bed, chair or wheelchair;
- **Feeding:** consuming food or drink that already have been prepared and made available

Waiting Period:

- Until the date the criteria above in Section 5.15 Loss of Independent Existence has been met.

Loss of Limbs

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.

Waiting Period:

- There is no waiting period for this condition.

Loss of Speech

Loss of Speech 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.

Exclusions: No benefit will be payable under this condition for all psychiatric related causes.

Waiting Period:

- Until the date the criteria above in Section 5.17 Loss of Speech has been met.

Major Organ Failure on Waiting List

Major Organ Failure on Waiting List is defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. The diagnosis of the major organ failure must be made by a Specialist.

Waiting Period:

- There is no waiting period for this condition.

Major Organ Transplant

Major Organ Transplant is defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person 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.

Waiting Period:

- There is no waiting period for this condition.

Motor Neuron Disease

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.

Waiting Period:

- There is no waiting period for this condition.

Multiple Sclerosis

Multiple Sclerosis is defined as a definite diagnosis of at least one of the following occurring after the later of the effective date, or the date of the last reinstatement of the policy:

- Two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

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

For purposes of the policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome;
- Neuromyelitis optica spectrum disorders; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion: No benefit will be payable under this condition if, within the first year following the later of the effective date of the policy or the date of the last reinstatement of the policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the diagnosis is made; or
- A diagnosis of multiple sclerosis (covered or not covered under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Waiting Period:

- Until the date the criteria above in Section 5.21 Multiple Sclerosis has been met.

Occupational HIV Infection

Occupational HIV Infection is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person'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:

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

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

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

- The Insured Person 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 and intravenous (IV) drug use.

Waiting Period:

- There is no waiting period for this condition.

Paralysis

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.

Waiting Period:

- Until the date the criteria above in Section 5.23 Paralysis has been met.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

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

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

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

1-Year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if within the first year following the later of, the effective date of the policy or the date of last reinstatement of the policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- A diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

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

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

Waiting Period:

- Until the date the criteria above in Section 5.24 Parkinson's Disease and Specified Atypical Parkinsonian Disorders has been met.

Severe Burns

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.

Waiting Period:

- There is no waiting period for this condition.

EARLY DIAGNOSED BENEFIT – CI COMPREHENSIVE ONLY

An early diagnosed benefit is payable to the proposed insured on the occurrence of one of the covered early diagnosed conditions if:

a. The insured person is diagnosed with a covered early diagnosed condition as defined in the policy; and
b. Completed the waiting period of thirty (30) days following the date of diagnosis or procedure; and
c. Has met the other terms and conditions of the contract.

If an early diagnosed benefit is payable, the amount of the benefit is the lesser of:

a. 15% of the amount of insurance or
b. $50,000.

The early diagnosed benefit is payable only once, regardless of the number of covered early diagnosed condition(s) the insured person may have. Payment of the early diagnosed benefit will not cause the policy to terminate and the critical illness benefit will not be reduced by the amount of the early diagnosed benefit payable.

EARLY DIAGNOSED DEFINITIONS

Coronary Angioplasty

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.

Waiting Period:

- The 30 days following the date of the procedure.

Chronic lymphocytic leukemia (CLL) Rai stage 0

Chronic lymphocytic leukemia (CLL) means a definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL).

The diagnosis of chronic lymphocytic leukemia must be made by a specialist and confirmed by pathological examination of the tissue.

Exclusion:

No benefit will be payable under this condition for Monoclonal B-cell lymphocytosis (MBL).

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

Waiting Period:

- There is no waiting period for this condition.

Ductal carcinoma in situ of the breast

Ductal carcinoma in situ of the breast is a non-invasive cancer.

The diagnosis of ductal carcinoma in situ of the breast must be made by a specialist and confirmed by pathological examination of the tissue.

Waiting Period:

- There is no waiting period for this condition.

Gastrointestinal stromal tumours classified as AJCC Stage 1

A definite diagnosis of a malignant gastrointestinal stromal tumour (GIST) classified as AJCC Stage 1. The diagnosis of a Gastrointestinal Stromal Tumour (AJCC Stage 1) must be made by a specialist and confirmed by pathological examination of the tissue.

For purposes of this policy, gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:

- Gastric and omental GISTs that are less than or equal to 10.0 cm in greatest dimension with five or fewer mitoses per 5.0 mm^2, or 50 per HPF; or
- Small intestinal, esophageal, colorectal, mesenteric and peritoneal GIST that are less than or equal to 5.0 cm in greatest dimension with five or fewer mitoses per 5.0 mm^2, or 50 per HPF

Waiting Period:

- There is no waiting period for this condition.

Grade 1 neuroendocrine tumours (carcinoid)

The diagnosis of grade 1 neuroendocrine tumours (carcinoid) must be made by a specialist and confirmed by pathological examination of the tissue. The grade 1 neuroendocrine tumours (carcinoid) must be confined to the affected organ, treated with surgery alone, and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour.

Waiting Period:

- There is no waiting period for this condition.

Papillary thyroid cancer or follicular thyroid cancer stage T1

Papillary thyroid cancer or follicular thyroid cancer means a definite diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.

The diagnosis of papillary thyroid cancer or follicular thyroid cancer must be made by a specialist and confirmed by pathological examination of the tissue

Waiting Period:

- There is no waiting period for this condition.

Stage T1a or T1b prostate cancer

The diagnosis of stage T1a or T1b prostate cancer must be made by a specialist and confirmed by pathological examination of the tissue.

Waiting Period:

- There is no waiting period for this condition.

Early stage malignant melanoma

Early stage malignant melanoma is a melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, without ulceration or without lymph node or distant metastasis.

The diagnosis of early stage malignant melanoma must be made by a specialist and confirmed by pathological examination of the tissue

Waiting Period:

- There is no waiting period for this condition.

OPTIONAL RIDERS

The following chart illustrates which policies are eligible for coverage enhancements:

	Plan	
	CI - Comprehensive	**CI - Core**
Child Critical Illness Rider	✓	✓
Issue age	18-60	18-60
Maturity age	75	75
Exchangeable	N/A	N/A
Disability Waiver of Premium Benefit	✓	N/A
Issue age	18-59	
Maturity age	60	
Exchangeable	✓	

RIDER DEFINITIONS

CHILD CRITICAL ILLNESS RIDER

The Child Critical Illness Rider provides $10,000 or $20,000 of critical illness coverage for all children (other than foster children) of the insured parent, upon diagnosis of one of 15 defined critical illness conditions. The child must be under age 21 (or 25 if full-time student) at the time of diagnosis. There is no underwriting required, but there is a 12 month pre-existing exclusion. The maximum combined benefit (from all Child Critical Illness Riders) for each child is $20,000.

The Child Critical Illness Rider is not exchangeable. The benefit will terminate on the policy anniversary immediately after the insured parent's 75th birthday.

Covered Critical Illness condition(s) for children

The benefit or rider provides for 15 critical illness conditions and should be read in conjunction with the policy definitions and provisions

1. Autism
2. Blindness
3. Cancer
4. Cerebral palsy
5. Congenital heart disease
6. Cystic fibrosis
7. Deafness
8. Down's syndrome
9. Kidney failure
10. Loss of speech
11. Major organ transplant
12. Major organ failure on waiting list
13. Muscular dystrophy
14. Paralysis
15. Severe burns

DISABILITY WAIVER OF PREMIUM BENEFIT

This benefit provides that the premium will be waived if the insured person under the basic plan becomes totally disabled prior to attaining age 60 and is disabled for 4 consecutive months. Upon receipt of proof of disability, all premiums paid during the 4 month waiting period will be refunded. The benefit will terminate on the policy anniversary immediately after the insured person's 60th birthday unless the insured person is then totally disabled.

If the insured person becomes disabled prior to attaining age 60 and continues to be disabled at the end of the exchange period, the plan will be exchanged to a Critical Illness Term to Age 75 plan.

The Disability Waiver of Premium applies to the base plan and all riders.

UNDERWRITING CI COMPREHENSIVE ONLY

Medical Requirements for Critical Illness

Amount	Application Choice	Age Last		
		18-40	41-50	51-60
$99,999 or Less	**Full App**	NM	NM	Para, Blood, Urine
	Quick App & Tele	NM	NM	Vitals, Blood, Urine
$100,000 - 249,999	**Full App**	NM	Para, Blood, Urine	Para, Blood, Urine
	Quick App & Tele	NM	Vitals, Blood, Urine	Vitals, Blood, Urine
$250,000 - 499,999	**Full App**	Para, Blood, Urine	Para, Blood, Urine	Para, Blood, Urine, APS
	Quick App & Tele	Vitals, Blood, Urine	Vitals, Blood, Urine	Vitals, Blood, Urine, APS
$500,000 - 1,000,000	**Full App**	Para, Blood, Urine	Para, Blood, Urine, APS	Para, Blood, Urine, APS
	Quick App & Tele	Vitals, Blood, Urine	Vitals, Blood, Urine, APS	Vitals, Blood, Urine, APS

Note: In order to obtain a Non-Tobacco User rate, the applicant must not have used any tobacco product within the last 12 months immediately prior to application for the life insurance policy.*

***Occasional Cigar Smokers will be granted Non-Tobacco user rates providing the applicant:**
Does not smoke more than 12 large cigars a year, does not have any traces of nicotine in the urine when fluids are required and makes full disclosure of smoking activities on the application or teleinterview. This ruling does not apply to cigarettes, cigarillos, colts, pipes, chewing tobacco, snuff, e-cigarettes, vaporizers, nicotine gum or patches or any form of nicotine substitute.

UNDERWRITING CI COMPREHENSIVE ONLY

Additional Information

MEDICAL REQUIREMENTS

Exceptions to the Medical Requirements Table:

- If resident in Canada for less than one year, a paramedical examination and blood profile, including hepatitis testing, are required for the Full Application. With the Quick Application, a teleinterview, vitals and blood profile with hepatitis testing are to be ordered.
- If there is limited ability to speak English, the coverage must be applied for on the basis of a Quick Life Application with Teleinterview. The use of an interpreter or translator for Paramedical Examination is not permitted.

Additional Medical Requirements may be ordered at Underwriter's discretion.

TELEUNDERWRITING & PARAMEDICALS

In cases where the 'Quick Application' is completed, **teleunderwriting will be required**. When the 'Full Application' (along with Part II) are completed, **traditional underwriting services are needed**, as teleunderwriting is not applicable. The age of the insured person and the amount applied for generally determine underwriting requirements. However, the company reserves the right to order any requirement on any case.

Amount - refers to all existing Wawanesa Life insurance and the new volume being applied for. In determining whether an application falls within a certain level, all existing critical illness insurance issued or pending with Wawanesa Life (or with other life insurers) in the last 12 months is added to the volume of the current application in the same line of business.

Paramedical Examination* - consists of the insured's medical history taken by a nurse who conducts a series of standardized health tests. Paramedical examinations are completed with Full Applications.

*If there are no paramedical nurses in the area, the paramedical firm will make arrangements to send the blood kit to the nearest facility (lab, hospital, doctor, etc.). Both the facility and the client will be sent detailed instructions.

Teleinterview - is completed with Quick Applications. The process consists of a telephone interview in which the applicant is asked medical and non-medical questions. Dynacare Insurance Solutions is the only firm that may be used when ordering teleinterviews.

Please Note: Under no circumstances should medical requirements be ordered if the client has been declined or highly rated by another company within the past 12 months.

The following paramedical firms may be used:

1. Dynacare Insurance Solutions**
2. Exam One

***This is the preferred paramedical firm and the only firm that may be used when ordering teleinterviews.*

CI CORE - QUALIFYING QUESTIONS

Critical Illness Core - Qualifying Questions

1. Within the last two years, have you had an application for individual life insurance or critical illness insurance rated, declined, postponed or had exclusions added by Wawanesa Life or any other company?	◯ YES ◯ NO
2. Have you ever been treated for, diagnosed, consulted a doctor, received abnormal test results or experienced symptoms of the following: a. Heart attack, congenital cardiac defects, angina, angioplasty, coronary artery bypass, congestive heart failure, heart valve disorder, stroke, transient ischemic attack (TIA), arteriosclerosis, or any other cerebrovascular disease or disease of the heart or the blood vessels, or an abnormal electrocardiogram (EKG)? b. Type 1 (insulin-dependent) diabetes or type 2 diabetes? c. Cancer or other malignant disease, including cancerous colon polyp, leukemia, lymphoma, cancerous tumour or cancerous growth (other than basal cell carcinoma)? d. Any breast disorders (mass, cyst, lump, unusual discharge, physical change, or abnormal mammogram, breast imaging test, or biopsy), or prostate disorders (nodule or abnormal PSA test)?	◯ YES ◯ NO
3. Have you ever had disorder of pancreas, chronic liver or kidney disease including but not limited to cirrhosis or tested positive for hepatitis B or C, hepatitis carrier, or HIV?	◯ YES ◯ NO
4. Within the last five years, have you received treatment or been advised to seek treatment or medical advice because of your alcohol or drug use?	◯ YES ◯ NO
5. Within the last 5 years, have you used heroin, cocaine, hallucinogens, Methadone, Fentanyl, marijuana (if used more than 3 times a week), or any drug not prescribed to you by a physician, other than over-the-counter medication?	◯ YES ◯ NO
6. a) Have you consulted a physician for any symptoms, illness or condition which has not yet been diagnosed or for which testing is still in progress or not yet completed, or are you awaiting the result of any clinical test? **b) Have you noticed any symptoms or health problems for which you have not yet consulted a physician, such as: lump or mass of the breasts, shortness of breath, chest pain, unexplained weight loss, dizziness, loss of balance, numbness, rectal bleeding, prostate disorder or other problems?**	◯ YES ◯ NO ◯ YES ◯ NO
7. Have any of your natural parents or siblings been diagnosed or had any of the following before their 55th birthday: heart disease, heart attack, cancer, stroke or transient ischemic attack (TIA)?	◯ YES ◯ NO
8. Does your current weight exceed the weight indicated in the maximum weight table below?	◯ YES ◯ NO

Feet/Inches	Centimeters	Pounds	Kilograms
5'0" - 5'3"	150-162	200	91
5'4" - 5'6"	163-169	230	104
5'7" - 5'9"	170-177	250	113
5'10" - 6'0"	178-183	275	113
6'1" - 6'2"	184-188	290	125
Over 6'2"	Over 188	315	143

IF ANY OF THE ABOVE EIGHT QUESTIONS IS ANSWERED 'YES', COVERAGE IS NOT AVAILABLE.

Note: Wawanesa Life reserves the right to carry out an assessment on factors other than the ones indicated above. Wawanesa Life also has a right to obtain a report from The Medical Information Bureau Inc. (MIB, Inc.) and, should this report be unfavorable, any premiums paid with the application will be refunded and coverage will not be in force during the investigation period.

CLAIMS

Assisting your client through a claim can be one of the most important services you can provide. When your client has been diagnosed with a covered condition, a claim should be initiated immediately, or as per the waiting period of the covered condition.

You can contact us by email at wawanesalife-claims@wawanesa.com or by phone at 1-844-318-0411, select option #3.

In the event of a claim you can submit your completed claim forms to:

Email: wawanesalife-claims@wawanesa.com

Fax: 1-855-496-3028

Mail: The Wawanesa Life Insurance Company
400 - 200 Main Street,
Winnipeg, Manitoba R3C 1A8

GENERAL EXCLUSIONS

No Critical Illness Benefit or Early Diagnosed Benefit will be payable that results directly or indirectly from any of the following:

a. self-inflicted injuries or illnesses, regardless of whether or not the Insured Person has any mental disease, illness, disorder, infirmity or disability,
b. any violation of, or attempt to violate, any criminal laws by the Insured Person,
c. the Insured Person's use of illegal or illicit drugs or substances, or the Insured Person's misuse of medication obtained with or without prescription, or the Insured Person's misuse of alcohol,
d. war, whether such war is declared or undeclared, or hostile action of the armed forces of any country, or insurrection or civil commotion, irrespective of whether the Insured Person were actually a participant or not.

No Critical Illness Benefit or Early Diagnosed Benefit will be due or payable if the Insured Person was negligent or non-compliant in seeking and/or following reasonable medical treatment, consultation, care, or services including diagnostic measure as prescribed by an attending physician.

TELADOC MEDICAL EXPERTS

Providing a **complete** continuum of care

Expert Medical Opinion

An expert opinion on the member's medical condition through analysis of their medical records and history.

Find a Doctor

Help finding a local in-person specialist with ease based on your medical needs.

Care Finder

Access to specialists or facilities outside of Canada for member's treatment/ condition needs.

Personal Health Navigator

Customized information and resources based on member's medical condition and location.

The insured person and their immediate family members have unlimited access to Teladoc Medical Experts services any time they have a medical condition – even if it's not a covered condition of their policy.

This service provides access to expert medical advice when you need it most, connecting the person to leading specialists, helping them get the right diagnosis and treatment plan.

Their services include: Expert Medical Opinion, Find a Doctor, Care Finder and Personal Health Navigator.

To get started go to Teladoc.ca/medical-experts or call 1-877-419-2378.

Note: The services offered by Teladoc Medical Experts are not part of the policy contract and Wawanesa Life cannot guarantee their availability and they may be withdrawn at any time.

CI 08/2022

wawanesalife.com
1-888-997-9965