LIFE AND HEALTH
INSURANCE

Advisors – Critical illness

Product description

beneva

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1. What is a critical illness insurance?

Progress in medical research currently enables many people who have been diagnosed with critical illnesses to survive and go on to lead a productive life. Critical Illness Insurance is an excellent complement to any financial planning.

Critical Illness Insurance is a protection that provides the necessary tools for insureds to maintain their standard of living and to alleviate their financial obligations following the diagnosis of a critical illness. Indeed, when the insured is diagnosed with a covered critical illness and survives for a minimum period of thirty (30) days, a lump sum tax-free benefit is payable.

The insured can use the benefit as he or she sees fit, for example:

- Cover daily living expenses (mortgage payment, child care expenses, credit cards payments, etc.);
- Choose treatments in a private clinic or abroad;
- Pay for medications or medical expenses not covered by another plan;
- Have the home refitted to his or her medical condition or get nursing care at home;
- Cover business expenses while in recovery;
- Provide income in case of absence from work for an extended period.

2. Why should your client consider critical illness insurance?

Several studies support the importance of this product, confirming that a significant number of Canadians will face the challenge of a critical illness in their lifetime.

Statistics[1] show that:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- There are an estimated 70,000 heart attacks each year in Canada. That is one heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That is one stroke every 10 minutes.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.
- In Canada, approximately 1 in 165 children has autism.
- 1 in every 3,600 children born in Canada has cystic fibrosis.

As we can see, the numbers illustrate the importance of Critical Illness Insurance. Indeed, it is an essential protection at the moment the financial well-being is compromised. It allows insureds to better cope with financial difficulties without having to deplete their savings or their retirement accounts. You can help your clients build a complete protection with the extensive choices and options that we offer.

1 Sources: Canadian Cancer Society, Heart and Stroke Foundation of Canada, Multiple Sclerosis Society of Canada, Autism Society Canada, Canadian Cystic Fibrosis Foundation.

3. Target market

Since critical illness can happen to anyone, it is important to include Critical Illness Insurance in the financial planning process completed with your clients. Recovery can be long and costly. The insurance amount can help them cover additional expenses incurred during their recovery.

This product is tailored to the needs of a diverse client base: families, children, young couples as well as business owners and independent workers. To sum up, this insurance allows clients to meet their needs, regardless of their situation.

4. Product features

4.1 Types of protection

Critical Illness Insurance offers three types of protection:

- **Basic protection** covering the 3 most common critical illnesses
- **Enhanced protection** covering 25 critical illnesses
- **Child protection** covering a total of 28 critical illnesses

4.2 Available plans and issue ages

Several plans are offered to meet the needs of each client. Whether it is for a term or permanent Critical Illness Insurance, you will be able to suggest a plan that suits your clients' profile. Basic and Enhanced protections are available under five plans whereas Child protection is offered under three plans. The insured's age is determined at the nearest birthday.

Plans	Issue ages	Description
T10 – Basic T10 – Enhanced	18 to 65	Term 10 protection, renewable up to age 75 and convertible up to age 65 of the insured. Premiums are level and guaranteed for the initial term and renewal premiums are guaranteed at issue.
T20 – Basic T20 – Enhanced	18 to 55	Term 20 protection, renewable up to age 75 and convertible up to age 65 of the insured. Premiums are level and guaranteed for the initial term and renewal premiums are guaranteed at issue.
T75 – Basic T75 – Enhanced	18 to 65	Protection up to age 75 of the insured. Premiums are level and guaranteed.
T75 – Child	30 days to 17	
T100 – Basic T100 – Enhanced	18 to 65	Protection up to age 100 of the insured. Premiums are level and guaranteed.
T100 – Child	30 days to 17	
T100 paid-up 20 – Basic T100 paid-up 20 – Enhanced	18 to 50	Protection up to age 100 of the insured. Premiums are level and guaranteed. The protection is completely paid up after 20 years of policy.
T100 paid-up 20 – Child	30 days to 17	

4.3 Covered critical illnesses

The table below outlines critical illnesses covered under each type of protection. For a complete definition of covered illnesses, please refer to the appendix at the end of this document.

	BASIC 3 critical illnesses	ENHANCED 25 critical illnesses	CHILD 28 critical illnesses
Cancer (life-threatening)	✓	✓	✓
Heart attack	✓	✓	✓
Stroke (cerebrovascular accident)	✓	✓	✓
Alzheimer's disease		✓	✓
Aortic surgery		✓	✓
Aplastic anemia		✓	✓
Bacterial meningitis		✓	✓
Benign brain tumour		✓	✓
Blindness		✓	✓
Coma		✓	✓
Coronary artery bypass surgery		✓	✓
Deafness		✓	✓
Heart valve replacement		✓	✓
Kidney failure		✓	✓
Loss of independent existence		✓	✓
Loss of limbs		✓	✓
Loss of speech		✓	✓
Major organ failure on waiting list		✓	✓
Major organ transplant		✓	✓
Motor neuron disease		✓	✓
Multiple sclerosis		✓	✓
Occupational HIV infection		✓	✓
Paralysis		✓	✓
Parkinson's disease		✓	✓
Severe burns		✓	✓
Autism			✓
Cystic fibrosis			✓
Muscular dystrophy			✓

4.4 Supplementary benefit

In addition to covered critical illnesses listed previously, 10% of the insurance amount, up to a maximum of $50,000, is payable when the insured is diagnosed with one of the following conditions:

- Coronary angioplasty;
- Ductal carcinoma in situ of the breast;
- Stage A (T1a or T1b) prostate cancer; or
- Stage 1A malignant melanoma.

The payment of the Supplementary benefit is not deducted from the insurance amount and the policy remains in force. Only one supplementary benefit is payable per insured.

The Supplementary benefit is available free of charge under Enhanced and Child protections only.

For a complete definition of covered conditions, please refer to the appendix at the end of this document.

4.5 Insurance amount

Basic and Enhanced

- Minimum: $25,000
- Maximum: $2,000,000

Child

- Minimum: $25,000
- Maximum: $250,000

4.6 Rate bands

Basic and Enhanced

- $25,000 to $99,999
- $100,000 to $249,999
- $250,000 to $2,000,000

Child

- $25,000 to $99,999
- $100,000 to $249,999
- $250,000

4.7 Renewal option

T10 and T20 plans are renewable up to age 75, without evidence of insurability. The renewal premium is guaranteed at issue and is based on the insured's age at the expiry of each 10-year term or 20-year term, according to the selected plan.

4.8 Conversion privilege

Before age 65, T10 and T20 plans are convertible, under the same type of protection, without evidence of insurability, into T75 or T100 plans.

4.9 Types of policy

Critical Illness Insurance offers the following types of policy:

- Individual; and
- Multi-Life covering up to 6 individuals with maximum of 20 coverages under the same policy.

Policy fees are $60 per year.

4.10 Assistance benefit

The Assistance Benefit is included at no additional cost with all Critical Illness Insurance plans. Following the diagnosis of a covered critical illness, consultation services, medical support and assistance are offered through a toll-free number, 24 hours a day, 7 days a week.[2]

- **Second medical opinion:** this service, based on an analysis of the insured person's medical reports, assesses the key elements of the diagnosis received and produces recommendations from a doctor specializing in the relevant field.
- **Medical referral:** this service provides the insured person with the names of up to three doctors who are best qualified to deal with the case.
- **Administrative services:** this service allows the insured person to receive administrative support such as verification of billing, to ensure that bills are justified and free from any duplication, error or over billing.
- **Hospital admission and accommodation assistance outside the province or country:** this service arranges appointments with doctors, hospital admission, hotel reservations, transportation or interpreter services. It also verifies that discounts have been obtained through the Preferred Provider Organization (PPO) of the Excellence Centres.
- **Psychological assistance:** this service, upon request, provides the insured person, their spouse and their children with professional psychological services, up to a limit of $750 CDN.
- **Medical assistance:** this service, offered by registered nurses, upon request from the insured person, provides answers to health, lifestyle and medical related questions.
- **Convalescence assistance:** this service provides the insured person with health professional referrals to meet his or her needs in case of convalescence.
- **Concierge services:** this service provides the insured person with answers to daily questions as well as professional referrals.
- **Legal assistance:** access to legal advice including legal assistance in the event of identity theft. This service, offered by lawyers, provides the insured person with legal information about all legal related matters. The main fields are the following:
  - Civil and common law
  - Property law
  - Family and estate law
  - Consumer law
  - Criminal law

Assistance Benefit services are provided even if a claim is pending or has been refused. In addition, concierge services and legal assistance are offered at all times as soon as the policy is issued. You may refer to the Assistance Benefit pamphlet for additional details (DIND0073A).

2 Legal assistance is offered Monday through Friday from 9 a.m. to 8 p.m. and Saturday from 10 a.m. to 5 p.m. (EST).

5. Return of premiums riders

Different optional return of premiums riders offer clients the possibility to get back the premiums they paid if no critical illness benefit has been paid. Return of premiums riders are offered at issue only.

The table below outlines different return of premiums options and their respective issue ages.

	Return of premiums (ROP) death	Return of premiums (ROP) at expiry	Return of premiums (ROP) on cancellation or at expiry
T10 – Basic **T10 – Enhanced**	18 to 65	18 to 60	N/A
T20 – Basic **T20 – Enhanced**	18 to 55	18 to 50	N/A
T75 – Basic **T75 – Enhanced**	18 to 65	18 to 55	18 to 55
T75 – Child	30 days to age 17	30 days to age 17	30 days to age 17
T100 – Basic **T100 – Enhanced**	18 to 65	N/A	18 to 65
T100 – Child	30 days to age 17	N/A	30 days to age 17
T100 paid-up 20 years – Basic **T100 paid-up 20 years – Enhanced**	18 to 50	N/A	18 to 50
T100 paid-up 20 years – Child	30 days to age 17	N/A	30 days to age 17

5.1 Return of premiums on death

Upon the insured's death, if no benefit in case of critical illness has been paid (except the payment of the Supplementary benefit), this rider allows the beneficiary to receive the sum of all premiums paid, including premiums paid for return of premiums at expiry or return of premiums on cancellation or at expiry (if applicable), as well as rated premiums, but excluding policy fees, without interest. Premiums paid for other additional benefits are excluded.

If there was a reduction in the insurance amount since the issue or the reinstatement of the Critical Illness Insurance benefit, the premiums paid are based on the insurance amount which is current at the time of the insured's death.

5.2 Return of premiums at expiry

On the anniversary date nearest to the insured's 75th birthday, if no benefit in case of critical illness has been paid (except the payment of the Supplementary benefit), this rider allows the beneficiary to receive the sum of all premiums paid, including premiums paid for return of premiums on death (if applicable), as well as rated premiums, but excluding policy fees, without interest. Premiums paid for other additional benefits are excluded.

If there was a reduction in the insurance amount since the issue or the reinstatement of the Critical Illness Insurance benefit, the premiums paid are based on the insurance amount which is current at the time of the request of the return of premiums.

Critical Illness Insurance benefit ends following the return of premiums at expiry.

5.3 Return of premiums on cancellation or at expiry

The return of premiums may be requested from the twentieth (20th) anniversary date of the benefit or from the anniversary date of the benefit nearest to the insured's fifty-fifth (55th) birthday, whichever occurs later. If no benefit in case of critical illness has been paid (except the payment of the Supplementary benefit), the policyowner may request a return of all premiums paid, including premiums paid for return of premiums on death (if applicable), as well as rated premiums, but excluding policy fees, without interest. Premiums paid for other additional benefits are excluded.

If there was a reduction in the insurance amount since the issue or the reinstatement of the Critical Illness Insurance benefit, the premiums paid are based on the insurance amount which is current at the time of the request of the return of premiums.

Critical Illness Insurance benefit ends following the return of premiums on cancellation or at expiry.

6. Additional benefits

6.1 Children's Endorsement (CE)

Offered with Basic and Enhanced protections, this rider is an alternative to the Child protection. The parent(s), namely the policyowner(s) of the Critical Illness Insurance policy, can choose to subscribe the Children's Endorsement benefit to insure their children.

Issue ages

- 30 days to age 17

Covered illnesses

- Autism
- Benign brain tumour
- Blindness
- Cancer (life-threatening)
- Cerebral palsy
- Congenital heart disease
- Cystic fibrosis
- Deafness
- Down syndrome
- Kidney failure
- Major organ failure on waiting list
- Major organ transplant
- Muscular dystrophy
- Paralysis
- Type 1 diabetes mellitus

Insurance amount

- Minimum: $5,000
- Maximum: $50,000

It is possible to increase the insurance amount up to the maximum allowed per insured.

Rate

- Minimum protection ($5,000): $75 per year to cover all children of the policyowner
- Additional protection: $15 annually per $1,000 of the insurance amount

Termination of benefit

This benefit ends at age of 21 or 25 if the insured is a full-time student. Only one benefit is payable.

For a complete definition of each of the covered critical illnesses, please refer to the appendix at the end of this document.

6.2 Waiver of Premium (WP)

When the policyowner or the insured is in a state of total disability for a continued period of 4 or 6 months, according to the waiting period selected, premiums due will be waived until the end of the disability period.

Definition of Total Disability

Total disability means a condition of continuous incapacity affecting the insured owing to sickness or accident, that began while this benefit was in effect and that renders the insured:

- Unable to perform any of the duties of his or her principal occupation during the first 24 months of this condition; and
- Unable to engage, while the condition persists, in any occupation that he or she is reasonably fit to engage in based on his or her education, training or experience, whether acquired before or after the start of total disability.

	Issue ages	Premium rate as a percentage (%) of the total premium	
		Male	Female
Waiver of premium 4 months	18 to 55	9.0%	12.0%
Waiver of premium 6 months	18 to 55	5.0%	7.5%

The waiver of premium benefit ends at the policy anniversary nearest to the 60th birthday of the policyowner or the insured.

6.3 Benefit in case of fracture

In the event of accidental fracture or severance, the following benefit is payable:

Fracture	Benefit
Skull, Spine, Pelvis (ilium bone) and Femur	$5,000
Breastbone, Larynx, Windpipe, Shoulder blade, Radius, Humerus, Kneecap, Ulna, Tibia and Fibula	$1,500
Bone not mentioned above	$750

The benefits are doubled when the accident occurs on public transportation or an escalator, in a public elevator, during a fire in a government building, during a hurricane or cyclone or when the insured is hit by lightning.

The premium cost is $45 per year to add the benefit in case of fracture.

The benefit in case of fracture ends at the policy's anniversary date nearest to the insured's 70th birthday.

7. Complementary protection

It is possible to combine Critical Illness Insurance protection with traditional life and universal life products under a single policy for the same insured or any additional insured, at no additional cost.

8. Premiums payment

Premiums can be paid on an annual basis or monthly basis by pre-authorized debit. If monthly option was chosen, the monthly pre-authorized debit premium is calculated as follows:

Monthly premium = Annual premium x 0.09

9. Benefit payable following the diagnosis of a covered critical illness

A lump sum critical illness benefit is paid tax-free when the insured is diagnosed with one of the critical illnesses covered, according to the type of protection chosen. The insured must survive for a minimum period of thirty (30) days before claiming for the insured amount. The benefit payment for certain illnesses is subject to certain conditions or to a different survival period.

The policy ends following the payment of the critical illness benefit.

Limitations

- Cancer (life-threatening): a moratorium period exclusion of 90 days applies.
- Bacterial meningitis: the condition must result from a neurological deficit documented for at least 90 days from the date of diagnosis.
- Benign brain tumour: a moratorium period exclusion of 90 days applies.
- Loss of independent existence: cognitive impairment must last for a continuous period of at least 90 days with no reasonable chance of recovery.
- Loss of speech: the condition must be proven for a continuous period of at least 180 days.
- Paralysis: the condition must last for a period of at least 90 days.

For complete definition of covered critical illnesses, please refer to the appendix at the end of this document.

General exclusions

No benefit is payable if the covered condition results, directly or indirectly, from one or many of the following causes or situations:

a) self-inflicted injuries, whether or not the insured was sane or insane;

b) the insured committing or attempting to commit a criminal offence, or being involved in such an offence, or from having provoked such an offence;

c) the insured's service, whether as a combatant or non-combatant, in any armed forces involved in surveillance, peacekeeping or war operations, whether war was declared or undeclared;

d) operating any aircraft, watercraft or land vehicle while exceeding the legal blood alcohol content limit or while under the influence of narcotics;

e) alcoholism, drug addiction or use of hallucinatory agents or illegal drugs, abuse or misuse of medication;

f) war, armed conflict, riot, insurrection or civil commotion, whether or not the insured was actually participating therein;

g) a cancer diagnosed within ninety (90) days following the issue date of the benefit or the date of the last reinstatement of the benefit, if applicable. In such a case, no benefits will be payable for a subsequent diagnosis of any cancer or other covered conditions directly resulting from any cancer or its treatment;

h) a benign brain tumour diagnosed within ninety (90) days following the issue date of the benefit or the date of the last reinstatement of the benefit, if applicable. In such a case, no benefits will be payable for a subsequent diagnosis of any benign brain tumour or other covered conditions directly resulting from any benign brain tumour or its treatment.

Termination of benefit

Critical Illness Insurance ends on the first of the following events:

- On the 10th (T10) or the 20th (T20) anniversary of the contract if the benefit is not renewed;
- On the insured's 75th or 100th anniversary, according to the plan selected;
- On the date a covered critical illness benefit is paid;
- On the date the policyowner requests a return of premiums on cancellation or at expiry, if applicable;
- On the date the insured dies;
- On the date a policy's cancellation or at expiry is requested.

10. Appendix

10.1 Definitions of covered critical illnesses under the Basic and Enhanced protections

Alzheimer's disease

A definite diagnosis of a progressive degenerative disease of the brain. The insured person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of eight (8) hours of daily supervision. The diagnosis of Alzheimer's disease must be made by a specialist.

Exclusions

No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Comments

This condition is difficult to diagnose. The definition therefore focuses specifically on behaviour and symptoms.

Aortic surgery

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

Comments

The affected artery must be replaced surgically.

Aplastic anemia

A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one (1) of the following:

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

The diagnosis of aplastic anemia must be made by a specialist.

Comments

Aplastic anemia is a disease in which the bone marrow is no longer able to produce blood cells. This results in anemia and a lack of white cells and platelets. It is treated by the transfusion of various blood cells or by medication, which stimulates the bone marrow to work harder. It can also be treated by a transplantation of bone marrow.

Bacterial meningitis

A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist.

Exclusion

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

Comments

Bacterial meningitis is an infection of the brain, caused by bacteria, which results in permanent neurological damage. This damage must be present for at least 90 days and must be confirmed by a neurologist.

Benign brain tumour

A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist.

Exclusion

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period 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 effective date of last reinstatement of the policy,
- the insured person has any of the following:
  - signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made; or
  - a diagnosis of benign brain tumour.

The medical information as described above must be reported to the Company within six (6) months of the date of the diagnosis. If this information is not provided, 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.

Comments

A benign brain tumour is a non-cancerous tumour that has been confirmed by the removal of brain tissue.

Blindness

A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist.

Comments

The 20/200 rule is aimed at avoiding the situation where the insured is "legally" but not totally blind.

Cancer (life-threatening)

A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist.

Exclusions

No benefit will be payable under this condition for the following non life-threatening cancers:

- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period 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 effective date of last reinstatement of the policy,
- the insured person 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).

The medical information as described above must be reported to the Company within six (6) months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Comments

Cancer is the growth and spread of abnormal cells that destroy healthy cells. Some cancers are less serious and are not considered life-threatening under the definitions for a critical illness product; these are listed above. When a cancer listed among the exclusions is not successfully treated but grows until it reaches another category, the critical illness benefit becomes payable.

Coma

A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma must be four (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; or
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

Comments

An individual who is in a coma for a short period may suffer no after effects. That is why it is specified that the coma must last four or more days and must require the use of a life-support system.

Coronary artery bypass surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a specialist.

Comments

If one or more cardiac arteries are blocked, surgery may be performed in order to bypass the blockage by substituting a vein or artery from another part of the body. This type of surgery is major and involves a long convalescence.

Deafness

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

Comments

Temporary deafness is more common than permanent deafness and may occur after an injury or accident. To provide coverage for the permanent loss of hearing in both ears, we have specified the acceptable level of deafness.

Heart attack

A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

- Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:
  - heart attack symptoms;
  - new electrocardiogram (ECG) changes consistent with a heart attack; or
  - 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.

Exclusions

No benefit will be payable under this condition for:

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

Comments

When a heart attack occurs, a portion of the heart muscle dies due to insufficient blood supply. To confirm the diagnosis of heart attack, the ECG must be reviewed in order to detect the damage (recent changes). Blood tests must also be performed to determine the level of cardiac enzymes.

Heart valve replacement

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist.

Exclusion

No benefit will be payable under this condition for heart valve repair.

Comments

The affected valve must be replaced surgically.

Kidney failure

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.

Comments

The benefit is payable when both kidneys have ceased to function and the insured requires regular dialysis or a kidney transplant.

Loss of independent existence

A definite diagnosis of:

- a total inability to perform, by oneself, at least two (2) of the following six (6) activities of daily living; or
- cognitive impairment, as defined below, 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 equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene.
- 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 use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight (8) hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

Exclusions

No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss of limbs

A definite diagnosis of the complete severance of two (2) 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.

Comments

The severance must entail the irreversible loss of the limbs.

Loss of speech

A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist.

Exclusions

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

Comments

Temporary loss of speech is more common than permanent loss of speech and may result from a simple sore throat. That is why the number of days is specified in the definition.

Major organ failure on waiting list

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the insured person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Comments

This coverage is intended for insureds who are enrolled on a transplant waiting list. The coverages in the event of the major organ transplant and of major organ failure on waiting list are determined on this basis.

Major organ transplant

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the 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.

Comments

Each of the organs specified above may be diseased to the point that a transplant is required. The benefit is payable when the new organ has been transplanted and the recipient has survived the operation by at least 30 days.

Motor neuron disease

A definite diagnosis of one (1) 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.

Comments

Motor neuron diseases are degenerative diseases of the nerve cells that control skeletal muscle movements. In some cases, individuals may have difficulty speaking and swallowing. However, their intellectual facilities remain intact.

Multiple sclerosis

A definite diagnosis of at least one (1) of the following:

- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

The diagnosis of multiple sclerosis must be made by a specialist.

Comments

Multiple sclerosis is a progressive disease that attacks the nervous system. It is difficult to diagnose in its early stages and sometimes the symptoms are present for only a short time. To increase the chances of a reliable diagnosis, the definition requires that neurological abnormalities be present and that the types of test used to obtain the diagnosis be specified.

Occupational HIV infection

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 Company within fourteen (14) days of the accidental injury;

b) A serum HIV test must be taken within fourteen (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 United States;

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United Sates workplace guidelines.

The diagnosis of occupational HIV infection must be made by a specialist.

Exclusions

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; or
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Comments

For the infection to be considered an occupation infection, all conditions specified hereinabove must be met.

Paralysis

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

Comments

A benefit is paid when the insured has no feeling in two or more limbs and is unable to move them voluntarily. The condition must have lasted for at least 90 days.

Parkinson's disease

A definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two (2) or more of the following clinical manifestations:

- muscle rigidity,
- tremor, or
- bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).

The insured person must require substantial physical assistance from another adult to perform at least two (2) of the following six (6) activities of daily living. The diagnosis of Parkinson's disease 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 equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene.
- 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 use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Exclusions

No benefit will be payable under this condition for all other types of Parkinsonism.

Comments

In view of the difficulty of diagnosing this condition, the diagnosis must be provided by a specialist in the field.

Severe burns

A definite diagnosis of third (3rd) degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist.

Comments

Third (3rd) degree burns are the most serious type of burns. To be considered life-threatening, the burn must cover at least 20% of the body.

Stroke (cerebrovascular accident)

A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, 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.

Exclusions

No benefit will be payable under this condition for:

- transient ischemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Comments

A stroke may occur when the blood supply to the brain is significantly reduced, causing permanent neurological sequelae. The sequelae must be present at least 30 days after the stroke.

10.2 Definitions of three additional critical illnesses covered under the Child protection

Autism

An organic defect in brain development characterized by failure to develop communicative language or other forms of social communication. The diagnosis of autism must be confirmed by a specialist before the third (3rd) birthday.

Comments

Autism entails a detachment from reality, including loss of communication with the outside world and the dominance of the inner world of the autistic's imagination.

Cystic fibrosis

A definitive and unequivocal diagnosis of cystic fibrosis, characterized by a hereditary disorder affecting the exocrine glands, resulting in chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be confirmed by a specialist before the twenty-fifth (25th) birthday.

Comments

A hereditary disease that leads to progressive respiratory failure and possible liver failure.

Muscular dystrophy

An unequivocal and definitive diagnosis of muscular dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy. The diagnosis of muscular dystrophy must be confirmed by a specialist before the twenty-fifth (25th) birthday.

Comments

Impairment of muscle group functions resulting in anatomical motor changes.

10.3 Definitions of four medical conditions covered under the Supplementary benefit

Coronary angioplasty

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

Comments

Coronary angioplasty is the widening of one coronary artery with a balloon. A balloon-tipped catheter is inserted into an artery (usually in the groin) and threaded up the body to the blockage or narrowing, where the balloon is then inflated. Recovery is short (approximately one day) and the risks of heart attack or emergency bypass surgery as a result of the procedure are low. Nearly 50% of patients with coronary artery disease are treated with this procedure. The medical term for this procedure is PTCA (percutaneous transluminal coronary angioplasty).

Ductal carcinoma in situ of the breast

The diagnosis of this illness must be made by a specialist and must be confirmed by biopsy.

Stage A (T1a or T1b) prostate cancer

The diagnosis of this illness must be made by a specialist and must be confirmed by pathological examination of prostate tissue.

Stage 1A malignant melanoma

A melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The diagnosis of this illness must be made by a specialist and must be confirmed by biopsy.

10.4 Definitions of critical illnesses covered under the Children's Endorsement benefit

Autism

An organic defect in brain development characterized by failure to develop communicative language or other forms of social communication. The diagnosis of autism must be confirmed by a specialist before the third (3rd) birthday.

Comments

Autism entails a detachment from reality, including loss of communication with the outside world and the dominance of the inner world of the autistic's imagination.

Benign brain tumour

A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist.

Exclusion

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period 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 effective date of last reinstatement of the policy,
- the insured person has any of the following:
  - signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made; or
  - a diagnosis of benign brain tumour.

The medical information as described above must be reported to the Company within six (6) months of the date of the diagnosis. If this information is not provided, 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.

Comments

A benign brain tumour is a non-cancerous tumour that has been confirmed by the removal of brain tissue.

Blindness

A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist.

Comments

The 20/200 rule is aimed at avoiding the situation where the insured is "legally" but not totally blind.

Cancer (life-threatening)

A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist.

Exclusions

No benefit will be payable under this condition for the following non life-threatening cancers:

- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized.

Moratorium Period 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 effective date of last reinstatement of the policy,
- the insured person 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).

The medical information as described above must be reported to the Company within six (6) months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Comments

Cancer is the growth and spread of abnormal cells that destroy healthy cells. Some cancers are less serious and are not considered life-threatening under the definitions for a critical illness product; these are listed above. When a cancer listed among the exclusions is not successfully treated but grows until it reaches another category, the critical illness benefit becomes payable.

Cerebral palsy

An unequivocal and definitive diagnosis of definite cerebral palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Comments

Presence of chronic neuro-motor problems.

Congenital heart disease

A diagnosis of the following heart conditions:

a) The following conditions are covered following a 30-day survival period from diagnosis or birth whichever comes later:

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

The diagnosis must be made by a specialist and supported by appropriate cardiac imaging.

b) 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 or birth whichever comes later:

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

The diagnosis must be made by a specialist and supported by appropriate cardiac imaging. The surgery must be recommended by a specialist and performed by a cardiac surgeon in Canada or the United States.

Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.

All other congenital cardiac conditions are excluded.

Comments

These defects may occur separately or together and may at any time cause significant deterioration of the cardiovascular or pulmonary systems.

Cystic fibrosis

A definitive and unequivocal diagnosis of cystic fibrosis, characterized by a hereditary disorder affecting the exocrine glands, resulting in chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be confirmed by a specialist.

Comments

A hereditary disease that leads to progressive respiratory failure and possible liver failure.

Deafness

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

Comments

Temporary deafness is more common than permanent deafness and may occur after an injury or accident. To provide coverage for the permanent loss of hearing in both ears, we have specified the acceptable level of deafness.

Down syndrome

A definitive and unequivocal diagnosis of Down syndrome supported by chromosomal evidence of Trisomy 21. Comments

Genetic disorder that results from having a third chromosome 21 in addition to the normal two.

Kidney failure

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.

Comments

The benefit is payable when both kidneys have ceased to function and the insured requires regular dialysis or a kidney transplant.

Major organ failure on waiting list

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the insured person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.

Comments

This coverage is intended for insureds who are enrolled on a transplant waiting list. The coverages in the event of the major organ transplant and of major organ failure on waiting list are determined on this basis.

Major organ transplant

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the 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.

Comments

Each of the organs specified above may be diseased to the point that a transplant is required. The benefit is payable when the new organ has been transplanted and the recipient has survived the operation by at least 30 days.

Muscular dystrophy

An unequivocal and definitive diagnosis of muscular dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy. The diagnosis of muscular dystrophy must be confirmed by a specialist.

Comments

Impairment of muscle group functions resulting in anatomical motor changes.

Paralysis

A definite diagnosis of the total loss of muscle function of two (2) 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.

Comments

A benefit is paid when the insured has no feeling in two (2) or more limbs and is unable to move them voluntarily. The condition must have lasted for at least 90 days.

Type 1 diabetes mellitus

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 specialist or a licensed endocrinologist and there must be evidence of dependence on insulin for a minimum of three (3) months.

Comments

Type 1 diabetes mellitus is caused by a failure of the pancreas to produce insulin, resulting in a daily dependence on insulin injections for survival.

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In 2020, La Capitale and SSQ Insurance, two very solid mutual insurance companies, announced that they would come together to become Beneva.

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