Canadian Conference of Mennonite Brethren Churches

Personal Accident Insurance
Critical ● Choice ● Care

Policy 1C500
(replaces Policy #9229206, 9229206A)

Effective: JANUARY 1, 2011

Revised: March 11, 2013

This Certificate Is An Important Document
Please Keep It In A Safe Place

PERSONAL ACCIDENT INSURANCE

Certificate of Insurance

SSQ INSURANCE COMPANY INC.
2020 University Street, Suite 1800
Montréal (Québec)
H3A 2A5
(Hereinafter called the Insurer)

Having issued Group **Policy No. 1C500**
to **Canadian Conference of Mennonite Brethren Churches**

(Hereinafter called the "Policyholder")

Hereby certifies that the bearer of this certificate, being an active full-time member of the Policyholder, who is participating in the Policyholder's Basic Group Life Insurance Program, provided application has been made and the applicable premium is paid.

Definitions

Wherever used in this certificate:

"You", "Your" and "Yourself" mean the person who holds this certificate and who is a Member of the Policyholder.

"We", "Us" and "SSQ" means SSQ Insurance Company Inc.

"Insured Person" means You.

"Member" means an active full-time member of the Policyholder who is participating in the Policyholder's Basic Group Life Insurance Program.

"Policy" means the Group Policy specified above, which is on file with the Policyholder.

"Injury" means bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by this policy, 24 hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

“Accident” means any unlooked for mishap or untoward event, which is not expected or designed.

“Sickness” means an impairment of normal physiological function and includes illness and infections.

“Disease” means any unhealthy condition of the body or any part thereof.

"Spouse" means an individual

(a) to whom You are legally married,

(b) to whom You have continuously cohabited and who has been publicly represented as Your Spouse for a minimum of 1 year immediately before a loss is incurred under the Policy.

Only 1 individual qualifies as a spouse.

If You are legally married but are also cohabiting with an individual as described in (b) or (c) above, You may elect in writing which one of the individuals is insured as a Spouse. This election must be filed with the Employer. We are not bound by an election not filed before the event insured against. If an election is not filed, the Spouse is the individual to whom You are legally married.

"Institution for higher learning" is limited to universities, colleges, CEGEPs or trade schools.

“Hospital ”means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one or more physicians available at all times and which continuously provides 24 hour nursing service by graduate registered nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care.

“Physician” means a doctor of medicine (other than the Insured Person or Immediate Family Member) who is licensed to practice medicine by:

(1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

(2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Immediate Family Member " means a person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

"Motorized Vehicle" means a passenger car, station wagon, van, jeep-type automobile, truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

"Seat Belt" means those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

"Accommodation" means lodging in the vicinity of the Hospital where the Insured Person is confined.

"Principal Sum", when referring to You, will be equal to the amount of insurance under Your Employer's current Basic Group Life Insurance, subject to a maximum of $750,000.

The male pronoun is construed as the feminine when the person is a female.

Specific Loss Schedule

When Injury results in any of the following losses within 365 days after the date of the Accident, SSQ pays:

For Loss of	Percentage of Principal Sum
Life	100%
Entire sight of both eyes	100%
Speech and hearing in both ears	100%
One hand and the entire sight of one eye	100%
One foot and the entire sight of one eye	100%
Entire sight of one eye	75%
Speech	75%

Hearing in both ears 75%
Hearing in one ear 40%
All toes of one foot 33 1/3%

For Loss or Loss of Use of

Both hands 100%
Both feet..... .....100%
One hand and one foot 100%
One arm..... .....80%
One leg 80%
One hand 75%
One foot..... .....75%
Thumb and index finger or
at least four fingers of one hand..... .....40%

For Paralysis of

Both upper & lower limbs (Quadriplegia).....200%
Both lower limbs (Paraplegia) 200%
Upper and lower limbs of one side of the body
(Hemiplegia)..... .....200%

"Loss of Life" means the death of the Insured Person.

"Loss" as used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb means the complete severance of one (1) entire phalanx of the thumb; as used with reference to finger means the complete severance of two (2) entire phalanges of the finger; as used with reference to toes mean the complete severance of one (1) entire phalanx of the big toe and all phalanges of the other toes; as used with reference to eye means the irrecoverable loss of the entire sight thereof.

"Loss" as used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

“Paralysis” means the loss of ability to move all or part of the body.

“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs.

“Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Loss" as used with reference to loss of use means the total and irrecoverable loss of use, provided the loss is continuous for twelve (12) consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section for all losses sustained by any 1 Insured Person as the result of any 1 Accident cannot exceed:

(a) with the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum.

(b) with respect to Quadriplegia, Paraplegia and Hemiplegia, 200% of the Principal Sum, or 100% if Loss of Life occurs within 90 days after the date of the Accident.

In no event will indemnity payable for all losses exceed, in the aggregate, 200% of the Principal Sum as the result of the same Accident.

Repatriation *

If You sustain Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, We will pay up to $15,000 for reasonable and necessary expenses actually incurred for the return home of Your body (including preparation charges for transportation). Such Loss must occur more that 50 kilometres from Your residence.

Education **

If You sustain Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum (maximum $5,000) is payable for each of Your Dependent Children under 25 years of age already enrolled full-time:

(1) in an Institution for Higher Learning above the secondary school level; or
(2) at the secondary school level but who will enroll as a full-time student in an Institution for Higher Learning within 365 days after Your death.

The benefit is equal to the reasonable and necessary expenses actually incurred and payable annually for each year (up to 4 consecutive years) that the Dependent Child continues his education in an Institution for Higher Learning, but payment is not made for expenses incurred prior to Your death, nor for room, board or other ordinary living, travelling or clothing expenses.

"Dependent Child" means a natural child, adopted child, stepchild or a child who is in a parent-child relationship with You. The child is unmarried, under twenty-five (25) years of age [twenty-six (26) in the province of Quebec] and dependent upon You for maintenance and support.

Day-Care **

If You sustain a Loss of Life because of Injury for which an amount of Principal Sum becomes payable under the program, 5% of Your Principal Sum to a maximum of $5,000 will be paid for each Dependent Children under 13 years of age who is enrolled in a Day-Care Centre or who will do so within 365 days after Your death.

The benefit is payable annually, for each year (up to 4 consecutive years) that the Dependent Child remains enrolled in a Day-Care Centre.

If none of Your insured Dependent Children satisfies the requirements as shown under the sections entitled "Education" and "Day-Care", an amount equal to 5% of Your Principal Sum or $2,500, whichever is lesser, will be paid to Your beneficiary.

"Day-Care Centre" means a facility which is run according to laws and regulations applicable to daycare facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will not include a hospital, the child's home or care provided during normal school hours while a child is attending grades 1 though 12.

"Dependant Child" means a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the Insured Person. The child is under thirteen (13) years of age and dependant upon the Insured Person for maintenance and support.

Rehabilitation *

If You sustain a Specific Loss for which an amount of Principal Sum becomes payable under the program, this benefit will refund expenses actually incurred for Your participation in a rehabilitation program in order to qualify in a different occupation, during the 3 year period following the loss, to a maximum of $15,000.

Room, board or other ordinary living, travelling or clothing expenses are not covered.

Workplace Modification and Accommodation

If You sustain a Specific Loss for which an amount of Principal Sum becomes payable under this program and You require special adaptive equipment and/or workplace modification in order to accommodate your active full-time work with the Employer, this benefit will reimburse the Employer for the actual expenses actually incurred up to $5,000.

Occupational Training *

If You sustain Loss of Life caused by an Accident for which an amount of Principal Sum becomes payable under the Policy, and Your Spouse must engage in a formal occupational training program in order to upgrade employment qualifications, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following Your death, to a maximum of $15,000.

Payment is not made for room, board or other ordinary living, travelling or clothing expenses.

In the event Your Spouse satisfies the requirements indicated above, such spouse will be deemed the beneficiary with respect to the benefits payable under this provision.

Permanent Total Disability

The Principal Sum will be paid to You in a lump sum, less any other amounts payable under the Specific Loss section as a result of the same Accident, if You become totally disabled and the following conditions are met:

(1) The disability results from an Injury caused by an Accident.

(2) The disability commences within 365 days of the Injury.

(3) The disability prevents You from engaging in each and every occupation or employment for compensation or profit for which You are reasonably qualified by education, training or experience.

(4) The disability has continued for a period of 12 consecutive months, and is total and permanent at the end of such period.

Family Transportation *

If any Loss covered under the "Specific Loss Schedule" section of the Policy confines You to a Hospital located more than 150 kilometres from Your residence, We will refund the reasonable and necessary expenses actually incurred by any Immediate Family Member or family representative for Accommodation and transportation by the most direct route from the normal place of residence of the Immediate Family Member or a family representative to You and return to the normal place of residence of such Immediate Family Member or a family representative up to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Payment is not made for board or other ordinary living, travelling or clothing expenses.

Identification*

If an Insured sustains a Loss of Life because of Injury and identification of the Insured's body is required by the police or similar governmental authority, this benefit will refund expenses actually incurred by the Insured's Immediate Family Member or family representative for lodging and board and transportation (via the most direct route) to the city or town where the body is located (location of the body must be more than 150 kilometres from the family member's normal place of residence), to a maximum of $10,000. Private transportation expenses are limited to $0.35 per kilometre travelled.

Seat Belt **

If You are driving or riding in a Vehicle and wearing a properly fastened Seat Belt at the time of the Accident, and a Loss becomes payable under the "Specific Loss Schedule" section of the Policy, We will pay an additional sum equal to 10% of the amount payable for such Loss, subject to a maximum of $25,000.

The driver of the Vehicle must hold a current and valid driver's license and is not intoxicated nor under the influence of drugs, unless such drugs

are taken as prescribed by a Physician, at the time of the Accident. "Intoxicated" and "under the influence of drugs" are as defined by the jurisdiction where the Accident occurs.

Home Alteration and/or Vehicle Modification

If You sustain the Loss of or Loss of Use of Both Feet or Legs or become Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and You subsequently require the use of a wheelchair to be ambulatory, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the Accident, to a maximum of $15,000, for the cost of alterations to Your principal residence and/or the cost of modifications to 1 motor vehicle utilized by You, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

Payment by Us for the total of all expenses incurred by or for You will not exceed a maximum of fifteen thousand dollars ($15,000) as the result of any one Accident. The amount payable under this section will be coordinated with any amount paid or payable under any other insurance plan providing the same or similar benefit.

Hospital Indemnity **

If any Loss covered under the "Specific Loss Schedule" section of the Policy confines You to a Hospital and You are under the Regular Care and Attendance of a Physician, You will receive a daily benefit of 1/30th of 1% of Your Principal Sum from the 1st day of hospitalization, up to a maximum of $2,500 per month and for a maximum duration of 365 days per Accident.

Hospitalization required for treatment of any Injury other than for a Specific Loss is also covered in accordance with the above terms, provided such hospitalization begins within 365 days of the date of the Accident which caused the Injury and insurance is in force. The daily benefit is payable from the 5th day of hospitalization.

Hospitalization is either a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less than 90 consecutive days. All confinements must occur within 730 days of the date of the Accident.

Only one period of hospitalization will be payable for all injuries sustained as the result of the same Accident.

“Period of Hospitalization” means a single uninterrupted confinement in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less 90 consecutive days and all such confinements occur within 730 days of the date of the Accident.

“Day of Hospitalization” means a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day’s room and board is charged.

"Regular Care and Attendance " means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

Note
Benefits marked with an asterisk (*) are only payable under 1 of the policies issued to the Employer by SSQ.

Benefits marked with 2 asterisks (**) are payable up to the percentage of Principal Sum as stated in the policy subject to one combined maximum for similar benefits provided under any other policy issued to your Employer by SSQ.

Aircraft Coverage

You are covered only while flying as a passenger in any aircraft holding a current and valid certificate of airworthiness (other than an aircraft owned, operated or leased by or on behalf of the Employer) and flown by a licensed pilot. Coverage also applies while flying as a passenger in a military aircraft.

Exposure and Disappearance

Unavoidable exposure to the elements will be covered under the program as any other loss, provided such exposure is sustained as the result of a covered Accident.

An Insured will be presumed to have suffered Accidental Loss of Life if the insured's body is not found within 1 year after the disappearance or sinking or wrecking of the conveyance in which the Insured was riding at the time of the Accident.

Aggregate Limit

A maximum limit of $5,000,000 is imposed on the total of all losses arising out of any one Accident covered under the program. This means that if you and any other persons insured under the program suffer losses occurring from the same Accident, and the total of all benefits (the benefit you are entitled to added to those which the others are entitled to) is greater than the aggregate limit of indemnity amount, then the amount payable to each individual will be proportionately reduced so that the total amount of all benefits payable equals $5,000,000.

The aggregate limit of indemnity only applies to losses payable under the following section of the Policy:

Specific Loss Schedule
Permanent Total Disability Indemnity

To Whom Are Benefits Paid

Your Loss of Life benefit is payable to the beneficiary designated on Your Basic Group Life Insurance application, otherwise to Your estate. All other indemnities payable are payable to You, with the exception of the following benefits:

Repatriation Benefit
Education Benefit
Day-Care Benefit
Workplace Modification and Accommodation Benefit
Occupational Training
Family Transportation Benefit
Identification Benefit

Effective Date of Coverage

Coverage commences on the date insurance under the Employers Basic Group Life Insurance contract becomes effective with respect to an Employee who becomes insured under such program after the Effective Date of the Policy.

When Insurance Coverage Stops

Your insurance coverage stops on the earliest of the following dates:

(1) on the date the Policy is terminated;

(2) on the premium due date if the Policyholder fails to pay Us Your premium, except as the result of an inadvertent error;

(3) on the date You cease to be an active employee on account of leave of absence, lay-off, maternity leave, disability, resignation, dismissal, pension or retirement, except as provided under:

Waiver of Premium
Continuation of Coverage
During Approved Leaves
Extension of Coverage

Waiver of Premium

Provided You have been approved for Waiver of Premium and remain eligible for such under the terms and conditions of the Employer's Basic Group Life Insurance policy, You need not pay any further premiums under the Policy for Yourself, while You remain disabled, until the earliest of the following dates:

(1) the Policy terminates;

(2) You reach age 65;

(3) You cease to be totally disabled.

All terms and provisions of the Policy in affect as of the date of commencement of disability will apply during the period premiums are waived, including provisions relating to reductions in amount of insurance.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the commencement date of disability.

Continuation of Coverage

Your coverage under this benefit will be continued, if coverage is continued under your Basic Group Life Insurance contract during any approved leave of absence, temporary lay-off, maternity leave or disability leave, provided payment of premium is continued.
All terms and provisions of the Policy apply during the period of the leave, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the commencement date of the leave.

Extension of Coverage

If Your employment is terminated by Your Employer, coverage will be continued for up to 12 months for You, provided such continuation is required by the Employment Standards Act or by a severance package agreement you receive from Your Employer and payment of premium is continued.

All terms and provisions of the program will apply during the period coverage is continued, including provisions relating to reductions in amounts of insurance.

What We Will Not Pay For

An Insured Person is not covered for Loss caused or contributed to by:

(1) suicide or intentionally self-inflicted Injury;

(2) war, whether declared or not;

(3) participation in a riot, insurrection, civil commotion or disturbance;

(4) active full-time, part-time or temporary service in the armed forces of any country;

(5) air travel, except as specifically provided for under the "Aircraft Coverage";

(6) medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

In the Event of a Claim

If a person insured under the Policy is injured and the Injury may lead to a claim under the Policy, We must be notified in writing within 30 days of the Accident causing the Injury. You or Your representative may notify our Head Office in Montreal, any of our Regional Offices in Canada or our authorized agent. Whomever You contact should be advised of Your name and the policy number under which You are insured. If You or

Your representative do not contact Us within 30 days, but can show that it was not reasonably possible to contact Us within the 30 day period, Your claim will not be invalidated solely because of failure to contact Us within the 30 day period, but in no event later than 1 year after the date of the Accident.

Upon receipt of Your notice of claim, We will supply You or Your representative with any form or forms necessary to show proof of loss. If We have not supplied the form or forms within 15 days of the date notice of claim was received, You or Your representative may satisfy Your obligation under this section by submitting a letter describing the Accident or occurrence causing the loss, the nature of the loss and the extent of the loss for which Your claim is made.

Written proof of loss that You have suffered must be provided to Us within 90 days of the loss. If it is shown that it was not reasonably possible to provide proof within this time, and if proof is supplied as soon as reasonably possible, the claim will not be invalidated solely because of failure to provide proof of loss within the 90 day period, but in no event later than 1 year after the date of the Accident.

While Your claim is pending, We will have the right and the opportunity to examine the person suffering the loss as often as necessary. If the claim is for loss of life, We will also have the right and opportunity to require an autopsy where it is not forbidden by law.

We will pay all amounts payable under the Policy immediately after We have received satisfactory proof of loss.

We will pay all claims under the Policy in Canadian Currency.

Limits Of The Policy

Any changes to the Policy which have been approved by Us will become part of the Policy. No change will be valid unless approved by an officer of SSQ Insurance Company Inc., with such approval set out in an endorsement attached to the Policy. No one else, including any agent, has the authority to change any part of the Policy. If the Policy is amended, the provisions of this certificate will automatically be amended to conform to the amended provisions of the Policy.

If You or Your representative believe there is cause to bring legal action against Us, action may be brought not sooner than 60 days after providing Us with proof of loss according to the terms of the Policy. No such action may be brought unless brought within 1 year (3 years in the

province of Quebec) of the expiration of the time within which proof of loss is required by the Policy.

If any time limits which We have prescribed in the Policy are less than those permitted by the law of the province in which the claimant is residing at the time of claim, then it is understood that such limits are extended to agree with the minimum period permitted by law.

The Policy may be cancelled by the Employer by mailing to SSQ Insurance Company Inc. written notice stating when cancellation is to be effective. The date of cancellation will not precede the date of written notice.

The Policy may be cancelled by SSQ Insurance Company Inc. by mailing to the Employer written notice stating when, not less than 30 days prior to the Policy anniversary date, cancellation is to be effective. The mailing of such notice will be sufficient proof of notice and the effective date of cancellation stated in the notice will become the end of the Policy period. Delivery of such notice by SSQ Insurance Company Inc. or by the Employer will be considered the same as mailing.

We will be permitted to examine the Policyholder's records relating to the Policy at any reasonable time up to 2 years after the Policy has expired or been cancelled, or until all claims under the Policy have been settled, whichever is later.

CRITICAL • CHOICE • CARE

Certificate of Insurance

SSQ INSURANCE COMPANY INC.
2020 University Street, Suite 1800
Montréal (Québec)
H3A 2A5
(Hereinafter called the Insurer)

Having issued **Group Policy No. 1C500**
to **Canadian Conference of Mennonite Brethren Churches**
(Hereinafter called the "Policyholder")

Hereby certifies that the bearer of this certificate, being an active full-time member of the Policyholder, provided application has been made and approved and the applicable premium is paid.

Definitions

"Critical Illness" means one of the following illnesses, conditions or surgical operations:

a) Alzheimer's Disease;

b) Blindness;

c) Cancer (life-threatening);

d) Coronary Artery Bypass Surgery;

e) Deafness;

f) Heart Attack;

g) Kidney Failure;

h) Loss Of Speech:

i) Multiple Sclerosis;

j) Paralysis;

k) Parkinson's Disease;

l) Stroke;

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable.

"Diagnosis" means the time when a Specialist establishes, using tests or other diagnostic methods, that the Insured Person has a specific Critical Illness. The diagnosis of any covered Critical Illness must be made by a licensed Specialist practising in Canada. Furthermore, his practice must be limited to the branch of medicine directly linked to the Critical Illness.

"Member" means an active Member of the Policyholder.

If a Member is absent from work for any reason other than bona fide vacation, such Member will only become eligible upon return to work.

“Insured Person” means an Insured Member, except where otherwise specified under the policy.

“Irreversible” means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the Insured Person’s health.

“Physician” means an individual who is legally licensed to practice medicine in Canada and provide treatment within the scope of his licence. The physician must not be the Insured Person, a relative of or business associate of the Insured Person.

"Pre-existing Condition" means:

- the existence of symptom(s) which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the twenty-four (24) month period preceding the Insured Person’s effective date of coverage; or
- an illness or condition for which the Insured Person, during twenty-four (24) months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

”Principal Sum" means the amount of $6,000 per Insured Person.

“Specialist” means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be diagnosed by a qualified Physician practising in Canada. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative of or business associate of the Insured Person.

“Surgery” means that the Insured Person undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada.

“Survival Period” means the thirty (30) days following the date of Diagnosis or thirty (30) days following the date of Surgery if applicable, except where otherwise specified under the policy. The Survival Period does not include the number of days on Life Support as defined below. The Insured Person must be alive at the end of the survival period and must not have experienced Irreversible cessation of all functions of the brain.

For those conditions which have a qualifying period, for example 90 days for Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Life Support means the Insured Person is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

The male pronoun will be construed as the feminine when the person is a female.

Definitions of Covered Illnesses

"Alzheimer’s disease" means 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 judgement, 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.

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

"Blindness" means a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of blindness must be made by a Specialist.

"Cancer" (life-threatening) means 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.

Exclusion: 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).

This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

"Coronary artery bypass surgery" means 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.

"Deafness" means 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.

"Heart attack" means 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.

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

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

"Kidney failure" means a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of kidney failure must be made by a Specialist.

"Loss of speech" means a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The Diagnosis of loss of speech must be made by a Specialist.

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

"Multiple sclerosis" means 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.

"Paralysis" means 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.

"Parkinson's disease" means 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
- bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

The Diagnosis of Parkinson's disease must be made by a Specialist.

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

"Stroke" (cerebrovascular Accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting for more than thirty (30) days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Diagnosis of stroke must be made by a Specialist.

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

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

Conditions for Payment

When the Insured Person is diagnosed with a Critical Illness while the policy is in force as to the Insured Person whose Critical Illness is the basis of claim, the Insurer shall pay the Principal Sum subject to survival by the Insured Person of the Survival Period.

Beneficiary Designation

With respect to an Insured Member, the Principal Sum payable in the event of a Critical Illness will be payable to the Insured Member.

Accrued benefits, if any, unpaid at the time of the Insured Member becoming unable to legally receive payment of benefits will be paid to the Insured Member's estate.

Effective Date of Individual Insurance:

Insurance as to each eligible Employee becomes effective:

a) on the Effective Date of the Policy with respect to a Member insured under the Policyholder's Basic Group Life Insurance program on or before the Effective date of the Policy.

b) on the date insurance under the Policyholder's Basic Group Life Insurance program becomes effective with respect to a Member who becomes insured under such program after the Effective Date of the Policy.

When Insurance Coverage Stops

The insurance of an Insured Person will immediately terminate on the earliest of the following dates:

(1) on the date this policy is terminated;

(2) on the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;

(3) on the next premium due date following the date the Member ceases to be an active Member of the Policyholder on account of resignation, dismissal or retirement;

(4) on the date the Insured Member dies;

(5) on the date the Principal Sum Payment has been paid;

What We Will Not Pay For

The Principal Sum will not be paid if a Critical Illness results directly or indirectly from any one or more of the following causes:

1. Within ninety (90) days following the effective date of the Insured Person's coverage:
   (a) Diagnosis of Cancer is made; or
   (b) Any signs, symptoms or investigations that lead to a Diagnosis of Cancer, regardless of when the Diagnosis is made.

2. Within ninety (90) days following the effective date of the Insured Person's coverage:
   a) Diagnosis of Benign Brain Tumour is made; or
   b) Any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.

3. The Insured Person does not satisfy the Survival Period limitations.

4. An intentionally self-inflicted injury or sickness, whether the Insured Person is sane or insane.

5. The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.

6. Any Cancer that manifests itself prior to the effective date of the Insured Person's insurance coverage when the same Cancer either recurs or metastasizes after such effective date.

7. From a Pre-existing Condition except if such Critical Illness is diagnosed twenty-four (24) months after the Insured Person's effective date of coverage.

Pre-existing Condition Exclusion

This Pre-existing Condition Exclusion applies only to amounts equal to the Guaranteed Issue Limit of $6,000.

The Principal Sum will not be paid for Critical Illness which results directly or indirectly from a Pre-existing Condition. However, if the Critical Illness is diagnosed after twenty-four (24) months from the effective date of the Insured Person's coverage, his claim will not be reduced or denied under this exclusion.

If this policy directly replaces one with another insurer providing similar benefits, an Insured Person who has satisfied the time period of Pre-Existing Conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the benefit amount and Critical Illnesses covered in the prior policy. Any additional benefit amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

An Insured Person who has not satisfied the time period of Pre-Existing Conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this Pre-existing Conditions Exclusion, but only to the extent of the benefit amount and Critical Illnesses covered in the prior policy. Any additional benefit amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came in.

Area of Diagnosis

Should a Critical Illness occur or be diagnosed outside of Canada, payment of the Principal Sum may be considered upon the Insured Person's return to Canada for medical assessment and confirmation of the Diagnosis of a Critical Illness.

In the Event of a Claim

Written notice of Critical Illness must be given to the Insurer within thirty (30) days after the date of Diagnosis. Such notice given by or on behalf of the Insured Person to the Insurer at it's Head Office, 2020 University Street, Suite 1800, Montreal, Quebec H3A 2A5 or to any Regional Office of the Insurer or to any authorized agent of the Insurer,

with particulars sufficient to identify the Insured Person, will be deemed to be notice to the Insurer. Failure to give notice within the time provided in this policy will not invalidate any claim, if it is shown not to have been reasonably possible to give such notice during such time and that notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

The Insurer, upon receipt of such notice will furnish to the claimant such forms as are usually furnished by it for filing proofs of a Critical Illness. If such forms are not so furnished within fifteen (15) days after the receipt of such notice, the claimant will be deemed to have complied with the requirements of this policy as to proof of such Critical Illness upon submitting, within the time fixed in the policy for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim is made.

Written proof of Critical Illness must be furnished to the Insurer within ninety (90) days after the date of Diagnosis. Failure to furnish such proof within such time will not invalidate any claim, if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event not later than one (1) year after the date of the Diagnosis.

The Insurer reserves the right to examination of the Insured Person and confirmation of the Critical Illness Diagnosis by a medical practitioner appointed by the Insurer.

The Principal Sum provided in this policy will be paid immediately after receipt of due proof.

All moneys payable under this policy are payable in the lawful money of Canada.

This policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance. No statement made by the applicant for insurance will void the insurance or reduce benefits hereunder unless contained in a written application signed by the applicant. No agent has authority to change this policy or to waive any of its provisions. No change in this policy will be valid unless approved by an officer of the Insurer and such approval be endorsed hereon or attached hereto.

All statements contained in any such application for insurance will be deemed representations and not warranties.

Legal action will not be taken to recover the Principal Sum under this policy until sixty (60) days after proof of claim has been submitted to the Insurer. Thereafter, the claimant will be limited to a one (1) year period [three (3) years in the province of Quebec] during which legal action may be taken.

If any time limitation specified in this policy for giving notice of claim, or undertaking legal action is less than that permitted by law of the province in which the claimant is residing at the time of claim, then the time limitation will not be less than that provided for by provincial law.

This policy may be cancelled by the Policyholder by mailing to the Insurer written notice stating when thereafter such cancellation will be effective. This policy may be cancelled by the Insurer by mailing to the Policyholder at the address shown in this policy written notice stating when, not less than thirty (30) days prior to the Anniversary Date of this policy, such cancellation will be effective. The mailing of such notice as aforesaid will be sufficient proof of notice and the effective date of cancellation stated in the notice will become the end of the policy. Delivery of such written notice either by the Policyholder or by the Insurer will be equivalent to mailing.

The Insurer will be permitted to examine the Policyholder's records relating to this policy at any reasonable time, and from time to time until two (2) years after expiration of this policy or until final adjustment and settlement of all claims hereunder, whichever is the later.

This certificate is an outline of the coverage and should be retained for reference. The Group Policy sets forth in detail the terms and conditions of the program and all rights and obligations are determined in accordance with the Group Policy, not this certificate. For exact provisions of coverage, please contact Your Employer.

The program is arranged by:

#100-215 Lawrence Avenue
Kelowna, BC
V1Y 6L2
250-763-6464
service@encompassbenefits.com.

and underwritten by:
SSQ Insurance Company Inc.