Introduction

Useful information for reading this contract

PARTS OF THE CONTRACT

The following are all part of this contract of insurance:

- Your Summary of Coverages;
- The various sections of your contract:
  - Introduction (this page);
  - Table of Contents;
  - Section A:
    - Cancer Insurance and Death Benefit;
    - Complete Critical Illness Option;
  - Section B – Definitions;
  - Section C – Statutory Conditions;
  - Section D – General Conditions.
- Your Application for Insurance:
  - Appendix A – Copy of your application;
  - Appendix B – Insurability Questionnaire.

The contract of insurance should be read as a whole. Consequently, clauses should be interpreted as they relate to each other and taking into account the meaning of the entire contract.

TABLE OF CONTENTS

You can refer to the Table of Contents to see how this contract is structured and locate specific information.

DEFINITIONS

The words and expressions in *italics* are explained in Section B – Definitions in this document.

EXAMPLES

Several examples are provided to help you understand this contract. They are identified by text boxes. Warning! These examples are simplified scenarios intended to help illustrate a principle of insurance and should not be taken out of context.

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Section A

Cancer Insurance and Death Benefit

Question 1 – What amount of insurance can I choose?

"AMOUNT OF INSURANCE"

- The amount of insurance you have chosen is shown in your **Summary of Coverages**. It is the total maximum *benefit* *you* can receive during the life of *your* contract, for all of your coverages combined.
- Upon a diagnosis of cancer, *you* will receive:
  - for a *major cancer*: 100% of the amount of insurance;
  - for an *early intervention cancer*: 15% of the amount of insurance;

    If after *you* develop:
    - a *major cancer*, the remainder of *your* amount of insurance (85%) will be paid to *you*;
    - a second *early intervention cancer*, no *benefit* will be paid to *you*.
- Upon death, whether or not it is related to cancer, your *beneficiary* will receive:
  - 15% of the amount of insurance;
- For more details about these coverages, refer to **Question 4 – What is covered under my cancer insurance and death benefit coverage?**
- The *benefit* is non-taxable and paid independently of any other policy/contract *you* may have with another insurance company.

After purchasing CANCER INSURANCE, Mary is diagnosed with breast cancer by a specialist. She completes the necessary documents and submits them to Humania Assurance. Humania Assurance may pay her a benefit, even if she also receives a benefit under her disability insurance contract.

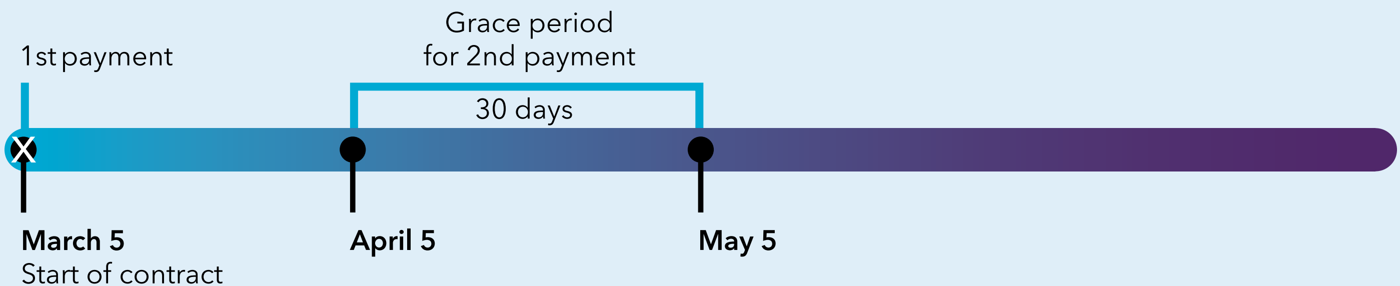
Question 2 – How do I make my *payments* and what happens in case of a late *payment*?

"TERMS OF PAYMENT"

- Payments for this insurance must be made monthly by pre-authorized debit or credit card as selected by the *owner*.
- A *payment* is considered to have been made only when honoured by *your* financial institution.

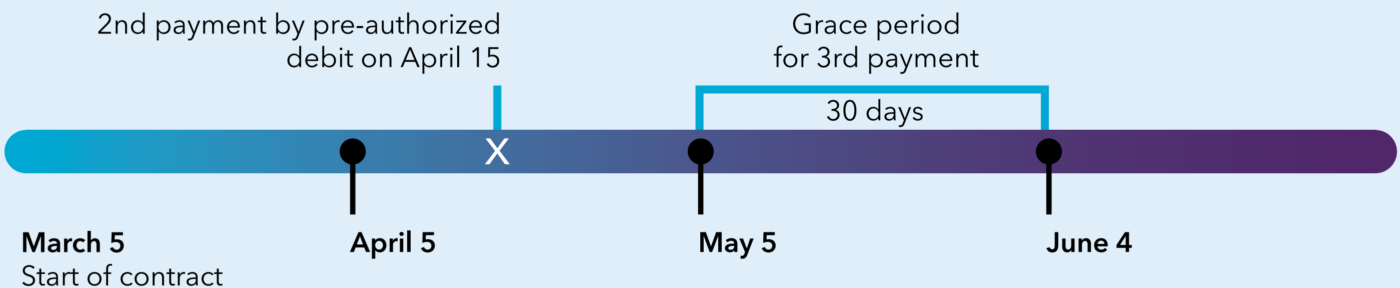
- In the case of a late *payment*, a grace period of thirty (30) days is granted. This means *you* have up to thirty (30) days after the date up until which *your* insurance has been paid to make *your payment*. *You* remain insured during this thirty (30) day period. The *payment* due will be deducted from any *benefit* payable by *Humania Assurance*.
    - If, after the end of the grace period, the *payment* has not been made, the insurance contract will end. A new application will be necessary in order to obtain insurance again.

Mary's contract starts on March 5. She makes her first monthly payment on that date. This first payment provides her with coverage up until April 5. Her grace period for her second payment runs from April 5 to May 5. Therefore, her next payment will have to made before May 5 for her to keep her contract.



Mary decides to set up pre-authorized debits from her bank account on the 15 of each month. Her second monthly payment is made on April 15 via pre-authorized debit. This payment provides her with coverage up until May 5. Her grace period for her third payment runs from May 5 to June 4. Therefore, her next payment will have to be made by June 4 in order for her to keep her contract.

If she does not make her payment on time, by April 5, her contract will end. Mary will have to submit a new application for insurance. The amount of her payments may increase or she may no longer be eligible for coverage.



Question 3 – Can I be covered under more than one insurance contract?

"LIMITATION IN CASE OF MULTIPLE CANCER INSURANCE CONTRACTS WITH *HUMANIA ASSURANCE*"

Yes; however an *insured* cannot be covered for a total amount of more than $75,000 in cancer insurance.

If, by mistake, the total amount of the selected cancer insurance contracts should exceed this limit, *Humania Assurance* will pay a maximum *benefit* of $75,000, cancel the cancer insurance contracts in excess of $75,000 and refund the portion of the overpayments made.

Question 4 – What is covered under my Cancer Insurance and Death *benefit* coverage?

A - "*BENEFIT* FOR *MAJOR CANCER*"

You ***will receive 100% of the amount of insurance*** if *you* are diagnosed with a *major cancer* that is not one of the *early intervention cancers* described in the following section.

A *major cancer* is a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of healthy tissue, diagnosed by a *specialist* and confirmed by means of a *pathology test*. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Your **contract ends after the** ***payment*** **of your** ***benefit*** **for a** ***major cancer*****.**

B - "REDUCED BENEFIT FOR *EARLY INTERVENTION CANCER*"

The *benefit* payable is 15% of the amount of insurance for the following forms of *early intervention cancers*:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in situ (*Tis*), or tumours classified as *Ta*;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as *T1a* or *T1b*, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as *T1*, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than *Rai* stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than *AJCC Stage 2*.

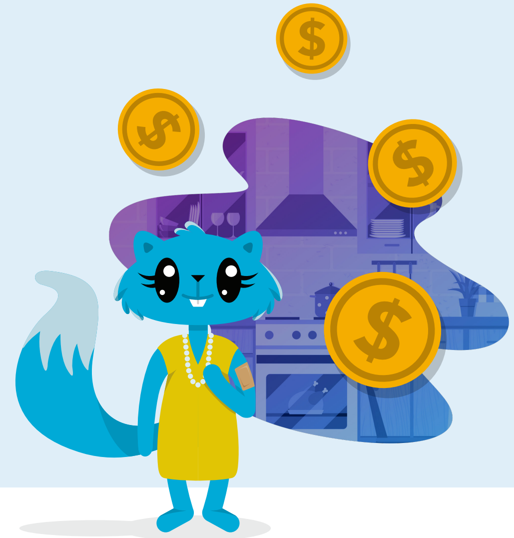
The definitions of early intervention cancers found in this contract were developed with commonly accepted insurance industry standards. If you have any questions about their meaning, speak to your doctor.

Your **contract will continue after** ***your benefit*** **for an** ***early intervention cancer*** **is paid and** ***your payments*** **will remain the same (see Question 7 – How long is the** ***payment*** **amount guaranteed?) If you later develop:**

- a *major cancer*, the remainder of your amount of insurance (85%) will be paid to *you*;
- a second *early intervention cancer*, no *benefit* will be paid to *you*.

Mary chose to be covered for $50,000. Her specialist tells her she has been diagnosed with skin cancer (melanoma). Luckily, Mary has the skin cancer removed while it is still small and measures less than one (1.0) millimetre. She can receive a benefit equal to 15% of $50,000, which is $7,500. Afterwards, she will continue to be protected by her CANCER INSURANCE.

If she is later diagnosed with a major cancer, she will be eligible to receive the remainder of the amount of insurance not yet paid, which is $50,000 minus $7,500, for a total of $42,500. After this second cancer, her insurance contract will end.



C - "DEATH BENEFIT"

If *you* should die while *your* contract is still in force or even within thirty (30) days of a cancer diagnosis, *Humania Assurance* will pay *your beneficiary* an amount equal to 15% of the amount of insurance selected in the application for insurance. At any time, the total amount of *your benefits* may not exceed the amount of insurance you selected.

Question 5 – What exclusions apply?

A - "PRE-EXISTING CONDITION EXCLUSION"

If you suffer from a *covered illness* during the first twenty-four (24) months following *your* contract start date, ***you* are required to notify *Humania Assurance* of the situation** and *Humania Assurance* will review your file:

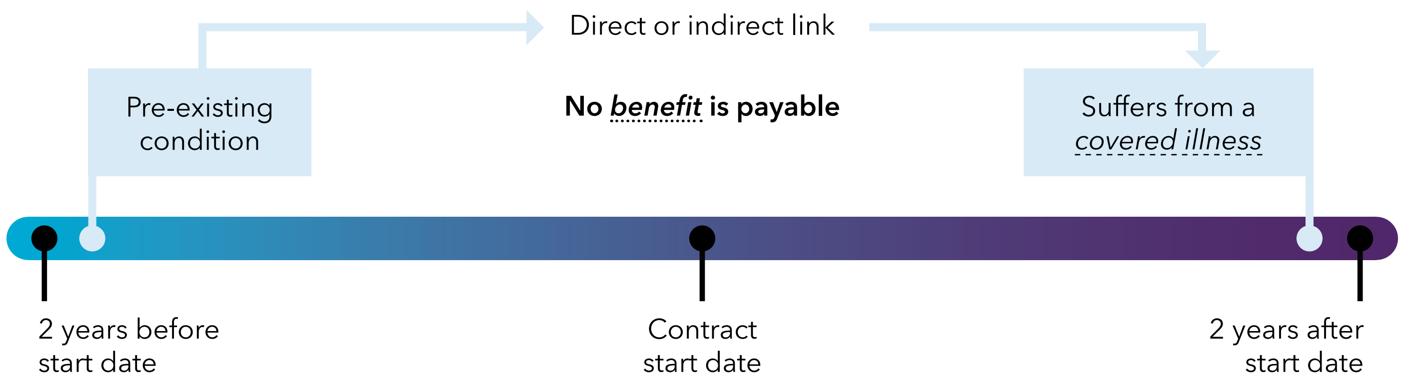
- If *your covered illness* does not result from a *pre-existing condition,* the applicable *benefit* may be paid to *you*;
- If *your covered illness* results directly or indirectly from, or is related in any way to, your *pre-existing condition*, *your* contract will end and all the *payments you* have made will be returned to *you*.

What is a *pre-existing condition*?

Pre-existing condition: an illness or condition for which, during the twenty-four (24) months preceding the contract start date:

- the *insured* was diagnosed or was treated, hospitalized or attended to by a *physician* or other health professional; or
- the *insured* was advised to seek treatment or consult a *physician* or other health professional; or
- the *insured* received a prescription or took medication; or
- the *insured* showed signs or symptoms or underwent tests or investigations.

Illustration of how a *pre-existing condition* exclusion applies



Jane, Mary's friend, has a cough that won't go away. For the past twenty-four (24) months, she's been on medication and consulted her physician. Her cough is a pre-existing condition. Jane decides to take out a CANCER INSURANCE contract.

Case 1: *If, during the first twenty-four (24) months after the contract start date, Jane is diagnosed with lung cancer directly or indirectly related to her cough, no benefit will be payable. Her insurance contract will end and her payments will be returned to her.*

Case 2: *If Jane is diagnosed with kidney cancer which is unrelated to her cough, she could receive a benefit.*

Case 3: *If, after twenty-four (24) months following the contract start date, Jane is diagnosed with any type of cancer, she could receive a benefit, whether or not her cancer is related to her cough.*

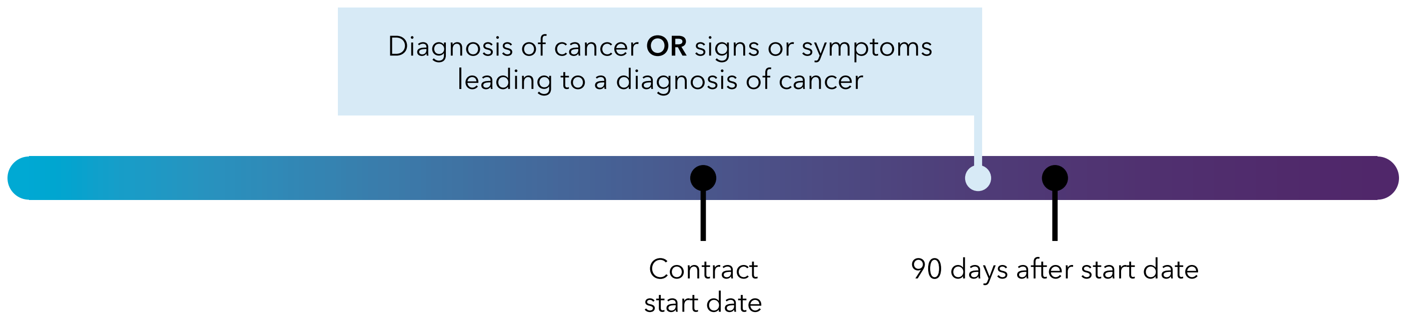
B - "MORATORIUM PERIOD EXCLUSION APPLICABLE ONLY TO CANCER"

No *benefit* will be paid if, within ninety (90) days after the contract start date:

- the *insured* showed signs or symptoms, or underwent investigations, that led to a diagnosis of cancer (whether or not covered by this contract), regardless of the date on which the diagnosis is made; or
- the *insured* was diagnosed with cancer (whether or not covered by this contract).

Your **contract will end and all the** ***payments*** **you have made will be returned to** ***you*****.**

Illustration of how a moratorium period exclusion applies



C - "SURVIVAL PERIOD LIMITATION"

In order for the *benefit* to be paid, *you* must still be alive thirty (30) days after the date of *your* diagnosis, excluding the number of days *you* are kept alive artificially.

If *you* should die before the expiration of this period, *your beneficiary* will receive the death *benefit* described in **Question 4 – What is covered under my cancer insurance and death *benefit* coverage ?, Section C - Death *Benefit*.**

Mary chose to be insured for $50,000. Her specialist tells her that she has been diagnosed with generalized cancer. Unfortunately, Mary's cancer is aggressive and she dies five days later. Her designated beneficiary will be eligible to receive a death benefit equal to 15% of $50,000, or $7,500, but will not be able to claim the full amount of $50,000 for the diagnosis she received.

D - "ADDITIONAL EXCLUSION APPLICABLE TO DEATH *BENEFIT*"

No death *benefit* is payable if death results from suicide within the first two (2) years of the contract, whether the *insured* is sane or insane.

***Your* contract will end and all the *payments you* have made will be reimbursed.**

Question 6 – What is the duration of coverage under my contract?

"DURATION"

The *insured* will remain covered until 11h59 PM on the day before the contract anniversary following your ninetieth (90th) birthday, provided *you* continue to make *your payments*. The contract renews automatically every ten (10) years.

Mary purchased CANCER INSURANCE when she was 56 years old. If she continues to make her monthly payments on time, her contract could end on the day before the contract anniversary following her 90th birthday. She will turn 90 on July 17, 2054 If her contract started on October 10, her contract will end on October 9, 2054.

Question 7 – When can my *payment* amount change?

"GUARANTEE"

- *Your payment* amount will be the same throughout the first ten (10) years of *your* contract.
- Afterwards, at the end of each ten (10) year period, the amount of *your payment* will be adjusted to reflect the age of the ***insured*** **and the applicable rates at that time**.
- **Health will have no impact on the new *payment* amount.**

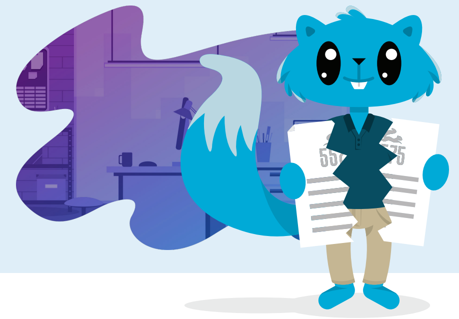
Frank is 60 years old and has severe health problems. He selected $10,000 of insurance at age 53 when he was in perfect health. He currently pays $20 a month. When he turns 63, his new monthly payment will be $32. Even though he now has severe health problems, this has no impact on the increase in his payments. He only needs to make his payments and his coverage will continue.

Question 8 – When does my contract end?

"END OF CONTRACT"

- *Your* insurance contract will end on the earliest of the following dates:
  - the date on which the insurer receives a written and signed cancellation request from the *owner*;
  - the date on which an exclusion ends the contract, as specified in **Question 5 – What exclusions apply?;**
  - the date on which the grace period for any *payment* expires, as specified in **Question 2 – How do I make my *payments* and what happens in the case of a late *payment*?;**
  - the date on which the maximum benefit is paid, as specified in **Question 3 – Can I be covered under more than one insurance contract? and Question 1 - What amount of insurance can I choose?;**
  - the date on which the *insured* dies;
  - at 11h59 on the day before the contract anniversary following the ***insured***'s ninetieth (90th) birthday.

Frank owns a CANCER INSURANCE contract for $10,000. He decides to cancel his contract and sends a written request to Humania Assurance to end his contract. His contract will end the date on which his written request is received by Humania Assurance.



Question 9 – Who does what?

"INSURED, OWNER AND BENEFICIARY"

- The *insured* is the person whose health will be assessed when a claim is submitted.
- The *owner* is the person who owns the insurance contract. He or she has the right to change the *beneficiary* and/or the method of *payment* and to cancel the contract.
- The *beneficiary* is the person who receives the *benefit*.
- *You* can refer to *your* application for insurance to see who is the *insured*, the *owner* and the *beneficiary*. Please note that the *beneficiary* or the *owner* may change if the *owner* submits the applicable form to *Humania Assurance*.

A person can be the owner, insured and beneficiary all at the same time. For example, if Mary insures herself under a CANCER INSURANCE contract, she will be the insured, the owner and the beneficiary all at the same time. She may receive a benefit if she is diagnosed with cancer. Since she is the owner, she can also decide to name her spouse as beneficiary or to cancel her contract.

Question 10 – How do I submit a claim?

"SUBMITTING A CLAIM"

A claim must be submitted in writing using the appropriate forms.

- Claim forms can be obtained on the Humania Assurance website (**www.humania.ca**):
  - to be completed by you:
    - Claim form;
    - Standard authorization to release information (this authorization allows Humania Assurance to obtain medical and financial information relevant to your claim);
    - Authorization specific to your province of residence (this authorization allows Humania Assurance to obtain information relevant to your claim from your provincial health insurance plan);
  - to be provided by your physician:
    - Physician's statement, specific to the *covered illness*;
    - A copy of the *pathology* report.
- You can contact Customer Service any time at 1-800-773-8404 if you need assistance.

Make sure you fill out your forms as completely as possible in order to speed up the processing of your claim. Please note that you are responsible for any charges to obtain this information.

In order to assess your claim to the best of its ability, *Humania Assurance* may also request the following:

- A review of your medical records:
  - By a medical consultant with *Humania Assurance*;
  - By an external *specialist*;
- A medical assessment of the *insured*;
- A copy of your medical records for the past five years.

If that is the case, a full cooperation it ask so that your claim can be processed as quickly as possible.

Section A
Complete Critical Illness Options

Note: All other contract sections apply to your critical illness insurance coverage.

Question 11 – What is covered under my Critical Illness Insurance coverage?

"*BENEFIT* FOR CRITICAL ILLNESSES"

You will receive **100% of your amount of insurance** if you suffer from one of five (5) covered critical illnesses.

Your contract ends after your *benefit* is paid for a critical illness.

The five (5) critical illnesses described below are *covered illnesses*:

Stroke

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 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

- EXCEPT FOR transient ischemic attacks;
- EXCEPT FOR intracerebral vascular events due to trauma;
- EXCEPT FOR lacunar infarcts that do not meet the "stroke" definition as described above.

Coronary artery bypass surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a *specialist*.

EXCLUSION

- EXCEPT FOR angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Heart attack (myocardial infarction)

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

- a rise and fall of biochemical markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
    - heart attack symptoms;
    - new electrocardiogram (ECG) changes consistent with a heart attack;
    - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a *specialist*.

EXCLUSION

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

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 ninety (90) days following the precipitating event. The diagnosis of paralysis must be made by a *specialist*.

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 ninety-six (96) hours, and for which period the Glasgow coma score must be four or less. The diagnosis of coma must be made by a *specialist*.

EXCLUSION

- EXCEPT FOR a medically induced coma;
- EXCEPT FOR a coma resulting directly from alcohol or drug use;
- EXCEPT FOR a diagnosis of brain death.

Mary chose to be covered for $50,000.

***Example 1:** A case of angioplasty and of coronary artery bypass surgery*

Mary has a heart disease. Her doctor recommended that she undergo angioplasty. The angioplasty enables him to unblock Mary's artery with an inflatable balloon and install a stent to keep her artery open. Angioplasty is not a covered illness under the terms of her contract. Consequently, Mary is not eligible to receive a benefit for her angioplasty.

Mary continues to make her monthly payments. Unfortunately, the angioplasty did not unblock her artery sufficiently. Her doctor then recommends that she have coronary artery bypass surgery. If Mary has this bypass surgery, she could receive a benefit equal to 100% of her amount of insurance, which totals $50,000. Her insurance contract will end.

***Example 2:** A case of early intervention cancer and a heart attack*

Mary chooses to add the Complete Critical Illness Option to her CANCER INSURANCE contract. Many years later, Mary is diagnosed with "carcinoma in situ" breast cancer. It is an early intervention cancer. This means she could receive 15% of her amount of insurance, or $7,500.

Mary continues to make her monthly payments. Later, she has a heart attack. Mary will therefore receive 85% of her amount of insurance, totalling $42,500. Her insurance contract will end.

Question 12 – What limitations and exclusions apply for critical illnesses?

"EXCLUSIONS AND LIMITATIONS"

- The ***benefit*** is payable only for the first appearance of a critical illness as defined in the contract.
- The exclusions and limitations outlined elsewhere in your contract also apply to *your* Complete Critical Illness Option coverage. You can find them in the following locations in Section A - Cancer Insurance and Death Benefit:
  - **Question 3 – Can I be covered under more than one insurance contract?**
    "Limitation in case of multiple *Humania Assurance* cancer insurance contracts"
  - **Question 5 – What exclusions apply?**
    A. "*Pre-existing condition* exclusion";
    C. "Survival period limitation".

"ADDITIONAL EXCLUSIONS APPLICABLE TO CRITICAL ILLNESSES"

In addition, no *benefit* is payable for a critical illness if it results from:

- A medical condition that does not meet the definition of the applicable critical illness, as defined **Question 11 – What is covered under my critical illness insurance coverage?;**
- Directly or indirectly, an illness that is diagnosed, or signs or symptoms that are known to exist, or an investigation that is not reported, prior to the contract start date;
- Attempted suicide or intentionally self-inflicted injury or dismemberment, whether the insured is sane or insane;
- Participation by the insured in the commission or attempted commission of an unlawful act or crime, driving a motor vehicle or piloting a boat while under the influence of drugs (including marijuana) or while his or her blood alcohol concentration exceeds the legal limit;
- Service, whether or not as a combatant, with armed forces engaged in surveillance, training, peacekeeping, insurrection, war (whether or not declared) or any related act, or participation by the *insured* in a popular uprising.

Question 13 – When does coverage under the Complete Critical Illness Option or the Cancer Insurance contract end?

"END OF COVERAGE UNDER COMPLETE CRITICAL ILLNESS OPTION OR CANCER INSURANCE CONTRACT"

- Coverage under the Complete Critical Illness Option ends:
  - on the date a written and signed cancellation request is received from the *owner*;
  - at the same time as the CANCER INSURANCE contract, in accordance with **Question 8 – When does my contract end?**
- The CANCER INSURANCE contract ends:
  - on the date a *benefit* is paid under the Complete Critical Illness Option.

While covered under the Complete Critical Illness Option, Mary undergoes coronary artery bypass surgery. She is eligible to receive the amount of insurance she selected upon purchasing her contract, i.e. $50,000.

Her CANCER INSURANCE contract ends when this benefit is paid.

Section B
Definitions

The terms in ***italics* throughout this contract are defined as follows:**

AJCC Stage 2, Tis, Ta, T1a, T1b and T1

These terms are to be applied as defined in the *American Joint Committee on Cancer (AJCC) Cancer Staging Manual* (7th Edition, 2010).

Beneficiary

The beneficiary is the person who receives the *benefit*. If no beneficiary has been named, the beneficiary is:

- if the *insured* is more than eighteen (18) years old:
    - the *insured*, or,
    - if the *insured* has passed away, the estate of the *insured*;
- if the *insured* is less than eighteen (18) years old: the *owner*.

Benefit

The amount payable for a coverage under *your* contract.

Covered illness

An illness shown in the Summary of Coverages.

Early intervention cancer

The following forms of cancer:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in situ (*Tis*), or tumours classified as *Ta*;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as *T1a* or *T1b*, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as *T1*, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than *Rai* stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than *AJCC Stage 2*.

Humania Assurance

Humania Assurance Inc., having its head office at 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8.

Insured

The insured is the person whose medical condition will be assessed when a claim is submitted. It is the person designated as such in the application for insurance.

Insurer

Humania Assurance Inc., having its head office at 1555 Girouard Street West, P.O. Box 10000, Saint-Hyacinthe, Quebec J2S 7C8.

Major cancer

A tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of healthy tissue, diagnosed by a specialist and confirmed by means of a *pathology test*.

Non-smoker

A person who has not used tobacco in any form whatsoever, including nicotine substitutes or nicotine products in the twelve (12) months before submitting the application for insurance.

Owner

The person who owns the insurance contract. He or she has the right to change the *beneficiary* and the payment method, and to cancel the contract. The owner is the person designated as such in the application for insurance or any other written document submitted to the *Insurer*.

Pathology test

Exam results that reveal the type and characteristics of cells and specify whether they are normal, abnormal but non-cancerous, or cancerous. The pathology test is signed by a pathologist.

Payment

The amounts you pay to *Humania Assurance* to maintain your insurance coverages.

Physician

Any person legally authorized to practise medicine in Canada within the scope of his or her medical degree (MD), and who does not have a family or business relationship with the *insured* or the *owner*.

Rai

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

Specialist

A *physician* who holds a licence and has specialized medical training related to the *covered illness* for which a claim has been submitted.

You, Your

Refers to the *insured*, the *owner* or the *beneficiary*, depending on the context. For more details on each of these roles, please refer to **Question 9 – Who does what?**

Section C
Statutory Conditions

An insurance contract is highly regulated. In order to protect consumers, most provinces and territories require insurers to have specific clauses which must be included as is in an insurance contract. Here are these mandatory clauses:

The contract

Sections A to D of this contract, your application for insurance, and any amendments to the contract agreed upon in writing after the contract is issued constitute the entire contract, and no agent has the authority to change the contract or waive any of its provisions.

The *insurer* is required, upon request, to provide the *owner* or a claimant under the contract with a copy of the application for insurance.

Material facts

No statement made by the *insured* at the time of application for this contract shall be used in defence of a claim under or to avoid this contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

Notice and proof of claim

The *insured*, the *owner* or a *beneficiary* entitled to make a claim, or the agent of any of them, shall:

a) give written notice of claim to the *insurer*:
   (i) by delivery thereof, or by sending it by registered mail to the head office or chief agency of the *insurer* in the province; or
   (ii) by delivery thereof to an authorized agent of the *insurer* in the province;

   no later than thirty (30) days after the date a claim arises under the contract on account of an accident or an illness;

b) within ninety (90) days from the date a claim arises under the contract on account of an accident or illness, furnish to the *insurer* such proof as is reasonably possible in the circumstances of the occurrence of the accident or the commencement of the illness, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the beneficiary, if relevant;

c) if so required by the *insurer*, furnish a satisfactory certificate as to the cause or nature of the accident or illness for which a claim may be made under the contract, as well as the duration of the illness.

Failure to give notice or proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if:

a) the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the accident or the date a claim arises under the contract on account of illness if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed; or

b) in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than one year after the date a court makes the declaration.

Insurer to furnish claim forms

The *insurer* shall furnish claim forms to any *owner* or claimant upon request. However, if a claimant has not received the forms within fifteen (15) days the claimant may submit proof of claim in the form of a written statement outlining the cause or nature of the accident or illness giving rise to the claim and of the extent of the loss.

Rights of examination

As a condition precedent to the recovery of insurance money under this contract:

a) the claimant shall afford to the *insurer* an opportunity to examine the person insured when and so often as it reasonably requires while the claim hereunder is pending; and

b) in the case of the death of the person insured, the *insurer* may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

Claims

Any *benefit* payable by the *insurer* under this contract shall be paid within sixty (60) days after it has received any document or information required by the *insurer*.

Limitation

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act* or any other applicable statute.

Section D
General Conditions

Contract start date

This contract of insurance takes effect from the start date of your contract as shown in the **Summary of Coverages**, provided the first *payment* has been made.

Grace period

There is no grace period for the first *payment*, as it must be made for the insurance contract to take effect. If *Humania Assurance* does not receive the first payment when due, this contract will be treated as if it had never been issued.

A grace period of thirty (30) days is granted for other *payments*. If the *payment* has not been made after the grace period, the contract will no longer be in effect and will end without value.

If you are diagnosed with a *covered illness* during the grace period, any *payment* due will be deducted from the *benefit* paid by *Humania Assurance*.

Dividends and cash value

The *owner* is not eligible to receive dividends or a cash value on this contract of insurance.

Disclosure

The *insured*, the *owner* and the *beneficiary* are required to cooperate fully with *Humania Assurance* and have to disclose to *Humania Assurance* in the application and in any written statements or answers given as evidence of insurability, in the claim and upon diagnosis of a *covered illness*, every fact within the person's knowledge that is material to the insurance and is not disclosed by the other.

The *insured*, the *owner* and the *beneficiary* are also required to sign every form or other document allowing *Humania Assurance* to obtain any relevant information.

Subject to the provisions of this contract pertaining to incontestability and age, a failure to disclose or a misrepresentation of a fact in the application or in any written statements or answers given as evidence of insurability renders this contract voidable by the *insurer*.

Incontestability

Where this contract has been in effect continuously for two (2) years with respect to a person insured, a failure to disclose or a misrepresentation of a fact with respect to that person does not, except in the case of fraud, render the contract voidable.

However, this rule does not apply if a claim is made for a *covered illness* diagnosed before this contract has been in force for two (2) years in respect of the person for whom the claim is made.

Waiver

Humania Assurance will not be deemed to have waived a condition contained in this contract, either wholly or partially, unless such waiver is clearly expressed in a written notice signed by *Humania Assurance*.

Change of *beneficiary*

Subject to compliance with requirements of applicable law, the *owner* may at any time designate, change or revoke a *beneficiary*. For a change of beneficiary to be recognized, *Humania Assurance* must receive written notice of that change. The *insurer* bears no responsibility with respect to the validity of a *beneficiary* designation.

Benefits payable to the *beneficiary*

Benefits will be paid to the *beneficiary*, unless a notice to the contrary is submitted in writing to *Humania Assurance*.

Diagnosis in Canada

The diagnosis of a *covered illness* must be made by a *specialist* licensed to practise in Canada and must be confirmed by customary modern investigation techniques appropriate to the illness at the time of claim.

Diagnosis outside Canada

When a *covered illness* is diagnosed outside Canada by a specialist practising in a jurisdiction deemed acceptable by the *insurer*, the *benefit* will be paid provided all the following conditions are met:

a) the *insurer* has received all medical records;

b) based on the medical records received, the *insurer* is satisfied that:

- i) the same diagnosis would have been made had the *covered illness* been diagnosed by a duly licensed *specialist* practising in Canada;
- ii) the same treatment would have been prescribed in accordance with Canadian standards; and
- iii) the same treatment, including any necessary surgery, would have been prescribed had the treatment been administered in Canada.

Reimbursement

No cheque in reimbursement of payments will be issued for amounts of less than twenty (20) dollars.

Currency

Any amount paid under the provisions of this contract will be made in the legal currency of Canada.

Right to change mind

The *owner* may obtain cancellation of this contract, within fifteen (15) days after reception by the *insurer* or within sixty (60) days after the contract start date. A written and signed cancellation notice must be received by *Humania Assurance* within these time limits. Any *payment* received under the contract will then be returned to the *owner*.

Compliance with the law

Any provision of the contract that, at the contract start date, does not comply with applicable legislation in the province where the contract was issued will be modified so as to meet the minimum requirements of that legislation.

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