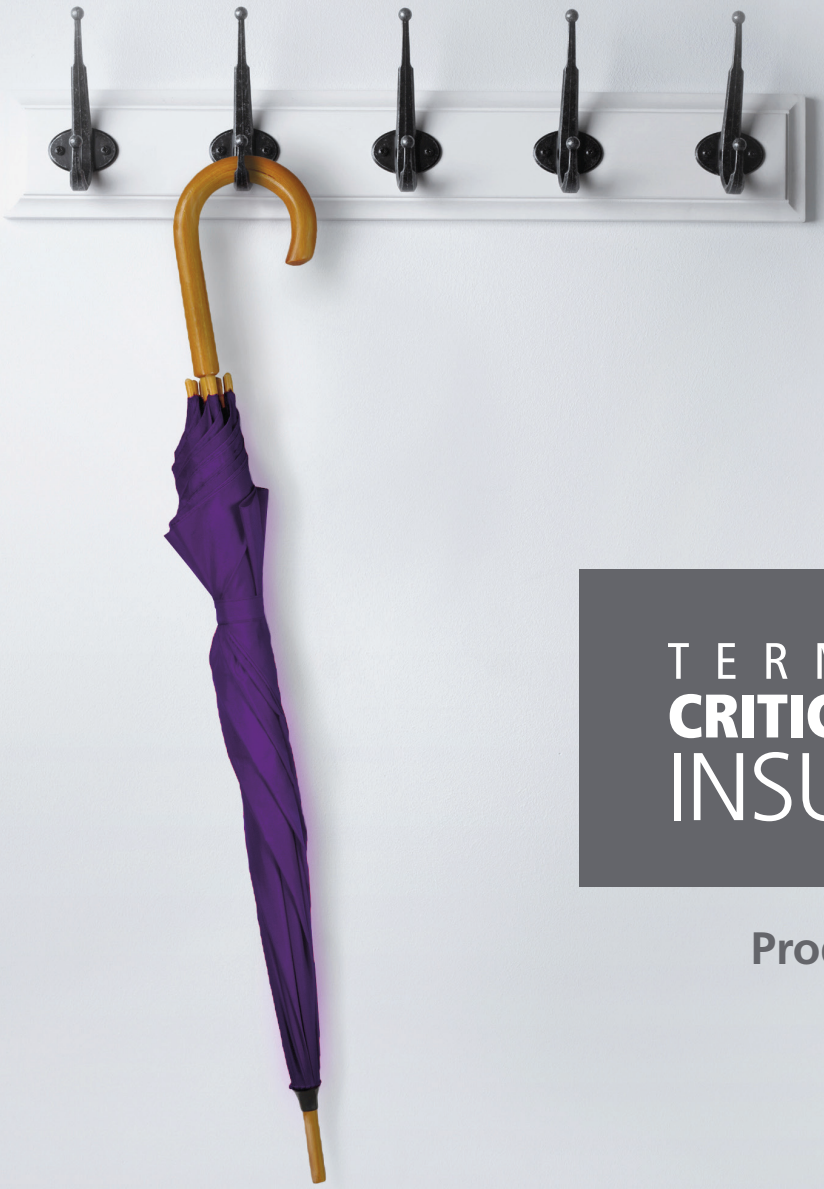

TERM CRITICAL ILLNESS INSURANCE

Product Guide

HUMANIA ASSURANCE MD®

SUMMARY

TERM CRITICAL ILLNESS INSURANCE
RENEWABLE TO AGE 75, CONVERTIBLE TO AGE 60

ELIGIBILITY AND POLICY FEATURES

Coverage available:

Term Critical Illness Insurance renewable	Age at issue
10 years	0-64
15 years	0-59
20 years	0-54
25 years	0-49
30 years	0-44
75 years	0-65

Minimum benefit: $25,000

Maximum benefit: $1,000,000

Definition of age: Last birthday

Termination age: Policy anniversary following date on which Insured reaches age 75.

Minimum premium:

- $12 including policy fees (if written alone)
- No minimum premium (if written and issued jointly with a policy eligible for multiple policy discount or family discount).

Guaranteed premium and non-cancellable coverage: Premiums are not subject to adjustments to reflect experience.

Issuance of insurance policies: Separate policy for each term selected.

Increase: Any increase in the amount of insurance or several desired terms will require the purchase of a separate policy.

Convertible: To age 60.

Conversion Option: To Age 60

While the Critical Illness coverage under this Policy is in force and prior to the policy anniversary immediately following the Life Insured's sixtieth (60th) birthday, the Policyowner may request that such coverage be converted without evidence of the Insured's insurability, to a new permanent Critical Illness insurance policy with similar benefits as designated by the Insurer on this date. The converted benefit cannot exceed the benefit indicated in the Schedule of Benefits.

The premium for the new policy shall be based on:

- the Insured's Insurance Age at the time of conversion;
- the premium rates in use at the date of conversion; and
- the Risk Class of this coverage.

If this coverage is issued with an extra premium or with limitations and exclusions, the converted coverage will also be issued subject to the same conditions.

If, at the time of conversion, this coverage includes the Waiver of Premium Coverage, the new policy will also include a Waiver of Premium Coverage, provided the Insured's premiums are not waived at the time of conversion.

Limitation

If the conversion occurs while the Insured's premiums are waived, the new policy will not include that coverage and the Policyowner will be required to pay the premiums.

GENERAL EXCLUSIONS

The following exclusions apply to the Critical Illness coverage and to the Waiver of Premium and the Accidental Death and Dismemberment benefits if those coverages are part of the policy. No Critical Illness, **Waiver of Premium** or **Accidental Death and Dismemberment benefits** will be payable that result from:

- attempted suicide or intentionally self-inflicted Injury or dismemberment, whether the Insured is sane or insane;
- the Insured's participation 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 narcotics or while his or her blood alcohol concentration exceeded the legal limit;
- drug addiction, alcohol abuse or the use of hallucinogens, drugs or narcotics;
- 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 the Insured's participation in a popular uprising.

No **Waiver of Premium** or Accidental Death and Dismemberment benefits will be payable that result from:

- injury sustained during a flight, except if the Insured is a passenger on an aircraft operated by a common carrier;
- cosmetic surgery or elective surgery, and any resulting complication;
- experimental treatments and treatments involving the application of new procedures or new treatments that are not yet standard practice.

No **Waiver of Premium** benefit will be payable for:

- any period during which the Insured is entitled to paid leave under an agreement between the Insured and his or her employer;
- pregnancy, childbirth, miscarriage or any resulting condition, except in the case of a pathologic complication;
- any period during which the Insured is incarcerated in a penitentiary or a government detention facility.

LIST OF COVERED CRITICAL ILLNESSES

Insureds age 18 or over can choose between the following two plans:

- a) only the first four illnesses below; or
- b) the complete list

For Insureds under 18 years of age, only the complete 25 illnesses list is available.

Basic

1) **Cancer**
2) **Coronary surgery (coronary artery bypass)**
3) **Heart attack (myocardial infarction)**
4) **Stroke (cerebrovascular accident)**

Enhanced

5) Alzheimer's disease
6) Aortic surgery
7) Autism
8) Benign brain tumour
9) Blindness
10) Burns
11) Coma
12) Cystic fibrosis
13) Deafness
14) Heart valve replacement
15) Kidney failure
16) Loss of autonomy
17) Loss of limbs
18) Loss of speech
19) Major organ failure (on waiting list)
20) Major organ transplant
21) Motor neuron disease
22) Multiple sclerosis
23) Occupational HIV infection
24) Paralysis
25) Parkinson's disease

N.B.: Two coverages, one for four illnesses and the other for 25 illnesses, are not allowed under the same policy.

Benefit payable for diagnosis of non-life-threatening cancer (offered exclusively with the complete 25 conditions list)

The amount of benefit payable for a non-life-threatening cancer is 10% of the principal sum, to a maximum of $10,000. This benefit is payable once only while the coverage is in force and will be deducted from any other benefit payable under this coverage or the Premium Refund at Age 65 rider of this policy. If the 15-Year Premium Refund rider has been selected, the benefit payable for a non-life-threatening cancer will trigger a new refund period.

Definition of Non-Life-Threatening Cancer:

- stage T1a or T1b (stage A) prostate cancer; or
- stage 1A malignant melanoma as defined by the TNM classification (melanoma less than or equal to one point zero (1.0) millimetre in thickness, not ulcerated and without Clark level IV or level V invasion); or
- ductal carcinoma in situ of the breast (requires confirmation by biopsy).

THREE TYPES OF COVERAGE

1) Critical Illness only

The Insurer will pay the Critical Illness benefit if the Insured is diagnosed with one of the covered illnesses. However, this benefit will be payable only if the Insured is still living 30 days after the date of diagnosis or during the period specified for the diagnosed covered illness, excluding the number of days during which the person is kept on life support.

2) Critical Illness / Life Insurance

The Insurer will pay, upon the earlier of the following two events:

a) the Critical Illness benefit, if the Insured is diagnosed with one of the covered illnesses; however, this benefit will be payable only if the Insured is still living 30 days after the date of diagnosis or during the period specified for the diagnosed covered illness, excluding the number of days during which the person is kept on life support; or

b) in the event of the Insured's death, the Critical Illness benefit.

3) Critical Illness / Return of Premiums Upon Death

The Insurer will pay, upon the earlier of the following two events:

a) the Critical Illness benefit, if the Insured is diagnosed with one of the covered illnesses; however, this benefit will be payable only if the Insured is still living 30 days after the date of diagnosis or during the period specified for the diagnosed covered illness, excluding the number of days during which the person is kept on life support; or

b) in the event of the Insured's death, a benefit equal to the total amount, without interest, of the premiums paid for this Critical Illness coverage and the administrative fees paid during the period of this coverage, subject to a maximum refund not exceeding the Critical Illness benefit and excluding the waived premiums paid by the Insurer.

N.B.: In each of the three coverages described above, any amount that has been paid for non-life-threatening cancer will be deducted from the amount of benefit payable (not applicable to four-illness coverage).

MULTIPLE POLICY DISCOUNT / FAMILY DISCOUNT

Eligibility Requirements

1. **Policies must be received and issued at the same time,** as they will be group-processed.
2. At the time of purchase, a **Pre-Authorized Debit Agreement must be completed and signed for each insurance application submitted.**
3. The fee discount applies only to TERM INSURANCE series administration fees, never to products such as PAIRE, ASSURE-DEBT, Prodige or Survie 2000.
4. Humania Assurance - Insurance Without Medical Exam and P.A.G.E. are not eligible for discount.

Discount Rules and Guidelines

Multiple Policy Discount:

If the same individual purchases, for himself or herself, a TERM series policy plus one or more additional policies (PAIRE, ASSURE-DEBT, Prodige, Survie 2000, Term Critical Illness and/or Term Life), the following rules apply:

- The administration fee for the first policy (PAIRE, ASSURE-DEBT, Prodige, Survie 2000 or TERM) will apply and the subsequent TERM policy or policies will not be subject to an administration fee.
- However, if the individual purchases, for example, a PAIRE and Prodige product: no fee discount, as the discount applies to the TERM series product only.

Family Discount:

The family discount is based on policies with the same payer (same bank account). Applications are submitted and issued at the same time, and policies have the same effective date. The discount is applicable for one family only: grandparent, parent, spouse, child (the discount does not apply to policies where a company or organization is the policyholder or payer).

- The administration fee for the first policy (PAIRE, ASSURE-DEBT, Prodige, Survie 2000, Term Critical Illness or Term Life) with the same payer and for the same family will apply.
- The administration fee for the second TERM series policy will be reduced by 50%: $37,50.
- Subsequent TERM series policies (three or more with the same payer and for the same family) will not be subject to an administration fee.

N.B.: Administration fees are payable at all times for the following products: PAIRE, ASSURE-DEBT, Prodige and Survie 2000. If the policy for which an administration fee is payable is no longer in force, the applicable administration fee will be charged on another eligible policy, where applicable, otherwise the discount will be cancelled and the administration fees for the TERM product will be payable.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Benefits

Accidental Death

If the Life Insured dies as a result of an Accidental Injury, the Insurer will pay the benefit indicated in the Schedule of Benefits, provided this Accidental Death and Dismemberment coverage is in force at the time the Life Insured suffers such Accidental Injury and the death of the Life Insured occurs on the date or within the three hundred and sixty-five (365) day period immediately following the date on which the Life Insured's Accidental Injury occurs.

Dismemberment

If, as a result of an Accidental Injury that occurs while this Accidental Death and Dismemberment coverage is in force, the Life Insured loses a limb, sight, hearing or speech, the Insurer will pay the percentage indicated below of the Dismemberment Benefit indicated in the Schedule of Benefits related to the loss:

100%	for both (2) feet or both (2) hands;
100%	for one (1) hand and one (1) foot;
100%	for one (1) hand and sight in one (1) eye;
100%	for one (1) foot and sight in one (1) eye;
100%	for hearing in both (2) ears and speech;
100%	for sight in both (2) eyes;
50%	for one (1) foot or one (1) hand;
50%	for hearing in both (2) ears or speech;
12.5%	for sight in one (1) eye;
12.5%	for hearing in one (1) ear;
2.5%	for two (2) or more phalanges of the same finger or the same toe.

Definitions

Dismemberment or Total Loss of Use:

- of a hand or a foot: the complete severance at or above the wrist or ankle joint; where there is no severance, total and permanent loss of use of the hand or foot;
- of speech: definite diagnosis of the total and irreversible loss of the ability to speak. The diagnosis of loss of speech must be made by a specialist.
- of an eye: the total and irrecoverable loss of sight in one (1) eye (visual acuity of twenty over two hundred (20/200) or less, or a field of vision of less than twenty (20) degrees);
- of hearing: the total and irrecoverable loss of hearing in both (2) ears, with a hearing threshold of ninety (90) decibels or over within a speech threshold of five hundred (500) to three thousand (3,000) cycles per second, confirmed by an otolaryngologist registered and licensed to practice in Canada;
- of a finger or toe: the complete severance of at least two (2) phalanges of the same finger or the same toe.

Limitations

If the Life Insured dies as a result of an Accidental Injury for which an Accidental Death benefit is payable under this Policy, no benefits shall be payable for any Accidental Dismemberment or Loss of Use suffered by the Life Insured as a result of the same Accident.

Benefits are not cumulative. In the event of multiple losses due to any one Accident, only one benefit amount, the largest, will be payable.

The Insurer will pay a benefit for a Total Loss of Use only if the Total Loss of Use remains a Total Loss of Use for a period of more than three hundred and sixty-five (365) consecutive days immediately following the date on which the Accident that caused the Total Loss of Use occurred.

The total of any benefits for Accidental Dismemberment or Total Loss of Use that become payable under this Policy cannot exceed one hundred percent (100%) of the benefit for Accidental Dismemberment or Total Loss of Use indicated in the Schedule of Benefits.

Any Dismemberment or Total Loss of Use of the Life Insured that exists as of the date on which this Policy is issued is not a loss covered under this Policy and the Insurer is not responsible to pay any benefits under this Policy in relation to such Dismemberment or Total Loss of Use.

The total amount of all benefits payable by the Insurer in respect of any one Life Insured for Accidental Dismemberment or Total Loss of Use cannot exceed five hundred thousand dollars ($500,000). If the amount of insurance coverage for Accidental Death and Dismemberment with respect to the Life Insured is greater than five hundred thousand dollars ($500,000) with the Insurer, regardless of the number of coverages in force with the Insurer, the Insurer will pay a single benefit equal to the coverage entitling the Policyowner to the highest amount and the Insurer will refund, to the Policyowner, all premiums paid for the Accidental Death and Dismemberment coverage for which no benefit is paid.

Termination of Coverage

In addition to the terms of this Policy's General Provisions, this Accidental Death and Dismemberment coverage terminates at the earliest of the following dates:

- the date a written request from the Policyowner is received by the Insurer stating that he wishes to terminate this Accidental Death and Dismemberment coverage or the date stipulated in that request if such date is later than the date of receipt by the Insurer;
- the Policy anniversary following the Life Insured's seventy-first (71st) birthday; or
- the date on which the Life Insured dies.

General Provisions

The definitions, limitations and exclusions of this Accidental Death and Dismemberment coverage apply in addition to those indicated in this Policy's General Provisions.

15-YEAR PREMIUM REFUND BENEFIT

Eligibility Requirements:

- Be between 0 and 65 years old;
- The coverage must be chosen when the policy is issued, and nothing can be added once it's taken effect.

IMPORTANT: It is necessary to consult a specialist ahead of time concerning any fiscal consequences that may result from adding premium refunding coverage to your contract. Premium refunds may constitute taxable income and it is your responsibility to be informed of the resulting implications.

Benefit

Under this rider, the Insurer will reimburse seventy-five percent (75%) of the Refundable Premiums for the Refund Period, provided the Insured is living at the date the Refund Period is completed. The refund is payable to the Beneficiary designated by the Policyowner.

Limitations

The refund applies to coverages that were issued before age sixty (60) and that have not been cancelled at the Policyowner's request.

Exclusions

The refund excludes:

- waived premiums paid by the Insurer.

Definitions

Refund Period: the period of fifteen (15) consecutive years of coverage beginning at the effective date of each coverage, during which no benefit was paid or is payable. If the Insurer pays a benefit of any kind, a new Refund Period begins to elapse at the date on which the next payable premium is paid following the date of the last benefit payment, provided the Insured is under age sixty (60).

Premiums Paid: premiums paid by or on behalf of the Policyowner to the Insurer, for all coverages under the Policy for which the benefit amount has not been reduced by more than twenty-five percent (25%) at the Policyowner's request.

If the benefit amount has been reduced by over twenty-five percent (25%) at the Policyowner's request, the resulting premium shall be considered to have been the premium paid from the start of the Refund Period for the purpose of this rider.

Refundable Premiums: the sum of all Premiums Paid to the Insurer, since the beginning of the Refund Period, for each in-force coverage at the start of the Refund Period.

PREMIUM REFUND AT AGE 65 BENEFIT

Eligibility Requirements:

- Be between 15 and 50 years of age;
- Coverage must be selected when the policy is issued, no additions possible after the effective date.

Benefit

When the Insured reaches the insurance age of sixty-five (65), the Insurer will pay the sum of refundable premiums less any benefits that may have been paid by the Insurer since the date on which the Policy was issued. The refund is payable to the Beneficiary designated by the Policyowner.

Limitations

The refund applies to coverages that have not been cancelled at the Policyowner's request.

Exclusions

The refund excludes:

- waived premiums paid by the Insurer.

Definitions

Refundable Premiums: the sum of premiums for all coverages eligible for a refund. For each coverage, the amount of refundable premiums will be equal to the sum of the premiums paid multiplied by the refundable percentage applicable to the coverage.

The percentage applicable to the premiums paid varies depending on the Insured's age when each coverage was issued, as follows:

Age of Insured when coverage was issued	Refundable percentage
0 to 40	100%
41 to 50	75%
51 and over	0%

Premiums Paid: premiums paid by or on behalf of the Policyowner to the Insurer, for all coverages under the Policy for which the benefit amount has not been reduced by more than twenty-five percent (25%) at the Policyowner's request.

If the benefit amount has been reduced by over twenty-five percent (25%) at the Policyowner's request, the resulting premium shall be considered to have been the premium paid from the start of the Refund Period for the purpose of this benefit.

Early Premium Refund

Beginning when the Insured reaches age sixty (60), the Policyowner may, upon written request, choose to terminate his or her Policy in order to benefit from an early premium refund. In this case, the refundable percentages indicated above are reduced by half of one percent (0.5%) per month remaining before the Insured reaches age sixty-five (65).

TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT

Age at issue: 18 to 60 years of age (last birthday);

Termination age: policy anniversary following the date on which the Insured reaches age 65;

Waiting period: 6 consecutive months;

Benefits

While this coverage is in force, the Insurer will waive policy premiums until the policy anniversary following the date on which the Insured reaches sixty-five (65) years of age, provided the Insured satisfies the following requirements:

- the Insured has been totally disabled for a period of six (6) consecutive months;
- the Insured's total disability is due to an accident or illness that occurred while this coverage is in force; and
- the Insured is still totally disabled.

When the Insurer determines that the Insured is eligible for waiver of premiums under the policy, all premiums due for the policy, during the qualifying period, will be waived retroactively.

Termination of Coverage

In addition to the specifications set out in the General Provisions section of the policy, this Waiver of Premium coverage will terminate on the earliest of the following dates:

- the date on which the Insurer receives a written request from the Policyowner to cancel the Insured's Waiver of Premium coverage, or the date indicated by the Policyowner in such request if later than the date received by the Insurer;
- the policy anniversary following the date on which the Insured reaches sixty-five (65) years of age; or
- the date on which the Insured dies.

General Provisions

The definitions, limitations and exclusions of this Waiver of Premium coverage apply in addition to those indicated in this Policy's General Provisions.

LIST OF COVERED CRITICAL ILLNESSES

Insureds age 18 or over can choose between the following two plans:

- a) only the first four illnesses below; or
- b) the complete list

For Insureds under 18 years of age, only the complete 25 illnesses list is available.

Basic

1) **Cancer**
2) **Coronary surgery (coronary artery bypass)**
3) **Heart attack (myocardial infarction)**
4) **Stroke (cerebrovascular accident)**

Enhanced

5) Alzheimer's disease
6) Aortic surgery
7) Autism
8) Benign brain tumour
9) Blindness
10) Burns
11) Coma
12) Cystic fibrosis
13) Deafness
14) Heart valve replacement
15) Kidney failure
16) Loss of autonomy
17) Loss of limbs
18) Loss of speech
19) Major organ failure (on waiting list)
20) Major organ transplant
21) Motor neuron disease
22) Multiple sclerosis
23) Occupational HIV infection
24) Paralysis
25) Parkinson's disease

N.B.: Two coverages, one for four illnesses and the other for 25 illnesses, are not allowed under the same policy.

Benefit payable for diagnosis of non-life-threatening cancer (offered exclusively with the complete 25 conditions list)

The amount of benefit payable for a non-life-threatening cancer is 10% of the principal sum, to a maximum of $10,000. This benefit is payable once only while the coverage is in force and will be deducted from any other benefit payable under this coverage or the Premium Refund at Age 65 rider of this policy. If the 15-Year Premium Refund rider has been selected, the benefit payable for a non-life-threatening cancer will trigger a new refund period.

Definition of Non-Life-Threatening Cancer:

- stage T1a or T1b (stage A) prostate cancer; or
- stage 1A malignant melanoma as defined by the TNM classification (melanoma less than or equal to one point zero (1.0) millimetre in thickness, not ulcerated and without Clark level IV or level V invasion); or
- ductal carcinoma in situ of the breast (requires confirmation by biopsy).

TELADOC MEDICAL EXPERTS ASSISTANCE PROGRAM

TELADOC® Medical Experts

Humania Assurance provides, free of charge, access to the world renowned integrated service of Medical Experts from Teladoc. For any health problem, simple or complex, anyone in your immediate family can receive the best advice and treatment available.

Four levels of service are available:

Find a Doctor

With Find a Doctor service, Teladoc Medical Experts carry out a tailor-made search of Canadian specialists to find those who are most qualified to meet your specific medical needs, criteria and geographical preference.

Care Finder

Help locate specialists or facilities outside of Canada for your treatment/condition needs. You can use 450 subspecialities.

Personal Health Navigator

Get a variety of information that's condition-specific from a registered healthcare professional including articles, and community resources that can assist your medical needs.

Expert Medical Opinion

Review of an existing diagnosis and treatment from a world-renowned expert to confirm them or recommend a change.

The services provided are not an integral part of the insurance policy. Humania Assurance has no obligation, based on the terms and conditions of the policy, to provide these services and can, at its discretion, at any time and without notice, cancel the access to these services.

SPECIAL PROVISIONS FOR CRITICAL ILLNESS INSURANCE

Payment Conditions

The benefit is payable only for the first manifestation of a Critical Illness.

Critical Illness benefits are not cumulative. As such, the Insurer's liability is limited to a single benefit under this coverage, that is, the benefit that entitles the Insured to the highest amount. However, an exception applies with respect to the benefit for Non-Life-Threatening Cancer (not applicable to four-illness coverage).

Diagnosis in Canada

The diagnosis of a Critical Illness must be made by a Specialist Physician licensed to practice in Canada and must be confirmed by customary modern investigation techniques appropriate to that Illness at the time of claim.

Diagnostic Outside Canada

When a Critical Illness is diagnosed outside Canada by a Specialist Physician exercising in a jurisdiction deemed acceptable by the Insurer, the benefit is 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 certain that:

   i. the same diagnosis would have been made had the Critical Illness or Accident been diagnosed by a duly licensed Specialist Physician practicing in Canada; and

   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.

The Insurer may require the Insured to undergo one or more independent medical examinations with a Physician of the Insurer's choice. In the case of elective surgery, the required medical examination must be performed prior to the surgery.

Exclusions

In addition to the exclusions stipulated in the General Provisions, no amount is payable if the Illness or Accident results directly or indirectly from an undeclared Illness that is diagnosed, or from undeclared signs or symptoms that are known or are being investigated, before the date at which the coverage is issued.

No benefit is payable for any Cancer or Benign Brain Tumour (not applicable to four illnesses coverage), for the entire duration of the coverage, if the date of diagnosis for any Cancer whether covered or excluded under this coverage or Benign Brain Tumour occurs within ninety (90) days of the coverage's effective date or reinstatement, or if the date at which signs or symptoms appear or at which medical consultations or tests leading to a diagnosis of any Cancer whether covered or excluded under this coverage or Benign Brain Tumour are conducted within ninety (90) days of the coverage's effective date or reinstatement.

Disclosure Obligation

Any diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

FOUR ILLNESSES COVERAGE

Under the four illnesses coverage, your client will be covered for the following illnesses:

Cancer is defined as:

A tumour characterized by the uncontrolled proliferation and spread of malignant cells and the invasion of tissue.

The following forms of cancer are excluded:

- carcinoma in situ;
- stage 1A malignant melanoma as defined by the TNM classification (no more than one (1.0) millimetre thick, without ulceration and without invasion at Clark's Level IV or V);
- any non-melanoma skin cancer that has not become metastatic (spread to adjacent organs);
- stage A (T1a or T1b) prostate cancer.

Moratorium period: No benefit is payable for any Cancer when the earliest of the following dates occurs within ninety (90) days of this coverage's effective date or reinstatement:

- the date of diagnosis for any Cancer, whether covered or excluded; or
- the date at which any early signs or symptoms for any Cancer, whether covered or excluded, appear; or
- the date at which the Insured has any medical consultation or test leading to the diagnosis of any Cancer, whether covered or excluded.

However, these exclusions do not result in termination of the coverage. The Insured remains insured against the other covered Illnesses.

Disclosure Obligation: Any diagnosis of Cancer (whether covered or excluded under this coverage) or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Coronary Surgery (coronary artery bypass surgery) is defined as:

Heart surgery that uses a coronary artery bypass to correct the narrowing or obstruction of at least one coronary artery. Non-surgical procedures such as angioplasty and laser relief of obstruction are not covered.

Heart Attack (myocardial infarction) is defined as:

Necrosis of a portion of the cardiac muscle resulting from inadequate blood supply, as evidenced by:

- recent electrocardiographic (ECG) changes indicative of a myocardial infarction; and
- elevation of cardiac biochemical markers to levels considered diagnostic for infarction.

Heart Attack during an angioplasty is covered provided new Q-wave changes on the electrocardiogram are diagnosed in addition to the elevation of cardiac markers.

Heart Attack does not include incidental discovery of ECG changes suggestive of a past symptomless myocardial infarction or a past myocardial infarction without a corroborating medical event.

Stroke is defined as:

A cerebrovascular accident that produces neurological sequelae that last over thirty (30) days and are caused by thrombosis, hemorrhage or extracranial embolism. There must be evidence of objective, measurable neurological deficit. Transient ischemic attacks (TIAs) are specifically excluded.

25 ILLNESSES COVERAGE

Under the 25 illnesses coverage, the four illnesses described above are covered, plus the illnesses defined below:

Cancer as defined above.

Coronary Surgery (coronary artery bypass surgery) as defined above.

Heart Attack (myocardial infarction) as defined above.

Stroke as defined above.

Alzheimer's Disease is defined as:

A definitive clinical diagnosis, by a Specialist, of Alzheimer's disease, which is a progressive degenerative disease of the brain. The Insured must present signs of significant loss of intellectual capacity impairing memory and judgment and resulting in significantly reduced mental and social functioning, such that the Insured requires continuous daily supervision. All other dementing organic brain disorders or psychiatric Illnesses are excluded.

Aortic Surgery is defined as:

Surgery to correct a condition of the aorta requiring surgical replacement of the affected artery with a graft. "Aorta" or "aortic" refers to the thoracic and abdominal aorta, excluding its branches.

Autism is defined as:

An organic abnormality in brain development, characterized by the inability to develop a language of communication or other forms of social communication. The diagnosis must be confirmed by a Specialist before the Insured's third (3rd) birthday.

Benign Brain Tumour is defined as:

A non-malignant tumour of the brain or meninges. The histological nature of the tumour must be confirmed by an examination of tissues through biopsy or surgical excision. Tumours of the bony cranium and pituitary microadenomas of less than ten (10) millimetres in diameter are excluded.

Moratorium period: No benefit is payable for any Cancer or Benign Brain Tumour when the earliest of the following dates occurs within ninety (90) days of this coverage's effective date or reinstatement:

- the date of diagnosis for any Cancer, whether covered or excluded, or for Benign Brain Tumour; or
- the date at which any early signs or symptoms for any Cancer, whether covered or excluded, or for Benign Brain Tumour appear; or
- the date at which the Insured has any medical consultation or test leading to the diagnosis of any Cancer, whether covered or excluded, or of Benign Brain Tumour.

However, these exclusions do not result in termination of the coverage. The Insured remains insured against the other covered Illnesses.

Disclosure Obligation: Any diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour or any sign or symptom or medical consultation or test leading to a diagnosis of Cancer (whether covered or excluded under this coverage) or of Benign Brain Tumour that manifests during the moratorium period must be reported in writing to the Insurer within six (6) months of the diagnosis. Failure to do so entitles the Insurer to refuse any Critical Illness claim under this coverage.

Blindness is defined as:

Total and irrecoverable loss of sight in both (2) eyes, confirmed by an ophthalmologist, with a corrected visual acuity of twenty over two hundred (20/200) or less in each eye, or a field of vision of less than twenty (20) degrees in both (2) eyes.

Burns are defined as: Third-degree burns over at least twenty percent (20%) of the body surface.

Coma is defined as:

A state of unconsciousness without reaction to external stimuli or response to internal needs for a continuous period of four (4) days. The Glasgow Coma Scale must continuously indicate four (4) or less during the four (4) days.

Exclusions:

- a medically induced coma;
- a coma resulting directly from alcohol or drug use.

Cystic Fibrosis is defined as:

A final diagnosis of cystic fibrosis made before the Insured reaches the age of eighteen (18), as evidenced by chronic lung disease and pancreatic failure.

Deafness is defined as:

Total and irrecoverable loss of hearing in both (2) ears, with a hearing threshold of ninety (90) decibels or greater, within a speech threshold of five hundred (500) to three thousand (3,000) cycles per second.

Heart Valve Replacement is defined as

Replacement of any heart valve with a natural valve, a valve made of animal tissue, or a mechanical valve. Heart valve repair is specifically excluded.

Kidney Failure is defined as:

End stage of the chronic, irreversible failure of both (2) kidneys, requiring treatment through regular dialysis, peritoneal dialysis or kidney transplant.

Loss of Autonomy is defined as:

A definitive diagnosis, by a specialist, for a continuous period of ninety (90) days, confirming the Insured's complete and permanent inability to perform, on his or her own, at least two (2) of the six (6) Activities of Daily Living listed in that definition, without reasonable likelihood of recovery, or confirming a **Cognitive Impairment** as defined below.

Cognitive Impairment is defined as:

Mental deterioration and loss of mental capacity resulting in a deterioration of memory, orientation and the faculty of reason, which are measurable and due to an objective organic cause, diagnosed by a specialist. The degree of cognitive impairment must be serious enough to warrant continuous daily supervision.

The finding of cognitive impairment must be based on clinical data and standardized assessments, validating the impairment. Any mental or nervous disorder without a demonstrable organic cause is not covered.

Loss of Limbs is defined as:

Irreversible severance of two (2) or more limbs above the wrist or ankle joint, resulting from an Accident or a medically necessary amputation. A loss resulting directly from drug or alcohol use is excluded.

Loss of Speech is defined as:

The total and irrecoverable loss of the faculty of speech, resulting from an Injury or a physical and persistent Illness for a continuous period of at least one hundred and eighty (180) days. Any psychiatric cause is specifically excluded.

Major Organ Failure on Waiting List is defined as:

The diagnosis of irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. Transplantation must be medically necessary.

To qualify under Major Organ Failure on Waiting List, the Insured must be an eligible recipient, as part of an approved government program for organ or bone marrow transplant in Canada or in the United States, for one (1) or more organs or of bone marrow, as specified in this clause.

With respect to the Survival Period, the date of diagnosis is the date at which the Insured's registration with the transplant program takes effect.

Major Organ Transplant is defined as:

The diagnosis of irreversible failure of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. Transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured must undergo surgery to receive transplantation of the heart, both (2) lungs, liver, both (2) kidneys, or bone marrow. For the purposes of this coverage, "Major Organ Transplant" is limited to the organs specified in this paragraph.

Motor Neuron Disease is defined as:

A definitive diagnosis of one of the following diseases: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, spinal muscular atrophy, progressive bulbar palsy or pseudobulbar palsy. For the purposes of this coverage, "Motor Neuron Disease" is limited to the diseases specified above.

Multiple Sclerosis is defined as:

A definitive diagnosis, by a neurologist, of multiple sclerosis, characterized by well-defined neurological abnormalities that persist for a continuous period of at least six (6) months or with two (2) separate episodes, documented with clinical facts. The disseminated demyelinating lesions must be confirmed by magnetic resonance imaging (MRI) or by a medical imaging technique customarily used to diagnose multiple sclerosis.

Occupational HIV is defined as:

A diagnosis of infection by the human immunodeficiency virus (HIV), resulting from Accidental Injury in the course of the Insured performing the regular duties of his or her Occupation, which exposes him or her to body fluids contaminated with HIV.

The benefit will be payable provided all of the following criteria are met:

a) the Accidental Injury must be reported to the Insurer within fourteen (14) days of the Accidental event;

b) a test for HIV must be performed within fourteen (14) days of the Accidental Injury and the result must be negative;

c) a test for HIV must be performed between ninety (90) and one hundred and eighty (180) days after the Accidental Injury and the result must be positive;

d) all HIV tests must be conducted by a laboratory approved by the Insurer;

e) the Accidental Injury must be reported, investigated and documented in accordance with Canadian labour standards.

No benefit will be payable if:

a) the Insured refuses a vaccine that is approved and available and that offers protection from HIV;

b) an approved preventive or curative treatment for HIV infection becomes available before the Accidental Injury;

c) the HIV infection was contracted otherwise than as the result of Accidental Injury (including, but not limited to, sexual transmission or the use of intravenous drugs).

Paralysis is defined as:

Complete and permanent loss of use of two (2) or more limbs during a continuous period of ninety (90) days following the event giving rise to the loss, without any sign of improvement during that period. Any psychiatric cause is specifically excluded.

Parkinson's Disease is defined as:

A definitive clinical diagnosis, by a specialist, of primary idiopathic Parkinson's disease, which is characterized by at least two (2) of the following clinical features: muscle rigidity, tremor or bradykinesia (abnormal slowing of movement, slowing of physical and mental reactions). The Insured must require substantial physical help from another adult to perform two (2) or more of the following six (6) Activities of Daily Living: bathing, dressing, toileting, continence, transferring or eating, as specified in the definitions. Any other type of parkinsonism is specifically excluded.

UNDERWRITING REQUIREMENTS

Age	Amount	Underwriting Requirement
0 - 17	$25,000 - $250,000	Teleunderwriting
0 - 17	$250,001 - $500,000	Teleunderwriting, urine-HIV, APS, FQ
0 - 17	$500,001 - $1,000,000	Teleunderwriting, vital signs, blood profile, APS, inspection report
18 - 40	$25,000 - $250,000	Teleunderwriting, urine-HIV
18 - 40	$250,001 - $500,000	Teleunderwriting, blood profile, APS, FQ
18 - 40	$500,001 - $1,000,000	Teleunderwriting, vital signs, blood profile, APS, ECG, inspection report
41 - 50	$25,000 - $250,000	Teleunderwriting, vital signs, urine-HIV
41 - 50	$250,001 - $500,000	Teleunderwriting, vital signs, blood profile, APS, FQ
41 - 50	$500,001 - $1,000,000	Teleunderwriting, vital signs, blood profile, APS, ECG, inspection report
51 - 60	$25,000 - $250,000	Teleunderwriting, vital signs, blood profile with PSA
51 - 60	$250,001 - $500,000	Teleunderwriting, vital signs, blood profile with PSA, APS, ECG, FQ
51 - 60	$500,001 - $1,000,000	Teleunderwriting, vital signs, blood profile with PSA, APS, ECG, R-X, inspection report
61 - 65	$25,000 - $1,000,000	Contact the Head Office

CHANGES AUTHORIZED AFTER POLICY ISSUE

Below are the changes that are requested most frequently.

If the change you want to make does not appear in the following table, please contact Humania Assurance Representative Services for more information.

Type of change permitted	Permitted at all times[1]	New policy
Change from smoker to non-smoker status	X	
Change from youth to non-smoker status (from age 18)	X	
Reduction in amount of coverage	X	
Termination of coverage**	X	
Conversion of insurance (before age 60)**	X	
Increase in amount of coverage*		X
Addition of coverage*		X
Change to banking information	X	
Change of beneficiary	X	
Change of owner	X	

[1] Permitted at all times: Applicable at the date of the next pre-authorized payment or invoicing.

Impact of Changes on Premium Refund Calculation

* For the changes marked by one asterisk, the change will trigger a new policy and the Insured's attained age at the effective date of the added coverage will be used for calculating the premium refund.

** For changes marked by two asterisks, the premiums for the cancelled coverages will be completely excluded from the premium refund calculation.

For all other changes indicated above, the age and effective date of the original coverage will be used to calculate the premium refund.

HUMANIA ASSURANCE MD®

Humania Assurance is one of the oldest and soundest insurance companies in Canada. It provides insurance coverage to over 200,000 clients and delivers exceptional customer service to meet the needs of its clients. Humania Assurance, putting you first.

Humania Assurance Inc.
1555 Girouard Street West
Saint-Hyacinthe, Quebec J2S 2Z6
Telephone: 450 773-6051
Toll-free: 1 888 400-6051

www.humania.ca

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