PROHEALTH

INCOME INSURANCE
ELITE PLAN

Insurance Contract

INSURER

Humania Assurance Inc.

1555 Girouard Street West, Saint-Hyacinthe, QC J2S 2Z6

Customer Service: 1-800-773-8404
Email: clients@humania.ca
Website: www.humania.ca

Name of Owner:

Name of Insured:

Contract Number:

Contract Start Date:

Schedule of Benefits
Elite Plan

Your contract includes this Schedule of Benefits, an Introduction, a Table of Contents, Sections A to C, your application for insurance (Appendixes A and B), and any change agreed upon with you in writing.

Please read your contract carefully, including this policy, the Appendix A - Copy of Application and Appendix B - Eligibility and Insurability Questionnaire and validate the answers given therein. If the answers do not reflect your statement or are inaccurate, you must notify the Insurer accordingly within thirty (30) days following the delivery of the policy. Failure to notify the Insurer of any inaccuracy or erroneous statement can render the contract void.

By completing your application for insurance, you declare that all your answers are accurate and complete. Your contract is issued on the basis of the information you provide us and may be cancelled by Humania Assurance if any information is inaccurate.

Subject to the provisions and riders of the policy, the Insurer will pay the benefits listed below when a covered event occurs. Should the Insurer receive a request to cancel the contract or a stop-payment order on any premium due, all obligations of the Insurer under the contract terminate immediately as of the date such is received.

Schedule of Benefits
Elite Plan

CONTRACT START DATE:

Description	Waiting Period	Maximum Benefit	Benefit(s)	Monthly Premium
Total Disability Benefit				
Regular Occupation				
Partial Disability Benefit				
Indexation				
Additional Insurance Option				
Critical Illness				
Accidental Death and Dismemberment				
Premium Refund Every 20 Years				
• Death benefit • Waiver of premiums • 1st day in case of hospitalization				
Your monthly payment, due on the X of each month, is				

This policy is guaranteed renewable up to 100 years old, provided the premiums on the benefits are paid.

Signing authority:

Valérie Le Roux
Director, Individual Insurance, Administration

Table of Contents

Part A
Definitions

For the purposes of this *Policy*, the terms in italics are defined as follows:

Accident (or Accidental)

An event that occurs while the *Policy* is in force and whose cause is external, violent, sudden, unexpected and beyond the control of the *Insured*, such as a fall, impact, collision or blow. False or repetitive movements that occur in the course of routine *Work* or daily activities are not considered an Accident. If an Accident results in a loss that first appears more than ninety (90) days after the Accident, the loss is considered to be the result of sickness.

Activities of Daily Living

Series of day-to-day actions carried out by a person in relation to eating, getting dressed, moving around, bathing, going to the bathroom, and being continent:

- Eating: Ability to consume food that has been cooked and served to them, with or without the aid of adapted utensils;
- Getting dressed: Ability to put on or take off the necessary articles of clothing, including orthotics, artificial limbs, or other surgical prosthetics;
- Moving around: Ability to move around outside of a bed, chair or wheelchair, with or without the aid of assistive devices technology;
- Bathing: Ability to wash themselves in a bathtub or shower, or with a bath mitt, with or without the aid of assistive devices;
- Going to the bathroom: Ability to get to and from the bathroom, and to ensure their personal hygiene;
- Being continent: Ability to manage bowel and urinary function, with or without protective undergarments, so as to maintain a level of personal hygiene compatible with good general health.

Average Monthly Earned Income

The greater of the *Earned Income* for the last **fiscal year** before the onset of *Disability*, divided by twelve (12), the average annual *earned income* for the best three (3) of the past five (5) years, divided by twelve (12) and $1,111.11.

For an individual, the fiscal year is the period corresponding to the calendar year, i.e. the period beginning on January 1st and ending on December 31st.

For a company, the fiscal year is the period corresponding to the financial year, i.e. the accounting period between the first day of the operating year and the day on which the year ends. It cannot exceed 12 months.

Beneficiary

A natural or legal person designated by the *Policyowner* in any written notice filed with the *Insurer* as being entitled to receive benefits under this *Policy*.

Care of a Physician

Regular and personal care that is provided by a *Physician* in Canada and in the United States and that, based on current medical standards, is appropriate for the condition underlying the *Insured*'s *Disability*. If the *Insured* refuses any treatment or medication deemed necessary for his or her health, the *Insurer* may suspend payment of the monthly benefits.

Coordinated

That has been the subject of coordination, in accordance with the General Provisions of this *Policy*.

Cost of Goods Sold

Also known as the cost of contracts or cost of products, any disbursements incurred for the performance of the work or professional services, including, but not limited to, inventory, subcontracting and leasing, as well as equipment or rolling stock maintenance, along with any costs or disbursements incurred on behalf of customers.

Day Surgery

A surgical procedure performed by appointment in a *Hospital*, clinic or department affiliated with a *Hospital*, that does not require *Hospitalization* and for which the *Insured* is admitted and discharged on the same day as the procedure.

Earned Income

All amounts that the *Insured* receives in return for services rendered, less the usual business expenses, but before income tax deductions. Earned Income includes salaries, bonuses, professional fees, commissions, gratuities and any other income from *Employment*.

For a business owner or a professional, Earned Income is the greater of the following:

- The aggregate income paid to him or her from that business on account of his or her professional activities, plus his or her share of the business's *Net Profits*; or
- 50% of his or her share of the business's *Gross Profits*.

LIMITATIONS

Earned Income excludes any income that is not derived directly from *Work*, such as interest income, rent, copyright, royalties, investment income, and any income from pension plans, annuity contracts, profit sharing plans, deferred compensation plans or any other income not received directly in return for a service provided. Dividends, whether related to or not related to *Work*, are not considered *Earned Income*.

Use of the company's *Gross Profits* is not allowed if the company posted a net loss for two or more consecutive years immediately before the *Disability*.

Eligible Benefit

The maximum amount payable as specified in the Schedule of Benefits. The maximum amount can be changed under the provisions, limitations and exclusions of the *Policy* and its coverages.

Gross Profit of the Company

Is defined as a company's revenue, for a given full fiscal year, minus:

- The *cost of goods sold*;
- The realized gains from a transaction outside the normal course of business; and
- Any business expense item related to salaries and payroll taxes, excluding the salaries and payroll taxes of the *Insured*.

Hospital

Any short-term health care institution considered to be a Hospital by the applicable Canadian federal or provincial authorities, not including the long-term care unit (the beds at that institution that are used by patients who are convalescing or suffering from a chronic disease).

Not considered a hospital: a clinic, a nursing home, a substance abuse treatment facility, or an institution whose services consist primarily of rehabilitation or custodial care, even if this institution is part of or affiliated with a hospital.

Hospitalization

A stay by the *Insured* in a *Hospital*, as an inpatient, further to an admission request by a *Physician*, for a period of at least eighteen (18) hours.

Injury

Bodily injury resulting directly from an *Accident* sustained by the *Insured* and independent of any sickness or other cause, while the *Policy* is in force.

Insured

The person designated as such in the application.

Insurer

Humania Assurance Inc., whose head office is located at 1555 Girouard Street West, Saint-Hyacinthe, Quebec J2S 2Z6.

Maximum Benefit Period

The maximum period of time, as specified in the Schedule of Benefits, during which benefits are payable as a result of a covered event.

Net Profit of the Company

Is defined as a company's revenue, for a given full fiscal year, after business expenses (excluding depreciation) and before the various mandatory government taxes and contributions.

Non-smoker

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

Occupation; Employment; Work

These terms collectively refer to the gainful or remunerative Occupation(s), Employment or Work performed by the *Insured* at the onset of *Disability*.

Partial Disability (or Partially Disabled)

Refers to an *Insured* who, although not Totally Disabled, is unable to perform at least one of the main duties of his or her *Occupation* at the onset of Disability or who is unable to *work* at least fifty percent (50%) of the time usually devoted to his or her *Occupation*, while under the continuous and appropriate treatment and *Care of a Physician*.

No Partial Disability benefit will be payable if the *Insured* has been unemployed for more than ninety (90) days at the onset of Disability.

Physician

Any person legally authorized to practice medicine in Canada and in the United States 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 *Policyowner*.

Policy

The present contract, the application for this *Policy*, any application for reinstatement, any written request for changes to the contract, and any related documents.

Policyowner

The person who owns this *Policy*.

Risk Class

The characteristics of the *Insured* that determine the premium rate for a coverage. The Risk Class is based on the *Insured*'s gender, age, tobacco use, health and *Occupation*.

Sickness

A deterioration of health or a disorder of the body confirmed by a *Physician* and requiring regular and ongoing medical care, that is not caused by an *Injury* and whose first symptoms appear while this *Policy* is in force. Pregnancy is not considered a sickness except in the case of pathological complications.

Total Disability (or Totally Disabled)

For an *Insured* who is gainfully employed or has been unemployed for ninety (90) days or less at the onset of Disability:

- During the *Waiting Period* and the the Regular Occupation period as indicated in the Schedule of Benefits: the inability of the *Insured*, due to an *Accident* or *Sickness*, to perform the main duties of his or her *Occupation* at the onset of Disability and who, during that period, is not engaged in any other gainful activity and is under the continuous and appropriate treatment and *Care of a Physician*;
- For a period that lasts beyond the Regular Occupation period as indicated in the Schedule of Benefits: the inability of the *Insured*, due to an *Accident* or a *Sickness*, to perform any gainful *Occupation* that he or she is reasonably qualified to perform based on his or her education, training or experience, while under the continuous and appropriate treatment and *Care of a Physician*.

For an *Insured* who has been unemployed for more than ninety (90) days at the onset of Disability, Total Disability means the inability of the *Insured*, due to an *Accident* or *Sickness*, to perform at least one of the *Activities of Daily Living*, while under the continuous and appropriate treatment and *Care of a Physician*.

When the Disability begins after the *Policy* anniversary date following the *Insured*'s sixty-five (65th) birthday, Total Disability means the inability of the *Insured*, due to an *Accident*, to perform at least one of the *Activities of Daily Living*, while under the continuous and appropriate treatment and *Care of a Physician*.

Waiting Period

A period, expressed in number of days, during which no benefit is payable. The Waiting Period begins on the date of the first medical consultation related to the *Disability* after the onset of that *Disability*.

Continuous periods of *Disability* lasting seven (7) days or more and resulting from the same cause may be added together to satisfy the Waiting Period.

Recurrent Disabilities may be added together over a period of six (6) months to satisfy the Waiting Period.

Part B

Total Disability Benefit

1. Benefits

Each month, the *Insurer* will pay the *Insured*, while *Totally Disabled* as a result of an *Accident* or *Sickness* the *Eligible Benefit* shown in the Schedule of Benefits, subject to the *Waiting Period* and the *Maximum Benefit Period* shown in the Schedule.

During the first thirty-six (36) months of benefit payments, the eligible *Disability* benefit shown in the Schedule of Benefits will not be *Coordinated* with any other income replacement insurance from a company or a private, public or parapublic organization, up to the first two thousand five hundred dollars ($2,500) of monthly benefits payable for all Disability coverages that the *Insured* has with the *Insurer*.

After the first thirty-six (36) months, the benefits payable will become fully *Coordinated*. Disability benefits will then be based on the *Insured*'s *Average Monthly Earned Income*, up to the *Insured* maximum amount shown in the Schedule of Benefits.

2. Limitations

The maximum benefit for all Disability coverages that the *Insured* has with the *Insurer* cannot be greater than ten thousand dollars ($10,000) per month.

If, by mistake, the sum of all benefits for all Disability benefits selected are greater than this amount, the *Insurer* will pay a maximum benefit of ten thousand dollars ($10,000), cancel the contracts that exceed ten thousand dollars ($10,000) in Disability benefits, and reimburse the overpayments made.

If the *Insured* has been **unemployed for more than ninety (90) days** at the onset of *Total Disability*, the Maximum Benefit for all Disability coverages that the *Insured* has with the *Insurer* cannot be greater than two thousand five hundred dollars ($2,500) per month.

3. Assumed Total and Permanent Disability

If, as a result of an *Accident* or *Sickness* the *Insured* sustains the total and permanent loss of use of two limbs or one sense, as described below, the *Insured* will be considered to be *Totally Disabled*, whether or not he or she holds other *Employment* and whether or not he or she is under the regular *Care of a Physician*.

Total and permanent loss of use of two limbs or one sense among those listed below is defined as:

- **One hand, one foot:** complete severance at or above the wrist or ankle joint; where there is no severance, total permanent loss of use of the hand or foot;
- **Hearing:** total and irreversible loss of hearing in both ears, with a hearing threshold of 90 decibels or more within a speech threshold of 500 to 3,000 cycles per second, confirmed by an otolaryngologist registered and licensed to practice in Canada and practicing in Canada;
- **Sight:** total irreversible loss of sight in both eyes (visual acuity of twenty over two hundred [20/200] or less, or a field of vision of less than twenty [20] degrees).

4. Hospitalization

The benefit for *Disability* resulting from an *Accident* or *Sickness* is payable from the first (1st) day of *Hospitalization* or *Day Surgery*, for *Policies* with a *Waiting Period* of ninety (90) days or less.

5. Changes to Coverage

Effective from the *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday, the *Total Disability* benefit will change as follows:

- The *Maximum Benefit Period* for *Total Disability* due to an *Accident* or *Sickness* will change to twenty-four (24) months from the onset of Disability, even if the Disability began before attaining the age of sixty-five (65) when the *Maximum Benefit Period* shown is greater than twenty-four (24) months;
- No *Total Disability* due to a *Sickness* shall be payable when the onset of the disability is after the *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday. The *Total Disability* due to an *Accident* Benefit at that date shall be reduced by 50% up to two thousand dollars ($2,000).

6. Termination of Total Disability Coverage

This coverage will terminate on the *Policy* termination date specified in the General Provisions of this *Policy*.

7. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part B

Partial Disability Benefit

1. Benefits

Each month, the *Insurer* will pay the *Insured*, while *Partially Disabled* as a result of an *Accident* or *Sickness*, the *Eligible Benefit* shown in the Schedule of Benefits, subject to the *Waiting Period* and the *Maximum Benefit Period* shown in the Schedule.

The *Partial Disability* benefit shown in the Schedule of Benefits will not be *Coordinated* with any other income replacement insurance from a company or a private, public or parapublic organization, up to the first one thousand two hundred and fifty dollars ($1,250) of monthly benefits payable for all Disability coverages that the *Insured* has with the *Insurer*.

2. Limitations

When for the same *Disability*, both *Total Disability* and *Partial Disability* benefits are paid, the total benefit period cannot exceed the *Maximum Benefit Period* for *Total Disability*.

No *Partial Disability* benefit is payable when the *Insured* has been unemployed for more than ninety (90) days at the onset of the Disability.

3. Termination of Partial Disability Coverage

This coverage will end on the earlier of the following dates:

- The *Policy* termination date specified in the General Provisions of this *Policy*; or
- The *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday.

4. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part B

Indexation Benefit

1. Benefits

When the *Insured*'s *Total Disability* extends beyond twelve (12) consecutive months and *Total Disability* benefits are paid, these benefits are indexed on January 1st of each year, in accordance with the Consumer Price Index published by Statistics Canada, subject to a maximum indexation of five percent (5%) per year.

Any new disability payment will always start based on the eligible benefit amount shown in the Schedule of Benefits.

2. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part B

Additional Insurance Option

1. Benefits

This coverage allows the *Policyowner* to increase the *Insured*'s monthly *Disability* benefit by twenty percent (20%) of the amount shown in the Schedule of Benefits at each *Policy* anniversary without having to provide a health declaration, subject to the following conditions:

- The *Insured* must be 50 years of age or under when the contract is issued;
- The coverage must be in force;
- The *Insured* must not be disabled at the time the option is exercised, or in the twelve (12) preceding months;
- Financial proof that meets the *Insurer*'s requirements must be provided to justify the increase;
- The request for an increase must be made no later than thirty (30) days before the anniversary date of the Additional Insurance Option;
- The Additional Insurance Option may be exercised up to five (5) times.

The *Waiting Period* and *Maximum Benefit Period* indicated in the Schedule of Benefits under the Additional Insurance Option determine the characteristics of the monthly disability benefit.

Disability benefits resulting from the exercise of these Additional Insurance Options shall be multiples of one hundred dollars ($100);

If the *Policyowner* does not take advantage of the maximum amount when exercising an Additional Insurance Option, the excess amount is not carried over to a later Additional Insurance Option.

Disability benefit coverage that results from exercising an Additional Insurance Option takes effect at the *Policy*'s anniversary date following the date on which the Additional Insurance Option is exercised.

The premium for this benefit is based on the *Insured's* attained age at that anniversary, the same *Risk Class* as the initial disability and the rates in effect at the time of the Additional Insurance Option. Coordination, as well as any disability benefit restrictions or exclusions, also apply to the supplementary coverage stemming from the exercise of the Additional Insurance Option.

Exercising the Additional Insurance Option automatically results in an increase in the following benefits (and related premiums), provided these appear in the Schedule of Benefits and are in force when the Additional Insurance Option is exercised:

- Indexation Benefits;
- 20-Year Premium Refund; or
- Premium refund at age 65.

2. Termination of coverage

This coverage will end on the earlier of the following dates:

- The date on which the maximum Additional Insurance Options have been exercised;
- The *Policy* anniversary date following the *Insured's* fifty-fifth (55th) birthday.

3. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part B

Critical Illness benefit

1. Benefits

When the *Insured* is diagnosed with a *Critical Illness* covered by the contract, the *Insurer* shall pay, while the coverage is in effect, the benefit corresponding to the benefit shown in the Schedule of Benefits, excluding any Additional Insurance Option. However, this benefit is payable only if the *Insured* is still alive after the *Survival Period*.

2. Definitions

Critical Illness

Refers to any of the conditions described in Section 3, List and Definitions of Covered Critical Illness Categories diagnosed by a *Physician* or a *Specialist* while the *Policy* is in effect.

Specialist

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

Survival Period

Period of thirty (30) days, during which the *Insured* must survive after the date of the diagnosis of a *Critical Illness* for the benefit amount to be payable.

3. List and Definitions of Covered Critical Illness Categories

STROKE (CEREBROVASCULAR ACCIDENT WITH PERSISTENT NEUROLOGICAL DEFICITS)

A formal diagnosis of an acute cerebrovascular event (CVA) caused by intracranial thrombosis, hemorrhage or embolism, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination that persist on an ongoing basis for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of stroke (cerebrovascular accident) must be made by a *Specialist*.

For *Policy* purposes, neurological deficits must be detectable by a *Specialist* and may include, but are not limited to, measurable hearing loss, measurable vision loss, measurable decline in neurocognitive function, objective loss of sensitivity, paralysis, localized weakness, dysarthria (difficulty pronouncing), dysphasia (difficulty speaking), dysphagia (difficulty swallowing), abnormal gait (difficulty walking), loss of balance, a lack of coordination or onset of seizures that are being treated. Headaches and fatigue shall not be considered neurological deficits.

Exclusions: no benefit will be payable under the definition of stroke (cerebrovascular accident) for the following conditions:

- transient ischemic attack;
- intracerebral vascular events due to trauma;
- ischemic disorder of the vestibular system;
- tissue death of the optic nerve or retina without the complete loss of sight of the affected eye; or
- lacunar infarcts which do not meet the definition of stroke (cerebrovascular accident) as described above.

CANCER

Formal diagnosis of a malignant tumour. The tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of healthy tissues. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma.

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

The following cancers are excluded:

- carcinoma in situ;
- stage 1A malignant melanoma as defined by the TNM classification (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- any non-melanoma skin cancer that has not become metastatic (spread to adjacent organs); or
- stage A (T1a or T1b) prostate cancer.

For the purposes of this *Policy*:

"T1a or T1b prostate cancer" refers to a tumour that is not clinically apparent or palpable by rectal examination and was incidentally detected in a prostate tissue collection.

- "AJCC stage 1 gastrointestinal stromal tumours [GISTs]" refers to:
  - stomach and/or omentum GISTs with a tumour diameter of less than or equal to 10 cm, with a maximum of 5 mitoses per 5 mm^2, or 50 per HPF; or
  - small intestine, esophagus, colon and rectum, mesentery and peritoneum GISTs, with a tumour diameter of less than or equal to 5 cm, with a maximum of 5 mitoses per 5 mm^2, or 50 per HPF.
- The terms "Tis," "Ta," "T1a," "T1b," "T1" and "AJCC Stage 1" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual (8th Edition, 2018).
- The term "Rai Stage 0" 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).

Exclusions: no benefit will be payable under the definition of cancer for the following conditions:

- lesions described as benign, non-invasive, pre-cancerous, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or Tis or Ta tumours;
- malignant skin melanoma that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or accompanied by lymph node metastases or distant metastases;
- any non-melanoma skin cancer without lymph node or distant metastasis; This includes, but is not limited to, cutaneous T-cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- stage T1a or T1b prostate cancer 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;
- Rai stage 0 chronic lymphocytic leukemia, without damage to the lymph nodes, spleen or liver, and with a normal number of red blood cells and platelets;
- AJCC stage 1 gastrointestinal stromal tumours;

- grade 1 neuroendocrine (carcinoid) tumours restricted to the affected organ, treated by surgery only and requiring no further treatment, other than taking medication to counteract the effects of hormonal hypersecretion; or
- stage 1 thymoma limited to the thymus, with no evidence of invasion into the capsule or spread beyond the thymus.

90-day exclusion period: no benefit will be payable for cancer if, within 90 days of the effective date of the contract or the effective date of the most recent reinstatement of the contract if that date is later, the *Insured*:

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

Medical information regarding the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be provided to the *Insurer* within six (6) months of the date of diagnosis. If this information is not provided within the prescribed time, the *Insurer* may deny a claim for cancer, or for any *Critical Illness* caused by a cancer or its treatment.

HEART SURGERY (CORONARY ARTERY BYPASS)

Heart surgery (coronary artery bypass surgery) is defined as: Heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical procedures such as angioplasty and the use of lasers to unblock the arteries are not covered.

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

Exclusions: no benefit will be payable under the definition of Coronary artery bypass surgery for the following conditions:

- angioplasty;
- intra-arterial surgery;
- percutaneous transcatheter procedures; or
- non-surgical procedures.

HEART ATTACK (MYOCARDIAL INFARCTION)

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 that confirm the diagnostic of myocardial infarction, with at least one of the following:
    - heart attack symptoms;
    - recent electrocardiogram (ECG) changes consistent with a heart attack;
    - development of new pathological Q-waves on the electrocardiogram (ECG) following an intra-arterial cardiac procedure, including, but not limited to, coronary angiography and/or coronary angioplasty.

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

Exclusions: no benefit will be payable under the definition of HEARTH ATTACK (MYOCARDIAL INFARCTION) for the following conditions:

- electrocardiogram (ECG) changes suggesting a prior myocardial infarction;
- other acute coronary syndromes such as angina pectoris and unstable angina; or
- elevated biochemical cardiac markers and/or symptoms resulting from medical procedures or diagnoses other than heart attack.

4. Limitations

The benefit is payable only after the *Survival Period* and provided this is the first manifestation of the *Critical Illness* covered by the contract under which the claim is made. *Critical Illness* benefits are not cumulative. As such, the *Insurer* will never be required to pay more than one benefit under this coverage.

MAXIMUM AMOUNT PAYABLE

The total benefit amount payable by the *Insurer* to an *Insured* for all *Critical Illness* benefit under the Income Insurance Coverages shall not exceed fifty thousand dollars ($50,000).

In the event that the amount held by an *Insured* person exceeds this amount, the *Insurer* will pay a total of fifty thousand dollars ($50,000).

5. Exclusions

If the *Insured* suffered from a covered *Critical Illness* prior to the effective date of this coverage, no benefit will be payable for that category of *Critical Illness*.

No *Critical Illness* benefit is payable when the Illness results from the *Insured*'s intentional use of a drug or medication not prescribed by a *Physician* or other health professional or if the *Insured* has used a drug or medication prescribed by a *Physician*, a *Specialist* or an health professional not used as directed.

6. Termination of coverage

This coverage will end on the earlier of the following dates:

- The *Policy* termination date specified in the General Provisions of this *Policy*;
- The *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday; or
- The date a benefit is paid under *Critical Illness* coverage.

7. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part B

Accidental Death, Dismemberment or Total Loss of Use Benefit

1. Benefits

DEATH

If the *Insured* dies as a result of an *Accidental Injury*, the *Insurer* will pay the benefit shown in the Schedule of Benefits, provided the *Policy* is in force and the death occurs within three hundred and sixty-five (365) days immediately following the date of the *Accident*.

DISMEMBERMENT OR TOTAL LOSS OF USE

While the *Policy* is in force and in the event of *dismemberment or total loss of use* resulting from an *Accidental Injury*, the *Insurer* will pay the following percentage of the dismemberment benefit shown in the Schedule of Benefits:

Types of Dismemberment or Total Loss of Use	Refundable Percentage
Both (2) feet or both (2) hands	100%
One (1) hand and one (1) foot	100%
One (1) hand and sight in one (1) eye	100%
One (1) foot and sight in one (1) eye	100%
Hearing in both (2) ears and speech	100%
Sight in both (2) eyes	100%
One (1) foot or one (1) hand	50%
Hearing in both (2) ears or speech	50%
Sight in one (1) eye	12.5%
Hearing in one (1) ear	12.5%
Two (2) or more phalanges of the same finger or same toe	2.5%

2. Definitions

Dismemberment or Total Loss of Use

- **Hand or foot:** 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;
- **Speech:** diagnosis of total and irreversible loss of the ability to speak. A diagnosis of loss of speech must be made by a specialist;
- **Eye:** total and irreversible 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);
- **Hearing:** total and irreversible loss of hearing in both (2) ears, with a hearing threshold of 90 decibels or over within a speech threshold of 500 to 3,000 cycles per second, confirmed by an otolaryngologist registered and licensed to practise in Canada and practising in Canada;
- **One (1) finger or one (1) toe:** complete severance of two (2) or more phalanges of the same finger or same toe.

3. Limitations

If the *Insured* dies as a result of *Accidental Injuries* for which an *accidental* death benefit is payable under this *Policy*, no benefit will be payable for dismemberment or loss of use suffered by the *Insured* as a result of the same *Accident*.

Benefits are not cumulative. If a single *Accident* results in multiple dismemberments or losses, the *Insurer* will pay only for the dismemberment or loss giving rise to the largest amount.

The benefit for total loss of use is payable if the loss persists beyond the period of three hundred and sixty-five (365) days immediately following the date of the *Accident*.

Total benefits for *dismemberment or total loss of use* cannot exceed one hundred percent (100%) of the benefit for *dismemberment or total loss of use* shown in the Schedule of Benefits.

Any dismemberment or loss of use that already exists on the date the *Policy* is issued will not be considered a loss covered under this benefit.

The total benefit payable by the *Insurer* to the *Insured* cannot be greater than three hundred thousand dollars ($300,000) for *dismemberment or total loss of use* resulting from an *Accident*. If the amount of insurance held by an *Insured* is greater than three hundred thousand dollars ($300,000) for *dismemberment or total loss of use* resulting from an *Accident*, regardless of the number of coverages in effect with Humania Insurance Inc., the *Insurer* will pay only a single benefit equal to that entitling the *Insured* to the highest amount. Premiums received for dismemberment or loss of use coverage for which no benefit is paid will be reimbursed to the *Policyowner*.

4. Termination of Coverage

This coverage terminates on the earliest of the following dates:

- The *Policy* termination date specified in the General Provisions of this *Policy*;
- The *Policy* anniversary date following the *Insured*'s seventieth (70th) birthday.

5. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part B

20-Year Premium Refund Benefit

1. Benefits

Under this coverage, the *Insurer* will refund the percentage of Refundable Premiums for the Refund Period shown in the Schedule of Benefits of the 20-Year Premium Refund Benefit, provided the *Insured* is still alive at the date of entitlement to the refund. This refund will be made to the *Policyowner* within sixty (60) days following the refund entitlement period.

LIMITATIONS

The refund applies to coverages issued prior to attainment of age forty-six (46) and to coverages that have not been cancelled at the *Policyowner*'s request.

If, following payment of a premium refund, a benefit is payable for the previous refund entitlement period, any amount paid by the *Insurer* under this coverage must be reimbursed beforehand.

No benefit will be payable by the *Insurer* following failure to return the premium refund.

EXCLUSIONS

The 20-year Premium Refund excludes waived premiums paid by the *Insurer*.

2. Definitions

Refund Period

The period of twenty (20) consecutive years of coverage beginning at the effective date of each coverage, during which no benefit has been paid or would have been payable under the coverages of this *Policy*. If the *Insurer* pays a benefit of any kind, a new *Refund Period* begins to elapse at the date on which the next premium is payable following the date of the last benefit payment, provided the *Insured* is under age 46.

Premiums Paid

Premiums paid by or on behalf of the *Policyowner* to the *Insurer*, for each coverage under the *Policy* where 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 more than twenty-five percent (25%) at the *Policyowner*'s request, the resulting premium will be considered the premium paid from the start date of the Refund Period.

Refundable Premiums

The total Premiums Paid to the *Insurer*, since the beginning of the *Refund Period*, for each coverage in force at the beginning of the *Refund Period*.

3. Termination of Coverage

This coverage terminates at the earliest of the following dates:

- The date on which the shortest *Waiting Period* under the *Policy* is changed to more than ninety (90) days;
- The *Policy* termination date specified in the General Provisions of this *Policy*;
- The *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday.

4. General Provisions

The definitions, limitations and exclusions of this coverage apply in addition to those indicated in the General Provisions. The General Provisions of the *Policy* govern this coverage when they are relevant to and compatible with its terms.

Part C

General Provisions

1. Contract

This *Policy* is issued by Humania Assurance Inc., an incorporated life insurance company, hereinafter called the "*Insurer*", based on the application for insurance, a copy of which is attached, as well as on any document subsequently submitted to reinstate or change the *Policy*. No representative is authorized to change this *Policy* or to render null any of its provisions.

Any change to the *Policy* or its riders must be signed by an officer of the *Insurer*.

2. Effective Date

This *Policy* takes effect on the date the *Insurer* approves the application, provided the application is approved without change, the first premium has been paid, and no change has occurred in the insurability and/or the state of health of the *Insured's* since the application was signed.

3. Disability Benefit

When the *Insured* suffers a *Disability* covered under this *Policy*, the *Insurer* will pay the monthly *Eligible Benefit*. Payments begin when the *Waiting Period* has elapsed and will continue for the *Maximum Benefit Period*, subject to the limitations, exclusions and General Provisions of the *Policy* and its coverages.

ONSET OF DISABILITY

For the purposes of this *Policy*, a *Disability* begins on the date of the first medical consultation related to the *Disability* after the onset of that *Disability*.

DISABILITY ADJUSTMENT

Where necessary, the monthly benefit payable will be adjusted to a daily rate based on one-thirtieth (1/30) of the monthly benefit for each day of *Disability*.

The *Disability* benefits are established based on the *Insured*'s actual earned income at the start of the *Disability*, up to the maximum insured amount shown in the Schedule of Benefits. It is important for the *Policyowner* to periodically make sure that the income reported on the application is accurate and to notify the *Insurer* of any decrease in income.

If the amount of the benefit paid by the *Insurer* is less than the *insured* benefit, the *Insurer* will not refund any excess premium.

COORDINATION

If the benefits payable under this *Policy* and any income replacement insurance from a company or a private, public or parapublic organization and any sum or amount that the person *insured* receives under government plans total more than ninety percent (90%) of the *Insured*'s *Average Monthly Earned Income*, the Disability benefits payable will then be reduced so that the total of all benefits does not exceed such ninety percent (90%).

Where lump-sum or retroactive payments are made to the *Insured*, the *Insured* will be required to reimburse the *Insurer* any amounts that would not have been payable by the *Insurer* on account of the Coordination of Benefits.

If the *Insured* fails or refuses to exercise his or her rights under government plans or an insurance plan through any company or private, public or parapublic organization, the *Insurer* will assess the amount of benefits to which the *Insured* would have been entitled and reserves the right to reduce the monthly benefits payable to the *Insured* accordingly.

RECURRENT DISABILITY

All recurrent Disabilities due to the same or a related cause are considered to be the continuation of one and the same *Disability*. The *Waiting Period* does not begin to elapse anew and benefit payments are added to past payments in determining the *Maximum Benefit Period* specified in the Schedule of Benefits, subject to the Multiple Causes of Disability clause.

If the *Insured* becomes disabled again after being able to engage in *Employment* and without having received disability benefits under this contract for a period of at least six (6) consecutive months, the *Disability* will be considered a new *Disability*, even if it is due to the same or a related cause. The *Waiting Period* and the *Maximum Benefit Period* specified in the Schedule of Benefits will apply again.

For an *Insured* who has been unemployed for more than ninety (90) days at the onset of *Disability*, if the *Insured* becomes disabled again after being able to perform all his or her *Activities of Daily Living* and without having received disability benefits under this contract for a period of at least six (6) consecutive months, the *Disability* will be considered a new *Disability*, even if it is due to the same or a related cause. The *Waiting Period* and the *Maximum Benefit Period* specified in the Schedule of Benefits will apply again.

REHABILITATION

When the *Insured* receives a *Disability* benefit under this *Policy*, the *Insurer* may pay the cost of services related to a rehabilitation program, provided such services are not already covered by another program or service and the *Insurer* approves the program in writing prior to the *Insured*'s participation therein.

DEATH BENEFIT

If the *Insured* dies while in receipt of *Disability* benefits, the *Insurer* will pay the *Beneficiary* a lump sum equal to five (5) times the monthly benefit amount that was being paid at the time of death, up to a maximum of ten thousand dollars ($10,000).

MULTIPLE CAUSES OF DISABILITY

If another *Accident* or *Sickness* occurs during the benefit period, no additional benefit will be payable under this *Policy* for the other *Accident* or *Sickness*.

If, at the end of the *Maximum Benefit Period*, the *Total Disability* continues and the *Insured* has not recovered from his or her first *Disability* and another *Accident* or *Sickness* occurs, no benefit will be payable under this *Policy* for the other *Accident* or *Sickness*.

4. Premiums

This *Policy* has a level premium up to the *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday. The level premium rate is based on the *Insured*'s *Risk Class* on the date the coverage is issued.

On the *Policy* anniversary date following the *Insured*'s sixty-fifth (65th) birthday, the premium will be adjusted according to the rates established by the *Insurer* at the time of the change in coverage. The only other possible increases are adjustments to reflect experience.

ADJUSTMENTS TO REFLECT EXPERIENCE

Once the *Policy* has been in effect for five years, the *Insurer* may change the premium for each guarantee based on the experience of contracts with similar features.

METHOD OF PAYMENT

The premium is payable annually or monthly by pre-authorized debit, as selected by the *Policyowner*.
A premium paid by pre-authorized debit is only considered paid if the payment is honoured.

A grace period of thirty (30) days is granted for payment of each premium. If the premium is unpaid after the grace period, the *Policy* will terminate.

Provided the *Insured* is not disabled, the *Policyowner* may change the method of payment by giving fifteen (15) days prior notice.

The *Insurer* will deduct outstanding premiums from any amount payable.

5. Waiver of Premium

While the *Insured* is eligible to receive benefits as a result of a *Disability*, the *Insurer* will waive the payment of premiums according to the method of payment in effect at the onset of *Disability*.

Waiver of premiums will end on the date the *Insured* is no longer eligible to receive *Disability* benefits.

6. Exclusions

NO BENEFIT WILL BE PAYABLE FOR DISABILITY THAT RESULTS DIRECTLY OR INDIRECTLY FROM:

- Attempted suicide or intentionally self-inflicted *Injury* or dismemberment, whether the *Insured* is sane or insane;
- Participation by the *Insured* in the perpetration or attempted perpetration of an assault or criminal offence, or driving a motor vehicle including a boat while under the influence of narcotics or while his or her blood alcohol concentration exceeds the legal limit;
- 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 participation by the *Insured* in a popular uprising;
- Injuries sustained during air travel, unless the *Insured* is a passenger on an aircraft used by a common carrier;
- Cosmetic surgery or a surgical procedure not required by the *Insured*'s health condition, and any complication resulting therefrom;
- Experimental treatments and treatments involving the use of new procedures or therapies that are not yet in mainstream use;
- Training for or participation in professional sports or motor vehicle speed contests;
- An *Injury* obtained during the practice of any high-risk activity, including, but not limited to: bungee jumping, freestyle skiing or snowboarding, heliskiing or heliboarding, ski jumping, sky diving, hang gliding, sky surfing, street luge, skeleton, mountain or rock climbing with or without ropes, and participation in rodeos or ultimate fighting competitions;
- Pregnancy, childbirth or miscarriage, and any resulting condition, except in the case of a pathological complication;
- Refusal by the *Insured* of any treatment or medication deemed necessary for his or her condition, or refusal to submit to a medical examination required by his or her condition;
- Refusal by the *Insured* to submit to a rehabilitation program recommended by the attending *Physician* or to actively participate in a rehabilitation program previously approved by the *Insured* and the *Insurer*;
- Organ donation(s), except where the donation is made after the coverage has been in force for at least six (6) months.

NO DISABILITY BENEFIT WILL BE PAYABLE FOR:

- Any period during which the *Insured* is receiving a salary, except as part of a *Partial Disability* and/or rehabilitation plan approve by the *Insurer*;
- Any period during which the *Insured* is incarcerated in a penitentiary or a government detention facility.

No death benefit will be payable if the *Insured* commits suicide within two (2) years of the effective date or reinstatement of coverage, whether he or she is sane or insane.

7. Age

For the purposes of this *Policy*, the *Insured*'s age is the attained age at his or her last birthday preceding the issuance of coverage.

8. Termination of Policy and Coverages

THIS POLICY TERMINATES ON THE EARLIEST OF:

- The date a written request to this effect is received from the *Policyowner* or the date specified in the request if later than the date of receipt;
- The date on which the Income Insurance is cancelled;
- The date on which the grace period for premium payment expires;
- The *Policy* anniversary date following the *Insured*'s one hundredth (100th) birthday; or
- The date on which the *Insured* dies.

9. Incontestability

Apart for fraud, the *Insurer* cannot cancel or reduce a coverage that has been in force or reinstated for more than two (2) years because of misrepresentation or concealment with respect to risk. However, this rule does not apply if the *Disability* began within the first two (2) years of the effective date of the coverage or its reinstatement.

10. Reinstatement

If this *Policy* terminates because the premium was not paid, it may be reinstated within ninety (90) days of the date of termination provided the *Policyowner* requests that it be reinstated, establishes the *Insured*'s insurability and/or the state of health of the *Insurer*'s satisfaction and pays any outstanding premiums. The periods related to incontestability and suicide apply again as of the date of the last reinstatement.

11. Change of Beneficiary

Subject to legal provisions, the *Policyowner* may at any time designate, change or revoke a *Beneficiary*. For a change of *Beneficiary* to be recognized, the *Insurer* must receive written notice of the change. The *Insurer* bears no responsibility with respect to the validity of a *Beneficiary* designation.

12. Assigment

Subject to legal provisions, the *Policyowner* may at any time assign his or her *Policy*. For an assignment to be recognized, the *Insurer* must receive written notice of the assignment. The *Insurer* bears no responsibility with respect to the validity of an assignment.

13. Notice and proof of claim

All claims must be made in writing and submitted to the *Insurer* within thirty (30) days of the date of the *Disability*, *Criticall Illness* or death giving rise to a claim under this *Policy*.

The *Policyowner* or any person entitled to submit a claim must provide the *Insurer* with all the documents it may require within ninety (90) days of the date of the *Disability*, *Critical Illness* or death giving rise to a claim.

Where the *Policyowner* or any person entitled to make a claim demonstrates that it was impossible for them to act in a timely manner, it will not prevent them from receiving the benefit, provided that the information is submitted to the *Insurer* within one year of the date of the *Disability*, *Critical Illness* or death giving rise to a claim under this *Policy*.

The *Insurer* reserves the right to require that the *Insured* undergo any examination(s) it may consider necessary by a *Physician* of its choice. Refusal to do so will deprive the person of the right to receive benefits. In the event of the *Insured*'s death, the *Insurer* may, if permitted under applicable law, require an autopsy and any failure to satisfy that request will give the *Insurer* grounds to refuse payment of the benefit.

The *Insured*, the *Policyowner* and the *Beneficiary* are required to cooperate fully with the *Insurer* by providing all the information it may require and by signing any form or other document allowing the *Insurer* to obtain any information it deems relevant, within no more than ninety (90) days.

The *Policyowner* must notify the *Insurer* of any change of address for the purpose of facilitating correspondence and the transmission of any document.

14. Payment under the Policy

Disability and *Critical Illness* benefits are payable to the *Insured*.

Death benefits are payable to the *Beneficiary* designated in the application or in any other document subsequently submitted to the *Insurer*.

15. Reimbursement

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

16. Legal Currency

Any payment under the provisions of this *Policy* will be made in the legal currency of Canada.

17. Right to Cancel

The *Policyowner* may have this *Policy* cancelled within fifteen (15) days of the date of its receipt or within sixty (60) days after the *Policy* start date. When a written and signed by the *Policyowner* cancellation request is received by the *Insurer* within these periods, any premium collected under the *Policy* will be reimbursed to the *Policyowner*.

18. Compliance with the Law

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

19. General Provisions

The exclusions, limitations and General Provisions apply to the *Policy* as well as to all coverages when they are relevant.

Some coverages contain exclusions and limitations specific to those coverages. These exclusions and limitations apply in addition to those indicated in the General Provisions.