# INSURANCE WITHOUT MEDICAL EXAM

## Critical Illness Coverage with Refund of Premium on Death

## (10 or 20 year as per Owner's application) Renewable Term to Age 65

## (Gold, Silver or Bronze) Protection



**Nicolas Moskiou**
President and Chief Executive Officer

**Luc Bergeron**
Chief Financial Officer and Treasurer

**Policy N°:**

**Effective Date:**

**Owner:**

HUMANIA ASSURANCE MD®

## Part A
# Definitions

The terms identified in *italic* in the text are defined below:

***Beneficiary:*** unless otherwise indicated, the default *beneficiary* is the *person insured*. The *Owner* can change the *beneficiary* by notifying the *Insurer* of the new designation in writing.

***Covered Critical Illnesses***

***Cancer:*** a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnostic of *cancer* must be made by a *specialist*.

**The following forms of *cancer* are excluded:**

- carcinome in situ;
- 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);
- any non-melanoma skin *cancer* that has not become metastatic (spread to adjacent organs);
- stage A (T1a or T1b) prostate *cancer*.

***Coronary surgery:*** heart surgery to correct narrowing or blockage of one or more coronary artery with bypass graft(s). Non-surgical procedures such as angioplasty and laser relief of obstruction are not covered.

***Heart attack:*** the death of a portion of cardiac muscle as a result of inadequate blood supply, as evidenced by:

a) recent electrocardiographic (ECG) changes indicative of a myocardial infarction; and

b) elevation of cardiac biochemical markers to levels considered diagnostic for infarction.

*Heart attack* during an angioplasty is covered provided that there are diagnostic changes of new Q-wave infarction on the ECG in addition to elevation of cardiac markers.

*Heart attack* does not include an incidental finding of ECG changes suggesting a prior symptomless myocardial infarction or a prior myocardial infarction or a past myocardial infarction in the absence of a corroborating medical event.

***Stroke:*** A cerebrovascular event producing neurological sequelae lasting more than thirty (30) days and caused by thrombosis or hemorrhage, or embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit. Transient ischemic attacks (TIAs) are specifically excluded.

***Illness:*** a deterioration of health or a disorder of the body confirmed by a *physician*, that is not caused by an *injury* and whose first symptoms appear while this *policy* is in force.

***Injury:*** bodily lesion resulting directly or indirectly from an accident sustained by the *person insured* and independent of any sickness or other cause while this *policy* is in force.

***Insurance age:*** the *person insured*'s age at the last *policy* anniversary.

***Owner:*** the *owner* of this *policy*.

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

***Non-smoker:*** a person who has not used tobacco in any form whatsoever, including nicotine substitutes, nicotine products, vapour or electronic cigarette, in the twelve (12) months before signing the application for insurance.

***Person Insured*:** a person designated as such in the application for insurance.

***Physician*:** any person legally authorized to practice medicine in Canada within the scope of his or her medical degree (M.D.), and who does not have a family or business relationship with the *person insured* or the *owner*.

***Policy*:** the present contract, the application for this *policy*, and any rider or change notice attached hereto.

***Pre-existing condition*:** an *injury*, sickness or condition that appeared during the (12 or 24 months, as per *Person Insured*'s rating) prior to the effective date of this *policy* and for which:

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

***Risk class*:** the characteristics of the *person insured* that determine the premium rate for coverage. *Risk classes* are based on gender, age, smoking status and health condition.

***Specialist*:** a *physician* who holds a license and has specialized medical training related to the *covered critical illness* for which a claim has been submitted.

***Survival period*:** a period of thirty (30) days during which the *person insured* must survive after the date on which a covered *illness* diagnosed, in order for the benefit amount to be payable.

**Part B**

# Critical Illness Coverage with Refund of Premium on Death

## (10 or 20 year as per *Owner*'s application) Renewable Term to Age 65 (Gold, Silver or Bronze) Protection



### Benefits

If the *person insured* is diagnosed with a *covered critical illness* and the *covered critical illness* does not result from or is not directly or indirectly related to a *pre-existing condition*, the *Insurer* will pay, while the coverage is in effect, the critical *illness* benefit shown in the Schedule of Benefits if the *person insured* is still alive after the *survival period*.

If the *person insured* is diagnosed with a *covered critical illness* and the *covered critical illness* results from or is directly or indirectly related to a *pre-existing condition*, but the *covered critical illness* is diagnosed after the (12 or 24 months, as per *Person Insured*'s rating) period following the effective date of this coverage, the *Insurer* will pay, while the coverage is in effect, the critical *illness* benefit shown in the Schedule of Benefits, if the *person insured* is still alive after the *survival period*.

No benefit for a *covered critical illness* will be payable during the (12 or 24 months, as per *Person Insured*'s rating) period following the effective date of this coverage if the critical *illness* results from or is directly or indirectly related to a *pre-existing condition* and is diagnosed during the (12 or 24 months, as per *Person Insured*'s rating) period following the effective date of this coverage. In such an instance, the *Insurer*'s liability will be limited to a refund of the premiums paid and the *policy* will terminate with no further value.

In the event that the *person insured* should die, provided no critical *illness* benefit is payable, the *Insurer* will pay, while the coverage is in effect, a benefit equal to the total amount, without interest, of the premiums paid for this critical *illness* coverage during the period of coverage under this benefit, subject to a maximum payment not to exceed the critical *illness* benefit shown in the Schedule of Benefits.

### List of *Covered Critical Illnesses* and Their Definition

***Cancer*** is defined as:

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

**The following forms of *cancer* are excluded:**

- carcinome in situ;
- 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);
- 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 occur within ninety (90) days of the effective date of this coverage:

- the date of diagnosis of any *cancer*, whether covered or excluded; or
- the date on which any early signs or symptoms for any *cancer*, whether covered or excluded, appear; or
- the date of medical consultations and tests leading to the diagnosis of any *cancer*, whether covered or excluded.

Any diagnosis of *cancer* (whether covered or excluded under this benefit) or any sign or symptom or any medical consultation or test leading to a diagnosis of *cancer* (whether covered or excluded under this benefit) that appears 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 claim under this coverage.

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

Heart surgery to correct narrowing or blockage of one or more coronary artery with bypass graft(s). Non-surgical procedures such as angioplasty and laser relief of obstruction are not covered.

***Heart attack (myocardial infarction)*** is defined as:

The death of a portion of cardiac muscle as a result of inadequate blood supply, as evidenced by:

a) recent electrocardiographic (ECG) changes indicative of a myocardial infarction; and

b) elevation of cardiac biochemical markers to levels considered diagnostic for infarction.

*Heart attack* during an angioplasty is covered provided that there are diagnostic changes of new Q-wave infarction on the ECG in addition to elevation of cardiac markers.

*Heart attack* does not include an incidental finding of ECG changes suggesting a prior symptomless myocardial infarction or a prior myocardial infarction or a past myocardial infarction in the absence of a corroborating medical event.

***Stroke (cerebrovascular accident)*** is defined as:

A cerebrovascular event producing neurological sequelae lasting more than thirty (30) days and caused by thrombosis or hemorrhage, or embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit. Transient ischemic attacks (TIAs) are specifically excluded.

## Limitations

**Conditions relating to payment of a benefit for *covered critical illnesses***

The benefit will not be payable until after the *survival period* and provided it is the first appearance of a *covered critical illness*. Critical *illness* benefits are not cumulative. Consequently, the *Insurer* can never be required to pay more than one benefit under this coverage.

**Maximum payable**

The total amount of benefits payable by the *Insurer* for all HUMANIA ASSURANCE – INSURANCE WITHOUT MEDICAL EXAM Critical *Illness policies* issued in respect of a single *person insured* may not exceed one hundred thousand dollars ($100,000). In the event that the amount of coverage held in respect of a single *person insured* is greater than one hundred thousand dollars ($100,000), the *Insurer* will pay a total benefit of one hundred thousand dollars ($100,000) and will refund any premiums paid in respect of any benefits in excess of that amount.

## Exclusions

No benefit will be payable during the (12 or 24 months, as per *Person Insured*'s rating) following the effective date of coverage if the *covered critical illness* results from or is directly or indirectly related to a *pre-existing condition*.

No benefit will be payable for a *covered critical illness* that results from:

- attempted suicide or intentionally self-inflicted *injury* or dismemberment whether the *person insured* is sane or insane;
- the *person 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; or
- the *person insured*'s intentional use of any drug or medication without a prescription by a *physician* or any other health professional or the *person insured*'s use of any drug or medication prescribed by a *physician* or any other health professional other than as directed.

No benefit will be paid for any of the following forms of *cancer*:

- carcinoma in situ;
- 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);
- any non-melanoma skin *cancer* that has not become metastatic (spread to adjacent organs);
- stage A (T1a or T1b) prostate *cancer;*
- if, during the ninety (90) days following the effective date of the *policy*, *cancer* is diagnosed or the results of a consultation or tests indicate any sign or symptom leading to the diagnosis of any *cancer* in the *person insured*.

**Moratorium Period**

No benefit will be paid for any *cancer* when the earliest of the following dates occurs within ninety (90) days of the effective date of this coverage:

- the date of diagnosis of any *cancer* whether covered or excluded;
- the date on which any early signs or symptoms for any *cancer*, whether covered or excluded, appear; or
- the date of medical consultations and tests leading to the diagnosis of any *cancer*, whether covered or excluded.

In such an instance, the *Insurer* will refund the paid premiums and any coverage will cease immediately, as the *policy* will terminate.

**Disclosure to the *Insurer***

Any diagnosis of *cancer* (whether covered or excluded) or any sign or symptom or medical consultation or test leading to a diagnosis of *cancer* (whether covered or excluded) that appears 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.

## General Provisions

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

## Part C

# General Provisions

## 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 *person insured*'s insurability since signing the application.

## Premiums

The premium is guaranteed for the (10 or 20 year as per *Owner*'s application) period indicated in the Schedule of Benefits. At the end of that (10 or 20 year as per *Owner*'s application) period and every (10 or 20 year as per *Owner*'s application) period thereafter, the premium will be adjusted to reflect the *person insured*'s attained age, the *person insured* original *risk class* and the premium rates applicable at that date. The new premium will also be guaranteed for a period of (10 or 20 year as per *Owner*'s application).

## Method of Payment

The premium is payable monthly by pre-authorized debit or yearly, at the choice of the *owner*. Where a cheque or other bill of exchange or a promissory note or other written promise to pay is given for the whole or part of a premium and payment is not made according to its tenor, the premium or part thereof shall be deemed never to have been paid.

## Grace Period

A grace period of thirty (30) days is granted for payment of each premium except the first. If a premium other than the first remains unpaid after the grace period, the *policy* will no longer be in effect and will lapse without value. If the *Insurer* does not receive the first premium when due, this *policy* will be treated as if it had never been issued.

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

## Age

For the purposes of this *policy*, the *person insured*'s age is his or her attained age at the birthday preceding or coincident with the issuance of coverage. If, mistakenly or otherwise, the age used to calculate the premium is incorrect, any amount payable by the *Insurer* at the time of a claim will be adjusted to reflect the correct age at the date on which the *person insured* became *insured*.

## Non-Participating *Policy*

This *policy* is non-participating and does not confer any right to participate in the profits of the *Insurer*.

## Diagnosis in Canada

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

## Diagnosis outside Canada

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

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

b) based on the medical records received, the *Insurer* is certain that:

i) the same diagnosis would have been made had the critical *illness* or accident been diagnosed by a duly licensed *specialist* practicing in Canada;

ii) the same treatment would have been prescribed in accordance with Canadian standards; and

iii) the same treatment, including any necessary surgery, would have been prescribed had the treatment been administered in Canada.

## Disclosure

Each of the *person insured* , the *owner* and the *beneficiary* are required to cooperate fully with the *Insurer* and shall disclose to the *Insurer* in the application, during a medical examination, if any, and in any written statements or answers furnished as evidence of insurability, every fact within the person's knowledge that is material to the insurance and is not so disclosed by the other such person. The *person Insured*, the *owner* and the *beneficiary* shall also sign any form or other document allowing the *Insurer* to obtain any information it deems relevant to this insurance coverage.

Subject to the provisions of this *policy* dealing with incontestability and age, where one or more of the *person insured*, the *owner*, and the *beneficiary* fails to disclose such a material fact or misrepresents such a material fact, the contract is voidable by the *Insurer*.

## Incontestability

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

However, this rule does not apply if the *disability* began before the coverage has been in effect for two (2) years with respect to the person for whom the claim is made.

## Misrepresentation Concerning Smoking Habits

If the premium for this *policy* is based on statements in the application for insurance to the effect that the *person insured* does not use tobacco in any form whatsoever, including nicotine substitutes, nicotine products, vapour or electronic cigarette, and those statements are in fact false, they will be considered fraudulent and this *policy* will be void from the effective date.

Accordingly, any claim paid by the *Insurer* will have to be reimbursed.

## Termination of *Policy* and Coverages

Unless stipulated otherwise in a given coverage, this *policy* and its coverages terminate at the earliest of the following dates:

- the date on which the *Insurer* receives a written request from the *owner* to cancel this *policy*;
- the date on which the grace period for any premium payment expires;

- the date on which the *person insured* suffers, within (12 or 24 months, as per *Person Insured*'s rating) after the effective date, from a critical *illness* resulting from or directly or indirectly related to a *pre-existing condition*;
- the date on which a benefit is paid under the critical *illness* insurance coverage;
- the *policy* anniversary date on which the *person insured* has reached the *insurance age* of sixty-five (65);
- the date on which the *person insured* dies.

## Change of *Beneficiary*

Subject to legislation governing this *policy*, the *owner* 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 that change by registered mail. The *Insurer* bears no responsibility with respect to the validity of a *beneficiary* designation or any change of *beneficiary*.

## Payment under this *Policy*

Benefits are payable to the *person insured* unless notification to the contrary is submitted in writing to the *Insurer*.

## Reimbursement

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

## Legal currency

Any payment under the provisions of this *policy* will be made in the lawful currency of Canada.

## Right to Cancel

The *owner* may have this *policy* cancelled within fifteen (15) days of the date of its receipt or within sixty (60) days after the date on which the *policy* is issued. A written cancellation request must be received by the *insurer* within this time period. Any premiums paid for the *policy* will then be refunded.

## Compliance with the Law

Any provision of this *policy*, on the effective date, that does not comply with applicable legislation in the province or territory in which this *policy* is issued is amended so as to meet the minimum requirements of that legislation.

## General Provisions

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

Certain coverages contain exclusions and limitations specific to those coverages. The exclusions and limitations apply in addition to the exclusions and limitations of the General Provisions.