Manulife

Lifecheque (Level) or Lifecheque (Renewable) Sample contract

This sample policy contract is provided for your information only.
It is not a valid contract or an offer of insurance.

(06/2017)

Manulife

We're pleased to provide you with your Lifecheque insurance policy. The features of your policy are explained in the policy sections that follow. Please read your policy carefully so that you can take full advantage of the benefits it offers.

Thank you again for selecting Manulife Financial.

In this policy, *you* and *your* mean the owner of the policy, and *we*, *our* and *us* mean The Manufacturers Life Insurance Company (Manulife Financial).

For an explanation of the words and phrases we use in this policy, see section *8 Words and phrases used in your policy*.

Your policy is an important part of the legal contract between you and us. We ask that you read it carefully to ensure that it gives you the coverage you applied for.

In the policy, we occasionally use the phrase *subject to our administrative rules in effect at the time*. We change our administrative rules from time to time to reflect corporate policy and economic and legislative changes, including revisions to the Income Tax Act. Any changes we make to our administrative rules will not affect the guaranteed benefits provided by this policy.

When we say *we will send a notice to you*, we mean that we will send it to your address as shown in our files. You must advise us of any change in your address. Our phone number is shown on page 3.1 and the address of our Canadian head office is
500 King Street N, PO Box 1669, Stn. Waterloo, ON, N2J 4Z6.

2 Table of contents

4 Statutory conditions

The contract

The application, this policy document, any document attached to this policy document when issued and any amendment or endorsement to the contract agreed upon in writing after the policy is issued constitute the entire contract.

The application consists of all documents which were provided to us in conjunction with your request that we provide insurance. This includes:

- any medical evidence forms
- any written statements and answers that were given as evidence of insurability
- all subsequent applications to reinstate or change the insurance or rider coverages and any amendments or new versions of the policy summary pages that result, and
- any endorsements.

Waiver

No agent has authority to change the contract or waive any of its provisions. We shall not be deemed to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in a written statement signed by us.

Copy of your application

We will provide a copy of your application at your request.

Material facts

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

Cancellation by owner

If you choose to cancel your contract, your contract ends on the business day we receive your written request to cancel the contract in our principal place of business in your province or at our Canadian head office. We will refund the unused portion, if any, of the premium paid during the policy year that you request cancellation. If no premium was paid during the policy year you request cancellation, no premium will be refunded.

Notice and proof of claim

How to claim benefits

Any claim for a payment of benefits must be made in writing to our principal place of business in your province or our Canadian head office. We must receive the notice of claim within 30 days of the date that a claim arises.

Within 90 days of the date a claim arises under the contract, you must provide us with such proof as is reasonably possible of the happening of the accident or the commencement of the sickness or disability and the resulting loss, the right of the claimant to receive payment and his or her age and the age of the beneficiary, if relevant.

We might also ask you to furnish information satisfactory to us as to the cause or nature and/or duration of the accident, sickness or the disability for which you are claiming a benefit under this policy.

Failure to give notice or proof

If you fail to notify us or provide proof satisfactory to us within the time prescribed in this statutory condition, this is how we will determine any benefit payable.

We will pay a benefit:

- if we determine that the insured person:
  - is functionally dependent and has satisfied the waiting period for a care benefit, or
  - qualifies for a critical illness benefit and has satisfied the waiting period for the critical illness benefit

and

- if you notify us as soon as reasonably possible and within one year from the date the insured person:
  - appeared to be functionally dependent, or
  - qualified for a critical illness benefit

and

- if we receive proof satisfactory to us that it was not reasonably possible for you to give us notice or provide proof within the time prescribed.

In all cases, you must provide proof of claim within one year of the date a claim arises under the policy.

Declaration of presumption of death

If we require a declaration of presumption of death to pay the death benefit, the person making the claim must give us appropriate notice or proof of the claim within one year of the court's declaration. That person can contact us for information on the documents we need to process the claim.

Insurer to furnish forms for proof of claim

Within 15 days of receiving a notice of claim, we will send you proof of claim forms. If you do not receive the proof of claim forms within 15 days, you may submit the proof of claim to us in a written statement that includes the cause, nature and extent of the accident, sickness or disability and the resulting loss that is the basis of this claim.

Rights of examination

We may require that the insured person be examined when and so often as we reasonably require while the claim is pending. In the case of the death of an insured person, we may also require an autopsy subject to any law of the applicable jurisdiction relating to autopsies. These conditions must be satisfied before we will pay a claim.

Payment of claim

We will pay all benefits payable under this contract within sixty days after we have received proof of claim.

Limitations of actions

An action or proceeding against us for the recovery of a claim under this policy must begin within one year of the date the insurance money became payable or would have become payable if the claim had been valid.

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

Provincial variations

If necessary, the provisions described in this contract will be adjusted to meet the minimum requirements of law within your province or territory.

5 Lifecheque benefits

The policy summary page indicates what type(s) of Lifecheque insurance coverage(s) you have purchased for each insured person. This policy document contains only the pages that apply to the coverage(s) you have purchased.

The Lifecheque critical illness benefit pages are numbered as follows:

5.1 Lifecheque (Primary)
5.2 Lifecheque (Renewable) or Lifecheque (Level)
5.3 Lifecheque (Permanent)

The Lifecheque long term care benefit pages are numbered as follows:

5.4 LivingCare benefit

5.2 Lifecheque (Renewable) or Lifecheque (Level)

Critical illness benefits

Covered condition benefit

We will pay a covered condition benefit to you if the insured person has one of the covered conditions and:

- satisfies the waiting period for the covered condition as described in the policy, and
- meets the other terms of this policy.

The covered conditions are described in this section under the subheading *Covered conditions*.

If a covered condition benefit is payable, the amount of the benefit is:

- the amount of insurance of the Lifecheque insurance coverage for that insured person as shown in section 3

minus

- any recovery benefit paid or payable for that Lifecheque insurance coverage for that insured person

minus

- any care benefits paid or payable for that Lifecheque insurance coverage for that insured person.

Recovery benefit

A recovery benefit is designed to help an insured person begin to recover by providing a benefit payment as quickly as possible. There is no waiting period for a recovery benefit.

We will pay a recovery benefit to you if you submit a claim for a covered condition benefit and:

- this Lifecheque insurance coverage was in effect at the time of the claim
- you provide us with a completed claimant's statement in a form acceptable to us
- you provide us with an attending physician's statement completed by the appropriate specialist in a form acceptable to us
- the evidence submitted in these forms, or in connection with them, provides at least some evidence satisfactory to us that the insured person has been diagnosed with the covered condition. Where the definition of the covered condition specifies one or more requirements for payment for that covered condition benefit, acceptable evidence must include at least some evidence that the insured person meets each of these requirements, and
- we have no evidence at the time that suggests that you are not eligible to receive the covered condition benefit for that condition.

If a recovery benefit is payable, the amount of the benefit is:

- 10 per cent of the amount of insurance of the Lifecheque insurance coverage for that insured person as shown in section 3 *minus* any care benefits paid or payable for that insured person for that coverage

or

- $10,000

whichever is less.

Only one recovery benefit will ever be paid for that Lifecheque insurance coverage for that insured person.

Other information about the recovery benefit

If we pay a recovery benefit that does not necessarily mean that you will be eligible to receive the associated covered condition benefit. We must complete our investigation of your claim before we can determine if you are eligible for that benefit.

If we decide you are not eligible for the covered condition benefit, the recovery benefit is yours to keep unless we determine that:

- the Lifecheque insurance coverage is voidable due to misrepresentation or fraud as described in section 7 under the subheading *Contesting the contract,* or
- a claim was made fraudulently.

In these cases, you must repay the recovery benefit to us.

Early intervention benefit

We will pay an early intervention benefit to you if the insured person has one of the early intervention conditions and:

- satisfies the waiting period for the early intervention condition as described in the policy, and
- meets the other terms of this policy.

The early intervention conditions are described in this section under the subheading *Early intervention conditions*.

If an early intervention benefit is payable, the amount of the benefit is:

- 25 per cent of the amount of insurance across all Lifecheque insurance coverages for that insured person

or

- $50,000

whichever is less.

If we pay an early intervention benefit for an insured person, we won't pay another early intervention benefit for that insured person under this policy or any other Lifecheque policy.

Early intervention conditions

Chronic lymphocytic leukemia (CLL) Rai stage 0

A definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL).

For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Conkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

The condition must be diagnosed by a specialist.

Waiting Period

The 30 days following the date the condition is diagnosed.

Exclusions

We will not pay an early intervention benefit for Monoclonal Lymphocytosis of Undetermined Significance (MLUS).

Additional exclusions are described in Section 6 under the subheading *Exclusions for Cancers and Related Conditions*

Coronary angioplasty

The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

The procedure must be determined to be medically necessary by a specialist.

Waiting period

The 30 days following the date of the procedure.

Ductal carcinoma in situ of the breast

A definite diagnosis of ductal carcinoma in situ of the breast.

The condition must be diagnosed by a specialist and confirmed by biopsy.

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusion

Exclusions are described in section 6 under the subheading *Exclusions for cancers and related conditions*.

Papillary or follicular thyroid cancer stage T1

A definite diagnosis of 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.

The condition must be diagnosed by a specialist and confirmed by a biopsy.

Waiting Period

The 30 days following the date the condition is diagnosed.

Exclusions

Exclusions are described in Section 6 of the Lifecheque contract under the subheading *Exclusions for Cancers and Related Conditions.*

Stage A (T1a or T1b) prostate cancer

A definite diagnosis of stage A (T1a or T1b) prostate cancer.

The condition must be diagnosed by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusion

Exclusions are described in section 6 under the subheading *Exclusions for cancers and related conditions*.

Stage 1 malignant melanoma

A definite diagnosis of Stage 1A or 1B malignant melanoma that is 1.0 mm or less in depth and non-ulcerated.

The condition must be diagnosed by a specialist.

Waiting Period

The 30 days following the date the condition is diagnosed.

Exclusions

We will not pay an early intervention benefit for malignant melanoma in situ.

Additional exclusions are described in Section 6 under the subheading *Exclusions for Cancers and Related Conditions.*

Covered conditions

Aortic surgery

The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist.

Waiting period

The 30 days following the date of surgery.

Exclusions

We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic anemia

A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents,
- immunosuppressive agents, or
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Bacterial meningitis

A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist.

Waiting period

Until the date the criteria outlined above have been met.

Exclusion

We will not pay a covered condition benefit for viral meningitis.

Benign brain tumour

A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

The diagnosis of a benign brain tumour must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusions

Exclusions are described in section 6 under the subheading *Exclusions for benign brain tumours and related conditions*.

Blindness

A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

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

The diagnosis of blindness must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Cancer (life threatening)

A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of cancer must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusions

Exclusions are described in section 6 under the subheading *Exclusions for cancers and related conditions*.

Coma

A definite diagnosis of a state of unconsciousness, with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

The diagnosis of coma must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusions

We will not pay a covered condition benefit for the following conditions:

- a medically induced coma
- a coma which results directly from alcohol or drug use, or
- a diagnosis of brain death.

Coronary artery bypass surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a specialist.

Waiting period

The 30 days following the date of surgery.

Exclusions

We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness

A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of deafness must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Dementia, including Alzheimer's disease

A definite diagnosis of dementia characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech)
- apraxia (difficulty performing familiar tasks)
- agnosia (difficulty recognizing objects), or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The insured person must exhibit:

- dementia of at least moderate severity evidenced by a Mini Mental State exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function, and
- evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a six month period.

For purposes of the policy, reference to the Mini Mental State exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res 1975;12(3):189.

The diagnosis of dementia must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusions

We will not pay a covered condition benefit for affective or schizophrenic disorders, or delirium.

Heart attack

A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack, or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

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

Waiting period

The 30 days following the date the condition is diagnosed.

Exclusions

We will not pay a covered condition benefit for:

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

Heart valve replacement or repair

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve, or to repair heart valve defects or abnormalities.

The surgery must be determined to be medically necessary by a specialist.

Waiting period

The 30 days following the date of surgery.

Exclusions

We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney failure

A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The diagnosis of kidney failure must be made by a specialist.

Waiting period

The 30 days following the date the condition is diagnosed.

Loss of limbs

A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The diagnosis of loss of limbs must be made by a specialist.

Waiting period

The 30 days following the date the second limb is severed.

Loss of speech

A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.

The diagnosis of loss of speech must be made by a specialist.

Waiting period

Until the date the criteria outlined in loss of speech above have been met.

Exclusions

We will not pay a covered condition benefit for all psychiatric-related causes.

Major organ failure (on waiting list)

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure (on waiting list), the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

The diagnosis of the major organ failure must be made by a specialist.

Waiting period

The 30 days following the date of the insured person's enrolment in the transplant centre specified above.

Major organ transplant

A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow and limited to these entities.

The diagnosis of the major organ failure must be made by a specialist.

Waiting period

The 30 days following the date of transplantation.

Motor neuron disease

A definite diagnosis of one of the following:

- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- primary lateral sclerosis
- progressive spinal muscular atrophy
- progressive bulbar palsy, or
- pseudo bulbar palsy

and limited to these conditions.

The diagnosis of motor neuron disease must be made by a specialist.

Waiting Period

The 30 days following the date the condition is diagnosed.

Multiple sclerosis

A definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination, or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of multiple sclerosis must be made by a specialist.

Waiting period

Until the date the criteria outlined in multiple sclerosis above have been met.

Occupational HIV infection

A definite diagnosis of infection with human immunodeficiency virus (HIV) resulting from accidental injury during the course of the insured person's normal occupation, which exposed the insured person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of:

- the coverage issue date, and
- the effective date of last reinstatement of that coverage.

Payment under this covered condition requires satisfaction of all of the following:

- the accidental injury must be reported to us within 14 days of the accidental injury
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States, and
- the accidental injury must have been reported, investigated and documented in accordance with current workplace guidelines in Canada or the United States.

The diagnosis of occupational HIV infection must be made by a specialist.

Waiting period

The 30 days following the date that all of the criteria outlined in occupational HIV infection above have been met.

Exclusions

We will not pay a covered condition benefit for occupational HIV infection if:

- the insured person has elected not to take any available licensed vaccine offering protection against HIV
- a licensed cure for HIV infection has become available prior to the accidental injury, or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use.

Paralysis

A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of paralysis must be made by a specialist.

Waiting period

Until the date the criteria outlined in paralysis above have been met.

Parkinson's disease and specified atypical Parkinsonian disorders

A definite diagnosis of primary Parkinson's disease, a permanent neurologic condition characterized by bradykinesia (slowness of movement) and at least one of:

- muscle rigidity; or
- rest tremor

Specified atypical Parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The insured person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

The diagnosis of Parkinson's disease or a specified atypical Parkinsonian disorder must be made by a neurologist.

Waiting period

Until the later of:

- the day all of the criteria outlined for Parkinson's disease above have been met, and
- 30 days from the date of diagnosis.

Exclusions

We will not pay a covered condition benefit for any other types of Parkinsonism.

We will not pay a covered condition benefit if, within the first year of the later of:

- the coverage issue date, and
- the date of last reinstatement of the coverage,

the insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, or a specified atypical Parkinsonian disorder, regardless of when the diagnosis is made, or
- a diagnosis of Parkinson's disease, or a specified atypical Parkinsonian disorder.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for:

- Parkinson's disease, or
- specified atypical Parkinsonian disorders,

or any critical illness caused by:

- Parkinson's disease, or
- specified atypical Parkinsonian disorder,

or its treatment.

Severe burns

A definite diagnosis of third-degree burns over at least 20 per cent of the body surface.

The diagnosis of severe burns must be made by a specialist.

Waiting period

The 30 days following the date the severe burns occurred.

Stroke (cerebrovascular accident)

A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist.

Waiting period

Until the date the criteria outlined in stroke above have been met.

Exclusions

We will not pay a covered condition benefit for:

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

Premium renewal tables

If you have Lifecheque (Renewable) coverage, see the premium renewal tables in section 9 for information about how the premium for your Lifecheque insurance coverage changes over the lifetime of your policy.

5.4 LivingCare benefit

The LivingCare benefit allows you to claim a specific portion of the amount of insurance of a Lifecheque insurance coverage as care benefits.

This specific portion is called the LivingCare benefit limit and is shown in section 3 for each Lifecheque insurance coverage with a LivingCare benefit.

Because the LivingCare benefit limit is included in the amount of insurance for a Lifecheque insurance coverage, any care benefits paid on that coverage will reduce the total amount of insurance of that Lifecheque insurance coverage.

The LivingCare benefit balance for an insured person is the amount available to pay care benefits across all Lifecheque policies.

For an explanation of the words and phrases we use in this section, see Section 8, *Words and phrases used in your policy*.

Limitation of the LivingCare benefit

We will pay care benefits to a maximum equal to the LivingCare benefit balance, or $500,000, whichever is less. This limitation applies across all Lifecheque policies.

If you exercise a continuation option, we will pay care benefits to a maximum equal to the LivingCare benefit balance, or $500,000, whichever is less, minus the amount of insurance that you purchased as a result of exercising the continuation option.

Care benefit

The care benefit is the amount that is payable for each month that the insured person is functionally dependent.

Unless you have given us other instructions, we pay the care benefit to the insured person.

We will pay care benefits when all of these five conditions are met:

1 We determine that the insured person is functionally dependent.
2 The insured person becomes functionally dependent on or after the coverage date.
3 The insured person is functionally dependent for a number of days equal to the waiting period as shown in section 3.
4 The Lifecheque insurance coverage is in effect on the first day of the waiting period for the care benefit.
5. The LivingCare benefit is in effect.

Determining if the insured person is functionally dependent

You, or the insured person, or a friend or relative should notify us within 30 days of noticing that the insured person appears to be functionally dependent. We will arrange for an initial assessment to help us determine if the insured person is functionally dependent.

An initial assessment is a face-to-face evaluation done where the insured person resides by a care advisor appointed by us.

The care advisor will assist us in determining:

- the insured person's ability to do the activities of daily living, and/or
- if the insured person has a cognitive impairment.

The care advisor will assess any factors that are relevant to the insured person's situation. These may include:

- functional, cognitive, behavioral, and emotional well-being
- family support, and
- the safety of their environment.

In their assessment, the care advisor will use professionally accepted tests that provide objective measures and produce verifiable results.

We may also require other proof including, but not limited to, hospital or facility records, information from government agencies, or medical reports. We may require that the insured person be examined by a health care professional designated by us at our expense.

We will need you and the insured person to co-operate, be available, and to provide the information we need to review and make a decision on the claim. If you or the insured person do not co-operate, we will not proceed with the claim.

When the insured person is functionally dependent

The insured person is functionally dependent when we determine that, even with the use of medications, assistive devices, appliances, or other aids:

- the insured person cannot do two or more of the activities of daily living without substantial assistance from another person, or
- due to a cognitive impairment, the insured person needs substantial supervision to protect themselves from threats to their health or safety.

To be considered functionally dependent, the insured person must also:

- be under the regular care of a physician
- follow recommended treatments, and
- use assistive devices that are appropriate for the conditions causing them to be functionally dependent.

Activities of daily living

The activities of daily living are specific basic daily tasks that the insured person needs to be able to do to maintain their own health and safety.

The activities of daily living used to determine if the insured person is functionally dependent are:

- **Bathing** which means washing their body in a bathtub (including getting into or out of the bathtub), or in a shower (including getting into or out of the shower), or by a sponge bath. Bathing does not include the insured person's ability to wash their hair or to reach their back or feet.
- **Eating** which means feeding themselves from a cup, bowl or plate, or by a feeding tube. Eating does not include preparing or serving their meals.
- **Dressing** which means putting on and taking off all necessary items of clothing and any medically necessary braces, surgical appliances or artificial limbs. A "necessary item of clothing" is any item of clothing that can be made, purchased, or purchased and altered and that is reasonable for the insured person's health, comfort and dignity in the environment in which they normally live.
- **Toileting** which means getting to and from, and on and off the toilet, and performing the associated personal hygiene.
- **Transferring** which means moving into or out of a bed, chair or wheelchair.
- **Maintaining continence** which means controlling their bowel and bladder function or, if they cannot maintain control, performing the associated personal hygiene (including the use of incontinence products and caring for a catheter or colostomy bag).

Substantial assistance

If an insured person needs substantial assistance to perform the activities of daily living, this means they usually and regularly need either:

- hands-on physical assistance from another person, or
- stand-by assistance, which means the presence of another person within arm's reach who will physically intervene to prevent the insured person from being injured. For example, a person providing stand-by assistance would be ready to catch a person who fell while getting into or out of the bathtub or shower, or would be ready to remove food from a person's throat if they choked while eating.

Substantial supervision

If an insured person needs substantial supervision, this means they need continual supervision by a responsible adult. This person must be willing and able to take the actions or provide the directions needed to protect the insured person from threats to their health or safety.

Cognitive impairment

A cognitive impairment is a loss of, or deterioration in, intellectual capacity. The insured person's loss or deterioration must meet these three conditions:

1 It must be comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia or the result of severe brain injury.
2 It must be demonstrated by impairment in:
   a short-term or long-term memory
   b orientation as to people, places, or time
   c deductive or abstract reasoning, or
   d judgment as it relates to the insured person's awareness of their own safety and the safety of others.
3 It must be confirmed and measured by clinical evidence and standardized tests.

Exclusion

A cognitive impairment does not include any mental or nervous disorder, including but not limited to anxiety disorders, mood disorders, sleep disorders, pain disorders, personality disorders and psychotic disorders.

Waiting period

The insured person must be functionally dependent for a number of days equal to the waiting period before they are eligible to receive a care benefit. The waiting period is shown in section 3.

The waiting period starts on the day of the assessment that leads to our decision that the insured person is functionally dependent. For this reason, we should be notified as soon as possible (and not later than 30 days) after you notice the insured person appears to be functionally dependent.

If we determine that we cannot perform an assessment promptly because of the insured person's health, the waiting period will begin on the date of a major health event (such as an accident or admittance to a hospital for a prolonged stay). We must have documented medical evidence of that event which we will use to determine if the insured person is functionally dependent.

To satisfy the waiting period, the insured person must be functionally dependent for the number of days shown in section 3. These days can be either:

- consecutive, or
- non-consecutive, as long as each day that the insured person is functionally dependent:
  - is separated by 180 days or less,
  - is a result of the same or a related cause, and
  - occurs before the Lifecheque insurance coverage expiry date shown in section 3.

Waiting period on subsequent claims

If we stopped paying a care benefit because the insured person was no longer eligible, and if we determine that the insured person is functionally dependent again:

- while that Lifecheque insurance coverage is in effect

and

- less than 180 calendar days after we stopped paying a care benefit for the previous period when they were functionally dependent, and
- from the same or related cause as the previous period when they were functionally dependent

then the insured person will not have to satisfy another waiting period. We will consider the subsequent period when the insured person is functionally dependent to be a continuation of the previous claim.

If we have stopped paying a care benefit because the insured person was no longer eligible, and if we determine that the insured person is functionally dependent again:

- while that Lifecheque insurance coverage is in effect

and

- 180 calendar days or more after we stopped paying a care benefit for the previous period when they were functionally dependent, or
- from a new or different cause than the previous period when they were functionally dependent

then the insured person will need to satisfy a new waiting period. We will consider the subsequent period when the insured person is functionally dependent to be a new claim.

Calculating the care benefit

We pay the care benefit once a month.

For a "not a facility" care setting, the monthly care benefit we will pay equals:

- one per cent of the initial LivingCare benefit balance for that insured person, or
- $5,000 per month

whichever is less.

For a "facility" care setting, the monthly care benefit we will pay equals:

- two times the monthly care benefit payable for the "not a facility" care setting, or
- $10,000 per month

whichever is less.

Care settings

"Not a facility" care setting

We will use "not a facility" for the care setting if the insured person is functionally dependent and is residing:

- in a private residence
- in a hospital (except in the specific circumstances described in *"Facility" care setting* below)
- in a facility that is used primarily for acute medical care, training or education, the treatment of alcoholism or chemical dependency or the treatment of mental or nervous disorders, or
- in any location other than a long term care facility as described under the subheading *Long term care facility*.

"Facility" care setting

We will use "facility" for the care setting if the insured person is functionally dependent and is residing in a long term care facility as described under the subheading "*Long term care facility*". We will require proof that is satisfactory to us that the insured person is residing in a long term care facility.

We will also use "facility" for the care setting if the insured person is functionally dependent and is:

- temporarily staying in a hospital at their own expense because they require care in a long term care facility and are waiting until those arrangements can be made, or
- temporarily staying in a hospital while they are eligible for a care benefit at the care setting of "facility".

Long term care facility

A long term care facility means a place of care in Canada or the continental United States (including Alaska) and Hawaii. That place of care must meet these three requirements:

1 Offer services performed by or continually supervised by a physician or registered nurse on-site 24 hours a day. The physician or nurse must be licensed in Canada or the United States.

or

Offer 24-hour on-site staff to provide custodial care to multiple residents, with established procedures for obtaining appropriate aid in the event of a medical emergency.

2 Maintain a daily record of care for each patient.

3 Administer a planned program of observation and treatment that meets existing standards of medical practice for the functional dependence causing the insured person's stay at that place of care.

Paying the care benefit

We will determine the care benefit based on the number of days that the insured person was functionally dependent and resided in either the "facility" or "not a facility" care setting during that month.

Unless you have given us other instructions, we pay the care benefit to the insured person.

While we are paying a care benefit, we have the right to require additional assessments or other proof that the insured person is still functionally dependent, when and as often as we require. We will need you and the insured person to co-operate, be available and provide the information we need to review and make a decision on the claim. If you and the insured person do not co-operate, we will stop paying the care benefit.

How your LivingCare benefit limit changes

Reducing the LivingCare benefit balance

The LivingCare benefit balance will be reduced by the amount of any care benefits that are paid or payable.

When the LivingCare benefit balance is $0

On the day that the LivingCare benefit balance is reduced to $0, or the paid or payable care benefits total $500,000 for the insured person, the LivingCare benefit on all Lifecheque insurance policies ends and no more care benefits will be paid.

If we pay a recovery benefit

If the amount of insurance for a Lifecheque coverage equals the LivingCare benefit limit shown in section 3 for that coverage, each will be reduced by the amount of any recovery benefit paid.

If you request a decrease

If you decrease the amount of insurance of the Lifecheque insurance coverage and that new amount of insurance is greater than the LivingCare benefit limit for that coverage shown in section 3, we will not change the LivingCare benefit limit.

If you decrease the amount of insurance of the Lifecheque insurance coverage and that new amount of insurance is less than the LivingCare benefit limit for that coverage shown in section 3, we will reduce the LivingCare benefit limit for that coverage to match the new amount of insurance of the Lifecheque insurance coverage. This will be the new LivingCare benefit limit for that coverage.

Care support services

Care support services are also available to you as a benefit of this policy.

While the insured person is functionally dependent, you can use the services of the care advisor once every 12 months. The care advisor will help you understand the long term care services in your area that could be available for the insured person. The care advisor will prepare written recommendations about the type, frequency and duration of long term care services that could benefit the insured person's health and safety.

The care advisor can also:

- help you secure recommended care services in your area
- prepare a list of local providers, community programs and health information resources, and explain the costs of any of these services
- review the care the insured person is receiving, and suggest changes or additions that could improve the insured person's health or safety, and
- arrange for necessary changes in the services the insured person is receiving.

We will pay the entire cost of services provided as care support services, but we reserve the right to put reasonable limits on the amount of care support services time available to you and the insured person.

If your LivingCare benefit is expected to terminate within three months you can ask us to have the care advisor conduct one final review of the care the insured person is receiving and make written recommendations about the services that will be needed.

We will not pay for the costs of other advisors or service providers you may use, or for the cost of any of the services, treatments or assistive devices recommended by the care advisor that you choose to implement.

Waiver of premium on claim benefit

A waiver of premium on claim benefit is included as part of the LivingCare benefit. We will waive the premium that is needed to keep your policy in effect while an insured person is eligible for a care benefit under that policy.

If we waive a premium or portion of a premium that you have already paid, we will refund the unused amount to you.

When an insured person satisfies the waiting period, we will refund any premiums due and paid during the waiting period.

If the insured person is no longer eligible to receive a care benefit, you will have to start paying premiums again. We will notify you of the premiums you must pay to keep your policy in effect from the day we stop paying a care benefit until the day of your next scheduled premium payment.

Continuation option

The continuation option allows you to buy a comparable long term care insurance policy that insures the same insured person as that Lifecheque (Permanent) insurance coverage. You can only exercise the continuation option on or after the 20th coverage anniversary.

These conditions also apply on the date you exercise this option:

- that Lifecheque (Permanent) insurance coverage and its LivingCare benefit are in effect
- that insured person has never received a recovery benefit under that Lifecheque (Permanent) insurance coverage
- that insured person is not receiving and has never received care benefits under the LivingCare benefit for any Lifecheque insurance coverage
- the premiums for that Lifecheque insurance policy are not being waived under any waiver of premium on disability rider, and you provide evidence satisfactory to us that no one insured by any waiver of premium on disability rider on that policy is totally disabled
- that insured person must meet the minimum and maximum age limits for the new long term care insurance policy described in the administrative rules in effect at that time for the new long term care insurance policy
- the maximum amount of insurance you can buy as a result of exercising a continuation option is equal to the sum of all LivingCare benefit limits on all Lifecheque (Permanent) insurance coverages for that insured person, or $500,000, whichever is less, and
- the new coverage on the new long term care insurance policy must insure only the same insured person as those Lifecheque (Permanent) insurance coverages
    - the new coverage must be comparable to the LivingCare benefit on that Lifecheque (Permanent) insurance coverage. To be comparable the new long term care insurance coverage must:
    - provide a total benefit limit that is equal to or less than the sum of all LivingCare benefit limits on all Lifecheque (Permanent) insurance coverages
    - have a waiting period that is equal to or greater than the waiting period on the LivingCare benefit on that Lifecheque (Permanent) insurance coverage

- have eligibility requirements to receive benefits that are equivalent to the eligibility requirements to receive benefits on the LivingCare benefit on that Lifecheque (Permanent) insurance coverage. The minimum eligibility requirements are:
  - the insured person cannot do two or more of the activities of daily living without substantial assistance from another person, or
  - due to a cognitive impairment, the insured person needs substantial supervision to protect themselves from threats to their health or safety.

To exercise the continuation option you must send us a written request.

If there is a return of premium with early surrender option rider in effect on that Lifecheque (Permanent) insurance coverage on the date you exercise your continuation option, you must also provide evidence satisfactory to us that on that date that insured person would not start the waiting period for, or qualify for, benefits under the new long term care insurance policy.

If there is no return of premium with early surrender option rider in effect on that Lifecheque (Permanent) insurance coverage on the date you exercise your continuation option

and

- the insured person has never received care benefits but is satisfying the waiting period for care benefits

then

- we will remove from the new long term care insurance policy any condition that states that the insured person must become functionally dependent on or after the coverage date. This will allow the insured person to submit a claim for benefits under the new long term care insurance policy.

The new long term care insurance policy we issue will take effect on the policy issue date shown in your new policy document. The Lifecheque (Permanent) insurance coverages and all benefits and riders associated with those coverages will end at 11:59 p.m. on the day before the new long term care insurance policy takes effect.

The following rules apply to buying the new long term care insurance policy:

- The amount of insurance you may buy must be within the minimum and maximum limits described in the administrative rules in effect at that time for the new long term care insurance policy.
- If that Lifecheque (Permanent) insurance coverage or any associated riders have an underwriting exclusion or an insurance rating, we reserve the right to apply that exclusion or rating to the new long term care insurance policy.
- The insured person must agree in writing to the new long term care insurance policy.
- Any irrevocable beneficiary or collateral assignee or hypothecary creditor (in Quebec), must give their consent in writing for you to exercise the continuation option.

Return of premium on death

You can buy a new return of premium on death rider on the new long term care insurance policy when you exercise the continuation option without providing evidence of insurability if:

- the associated Lifecheque (Permanent) insurance coverage has a return of premium on death rider in effect on the date you exercise the continuation option
- a return of premium on death rider is available on the new long term care insurance policy, and
- the return of premium on death rider on the new long term care insurance policy insures the same person as the original return of premium on death rider on the associated Lifecheque (Permanent) insurance coverage.

The administrative rules in effect at that time for the new long term care insurance will apply to adding the new return of premium on death rider on that insured person.

The maximum benefit allowed for the return of premium on death rider on the new long term care insurance policy cannot exceed the lesser of:

- the maximum benefit of the original return of premium on death rider, or
- the maximum benefit allowed for the new return of premium on death rider as described in the administrative rules in effect at that time for the new long term care insurance policy.

We will not transfer any accumulated eligible premiums from the return of premium on death rider benefit associated with that Lifecheque (Permanent) insurance coverage to the new return of premium on death rider benefit associated with your new long term care insurance policy.

Waiver of premium on disability rider

If there is a waiver of premium on disability rider in effect on the associated Lifecheque (Permanent) insurance coverage on the date you exercise the continuation option

and

- if you provided evidence satisfactory to us that no one insured by any waiver of premium on disability rider on that policy is totally disabled on the date you exercise the continuation option

then

- you can buy a waiver of premium on disability rider on your new long term care insurance policy without providing any more evidence of insurability if:
  - a waiver of premium on disability rider is available on the new long term care insurance policy, and
  - the waiver of premium on disability rider on the new long term care insurance policy insures the same person as the waiver of premium on disability rider on the associated Lifecheque (Permanent) insurance coverage

Adding the new waiver of premium on disability rider on that insured person is subject to underwriting approval and the administrative rules in effect at that time for the new long term care insurance.

Cost of new insurance

The premium for the new long term care insurance policy will be determined based on:

- the age of the insured person when you exercise the continuation option, and
- the method used to calculate premiums for the new long term care insurance policy as described in the administrative rules in effect at that time for the new long term care insurance policy.

Return of unused premiums

We will refund the unused portion, if any, of any premiums you paid during that policy year for

the Lifecheque (Permanent) insurance coverage or any associated riders that end as a result of exercising the continuation option.

Contestability provisions

The time limits in the contestability provisions relating to our right to question the validity of your new long term care insurance policy or any new rider or insurance coverage will be determined as described below.

- If we do not require any evidence of insurability when you exercise the continuation option, we will use the coverage issue date or the date of the last reinstatement of the original Lifecheque (Permanent) insurance coverage or associated rider.
- If we require evidence of insurability when you exercise the continuation option, we will use the coverage issue date of the new long term care insurance or associated rider.

If we question the validity of the new long term care insurance policy or any new rider or insurance coverage, we can rely upon any information provided to us to obtain the original coverage or associated riders, and any additional information provided to us when you exercised the continuation option or to buy any new rider coverage under the new long term care insurance policy.

When a LivingCare benefit ends

A LivingCare benefit ends on the earliest of:

- the monthly processing day that coincides with or next follows the day we receive your written request to cancel that LivingCare benefit at our Canadian head office
- the day that the LivingCare benefit balance is reduced to $0,
- the day the Lifecheque insurance coverage for that LivingCare benefit ends as described in section 7 under the subheading *When a Lifecheque insurance coverage ends,* and
- the day your policy ends.

6 Exclusions and limitations

In this policy document, the United States refers to the continental United States (including Alaska) and Hawaii.

In addition to the exclusions noted in section 5, the following exclusions also apply to your policy.

Exclusions and limitations for critical illness benefits

General

No benefit will be paid if the person insured for any critical illness benefit under this policy, while sane or insane, suffers a covered condition or an early intervention condition as a result of any of the following:

a intentional self-inflicted injuries

b committing or attempting to commit a criminal offence

c operating a motor vehicle while the concentration of alcohol in 100 millilitres of blood exceeds 80 milligrams, or

d the insured person's intentional use or intake of:

- any prescription drug or narcotic other than as instructed by a physician
- any drug or narcotic legally available for sale in Canada without a prescription other than as recommended by the manufacturer
- any drug or narcotic not legally available in Canada, or
- any poisonous substance or intoxicant, including alcohol.

Waiting period

No covered condition benefit or early intervention benefit will be paid unless the insured person satisfies the waiting period. The waiting period is specified for each covered condition or early intervention condition in section 5.

Exclusions for cancers and related conditions

In these exclusions, the term "any cancer" includes all cancers, even if they would not have been covered under the definitions for cancer for a covered condition benefit or an early intervention benefit.

We will not pay a covered condition or early intervention benefit if, within the first 90 days following the later of:

- the coverage issue date, and
- the date of last reinstatement of the coverage,

the insured person has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the coverage), regardless of when the diagnosis is made, or
- a diagnosis of cancer (covered or excluded under the coverage)

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

We will not pay a covered condition benefit for the following:

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

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

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

Exclusions for benign brain tumours and related conditions

We will not pay a covered condition or early intervention benefit if, within the first 90 days following the later of:

- the coverage issue date, and
- the date of last reinstatement of the coverage,

the insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the coverage), regardless of when the diagnosis is made, or
- a diagnosis of benign brain tumour (covered or excluded under the coverage).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within 6 months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

We will not pay a covered condition benefit for pituitary adenomas less than 10 mm.

Out of country diagnosis

If a covered condition or early intervention condition is diagnosed in a jurisdiction other than Canada and the United States, no critical illness benefit will be payable unless the insured person affected by that condition makes all medical records that we request available to us. Based on the medical records, we must be satisfied that all of the following criteria have been met:

- the same diagnosis would have been made if the covered condition or early intervention condition had occurred in Canada or the United States
- the physician making the diagnosis was licensed to practise in the jurisdiction in which the diagnosis was made and had credentials equal to any defined for that condition in your policy,
- the diagnosis is fully supported by all appropriate diagnostic tests and other investigation which would normally be completed in Canada or the United States (including those required by the specific definition of the covered condition or early intervention condition), and
- the same surgery or medically-necessary non-surgical interventional procedure as defined in your policy for an early intervention condition or covered condition would have been advised if the diagnosis had been made in Canada or the United States.

We also have the right to request that an insured person undergo an independent medical examination by a specialist appointed by us.

Exclusions and limitations for the LivingCare benefit

General

We will not consider the insured person to be functionally dependent and we will not pay any care benefits under this policy if the insured person, while sane or insane, becomes functionally dependent because of any of the following:

a intentionally self-inflicted injuries

b committing an act that would be a criminal act according to the laws of Canada, no matter where the act was committed

c operating a motor vehicle while the concentration of alcohol in 100 millilitres of blood exceeds 80 milligrams, or

d the insured person's intentional use or intake of:
   - any prescription drug or narcotic other than as instructed by a physician
   - any drug or narcotic legally available for sale in Canada or the United States without a prescription, in a manner other than as recommended by the manufacturer
   - any drug or narcotic not legally available in Canada or the United States, or
   - any poisonous substance or intoxicant.

Residing outside Canada and the United States

The insured person will not be considered functionally dependent while he or she is residing outside Canada and the United States, and we will not pay a care benefit while the insured person resides outside Canada and the United States.

Any days when the insured person resides outside Canada and the United States will not be considered days when the person is functionally dependent for the purpose of satisfying the waiting period.

7 Information about your policy

Making payments

You can choose to make your payments monthly, quarterly, semi-annually or annually, subject to our administrative rules in effect at the time. If you choose to pay monthly, you must arrange for us to make automatic monthly withdrawals from a bank account.

If you choose to pay quarterly, semi-annually or annually, you can mail or deliver your payments to us at our Canadian head office. Payments by cheque or electronic transfer must be in Canadian funds, drawn on a Canadian financial institution and made payable to Manulife Financial.

Fees and charges

The policy fee

We charge a policy fee for administering your policy. The amount that applies to your policy appears in section 3 and is guaranteed never to increase unless you add a new insured person to a policy that covers one insured person.

How we determine the premium for your policy

We determine the premium that applies to each Lifecheque insurance coverage based on the coverage type, coverage option and premium duration you select, the amount of insurance you purchase and the personal information that applies to the person or people insured by that coverage. In section 3, we show the premium that applies to your policy and each coverage.

If you have renewable coverage, your premium will increase on a scheduled basis. The frequency of the increases depends on the coverage option you have chosen. These increases are guaranteed to never exceed the amounts shown in the premium renewal tables in section 9.

Insurance coverages

Coverage types

The four Lifecheque insurance coverage types are:

- Lifecheque (Primary)
- Lifecheque (Renewable)
- Lifecheque (Level)
- Lifecheque (Permanent)

The coverage type that applies to each Lifecheque insurance coverage under your policy is shown in section 3 and is described in section 5.

Coverage options

There are three coverage options available. You can have more than one Lifecheque insurance coverage in your policy and you can choose a different coverage option for each, depending on the coverage type and subject to our administrative rules in effect at the time. Each coverage option guarantees that the premiums will remain the same for a certain length of time, as long as you don't make a change to your Lifecheque insurance coverage.

If the coverage type is Lifecheque (Primary), Lifecheque (Level) or Lifecheque (Permanent), your coverage option is level premiums, which means that your premiums for that Lifecheque insurance coverage stay the same for the premium duration.

If the coverage type is Lifecheque (Renewable), two coverage options are available:

- 10-year renewable premiums stay the same for 10 years or until the coverage expiry date, if earlier
- 20-year renewable premiums stay the same for 20 years or until the coverage expiry date, if earlier.

The coverage option, coverage expiry date and premium duration that apply to each Lifecheque insurance coverage are shown in section 3.

Changing the amount of your insurance

You can request an increase or a decrease in the amount of your Lifecheque insurance coverage subject to our administrative rules in effect at the time. Only our president or one of our vice-presidents can agree to any change in the policy and only in writing.

Before we agree to an increase in the amount of insurance, we will ask you to provide evidence of insurability satisfactory to us for the insured person or people covered by the increase. The increase will be subject to our rules regarding minimum and maximum increases and ages.

If we agree to your request, the additional amount of insurance will be issued, at our option, as a separate Lifecheque insurance coverage or as a separate policy. We determine the insurance rating for this additional coverage as of the issue date for the new coverage, based on the evidence of insurability that you provide to us.

Decreases in the amount of insurance take effect on the business day we receive your request, provided it is received before a time specified in our administrative rules. Requests received after that time will be effective on the next business day.

Changing your coverage type

You can change from a Lifecheque (Renewable) coverage to a different Lifecheque coverage type. You must request this change on or after the 1st coverage anniversary, and on or before the coverage type change expiry date shown in section 3 for that coverage. You do not need to provide evidence of insurability to make this change. This change is subject to our administrative rules in effect at that time.

Changing your coverage option

You can change a Lifecheque (Renewable) coverage with a 10-year coverage option to a Lifecheque (Renewable) coverage with a 20-year coverage option on or after the 1st coverage anniversary but on or before the earlier of:

- the 5th coverage anniversary, and
- the coverage anniversary nearest the insured person's attained age 54.

You do not need to provide evidence of insurability to make this change. This change is subject to our administrative rules in effect at that time.

How to change your insurance

To make any change to your insurance coverage you must send a written request to the individual insurance department of our Canadian head office. The change will take effect on the monthly processing day coinciding with or next following the day we receive your request.

The premium for your new Lifecheque insurance coverage

If you change your coverage type or coverage option, the premiums for the new Lifecheque insurance coverage will be based on:

- the amount of insurance on the new Lifecheque insurance coverage
- the insured person's age on their birthday nearest the coverage date of the new Lifecheque insurance coverage
- other personal information as shown in section 3
- the coverage type and coverage option selected, and
- the current rates for a comparable coverage

A *comparable coverage* is an insurance coverage on a policy with the same policy date as your policy and with the same coverage date, personal information, amount of insurance and coverage type and coverage option as your new coverage.

Rider coverages

Optional benefits and coverages may be added to your policy as riders, subject to our approval. You can refer to section 3 for information about the rider coverages you have purchased and to each rider for details on the benefit it provides.

When a Lifecheque insurance coverage ends

A Lifecheque insurance coverage ends on the earliest of the following dates:

- the date a covered condition benefit becomes payable for that coverage
- the date of death of that insured person for that coverage
- the monthly processing day that coincides with or next follows the day we receive your written request to cancel that coverage at our Canadian head office
- the day that the sum of any recovery benefit paid or payable and any care benefits paid or payable on that coverage equals the amount of insurance of that Lifecheque insurance coverage
- the coverage expiry date shown on your policy summary page. If that insured person is satisfying the waiting period for a covered condition benefit, early intervention benefit, or care benefit, or is receiving care benefits on the coverage expiry date, then that coverage will expire as described below.

If the insured person is satisfying the waiting period for a covered condition or an early intervention condition

If the insured person is satisfying the waiting period for a covered condition or an early intervention condition on the coverage expiry date, then:

- if the insured person *does not satisfy* that waiting period, we will not pay that covered condition benefit or early intervention benefit for that coverage

or

- if the insured person *satisfies* that waiting period, we will pay that covered condition benefit or early intervention benefit for that coverage.

We will not pay any covered condition benefit, early intervention benefit or care benefits for that coverage other than that covered condition benefit or early intervention benefit, if payable.

If the insured person *does not satisfy* that waiting period, that Lifecheque insurance coverage expires on the first day that the insured person is no longer satisfying that waiting period. If the insured person *satisfied* that waiting period, that Lifecheque insurance coverage expires on the date that early intervention benefit or covered condition benefit becomes payable for that coverage.

If the insured person is satisfying the waiting period for care benefits

To satisfy the waiting period for care benefits after the Lifecheque insurance coverage expiry date shown in section 3, each day of functional dependence that occurs after that coverage expiry date must be consecutive.

If the insured person is satisfying the waiting period for care benefits on the coverage expiry date, then:

- if the insured person *does not satisfy* that waiting period, we will not pay care benefits for that coverage

or

- if the insured person *satisfies* that waiting period, we will pay care benefits for that coverage until the earliest of:
  - the first day the insured person for that coverage is no longer functionally dependent
  - the day the care benefits paid or payable for that coverage are equal to the LivingCare benefit limit for that coverage
  - the day the LivingCare benefit balance is $0, or
  - the date of death of the insured person for that coverage.

We will not pay any covered condition benefit or early intervention benefit, or care benefits for that coverage other than those care benefits, if payable.

If the insured person *does not satisfy* that waiting period, that Lifecheque insurance coverage expires on the first day the insured person is no longer satisfying that waiting period. If the insured person *satisfied* that waiting period, that Lifecheque insurance coverage expires on the day we stop paying care benefits for that coverage.

If the insured person is receiving care benefits

If the insured person is receiving care benefits on the coverage expiry date, we will continue to pay the care benefits until the earliest of:

- the first day the insured person for that coverage is no longer functionally dependent
- the day the care benefits paid or payable for that coverage are equal to the LivingCare benefit limit shown in section 3
- the day the LivingCare benefit balance is $0, or
- the date of death of the insured person for that coverage.

We will not pay any covered condition benefit, early intervention benefit, or care benefits for that coverage other than those care benefits payable.

That Lifecheque insurance coverage expires on the day that we stop paying care benefits for that coverage.

Refund of unused portion of premiums

If we pay a covered condition benefit or the insured person dies, we will refund the unused portion, if any, of any premiums you paid during that policy year for any coverages or riders that terminated as a result of that covered condition benefit being paid or the insured person's death.

We will refund the unused portion, if any, of the policy fee you paid during that policy year if the policy terminated as a result of that covered condition benefit being paid or the insured person's death.

The unused portion of premiums is calculated according to our administrative rules in effect at that time.

When your insurance policy ends

Your policy ends on the earliest of the following dates:

- the business day coinciding with or next following the day you ask us to cancel the policy
- 31 days after your policy enters the grace period, if you do not pay the required premium in full by the end of the grace period, or
- the day the last Lifecheque insurance coverage under your policy ends as described in section 7 under the heading *When a Lifecheque insurance coverage ends*.

Grace period

For payment of each premium except the first, we allow a grace period of 31 days after the due date. During that time, the policy stays in force. If all required payments are not made by the end of the grace period, the policy will lapse and all coverages under it will be automatically cancelled. This means that our liability under the policy will end.

We will refund to you any partial payments you make to your policy between the start of the grace period and the day all coverages are cancelled.

If any benefit becomes payable during the grace period, we will pay the benefit but we will deduct any overdue premiums from the amount paid.

Reinstating your policy

At any time within two years from the last day of the grace period, you may apply to reinstate your policy. To reinstate your policy, we must, within those two years, receive your written application for reinstatement and evidence of insurability satisfactory to us. We must also receive payment from you for:

- any amounts that were due on or before the first day of the grace period, plus
- the total of all payments due from the first day of the grace period to the date of reinstatement, plus
- interest on these amounts at a rate determined by us at that time.

The effective date of the reinstatement of the policy is the date on which we determine these requirements have been met.

Contesting the contract

Our right to contest the contract

For statements about the insured person's age or sex, this section is subject to the provisions under the heading *What we will do if an insured person's age or sex has been stated incorrectly*.

Fraudulent misrepresentation

We have the right at any time to question the validity of your policy or any insurance or rider coverage under it. We can deny any claim if you, or any insured person, fraudulently misrepresented a material fact by not disclosing it or stating it incorrectly in any application or on any medical examination or in any other information we have used as evidence of insurability.

Misrepresentation or non-disclosure of a material fact

The contestability period for any insurance or rider coverage on your policy is the first two years from these dates:

- the policy issue date
- the coverage issue date
- the effective date you made a change that required updated evidence of insurability for that coverage on your policy, and
- the date your policy was last reinstated.

During the contestability period (or if an insured person under your policy has any signs, symptoms, conditions, or medical problems during a contestability period that leads to functional dependence or to a diagnosis of a covered condition or early intervention condition at any time in the future), we have the right to question the validity of your policy or any insurance or rider coverage under it. We have this right if you, or any insured person misrepresented a material fact by not disclosing it or stating it incorrectly in any application or on any medical examination or in any information we have used as evidence of insurability.

What we will do if an insured person's age or sex has been stated incorrectly

If the age or sex of any insured person has been stated incorrectly, any benefit payable on any insurance or rider coverage for that insured person will be increased or decreased to the amount that we would have paid based on:

- the last premium you paid for that coverage, and
- the amount of insurance it would have purchased according to this person's correct age or sex.

However, if we would not have issued the coverage because the correct age does not meet our rules regarding the minimum and maximum age, we can declare the coverage invalid, within the period permitted by any applicable law.

Transferring ownership

You can transfer ownership of your policy (called absolute assignment) unless prohibited by law.

These rules apply if you transfer ownership:

- you can only transfer the entire policy, not selected coverages, and
- the effective date of the transfer is the day we receive an original or notarized copy of the transfer at our Canadian head office or at our principal place of business in your province.

We are not responsible for the validity or sufficiency of the transfer of ownership.

Using your policy as security for a loan

You can use your policy as security for a loan by assigning it to a lender. This type of security is called a collateral assignment or, under the Quebec Civil Code, a hypothec. These rules apply when you assign a policy:

- You can only assign or hypothecate the entire policy, not selected coverages.
- We are bound by the assignment or hypothec when we receive written notice of it at our Canadian head office.
- The lender should send a copy of the assignment or hypothec to us.
- After you have collaterally assigned or hypothecated your policy, you may need the consent of the lender to make changes to your policy. These changes include but are not limited to reducing or cancelling a coverage or cancelling your policy.
- We are not responsible for making sure that any assignment or hypothec is valid or adequate.
- The rights of the lender will take precedence over the rights of any other person claiming a benefit.

Currency

All payments to or by us will be in Canadian dollars.

Type of policy

This policy is non-participating. This means that it does not provide the rights of a participating policy, such as eligibility for dividends or the right to vote at our annual meetings.

8 Words and phrases used in your policy

adjusted age, if applicable, is the age we use to calculate premiums. If your policy is issued with an adjusted age, the adjusted age will be shown in section 3.

amount of insurance is the amount of each Lifecheque insurance coverage shown in section 3.

care benefit is the benefit payable when the insured person is functionally dependent and has satisfied the waiting period.

care setting is the location where the insured person resides. The care setting can be either "facility" or "not a facility". (See page 5.4.5)

cognitive impairment (See page 5.4.4)

coverage provides a benefit under this policy. The word coverage applies to both insurance coverage and rider coverage provided under this policy.

coverage date is the day an insurance or rider coverage begins. Coverage years, months and anniversaries are measured from the coverage date.

coverage issue date is the day we issue an insurance or rider coverage. If your policy has been reinstated, the coverage issue date in section 3 reflects the day the policy was last reinstated.

coverage type change expiry date is the last day you can request a Lifecheque (Renewable) coverage to be changed to a different Lifecheque coverage type subject to our administrative rules in effect at the time. The coverage type change expiry date is shown in section 3 for your Lifecheque (Renewable) coverage.

critical illness benefit is any benefit payable as a covered condition benefit, an early intervention benefit, a recovery benefit or an age 100 benefit (if applicable).

definite diagnosis means the written statement by a specialist, supported by the appropriate investigation and medical evidence, that the insured person meets the definition of a covered condition or early intervention condition in this policy.

evidence of insurability is any information that we require to decide if the person who is to be insured is insurable, and if so, on what terms. This can include financial information.

facility (See page 5.4.5)

functionally dependent (See pages 5.4.1–5.4.2)

insurance rating is used in the calculation of the premiums shown in section 3 and section 9, if applicable. We rate each insured person primarily on his or her health, family medical history and recreational or employment activities. Our standard rating is 100 per cent, but an insured person may have an insurance rating that is higher than our standard rating of 100 per cent if we consider him or her to be more of a risk to insure. The higher the percentage, the higher the premium. The insurance rating may also be a flat dollar amount. We show the insurance rating on the policy summary page. Subject to our administrative rules in effect at the time, you may apply for an improved insurance rating after the policy issue date as long as you provide evidence of insurability satisfactory to us for the improved rating.

insured person is any person who we have agreed to insure in this policy. We've shown the insured people in section 3.

LivingCare benefit balance is equal to the lesser of:

- the sum of all the LivingCare benefit limits across all Lifecheque policies for that insured person, or
- $500,000,

less any care benefits paid or payable for that insured person.

LivingCare benefit limit is shown in section 3 for each insured person with a LivingCare benefit.

monthly processing day is the first day of each policy month. For example, if your policy date is April 12, your monthly processing day will be the 12th of each month. We show this day in section 3.

necessary items of clothing (See page 5.4.2)

not a facility (See page 5.4.5)

physician means a person legally licensed to practice medicine in Canada or the United States or other jurisdictions that we may approve. The physician must not be the policy owner, the insured, or a relative or business associate of the owner or any insured person.

policy is this policy document and all insurance coverages provided by it.

policy date is the effective date of the policy. Policy years, months, and anniversaries are measured from the policy date.

policy fee is the amount we charge to administer your policy. It is included in your total premium.

policy issue date is the day we issue the policy as shown in section 3. If your policy was reinstated, the policy issue date reflects the day the policy was last reinstated.

policy owner is the owner of the policy who holds all rights under the policy, unless these rights are limited by law or by collateral assignment or, under Quebec Civil Code, hypothecation of the policy. The policy owner may be an insured person under the policy.

premium duration is the period of time that premiums are payable for an insurance coverage as shown in section 3.

regular care of a physician means consultations with and treatment by a physician which are appropriate in nature and frequency for the condition causing the insured person to be functionally dependent.

riders are optional benefits you can purchase to protect against a variety of losses.

rider coverage is additional protection provided by a rider. You can have several rider coverages. The benefit provided by each of your rider coverages is shown in section 3.

satisfy or satisfies means that the insured person must be living and meets all the requirements in the policy for the benefit they are claiming. If an insured person is placed on artificial life support, we will consider the date that person is no longer living to be the date the insured person experiences irreversible cessation of all functions of the entire brain (including brain stem) as determined by generally accepted medical criteria.

specialist is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered condition or early intervention condition for the benefit that is being claimed, and who has been certified by a specialty examining board. If a specialist is not available and if we approve, a condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, pathologist, burn specialist and internist. The specialist must not be the policy owner, the insured person or a relative or business associate of the owner or insured person.

substantial assistance (See page 5.4.3)

substantial supervision (See page 5.4.3)