PARACHUTE
Critical Illness Insurance

Parachute Essential Critical Illness Insurance Policy

This **Policy** sets out the critical illness insurance coverage provided to **You** by Humania Assurance Inc. In this **Policy**, Humania Assurance Inc. is called "**We**" or "**Us**".

"**You**" and "**Your**" refer to the individual identified as the **Policyholder** in the **Summary of Coverage**.

It is important that **You** read this **Policy** carefully along with **Your Summary of Coverage**, which sets out details of **Your** coverage, including the amount of **Your** coverage, and whether **Your Spouse** and **Children** are covered. If **You** have any questions about **Your** coverage or for customer service please contact the **Agent** at:

Parachute Digital Solutions Inc.
390, Bay Street, 24th Floor,
Toronto, Ontario,
M5H 2Y2
Toll Free: 1-833-756-0372
Email: support@parachutedigital.ca

Humania Assurance Inc. hereby agrees to pay the benefits in accordance with and subject to the provisions of this **Policy**.

This **Policy** is subject to exclusions and limitations, including, without limitation, an exclusion relating to **Pre-Existing Conditions** and **Covered Condition** exclusions. This **Policy** contains a provision removing or restricting the right of the **Insured** to designate persons to whom or for whose benefit insurance money is to be payable (not applicable in Quebec).

Please take the time to review this Policy

Within 10 days of delivery of the **Policy** and on the condition that no **claim** has been made, **You** may cancel for any reason and receive a full refund of any premium **You** have paid if **You** provide **Us** with written **Notice** of cancellation, dated and signed by **You**.

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Schedule of Benefits

Refer to **Your Summary of Coverage** to determine those **Covered Conditions** for which **You** are covered or for which coverage is specifically excluded. Also, refer to "**Covered Conditions, Limitations and Exclusions**" for the precise definitions of the following **Covered Conditions**.

You and Your Spouse
(100% of the **Face Amount**)

- Aortic Surgery
- Benign Brain Tumour
- Cancer (Life-Threatening)
- Coronary Artery Bypass Surgery
- Heart Attack
- Heart Valve Replacement or Repair
- Stroke

Child
(100% of the **Face Amount**)

- Autism
- Benign Brain Tumour
- Cancer (Life-Threatening)
- Cerebral Palsy
- Congenital Heart Disease Requiring Surgery
- Cystic Fibrosis
- Down Syndrome
- Heart Attack
- Muscular Dystrophy
- Stroke
- Type 1 Diabetes Mellitus

Face Amounts Available

Minimum and Maximum Face Amounts

*The maximum **Face Amount** per **Child** is $25,000 or 50% of **Your Face Amount**, rounded to the next $1,000, whichever is the lesser. All eligible **Children** will be insured for the same **Face Amount**.

Refer to your **Summary of Coverage** to determine the **Face Amount You** have purchased.

	Units	Minimum	Maximum
You	$5,000.00	$10,000.00	$100,000.00
Spouse	$5,000.00	$10,000.00	$100,000.00
Child	$1,000.00	$5,000.00	$25,000.00*

Charitable Donation	$500
Non-Evidence Maximum	$ [GI_Amount]
Pre-Existing Condition Period	24 months
Pre-Existing Condition Exclusion Period	24 months
Waiting Period	90 days for Benign Brain Tumour and for Cancer (Life-Threatening)
Maximum Issue Age	64 years of age
Termination Age	70 years of age
Covered Conditions & Exclusions	As indicated in the Covered Conditions, Limitations and Exclusions provision.

Definitions

This article sets out the definitions for words and phrases that have specific meanings when used in this **Policy** document. These words and phrases appear in bold in this **Policy**. They include the plural as well as the singular.

Accident means an unexpected event involving an external force, causing loss or **Injury**, independently of any other causes.

Actively at Work means **You** perform all the functional and crucial duties of **Your** occupation for a full workday at:

1. **Your** employer's place of business;
2. an alternate place approved by **Your** employer; or
3. a place where **Your** employer requires **You** to travel.

You are considered **Actively at Work** on any day that is not **Your** regular scheduled workday (e.g. vacation or holiday), provided **You** were **Actively at Work** on the preceding scheduled workday and **You** are not confined to **Hospital** or otherwise incapacitated from reporting to place of employment for **Your** employer. If **You** are on parental leave under a Provincial or Federal program, or on an employer-approved leave of absence which does not exceed one year and is unrelated to your ability to perform all the functional tasks of **Your** occupation, **You** are considered **Actively at Work**.

Agent means Parachute Digital Solutions Inc.

Application means the form requesting coverage under this **Policy** submitted by **You** to **Us** for approval. The **Application** forms part of **Your Contract.**

Beneficiary means the individual who is entitled to receive the benefits under this **Policy**.

Benefit Amount is the dollar amount of coverage that is payable in the event of a **Diagnosis** of a **Covered Condition** in accordance with the terms of this **Policy**, calculated as all or a portion of the **Insured Person**'s **Face Amount**.

Child means **Your** natural or adopted child or stepchild who, at the time of **Application** for coverage, is wholly dependent on **You** for support, over 25 hours old, and either (i) less than 21 years old, or (ii) less than 26 years old, and in attendance at an accredited school as a full-time student, and is:

1. a **Resident of Canada**;
2. unmarried;
3. not employed on a full-time basis; and
4. not eligible for voluntary critical illness coverage as an employee under a group benefit plan.

We may require written proof of the **Child**'s status as often as **We** determine is reasonably necessary.

Claim means a formal request to **Us** for payment of a **Benefit Amount** under this **Policy**, along with supporting documents.

Claimant means an individual who makes a **Claim** for a **Benefit Amount** under this **Policy.**

Contract means the entire contract of insurance consisting of this **Policy**, the **Summary of Coverage**, the **Application**, any documents attached to the **Policy** when issued and any amendments to the **Policy** agreed upon in writing after the **Policy** is issued.

Covered Condition means the medical conditions or events for which a **Benefit Amount** may be paid under this **Policy.**

Date of Diagnosis means the date on which an **Insured Person** is first **Diagnosed** with a given **Covered Condition**.

The **Date of Diagnosis** must occur while the **Policy** is in force.

Diagnosis or **Diagnosed** means the medical diagnosis (including diagnostic measures) by a **Physician** of an **Insured Person** with a **Covered Condition**.

The **Diagnosis** must be made according to generally accepted medical classification systems including but not limited to: biopsy, bone scans, CT-scan, hematological tests, MRI or X-rays. Any tests or examinations that must be performed in order to satisfy the **Covered Condition** requirements must be conducted by a **Physician** who is not the **Insured Person**, or a relative of or business associate, or live with the **Insured Person**.

Effective Date of Coverage means the date and time that coverage becomes effective for an

Insured Person or, for an increase in coverage, the date the increase becomes effective as shown on **Your Summary of Coverage**.

Evidence of Insurability means:

1. any information that **We** may require to determine if the person to be insured is insurable, including but not limited to medical, lifestyle and family medical history; and
2. the information about the existence of **Grandfathered Coverage** supplied by **You** as part of the **Application** and used by **Us** in our decision to issue this **Policy**.

All **Evidence of Insurability** must be submitted on forms provided by **Us**.

Face Amount means the dollar amount of coverage applicable to an **Insured Person** that is used to determine the **Benefit Amount** payable for any Claim.

Grace Period means the number of days in which coverage for an **Insured Person** under this **Policy** remains effective although the required premium is late.

Grandfathered Coverage means that an **Insured Person** was covered by a **Prior Policy**, the existence of such **Prior Policy** being part of the **Evidence of Insurability** and material to our decision to issue this **Policy**.

Hospital means a facility licensed to provide full-time medical care and treatment under the direction of a full-time staff of licensed **Physicians**. It does not include a facility that is primarily a nursing home, rest home or facility for treating drug or alcohol abuse.

Injury means physical harm or damage to an **Insured Person**'s body caused by an **Accident**.

Insured or **Insured Person** means **You**, **Your Spouse** and **Your Children** who are insured under this **Policy**. An **Insured Person** cannot be insured as both the **Policyholder** and as a **Spouse** or **Child** under one of our Parachute Critical Illness policies.

Insurer, **We**, and **Us** means Humania Assurance Inc.

Irreversible means not able to be undone or alterable.

Life Event means one of the following events:

1. **Your** marriage (including common-law) or divorce,
2. the birth or adoption of **Your Child**; or
3. the death of **Your Spouse** or **Child**.

For the purposes of this definition, **We** will consider that **Your** marriage has occurred on the date:

1. of **Your** legal marriage;
2. **You** have been living with another person in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
3. **You** enter into a civil union as defined by the Civil Code of Quebec; or
4. **You** register a domestic partnership in Nova Scotia.

Life Support means the **Insured Person** is under the regular care of a **Physician** for nutritional, respiratory and/or cardiovascular support when **Irreversible** cessation of all functions of the brain has occurred.

Medically Necessary means broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a **Sickness** or **Injury**.

Non-Evidence Maximum means the maximum **Face Amount** available under this **Policy** without requiring **You**, **Your Spouse** or Your **Children** to provide satisfactory **Evidence of Insurability**.

If the requested **Face Amount** exceeds the **Non-Evidence Maximum**, the amount in excess of this limit is available only if **You**, **Your Spouse** or **Your Children** provide **Evidence of Insurability** to **Us** and **We** approve this excess amount.

Notice means a written communication by an **Insured Person** or **Claimant** to **Us**, or vice versa.

Notice of Claim means the initial written **Notice** given to **Us** that a **Claimant** is making a **Claim** under this **Policy**, using a form provided by **Us**.

Physician means a medical doctor who is legally qualified and lawfully entitled to practise medicine and prescribe and administer drugs or perform **Surgery**, and who is operating in accordance with and within the scope of his or her licence in the jurisdiction where he or she provides such services.

The **Physician** must not be the **Insured Person**, a relative of or business associate of the **Insured Person**, or reside with any such person.

Policy means this insurance contract. The **Policy** forms part of **Your Contract**.

Policy Anniversary means the first anniversary of the **Your** original **Effective Date of Coverage** and each subsequent anniversary of such date thereafter.

Policyholder means the person named on the **Summary of Coverage** as the "Policyholder".

Pre-Existing Condition means a condition, whether **Diagnosed** or not, for which the **Insured Person** sought medical investigation, medical care or services, **Diagnosis**, treatment, including diagnostic measures, medication or medical advice, or for which there were symptoms, signs or evidence that should have caused an individual to seek a medical investigation, care or services, **Diagnosis**, treatment, including diagnostic measures, medication or medical advice.

Pre-Existing Condition Exclusion Period means the 24-month period immediately following the Pre-Existing Condition Starting Date.

Pre-Existing Condition Period means the 24-month period immediately prior to the Pre-Existing Condition Starting Date.

Pre-Existing Condition Starting Date means:

1. the **Effective Date**; or
2. in respect of any new **Covered Condition** or increase in **Face Amount**, the date of the **Policy** amendment to (a) add such new **Covered Condition**, or (b) increase such **Face Amount**, as applicable.

Prior Policy means a group critical illness policy under which **You** were insured that terminated within 31 days of **Your Effective Date of Coverage** of this **Policy**.

Proof of Claim means evidence or documentation submitted by the **Claimant** or obtained in the course of the investigation of a **Claim**.

Provincial or Territorial Health Care Insurance Plan means any plan that provides hospital, medical or dental benefits established by the government in the **Insured Person**'s province or territory of primary residence.

Resident of Canada means an individual who resides in Canada and who is covered by a Canadian **Provincial or Territorial Health Care Insurance Plan**.

Schedule of Benefits summarizes the benefit features available to **You**, **Your Spouse** and **Your Children** according to the terms and conditions of this **Policy**.

Sickness means the state of being ill, either through disease or malady, but not as the result of an **Accident**.

Smoker means an individual who, in the 12 months before declaring their smoking status on an **Application** or Change in Smoking Status form:

1. has used tobacco in any form (with the exception of one large cigar per month), nicotine products, nicotine substitutes, e-cigarettes, vaping, oral and nasal sprays, or smoking cessation products; or
2. has consumed marijuana or hashish more than three times per week.

Specialist means a licensed **Physician** who has been trained in the specific area of medicine relevant to the **Covered Condition** for which a **Benefit Amount** is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a **Specialist**, and as approved by **Us**, a **Covered Condition** may be **Diagnosed** by a qualified **Physician** practising in Canada or the United States of America.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The **Specialist** must not be the **Insured Person**, a relative of or business associate of the **Insured Person**, or reside with any such person.

Spouse means an individual who:

1. is a **Resident of Canada**; and
2. satisfies one of the following:
   a. is legally married to **You**, or
   b. has been living with **You** in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
   c. is in a civil union with **You** as defined by the Civil Code of Quebec;
   d. is **Your** registered domestic partner in Nova Scotia; or
   e. is the biological or adoptive father or mother of at least one of Your Children.

Only one **Spouse** is eligible for coverage under this **Policy** and it is the person who most recently satisfies the definition of **Spouse** who is eligible to apply for coverage under the **Policy**.

We may require written proof of the **Spouse**'s status as often as **We** determine is reasonably necessary.

Summary of Coverage means the insurance document called a "Summary of Coverage", or any replacement of such document, which **We** issue to **You**, which summarizes the **Benefit Amount You**, **Your Spouse** and **Your Children** have under this **Policy**. The **Summary of Coverage** forms part of **Your Contract**.

Surgery means the treatment of disorders of the body by incision or manipulation with surgical instruments.

Survival Period means the period starting on the **Date of Diagnosis** and ending 14 days later, except as specifically provided elsewhere under the **Policy**. The **Survival Period** does not include the number of days on **Life Support**. The **Insured Person** must not have experienced **Irreversible** cessation of all functions of the brain and must be alive at the end of the **Survival Period**.

Termination Date means the date on which the **Insured Person** is no longer eligible for coverage under his or her **Policy**.

You and **Your** refer to the individual identified as the **Policyholder** in the **Summary of Coverage**.

Benefits Provisions

Your Spouse and Children

When are Your Spouse and Children eligible for coverage under this Policy?	**Your Spouse** and **Children** are eligible for coverage under this **Policy** on the latest of: 1. the date **You** are eligible for coverage under this **Policy**; and 2. the date such **Spouse** or **Child** first satisfies the definition of **Spouse** or **Child** under this **Policy**.
Who can apply for coverage under the Policy?	**You** must make **Application** to add coverage for **Your Spouse** or **Children**. **Your Summary of Coverage** will indicate whether **You** have this coverage.

Payment of Benefit Amount

When is the Benefit Amount payable?	If an **Insured Person** is first **Diagnosed** with a **Covered Condition** while insured under this **Policy**, **We** will pay the **Benefit Amount** for that **Covered Condition**, subject to the terms and conditions of this **Policy**. The **Benefit Amount** will become payable provided that the following conditions are met: 1. **We** receive evidence, satisfactory to **Us**, including but not limited to medical evidence, documenting the **Insured Person**'s **Diagnosis**; 2. the **Diagnosis** is made by a **Physician**, unless the **Policy** requires that the **Diagnosis** be made by a **Specialist**. If the **Diagnosis** is made outside of Canada, **We** reserve the right to require the **Diagnosis** be confirmed by a **Physician** or **Specialist** licensed and practising in Canada; and 3. no **Policy** Exclusions or Limitations apply.

Charitable Donation

What is the Charitable Donation benefit?	When **We** determine that a **Benefit Amount** is payable in respect of an **Insured Person**'s first payable **Claim** under this **Policy**, the **Claimant** may designate a Canadian registered charitable organization to receive the one-time Charitable Donation listed on the **Schedule of Benefits**. **We** will pay this Charitable Donation to such organization, provided that **We** may, in our discretion, pay the Charitable Donation to another Canadian registered charity with similar purposes.

Premium Provisions

Payment of Premiums

What is the premium amount and when are premiums due?

Your first premium is due on or before **Your Effective Date of Coverage**. Thereafter, premiums are due on the same day of each month while the **Policy** is in force. The amount of **Your** premium for the first 12 months, following **Your Effective Date of Coverage**, including premiums payable for **Your Spouse** and **Children**, is set out in **Your Summary of Coverage**.

If You cancel the **Policy**, Your premium refund will be calculated on a pro-rata basis from the effective date of the cancellation until the next premium due date. Premium adjustments for any other changes to the **Policy** will be calculated on a pro-rata basis from the effective date of the change until the next **Policy Anniversary**.

Premium Rates

Can the Insurer change the premium amount?

Your premiums are guaranteed for the first 12 months following **Your Effective Date of Coverage** if **You** do not make any changes to **Your** coverage or **Your Spouse's** or **Children's** coverage. Afterwards, We may change the amount of the premiums on any **Policy Anniversary**. We will notify You at least 60 days in advance of any increase.

Grace Period

What happens if a premium payment is late?

Other than for payment of the initial premium, which must be paid or **Your** coverage and that of **Your Spouse** and **Children** will not come into effect, **We** will grant a **Grace Period** of 60 days from the premium due date for the payment of overdue premium. **Your** coverage and that of **Your Spouse** and **Children** will remain in force during the **Grace Period** but will automatically terminate at the end of the **Grace Period** upon at least 15 days advance written notice if **You** do not pay the required premium during the **Grace Period**.

Reinstatement of Your Policy

Can a terminated Policy be reinstated?

If **Your Policy** terminates due to non-payment of premium it may not be reinstated.

Effective Date and Termination of Coverage

Effective Date of Coverage for an Insured Person

When is coverage effective?

Your coverage will be effective on the **Effective Date of Coverage** set out in the **Summary of Coverage**.

Coverage for **Your Spouse** and **Children** will be effective on the latest of the following dates:

1. the **Effective Date** of Coverage set out in the **Summary of Coverage**; or
2. the date **You** apply, and are approved, for coverage for **Your Spouse** or **Children**.

Transfer of Coverage from a Prior Policy

What happens if coverage under this Policy is replacing coverage under a Prior Policy?

If this **Policy** is replacing **Your** coverage under a **Prior Policy**,

1. The **Insured Person** will be insured under this **Policy** in an amount equivalent to the **Face Amount** of the **Prior Policy** on the **Effective Date of Coverage**, for all **Covered Conditions** identified by the **Insurer** as being common between the **Prior Policy** and this **Policy**, subject to the maximum **Face Amount** available.
2. The **Pre-Existing Condition Exclusion Period** will be reduced by the time the **Insured Person** was covered under such **Prior Policy**, but only with respect to any **Grandfathered Coverage**. All new **Covered Conditions We** identify and all increases in **Face Amount** that are not **Grandfathered Coverage** will be deemed to be issued on the **Effective Date of Coverage**.

Life Event

Can You request a change to the Face Amount?

You may request an increase in any or all of **Your Face Amount**, **Your Spouse**'s **Face Amount** or **Your Children's Face Amount**, within 60 days of the occurrence of a **Life Event**, provided that **You** are **Actively at Work** on the date **You** request the increase.

If the new **Face Amount** is less than or equal to the **Non-Evidence Maximum**, **Evidence of Insurability** is not required. The increase will be effective on the latest of the following dates:

1. the date **You** apply for the increase; or
2. the date of **Your Life Event**.

	If the new **Face Amount** is greater than the **Non-Evidence Maximum**, **Evidence of Insurability** will be required. The increase will be effective on the latest of the following dates: 1. the date **You** apply for the increase; 2. the date of **Your Life Event**; or 3. the date **We** approve the **Evidence of Insurability**. If **You** do not apply within 60 days of the occurrence of a **Life Event**, **Your** coverage remains unchanged. To increase coverage after the 60-day period has passed, **Evidence of Insurability** will be required.

Renewal of the Policy

Will the Policy be renewed?	This **Policy** renews on each **Policy Anniversary**, provided that **You** are under 70 years of age, and **You** are a **Resident of Canada** on the **Policy Anniversary**. In addition, **You** must confirm **Your** intention to renew **Your** coverage by paying to **Us** the premium due on the **Policy Anniversary**.
When does the Policy terminate?	**Your Policy** expires on the date **You** turn 70 and it terminates as specified in the termination provisions. **You** may terminate this **Policy** by providing written **Notice** to **Us**. Coverage will be terminated as of the date **We** receive such **Notice**.

Termination of the Policy

When does the Policy terminate?	**You** may terminate this **Policy** by providing written **Notice** to **Us**. Coverage will be terminated as of the date **We** receive such **Notice** or such later date as **You** have requested. **Your Policy** will terminate on the earliest of the following dates: 1. upon the expiry of the **Grace Period**, if as of such expiry, the required premium has not been paid; 2. any **Policy Anniversary** upon which **You** are no longer a **Resident of Canada**; or 3. the date **You** reach the age of 70 years.

Termination of Your Coverage

When does the Policyholder's coverage terminate?	**You** will cease to be insured on the earliest of the following dates: 1. the date this **Policy** terminates; 2. the date the maximum amount payable under this **Policy** is paid out; or 3. the date **You** die.

Termination of a Spouse's Coverage

When does the Spouse's coverage terminate?

Your Spouse will cease to be insured on the earliest of the following dates:

1. the date this **Policy** terminates;
2. the date **We** receive Your request to terminate **Your Spouse**'s coverage in writing or such later date as **You** have requested;
3. the **Policy Anniversary** if **Your Spouse** is no longer a **Resident of Canada**;
4. the date **Your Spouse** reaches the age of 70 years;
5. the date the maximum amount payable for **Your Spouse** under this **Policy** has been paid out; or
6. the date **Your Spouse** dies.

Termination of a Child's Coverage

When does the Child's coverage terminate?

Your Child will cease to be insured on the earliest of the following dates:

1. the date this **Policy** terminates;
2. the date **We** receive **Your** request to terminate **Your Child**'s coverage in writing or such later date as **You** have requested;
3. the **Policy Anniversary** if **Your Child** is no longer a **Resident of Canada**;
4. the date the **Child** becomes employed on a full-time basis;
5. the date the **Child** turns 21, or 26 if in attendance at an accredited school as a full-time student;
6. the date the **Child** gets married or enters into a civil union as defined by the Civil Code of Quebec or a registered domestic partnership in Nova Scotia, or has been living with another person in a role like that of a marriage partner continuously for the immediately preceding 12-month period;
7. the date the **Child** becomes eligible for voluntary critical illness insurance as an employee under any group benefit plan;
8. the date the **Child** is paid a **Benefit Amount** under this **Policy**; or
9. the date the **Child** dies.

Claim Provisions

Notice of Claim

What is required to file a Claim?	Written **Notice of Claim** must be given to **Us** within 30 days of the **Date of Diagnosis**. If such **Notice of Claim** is not provided within that time, the **Claim** will not be invalidated if **Notice of Claim** is given as soon as reasonably possible.

Proof of Claim

What Proof of Claim is required?	The **Claimant** must submit a **Claim** for benefits under this **Policy** using our approved **Claim** forms. **We** will not pay any **Claim** until receipt of satisfactory proof in writing that such benefits are payable under the terms of this **Policy**. Written **Proof of Claim** must be within 90 days of the **Date of Diagnosis**. Failure to provide such **Proof of Claim** within this time will not invalidate the **Claim** if the **Proof of Claim** is given as soon as reasonably possible, provided the information is provided within one year of **Date of Diagnosis**. The **Claimant** will be responsible for expenses incurred for providing **Claim** information.
Will the Insured Person need to be examined?	**We** may determine a physical examination of the **Insured Person** by one or more **Physicians** is necessary to assist in adjudicating the **Claim**. **We** will be responsible for any costs associated with such physical examinations. If the **Insured Person** refuses to be examined, **We** may not be able to make a favourable decision in respect of the **Claim.**

Beneficiary

Who receives the Benefit Amount under this Policy?	Benefits are paid to the **Insured Person**, provided that benefits with respect to a **Child** are payable to **You**. If the **Insured Person** is no longer living at the time payment is made, these benefits are payable to his or her estate. **We** do not accept beneficiary designations for any benefits under this **Policy**, other than in Quebec. In such cases, the benefit will be paid to the **Beneficiary**.

Methods of Payment

How is the Benefit Amount Paid?	The **Benefit Amount** is payable as a lump sum.

Review Procedure

Can a Claimant request that a denial of a Claim be reviewed?

If all or any part of a **Claim** is denied, the **Claimant** may request a review of the denial within 6 months after receiving a **Notice** of denial by writing to **Us**. The **Claimant** may submit written comments, documents, records or other information relating to the **Claim**, and may request free of charge a copy of the **Application** and any document provided to **Us** regarding the **Insured Person**'s **Evidence of Insurability** and this **Policy**.

We will review the **Claim** and the **Claimant**'s written submissions, and will notify the **Claimant** of our decision within a reasonable time upon receipt of all required information.

Legal Proceedings

When can legal actions be brought against the Insurer?

No legal action may be brought against **Us** within 60 days after **Proof of Claim** has been submitted, or after the time limit for bringing such an action set out in applicable legislation has expired.

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 (Alberta, Manitoba and British Columbia), the Limitations Act, 2002 (Ontario), or other applicable provincial legislation.

Covered Conditions, Limitations and Exclusions

Covered Condition

What are the Covered Conditions under the Policy?	An **Insured Person** is only covered for those **Covered Conditions** set out as applicable to them on the **Schedule of Benefits**.
	Aortic Surgery is defined as 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**.
Exclusion:	No benefit will be payable under this **Covered Condition** for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
	Autism is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the **Diagnosis** confirmed by a **Specialist** before the third birthday of the **Child**.
	Benign Brain Tumour is defined as 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 Benign Brain Tumour must be made by a **Specialist**. Medical information about the **Diagnosis** and any signs, symptoms or investigations leading to the **Diagnosis** must be reported to the Insurer within 6 months of the date of the **Diagnosis**. If this information is not provided within this period, the **Insurer** has the right to deny any **Claim** for Benign Brain Tumour or any critical illness caused by any Benign Brain Tumour or its treatment.
Exclusion:	No benefit will be payable under this Covered Condition if, within the first 90 days following the later of: 1. the Effective Date of Coverage, or 2. the date of the last reinstatement of the Insured Person's coverage, the Insured Person has any of the following: a. signs, symptoms, evidence or investigations that lead to a Diagnosis of benign brain tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or b. a Diagnosis of benign brain tumour (covered or excluded under the Policy).

Exclusion:	No benefit will be payable under this Covered Condition for pituitary adenomas less than 10 mm.
	Cancer (Life-Threatening) is defined as a definite **Diagnosis** of a tumour, which must be 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**.
Exclusion:	No benefit will be payable under this **Covered Condition** if, within the first 90 days following the later of (i) the **Effective Date of Coverage** or (ii) the date of the last reinstatement of the **Insured Person**'s coverage, the **Insured Person** has any of the following: 1. signs, symptoms or investigations that lead to a **Diagnosis** of cancer (covered or excluded under the Policy), regardless of when the **Diagnosis** is made; or 2. a **Diagnosis** of cancer (covered or excluded under the **Policy**). Medical information about the **Diagnosis** and any signs, symptoms or investigations leading to the **Diagnosis** must be reported to the **Insurer** within 6 months of the date of the **Diagnosis**. If this information is not provided within this period, the **Insurer** has the right to deny any **Claim** for **Cancer** or any critical illness caused by any **Cancer** or its treatment.
Exclusion:	No benefit will be payable for the following: 1. lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta; 2. 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; 3. any non-melanoma skin cancer, without lymph node or distant metastasis; 4. prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; 5. 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; 6. chronic lymphocytic leukemia classified less than Rai stage 1; or 7. 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.
	Cerebral Palsy is defined as a definitive **Diagnosis** of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Congenital Heart Disease is defined as any one or more Diagnosis(es) from the following lists of heart conditions that are Covered Conditions:

List A

- Atresia of any heart valve
- Coarctation of The Aorta
- Double Inlet Ventricle
- Double Outlet Left Ventricle
- Ebstein's Anomaly
- Eisenmenger Syndrome
- Hypoplastic Left Heart Syndrome
- Hypoplastic Right Ventricle
- Single Ventricle
- Tetralogy of Fallot
- Total Anomalous Pulmonary Venous Connection
- Transposition of The Great Vessels
- Truncus Arteriosus

The Covered Conditions described in List A will be covered commencing from the date of birth. The **Diagnosis** of any of **the Covered Conditions** in List A must be made by a **Specialist** who is a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B

- Aortic Stenosis
- Atrial Septal Defect
- Discrete Subvalvular Aortic Stenosis
- Pulmonary Stenosis
- Ventricular Septal Defect

The Covered Conditions described in List B will be covered only when open heart **Surgery** is performed for correction of the **Covered Condition** following the date of birth. The **Diagnosis** of any of the **Covered Conditions** in this List B must be made by a **Specialist** who is a qualified pediatric cardiologist, and supported by appropriate cardiac imaging. The **Surgery** must be recommended by a **Specialist** who is a qualified pediatric cardiologist and performed by a **Specialist** who is a cardiac surgeon in Canada.

List B Exclusion:	Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.
General Congenital Heart Disease Exclusion:	All other congenital cardiac conditions not specifically described in List A or List B are not **Covered Conditions** and are excluded.

Coronary Artery Bypass Surgery is defined as the undergoing of heart **Surgery** to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The **Surgery** must be determined to be **Medically Necessary** by a **Specialist**.

Exclusion:	No benefit will be payable under this **Covered Condition** for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Cystic Fibrosis is defined as a definitive **Diagnosis** of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down Syndrome is defined as a definitive **Diagnosis** of Down Syndrome, confirmed by a **Physician Specialist** with expertise in the specialty normally designated to assess and manage Down Syndrome.

Heart Attack is defined as a definite **Diagnosis** of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of cardiac biochemical

markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

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

The **Diagnosis** of Heart Attack must be made by a **Specialist**.

Exclusion:

No benefit will be payable under this **Covered Condition** for:

1. elevated cardiac biochemical 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
2. ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair is defined as 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**.

Exclusion:

No benefit will be payable under this **Covered Condition** for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Muscular Dystrophy is defined as a definitive **Diagnosis** of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Stroke (Cerebrovascular Accident) is defined as a definite **Diagnosis** of an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

1. acute onset of new neurological symptoms, and
2. new objective neurological deficits on clinical examination,
3. 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**.

Exclusion:

No benefit will be payable under this **Covered Condition** for:

1. transient Ischaemic Attacks;
2. intracerebral vascular events due to trauma; or
3. lacunar infarcts which do not meet the definition of Stroke as described above.

Type 1 Diabetes Mellitus (Juvenile Diabetes) is defined as the **Diagnosis** of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival.

The **Diagnosis** must be made by a **Specialist** who is a qualified pediatrician or endocrinologist licensed and practising in Canada, and there must be evidence of dependence on insulin for a minimum of 3 months.

Pre-Existing Condition Limitation

Will a Benefit Amount be payable for a Pre-Existing Condition?

No **Benefit Amount** will be payable for a **Pre-Existing Condition**, whether **Diagnosed** or not, that existed during the **Pre-Existing Condition Period** and is **Diagnosed** during the **Pre-Existing Condition Exclusion Period**.

General Exclusions for All Covered Conditions

What exclusions apply to all coverage?

1. No benefit will be payable if the **Pre-Existing Condition Limitation** applies.
2. No benefit will be payable for a **Covered Condition Diagnosed** while the **Insured Person** is not covered under this **Policy**.
3. No benefit will be payable if the **Survival Period** limitations are not satisfied.
4. No benefit will be paid if **You** or **Your Spouse** have made a fraudulent statement in your **Application** or **Claim**.
5. No benefit will be payable if the **Insured Person**'s condition was either directly or indirectly caused by, contributed to, resulted from or was in any way associated with one or more of the following:
    a. attempted suicide or self-inflicted **Injury** or **Sickness**, regardless of the state of mind;
    b. the consumption, absorption, inhalation or use of any gas, poison, medication (other than medication taken in accordance with the instructions of a licensed **Physician**), alcohol, drug or intoxicant;
    c. **Injury** sustained while committing, attempting or provoking a criminal offence
    d. **Injury** sustained while committing, or attempting an assault;
    e. **Injury** sustained while operating a vehicle under the influence of alcohol, THC or any intoxicant with a concentration that is:
        i. in excess of the criminal limit applicable to the category of your driver's license, in the jurisdiction where injury is sustained;
        ii. in excess 80 mg of alcohol in 100 ml of blood;
        iii. in excess of 5 ng of THC in 100 ml of blood; or
        iv. in excess of both 2.5 ng of THC in 100 ml of blood and 50 mg of alcohol in 100 ml of blood;
    f. while in service, whether or not as a combatant, with armed forces engaged in surveillance, training, peacekeeping, insurrection, war (whether or not declared) or any related act, or participation in a popular uprising, insurrection, riot, civil commotion, hostilities of any kind, war (whether declared or not), or active service in the armed forces of any country;
    g. any **Accident**, **Injury** or **Sickness** caused by hazardous activities or sports such as, but not limited to: professional sports, racing, B.A.S.E. jumping, bungee jumping, parachuting, ultra-light flying, hang gliding, scuba diving, rock or mountain climbing, back country or heli-skiing, motocross or extreme sports;

h. medical care which is not **Medically Necessary** or which is cosmetic in nature (the donation of an organ or tissue will be considered as **Medically Necessary** care); or
i. any specific exclusions relating to any given **Covered Condition** as set out within the definition for that **Covered Condition** in this article.

6. No benefit will be payable if the **Insured Person** fails to seek treatment in order to avoid the **Pre-Existing Condition Period** limitations or other conditions and restrictions of this **Policy**.
7. No benefit will be payable if, within 90 days following the later of the **Effective Date of Coverage** or date of last reinstatement of coverage:
   a. a **Diagnosis** of Cancer **(Life-Threatening)** or **Cancer (Non-Life-Threatening)** is made or the **Insured Person** has any signs, symptoms or investigations that lead to a **Diagnosis** of cancer (life-threatening) or cancer (non-life-threatening) (covered or excluded under this benefit), regardless of when the **Diagnosis** is made; or
   b. a **Diagnosis** of **Benign Brain Tumour** is made or the **Insured Person** has any signs, symptoms or investigations that lead to a **Diagnosis** of benign brain tumour (covered or excluded under this benefit), regardless of when the **Diagnosis** is made.

Additional Child Critical Illness Exclusions and Limitations

What additional exclusions and Limitations apply to Child coverage?

1. When a **Child** is born within ten months of **Your Effective Date of Coverage**, and is **Diagnosed** with any **Covered Condition** within 31 days after their date of birth, no benefit will be payable for such **Covered Condition**.
2. Any cancer tumour in the presence of the human immunodeficiency virus (HIV).

General Provisions

Entire Contract

What is included in the Contract?	The entire **Contract** consists of this **Policy**, the **Summary of Coverage**, the **Application**, any documents attached to the **Policy** when issued and any amendments to the **Policy** agreed upon in writing after the **Policy** is issued.

Misstatement of Facts and Clerical Error

What if an Insured Person misstates any information?	If **You** or any **Insured Person** misstates any relevant information relating to the **Application**, the true facts will be used to determine whether or not coverage is in force under this **Policy**. Where **Evidence of Insurability** is required, **You** and each other **Insured Person** must disclose to **Us** at the time of **Application** every fact of which **You** and they are aware that may be material to the coverage. Premium adjustments or refunds will be made if appropriate.
What if a clerical error is made?	A clerical error is a mistake in writing or copying data that is made by **Us**. A clerical error will not invalidate coverage that is otherwise in force or continue coverage otherwise terminated under the terms and conditions of the **Policy**.

Age

What if an Insured Person's age has been misstated?	**We** have the right to require satisfactory proof of the **Insured Person**'s age before making payment of any **Claim**. If the age of an Insured Person has been misstated, the **Face Amount** will be adjusted upwards or downwards based on the premium rates and the **Insured Person**'s true age. If **You** were not eligible for coverage based on **Your** true age, then **Your** coverage, and that of **Your Spouse** and **Children**, if any, will be voided and an equitable adjustment of premiums will be made with **You**. If **Your Spouse** has misstated his or her age and is not eligible for coverage based on his or her true age, then **Your Spouse**'s coverage will be voided and an equitable adjustment of premiums will be made with **You**.

Contestability of Policy

When is the Policy incontestable?	**We** will not contest the validity of this **Policy** or any statement made by an **Insured Person**, after the **Policy** has been in force for two years from the **Effective Date of Coverage,** except for fraud.

Currency

Are payments made in Canadian currency?	All payments under this **Policy** made either to or by **Us**, will be made in Canadian currency.

Non-Participating Policy

Is this a Participating Policy?	This **Policy** is non-participating. **You** are not eligible to share in our profits or surplus.

Conformity

What if this Policy does not comply with applicable provincial law?	This **Policy** is governed by the laws of the province or territory where the **Insured Person** is resident on the date this **Policy** is purchased. Any provision of this **Policy** that is inconsistent with such laws is automatically amended to conform to the minimum requirements of such laws.

Assignment

Can the benefits under this Policy be assigned?	Neither **You** nor any **Insured Person** may assign this **Policy** or any of **Your** rights under the **Policy**

Statutory Conditions

Applicable in all provinces and territories (with the exception of Quebec).

The Contract

The **Application**, this **Policy**, the **Summary of Benefits,** any document attached to this **Policy** when issued, and any amendment to the **Contract** agreed on in writing after this **Policy** is issued constitute the entire **Contract**, and no agent has authority to change the Contract or waive any of its provisions.

Waiver

The **Insurer** shall be deemed not to have waived any condition of this **Contract**, either in whole or in part, unless the waiver is clearly expressed in writing signed by the **Insurer**.

Copy of Application

The **Insurer** shall, upon request, furnish to the **Insured** or to a **Claimant** under the **Contract**, a copy of the **Application**.

Material Facts

No statement made by the **Insured** or an **Insured Person** at the time of **Application** for the **Contract** shall be used in defence of a **Claim** under or to avoid the **Contract** unless it is contained in the **Application** or any other written statements or answers furnished as evidence of insurability.

Termination of Insurance

1. The **Contract** may be terminated by the **Insured** at any time on request.
2. If the **Contract** is terminated by the **Insured**, the **Insurer** must refund as soon as practicable the excess of premium actually paid by the **Insured** over the short rate premium calculated to the date of receipt of the **Notice** according to the table in use by the **Insurer** at the time of termination.

Notice and Proof of Claim

1. The **Insured** or an **Insured Person**, or a **Beneficiary** entitled to make a **Claim**, or the agent of any of them, shall
   a) give written **Notice of Claim** to the **Insurer**
      i) by delivery of the **Notice**, or by sending it by registered mail, to the head office or chief agency of the **Insurer** in the province, or
      ii) by delivery of the **Notice** to an authorized agent of the **Insurer** in the province, not later than 30 days after the date a **Claim** arises under the Contract on account of an **Accident** or I**njury**,
   b) within 90 days after the date a **Claim** arises under the **Contract** on account of an **Accident** or **Injury**, furnish to the **Insurer** such proof as is reasonably possible in the circumstances of
      i) the happening of the **Accident** or **Injury**,
      ii) the loss caused by the **Accident** or **Injury**,
      iii) the right of the **Claimant** to receive payment,
      iv) the **Claimant'**s age, and

v) if relevant, the **Beneficiary**'s age, and

c) if so required by the **Insurer**, furnish a satisfactory certificate as to the cause or nature of the **Accident** or **Injury** for which **Claim** is made under the **Contract** and, in the case of **Injury**, its duration.

2. Failure to give **Notice of Claim** or furnish **Proof of Claim** within the time required by this statutory condition does not invalidate the Claim if
   a) the **Notice** or proof is given or furnished as soon as reasonably possible, and in no event later than one year or, in Saskatchewan, not later than the limitation period set out in The Limitations Act, after the date of the **Accident** or the date a Claim arises under the Contract on account of **Injury**, and it is shown that it was not reasonably possible to give the **Notice** or furnish the proof in the time required by this condition, or
   b) in the case of the death of the person insured, if a declaration of presumption of death is necessary, the **Notice** or proof is given or furnished no later than one year or, in Saskatchewan, not later than the limitation period set out in The Limitations Act, after the date a court makes the declaration.

Insurer to furnish forms for Proof of Claim

The **Insurer** shall furnish forms for **Proof of Claim** within 15 days after receiving **Notice of Claim**, but if the **Claimant** has not received the forms within that time the **Claimant** may submit his or her **Proof of Claim** in the form of a written statement of the cause or nature of the **Accident** or **Injury** giving rise to the **Claim** and of the extent of the **Loss**.

Rights of Examination

As a condition precedent to recovery of insurance money under the **Contract**,

1. the **Claimant** must give the **Insurer** an opportunity to examine the **Insured Person** when and as often as it reasonably requires while the **Claim** hereunder is pending, and
2. in the case of death of the **Insured Person**, the **Insurer** may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies.

When Money Payable

All money payable under this **Contract** shall be paid by the **Insurer** within 60 days after it has received **Proof of Claim**.

Limitation of Actions

Applicable in New Brunswick, Nova Scotia, Newfoundland and PEI only:

An action or proceeding against the **Insurer** for the recovery of a **Claim** under this **Contract** shall not be commenced more than one year after the date the insurance money became payable or would have become payable if it had been a valid **Claim**.

Applicable in Yukon, NWT and Nunavut only:

An action or proceeding against the **Insurer** for the recovery of a **Claim** under this **Contract** shall not be commenced more than two years after the date the insurance money became payable or would have become payable if it had been a valid **Claim.**

End of Policy

Privacy Policy

The collection, use, disclosure and retention of personal information in connection with this Policy will be done in accordance with the provisions of applicable privacy legislation and Our Privacy Statement.

We collect, use and disclose personal information to process Applications and, if such Applications are approved, to provide and administer the relevant product(s) to the Insured Persons, including investigating and assessing Claims and creating and maintaining Our records.

The Insured Person may exercise certain rights of access and rectification with respect to the information in the Insured Person's file by sending a request in writing to Us. We limit access to personal information in such files to:

1. our employees who have a need to access such information to perform their jobs;
2. people We approve who need such information to perform their duties as they relate to Your Policy;
3. people to whom the Insured Person has granted access; and
4. people authorized by law to access such items.

For questions about Our personal information policies and practises, please contact Us:

Director, Compliance
Humania Assurance Inc.
1555 Girouard Street West
P.O. Box 10000
Saint-Hyacinthe, Quebec J2S 7C8

By email at: conformite@humania.ca

At our website: https://www.humania.ca/en-CA/personal-information-protection

HUMANIA ASSURANCE INC.

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