ACE INA Life Insurance
(Hereinafter called the Company)

Group Policy Number: CI10344401
GL10344401

1. **Policyholder:** The Vero Health Care Plan
(Hereinafter called the Policyholder)

2. **Policy Effective Date:** August 1, 2009 to Open
(From: 12:01 a.m. Standard time at the Policyholder's Address)

3. **Premium:** This policy is issued in consideration of the payment of the premium. All premiums are payable solely by the Policyholder on or before the date they become due.

IN WITNESS WHEREOF, ACE INA Life Insurance has caused this policy to be signed by its President in the City of Toronto, Ontario, but said policy shall not be binding upon the Company unless countersigned by a duly authorized representative of the Company.

Countersigned

Terri Mitchell
Executive Vice President & Chief Operations Officer

David Brosnan
President & Chief Executive Officer

GENERAL PROVISIONS - DEFINITIONS

"Accident" means a sudden, unforeseen, fortuitous event.

"Actively at Work" means an Employee must:

a) be actually working at the Employer's place of business or a place where the Employer's business requires him to work on a permanent, full time basis for at least 20 hours per week; or
b) be actually working at the Employer's place of business or a place where the Employer's business requires him to work on a permanent part-time basis for less than 20 hours per week (if approved by the Company); or
c) be absent due to vacation, weekends, statutory holidays, or shift variances.

"Anniversary Date" means the date on which the policy will renew. The initial anniversary date will be 12 months from the effective date and every 12 months thereafter.

"Annual Salary" means the gross annual earnings, excluding bonuses, and overtime while the Employee was last Actively at Work.

"Commissions" are earnings based on the average commissions received over the last 24 months or the period of commissioned employment if less.

"Dependent Child or Dependent Children" means the Employee's eligible unmarried natural, legitimate, illegitimate, adopted, step child or common law child who is principally dependent on the Employee or the Employee's Spouse for financial support.

"Employer" means the Policyholder and any other company listed on the application.

"Employee" means any person who is directly employed and compensated for services by the Employer and is eligible for insurance as defined within this policy. This person must be listed in the Policyholder's (or Third Party Administrators') list of eligible Employees.

"Hospital" means a legally constituted establishment which meets all of the following requirements:

a) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
b) provides 24 hour a day nursing service by registered or graduate nurses;
c) has a staff of one or more licensed Physicians available at all times;
d) provides organized facilities for diagnosis and surgical facilities; and
e) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"Injury" means bodily injury resulting directly or independently of all other causes from an Accident, which is caused by external, violent, and visible means and sustained while an Insured Person is covered under this policy. Injury must result within a 365 day period after the date of the Accident.

"In-Patient" means a person admitted to a Hospital as a resident or bed-patient who is provided at least one day of room and board by the Hospital.

"Insured or Insured Person" means

a) any Employee qualifying for any eligible class as defined herein; or
b) an Employee's eligible Spouse or Dependent Child as defined herein.

No Insured Person may be covered more than once under this policy. If an individual is covered as an Employee, he cannot be covered as a Spouse or Dependent Child of another Employee. In addition, only one Spouse can choose coverage for Dependent Children.

"Non-Smoker" means someone who has not smoked cigarettes, cigarillos, cigars, pipe or chewing tobacco or used any nicotine products (patch, gum, etc.) for twelve months or more prior to the date of enrollment.

"Physician" means a Doctor of Medicine (M.D.) duly licensed to practice medicine in Canada and recognized by the College of Physicians and Surgeons in the Province in which the treatment is rendered, who is not the Insured Person and who is not a member of the Insured Person's Immediate Family.

"Policy Effective Date" means the date that coverage under the policy will commence.

"**Premium Due Date"** means the Policy Effective Date for the initial premium due, and the same day of the month in each and every month thereafter.

"Professional Counsellor" means the treatment or counselling by a therapist or counsellor who is licensed, registered or certified to provide such treatment.

"Seat Belt" means those belts that form a restraint system.

"Sickness" means any illness, disease or physical condition which causes a covered loss covered and for which symptoms are manifested while the policy is in force.

For Critical Illness insurance, a "Sickness" means any of the Insured Conditions or any other illness, disease, or physical condition.

"Spouse" means a person of the same or opposite sex who:

a) is legally married to the Employee and cohabitates with the Employee; or
b) cohabitates with the Employee and has been publicly represented as their domestic partner for a period of at least one year in the community in which they reside and continues to be represented as such.

"Vehicle" means a private passenger vehicle, station wagon, van, or jeep-type automobile.

"Totally Disabled or Total Disability" with respect to waiver of premium means disability resulting from Injury or Sickness which prevents engagement in the Employee's regular occupation for six (6) consecutive months.

GENERAL PROVISIONS - POLICY CONDITIONS

The Contract
This policy, the Application for Group Insurance, the proposal and the individual applications of the eligible persons, where applicable, constitute the entire contract between the parties, this includes the endorsements, insertions or riders, if any. No agent has authority to change the contract or waive any of its provisions.

Waiver
The Company 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 Company.

Assignment
Benefits payable under this policy shall not be assigned.

Participating
This policy is non-participating.

Participation Requirements
90% of eligible Employees must be insured for Employee Life, Accidental Death & Dismemberment, and/or Employee Critical Illness, where applicable. 10 lives must be insured for Optional Critical Illness.

Minimum Participation Requirements
If participation for the Employee Life, and/or Accidental Death & Dismemberment insurance drops below 5 lives each or 10 lives each for Employee Critical Illness or Optional Critical Illness, where applicable, the Company will renew the insurance on a month-to-month basis and may terminate within 31 days' written notice to the Policyholder.

Notice to New Employees
It is the responsibility of the Policyholder to supply enrolment material to eligible Employees and to inform the Company of the addition of new Employees within 31 days of becoming eligible.

Grace Period
A Grace Period of 31 days will be granted for the payment of premiums accruing after the first premium, during which Grace Period the policy shall continue in force, but the Policyholder shall be liable to the Company for the payment of the premium accruing for the period the policy continues in force. No Grace Period will be granted when a written notice of cancellation or termination has been received by us at our offices.

Beneficiary
An Employee or any Spouse has the right to name a beneficiary when he applies for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under this policy, unless a further designation has been made that specifically identifies this policy. Failing such designation, all benefits will be paid to the Estate of the Insured Person.

All other indemnities of this policy will be payable to the Insured Person.

An Insured Person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

Examination and Audit
The Company shall be permitted to examine the Policyholder's records relating to this policy at any reasonable time and place during the policy term and after expiration of the policy until final adjustment

and settlement of all claims and other matters hereunder.

When Monies Payable Other Than For Loss of Time
All monies payable under this contract other than benefits for loss of time shall be paid by the Company within sixty days after it has received proof of claim.

When Loss of Time Benefits Payable
The initial benefits for loss of time shall be paid by the Company within thirty days after it has received proof of claim, and payments shall be made thereafter within each succeeding 60 day period while the Company remains liable for the payments if the Policyholder, whenever required to do so, furnishes prior to payment proof of continuing disability.

Government Hospital Plans
No payment shall be made for services rendered by a Hospital, except for reimbursement of charges which are in excess of benefits payable for Hospital services under any government laws of Canada or any Province/Territory.

Not in Lieu Of
This policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance, or similar coverage.

Currency
All monies payable under this contract shall be paid in lawful Canadian currency.

Gender
Any reference to the masculine gender in this policy will also include the feminine gender.

Conformity with Provincial Statutes
Any provision of this policy or any condition of this policy which is in conflict with the statutes of the province in which the policy is delivered is hereby amended to conform to the minimum requirements of such province.

Limitation of Actions
An action or proceeding against the Company for the recovery of a claim under this contract shall not be instituted after 1 year from the date on which the cause of action arose.

Clerical Error
A clerical error is a mistake in writing, typing or copying data. A clerical error made by the Policyholder or the Company will not invalidate insurance otherwise in force, or continue insurance otherwise terminated under the terms of this policy. If an Insured Person's age has been misstated, his true age will be used to determine:

a) the effective date or termination date of insurance;
b) the amount of insurance; and
c) any other rights or benefits under this policy.

The Company will adjust the insurance in force where this is affected by a clerical error or a misstatement of age. A premium adjustment which reflects the adjustment in insurance will be made on a subsequent premium due date.

Booklets
The Company will produce a booklet for each Employee insured under this policy, unless the Company and the Policyholder have otherwise agreed. The booklet will set out the main features of insurance and will be distributed by the Policyholder to each insured Employee.

Possession of a booklet alone does not entitle an Employee to insurance under this policy. The policy must be in effect, premiums must be paid and the Employee must satisfy all the requirements. The booklet is not a contract of insurance, nor does it create or confer any contractual or other rights. The

provisions of this policy will govern if they are in conflict with the booklet.

Contesting the Policy
In the absence of fraud, the validity of this policy will not be contested if it has been in force for two (2) years from its issue date and all premiums due in that time have been paid.

Misrepresentation
If it is found that an Employee materially misrepresented his eligibility or medical status in order to obtain insurance under this policy, the Company has the right to void the application within the first two (2) years of the date of issue or within two (2) years of any change requested by the Employee.

A misrepresentation is a false statement on an insurance application as to a past or present fact which leads the Company to issue an insurance contract whereas the Company would not have issued the contract if the accurate facts were known.

Legal Actions
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of this policy. No such action shall be brought after the expiration of three (3) years (or the minimum time, if more than three (3) years, permitted by law in the province/territory where the Insured Person resides) after the time written proof of loss is required to be furnished.

Continuance of Coverage
Coverage shall be extended for a period of 12 months, subject to payment of premiums if the Employees of the Policyholder are:

a) laid-off on temporary basis;
b) temporarily absent from work due to short-term disability;
c) on leave of absence; or
d) on maternity leave.

If an Employee of the Policyholder assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

GENERAL PROVISIONS – AFFILIATED CORPORATIONS

Employees who are in the classes of eligible persons set forth in the policy, employed by one of the following corporations shall be considered employees of the Policyholder:

Not Applicable

NEWLY ACQUIRED CORPORATIONS

It is understood and agreed that, whereas the premium for this policy applies to the corporations listed above, eligible employees of corporations newly acquired through stock purchase, exchange of stock or otherwise, shall be insured under this policy only under the following conditions:

(1) The Policyholder shall pay an appropriate additional premium and shall report to the Company, the name of any such newly acquired corporation together with the underwriting information necessary for the Company to determine such additional premium.

(2) Insurance shall commence on the date of acquisition, but no coverage shall continue for more than sixty (60) days thereafter unless the required report has been made and an additional premium agreed upon and paid. In any event, the Policyholder shall be liable for payment of premium for the period such coverage remains in effect.

GENERAL PROVISIONS – PREMIUMS

Premium Due Date
Premiums are due on the first of the month in which they are due. A Grace Period of 31 days will be provided unless a written notice of termination or cancellation has been received by us at our offices. If premiums remain outstanding after expiration of the Grace Period, the policy will be terminated.

Premium for Each Insured Individual
The amount of premium payable for each Insured Person shall be determined according to the benefits for which that person is insured and the premium rates then applicable to those benefits.

Reports and Premium Payments
Where the policyholder does not receive a billing statement from the Company, the Policyholder, or the Administrator or Transmittal Agent appointed by the Policyholder shall submit to the Company (1) an initial report within 45 days after the Policy Effective Date listing the names of such persons insured on the Policy Effective Date, (2) an annual report detailing Employee movement for Life Insurance, as specified by the Company, and (3) a regular periodic report at the same intervals as the mode of premium payment specified in the Application for Group Insurance, and naming the eligible persons added and those whose coverage terminated, together with the applicable premium therefore, within 15 days after the end of the reporting period.

The Policyholder shall co-operate with and assist the Company in the reconciliation of eligible persons during the open enrollment periods scheduled at reasonable times.

Premium Rate Changes
The Company may set new rates:

a) for mandatory coverage and optional Accidental Death and Dismemberment (where applicable) – on any premium due date after the first 12 months, but not more than once in any policy year;
b) for optional Critical Illness and Life Insurance coverage (where applicable) – on the first of the month following the Insured Person's birthday;
c) upon amendment or termination of any other plan which provides benefits which are offset against benefits under this policy;
d) at any time after the passage of Provincial/Territorial or Federal law or regulation which results in a change to:
    i. the liability for provision of benefits under this policy; or
    ii. the taxability of premiums or benefits.

Premium Adjustments
A premium adjustment will be made for each of the following changes to the amount of insurance in force under this policy:

a) changes due to an amendment of the policy;
b) retroactive changes made to correct the effect of a clerical error or age misstatement;
c) retroactive changes required due to the late reporting of the addition or termination of Employees; and
d) any other changes that take effect more than one (1) month prior to the next premium due date.

Retroactive adjustments which result in a credit to the Policyholder will be limited to three (3) months.

GENERAL PROVISIONS – EFFECTIVE DATE OF COVERAGE

To become insured under this policy, an eligible Employee must apply in writing on forms approved by the Company or policyholder when the appropriate waiting period has passed. Coverage for optional dependent coverage must also be applied for on approved forms.

Effective Date of Insurance – Employee
Once an application for Employee insurance has been completed, this insurance becomes effective as follows, if the Employee is then Actively at Work:

a) on the Policy Effective Date for Employees who are Actively at Work on the Policy Effective Date (provided that the employee application forms are received on or before such Policy Effective Date, if applicable); and
b) for all insurance which does not require evidence of insurability, on the date the Employee or Dependent becomes eligible for this insurance; and
c) for all insurance which does require evidence of insurability, on the first of the month following the date this evidence is approved by the Company.

If the Employee is not Actively at Work when insurance would otherwise take effect, this insurance will take effect on the next day on which he is again Actively at Work.

Late Entrants
An application is considered late when an Employee:

a) applies for insurance after having been eligible for more than 31 days; or
b) re-applies for insurance on any person whose insurance has earlier been cancelled.

Effective Date of Insurance – Dependent
Coverage for Dependents will become effective at the same time that the Employee becomes eligible for Insurance. If any Dependent declines coverage at the time it is made available (with or without the presence of other coverage), then wishes to apply at a later date, the Company reserves the right to request medical information.

A Spouse or Child who becomes a Dependent after the Employee becomes insured is eligible for Dependent Insurance on the date that person becomes a Dependent if reported to the Company within 31 days of becoming eligible. If coverage is not applied for within 31 days, the Company reserves the right to request medical information.

In order to be eligible for Optional Insurance, the Spouse must submit a statement of health and be approved by the Company. Coverage will be effective on the date the Spouse is approved by the Company.

Dependent Insurance will not take effect prior to the Effective Date of the Employee's insurance. However, Dependent Optional Insurance may still become effective if the Employee is declined for Employee Optional Insurance.

GENERAL PROVISIONS – EMPLOYEE CHANGES

Employee Changes
All Employee changes must be reported to the Company within 31 days of the date of change. Failure to report the change within 31 days may be considered late reported and as a result, may require satisfactory medical evidence in order to become effective.

Class Changes
If an Employee changes from one class to another class, the Policyholder must advise the Company in writing within 31 days of the change. The change will take effect on the effective date of the class change and any change in premium will be reflected on the following month's billing statement.

If the Policyholder neglects to mention the change and a claim is presented, the Company will pay the benefit for the lesser of the two classes.

Increases in Insurance
An increase in insurance on an Employee or a Dependent will take effect as follows, if the Employee is Actively at Work:

a) if evidence of insurability is not required, on the first of the month following advice to the Company by the Policyholder;
b) if evidence of insurability is required, on the first of the month following the date this evidence is approved by the Company.

Decreases in Insurance
Decreases in the amount of insurance on an Employee or a Dependent will take effect on the first of the month following receipt of the Employee's written request to the Company.

Reinstatement of Insurance
If an Employee is re-hired within six (6) months of termination of insurance under this policy due to termination of employment, he must re-apply for insurance under this policy, but will not be required to satisfy another waiting period.

Failure to apply within six (6) months will require approval of satisfactory medical evidence in order to be effective.

Change in Smoker Status
Any Employee or Dependent who requires a change from smoker to non-smoker must refrain from all tobacco or nicotine product use for 12 consecutive months and complete a Non-Smoker Declaration.

GENERAL PROVISIONS - TERMINATION OF INSURANCE

Termination of Employee Insurance
Insurance for an Employee terminates on the earliest of the following dates:

a) the date this policy terminates;
b) the date the Employee ceases to be in an eligible class;
c) the date the Employee ceases to be an eligible Employee;
d) death of the Insured;
e) the date the Employee ceases to satisfy the Actively at Work requirement. If the Employee is not at work because of Sickness or Injury, temporary lay-off, or leave of absence, this date will be extended to the earliest of:
    i. the date the Employer stops paying premiums or otherwise determines that insurance has terminated. This date must be determined on the same basis for all Employees in like circumstances;
    ii. The date the Employee starts to work in another job more than 20 hours per week, except in an approved rehabilitation plan or program;
f) For Critical Illness insurance (if applicable), at the latest of:
    i. the date where the sum of previous claim payments equal the Principal Sum or;
    ii. the date of payment of the Second Event Benefit(if applicable).
g) For Critical Illness insurance Rider(if applicable), on the date of payment of any claim.

Termination of Dependent Insurance
Insurance on an Employee's Spouse, Former Spouse and/or Children terminates on the earliest of:

a) the date the Employee's insurance terminates;
b) the date the Spouse or Child is no longer eligible for insurance under the provisions of this policy;
c) the date written notification is received from the Employee to cease his Spouse/Child coverage because his Dependents are covered under another insurance plan;
d) the date a required premium payment is due but not paid.

Termination by the Policyholder
The Policyholder may terminate the contract at any time by giving written notice of termination to the Company at it's head office or authorized regional office. Notice must be received within 30 days prior to the date of cancellation.

Termination by the Company
The Company may terminate the contract, under the following circumstances:

a) at any time that the number of insured Employees falls below the minimum participation requirement; or
b) during any period where premiums have not been paid beyond the Grace Period; or
c) at any time prior to the policy Anniversary Date as long as the Company provides 30 days notice of its intent to cancel the policy.

GENERAL PROVISIONS – EMPLOYEE LIFE INSURANCE

Benefit Payment
If an Employee dies while insured, the Company will pay the amount of the Employee's Life insurance to the beneficiary. If no beneficiary has been named at the time of death, benefits will be payable to the Employee's estate.

In the event of a terminal illness, if an Employee while insured provides the Company with satisfactory written proof of a prognosis of death within twelve months of such proof being provided, the Company will advance 50% of the Employee's Life insurance to the Employee up to a maximum of $100,000. The amount advanced will reduce the Employee's Life insurance payable to the beneficiary upon the Employee's death.

Eligibility
The Employee is eligible for coverage if they are:

a) over the age of 18;
b) under the age of 70; and
c) a Canadian resident; and
d) is Actively At Work for the employer on a permanent, full-time basis for at least 20 hours per week (or part time less than 20 hours per week if approved by the Company); and
e) is a non-seasonal worker.

Amount of Benefit
An Employee will be eligible for the amount of insurance outlined in the Schedule of Benefits. In order to be eligible for amounts in excess of the non-evidence maximum, satisfactory medical evidence must be submitted to the Company. Medical evidence must be approved by the Company before excess coverage will become effective.

Auxiliary Benefits

1. Repatriation Benefit
If an Insured Person suffers loss of life while outside Canada, the Company will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, to a maximum of $5,000.

2. Seat Belt Benefit
If an Insured Person suffers loss of life, the Insured Person's amount of Principal Sum will be increased by 10%, up to a maximum of $10,000, if, at the time of the accident, the Insured Person was driving or riding in a Vehicle and wearing a properly fastened Seat Belt.
Due proof of Seat Belt use must be provided as part of the written proof of loss.

3. Special Education Benefit
If an Insured Employee suffers loss of life, the Company will pay, in addition to all other benefits payable under the policy, a "special education benefit", equal to 5% of the Insured Employee's Principal Sum up to a maximum of $5,000 per year, on behalf of any Dependent Child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning beyond the 12th grade level, or was at the 12th grade level and subsequently enrolls as a full-time student in an institution of higher learning, within 365 days following the date of death.

The "special education benefit" is payable annually for a maximum of four consecutive annual payments, but only if the dependent child continues his/her education as a full-time student in an institution of higher learning.

Maximum Issue Age
An Employee must be under the age of 65 in order to apply for Employee Life Insurance.

Reduction and Termination
For all Employees, the amount of insurance reduces by 50% at age 65 and terminates at age 70 or as stipulated under "General Provisions, Termination of Employee Insurance".

Conversion of Insurance
An Employee is entitled to convert all or part of their coverage to an individual life insurance policy without providing medical evidence of insurability if he meets the following conditions:

1. Written application and premium equal to the first month's premium is received at the head office of the Company within 31 days of termination.
2. If the insurance terminates under one of the following circumstances, the Employee must have been continuously insured under the Employer's group life plan for the last 5 years:
    (a) it terminated because of termination of the policy or the entire Employee Life Insurance benefit; or
    (b) it terminates at the end of a waiver of premium period that extends beyond the date of termination of this policy or this policy's life insurance benefit.

The individual policy is a yearly renewable term insurance policy with premium frequency not less than quarterly.

The premium for the individual policy will be based on the person's age, sex, smoker status and class of risk, and on the amount of the policy being issued.

The amount of the individual policy will not exceed the lesser of:
1. the amount of terminated insurance less the amount of any group term life insurance for which the person becomes eligible within the 31 days allowed for conversion; and
2. $200,000.

The amount converted shall not be less than the Company's minimum issue amounts in force at the time of conversion.

Conversion Policy Effective Date
The individual policy takes effect at the end of the 31 days allowed for conversion.

Death During Conversion
If a person dies within the 31 days allowed for conversion, it is assumed that the Employee would have converted their insurance to an individual policy and the total amount of terminated life insurance is payable (upon receipt of due proof) under the death benefit provision of this policy's life insurance benefit as if the death occurred while the insurance was still in force.

GENERAL PROVISIONS – CRITICAL ILLNESS ENHANCED PLAN

"Insured Conditions" means Aorta Surgery, Alzheimer's Disease, Amyotrophic Lateral Sclerosis, Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Heart Attack, Major Organ Failure, Multiple Sclerosis, Paralysis, Parkinson's Disease, Severe Burns and Stroke.

"AIDS" means Acquired Immune Deficiency Syndrome.

"Activities of Daily Living" means the following activities:

Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.

Toileting – the ability to get to and from the toilet and maintain personal hygiene.

Bladder and Bowel Continence – the ability to manage bowel and bladder function with or without protective undergarments, with or without use of catheters, with or without surgical appliances or other artificial aids so that a reasonable level of hygiene is maintained.

Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.

Feeding – the ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.

"Aorta Surgery" means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a Physician certified as a cardiovascular surgeon. Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

"Alzheimer's Disease" means the diagnosis that the Insured Person has Alzheimer's Disease, which is a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that the Insured Person exhibits the loss of intellectual capacity resulting in impairment of their memory and judgment, which results in a significant reduction in their mental and social functioning, such that they require permanent daily personal supervision for the Activities of Daily Living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this Insured Condition definition. A Physician who is certified as either a neurologist or a psychiatrist must confirm diagnosis in writing.

"Amyotrophic Lateral Sclerosis (ALS)" means unequivocal diagnosis of ALS resulting in the inability to perform three (3) of the six (6) Activities of Daily Living without assistance. A Physician who is certified as a neurologist must confirm diagnosis in writing.

"Benign Brain Tumour" means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

"Blindness" means the total and irrecoverable loss of sight in both eyes due to Injury or Sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing.

"Cancer" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

a) Carcinoma in situ;
b) Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of human immunodeficiency virus (HIV);
c) Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth;
d) Prostate cancer diagnosed as T1N0 M0 or equivalent staging.

A Physician certified as an oncologist must confirm diagnosis in writing.

"Cognitive Impairment" means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which is measurable and results from demonstrable organic cause as diagnosed by a Physician. The degree of Cognitive Impairment must be sufficiently severe as to require a minimum of eight continuous hours of daily supervision.

"Coma" means the Insured Person has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A Physician who is certified as a neurologist must confirm diagnosis in writing.

"Coronary Artery Bypass Surgery" means surgery performed by a Physician who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered critical illness.

"**DCIS**" means the diagnosis by a licensed Physician, of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A Physician certified as an oncologist must confirm the diagnosis in writing.

"Deafness" means the diagnosis of permanent loss of hearing in both of the Insured Person's ears, with an auditory threshold of more than 90 decibels in each ear. A Physician, who is certified as an otolaryngologist must confirm diagnosis in writing.

"Eligible Dependent Children" means only Dependent Children who are:

a) over the age of 14 days and under the age of 21; or
b) under age 25 and attending school on a full-time basis; or
c) over age 25 and a dependent by reason of mental or physical infirmity; and
d) a Canadian resident.

"Heart Attack" means the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. Diagnosis must be confirmed in writing by a Physician who is a certified specialist in internal medicine or a cardiologist and should be based on new electrocardiograph changes consistent with heart attack and at least one of the following; elevation of cardiac biochemical markers or elevation of cardiac enzyme, to levels consistent with heart attack.

Heart attack does not include elevation of cardiac biochemical markers or elevation of cardiac enzymes due to coronary angioplasty unless accompanied by diagnostic changes of a new Q wave infarction of the ECG.

"Loss of Independence" means the definitive diagnosis by a licensed Physician of either:

(1) Being totally and permanently unable to perform, by oneself, at least two (2) of the six (6) Activities of Daily Living or,
(2) Cognitive impairment

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of independence must persist for at least ninety (90) days from the date of the diagnosis.

"Major Organ Failure" means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded), both lungs, both kidneys, or bone marrow, in which the affected organ is unresponsive to any treatment and for which the insured is medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

"Multiple Sclerosis" means the unequivocal written diagnosis by a Physician who is certified as a neurologist confirming at least moderate persisting neurological abnormalities, with impairment of function, but not necessarily confining the Insured Person to a wheelchair or bed.

"Paralysis" means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to Injury or Sickness, provided such loss of function continually lasts for 365 consecutive days and such loss of function is thereafter determined on evidence satisfactory to the Company to be permanent. A Physician certified as a neurologist must confirm diagnosis in writing.

"Parkinson's Disease" means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform three (3) of the six (6) Activities of Daily Living without assistance. Diagnosis should show signs of progressive impairment and must be confirmed in writing by a Physician who is certified as a neurologist.

"Pre-existing Medical Condition" means a Sickness suffered from or Injury sustained by an Insured Person for which he sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a licensed medical practitioner during the 24 months immediately prior to such Insured Person's effective date of insurance or prior to any increase in the amount of insurance and which directly or indirectly causes the Insured Condition to occur within the first 24 months from the Insured Person's effective date of insurance or from any increase in the amount of insurance.

"Severe Burns" means the Insured Person has third degree burns covering at least 20% of the surface area of their body. A Physician who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.

"Stroke" means that the Insured Person has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the Stroke, confirmed in writing by a Physician who is certified as a neurologist.

GENERAL PROVISIONS – EMPLOYEE CRITICAL ILLNESS INSURANCE ENHANCED PLAN

90 Day DCIS and Cancer Exclusion
The Cancer and DCIS exclusion period is 90 days from the later of:
a) the Effective Date, or;
b) the date of the last reinstatement of the policy.

Within this exclusion period, there shall be no coverage for DCIS or cancer if a diagnosis of DCIS or any type of cancer, whether included or excluded under this contract, is made or if any symptoms or medical problems manifest themselves which, or the persistence or recurrence of which, subsequently results in an investigation leading to the diagnosis of cancer. In the event of any such diagnosis the policy will remain in force but cancer will no longer be considered an Insured Condition, except for a subsequent diagnosis of an unrelated cancer.

30 day Survival
If, while coverage is in effect, the Insured Person suffers a Benign Brain Tumour, Heart Attack, Stroke, Cancer, Coma, Major Organ Failure, Multiple Sclerosis, Paralysis, Deafness, Severe Burns, becomes Blind, contracts Alzheimer's or Parkinson's disease, or Amyotrophic Lateral Sclerosis, and the Insured Person survives for a period of 30 days thereafter (365 days for Paralysis), the Company will pay the Principal Sum.

If, while coverage is in effect, the Insured Person, undergoes Aortic Surgery, Coronary Artery Bypass Surgery and the Insured Person survives for a period of 30 days thereafter, the Company will pay the Principal Sum.

Principal Sum
The Principal Sum for the Employee and the Spouse shall be the benefit amount selected by the Employer.

One Payment
The Company shall only be obligated to pay the Principal Sum once notwithstanding that an Insured Person may be diagnosed with, suffer or undergo more than one of the Insured Conditions.

DCIS Benefit
Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured Person 10% of the Principal Sum up to a maximum of $10,000 if, while insured, the Insured Person is diagnosed with DCIS and the Insured Person survives 30 days thereafter.

The DCIS benefit is payable only once, without interest. Payment of the DCIS benefit reduces the Principal Sum selected by the Insured Person on the Critical Illness enrollment form. Payment of the DCIS benefit will represent full and final discharge of all claims under the DCIS benefit.

The DCIS benefit is not payable if the Principal Sum has already been paid as a result of the Insured suffering or undergoing one of the Insured Conditions.

Loss of Independence Benefit
Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured Person 25% of the Principal Sum if, while insured, the Insured Person is diagnosed with Loss of Independence.

The Loss of Independence benefit is payable only once, without interest. Payment of the Loss of Independence benefit reduces the Principal Sum selected by the Insured Person on the Critical Illness enrollment form. Payment of the Loss of Independence benefit will represent full and final discharge of all claims under the Loss of Independence benefit.

The Loss of Independence benefit is not payable if the Principal Sum has already been paid as a result of the Insured suffering or undergoing one of the Insured Conditions.

Second Event Benefit
If the Employee is diagnosed with Cancer for which the Principal Sum has been paid and the Employee has thereafter been considered Actively at Work for at least 90 days and is then diagnosed with a Heart Attack, Stroke or Coronary Artery Bypass, the Second Event benefit payable will be equal to the Principal Sum. The Second Event Benefit is subject to the Employee surviving 30 days after the diagnosis of Heart Attack, Stroke or Coronary Artery Bypass.

If the Employee is diagnosed with Heart Attack, Stroke or Coronary Artery Bypass for which the Principal Sum has been paid and the Employee has thereafter been Actively at Work for at least 90 days and is then diagnosed with a Cancer, the Second Event benefit payable will be equal to the Principal Sum. The Second Event Benefit is subject to the Employee surviving 30 days after the diagnosis of Cancer.

If the Spouse is diagnosed with Cancer for which the Principal Sum has been paid and then at least 90 days thereafter is diagnosed with a Heart Attack, Stroke or Coronary Artery Bypass, the Second Event benefit payable will be equal to the Principal Sum. The Second Event Benefit is subject to the Spouse surviving 30 days after the diagnosis of Heart Attack, Stroke or Coronary Artery Bypass.

If the Spouse is diagnosed with Heart Attack, Stroke or Coronary Artery Bypass for which the Principal Sum has been paid and then at least 90 days thereafter is diagnosed with a Cancer, the Second Event benefit payable will be equal to the Principal Sum. The Second Event Benefit is subject to the Spouse surviving 30 days after the diagnosis of Cancer.

The Second Event benefit is payable only once. Payment of the Second Event benefit will represent full and final discharge of all claims under the Second Event benefit.

Pre-existing Medical Conditions
This policy does not provide coverage if an Insured Person suffered from Sickness or sustained an injury for which he or she sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a licensed medical practitioner during the 24 months immediately prior to such Insured Person's effective date of insurance or prior to any increase in the amount of insurance and which directly or indirectly causes the Insured Condition to occur within the first 24 months from the Insured Person's effective date of insurance or from any increase in the amount of insurance.

Continuance of Coverage
In the case of an Employee who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, (3) on leave of absence, or (4) on maternity leave, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

Conversion Options

Option A – Cancer Only
On the date of termination of employment or during the 31 day period following termination of employment, an Insured Person may convert his insurance to an individual insurance policy of the Company. The individual policy will be effective either as of the date that the Company receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as an Insured Person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of the Company. The amount of Critical Illness insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of $25,000. The individual policy will cover CANCER only.

Option B – Spectrum Coverage
On the date of termination of employment or during the 31 day period following termination of employment, an Insured Person may convert his insurance to an individual insurance policy of the

Company, subject to medical evidence of insurability. The individual policy will be effective either as of the date that the Company receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as an Insured Person would ordinarily pay when applying for an individual policy at that time. Application for an individual policy may be made at any office of the Company. The amount of Critical Illness insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of $25,000. The individual policy will cover the same conditions as those available under the group policy currently in force.

GENERAL PROVISIONS - CRITICAL ILLNESS INSURANCE

Limitations and Exclusions

This policy does not provide benefits for any claim caused directly or indirectly by or resulting from any of the following:

1. intentionally self-inflicted Injury, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;
3. for Injury or Sickness, other than one of the Insured Conditions, even though such Injury or Sickness may have been complicated by one of the Insured Conditions;
4. a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;
5. the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
6. the commission or attempted commission by the Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed;
7. misuse of medication or the abuse of drugs or intoxicants;
8. any Pre-existing Medical Condition, if applicable.

Pre-existing Medical Condition

If Insured Person suffered from Sickness or sustained an injury for which he or she sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a licensed medical practitioner during the 24 months immediately prior to such Insured Person's effective date of insurance or prior to any increase in the amount of insurance and which directly or indirectly causes the Insured Condition to occur within the first 24 months from the Insured Person's effective date of insurance or from any increase in the amount of insurance.

GENERAL PROVISIONS – CLAIMS

Payment of Claims

Benefits payable due to the accidental death of an Employee will be payable to the beneficiary on record in a lump sum. Benefits payable due to the accidental death of a Spouse or Dependent Child will be payable to the Employee in a lump sum. Lump sum payments will be made immediately upon approval of the required proofs of claim. Benefits payable for all other indemnities under the Accidental Death and Dismemberment schedule will be paid to the Employee.

Benefits payable due to a critical illness will be payable directly to the Insured Person. Benefits payable due to a critical illness on an insured Dependent Child, if applicable, will be paid to the Employee. In the event the Insured Person dies prior to the benefit being paid, the payment will be made to the beneficiary on record.

If, at the death of the Employee, there is no surviving beneficiary, the benefit shall be payable in one sum to the Estate of the Insured Person.

Should a discrepancy occur, the benefit proceeds may be paid into court.

Notice and Proof of Claim

The Policyholder or his agent, or a beneficiary entitled to make a claim or his agent, shall

(a) give written notice of claim to the Company not later than thirty days from the date of the accident, the beginning of the disability, or after the Survival Period;

  (i) by delivery thereof, or by sending it by registered mail, to the head office or chief agency of the Company in the province; or
  (ii) by delivery thereof to an authorized agent of the Company in the province.

(b) within ninety days from the date of the accident or after the Survival Period, for which the claim is made, furnish to the Company such proof of claim as is reasonably possible in the circumstances of the happening of the accident and the loss occasioned thereby; and

(c) if so required by the Company, furnish a certificate as to the cause and nature of the accident for which the claim is made and as to the duration of the disability caused thereby, from a medical practitioner legally qualified to practice in the province.

Failure to Give Notice of Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed in this policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will the Company accept notice of claim beyond one (1) year.

Company to Furnish Forms for Proof of Claim

The Company shall furnish forms for proof of claim within 15 days after receiving notice of claim but where the claimant has not received the forms within that time he may submit proof of claim in the form of a written statement of the happening and character of the accident giving rise to the claim and of the extent of the loss.

Right to Examination

The Company has the right, and the claimant or beneficiary, executor or any other person representing the deceased, shall afford to the Company an opportunity to examine the Insured Person when and as often as it may reasonably require while the claim hereunder is pending, and also, in the case of the death of the person, to make an autopsy subject to any law of the province relating to autopsies.

When Monies Payable

All monies payable under this contract shall be paid by the Company within 60 days after it has received proof of claim sufficient to the Company.

Claims Forms

The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.