SmartChoice Benefits Inc.

GROUP CRITICAL ILLNESS

PLAN PROVISIONS*

Client: **ABC Company** Plan Effective Date: **June 1, 2011**

Insurer: **ACE INA Life Insurance**

Policyholder: **SmartChoice Benefits Inc.**

Plan Administrator**:** **SmartChoice Admin.**

Plan Broker: **DEF Brokers Inc.**

Covered Employees:	**Coverage Amount:**	**Smart Choice Policy No.:**
Class A - Management	$100,000	CI1033990X
Class B – Hourly	$50,000	CI1033990X

Dependent Coverage	**Coverage Amount:**	**SmartChoice Policy No.:**
Class A - Management	$15,000 spouse, $5,000 dependent	CI1033990X

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***This document provides a partial summary of policy General Provisions and is intended only as a reference. It is not a contract of insurance.**

GENERAL PROVISIONS - DEFINITIONS

"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.

"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.

"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.

"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.

"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

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.

The beneficiary designation made by the group insured (if any) under the replaced group policy has been retained. The group insured should review the existing designation to ensure it reflects his/her current intention.

This policy contains a provision removing or restricting the right of the group person insured to designate persons to whom or for whose benefit insurance money is to be payable.

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.

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. For residents of Alberta and British Columbia: 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. For residents of Manitoba: 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. For residents of Ontario: 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 Limitations Act, 2002. Otherwise, every action must be brought within one year from the date of loss or such longer period as may be required under the law applicable in the insured person's province of residence.

Change of Insurer
A person insured under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under this policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Group Policy, on request, subject to certain access limitations.

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 – 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.

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.

GENERAL PROVISIONS – CRITICAL ILLNESS

"Insured Conditions" means Alzheimer's Disease, Aorta Surgery, Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Dismemberment, Heart Attack, Heart Valve Replacement, Loss of Speech, Major Organ Failure, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, 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.

"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.

"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.

"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.
e) A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage.

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

"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.

Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured Person 20% of the Principal Sum up to a maximum of $20,000 if, while insured, the Insured Person is diagnosed with DCIS and the Insured Person survives 30 days thereafter.

"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.

"Dismemberment" means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a specialist.

"Early Stage Prostate Cancer (T1a or T1b) Treatment" means the diagnosis must be made by a specialist. No benefit will be payable unless the specialist has recommended one of the following treatments:

- Prostate Surgery
- Radiation Therapy
- Chemotherapy
- Hormone Therapy

Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured Person 20% of the Principal Sum up to a maximum of $20,000 if, while insured, the Insured Person undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and the Insured Person survives 30 days thereafter.

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

a) heart attack symptoms; or
b) new electrocardiogram (ECG) changes consistent with a heart attack; or
c) 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.

Exclusions: No benefit will be payable under this condition for:

A) elevated biochemical cardiac markers with a:
   (i) Troponin Level of less than 1
   (ii) CK-Mb Level of less than 4, or
B) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

"Heart Valve Replacement" means undergoing surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist. **Exclusion:** No benefit will be payable under this condition for heart valve repair.

"Hip or Knee Replacement Surgery" means the insured person has undergone surgery to replace either the hip or the entire knee through the procedures defined below. The benefit paid is based on an amount of 10% of the Principal Sum up to a maximum of $10,000, and in no event will this benefit be paid more than once.

- Hip replacement qualifies if the femoral stem is replaced. This procedure is performed in both total arthroplasty and hemiarthroplasty (both monopolar and biopolar)
- Knee replacement qualifies if all three compartments of the knee (medial, lateral and patellofemoral compartments) are replaced. This procedure is also known as total knee replacement.
- The surgery must be performed by a specialist

"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.

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.

"Loss of Speech" means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a specialist.

"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.

"Major Organ Transplant" means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist."

"Motor Neuron Disease" means a definite diagnosis of one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal muscular atrophy
- Progressive bulbar palsy
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

"Multiple Sclerosis" means the unequivocal written diagnosis by a Physician who is certified as a neurologist confirming at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

"Occupational HIV Infection" means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Person's effective date of coverage.

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

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;
b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
e) The accidental injury must be reported, investigated, and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.
Exclusions: No benefit will be payable under this condition if:

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

"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 180 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.

"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

90 Day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion
The DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer 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, Early Stage Prostate Cancer (T1a or T1b) Treatment or Cancer if a diagnosis of DCIS or any type of Cancer is made, or the insured person undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment, 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 but only after coverage has been in effect on the Insured Person for a period of 90 days, the Insured Person, is then diagnosed with DCIS or Cancer, or undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and the Insured Person survives for a period of 30 days thereafter, the Company will pay the applicable benefit.

If, while coverage is in effect, the Insured Person, meets the definition of Alzheimer's Disease, Benign Brain Tumor, Blindness, Coma, Deafness, Dismemberment, Heart Attack, Loss of Independence, Loss of Speech, Major Organ Failure, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV, Paralysis, Parkinson's Disease, Severe Burns and Stroke, and the Insured Person survives for a period of 30 days thereafter (180 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, Heart Valve Replacement or Hip or Knee Replacement 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 sSpouse 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, except as outlined under the Second Event Benefit and Partial Payment Benefits.

DCIS Benefit
Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured Person 20% of the Principal Sum up to a maximum of $20,000 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 enrolment 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 enrolment 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 Insured Person is diagnosed with either of the following:

Category of Conditions
A. Cancer, or
B. Cardiovascular Condition (defined as Heart Attack, Stroke, Coronary Artery Bypass, undergoes Aorta Surgery or Heart Valve Replacement)

for which the Principal Sum has been paid and the Insured Person is thereafter considered (by the treating physician) fully recovered and not actively receiving treatment and has returned to work for a period of at least 90 days and is then diagnosed with another Insured Condition, the Second Event benefit payable will be equal to the Principal Sum (less any partial payment benefit paid after the first

Principal Sum was fully paid). The Second Event Benefit is subject to the Insured Person surviving 30 days after the diagnosis of such Insured Condition. An insured spouse is considered eligible for a Second Event 90 days after the required treatment has finished and they have survived 30 days after the diagnosis of such Insured Condition.

In order to be considered an eligible Second Event condition the first event and the second event cannot fall into the same Category of Conditions.

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. Following Payment of the Second Event Benefit, coverage under this policy will terminate.

Partial Benefits are not considered an event and therefore are not included in the above definition of Second Event. Any benefit payment made will reduce the amount payable under either a First or Second Event.

Conversion
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, which would cover: Cancer, Heart Attack, Kidney Failure and Stroke. 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.

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.

GENERAL PROVISIONS – WAIVER OF PREMIUM
CRITICAL ILLNESS

Waiver of Premium
If an Insured Employee, under age 65, becomes Totally Disabled for six (6) consecutive months, while this policy is in force and the Insured Employee provides evidence of Total Disability satisfactory to the Company, the Company will then waive the payment of each premium which falls due with respect to the Insured Employee and any insured dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to the Insured Employee until age 65 or earlier termination of the policy. If the Insured Employee ceases to be disabled and the Insured Employee returns to employment with the Policyholder and is a member of an eligible class, insurance with respect to the Insured Employee may be continued upon resumption of premium payments by the Insured Employee or the Policyholder.

If after 120 days, an Insured Employee receives approval of any Long Term Disability claim provided under a policy of group insurance through the Employer, the Company will then waive the payment of each Critical Illness insurance premium subject to the terms stated above.

Recurrent Disabilities
When an Employee becomes Totally Disabled again from the same or related causes within 6 months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and the Company will waive the 6 month qualification period.

If the same disability recurs more than 6 months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

Termination of Waiver of Premium
Waiver of Premiums will cease on the earliest of:

a) the date the Employee ceases to meet this policy's definition of Totally Disabled;
b) the date the Employee does not supply the Company with appropriate medical evidence as deemed necessary by the Company;
c) the date the Employee is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by the Company;
d) the date the Employee does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by the Company;
e) the date the Employee turns 65;
f) the date the policy terminates; or
g) the date the Employee dies.

Coverage during Waiver of Premium
While premiums are being waived, Critical Illness Insurance under this policy on the Employee and their Dependents will continue to be in force. The amount of such Critical Illness Insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

GENERAL PROVISIONS – CLAIMS FOR CRITICAL ILLNESS

Payment of Claims
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.

Notice and Proof of Claim
Written notice of claim must be given to the Company within 30 days after the Survival Period of the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible but in no event later than one (1) year from the date of diagnosis. Notice given by or on behalf of the claimant to the Company, or to any authorized agent of the Company, with information sufficient to identify the Insured Person, shall be deemed notice to the Company.

Failure to furnish forms for Proof of Claim
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.

Right to Examination
The Company has the right, and the claimant shall afford to the Company an opportunity to examine the Insured when and as often as it may reasonably require while the claim hereunder is pending.

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.