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ACCI 7 PLUS
GENERAL PROVISIONS

The general provisions of the contract apply to each coverage provided they are compatible with the special provisions of that coverage.

The contract contains general provisions that remove or restrict the insured's right to designate persons to whom or for whose benefit the sum insured will be paid.

CONTRACT

The contract consists of these general provisions, the provisions specific to each coverage, the SUMMARY OF COVERAGES, the application, the riders and any other document which, by agreement, becomes part thereof. No provision of the contract may be cancelled or modified except by a rider signed by an authorized representative of the insurer. No agent or advisor has the authority to change the contract or waive any of its provisions.

PURPOSE OF THE CONTRACT

The insurer undertakes to pay the benefits stipulated in the contract subject to the conditions, limitations and exclusions described therein. In all cases, the event must occur during the coverage period. For an amount to be payable, the applicable coverage must be in effect at the time of the event that gives rise to a claim.

RECONSIDERATION PERIOD

The policyholder may, within 10 days of receiving the contract, or within 60 days of the contract's effective date, whichever is earlier, request that the contract be cancelled by sending the insurer a written notice to this effect along with this contract and the SUMMARY OF COVERAGES. The contract is then declared null and void since the effective date, and if the premium was paid, it is entirely refunded.

NOTICE OF CORRECTION

The policyholder must, within 10 days of receiving the contract, inform the insurer in writing of any omission or error in his or her application for insurance, particularly with respect to the age, the sex or the health status of the person insured.

EFFECTIVE DATE OF CONTRACT

The contract becomes effective the day the insurance application is received to the insurer's Montreal office at the address on page 1 of the contract, provided that the application is duly completed and payment for the first premium is honoured upon initial presentation.

INCONTESTABILITY

Where a contract has been in effect for two years, the insurer will not have the right to contest the validity of the contract except in the case of:

a) fraud and fraudulent representations; or
b) misrepresentation of age, sex or tobacco use.

However, if the event giving entitlement to benefits occurred within the first two years following the effective date of the contract or the date a coverage is added, the above rule does not apply and the insurer may cancel the contract.

If the insured's application or evidence of insurability contains an omission, concealment or misrepresentation that influences the insurer's accurate assessment of the risk, the contract may be cancelled or a claim may be denied.

CHANGE OF BENEFICIARY

The beneficiary may be changed upon written request by the policyholder. If the beneficiary's designation is irrevocable, he or she must agree expressly to any request to replace him or her as the beneficiary. The insurer will record the requested change but assumes no liability with respect to its validity.

ELIGIBILITY FOR INSURANCE

Subject to the specific provisions of chosen coverages, the insured is eligible for insurance on the effective date of the contract provided that he or she is under the age of 75 on that date, living in Canada for at least 12 months and is covered by a provincial health insurance plan in Canada. Eligibility is denied to persons holding a visitor visa, regardless of its duration, or a super visa.

RENEWAL

The insurer undertakes to renew this insurance from year to year until the 80th birthday of the insured, provided that the renewal premium is paid within the prescribed timeframe.

PAYMENT OF PREMIUMS

Premiums are payable in advance as of the effective date of the contract or the coverage indicated in the contract.

Premiums shall be paid directly to the insurer or to a representative duly authorized to receive them.

DETERMINATION OF PREMIUMS

The policyholder must inform the insurer in writing if any change occurs in the determination of his or her coverages or insurance needs since the insurer cannot amend the contract or issue a refund until the information is received in writing.

CHANGE IN PREMIUM

The insurer may modify the rates of each coverage provided all policyholders are notified in writing of that change before the annual renewal. At each renewal, the insurer may change the premium for all contracts issued, in which case the premium will be the same as that payable for a similar contract issued by the insurer and including the same coverages. Come renewal date, the policyholder can add or change the coverages that are part of the insurance.

MISSTATEMENT OF AGE

The insurer is entitled to void the contract if the age of the insured at the effective date was not within the age limits set by the insurer.

If the effective date or the termination date of the coverage depends on the age of the insured, the only deciding factor will be the actual age of the insured. The actual age of the insured also determines the end of the coverage if the misrepresentation is discovered prior to the insured's death.

GRACE PERIOD

The policyholder is granted a period of 30 days for payment of every premium except the first. The contract remains effective during that time. In the event of a claim, the insurer will deduct any payable premiums in arrears.

TERMINATION OF CONTRACT

If the premium remains unpaid by the end of the grace period, the contract is automatically terminated and the obligations of the insurer cease retroactively to the beginning of the grace period.

SUBROGATION

If the insured acquires a cause of action against a physical or legal person with respect to a benefit covered hereunder, the insurer is subrogated to the rights of the insured. The latter must sign and remit all essential documents to this effect and act as necessary to protect such rights.

The insured shall reimburse the insurer any benefits paid or otherwise payable in the future under this contract out of the damages recovered in any judgment or settlement whether or not the insured has received full indemnification.

LEGAL COMPENSATION

The benefits that are provided for in the coverages of the contract and to which the insured may be entitled are subject to the rules of legal compensation in the event of overpayment by the insurer. Any benefit or part thereof owed by the policyholder or the insured under a coverage may be applied against an overpayment by the insurer under another coverage.

DIAGNOSIS IN CANADA OR IN THE UNITED STATES

Any diagnosis giving entitlement to benefits under this contract must be made by a physician, authorized to practice in Canada or the United States and confirmed by modern investigative techniques relevant to this illness, normally used at the time of settlement. The physician who must perform any tests or examinations in order to meet the required conditions must not be the insured, the policyholder, a relative or a business associate of the insured or of the policyholder and must not be a person residing in the same household as the insured or the policyholder.

DIAGNOSIS OUTSIDE OF CANADA AND THE UNITED STATES

Whenever the diagnosis giving entitlement to benefits under this contract is made outside of Canada and the United States, the sum insured will be payable only if:

a) the complete medical records are made available to the insurer; and
b) based on these medical records, the insurer is satisfied that the same diagnosis would have been made by a physician practising in Canada.

The insured must undergo an independent medical examination by a physician appointed by the insurer, if the insurer makes such a request.

EXAMINATION AND AUTOPSY

The insurer reserves the right to require the insured to undergo a medical examination or, if he or she is deceased, to request an autopsy subject to the limits prescribed by law.

FRAUD OR ATTEMPTED FRAUD

An insured person's entitlement to benefits is automatically revoked if he or she obtains or seeks to obtain directly or indirectly, by fraudulent means, any payment of benefits under this contract. In such a case, the insurer will be exempt from any obligation under the contract and reserves the right to require that benefits previously paid be reimbursed. Any fraud or attempted fraud may result in termination of the contract and no premium will be reimbursed.

TERMINATION BY THE INSURER

Subject to the specific provisions of this contract, the insurer cannot terminate the contract before the insured reaches the maximum age applicable to each coverage, as long as the policyholder pays the premium.

TERMINATION BY THE POLICYHOLDER

The policyholder may terminate the contract by sending a written notice to the insurer's Montreal office at the address on page 1 of the contract. Termination shall take effect on the date the notice is received. For premium collection to cease upon contract termination, the insurer must receive the notice at least five business days before a pre-authorized debit. No monthly premium will be reimbursed.

COMPLIANCE WITH LAW

Any provision of the contract, at the effective date, that is not consistent with the laws of the province in which the contract was made will be amended to meet the minimum requirements of such legislation.

LIMITATION PERIOD

Every action or proceeding against an insurer is governed by a limitation period set out in the *Insurance Act* or any other applicable legislation in the insured's province (e.g., *Limitations Act*, 2002 (Ontario), Civil Code of Quebec (Quebec)). This means that the insured cannot sue after a certain period of time has passed and that the insured must obtain independent advice regarding this limitation period.

DEFINITIONS

We mean by:

1) **Accident:** a sudden and unforeseeable event that causes, directly and independently of any other cause, bodily injury resulting exclusively from a cause that is external, violent and unintended by the insured and which requires regular and continuous medical care, recommended by a physician.

2) **Beneficiary:** the person designated as such by the policyholder. If no beneficiary has been designated, the beneficiary will be the policyholder.

3) **Day surgery:** surgery performed in a hospital, while coverage is in effect, which does not require admission to hospital and in which the insured is discharged the same day as the surgery. Not considered as day surgeries: the biopsies performed during a visit to an outpatient unit and mole removals.

4) **Fracture:** the violent rupture of a bone confirmed by medical imaging and a radiologist's written report.

5) **Hospital:** an institution that has been recognized and accredited as a hospital or as a short-term care centre by the government authorities that regulate it. Not considered as hospitals: clinics, nursing homes, long-term care centres, residential and long-term care centre, rest homes, convalescent homes, homes for the aged, homes for the chronically ill, homes for the handicapped, rehabilitation centres, home-care centres, drug and alcohol rehabilitation centres, and all other institutions that do not meet the requirements of the definition. Areas within a hospital which offer such treatments and services are also excluded.

6) **Hospitalization:** room occupancy in a hospital as a patient for a minimum of 18 consecutive hours or a stay during which a bedridden person is under medical care or observation in the emergency room of a hospital for a minimum of 18 consecutive hours.

7) **Illness:** a disease or a condition, an impairment of health or a disorder of the body that occurs while a coverage is in effect, the signs and symptoms of which must be assessed and documented by a physician and corroborated by objective medical evidence. Pregnancy is not considered an illness, except in the case of pathological complications.

8) **Injury:** any bodily harm certified by a physician and resulting, directly and independently of any other cause, from an action that is sudden, violent, unforeseeable and unexpected and from a cause that is external and unintended by the insured.

9) **Insured:** the person who is insured under the present contract.

10) **Insurer:** Industrial Alliance Insurance and Financial Services Inc.

11) **Major burn:** a second or third-degree skin burn that results in immediate medical consultation requiring treatment and that causes a total disability.

12) **Major laceration:** an external cut that requires suture treatment by a physician and that causes total disability.

13) **Policyholder:** the person who completed and signed the application resulting in the issuance of the contract. The policyholder is the person who has all the rights, privileges and interests in respect of the contract.

14) **Physician:** a doctor licensed in medicine who is a member of the college or board of physicians in the insured's province of residence. The physician must not be the insured, the policyholder or be directly or indirectly related to either or be a business partner of the insured or the policyholder.

NOTICE AND EVIDENCE OF LOSS

When a loss gives rise to benefit entitlement, notice must be given to the insurer within 30 days. Within 90 days of that loss, the insurer must receive all necessary information to review the claim. The person who files the claim must provide the insurer with any information or evidence the insurer may deem useful. Failure to file notice or evidence of loss within the prescribed timeframes may result in acceptance of the loss

only at the date of receipt by the insurer, where such failure is not the result of factors beyond the insured's control.

Where notice or evidence of loss is filed over 90 days after the loss, the insured or the person who filed the claim must demonstrate, to the satisfaction of the insurer, why it was impossible for him or her to file notice and evidence of claim within the prescribed timeframe. A claim shall in no case be payable under the contract if submitted to the insurer more than 365 days after the date of the loss giving rise to benefit entitlement.

GUARANTEED PAYMENT FURTHER TO AN ACCIDENT

Subject to receipt of a complete file, the insurer undertakes to indemnify the insured within seven business days, in the event of an accident only, provided that the claim respects the terms and conditions of the contract. The business days begin to elapse when the insurer receives the documents and ends when the payment or the decision is transmitted. Where the insurer fails to respect the above timeframe, the insured will be compensated in the amount of $30 for every business day the payment is late, to a maximum of seven business days.

EXCLUSIONS

No benefit is payable for all periods during which the insured is not covered under a provincial health insurance plan in Canada.

DISABILITY INSURANCE IN CASE OF AN ACCIDENT

PURPOSE OF COVERAGE

Subject to the terms of this coverage and to those of the contract, when the insured becomes totally disabled further to an accident resulting in:

a) hospitalization
b) dismemberment
c) fracture
d) major burn
e) major laceration

the insurer shall pay him or her the monthly benefit stipulated in the SUMMARY OF COVERAGES, starting on the date of the first medical consultation related to the disability, for a maximum of seven months.

ELIGIBILITY FOR COVERAGE

An insured who is at least 18 years old and less than 75 years of age at the effective date of the contract is eligible for this coverage.

SUPPLEMENTARY DEFINITIONS

We mean by:

1. **Total disability for a person with remunerative work at the time of accident:** the state of disability resulting, directly and independently of any other cause, from an accident that leads to hospitalization, dismemberment, fracture, major burn or major laceration, and that is sustained while this coverage is still in force and requires continuous medical care, recommended by a physician, according to the necessary frequency for that disability and which prevents the insured from performing the duties of his or her regular occupation prior to the onset of disability.

2. **Total disability for a person without remunerative work at the time of accident:** the state of disability resulting, directly and independently of any other cause, from an accident that leads to hospitalization, dismemberment, fracture, major burn or major laceration, and that is sustained while this coverage is still in force and requires continuous medical care, recommended by a physician, according to the necessary frequency for that disability and which prevents the insured from performing most normal activities of daily living, such as, but not limited to, meal preparation, housekeeping and shopping for groceries and daily needs.

3. **Regular occupation:** any employment, job, occupation or profession for which the insured was receiving eligible income prior to the onset of disability.

RECURRENT DISABILITY

All consecutive periods of total disability separated by less than seven months shall be considered a single period of disability, unless the subsequent disability is the result of an accident entirely separate from the first disability and begins only:

- once the insured has resumed his or her occupation on an active and continuous basis for at least one day, applicable to a person with remunerative work; or
- once the insured has resumed his or her daily activities, applicable to a person without remunerative work.

The total benefits resulting from the initial disability and the recurrent disability shall not exceed the maximum period of seven months.

LOSS OF ENTITLEMENT TO DISABILITY BENEFITS

Entitlement to disability insurance benefits ceases at the earliest of the following events:

a) at the date the insured reaches the age of 80;
b) upon cessation of total disability or the death of the insured;
c) at the end of the maximum benefit period of seven months;
d) upon refusal to undergo a medical examination, to produce evidence of ongoing disability as required by the insurer or to undergo treatment recommended by a physician;
e) performance of remunerative work or work that should be remunerated.

LIMITATIONS

As of age 70, the monthly benefit payable under this coverage shall be reduced to 50% of the benefit indicated in the SUMMARY OF COVERAGES. The reduction in the amount of insurance coverage due to age shall commence on the date of renewal that follows the insured's 70th birthday.

If a disability begins over 90 days after the accident, it is deemed to be the result of an illness and no benefits will be payable under this coverage.

EXCLUSIONS

No indemnity or benefit under this coverage shall be payable for a disability resulting directly or indirectly from any of the following:

a) suicide, attempted suicide, self-inflicted injury or dismemberment, whether the insured is sane or insane;

b) injury sustained while the insured is actively participating in a riot, an insurrection or hostilities, or injury sustained during a war, whether declared or not;

c) injury when the insured is engaged as an active member of the armed forces of any country, including Canada;

d) commission or attempted commission of a criminal act or hybrid offence by the insured;

e) participation by the insured in any type of flight or attempted flight while he or she is travelling aboard the craft other than as a passenger;

f) pregnancy, natural childbirth, childbirth by Caesarian section, or miscarriage;

g) operation of a motor vehicle by the insured while impaired or under the influence of any drug, whether legal or illegal, or while his or her blood alcohol concentration exceeds the limit prescribed by law;

h) while the insured is under the influence of alcohol or any drug or other intoxicant, including medication where dosage is not followed;

i) participation in a race, trial or speed contest for automobiles, motorcycles or any other motor vehicle;

j) participation in any sport for compensation;

k) intentional inhalation of gas, asphyxia or poisoning;

l) treatment or surgery undergone for cosmetic purposes;

m) any medical treatment or surgery, or a medical error during treatment of the insured or during a high-risk medical procedure based on the health condition of the insured;

n) illness, even if the illness was contracted accidentally.

ACCIDENTAL DEATH, DISMEMBERMENT OR LOSS OF USE

PURPOSE OF COVERAGE

Subject to the terms of this coverage and to those of the contract, if the insured suffers a loss as the result of an accident, the insurer will pay the policyholder or the beneficiary, as applicable, the percentage of the insured amount specified in the SUMMARY OF COVERAGES, according to the Table of Benefits below, provided that all proof deemed satisfactory by the insurer is submitted to the effect that:

- the loss results, directly and independently of any illness or other cause, from an accident causing bodily injury or accidental drowning; and
- the loss occurs within 365 days of the date of the accident.

DEFINITIONS

We mean by:

1) Accident: a sudden and unforeseeable event that causes, directly and independently of any other cause, bodily injury resulting exclusively from a cause that is external, violent and unintended by the insured and which requires regular and continuous medical care, recommended by a physician.

2) Accidental loss:

- with reference to life: death;
- with reference to an eye: the total and irrecoverable loss of sight;
- with reference to hands and feet: the complete amputation at the wrist or ankle joint, or above;
- with reference to arms and legs: the complete amputation at the elbow or knee joint, or above;
- with reference to hearing: the total and irrecoverable loss of the ability to hear with both ears;
- with reference to speech, the total and irrecoverable loss of the ability to utter intelligible sounds;
- with reference to one finger: complete amputation at distal phalange, or above;
- with reference to one toe: complete amputation of two phalanges.

3) Injury: any bodily harm certified by a physician and resulting, directly and independently of any other cause, from an action that is sudden, violent, unforeseeable and unexpected, and from a cause that is external and unintended by the insured.

4) Insured: the person who is insured under this coverage.

5) Loss: means the accidental loss or the loss of use.

6) Loss of use: the total and irrecoverable loss of use of the limb in question, of sight, of hearing or of speech, provided the loss is continuous for a period of 12 consecutive months and is deemed permanent.

Any claim for loss of use filed under this coverage shall be confirmed, and agreed upon, by two practicing licensed physicians, one of whom shall be designated by the insured and the other by the insurer. In the event that the two designated physicians disagree, a third practicing licensed physician, selected by the first two, shall be asked to express his or her opinion, in which case the decision of the majority of the three physicians shall be deemed the final decision both for the insurer and for the insured.

TABLE OF BENEFITS

The table below describes the benefits payable based on the insured amount specified in the SUMMARY OF COVERAGES:

Loss	Percentage of insured amount
Loss of life (death), loss of sight in both eyes, loss of both hands or both feet, loss of one hand and one foot, loss of one hand and sight in one eye, loss of one foot and sight in one eye, loss of hearing and speech	100 %
Loss of one arm or one leg	75 %
Loss of one hand or one foot, loss of sight in one eye or loss of hearing or speech	50 %
Loss of one toe or one finger	5 %

LIMITATIONS

If the insured sustains multiple covered losses resulting from the same accident, the insurer will pay a single amount of insurance, corresponding to the largest covered loss.

An insured cannot be indemnified for the same injury under this coverage and under a coverage for accidental fracture.

As of age 70, the benefit payable under this coverage shall be reduced to 50% of the insured amount. The reduction in the amount of insurance coverage due to age shall commence on the date of renewal that follows the insured's 70th birthday.

EXCLUSIONS

No benefit will be paid if death results from natural causes.

No benefit will be paid if the accident or loss happened prior to the effective date of this coverage.

No indemnity or benefit under this coverage shall be payable for a loss resulting directly or indirectly from any of the following:

a) suicide, attempted suicide, self-inflicted injury or dismemberment, whether the insured is sane or insane;
b) injury sustained while the insured is actively participating in a riot, an insurrection or hostilities, or injury sustained during a war, whether declared or not;
c) injury sustained while the insured is an active member of the armed forces of any country, including Canada;
d) commission or attempted commission of a criminal act or hybrid offence by the insured;
e) participation by the insured in any type of flight or attempted flight while he or she is travelling aboard the craft other than as a passenger;
f) operation of a motor vehicle by the insured while impaired or under the influence of any drug, whether legal or illegal, or while his or her blood alcohol concentration exceeds the limit prescribed by law;
g) participation in a race, trial or speed contest for automobiles, motorcycles or any other motor vehicle;
h) participation in any sport for compensation;
i) intentional inhalation of gas, asphyxia or poisoning;
j) treatment or surgery undergone for cosmetic purposes;
k) any medical treatment or surgery, or a medical error during treatment of the insured or during a high-risk medical procedure based on the health condition of the insured;
l) illness, even if the illness was contracted accidentally;
m) death or loss of use resulting from a high-risk medical intervention is not deemed to be accidental given the insured's medical condition.

TERMINATION OF COVERAGE

This coverage will automatically terminate at the earliest of the following events:

a) at the date the insured reaches the age of 80;
b) when the aggregate amount paid under this coverage equals the amount of insurance specified in the SUMMARY OF COVERAGES;
c) at the death of the insured.

ACCIDENTAL FRACTURE

PURPOSE OF COVERAGE

Subject to the terms of this coverage and to those of the contract, if the insured sustains a fracture as the result of an accident, the insurer will pay the policyholder the percentage of the insured amount specified in the SUMMARY OF COVERAGES, according to the Table of benefits below. The fracture must be diagnosed within 30 days of the accident.

DEFINITIONS

We mean by:

1) **Accident:** a sudden and unforeseeable event that causes, directly and independently of any other cause, one or many fractures resulting exclusively from a cause that is external, violent and unintended by the insured and which requires regular and continuous medical care recommended by a physician.

2) **Fracture:** the violent rupture of a bone, confirmed by medical imaging and a radiologist's written report.

3) **Insured:** the person who is insured under this coverage.

TABLE OF BENEFITS

The table below describes the benefits payable based on the insured amount specified in the SUMMARY OF COVERAGES:

Fracture	Percentage of insured amount
Skull, spine, pelvis, femur, hip	100 %
Sternum, larynx, trachea, scapula, radius, humerus, ulna, patella, tibia, fibula, coccyx	25 %
Other bone	10 %

LIMITATIONS

The maximum amount payable for multiple fractures shall be the highest amount payable for any one of the sustained fractures in the same accident.

An insured cannot be indemnified for the same injury under this coverage and under a coverage for accidental death, dismemberment or loss of use.

As of age 70, the benefit payable for accidental fracture shall be reduced to 50% of the insured amount. The reduction in the amount of insurance coverage due to age shall commence on the date of renewal that follows the insured's 70th birthday.

EXCLUSIONS

No benefit will be paid if the accident or fracture happened prior to the effective date of this coverage.

No benefit under this coverage shall be payable for a fracture resulting directly or indirectly from any of the following:

a) suicide, attempted suicide, self-inflicted injury or dismemberment, whether the insured is sane or insane;

b) injury sustained while the insured is actively participating in a riot, an insurrection or hostilities, or injury sustained during a war, whether declared or not;

c) injury sustained while the insured is an active member of the armed forces of any country, including Canada;

d) commission or attempted commission of a criminal act or hybrid offence by the insured;

e) participation by the insured in any type of flight or attempted flight while he or she is travelling aboard the craft other than as a passenger;

f) operation of a motor vehicle by the insured while impaired or under the influence of any drug, whether legal or illegal, or while his or her blood alcohol concentration exceeds the limit prescribed by law;

g) participation in a race, trial or speed contest for automobiles, motorcycles or any other motor vehicle;

h) participation in any sport for compensation;

i) intentional inhalation of gas, asphyxia or poisoning;

j) treatment or surgery undergone for cosmetic purposes;

k) avulsion fracture, chip fracture;

l) illness, even if the illness was contracted accidentally.

TERMINATION OF COVERAGE

This coverage will automatically terminate at the earliest of the following events:

a) at the date the insured reaches the age of 80;

b) when the aggregate amount paid under this coverage equals the amount of insurance specified in the SUMMARY OF COVERAGES;

c) at the death of the insured.

EXTENDED MEDICAL CARE FURTHER TO AN ACCIDENT

PURPOSE OF COVERAGE

Subject to the terms of this coverage and to those of the contract, if an insured incurs medically necessary expenses within 12 months of the date of the accident, the insurer will reimburse the eligible portion of reasonable and customary expenses according to the terms of payment. Care must be provided in Canada.

Eligible expenses are deemed to be incurred the date on which the care is rendered or the products supplied. For the purpose of determining benefits, the insured is deemed to be covered under a government or para-governmental plan that offers taxpayers health care services such as hospitalization, medical care and other eligible services in the insured's province of residence. Sums paid by the insurer will in no case exceed those that would have been payable had the insured been covered under such plans. However, when expenses are incurred in a Canadian province other than the insured's province of residence, the insurer will reimburse the excess amount of expenses claimed, where applicable, in accordance with the terms set out below under "Benefits" section.

DEFINITIONS

We mean by:

1) **Accident:** a sudden and unforeseeable event that causes, directly and independently of any other cause, bodily injury resulting exclusively from a cause that is external, violent and unintended by the insured and which requires regular and continuous medical care, recommended by a physician.

2) **Insured:** the person who is insured under this coverage.

BENEFITS

Eligible expenses are covered at a rate of 100%, without deductible, for all of the following benefits:

a) acute care hospitalization to a maximum of the reasonable and customary cost of a semi-private room, subject to a maximum of $10,000 per accident;

b) expenses for transportation by ambulance or taxi, including air or rail transportation when, for reasons the insurer deems justified and where no other means of transportation is available, such transportation must be used to convey the insured to or from the nearest hospital that can provide the emergency care he or she requires;

c) the professional services of a registered nurse upon recommendation by the attending physician, for services rendered in the insured's home, when medically necessary, provided such services are not rendered by a family member or a person who resides in the patient's home, subject to a maximum of $200 per day and $18,000 per accident. Daycare services are not covered;

d) upon medical recommendation, the following expenses:

- laboratory services for diagnostic purposes during treatment;
- artificial eyes and limbs (initial cost only);
- casts, slings, trusses, crutches, walkers and canes;
- rental of orthopedic appliances;
- rental of a manual, conventional wheelchair or a manual, conventional hospital bed;
- rental of equipment to administer oxygen or purchase of the device upon approval by the insurer;
- any initial prosthesis (excluding eyeglasses, contact lenses, mammary prostheses or capillary prostheses);
- reasonable and customary expenses for medication requiring prescription by a physician, used in accordance with the manufacturer's recommendations as part of an officially recognized treatment, subject to a maximum prescription of 60 days and $5,000 per accident;
- reasonable and customary expenses for medical treatment and services provided by a public hospital that are not reimbursed by the insured's government plan, including in particular, X-rays and medication, subject to a maximum of $10,000 per accident;

e) without medical recommendation, the fees of professionals, up to $40 per visit, to a maximum of $1,000 per professional and $5,000 per accident, for all the following professionals:

- chiropractor, physiotherapist, osteopath, podiatrist, psychologist, speech-language pathologist, occupational therapist;
- X-rays for chiropractic purposes, to a maximum of $50 per accident, per insured.

f) the professional services of a dental surgeon, to repair accidental damage to natural, healthy teeth or the cost of purchasing an initial dental prosthesis made necessary as the result of an accident, provided the services are rendered or the purchase made within one year of the accident. The cost of eligible professional services is based on the current suggested fee guide for dental services published by the association of dental surgeons in the province where the services are provided, to a maximum of $10,000 per accident.

COORDINATION OF BENEFITS

The present clause applies to any insurance that reimburses expenses for medical care and services or supplies.

a) In this clause, "**insurance**" means any coverage that provides benefits for medical care, services or supplies under:

   i) a group insurance plan, family insurance plan, or loan and savings insurance plan;

   ii) a government plan with benefits for similar care;

   iii) an uninsured fringe benefits plan.

   The benefits payable under any insurance include benefits to which the insured would have been entitled if he or she had duly filed a claim.

b) Where an insured is eligible for benefits under both this coverage and another insurance plan, the benefits payable for the insured are based on the following order of precedence:

   i) benefits under an insurance plan that does not contain a coordination of benefits provision are payable before those that would otherwise be payable under this coverage;

   ii) benefits under an insurance plan that contains a coordination of benefits provision are payable, based on the following order of precedence, by the insurance under which the insured is qualified to receive benefits:

   - as an employee: precedence will be given to the plan under which the participant is covered as:
     - an active full-time employee;
     - an active part-time employee;
     - a retiree.
   - as a dependent spouse;
   - as a dependent child: precedence will be given as follows:
     - the plan of the parent with an earlier date of birth in the year;
     - the plan of the parent whose first name begins with the earlier letter in the alphabet, if the parents have the same date of birth.
   - as a dependent child of separated or divorced parents: precedence will be given as follows:
     - the plan of the parent with custody of the child;
     - the plan of the spouse of the parent with custody of the child;
     - the plan of the parent who does not have custody of the child;
     - the plan of the spouse of the parent who does not have custody of the child.

c) Where, under this clause, the benefits of this coverage are payable after those of another insurance plan, the benefits payable under this coverage are equal to the lesser of:

   i) the total benefits that would have been payable had it not been for this clause;

   ii) the total eligible expenses under this contract, less the benefits payable by any other insurance plan.

LIMITATIONS

Care must be provided in Canada.

The initial necessary expenses must be incurred within 30 days following the accident and all expenses must be incurred no later than 12 months following the accident.

This coverage is subject to the COORDINATION OF BENEFITS clause.

This coverage is subject to a lifetime maximum of $100,000.

EXCLUSIONS

No benefit will be paid if the accident happened prior to the effective date of this coverage.

No benefit under this coverage shall be payable for an accident resulting directly or indirectly from any of the following:

a) suicide, attempted suicide, self-inflicted injury or dismemberment, whether the insured is sane or insane;

b) injury sustained while the insured is actively participating in a riot, an insurrection or hostilities, or injury sustained during a war, whether declared or not;

c) injury sustained while the insured is an active member of the armed forces of any country, including Canada;

d) commission or attempted commission of a criminal act or hybrid offence by the insured;

e) participation by the insured in any type of flight or attempted flight while he or she is travelling aboard the craft other than as a passenger;

f) operation of a motor vehicle by the insured while impaired or under the influence of any drug, whether legal or illegal, or while his or her blood alcohol concentration exceeds the limit prescribed by law;

g) while the insured is under the influence of alcohol or any drug or other intoxicant, including medication where the dosage is not respected;

h) participation in a race, trial or speed contest for automobiles, motorcycles or any other motor vehicle;

i) participation in any sport for compensation;

j) intentional inhalation of gas, asphyxia or poisoning;

k) treatment or surgery undergone for cosmetic purposes;

l) any medical treatment or surgery, or a medical error during treatment of the insured or during a high-risk medical procedure based on the health condition of the insured;

m) illness, even if the illness was contracted accidentally;

n) medical care or services which the insured is entitled to receive without charge under federal or provincial legislation, or which are covered under such legislation;

o) experimental care or treatment or new procedures and treatments that are not yet common practice according to the ministry of health in the insured's province of residence.

TERMINATION OF COVERAGE

This coverage will automatically terminate at the earliest of the following events:

a) at the date the insured reaches the age of 80;

b) when the lifetime maximum specified in this coverage is reached;

c) at the death of the insured.

HOSPITAL BENEFIT IN CASE OF ACCIDENT

PURPOSE OF COVERAGE

Subject to the terms, conditions, limitations and the summary of this coverage, the insurer undertakes to pay an amount that corresponds to the daily benefit indicated in the SUMMARY OF COVERAGES when the insured is hospitalized as the result of an accident for at least 18 hours. For the purposes of this contract, where the insured undergoes day surgery further to an accident, the hospitalization period corresponds to a period of 18 hours.

In all cases, hospitalization or day surgery must occur during the coverage period. For an amount to be payable, hospitalization and day surgery must be medically necessary as a result of an accident.

CONVALESCENCE BENEFIT

Subject to the terms of this coverage, the insurer will pay an amount that corresponds to a convalescence daily benefit of 7 days immediately following the date the insured underwent day surgery or after any episode of hospitalization. This convalescence benefit is paid even if the insured happens to die at the hospital. The daily convalescence allowance corresponds to the hospitalization coverage described in the SUMMARY OF COVERAGES.

DEFINITIONS

We mean by:

1) **Day surgery:** surgery performed in a hospital, while coverage is in effect, which does not require admission to hospital and in which the insured is discharged the same day as the surgery. Not considered as day surgeries: the biopsies performed during a visit to an outpatient unit and mole removals.

2) **Illness:** a disease or a condition, an impairment of health or a disorder of the body that occurs while a coverage is in effect, the signs and symptoms of which must be assessed and documented by a physician and corroborated by objective medical evidence.

LIMITATIONS

The total amount of all benefits under this coverage is limited to a lifetime maximum of 700 days, including convalescence benefits.

Hospital care must be provided in Canada or the United States.

EXCLUSIONS

When the hospitalization begins over 30 days after the accident, it is deemed to be the result of an illness and no benefit will be payable under this coverage.

No indemnity or benefit under this coverage shall be payable for hospitalization resulting directly or indirectly from any of the following:

a) suicide, attempted suicide, self-inflicted injury or dismemberment, whether the insured is sane or insane;

b) injury sustained while the insured is actively participating in a riot, an insurrection or hostilities, or injury sustained during a war, whether declared or not;

c) commission or attempted commission of a criminal act or hybrid offence by the insured;

d) participation by the insured in any type of flight or attempted flight while he or she is travelling aboard the craft other than as a passenger;

e) operation of a motor vehicle by the insured while impaired or under the influence of any drug, whether legal or illegal, or while his or her blood alcohol concentration exceeds the limit prescribed by law;

f) participation in a race, trial or speed contest for automobiles, motorcycles or any other motor vehicle;

g) participation in any sport for compensation;

h) intentional inhalation of gas, asphyxia or poisoning;

i) treatment or surgery undergone for cosmetic purposes;

j) illness, even if the illness was contracted accidentally;

k) experimental care or treatment or new procedures and treatments that are not yet common practice according to the ministry of health in the insured's province of residence.

TERMINATION OF COVERAGE

This coverage will automatically terminate at the earliest of the following events:

a) at the date the insured reaches the age of 80;

b) when the lifetime maximum of 700 days is reached;

c) at the death of the insured.

HOSPITAL BENEFIT IN CASE OF ACCIDENT OR ILLNESS

PURPOSE OF COVERAGE

Subject to the terms, conditions, limitations and the summary of this coverage, the insurer undertakes to pay an amount that corresponds to the daily benefit indicated in the SUMMARY OF COVERAGES when the insured is hospitalized as the result of an accident or an illness for at least 18 hours. For the purposes of this contract, where the insured undergoes day surgery further to the accident or illness, the hospitalization period corresponds to a period of 18 hours.

In all cases, hospitalization or day surgery must occur during the coverage period. For an amount to be payable, hospitalization or day surgery must be medically necessary as a result of an accident or an illness.

CONVALESCENCE BENEFIT

Subject to the terms of this coverage, the insurer will pay an amount that corresponds to a convalescence daily benefit of 7 days immediately following the date the insured underwent day surgery or after any episode of hospitalization. This convalescence daily benefit is paid even if the insured happens to die at the hospital. The daily convalescence allowance corresponds to the hospitalization coverage described in the SUMMARY OF COVERAGES.

ELIGIBILITY FOR COVERAGE

An insured who is at least six months old and under 75 years of age at the effective date of the contract is eligible for this coverage.

CALCULATION OF PREMIUMS

Premiums are calculated using actuarial data based on, among other factors, age and amount of chosen coverage.

DEFINITIONS

We mean by:

1) **Day surgery:** surgery performed in a hospital, while coverage is in effect, which does not require admission to hospital and in which the insured is discharged the same day as the surgery. Not considered as day surgeries: the biopsies performed during a visit to an outpatient unit and mole removals.

2) **Illness:** a disease or a condition, an impairment of health or a disorder of the body that occurs while a coverage is in effect, the signs and symptoms of which must be assessed and documented by a physician and corroborated by objective medical evidence. Pregnancy is not considered an illness, except in the case of pathological complications.

LIMITATIONS

The total amount of all benefits under this coverage is limited to a lifetime maximum of 700 days, including convalescence benefits.

Hospital care must be provided in Canada or the United States.

No benefit is payable during the nine months immediately following the date the contract became into force when hospitalization is due to pregnancy, childbirth, miscarriage or any other pregnancy-related complications.

The guaranteed payment within seven working days described in the General Provisions does not apply in case of hospitalization due to illness.

EXCLUSIONS

No indemnity or benefit under this coverage shall be payable for hospitalization resulting directly or indirectly from any of the following:

a) suicide, attempted suicide, self-inflicted injury or dismemberment, whether the insured is sane or insane;

b) injury sustained while the insured is actively participating in a riot, an insurrection or hostilities, or injury sustained during a war, whether declared or not;

c) commission or attempted commission of a criminal act or hybrid offence by the insured;

d) participation by the insured in any type of flight or attempted flight while he or she is travelling aboard the craft other than as a passenger;

e) operation of a motor vehicle by the insured while impaired or under the influence of any drug, whether legal or illegal, or while his or her blood alcohol concentration exceeds the limit prescribed by law;

f) participation in a race, trial or speed contest for automobiles, motorcycles or any other motor vehicle;

g) participation in any sport for compensation;

h) intentional inhalation of gas, asphyxia or poisoning;

i) treatment or surgery undergone for cosmetic purposes;

j) experimental care or treatment or new procedures and treatments that are not yet common practice according to the ministry of health in the insured's province of residence.

TERMINATION OF COVERAGE

This coverage will automatically terminate at the earliest of the following events:

a) at the date the insured reaches the age of 80;

b) when the lifetime maximum of 700 days is reached;

c) at the death of the insured.