Sun Life Financial

Sun Long Term Care Insurance

Policy number: LI-1234,567-8

Owner: Mary Doe

Additional options included in this sample policy:
- Inflation protection (IP 2/3%)
- Return of premium on death (ROPD)

The following policy wording is provided solely for your convenience and reference. It is incomplete and reflects only some of the general provisions that may be found in some of our insurance policies. We periodically make changes to policy wording and therefore this incomplete sample may not duplicate the wording of any actual issued policy. It is not to be construed or interpreted in any manner as a contract or an offer to contract. The actual policy issued to any given client will govern that relationship.

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Policy summary

In this document, *you* and *your* mean the owner of this policy. *We, us*, *our,* and *the company* mean Sun Life Assurance Company of Canada.

Your policy is issued and underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

It's important that you read your entire policy carefully. It sets out the benefits payable and has exclusions and limitations. To help you understand insurance terms, refer to the explanations described under the heading, *Insurance terms*.

Sun Long Term Care Insurance

Your policy number is:	LI-1234,567-8
Your policy date is:	October 2, 2017 This policy is in effect from this date, while the insured person is alive and the required premiums are paid.
The owner is:	Mary Doe
The insured person is:	Mary Doe born on March 10, 1961

Your comprehensive benefit:

Benefit amount:	$750 weekly
Waiting period:	90 consecutive days
Benefit period:	unlimited

(additional option)
Inflation protection: The weekly benefit amount increases by 2% annually if not receiving benefits and 3% annually while receiving benefits, as described in the section *Inflation protection*.

(additional option)
Return of premium on death: If the insured person dies while this policy is in effect, a claim may be submitted as described in the section *Return of premium on death.*

Premiums: Premiums are due monthly, on the 2nd day of the month, starting on October 2, 2017.

Premiums are payable until the policy anniversary following the 100th birthday of the insured person.

Premium guarantee: For the first 5 policy years, your premium is $XXX.XX monthly. The premium guarantee is described in the section *Paying for your policy*.

Policy summary (continued)

Extended term insurance:	If the required premium is not received, this policy may continue in effect as described in the section *Extended term insurance*.
When we waive premiums:	When we approve a claim, you are not required to pay premiums. This is described in the section *When premiums are waived.*
First payment bonus:	For a new claim, the first payment includes an additional amount as described in the section *First payment bonus*.

This permanent long term care insurance policy provides protection for the entire lifetime of the insured person.

This is not a participating policy. You are not eligible to receive dividends on this policy.

If you change your mind within 10 days

You may send us a written request to cancel your policy within:

- 10 days of receiving it from us, or
- 60 days after the policy is issued, whichever date is earlier.

You are considered to have received your policy 5 days after it's mailed from our office, or on the date your advisor delivers it to you.

When we receive your written request we'll refund any amount paid. This is called rescission.

Your decision to cancel your policy is your personal right. When we receive your request to cancel it, all of our obligations and liabilities under this policy end immediately. The cancellation is binding on you and any person entitled to make a claim under this policy, whether their entitlement is revocable or irrevocable.

To cancel your policy, send your request in writing to:

Sun Life Assurance Company of Canada
227 King Street South
PO Box 1601, Stn. Waterloo
Waterloo ON Canada N2J 4C5

Contesting your policy

The incontestability provisions set out in the provincial or territorial insurance legislation applicable to this policy apply.

Limit on contesting
We cannot challenge the validity of the policy after it has been in effect continuously for two years from the later of the date it took effect and the date it was last reinstated. If the policy is amended to increase or change a benefit or improve a rating, we cannot challenge the validity of the amendment after it has been in effect continuously for two years from the later of the date the amendment took effect and the date the policy was last reinstated.

Exception to the limit on contesting
We can challenge the validity of the policy or an amendment at any time in cases of fraud. In cases involving dependency we can challenge the validity at any time when the dependency occurred within the first two policy years or within two policy years from the date this policy was last reinstated.

About your Sun Long Term Care Insurance

This long term care insurance policy continues in effect until all benefits have been paid or the insured person dies, whichever comes first, provided all premiums are paid when due.

We pay a benefit to you when the insured person qualifies for it. The benefit is calculated weekly and paid monthly. The weekly comprehensive benefit amount, waiting period and benefit period are shown under the heading, *Policy summary*.

The insured person qualifies for benefits when they are dependent longer than the waiting period. The conditions described under the heading, *How we determine dependency,* must be satisfied while this policy is in effect. If the insured person is receiving palliative care as described under the heading, *Palliative care (end-of-life care)*, a shorter waiting period applies.

The waiting period is the length of time the insured person must be continuously dependent before a claim is submitted. It starts on the date they first require assistance for 2 or more activities of daily living or the date they first require continual supervision.

The benefit period is the length of time we may pay a claim. If your benefit period is limited by a maximum number of weeks, each payment we make reduces the number of weeks you are eligible to be paid. The maximum number of weeks in the period does not start over with a new claim.

If the benefit period is unlimited, it's not affected by the payments we make.

How we determine dependency

The insured person is dependent when we've determined there are objective measures of functional limitations for either deteriorated mental ability (cognitive impairment) or activities of daily living including stand-by assistance for bathing and transferring, as described below.

Deteriorated mental ability (cognitive impairment)

The insured person is dependent when they need constant supervision by another person for protection from threats to their physical health and safety as the result of deterioration in or a loss of:

- short-term or long-term memory
- orientation as it relates to people, place and time
- reasoning, or
- judgement, as it relates to safety awareness.

Deteriorated mental ability must result from an organic brain disorder such as Alzheimer's disease, irreversible dementia, or brain injury. The diagnosis must be made by a specialist licensed and practicing in Canada or the United States, based on:

- clinical examination
- radiological studies, and
- psychological testing.

Activities of daily living

The insured person is dependent when they require substantial physical assistance, with or without assistive devices, to safely and completely perform 2 or more activities of daily living. Activities of daily living include bathing, dressing, toileting, transferring, continence and feeding.

Assistive devices are aids that we determine could be used to improve the insured person's functioning. These aids include adjustable beds, buttonhooks, canes, crutches, grab bars, handheld showerheads, bath brushes, seat lifts, transfer benches, walkers and wheelchairs. If using an assistive device allows the insured person to perform an activity of daily living safely and completely, the insured person is not dependent for that activity.

Stand-by assistance for bathing and transferring
The insured person is also dependent when they require stand-by assistance for bathing and transferring. Stand-by assistance means another person must always be within arm's reach of the insured person so that they may safely and completely perform the activities of **bathing** and **transferring**.

If the insured person requires stand-by assistance for only one of bathing or transferring, we consider them dependent when they also require substantial physical assistance to perform one of the other activities of daily living.

Bathing means washing with or without the aid of assistive devices:
- in a bathtub or shower, including getting in and out of the bathtub or shower, or
- by sponge bath.

Bathing does not include the ability to reach and wash the back or feet.

Dressing means putting on, taking off, fastening and unfastening, with or without the aid of assistive devices:
- clothing, and
- medically necessary braces or artificial limbs.

There is no dependency if reasonable alterations to or changes in the clothing the insured person usually wears would enable them to dress without substantial physical assistance.

Toileting means getting to and from and on and off the toilet, with or without the aid of assistive devices, and performing associated personal hygiene.

Transferring means moving into or out of a bed, chair or wheelchair, with or without the aid of assistive devices.

Continence means the ability to control both bladder and bowel functions, or maintain a reasonable level of personal hygiene (including caring for catheter or colostomy bag) when not able to control bowel or bladder functions.

Feeding means the ability to get food into the body, with or without the aid of assistive devices, through the mouth, or by feeding tube. Feeding does not include cooking or preparing a meal.

Palliative care (end-of-life care)
Regardless of the waiting period, a claim may be submitted **30 days after** the insured person:
- requires substantial physical assistance for at least 4 activities of daily living
- has been diagnosed with a terminal disease or illness by a qualified physician or another health care professional acceptable to us, and
- is receiving palliative care that is supportive and provides comfort.

Exclusions and limitations

This policy will end and benefits are not payable if the insured person's dependency started before the later of:

- the most recent date an application for this policy was signed
- the policy date shown under the heading, *Policy summary*, or
- the most recent date this policy was put back into effect, if the policy has been reinstated.

We will not pay benefits if the insured person's dependency is directly or indirectly caused by or associated with the insured person operating a vehicle while their blood alcohol level is more than 80 milligrams of alcohol per 100 millilitres of blood. A vehicle includes any form of ground, air or marine transportation that can be put into motion by any means, including muscular power. We do not take into account whether or not the vehicle is in motion.

We will not pay benefits if the insured person's dependency is directly or indirectly caused by or associated with the insured person:

- committing or attempting to commit a criminal offence
- attempting to take their own life, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
- causing themself bodily injury, regardless of whether the insured person has a mental illness or understands or intends the consequences of their action(s)
- intentionally taking any drug other than as prescribed by a licensed medical practitioner and in accordance with the instructions given
- intentionally taking any intoxicant, narcotic or poisonous substance. This does not include smoking cigarettes, cigarillos, cigars, chewing tobacco or occasional use of alcohol.

We will not pay benefits if the insured person's dependency is directly or indirectly caused by or associated with civil disorder or war, whether declared or not.

We will not pay benefits when the insured person is outside Canada or the United States for more than 8 consecutive weeks. The insured person must inform us of the date of departure and when they return to their permanent residence. The insured person must return to their permanent residence for benefit payments to resume. If we've paid beyond the 8 consecutive week limitation, we have the right to deduct the overpayment from any future payments we make.

(Note: Inflation protection is an additional option)

Inflation protection

While Inflation protection is in effect, we increase the weekly benefit amount on each policy anniversary. The increase we apply is:

- 2% if we are not paying benefits on the policy anniversary date, or
- 3% if we are paying benefits on the policy anniversary date.

Increases are compounded annually and rounded to the nearest dollar.

Inflation protection ends on the earliest of the date:

- you tell us to cancel it
- the policy continues as extended term insurance, if available
- the insured person dies, or
- this policy ends.

Making a claim for benefits

To make a claim, contact us at the toll free phone number shown at the beginning of this policy. We will then send the claim form to be completed. The person making the claim must complete the form and give us the information we need to assess the claim.

The insured person must be in Canada or the United States at the time a claim is made. If they are not, they must return to be assessed by a physician licensed and practicing in Canada or the United States.

Before we approve the claim, the insured person's date of birth must be verified. If the date of birth given on the application is incorrect, we'll adjust the amount we pay to reflect the insured person's correct age.

You must continue to pay your premiums until we notify you that we've approved the claim.

When to make a claim

The policy must be in effect on the date a claim is submitted. The insured person must be continuously dependent for longer than the waiting period and the conditions described under the heading, *How we determine dependency* are satisfied.

A claim may be submitted before the waiting period is satisfied if the insured person is receiving palliative care. This is described under the heading, *Palliative care (end-of-life care)*.

We must receive the claim immediately following the end of the waiting period and no later than 120 days from that date. Any claim received after that time is late and we may decline it without assessing dependency.

We'll consider a late claim exception if:

- we receive the claim no later than 1 year from the date the insured person became dependent, and
- the claimant provides a written explanation describing why the claim is late and we agree the explanation is reasonable.

What proof is required

The claimant must give us the information we need to assess the claim. This includes our form which must be completed by a physician or another health care professional acceptable to us. The physician must describe the insured person's medical condition, limitations and functional abilities and provide objective medical information about their dependence.

We will tell you if we need any other information to assess the claim. This could include medical records, clinical tests, physiotherapy reports, psychological tests and any other objective medical information that supports the claim.

Any fees charged by physicians to complete forms or provide information are the claimant's responsibility.

Physicians, specialists or health care practitioners who provide information to us must be licensed and practicing in Canada or the United States. They may not be the policy owner, insured person, anyone entitled to make a claim under this policy, or any relative or business associate of these people.

We may require the insured person to be examined by any health care practitioners that we appoint. These may be licensed physicians, physiotherapists, occupational therapists, psychiatrists, psychologists or others. We pay for these examinations.

We may also require the insured person to authorize us to gather and use information from other insurers or government agencies.

When a claim is approved

We will pay benefits effective the day after the waiting period is satisfied. The benefit is paid to you or your estate if applicable.

First payment bonus

When we approve a new claim, the first payment includes a bonus amount. It is equal to 12 times the weekly benefit amount. However, when the insured is receiving palliative care and qualifies for benefits, the bonus is equal to 4 times the weekly benefit amount.

If this policy includes Inflation protection, the bonus includes any accumulated increases to the weekly benefit amount.

We will not pay a bonus if:

- there is a continuation of a previous claim, or
- the policy continues as extended term insurance, if available.

How to continue to qualify for benefits

To continue to qualify, the insured person must:

- satisfy the conditions for dependency and any additional conditions described in this policy
- be under the continuous care of a physician and follow that physician's medical advice, and
- make reasonable efforts to participate in any appropriate rehabilitation program that is available.

From time to time, we may ask for proof, that we consider satisfactory, that the insured person remains dependent and continues to qualify for benefits. You must provide the proof we request within 31 days of the date we make the request and pay any cost associated with supplying this proof.

We will stop paying benefits if the claimant or the insured person restricts our access to any information we need to assess the claim. This information includes records from health care professionals, medically related facilities, insurance companies and government agencies.

Making a claim within 180 days of a previous claim

For each claim, the applicable waiting period must be satisfied. However, the waiting period does not have to be met again when we receive proof the insured person qualifies for benefits within 180 days after we stopped paying benefits. The reason for the dependency doesn't have to be the same as for the previous claim. Benefits are payable on the date the dependency began.

When benefits are no longer payable

We stop paying benefits on the date the insured person:

- is no longer dependent
- is no longer under the continuous care of a physician
- does not make reasonable efforts or refuses to participate in any appropriate rehabilitation program that is available to them
- no longer satisfies all the conditions to qualify for benefits, or
- dies.

If the benefit period is limited by a maximum number of weeks, each payment we make reduces the number of weeks you are eligible to be paid. The maximum number of weeks in the period does not start over with a new claim. We stop paying benefits when the maximum is reached, at which time the policy ends.

When premiums are waived

Waiver of premium when a claim is approved

When we approve your claim, you don't have to pay premiums for this policy. You must continue to pay your premiums until we notify you that we approved the claim.

Spousal waiver of premium

If we've issued a long term care insurance policy on the insured person's spouse and approved a claim for benefits on that policy, we may waive premiums for this policy.

To have premiums waived, both policies must have Spousal waiver. Each policy must have been continuously in effect with no approved claim, from the dates they came into effect until:

- both policies have reached their 10th policy anniversary, or
- the insured person and their spouse have had their 86th birthday.

Spouse means the person who is married to the insured person, is in a civil union with the insured person, or the person who lives with the insured person in a conjugal relationship for at least 12 consecutive months before the date a claim is submitted for the spouse.

To request premiums be waived for this policy, the policy number must be included on the spouse's claim form. We may ask you to prove the spouse's relationship to the insured person.

We will waive premiums for this policy when we're paying benefits for the spouse's policy. We will continue to waive premiums for this policy even after we've paid benefits for the entire benefit period for their policy.

We will also waive premiums for this policy if the spouse dies while their insurance is in effect, whether or not we were paying benefits at the time they die. You must provide proof of the spouse's death and request that we waive premiums for this policy.

You must continue to pay your premiums for this policy until we notify you the request is approved.

When premiums are no longer waived

Premiums for this policy are no longer waived on the date we stop paying benefits for this policy or a long term care insurance policy on the insured person's spouse, as described earlier. We'll tell you when you need to start paying premiums to keep this policy in effect and the required amount.

A plan of care

You are entitled to one free plan of care for the insured person. You may request a plan of care after a claim has been approved and while the insured person is dependent. To make a request, contact us at the toll free phone number shown at the beginning of this policy.

The plan of care will outline the type and amount of care the insured person requires. It will also explain how care can be provided and if government programs are available.

(Note: Return of premium on death is an additional option)

Return of premium on death

If the insured person dies, this policy ends and we may make a payment as described below. We require proof that the insured person died while this policy was in effect. To make a claim, contact us at the toll free phone number shown at the beginning of this policy.

We pay the returnable premium amount to you, or your estate, or any beneficiary you named in writing.

We calculate the returnable premium amount on the date the insured person dies. It is the total of:

- all premiums paid for this policy
- **minus** any unpaid premiums plus interest
- **minus** any benefit payments we made.

The Return of premium on death ends on the earliest of the date:

- you notify us to cancel it
- the policy continues as extended term insurance, if available
- this policy ends, or
- the insured person dies.

Paying for your policy

We will provide the insurance described in this policy if you pay the required premium. Payment must be made to Sun Life Assurance Company of Canada. We reserve the right to refuse cash payments.

If you do not pay a premium when it's due, we will withdraw the unpaid premium from the withdrawable premium fund if it has enough funds to pay the premium.

Premium guarantee

The premium shown on the *Policy summary* won't change for the first 5 policy years. After this period, we may increase or decrease the premium on a policy anniversary. If we change the premium, we will tell you in advance and that premium is guaranteed for at least another 5 policy years.

Any premium change is based on the insured person's age on the policy date. We do not consider the insured person's health when we make a premium change.

Withdrawable premium fund

If you send us more than you owe us in premiums, we will hold the excess amount in the withdrawable premium fund. We may set a maximum amount that you can have in the fund. You may use this fund to pay premiums at any time.

The amount in your withdrawable premium fund will earn interest daily. We set the interest rate each day based on short-term interest rates. Interest earned on your premium fund is taxable.

You may withdraw money from this fund at any time. To make a withdrawal, you must follow our rules about minimum withdrawals.

We may charge a fee for these withdrawals and we determine the amount of any fee that we charge.

If premiums are not received

To prevent your policy from ending, we must receive the required premium before the end of the 31st day after it is due. We will tell you the required amount.

Your policy will end if:
- we do not receive the required premium within 31 days after it's due
- there is not enough money in the withdrawable premium fund to pay the required premium, and
- extended term insurance is not available.

If your policy ends this way, it has lapsed.

The policy may continue for a limited period of time as described in the section *Extended term insurance.*

Putting your policy back into effect

If your policy ended because it lapsed, you may apply to have it put back into effect if the insured person is alive. This process is called reinstatement.

If you want to put your policy back into effect, you must:
- apply within 2 years of the date the policy ended
- give us new evidence of insurability that we consider satisfactory, and
- make a payment equal to the reinstatement charge we set.

If we don't approve your application, we refund the amount you paid when you applied to put your policy back into effect.

(The policy includes a provision about Extended term insurance if the illustration shows Extended term insurance is available.)

Extended term insurance

If premiums are not paid and the policy has been in effect for the number of years set out in the *Extended term insurance schedule*, your policy will automatically continue for a period of time. At the end of that period, the policy ends.

Your policy continues in effect if:
- we do not receive the required premium within 31 days after it is due
- there is not enough money in the withdrawable premium fund to pay the required premium, and
- extended term insurance is available.

The weekly benefit amount, waiting period, and benefit period will not change.

While this policy continues as extended term insurance:
- you may not pay premiums
- you may not put money into the withdrawable premium fund
- we will not pay a First payment bonus
- Return of premium on death ends, if included in this policy, and
- Inflation protection ends, if included in this policy (any accumulated increase to the weekly benefit amount remains in effect).

Extended term insurance schedule

Number of policy years this policy has been in effect	Number of policy years extended term insurance is available
X	X
X	X
X	X
X	X
X	X
X	X
X	X
X	X
X	X
X	X
X	X
X	X

Making a claim while this policy continues as extended term insurance

A claim may be submitted if the insured person is continuously dependent longer than the waiting period and the requirements described in this policy are satisfied.

We must receive the claim immediately following the end of the waiting period and no later than 120 days from that date. If we receive a claim after 120 days, we will not approve it and no late claim exception will be made.

If we approve a claim while extended term insurance is in effect, your policy continues as set out in the schedule. If we stop paying a claim before the end of the last available year shown in the schedule, the policy continues as extended term insurance.

If we're still paying benefits at the end of the last available year shown in the schedule, we will continue to pay benefits while the insured person qualifies. On the date they no longer qualify, the policy ends.

Reversing extended term insurance

You may apply to reverse extended term insurance and resume paying premiums for this policy if the insured person is alive.

If you want to reverse extended term insurance you must:

- apply within 2 years of the date extended term insurance took effect
- give us new evidence of insurability that we consider satisfactory, and
- make a payment equal to the reinstatement charge we set.

If we don't approve your application, we refund any amount you paid when you applied.

Your right to cancel this policy

You may cancel your policy at any time. Your decision to cancel your policy is your personal right. The cancellation is binding on you and any person entitled to make a claim under this policy.

All of our obligations and liabilities under this policy end immediately on the date we receive your request to cancel your policy or on any later date you indicate in your request.

If you cancel this policy, it will not continue under extended term insurance.

To cancel your policy, send your request in writing to:

Sun Life Assurance Company of Canada
227 King St. S.
PO Box 1601, Stn Waterloo
Waterloo ON Canada N2J 4C5

If you apply to cancel your policy within the first 10 days of receiving it from us, we will treat this as a rescission. This is described under the heading, *If you change your mind within 10 days.*

If you apply to cancel your policy after the 10th day of receiving it from us, we'll pay you:

- any amount in the withdrawable premium fund
- **minus** any unpaid premiums plus interest.

When your policy ends

If your policy hasn't ended for any other reason already described, it will automatically end on the earlier of:

- the date we've paid benefits for the total number of weeks in the selected benefit period, or
- the date the insured person dies.

When this policy ends, we will pay to you, or your estate:

- any balance in the withdrawable premium fund
- **minus** any overpayment of benefits.

Other information about your policy

Information about our contract with you

Once your policy is in effect, the following documents make up our entire contract with you:

- your application for insurance, including any evidence of insurability, and
- this policy, including any amendments.

All of our obligations to you are contained in the documents described above. Any other document or oral statement does not form part of this contract. This policy or any part of this policy may not be amended or waived except by a written amendment signed by two authorized signing officers of the company.

Time limit for recovery of insurance money

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or the provincial or territorial legislation that applies to this policy.

Currency of this policy

All amounts of money referred to in this policy are in Canadian dollars.

Transferring your policy (assignment)

You may be able to transfer your rights under this policy to someone else by assigning the policy. We are not responsible for ensuring that the assignment of your policy is legally valid. If you transfer this policy, send a notice of the assignment to:

Sun Life Assurance Company of Canada
227 King St. S.
PO Box 1601, Stn. Waterloo
Waterloo ON Canada N2J 4C5

Insurance terms

The following explanations describe insurance terms that may or may not apply to this policy.

Claimant

The person entitled to make a claim for benefits.

Contingent owner

The person or persons you name in writing, who will own this policy, if you die before the insured person.

If no contingent owner is named, when a policy owner dies the policy owner's estate becomes the new policy owner.

Evidence of insurability

This may include medical, financial, lifestyle, and family medical history information and other personal history information needed to approve your application for insurance.

Policy date

The policy date is the start date of your insurance policy. This date is shown under the heading, *Policy summary*.

Policy anniversary

The month and day every year that is the same as your policy date.

Policy year

The 12 month period that runs from one policy anniversary to the next policy anniversary.

Premium

The amount paid to purchase or maintain an insurance policy.

Statutory conditions

1. The contract

1) The application, this policy, any document attached to this policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Copy of application

2) The insurer shall, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

2. Material facts

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

3. Notice and proof of claim

1) The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall:

a) give written notice of claim to the insurer,

- by delivery thereof, or by sending it by registered mail to the head office or chief agency of the insurer in the province, or
- by delivery thereof to an authorized agent of the insurer in the province,

not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability,

b) within 90 days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the insurer such proof, as is reasonably possible in the circumstances, of:

- the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby
- the right of the claimant to receive payment
- the claimant's age, and
- if relevant, the beneficiary's age, and

c) if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such sickness or disability.

Failure to give notice or proof

2) Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if:

a) the notice or proof is given or furnished as soon as reasonably possible, and in no event later than 1 year from the date of the accident or the date a claim arises under the contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed, or

b) in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than 1 year after the date a court makes the declaration.

4. Insurer to furnish forms for proof of claim

The insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

5. Rights of examination

As a condition precedent to recovery of insurance money under the contract:

a) the claimant shall afford to the insurer an opportunity to examine the person of the person insured when and so often as it reasonably requires while the claim hereunder is pending, and

b) in the case of death of the person insured, the insurer may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies.

6. When money is payable other than for loss of time

All money payable under this contract, other than benefits for loss of time, shall be paid by the insurer within 60 days after it has received proof of claim.