Sun Life Financial

SunSpectrum Universal Life

(plus policy fund)
(one insured person, age 30)

Policy number: LI-1234,567-8

Owner: John Doe

SAMPLE

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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SAMPLE

Policy particulars

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*.

SunSpectrum Universal Life

Your policy number is:	LI-1234,567-8
Your policy date is:	September 17, 2012
Monthly anniversary day:	the 17th day of every month
Owner:	John Doe
Insured person:	Mary Doe born on January 5, 1982
Additional insured person:	John Doe born on March 14, 1983
Beneficiary:	is named on your application, unless you make a change in writing to us.

SAMPLE

This is a permanent life insurance policy.

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

Policy particulars (continued)

Principal insurance death benefit:	on Mary Doe
Death benefit option:	Principal insurance amount plus the policy fund
Amount:	$XXX,XXX In addition to the principal insurance amount, we pay the balance of your policy fund when the insured person dies.
Risk classification:	Non-smoker

<u>Additional benefits:</u>

Disability waiver benefit:	on Mary Doe
Date this benefit ends:	September 17, XXXX
Term insurance benefit on the insured person:	$XXX,XXX on Mary Doe This insurance renews every 10 years. A death benefit is payable when Mary Doe dies.
Last date to convert this benefit:	September 17, XXXX
Date this benefit ends:	September 17, XXXX
Term insurance benefit on an additional insured person:	$XXX,XXX on John Doe This insurance renews every 5 years. A death benefit is payable when John Doe dies.
Risk classification:	Non-smoker
Last date to convert this benefit:	September 17, XXXX
Date this benefit ends:	September 17, XXXX
Child term insurance benefit:	$XXX,XXX on each insured child, as described under the heading, *Child term insurance benefit.*
Date this benefit ends:	September 17, XXXX
Critical illness term insurance benefit:	$XXX,XXX on Mary Doe The amount we pay for Group 1 and Group 2 Covered critical illnesses is described under the heading, *Critical illness term insurance benefit.*
Last date to convert this benefit:	September 17, XXXX
Date this benefit ends:	September 17, XXXX

Any Critical illness insurance benefit payable is paid to the Critical illness benefit payee named on your application, unless you make a change in writing to us.

SAMPLE

Schedule for the guaranteed monthly cost of insurance

Each monthly anniversary day, we deduct money from the policy fund to pay for the cost of insurance. On September 17, XXXX we will no longer make monthly deductions for the cost of insurance for the principal insurance death benefit.

We determine the cost of insurance from the table below. The first column shows the monthly cost of insurance for your principal insurance death benefit. Any remaining columns show the monthly cost of insurance for any additional benefits in your policy. We determine the total monthly cost of insurance by adding the columns together.

(1) Principal insurance
(2) Disability waiver benefit
(3) Term insurance benefit on the insured person
(4) Term insurance benefit on an additional insured person
(5) Child term insurance benefit
(6) Critical illness term insurance benefit

Beginning on	(1)	(2)	(3)	(4)	(5)	(6)
17 Sept XXXX	XXX.XX	XXX.XX	XXX.XX	XXX.XX	XXX.XX	XXX.XX
17 Sept XXXX	XXX.XX	XXX.XX	XXX.XX	XXX.XX	XXX.XX	XXX.XX
17 Sept XXXX	XXX.XX	XXX.XX	XXX.XX	XXX.XX	XXX.XX	XXX.XX

SAMPLE

E12001A

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

SAMPLE

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Contesting the 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 or cases involving a disability benefit.

E02505A

About your SunSpectrum Universal Life policy

SunSpectrum Universal Life is a flexible payment permanent life insurance policy, with several investment options available to you. To prevent your policy from ending, the value of your policy fund, minus any policy loans including interest, must not be less than zero.

Payments must be made to Sun Life Assurance Company of Canada and are subject to a minimum and maximum limit that we determine. We reserve the right to refuse cash payments.

Any payment we receive at our head office before the Toronto Stock Exchange is closed for the day is applied to your policy effective that day. Any payment we receive at our head office after the Toronto Stock Exchange is closed is applied to your policy effective on the following business day.

Any request for transfer, withdrawal, policy loan or policy cancellation that we receive at our head office before the Toronto Stock Exchange is closed for the day is effective that day but processed the following business day. If money is moved to or from an investment account, we reserve the right to delay the effective date of the transaction for up to 5 business days from the day we receive your request or the day we receive funds.

Payments we receive are held in our general fund. When you invest in any investment account you do not:

- acquire any ownership interest in the designated fund or index
- purchase units, or
- have any legal interest in any security.

SAMPLE

E02510B

Death benefit

We pay the death benefit to the beneficiary if the insured person dies while this policy is in effect. The amount we pay is determined as of the date the insured person died. This amount is:

- the principal insurance death benefit shown at the beginning of your policy under the heading, *Policy particulars*
- **plus** the balance of your policy fund
- **minus** the amount of any policy loan, including interest. The principal insurance death benefit will be reduced by the amount of any outstanding policy loan.

We guarantee the policy fund we pay as part of the death benefit will never be less than:

- payments made to your policy fund
- **minus** the total cost of insurance while your policy was in effect
- **minus** any withdrawals and any applicable interest rate penalties
- **minus** any transaction fees we deduct from your policy fund.

This policy ends on the date the insured person dies. At that time, if there's any amount in the overflow fund, we pay it to the beneficiary who receives the death benefit at the time the policy ends.

When we will not pay the principal insurance death benefit (exclusions and reductions in coverage)

We will not pay the principal insurance death benefit if the insured person dies before reaching the age of 15 days.

We will not pay the principal insurance death benefit if the insured person takes their own life, while sane or insane, within 2 years of the later of:

- the date the application for this policy was signed
- the policy date, or
- the most recent date your policy was put back into effect, if your policy has been reinstated.

In these circumstances, the principal insurance death benefit ends and instead of paying a death benefit we pay the beneficiary:

- the balance of your policy fund as of the date the insured person dies
- **plus** the balance of your overflow fund as of the date the insured person dies
- **plus** the total cost of insurance we have deducted
- **minus** the amount of any policy loan, including interest. as of the date the insured person dies. The principal insurance death benefit will be used to pay the outstanding policy loan.

If the policy had previously been put back into effect, we'll refund only the cost of insurance we deducted since the most recent date the policy was reinstated.

If the insured person takes their own life, while sane or insane, within 2 years of any policy change that increases the principal insurance death benefit, this policy will end. We will not pay the amount of the increase. Instead, if this policy has been continuously in effect for at least 2 years at the time the insured person dies, we will pay the following amount to the beneficiary:

- the principal insurance death benefit we would have paid before the increase
- **plus** the balance of your policy fund as of the date the insured person dies
- **plus** the balance of your overflow fund as of the date the insured person dies
- **plus** the cost of insurance for the increase in the principal insurance death benefit
- **minus** the amount of any policy loan, including interest. as of the date the insured person dies. The principal insurance death benefit will be used to pay the outstanding policy loan.

SAMPLE

If this policy is the result of a replacement of insurance
If the death benefit is the result of a replacement of life insurance that was issued by us, we determine the amount payable for the part that is a replacement based on the effective date or dates of your previous insurance and any additional benefits.

E02516B

Making a claim for the death benefit

To make a claim, first contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed. The person making the claim must complete the form and give us the information we need to assess the claim, including proof that the insured person died while this policy was in effect.

The form and information must be sent to this address:
Life Claims Services
Sun Life Assurance Company of Canada
227 King St. S.
PO Box 1601, Stn. Waterloo
Waterloo ON Canada N2J 4C5

Physicians may charge a fee to complete certain forms. The person making the claim is responsible for any fees for this information.

Before we pay any death benefit, the age of the insured person must be verified. If the age given on the application is incorrect, we adjust the amount we pay to reflect the insured person's correct age.

SAMPLE

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Policy fund

When we receive a payment for this policy, we deduct premium tax. We then add the remaining amount to your policy fund.

As explained below, money in your policy fund may be allocated to a variety of investment accounts. Money is added to or deducted from your policy fund daily based on your investment account choices.

Each monthly anniversary, we deduct money from your policy fund to pay for the cost of insurance. The amounts we deduct are determined from the cost of insurance schedule. We deduct this money proportionately from each of your accounts. If you have guaranteed interest accounts, within each of those accounts, the money will be deducted from the layers closest to maturity.

On the policy anniversary immediately following the insured person's 100th birthday, we will no longer make monthly deductions for the cost of insurance for the principal insurance death benefit.

You may make withdrawals from your policy fund. This is explained later under the heading, *Withdrawing money from your policy*. Any withdrawals from the policy fund will reduce the balance of your policy fund.

In addition, we may deduct transaction fees and charges from your policy fund. These are explained in the *Transaction fees* provision of this policy.

We will limit the amount of money you may have in your policy fund, based on the tax-exempt limit. This is described later in your policy under the heading, *Overflow fund*.

E02560B

Investment accounts

Several investment accounts are included in this policy: floating interest account, guaranteed interest accounts (GIAs), accounts based on the performance of indices and accounts based on the performance of managed funds. The choices you originally made are shown on the application included in this policy. You may apply for a change in your investment choices at any time. We may charge a transaction fee for a change and we determine the amount of any fee that we charge.

The amount of money in your policy fund is the total of all investment accounts.

Floating interest account
We set the floating interest rate each day based on short-term interest rates. Your money earns interest each day at the rate in effect on that day. The interest earned is added to this account each day.

Guaranteed interest accounts (GIAs)
The guaranteed interest accounts are:
1-year term account
3-year term account
5-year term account, and
10-year term account.

Money you want to allocate to GIAs accumulates in a holding account until there is a balance of at least $250. Once this minimum amount is reached, we transfer the balance to the GIAs according to your current investment choices. Each time money is transferred to a GIA, we establish a new layer with a specific maturity date and interest rate. Your money earns interest at the rate for the term you chose.

SAMPLE

We set the maturity date and interest rate for each new GIA layer on the day money is:
- transferred from the holding account, or
- added directly to the GIA.

The interest rate we set will not be less than 90% of the Government of Canada bond rate in effect on the day we set the interest rate for the same term, less 1.75 percentage points. If Government of Canada bonds with the same term are not available, we will use our best estimate of what these yields would be if such Government of Canada bonds were available.

Money in your holding account earns interest at the rate we set for the floating interest rate account.

When a layer matures, we put your money including the interest earned, in a new layer for the same term.

You will have to pay an interest rate penalty if:
- you withdraw or transfer money before the layer matures, and
- interest rates for the same term at the time you make the withdrawal or transfer, are greater than the interest rate of that layer.

We determine the amount of the interest rate penalty.

We may change the GIAs available to you at any time. If we discontinue any of your current choices, we'll tell you at least 10 days in advance and substitute another choice at our discretion.

Accounts based on the performance of indices
You may put money into one or more index accounts. These accounts, the indices they are based on and the applicable management fees are shown in the table below.

Index accounts	Indices they are based on	Annual management fee
Canadian Bond	DEX Mid Term Bond Index™	2.5%
Canadian Equity	S&P /TSX 60™	2.5%
American Equity	S&P 500®	2.5%

Each business day, we determine the percentage change since the previous business day in the value of each index. An amount will be added to or deducted from your index account to reflect the percentage change in the index on that day. The daily value of the index is the latest value available to us.

As part of the above calculation, any index that is not valued in Canadian dollars is converted to an equivalent Canadian dollar value daily. This means that changes in exchange rates will affect the total amount in your index accounts.

On days when an index on which one of your investment accounts is based loses value, the percentage change in the value of the index for that day will be negative and money will be deducted from that account according to the change in the value of the index.

We may change the index accounts or the indices on which they are based on at any time. If we discontinue any of your current index accounts, we'll tell you at least 10 days in advance and we will transfer the balance for that account to either an account with a similar investment objective or to the floating interest account if there is no account with a similar investment objective.

SAMPLE

Each business day, we subtract a management fee from each index account at the annualized rate shown in the table above. We may change the management fee at any time. If we make a change, we'll tell you at least 10 days in advance.

Accounts based on the performance of managed funds

The accounts offer returns based on the performance of designated funds managed by a third party (fund manager) that we select. Account balances will be adjusted daily. Each daily adjustment may increase or decrease the balance of the account, depending on the rate of return.

We may change, merge, or withdraw accounts at any time. If we change or merge accounts in which you have a balance, we will tell you.

If we withdraw an account in which you have a balance, we will notify you and we will transfer the balance for that account to either another account with similar investment objectives or to the floating interest account if there is no account with a similar investment objective.

The daily rate of return for this account on a business day is:

- the Canadian dollar rate of return on the designated fund, which reflects the fund manager's expenses and fund distributions
- **minus**, if applicable, an additional management fee we charge. This additional management fee may change from time to time.

The rate of return is not guaranteed and may be positive or negative. We reserve the right to revise or correct any rate of return that was based on incorrect information provided by the fund manager.

E02565A

Overflow fund

Your policy includes an overflow fund. We use your overflow fund to prevent your policy fund from exceeding the tax-exempt limit set by current Canadian tax law.

According to current Canadian tax law, the money in your policy fund is not taxed if:
- it remains in your policy fund, and
- it remains below the tax-exempt limit.

This limit changes annually and is defined by Canadian tax law.

If a payment you make would cause your policy fund to exceed the tax-exempt limit, the excess portion of that payment goes directly into your overflow fund. Premium tax is not deducted from that portion of your payment.

At each policy anniversary, we compare the amount of your policy fund to the tax-exempt limit and move any excess amount to your overflow fund. Any amount we move under these circumstances is taken proportionately from each of your investment accounts. If you have GIAs, within each account, the money will be taken from the layers closest to maturity.

At the start of each policy year, the tax-exempt limit will generally increase, and we will transfer as much money as the tax-exempt limit allows from your overflow fund to your policy fund. This minimizes the tax you pay on your overflow fund and allows you to take advantage of your investment choices. Premium tax is deducted from the amount we transfer to your policy fund.

Money in your overflow fund earns interest at the floating rate. According to current Canadian tax law, interest earned on your overflow fund is taxable.

We may set a maximum amount you can have in your overflow fund.

You may withdraw money from your overflow fund at any time. We may charge a transaction fee for these withdrawals and we determine the amount of any fee that we charge.

SAMPLE

E02570A

Withdrawing money from your policy

Withdrawing money from your overflow fund
You may withdraw money from your overflow fund at any time. We may charge a transaction fee for these withdrawals and we determine the amount of any fee that we charge.

Withdrawing money from your policy fund
You may withdraw money from your policy fund at any time. We may set a minimum amount you can withdraw.

The maximum amount you can withdraw from your policy is your cash surrender value less the current monthly cost of insurance times 6.

The cash surrender value of your policy is:
- the balance of your policy fund
- **minus** any interest rate penalties that may apply to GIAs
- **minus** the amount of any policy loan, including interest
- **minus**, in the first 10 policy years, a $250 cancellation charge.

When you request a withdrawal you must tell us which account to take the money from. If you make a withdrawal from a GIA, we will take the money from the layer closest to maturity.

When you withdraw money from a guaranteed interest rate account, you will pay an interest rate penalty if:
- you withdraw money before the layer matures, and
- interest rates for the same term at the time you make the withdrawal or transfer, are greater than the interest rate of that layer.

There is a transaction fee for withdrawing money from your policy. We determine the amount of the fee that is charged and deduct it from the same account or layer as your withdrawal. If your withdrawal is taken from more than 1 account or layer, we deduct the fee from the account or layer with the most amount of money.

You may have to pay tax on withdrawals from your policy fund.

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Borrowing money from your policy (policy loans)

After your policy has been in effect for 3 policy years, you may borrow money against the cash surrender value of your policy.

The cash surrender value of your policy is:
- the balance of your policy fund
- **minus** any interest rate penalties that may apply to GIAs
- **minus** the amount of any policy loan, including interest
- **minus**, in the first 10 policy years, a $250 cancellation charge.

The most that you can borrow is:
- 75% of the cash surrender value of your policy
- **minus** the cost of insurance until your next policy anniversary.

We may set a minimum amount you can borrow.

We charge interest on the loan each day. The interest is compounded annually. This means the interest accumulates and we add it to the balance of the loan at the end of the policy year. We set the interest rate at the time the loan is taken and notify you of the interest rate charged on the loan. At each policy anniversary, we change the interest rate charged on the loan to the rate we would charge on new loans on your policy at that time whether a new loan is taken or not.

If the amount of your policy loan, including interest, becomes greater than your policy fund, your policy will end 31 days later unless we receive a payment within that period. We set the minimum amount of this payment.

We may charge a transaction fee when you borrow money against your policy and we determine the amount of any fee we charge.

You may repay your policy loan at any time.

SAMPLE

E02580B

Accessing the policy fund when disabled, ill or injured

You may make one withdrawal from your policy fund each time an insured person becomes disabled by illness or injury as defined below. The minimum and maximum amount you may withdraw is described under the heading, *The Amount you may withdraw.* According to tax rules in effect as of the policy date you may make this withdrawal without incurring a taxable disposition. The tax rules may change at any time, without notice. The tax rules in effect on the date you request a withdrawal will apply.

Defining disabled

Each disability must continue for at least 60 consecutive days. To be considered disabled in any of the four disabled categories (occupationally disabled, critically disabled due to illness or injury, critically disabled due to deteriorated mental ability and critically disabled - terminal illness) set out below, the insured person must be:

- under the active, continuous and medically appropriate care of a physician, or other health care practitioner acceptable to us
- following the treatment prescribed and any other recommendations made by a physician or health care practitioner, and
- occupationally disabled or critically disabled as defined below.

Occupationally disabled

To be considered occupationally disabled under this provision, the insured person must as a result of illness or injury, qualify under one of the following:

If employed

- if the insured person is unable to perform the substantial duties of their regular occupation, and is not engaged in any gainful occupation, or
- if the insured person is employed in a gainful occupation but they have experienced at least a 50% loss of income over 60 consecutive days compared to the earned income from their regular occupation during the 60 days immediately before the day they became disabled.

If unemployed or retired

- if the insured person is unemployed or retired at the time of claim, the insured person is unable to perform the essential duties of their regular occupation from which they were last employed**.**

If employed in the home

- if the insured person is responsible for maintaining their home or caring for immediate family members, the insured person is unable to perform all of the essential duties of maintaining that home or caring for those individuals.

If the insured person is a student age 16 or older at the time they become disabled, we consider them to be occupationally disabled if they are unable to attend or participate as a student, or perform any occupation for remuneration or profit within their education, training or experience, during the entire time they are disabled.

If the insured person is under age 16, we consider them to be disabled if, as a result of illness or injury, they require the presence of an adult attendee.

Critically disabled - due to illness or injury

Critically disabled means the insured person, as a result of illness or injury, is unable to perform one or more of the activities described below. The activities are:

SAMPLE

Bathing
Bathing means washing oneself:
- in a bathtub or shower, including getting in and out of the bathtub or shower, or
- by sponge bath.

Dressing
Dressing means putting on, taking off, fastening and unfastening:
- clothing, and
- medically necessary braces or artificial limbs.

An insured person is not dependent for dressing if reasonable alterations to or changes in the clothing they usually wear would enable them to dress without substantial physical assistance.

Feeding
Feeding means the insured person's ability to get food into their body:
- through the mouth, or
- by a feeding tube.

Feeding does not include cooking or preparing a meal.

Toileting
Toileting means getting to and from and on and off the toilet, and performing associated personal hygiene.

Transferring
Transferring means moving into or out of a bed, chair or wheelchair. This does not include getting into or out of the bathtub or shower, as we include this in bathing.

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

Critically disabled - due to deteriorated mental ability
We consider the insured person critically disabled if they have deteriorated mental ability and need continual 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
- judgment, 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. Deteriorated mental ability is also known as cognitive impairment. Deteriorated mental ability is determined by a neurologist licensed and practising in Canada or the United States, based on clinical observation, radiological studies and psychological testing.

Critically disabled - terminal illness
We consider the insured person critically disabled if they have a condition which has been diagnosed as terminal by a physician, and the prognosis for living is less than 24 months.

SAMPLE

The amount you may withdraw

The maximum amount you may withdraw from your policy fund is:

- the balance of your policy fund
- **minus** any interest rate penalties that may apply to GIAs
- **minus** the amount of any policy loan, including interest
- **minus**, in the first 10 policy years, a $250 cancellation charge
- **minus** an amount equal to the cost of insurance for the next 12 months
- **minus** a claim assessment fee.

The minimum amount you may withdraw is $500.

The company will credit interest up to the date of withdrawal as described above.

When you request a withdrawal you must tell us which account to take the money from. If you make a withdrawal from a GIA, we will take the money from the layer closest to maturity.

The death benefit will be reduced by the amount of your withdrawal.

Making a claim for this benefit

To make a claim for this benefit, contact us at the toll free phone number shown at the beginning of this policy for the appropriate form. You must pay a claim assessment fee each time you submit a claim to access your policy fund when disabled.

SAMPLE

You may not make any withdrawal under this provision if:

- we rated the insured person as a substandard risk for medical reasons and they continue to be rated on the date they become disabled, or
- this policy came into effect as the result of a conversion from another life insurance policy while the insured person was disabled.

Before we approve the claim, the age of the insured person must be verified.

If the insured person is disabled when you make a claim for this benefit, we must receive proof of their disability after it continued for more than 60 consecutive days.

If the insured person is no longer disabled when you make a claim for this benefit, we must receive proof:

- that the disability continued for more than 60 consecutive days, and
- of the disability within 1 year of the date the insured person is no longer disabled.

In addition to the claim assessment fee, you must pay any cost associated with supplying proof of the disability.

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

When you do not qualify for this benefit (exclusions and reductions of coverage)

You do not qualify for this benefit if the disability is directly or indirectly caused by or associated with the insured person committing or attempting to commit a criminal offence.

E02590A

When your policy will end (lapse)

Your policy will end 31 days after the day the value of your policy fund, minus any policy loans including interest, is equal to or less than zero. To prevent your policy from ending, we must receive a payment before the end of the 31st day. We set the minimum amount of this payment.

If your policy ends this way, it is called a lapse.

E02600A

Putting your policy back into effect (reinstatement)

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

If you want to put your policy back into effect, you must:

- apply within 2 years of the policy ending
- give us new evidence of insurability that we consider satisfactory, and
- make a payment equal to the reinstatement charge plus the cost of insurance for the next 6 months. We set the amount of the reinstatement charge.

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

SAMPLE

E02610A

Transaction fees

We charge a fee each time you withdraw money from your policy. We may charge a fee for policy transactions and policy changes. In each policy year, we do not charge for the first two of either policy transactions or policy changes. If we charge a fee, it will never be more than $100 per transaction or policy change.

E02620B

Applying for changes to your policy

You may apply for the following types of changes to this policy:

- a change in your investment choices
- increase or decrease the principal insurance death benefit, depending on our rules about the age of the insured person and the amount of insurance.

You may change to a different SunSpectrum Universal Life insurance plan, provided the plan was one that we offered at the time you signed the application for this policy. The available plans are:

- SunSpectrum Universal Life with a level death benefit, or
- SunSpectrum Universal Life with a death benefit equal to the principal insurance death benefit plus the balance of the policy fund.

For any policy change we may ask for new evidence of insurability. Your application must be in a form acceptable to us and satisfy our administrative rules. If we approve the application, we will change your policy accordingly.

If you increase the principal insurance death benefit amount, the cost of insurance for the increase will be different than that shown in this policy.

We may charge a transaction fee if you make a change to your policy and we determine the amount of any fee that we charge.

E02635A

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 beneficiaries or payees you've named, whether the beneficiaries or payees are revocable or irrevocable.

Your policy will end on the date we receive your request or any later date you indicate in your request. 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 earlier in your policy 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:

- the balance of your policy fund
- **minus** any interest rate penalties that may apply to GIAs
- **minus** the amount of any loan against your policy, including interest
- **minus**, in the first 10 policy years, a $250 cancellation charge.

In addition, we will pay you any amount in the overflow fund, if included in this policy.

The amount we pay is determined on the business day immediately following the day we receive your request.

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

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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.

SAMPLE

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

E02645B

Insurance terms

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

SAMPLE

Benefits
We offer a variety of insurance coverages. Some, such as the principal insurance are standard features of your policy and are included automatically. Additional benefits may be available. An example of an additional benefit is the Disability waiver benefit.

Beneficiary
The person or persons you name in writing to receive the death benefit.

Business day
For the purposes of this policy, a business day is a day when our administrative offices are open for business and the Toronto Stock Exchange (or other stock exchange or securities market that we may designate) is open for business.

Contingent owner
The person or persons you name in writing to take ownership of this policy if you die before the date this policy ends.

What happens if no contingent owner is named when a policy owner dies?

- If there is only one policy owner at the time of death, then the policy owner's estate becomes the new policy owner.
- If there are two or more policy owners at the time of death, then the deceased policy owner's estate along with the surviving policy owner(s) own the policy.

Cost of insurance
The amount we deduct from the policy fund at monthly intervals to maintain your policy.

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.

Permanent insurance
A type of insurance that provides protection for the entire lifetime of the insured person.

Policy date

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

Monthly anniversary day

This is the day each month on which policy transactions described in this policy may be processed. This date is shown at the beginning of your policy under the heading, *Policy particulars.*

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.

Policy transaction

Examples of policy transactions are payments, withdrawals, policy loans and transfers of money between accounts.

Term insurance

A type of insurance that provides protection for a limited number of years.

E02655B

Trade-mark disclaimers

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SAMPLE

Additional benefits

E02670B

Disability waiver benefit (waiving the cost of insurance)

The insured person for this benefit and the end date for this benefit are shown at the beginning of your policy under the heading, *Policy particulars*.

If the insured person becomes disabled as described below, and the disability continues for more than 6 consecutive months, we stop deducting the cost of insurance from your policy fund for the duration of the disability. This is called waiving the cost of insurance.

Qualifying for this benefit

We consider the insured person to be disabled if, as a result of injury or disease, they are unable to perform any occupation for remuneration or profit within their education, training or experience.

In determining whether or not the insured person is able to perform any occupation, we do not take into account whether a suitable occupation is actually available. In addition, we do not consider whether a suitable occupation would provide a level of remuneration comparable to the one the insured person had before becoming disabled.

SAMPLE

When we will not waive the cost of insurance (Exclusions and reductions of coverage)

We will not waive the cost of insurance before the policy anniversary immediately following the insured person's 18th birthday. If the insured person is disabled on the policy anniversary immediately following their 18th birthday, we will not waive the cost of insurance if the disability started before the policy anniversary immediately following their 5th birthday.

We will not waive the cost of insurance if the insured person's disability begins after the end date of the *Disability waiver benefit* shown at the beginning of your policy under the heading, *Policy particulars.*

We will not waive the cost of insurance if the disability 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 milliliters 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 waive the cost of insurance if the disability 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, while sane or insane
- causing themself bodily injury, while sane or insane
- taking any drug, unless the drug was taken as prescribed by a licensed medical practitioner
- inhaling or ingesting any poisonous substance, whether voluntarily or otherwise, or
- inhaling any type of gas, whether voluntarily or otherwise.

We will not waive the cost of insurance if the insured person's disability is directly or indirectly caused by or associated with civil disorder or war, whether declared or not.

We do not consider the insured person to be disabled unless:

- they are under the active, continuous and medically appropriate care of a physician, or other health care practitioner acceptable to us, and

- they are following the treatment prescribed and any other recommendations made by a physician or health care practitioner.

Making a claim for this benefit

While this benefit is in effect, you may submit a claim if the insured person's disability began before the policy anniversary immediately following their 60th birthday.

To make a claim for this benefit, contact us at the toll free phone number shown at the beginning of this policy for the appropriate form.

Before we approve the claim, the age of the insured person must be verified.

We must receive proof of the disability:
- while the insured person is alive
- after the insured person's disability continued for more than 6 consecutive months, and
- within 1 year of the date the disability began.

We'll consider a late claim exception if we receive proof of disability no later than 1 year following the end date of this benefit. If we receive proof of the disability more than 1 year after it starts and the insured person qualifies for this benefit, we consider the disability to have started 1 year before we received the proof. This means that we will only waive the cost of insurance starting from 1 year before we received the proof, regardless of when the disability actually started.

You must pay any cost associated with supplying proof of the disability.

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

SAMPLE

When we waive the cost of insurance

The cost of insurance continues to be deducted from your policy fund until we notify you that we've waived it. At that time, we waive the cost of insurance from the month after the insured person's disability started.

If any cost of insurance is deducted from your policy fund and later waived, we credit the same amount back to your policy fund as of the date the cost of insurance was deducted.

If we are waiving the cost of insurance, you may not apply for a change that would increase any benefit under this policy.

How to continue to qualify for this benefit

We continue to waive the cost of insurance as long as the insured person:
- continues to be disabled
- is under the continuous care of a physician
- follows a prescribed treatment program for the disability, and
- makes reasonable efforts to use any appropriate rehabilitation program.

From time to time, we will ask for proof, that we consider satisfactory, that the insured person is still disabled. You must pay any cost associated with supplying this proof.

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 the cost of these examinations.

The physicians, specialists or health care practitioners who provide information to us may not be the owner of this policy, any person insured under this policy, anyone entitled to make a claim under this policy, or any relative or business associate of these people.

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

Continuation of a previous disability claim
You may apply to have the cost of insurance waived without having to wait another 6 months if there is a continuation of a previous disability claim. We consider the disability to be a continuation of the previous one if:
- the cost of insurance had been waived
- the disabled insured person recovers from their disability and then becomes disabled again from the same cause within 6 months from the date we stopped waiving the cost of insurance, and
- the insured person is disabled as described under the heading, *Qualifying for this benefit.*

We waive the cost of insurance from the date the disability started again.

SAMPLE

When we stop waiving the cost of insurance

We stop waiving the cost of insurance on the date the insured person:
- is no longer disabled
- takes part in any occupation for remuneration or profit
- fails to submit any required proof of disability
- refuses to attend any examinations or rehabilitation programs without a valid medical reason, or
- fails to meet any other requirements to have the cost of insurance waived.

When your policy may be put back into effect (reinstatement) if it ended while the insured person was disabled

We will not put your policy back into effect if you cancelled it. However, if your policy ended for any other reason while the insured person was disabled, you may apply to have it put back into effect, without giving us new evidence of insurability. This process is called reinstatement.

We will put your policy back into effect if it ended:
- while the insured person was disabled and the disability continued for more than 6 consecutive months
- after the policy anniversary immediately following the insured person's 18th birthday, and
- before the end date of this benefit.

If you want to put your policy back into effect, you must:
- apply while the insured person is alive
- apply within 1 year of the policy ending, and
- give us proof, that we consider satisfactory, of the disability and the length of time the insured person was disabled.

When this benefit ends

This benefit automatically ends on the earliest of:
- the date the insured person for this benefit dies
- the date this benefit ends, or
- the date this policy ends.

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Term insurance benefit on the insured person

If the insured person dies while this benefit is in effect, we pay the beneficiary an additional amount called the term insurance benefit.

The insured person for this benefit and the amount of their death benefit are shown at the beginning of your policy under the heading, *Policy particulars*.

You may not convert this benefit if the insured person is age 70 or older when this benefit takes effect.

The cost of insurance for this benefit changes at the beginning of each renewable term period as shown in the cost of insurance schedule. The renewable term period that you chose for this benefit is shown at the beginning of this policy under the heading, *Policy particulars*.

When we will not pay this death benefit (exclusions and reductions of coverage)

We will not pay the term insurance death benefit on the insured person if the insured person takes their own life, while sane or insane, within 2 years of the latest of:

- the policy date, shown at the beginning of your policy under the heading, *Policy particulars*
- the effective date of this benefit, if you added it after the policy date, or
- the most recent date your policy was put back into effect, if your policy has been reinstated.

Your right to convert this benefit to a permanent life insurance policy

You may convert this benefit to a permanent life insurance policy on the life of the insured person, without giving us new evidence of insurability.

SAMPLE

To do so, you must send us an application before the final conversion date for this benefit shown at the beginning of your policy under the heading, *Policy particular*s.

The new permanent life insurance policy

We determine the type of policy you may convert to and the terms and conditions of that policy. The new policy we offer to you will:

- be determined by the information about the insured person in the application for this benefit
- depend on our rules about the age of the insured person and the amount of insurance
- have a death benefit that is not greater than the amount of the term insurance death benefit on the insured person on the date the new application is signed, and
- not include any additional benefits, except, in the circumstances described below, a disability waiver benefit on the insured person.

Your application must be in a form acceptable to us and satisfy our administrative rules. If we approve your application, this benefit ends on the date the new policy takes effect.

If this policy includes a *Disability waiver benefit* on the insured person, a disability benefit may only be included in the new policy if:

- you request a disability waiver benefit when you apply for the new policy
- we offer a disability waiver benefit on the new policy at the time you apply to convert, and
- the insured person is not disabled when you apply to convert this benefit.

If the insured person is disabled

If this policy includes a *Disability waiver benefit* on the insured person, you cannot convert this benefit while the insured person is disabled. However, if we are waiving the cost of insurance and the insured person remains disabled at age 70, you can convert this benefit on the policy anniversary immediately following the insured person 70th birthday. The premiums on the new policy will continue to be waived.

Paying for the new policy
The cost for the new policy will be based on:

- the same evidence of insurability we used to determine the cost of insurance for this benefit
- the rates we charge for the new insurance at the time you apply for the new policy, and
- the age of the insured person when you apply for the new policy.

The first payment for the new policy must be included with the application.

When this benefit ends

This benefit automatically ends on the earliest of:

- the date this benefit is converted as described under the heading, *Your right to convert this benefit to a permanent life insurance policy*
- the death of the insured person
- the date this benefit ends, shown at the beginning of your policy under the heading, *Policy particulars*, or
- the date this policy ends.

SAMPLE

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Term insurance benefit on an additional insured person

If the additional insured person dies while this benefit is in effect, we pay this term insurance death benefit to you, the owner of this policy, unless you make a change in writing to us.

The insured person for this benefit and the amount of their death benefit are shown at the beginning of your policy under the heading, *Policy particulars.*

You may not convert this benefit if the additional insured person is age 70 or older when this benefit takes effect.

The cost of insurance for this benefit changes at the beginning of each renewable term period as shown in the cost of insurance schedule. The renewable term period that you chose for this benefit is shown at the beginning of this policy under the heading, *Policy particulars*.

When we will not pay this death benefit (exclusions and reductions of coverage)

We will not pay the term insurance death benefit on the additional insured person if they take their own life, while sane or insane, within 2 years of the latest of:

- the policy date, shown at the beginning of your policy under the heading, *Policy particulars*
- the effective date of this benefit, if you added it after the policy date, or
- the most recent date your policy was put back into effect, if your policy has been reinstated.

Instead, this benefit will end and we will refund the cost of insurance for this benefit. If the policy has been put back into effect, we'll refund only the cost of insurance we deducted for this benefit since the most recent date the policy was put back into effect.

SAMPLE

Making a claim for this benefit

To make a claim, first contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed. The person making the claim must give us any information we need to assess the claim, including proof that the additional insured person died while this benefit was in effect.

Physicians may charge a fee to complete certain forms. The person making the claim is responsible for any fees for this information.

Before we pay this death benefit, the age of the additional insured person must be verified. If the age given on the application is incorrect, we adjust the amount we pay to reflect the additional insured person's correct age.

The right to convert this benefit to a permanent life insurance policy

This benefit may be converted to a permanent life insurance policy on the life of the additional insured person, without giving us new evidence of insurability.

To do so, either you, or the additional insured person with your written consent, must send us an application before the final conversion date for this benefit shown at the beginning of your policy under the heading, *Policy particulars*.

The new permanent life insurance policy

We determine the type of policy this benefit may be converted to and the terms and conditions of that policy. The new policy that we offer will:

- be determined by the information about the additional insured person in the application for this benefit

- depend on our rules about the age of the additional insured person and the amount of insurance, and
- have a death benefit that is not greater than the term insurance death benefit on the additional insured person on the date the new application is signed.

Your application must be in a form acceptable to us and satisfy our administrative rules. If we approve your application, this benefit ends on the date the new policy takes effect.

Paying for the new policy
The cost for the new policy will be based on:
- the same evidence of insurability we used to determine the cost of insurance for this benefit
- the rates we charge for the new insurance at the time you apply for the new policy, and
- the age of the additional insured person when you apply for the new policy.

The first payment for the new policy must be included with the application.

The additional insured person's right to buy life insurance if the insured person dies

If the insured person dies while this policy is in effect, the additional insured person may buy a new life insurance policy on their own life. We will not require new evidence of insurability if:
- the amount of insurance on the new policy does not exceed the amount of the death benefit for this term insurance benefit, and
- no additional benefits are added.

The additional insured person must apply for the new policy within 30 days of the death of the insured person.

SAMPLE

The new life insurance policy
We determine the type of policy the additional insured person may apply for and the terms and conditions of that policy. The new policy that we offer will:
- be determined by the information about the additional insured person in the application for this benefit
- depend on our rules about the age of the additional insured person and the amount of insurance, and
- have a death benefit that is not greater than the amount of this benefit on the date the new application is signed.

Your application must be in a form acceptable to us and satisfy our administrative rules. If we approve your application, this benefit ends on the date the new policy takes effect.

Paying for the new policy
The cost for the new policy will be based on:
- same evidence of insurability we used to determine the cost of insurance for this benefit
- rates we charge for the new insurance at the time you apply for the new policy, and
- age of the additional insured person when they apply for the new policy.

The first payment for the new policy must be included with the application.

When this benefit ends

This benefit automatically ends on the earliest of:
- the date this benefit is converted as described under the heading, *The right to convert this benefit to a permanent life insurance policy*
- the death of the additional insured person
- the date this benefit ends, shown at the beginning of your policy under the heading, *Policy particulars*, or
- the date this policy ends.

If the insured person dies while this benefit is in effect, we continue to insure the additional insured person under this benefit until the earliest of:

- 30 days after the death of the insured person, or
- the date an application is signed to buy a new insurance policy as described under the heading, *The additional insured person's right to buy life insurance if the insured person dies*.

SAMPLE

E03861A

Child term insurance benefit

The children insured under this benefit are those named on the application for this benefit, unless we tell you that we will not insure a child you have named. The children insured must be:

- born to the insured person
- legally adopted by the insured person, or
- step-children of the insured person.

Children born to or legally adopted by the insured person after the date you applied for this benefit are automatically insured under this benefit. We may ask you to prove the child's relationship to the insured person. To insure a step-child after this benefit is in effect, you must apply in writing and evidence of insurability that we consider satisfactory may be required. Your application must be in a form acceptable to us.

If a child dies while insured under this benefit, we pay the child term insurance benefit shown under the heading, *Policy particulars*. We pay this benefit to you, the owner of this policy.

We will pay the Child term insurance benefit even if the insured child takes their own life, while sane or insane.

SAMPLE

If all children insured have had their 25th birthday before the date this benefit ends

The date this benefit ends is shown under the heading, *Policy Particulars*. If all children insured have had their 25th birthday before the date this benefit ends, you may want to cancel the benefit. You can cancel the benefit and stop paying the premiums for it by sending us your written request to cancel it.

When we will not pay the child term insurance benefit (exclusions and limitations)

We will not pay a child term insurance benefit if the insured child dies:

- before they are 15 days old, or
- after they are 25 years old.

When we pay a reduced child term insurance benefit

If an insured child dies after age 14 days and before age 180 days and we approve a claim for this benefit, the maximum amount we pay is 25% of the child term insurance benefit.

Making a claim for this benefit

To make a claim when an insured child dies, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed. The person making the claim must give us any information we need to assess the claim, including proof that the insured child died while this benefit was in effect.

Physicians may charge a fee to complete certain forms. The person making the claim is responsible for any fees for this information.

Before we pay this death benefit, the child's date of birth must be verified.

Your right to buy life insurance on the insured children

You may buy a separate life insurance policy on each of the insured children, without giving us new evidence of insurability. However, you must give us proof of each child's date of birth at the time you apply for insurance.

You can apply to buy a separate life insurance policy on the life of an insured child on any date after their 18th birthday and before their 25th birthday. The child must have been insured under this benefit for at least 3 years before you apply for a new policy.

Within the 30 days immediately before the date this benefit ends, as shown under the heading, *Policy particulars*, you may buy a separate life insurance policy on an insured child:

- before their 18th birthday, or
- on or after their 18th birthday if they have not been insured for 3 years under this benefit. You may not buy a separate life insurance policy for an insured child on or after their 25th birthday.

The following people may buy a separate life insurance policy on each of the insured children:

- the owner of this policy, or
- the insured child on their own life, with your written consent.

Under this benefit, we will not issue more than one new life insurance policy on any child insured under this benefit.

The new life insurance policy

We determine the type of policy you may apply for and the terms and conditions of that policy. The new policy we offer to you will:

- be determined by the information about the insured child in the application for this benefit
- depend on our rules about the age of the insured child and the amount of insurance
- have a death benefit that is not greater than 5 times the child term insurance benefit under this policy, and
- include additional premiums for smoking, unless the insured child gives us evidence of insurability and qualifies as a non-smoker.

SAMPLE

Your application must be in a form acceptable to us and satisfy our administrative rules. If we approve the application, the new policy takes effect on the date the application is signed.

Paying for the new policy

The amount you are required to pay for the new policy will be based on:

- the same evidence of insurability we used to determine the cost of insurance for this benefit
- the rates we charge for the new insurance at the time you apply for the new policy, and
- the age of the insured child when you apply for the new policy.

The first payment for the new policy must be included with your application for the new policy.

When this benefit ends for each child

This benefit automatically ends for each child on the earliest of:

- that child's 25th birthday
- the date an application to buy a new life insurance policy for that child was signed, as described under the heading, *Your right to buy life insurance on the insured children*
- the date this benefit ends, shown under the heading, *Policy particulars*, or
- the date this policy ends, unless the insured person dies while this benefit is in effect.

If the insured person dies while the Child term insurance benefit is in effect, the benefit stays in effect and you do not need to make payments for it. We continue to insure any children still covered under this benefit until the earliest of:

- the date an application is signed to buy a new life insurance policy for that child under this benefit
- that child's 25th birthday, or
- the date you cancel the benefit.

Critical illness term insurance benefit

The insured person for this benefit is shown under the heading, *Policy particulars*. The maximum amount we pay under this benefit is the Critical illness insurance benefit amount shown under the heading, *Policy particulars.*

When a Critical illness insurance benefit is payable

A Critical illness insurance benefit is payable if this benefit is in effect and all requirements for a Group 1 or Group 2 illness as defined under the heading, *Covered critical illnesses* are satisfied. If we make a payment, it's paid to the Critical illness benefit payee named on your application, unless you make a change in writing to us.

Before we make a payment, we verify the insured person's date of birth. 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.

Group 1 Covered critical illness payment

If the insured person qualifies for a Group 1 Covered critical illness we make a one-time payment. The amount we pay is the Critical illness insurance benefit amount at the time the benefit is payable.

The Critical illness term insurance benefit ends on the date we make the payment.

Group 2 Covered critical illness payment

If the insured person qualifies for a Group 2 Covered critical illness we make a payment. For each claim, the amount we pay is the lesser of:

- 10% of the Critical illness insurance benefit amount at the time the benefit is payable, or
- $50,000.

SAMPLE

The amount we pay is reduced by any unpaid premiums plus interest at the time the benefit is payable.

Once we make a payment for a Group 2 Covered critical illness, you may not make another claim for that same illness. Coverage continues for all Group 1 and any Group 2 Covered critical illnesses for which we have not made a payment.

Exclusions (when a Critical illness insurance benefit is not payable)

In addition to the exclusions described under the heading, *Covered critical illnesses,* the following describes when we will not make a Critical illness insurance benefit payment.

We will not make any payment if the Covered critical illness 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 milliliters 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 make any payment if the Covered critical illness is directly or indirectly caused by or associated with the insured person:

- committing or attempting to commit a criminal offence
- taking or attempting to take their own life, while sane or insane
- causing themself bodily injury, while sane or insane
- 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 or occasional use of alcohol.

We will not make any payment if the Covered critical illness is directly or indirectly caused by or associated with civil disorder or war, whether declared or not.

Covered critical illnesses

The insured person has coverage for the following Group 1 and Group 2 Covered critical illnesses only. Each Covered critical illness describes a survival period. The insured person must be alive at the end of the survival period to satisfy this requirement for the illness.

The Covered critical illnesses Benign brain tumour and Cancer have a restriction described as the *90 day exclusion period*. Under this exclusion period, you have a responsibility to report information about those illnesses to ensure other Covered critical illnesses are not excluded. This responsibility is described in the definitions for Benign brain tumour and Cancer.

Group 1 Covered critical illnesses

Alzheimer's disease

Alzheimer's disease means a definite diagnosis of a progressive degenerative disease of the brain. The insured person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision.

The diagnosis of Alzheimer's disease must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusion
No benefit is payable for all other dementing organic brain disorders and psychiatric illnesses.

SAMPLE

Aortic surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of surgery.

Aplastic anemia

Aplastic anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents
- immunosuppressive agents
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Bacterial meningitis

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days following the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist. The insured person must survive for 90 days following the date of diagnosis.

Exclusion
No benefit is payable under this condition for viral meningitis.

Benign brain tumour

Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficits.

The diagnosis of benign brain tumour must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusion
No benefit is payable under this condition for pituitary adenomas less than 10 mm.

90 day exclusion period for Benign brain tumour
No benefit is payable for Benign brain tumour if the insured person has:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made, or
- a diagnosis of benign brain tumour

within the first 90 days following the later of:

- the most recent date an application for this policy was signed
- the policy date shown under the heading, *Policy particulars*, or
- the most recent date this policy was put back into effect (reinstatement).

Your responsibility to report
You have a responsibility to report information about benign brain tumour to us, regardless of when a diagnosis is made. If information is reported to us within 6 months of the date of the diagnosis, coverage for all other Covered critical illnesses will continue. If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for any or all of the following:

- Benign brain tumour
- any Covered critical illness caused by benign brain tumour, or
- any Covered critical illness caused by the treatment of benign brain tumour.

To report the information, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Blindness

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of blindness must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

SAMPLE

Cancer
Cancer means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

The diagnosis of cancer must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusions
Conditions not covered by this definition are:
- carcinoma in situ
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion)
- any non-melanoma skin cancer that has not become metastatic (spread to distant organs), or
- Stage A (T1a or T1b) prostate cancer.

90 day exclusion period for Cancer
No benefit is payable if the insured person has:
- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this policy), regardless of when the diagnosis is made, or
- a diagnosis of cancer (covered or excluded under this policy)

within the first 90 days following the later of:
- the most recent date an application for this policy was signed
- the policy date shown under the heading, *Policy particulars*, or
- the most recent date this policy was put back into effect (reinstatement).

SAMPLE

Your responsibility to report
You have a responsibility to report information about cancer to us, regardless of when a diagnosis is made. If information is reported to us within 6 months of the date of the diagnosis, coverage for all other Covered critical illnesses will continue. If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for any or all of the following:
- Cancer
- any Covered critical illness caused by cancer, or
- any Covered critical illness caused by the treatment of cancer.

To report the information, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Coma
Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.

The diagnosis of coma must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusion
No benefit is payable under this condition for:
- a medically induced coma
- a coma which results directly from alcohol or drug use, or
- a diagnosis of brain death.

Coronary artery bypass surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

The surgery must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of surgery.

Deafness

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The diagnosis of deafness must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Heart attack

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

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- 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. The insured person must survive for 30 days following the date of diagnosis.

SAMPLE

Exclusion

Heart attack does not include:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart attack definition as described above.

Heart valve replacement

Heart valve replacement means the undergoing of 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. The insured person must survive for 30 days following the date of surgery.

Exclusion

No benefit is payable under this condition for heart valve repair.

Kidney failure

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The diagnosis of kidney failure must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Loss of limbs

Loss of limbs means 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. The insured person must survive for 30 days following the date of diagnosis.

Loss of speech

Loss of speech means a 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. The insured person must survive for 180 days following the date of diagnosis.

Exclusion
No benefit is payable under this condition for all psychiatric related causes.

Major organ failure on waiting list

Major organ failure on waiting list 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 failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

The date of diagnosis is the date of the insured person's enrollment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

SAMPLE

Major organ 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 for transplantation 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. The insured person must survive for 30 days following the date of their transplant.

Motor neuron disease

Motor neuron disease means a definite diagnosis of one of the following conditions and is limited to these conditions:

- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- primary lateral sclerosis
- progressive spinal muscular atrophy
- progressive bulbar palsy, or
- pseudo bulbar palsy.

The diagnosis of motor neuron disease must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Multiple sclerosis

Multiple sclerosis means a definite diagnosis of 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
- 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.

The diagnosis of multiple sclerosis must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Occupational HIV infection

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 most recent date an application for this policy was signed
- the policy date shown under the heading, *Policy particulars*, or
- the most recent date this policy was put back into effect (reinstatement).

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

- the accidental injury must be reported to us within 14 days of the accidental injury
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States
- the accidental injury must have been reported, investigated and documented in accordance with current workplace guidelines for Canada or the United States.

SAMPLE

The diagnosis of occupational HIV infection must be made by a specialist. The insured person must survive for 30 days following the date of the second serum HIV test described above.

Exclusion

No benefit is payable under this condition if:

- the insured person has elected not to take any available licensed vaccine offering protection against HIV
- a licensed cure for HIV infection has become 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

Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The diagnosis of paralysis must be made by a specialist. The insured person must survive for 90 days following the precipitating event.

Parkinson's disease

Parkinson's disease means a definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses). The insured person must require substantial physical assistance from another adult to perform at least 2 of the following 6 activities of daily living.

Activities of daily living are:

- 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 on and off the toilet and maintain personal hygiene.
- Bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances 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 or drink that already have been prepared and made available, with or without the use of adaptive utensils.

The diagnosis of Parkinson's disease must be made by a specialist. The insured person must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Exclusion

No benefit is payable under this condition for all other types of Parkinsonism.

SAMPLE

Severe burns

Severe burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

The diagnosis of severe burns must be made by a specialist. The insured person must survive for 30 days following the date the severe burn occurred.

Stroke

Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusion

No benefit is payable under this condition for:

- transient ischaemic attacks
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Group 2 Covered critical illnesses

Cancer

Ductal carcinoma in situ of the breast

Ductal carcinoma in situ of the breast is a non-invasive cancer and must be confirmed by biopsy.

The diagnosis of ductal carcinoma in situ of the breast must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Stage A (T1a or T1b) prostate cancer

Stage A (T1a or T1b) prostate cancer must be confirmed by pathological examination of prostate tissue.

The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Stage 1A malignant melanoma

Stage 1A malignant melanoma is a melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion.

The diagnosis of stage 1A malignant melanoma must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

90 day exclusion period for Cancer

No benefit is payable if the insured person has:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this policy), regardless of when the diagnosis is made, or
- a diagnosis of cancer (covered or excluded under this policy)

within the first 90 days following the later of:

- the most recent date an application for this policy was signed
- the policy date shown under the heading, *Policy particulars*, or
- the most recent date this policy was put back into effect (reinstatement).

Your responsibility to report

You have a responsibility to report information about cancer to us, regardless of when a diagnosis is made. If information is reported to us within 6 months of the date of the diagnosis, coverage for all other Covered critical illnesses will continue. If information is not provided within 6 months of the
date of diagnosis, we have the right to deny a claim for any or all of the following:

- Cancer
- any Covered critical illness caused by cancer, or
- any Covered critical illness caused by the treatment of cancer.

To report the information, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Coronary angioplasty

Coronary angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

The procedure must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of the procedure.

SAMPLE

Making a claim for a Critical illness insurance benefit

You may submit a claim if the requirements described in this policy are satisfied. To make a claim, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

The person making a claim for a Critical illness insurance benefit must complete the form and give us information we need to assess the claim, including:

- proof that they have the right to receive the benefit
- proof that the insured person had a Covered critical illness while this benefit was in effect
- a written diagnosis which describes the condition and the cause of the illness, and
- the insured person's complete medical records.

Physicians may charge a fee to complete certain forms. The person making the claim is responsible for any fees for this information.

When to submit the claim

The Critical illness term insurance benefit must be in effect on the date a claim is submitted. You must send us the claim within 1 year of the date the insured person has a Covered critical illness.

Information must be provided by a specialist

The diagnosis and treatment for any Covered critical illness must be made by a specialist. The written diagnosis must:

- include appropriate information to assess the Covered critical illness, and
- be prepared and signed by a specialist licensed and practising in Canada or the United States or another physician acceptable to us.

SAMPLE

A specialist is a licensed physician who has been trained in the specific area of medicine relevant to the Covered critical illness for which a claim is being submitted and who has been certified by a specialty examining board. In the absence or unavailability of a specialist, a condition may be diagnosed by another qualified physician acceptable to us.

Any physician or specialist who makes the diagnosis or any physician, specialist, health care practitioner or medical professional who provides treatment, tests or examinations for a Covered critical illness must not be:

- the owner
- the 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 health care practitioners that we appoint. These may include licensed physicians, physiotherapists, occupational therapists, psychiatrists, psychologists, neurologists. We pay for the cost of these examinations.

If an illness develops or is diagnosed while outside of Canada or the United States

You may make a claim for a Critical illness insurance benefit if a Covered critical illness develops or is diagnosed while outside of Canada or the United States.

You will be required to provide us with all of the information we need to assess the claim. If the medical records of the insured person are not in French or English, you must provide the original records along with a translation of the records into either French or English. The translator must not be:

- the owner
- the insured person

- anyone entitled to make a claim under this policy, or
- any relative or business associate of these people.

The person making the claim is responsible for any cost associated with providing the translation.

Based on the medical records we receive, we must be satisfied that the same diagnosis or treatment would have been made if the illness developed or was diagnosed in Canada.

Your right to convert the Critical illness term insurance benefit

If the insured person is younger than age 65 when this benefit takes effect, you may convert it to a critical illness insurance policy, with level premiums, on the insured person. We will not require new evidence of insurability. The last day you may apply to convert this benefit is the policy anniversary immediately following the insured person's 65th birthday. This date is shown on the *Policy particulars* page.

The new Critical illness insurance policy

We determine the type of policy you may convert to and the terms and conditions of that policy. The new policy we offer to you will:

- be determined by the information about the insured person in the application for this benefit
- depend on our rules about the age of the insured person and the amount of insurance for that age
- exclude any Group 2 Covered critical illness for which we have made a payment
- have a Critical illness insurance benefit that is not greater than the amount of this benefit on the date the new application is signed
- not include any additional benefits, except, in the circumstances described below, a *Disability waiver benefit* on the insured person.

SAMPLE

Your application must be in a form acceptable to us and satisfy our administrative rules. If we approve your application, this benefit ends on the date the new policy takes effect.

If this policy includes a *Disability waiver benefit* on the insured person, a disability benefit may only be included in the new policy if:

- you request a disability waiver benefit when you apply for the new policy
- we offer a disability waiver benefit on the new policy at the time you apply to convert, and
- the insured person is not disabled when you apply to convert this benefit.

Paying for the new policy

The cost for the new policy will be based on:

- the same evidence of insurability we used to determine the cost for this benefit
- the rates we charge for the new insurance at the time you apply for the new policy, and
- the age of the insured person when you apply for the new policy.

The first payment for the new policy must be included with the application.

If the insured person is disabled

If this policy includes a *Disability waiver benefit* on the insured person, you cannot convert this Critical illness term insurance benefit while the insured person is disabled. However, if we are waiving the cost of insurance and the insured person remains disabled at age 65, you can convert this Critical illness term insurance benefit on the policy anniversary immediately following the insured person's 65th birthday. The premiums on the new policy will continue to be waived while the insured person is disabled.

When this benefit ends

This benefit automatically ends on the earliest of:

- the date we make a payment for a Group 1 covered critical illness
- the date this benefit is converted as described under the heading, *Your right to convert the Critical illness term insurance benefit*
- the date this benefit ends, shown under the heading, *Policy particulars*
- the date the insured person dies, or
- the date this policy ends.

SAMPLE