This guide will help you understand the illnesses and procedures covered by your critical illness insurance policy. Each of the covered illnesses are defined and then explained for you. We have also outlined any exclusions and the survival periods required.

In this guide, when we refer to specialists, we mean a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness for which a benefit is being claimed, 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 medical practitioner as approved by us.

This guide is for your reference only, and does not replace the policy

Your critical illness insurance policy:
• defines the illnesses you are insured for, and
• includes the terms and conditions you will have to meet to receive the critical illness insurance benefit.

Please review your policy carefully.
Illnesses not specifically mentioned or not meeting the stated criteria are not covered. All illnesses must satisfy the description in your policy.
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Acquired brain injury

Definition
Acquired brain injury means a definite diagnosis of damage to brain tissue caused by traumatic injury, anoxia or encephalitis, resulting in signs and symptoms of neurological impairment that:

- are present and verifiable on clinical examination or neuropsychological testing,
- persist for more than 180 days following the date of diagnosis, and
- are corroborated by imaging studies of the brain consistent with the diagnosis.

The diagnosis of acquired brain injury must be made by a specialist.

Survival period
No additional survival period is required once the conditions described above are satisfied.

Exclusion
No benefit is payable under this condition for:

- an abnormality seen on brain or other scans without definite related clinical impairment, or
- neurological signs occurring without symptoms of abnormality.

Explanation
Acquired brain injury is damage to the brain that occurs after birth. It is not related to a congenital disorder, a developmental disability or a progressive process or disease. It may be caused by traumatic injury, anoxia (an absence of oxygen) or encephalitis (an inflammation of the brain).
Alzheimer’s disease

Definition
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.

Survival period
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.

Explanation
Alzheimer’s disease is the leading cause of dementia. Its symptoms include loss of memory, judgment and reasoning, and changes in mood and behaviour. Alzheimer’s disease gradually destroys vital nerve cells in the brain. It is not a normal part of aging.
Aortic surgery

Definition
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.

Survival period
The insured person must survive for 30 days following the date of surgery.

Explanation
The diseased artery must be surgically replaced.
Aplastic anemia

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
Aplastic anemia is a rare and serious disorder. In aplastic anemia, the bone marrow stops producing enough new blood cells. It is not reversible. This means that there will be a deficit of red and white blood cells and platelets. Infections, serious uncontrolled bleeding and fatigue can occur. An examination of the bone marrow is necessary to make this diagnosis. The cause is often unknown.
Bacterial meningitis

Definition
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 from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist.

Survival period
The insured person must survive for 90 days following the date of diagnosis.

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

Explanation
Meningitis is an infection of the fluid of a person’s spinal cord and the fluid that surrounds the brain. Bacterial meningitis is caused by one of many bacteria and requires in-hospital antibiotic treatment. It can be infectious. Laboratory analysis of the spinal fluid is necessary and must demonstrate the presence of a bacterial infection.
Benign brain tumour

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Exclusions
No benefit is payable under this condition for pituitary adenomas less than 10 mm.
No benefit will be payable under this condition if within the first 90 days following the later of:
• the most recent date the application for the policy was signed,
• the policy date,
• the underwriting decision date if included in the policy, or
• the most recent date the policy was put back into effect (reinstatement),
the insured person has any of the following:
• signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made,
• a diagnosis of benign brain tumour (covered or excluded under the policy).
Your responsibility to report benign brain tumour
This information described above must be reported to us, regardless of when the diagnosis is made. If information is reported to us within 6 months of the date of diagnosis, coverage for all other covered critical illnesses will continue. If this information is not provided within 6 months of the date of diagnosis, we have the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

Explanation
A benign brain tumour is a non-cancerous tumour (mass of extra cells) arising from the brain or its protective membranes (meninges).

When coverage for benign brain tumour ends
The coverage for benign brain tumour will end and we will not make any payment if within the first 90 days following the later of:

• the date the application for the policy was signed,
• the policy date,
• the underwriting decision date if included in the policy, or
• the most recent date the policy was put back into effect (reinstatement),

the insured person has:

• signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made,
• a diagnosis of benign brain tumour (covered or excluded under the policy).

Coverage for all other covered critical illnesses will continue provided the insured person’s critical illness does not result directly or indirectly from any benign brain tumour or treatment for benign brain tumour.
Blindness

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
A person may be registered as blind with only partial loss of sight. Therefore being registered as blind will not necessarily validate a claim. It is necessary to demonstrate permanent and irreversible loss of sight such that the corrected visual acuity is 20/200 or worse in both eyes, or the field of vision is less than 20 degrees in both eyes.
Cancer

Definition
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.

Survival period
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 metastasized, or
• Stage A (T1a or T1b) prostate cancer.
No benefit is payable under this condition if within the first 90 days following the later of:
• the most recent date the application for the policy was signed,
• the policy date,
• the underwriting decision date if included in the policy, or
• the most recent date the policy was put back into effect (reinstatement),
the insured person has any of the following:

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

- a diagnosis of cancer (covered or excluded under the policy).

**Your responsibility to report cancer**

This information described above must be reported to us, regardless of when a diagnosis is made. If information is reported to us within 6 months of the date of diagnosis, coverage for all other covered critical illnesses will continue. If this information is not provided within 6 months of the date of diagnosis we have the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

**Explanation**

Cancer (also known as carcinoma) is the abnormal or malignant growth of cells which spread throughout the body destroying healthy tissue. Critical illness insurance covers all life threatening cancers, leukemia, lymphoma, Hodgkin’s disease as well as tumours in the presence of Human Immunodeficiency Virus (HIV). Cancer is a general term used to describe a wide variety of growths, some less serious than others, including those that are not critical. The less serious and those not critical are excluded from the list of covered illnesses. An example of an excluded cancer is cancer-in-situ of the cervix, which is usually identified and treated before the malignant cells have invaded adjacent tissues. However, if one of these excluded cancers is not cured and then worsens, benefits may become payable providing the policy remains in force. Certain less serious forms of cancer may be eligible for a partial benefit payout, as described later in this booklet.
When coverage for cancer ends

The coverage for cancer will end and we will not make any payment if within the first 90 days following the later of:

• the date the application for the policy was signed,
• the policy date,
• the underwriting decision date if included in the policy, or
• the most recent date the policy was put back into effect (reinstatement),

the insured person has:

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

Coverage for all other covered critical illnesses will continue provided the insured person’s critical illness does not result directly or indirectly from any cancer or cancer treatment.
Coma

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

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

Explanation
A coma is a state of deep unconsciousness from which a person cannot be aroused, even with intense external stimulation. It is necessary for this state to persist continuously for at least four days. The Glasgow Coma Scale is designed to assess the depth and duration of coma and impaired consciousness. It is based on the motor responsiveness, verbal performance and eye opening to appropriate stimuli. It is repeated over the course of the coma to assess the progression of the coma. The range of the scale is 3 to 15 with 15 being awake and responsive and 3 being totally unresponsive to everything. It is universally used in cases of coma.
Coronary artery bypass surgery

Definition
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.

Survival period
The insured person must survive for 30 days following the date of surgery.

Explanation
The heart, like any other organ in the body, needs an adequate supply of oxygen that is normally provided by the coronary arteries. If these become blocked, the blood flow may be interrupted. The chances of having a heart attack are greatly increased. In such cases it may be advisable to undergo open-heart surgery to bypass the blockage. Because bypass surgery is a critical surgical procedure, it is included in the list of covered illnesses, while less traumatic procedures are not included.
Deafness

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
It is necessary to demonstrate total and irreversible loss of hearing such that the auditory threshold in each ear is more than 90 decibels (sounds of less than 90 decibels cannot be distinguished).
Heart attack

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Exclusions
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.
Explanation

A heart attack (also known as myocardial infarction or coronary thrombosis) may occur when the normal supply of blood to the heart is interrupted by a blocked artery or clot, causing part of the heart muscle to die. The usual symptom is acute chest pain but symptoms are not limited to chest pain. The diagnosis of a recent heart attack therefore, is confirmed by the detection of abnormal electrical activity over the surface of the heart, which is seen on an electrocardiograph (ECG) and the detection of raised levels of cardiac biochemical markers released from the damaged heart muscle tissue.
Heart valve replacement

Definition
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.

Survival period
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.

Explanation
The diseased valve must be surgically removed and replaced.
Kidney failure

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
Kidneys can fail for a variety of reasons, but whatever the cause, the result is an inability to remove waste material from the blood. If both kidneys fail, the build-up of these waste products can eventually be life threatening, requiring one of two forms of treatment. Renal dialysis involves regular connection to a machine that replaces the kidney’s function. Transplant surgery replaces the failed kidneys with a healthy donor kidney.
Loss of limbs

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

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
Loss of limbs is also referred to as dismemberment or severance. To claim, the insured person must lose two or more limbs. The arm must be lost at the wrist or higher up the arm; the leg must be lost at the ankle or higher up the leg. The severance must be permanent, therefore unable to be corrected by surgery or other means.
Loss of speech

**Definition**

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.

**Survival period**

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.

**Explanation**

The inability to speak must be total and permanent, and therefore unable to be corrected by surgery or other means. This could be the result of injury or illness but it excludes all psychiatric related causes.
Major organ failure on waiting list

Definition

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.

Survival period

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

Explanation

Because the time required to find a suitable donor is usually unpredictable, it is not necessary to have undergone transplant surgery in order to claim. Once accepted onto the waiting list of a recognized Canadian transplant program, or in another transplant program acceptable to us, a claim can be made.
Major organ transplant

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

Survival period
The insured person must survive for 30 days following the date of their transplant.

Explanation
In certain conditions, one or more of the major organs may be so seriously diseased that the only effective treatment is an organ or tissue transplant.
Motor neuron disease

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
ALS is a degenerative disease that attacks the motor neurons responsible for transmitting electrical impulses from the brain to the voluntary muscles throughout the body. The muscles eventually lose strength, atrophy and die. There is no known treatment. Because it attacks only motor neurons, ALS does not affect the mind. The person with ALS remains mentally sharp and in full possession of the senses of sight, hearing, taste, smell and touch.
Multiple sclerosis

Definition
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.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
Multiple sclerosis is a progressive disease where nerve fibres in the brain and spinal cord lose their insulating cover of myelin with a resulting loss of nerve function. The symptoms and severity of the illness are dependent on which areas of the nervous system are affected. The symptoms may last for long or short periods with intermittent periods of remission and relapse. For these reasons, multiple sclerosis can be difficult to diagnose.
Occupational HIV infection

Definition

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 the application for the policy was signed,
• the policy date, or
• the most recent date the 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.

The diagnosis of occupational HIV infection must be made by a specialist.
Survival period

The insured person must survive for 30 days following the date of the second serum HIV test described above.

Exclusions

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.

Explanation

The HIV infection must result from accidental exposure to HIV-contaminated body fluids during the normal course of performing an occupation for which remuneration is earned. To prove no HIV was present before the accident, an HIV test showing negative results must be performed 14 days following the accident. To prove HIV contamination resulted from the accident, an HIV test with positive results must be performed between 90 and 180 days following the accident. To prove the injury was a result of an accident while at work, appropriate documentation and investigations must be presented with the claim. These and other requirements for claim are explained in detail in your policy.
Paralysis

**Definition**

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.

**Survival period**

The insured person must survive for 90 days following the precipitating event.

**Explanation**

Paralysis occurs when the messages that normally travel from the brain and spinal cord to the muscles are prevented from doing so. Whether the cause is disease or injury, the result is a complete loss of voluntary movement in an arm or leg. Hemiplegia is paralysis of one side of the body; paraplegia generally refers to paralysis of the legs; and quadriplegia affects all four limbs. Hemiplegia, paraplegia, and quadriplegia are all covered by the plan.
Parkinson’s disease

Definition
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
• bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).
The diagnosis of Parkinson’s disease must be made by a specialist.

Survival period
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.

Explanation
Parkinson’s disease progressively attacks the central nervous system. People with the disease usually experience a decrease in spontaneous movements and have difficulty with walking and balance. They also suffer from muscle rigidity and tremor.
Severe burns

Definition
Severe burns means a definite diagnosis of third-degree burns over at least 20 per cent of the body surface.
The diagnosis of severe burns must be made by a specialist.

Survival period
The insured person must survive for 30 days following the date the severe burn occurred.

Explanation
A third degree burn affects all layers of the skin. Third-degree burns over at least 20 per cent of the body are covered.
**Stroke**

**Definition**

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.

**Survival period**

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

**Exclusions**

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.

**Explanation**

A stroke (also known as cerebrovascular accident (CVA)) occurs when the blood supply to the brain is reduced either by a blockage (embolus) or a blood clot (thrombosis) or due to haemorrhage, resulting in permanent damage to functions controlled by the brain. Depending on which part of the brain is damaged, this can result in paralysis to one side of the body and impairment of speech or vision. Tiny mini-strokes that do not produce symptoms or persisting neurologic impairment are not covered.
Additional illness eligible for full benefit payout when included in the policy

Loss of independent existence

Definition

Loss of independent existence means a definite diagnosis of either:

• a total inability to perform, by oneself, at least 2 of the following 6 activities of daily living, or,
• cognitive impairment, as defined below,

for a continuous period of at least 90 days with no reasonable chance of recovery.

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.
Cognitive impairment means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a specialist. The degree of cognitive impairment must be sufficiently severe to require a minimum of 8 hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments. The diagnosis of loss of independent existence must be made by a specialist.

Survival period

No additional survival period is required once the conditions described above are satisfied.

Exclusion

No benefit is payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Explanation

To claim, the loss of independent existence must be expected to be permanent. If the loss results from a cognitive impairment, it must be from a demonstrable organic cause. Organic cognitive impairments are accompanied by physical changes in the brain.
Cerebral palsy

**Definition**

Cerebral palsy means a definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements. The diagnosis of cerebral palsy must be made by a specialist.

**Survival period**

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

**Explanation**

Cerebral palsy results in impaired muscle co-ordination and weakness caused by damage to the brain before or at birth. It can also occur after birth from a stroke or infection in the baby.
Definition
Congenital heart disease means a definite diagnosis of at least one of the covered heart conditions described below. It also means the specific conditions described below for which open heart surgery is performed to correct the condition.

Covered heart conditions

- Coarctation of the aorta
- Ebstein’s anomaly
- Eisenmenger syndrome
- Tetralogy of Fallot
- Transposition of the great vessels

The diagnosis of the heart condition must be:
- made before the insured person’s 24th birthday,
- made by a specialist, and
- supported by cardiac imaging acceptable to us.

Covered heart conditions if open heart surgery is performed
These heart conditions are covered only if open heart surgery is performed to correct at least one of them:
- Aortic stenosis
- Atrial septal defect
- Discrete subvalvular aortic stenosis
- Pulmonary stenosis
- Ventricular septal defect

The diagnosis of the heart condition must be made and the surgery:
- recommended by a specialist,
• supported by cardiac imaging acceptable to us, and
• performed by a specialist

Survival period
For the first list of covered heart conditions, open heart surgery is not required for the condition to be covered. The insured person must survive for a period of 30 days following the date of diagnosis. For the second list – “covered heart conditions if open heart surgery is performed” – open heart surgery is required for the condition to be covered. The insured person must survive for a period of 30 days following the date of surgery.

Exclusions
Procedures not covered by this definition are:
• Percutaneous atrial septal defect closure,
• Trans-catheter procedures which include balloon valvuloplasty.

Explanation
Congenital heart disease refers to a group of cardiac malformations that are present at birth, but may not be diagnosed until later in childhood. The list of conditions that are covered regardless of method of treatment includes conditions that are generally serious, although not all of them are treated by surgery. The conditions listed under “Covered heart conditions if open heart surgery is performed” includes conditions that vary in severity. Some cases may be mild, or even disappear on their own as the child grows. Generally, severe cases will be treated by surgery, and it is these cases requiring surgery that are covered by critical illness insurance.
Cystic fibrosis

Definition
Cystic fibrosis means a definite diagnosis of cystic fibrosis where the insured person has chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be:
• made before the insured person’s 24th birthday, and
• made by a specialist.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
Cystic fibrosis is a genetic disorder that results in production of abnormally thick mucus leading to blockage of the pancreatic ducts, intestines and bronchi. In the lungs the mucus can lead to breathing problems and lung disease. In the pancreas the mucus can lead to malnutrition and problems with growth and development.
Muscular dystrophy

**Definition**

Muscular dystrophy means a definite diagnosis of muscular dystrophy where the insured person has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

The diagnosis of muscular dystrophy must be:
- made before the insured person’s 24th birthday, and
- made by a specialist.

**Survival period**

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

**Explanation**

Muscular dystrophy is a hereditary condition that is marked by progressive weakening and wasting of muscles.
Type 1 diabetes mellitus

Definition
Type 1 diabetes mellitus means a definite diagnosis where the insured person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.
The diagnosis of type 1 diabetes mellitus must be:
• made before the insured person’s 24th birthday, and
• made by a specialist.

Survival period
The insured person must survive for 30 days following the date of diagnosis.

Explanation
Type 1 diabetes mellitus is caused by a failure of the pancreas to produce insulin, resulting in a daily dependence on insulin injections for survival. Insulin lets sugar (glucose) enter body cells, where it is used for energy. Without insulin, sugar remains in the blood and the blood sugar level rises above what is safe for the body.
Illnesses eligible for partial benefit payout

Group 2 illnesses

Definitions

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.

• 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.

• 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.

Exclusions

No benefit is payable under these conditions if within the first 90 days following the later of:

• the date the application for this policy was signed,
• the policy date,
• the underwriting decision date if included in the policy, or
• the most recent date this policy was put back into effect (reinstatement),
the insured person has any of the following:

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

- a diagnosis of cancer (covered or excluded under this policy).

This information described above must be reported to us within 6 months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

**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.

**Survival periods**

For each type of cancer, the insured person must survive for 30 days following the date of diagnosis. For coronary angioplasty, the insured person must survive for 30 days following the date of the procedure.

**Explanation**

These are illnesses where treatment is more limited but very effective in reducing the risk to your life.