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.
Table of contents

Policy particulars .......................................................................................................................................... 3
Premium schedule ....................................................................................................................................... 5
If you change your mind within 10 days........................................................................................................ 6
Contesting the policy .................................................................................................................................. 6

When a Critical illness insurance benefit is payable.................................................................................. 7
   Group 1 Covered critical illness payment .............................................................................................. 7
   Group 2 Covered critical illness payment .............................................................................................. 7
   Exclusions (when a Critical illness insurance benefit is not payable).................................................... 7
Covered critical illnesses ................................................................................................................................ 8
   Group 1 Covered critical illnesses.......................................................................................................... 8
   Loss of independent existence (an additional Group 1 Covered critical illness) .................................... 16
   Group 2 Covered critical illnesses........................................................................................................ 17
Making a claim for a Critical illness insurance benefit.................................................................................. 18
   If an illness develops or is diagnosed while outside of Canada or the United States............................ 19
Automatic Return of premium and Return of premium on cancellation benefit ........................................... 19
Return of premium on death benefit ........................................................................................................... 20
Paying for your policy .................................................................................................................................. 21
Applying to decrease the Critical illness insurance benefit amount .......................................................... 22
Applying for non-smoker classification ...................................................................................................... 22
Your right to cancel this policy ................................................................................................................... 22
When your policy ends .................................................................................................................................. 23
Other information about your policy .......................................................................................................... 23
Insurance terms ........................................................................................................................................... 23
Statutory conditions .................................................................................................................................... 24
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.

Sun Critical Illness Insurance - Lifetime

Your policy number is: LI-1234,567-8
Your policy date is: September 17, XXXX
The owner is: John Doe
The insured person is: Mary Doe
born on March 10, XXXX
Age nearest on the policy date: XX

Critical illness 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, When a Critical illness insurance benefit is payable.

Loss of independent existence is an additional Group 1 Covered critical illness for this policy. The earliest a claim may be submitted for this illness is the policy anniversary nearest the insured person’s 18th birthday.

(optional benefit)
Automatic Return of premium and Return of premium on cancellation benefit:
You may be eligible to receive returnable premium payments as described later in this policy.

(optional benefit)
Return of premium on death benefit:
If the insured person dies while this policy is in effect, please see the Return of premium on death benefit described later in this policy.

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.

Any Returnable premium amount payable on cancellation of this policy is paid to the owner of this policy.
Policy particulars (continued)

Any Returnable premium amount on death is paid to the person named on your application as the Return of premium on death beneficiary, unless you make a change in writing to us.

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

The premium schedule included in this policy describes your premium guarantees.

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

Premiums are due monthly, on the 17th day of the month, starting on September 17, XXXX.

The premiums shown in this schedule are guaranteed while this policy is in effect.

On the policy anniversary nearest the insured person’s 18th birthday the insured person will be classified as a smoker and the premium will increase as shown in the schedule below. You may apply to have the insured person classified as a non-smoker as described later under the heading *Applying for non-smoker classification*. If we approve your application, the insured person will be classified as a non-smoker. We determine the new premium according to the rate that was in effect for a non-smoker of the same sex and age of the insured person on the policy date.

If this policy is still in effect, we will stop charging premiums on September 17, XXXX.

**Guaranteed premiums**

(1) Critical illness insurance benefit  
(2) Return of premium benefit(s)

<table>
<thead>
<tr>
<th>Beginning on</th>
<th>(1)</th>
<th>(2)</th>
<th>Annual Premium ($)</th>
<th>Monthly Premium ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Sept XXXX</td>
<td>XXX.XX</td>
<td>XXX.XX</td>
<td>XXX.XX</td>
<td>XXX.XX</td>
</tr>
</tbody>
</table>
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

E12003A

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.
When a Critical illness insurance benefit is payable

A Critical illness insurance benefit is payable if this policy 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 and this policy ends. The amount we pay is:

- the greater of the Critical illness insurance benefit amount at the time the benefit is payable or the Returnable premium amount for the Return of premium on cancellation benefit
- minus any unpaid premiums plus interest at the time the benefit is payable.

When this policy ends, we will pay you any amount in the withdrawable premium fund as described later in this policy.

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:

- 15% of the Critical illness insurance benefit amount at the time the benefit is payable, or
- $50,000.

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.

**E12013A**

**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**

**Acquired brain injury**

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 neuro-psychological testing,
· persist for more than 180 days following the date of diagnosis, and
· are corroborated by imaging studies of the brain that are consistent with the diagnosis.

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

**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.

**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.

**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).

**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.
**Cerebral palsy**
Coverage for this illness ends on the insured person’s 24th birthday.

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 before the insured person’s 24th birthday, and
· made by a specialist.

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

**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.

**Congenital heart disease**
Coverage for this illness ends on the insured person’s 24th birthday.

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.

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

**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.

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

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.

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

**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.

**Cystic fibrosis**

Coverage for this illness ends on the insured person’s 24th birthday.

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.

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

**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.
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.
**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.

**Muscular dystrophy**

Coverage for this illness ends on the insured person’s 24th birthday.

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.

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.

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 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.

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.

Type 1 diabetes mellitus
Coverage for this illness ends on the insured person’s 24th birthday.

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.

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

E12014A
Loss of independent existence (an additional Group 1 Covered critical illness)

Loss of independent existence is an additional Group 1 Covered critical illness for this policy.

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. 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.

E12016A
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.

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 policy 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
This policy must be in effect on the date a claim is submitted.

If the insured person has a Loss of independent existence before the policy anniversary nearest their 18th birthday, you must wait to send us a claim for this illness. The earliest you may submit a claim is the policy anniversary nearest the insured person’s 18th birthday. The latest you may submit a claim is the policy anniversary nearest the insured person’s 19th birthday.

For all other Covered critical illnesses, 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.
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.

E12033A  (optional benefit)
**Automatic Return of premium and Return of premium on cancellation benefit**

You may be eligible to receive returnable premium payments as described below.

**When we make a payment**
**Automatic Return of premium**
You do not have to apply - we will automatically pay you 75% of the Returnable premium amount on the later of:
- the 15th policy anniversary, or
- the policy anniversary nearest the insured person’s 25th birthday.

Your policy does not end when we make this payment.
If you cancel this policy
We will pay you the Returnable premium amount if you cancel this policy at any time on or after the later of:
· the 30th policy anniversary, or
· the policy anniversary nearest the insured person’s 40th birthday.

To cancel this policy, refer to Your right to cancel this policy.

Returnable premium amount for this benefit
The Returnable premium amount is the total of:
· all premiums paid
· minus any Automatic Return of premium amount we paid
· minus any premiums paid for the Long term care conversion option
· minus any unpaid premiums plus interest.

We will also pay you any amount in the withdrawable premium fund on the date the policy ends.

If the Critical illness insurance benefit amount is decreased
If you decrease the Critical illness insurance benefit amount, the Returnable premium amount for this benefit is reduced. The reduced amount is calculated based on the premiums you would have paid if your Critical illness benefit amount was always the decreased amount.

For a decrease before the policy anniversary nearest the 40th birthday of the insured person
You will lose the premiums paid for the difference between the Critical illness insurance benefit amount on the date immediately before the decrease and the remaining Critical illness insurance benefit amount.

For a decrease on or after the policy anniversary nearest the 40th birthday of the insured person - transfer to the withdrawable premium fund
We transfer the premiums paid for the difference between the Critical illness insurance benefit amount on the date immediately before the decrease and the remaining Critical illness insurance benefit amount to the withdrawable premium fund.

E12037A (optional benefit)
Return of premium on death benefit

We will pay either the Returnable premium amount or a Critical illness insurance benefit, but not both. If we pay the Returnable premium amount on death, we will not pay a Returnable premium amount for any other benefit in this policy.

When the Returnable premium is payable
If the insured person dies we pay the Returnable premium amount on death to the person named on your application as the Return of premium on death beneficiary, unless you make a change in writing to us.

Returnable premium amount on death
The Returnable premium amount on death is the total of:
· all premiums paid
· minus any Automatic Return of premium amount we paid
· minus any premiums paid for the Long term care conversion option
· minus any unpaid premiums plus interest.

We will also pay you any amount in the withdrawable premium fund on the date the insured person dies.
Making a claim for this benefit
To make a claim, contact us at the toll free phone number shown at the beginning of this policy. We will then send the appropriate form to be completed.

The person making the claim and completing the form must be the Return of premium on death beneficiary. We require proof that the insured person died while this policy was in effect.

Paying for your policy

Premiums for this policy
We will provide you with the benefits described in this policy if you pay the premiums shown in the premium schedule. The premium schedule in this policy describes your premium guarantees. You must pay all premiums by the due date. Payment must be made to Sun Life Assurance Company of Canada. We reserve the right to refuse cash payments.

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

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

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

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

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

If premiums are not received
This policy will end if:
· we do not receive the required premium within 31 days after it is due, and
· there is not enough money in the withdrawable premium fund to pay the required premium.

If your policy ends this way, it has lapsed.

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

Putting your policy back into effect
If your policy ended because it lapsed, you may apply to have it put back into effect if the insured person is alive and has not had a Covered critical illness or any signs or symptoms of a Covered critical illness. This process is called reinstatement.

If you want to put this policy back into effect, you must:
· apply within 2 years of the date the policy ended
· give us new evidence of insurability that we consider satisfactory, and
· make a payment equal to the reinstatement charge we set.
If we don’t approve your application, we refund the amount you paid when you applied to put your policy back into effect.

E12047A

Applying to decrease the Critical illness insurance benefit amount

You may apply to decrease the Critical illness insurance benefit amount. To keep this policy in effect, any decrease is subject to the minimum limit we set for the Critical illness insurance benefit.

A decrease to the Critical illness insurance benefit amount will reduce the Returnable premium amount payable for a Return of premium benefit, as described earlier under any heading, If the Critical illness insurance benefit amount is decreased.

E12049A

Applying for non-smoker classification

On the policy anniversary nearest the insured person’s 18th birthday, we will classify them as a smoker. If the insured person is a non-smoker at that time, you may apply to have them classified as a non-smoker.

If applying before the policy anniversary nearest the 19th birthday
If you apply after the policy anniversary nearest the insured person’s 17th birthday and before the policy anniversary nearest their 19th birthday, we require a non-smoker declaration signed by the insured person and you.

If applying on or after the policy anniversary nearest the 19th birthday
If you apply on or after the policy anniversary nearest the insured person’s 19th birthday, we require new evidence of insurability on the insured person. The application must be signed by the insured person and you.

If we approve your application, the insured person will be classified as a non-smoker. We determine the new premium according to the rate that was in effect for a non-smoker of the same sex and age of the insured person on the policy date.

E12054A

Your right to cancel this policy

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

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

To cancel your policy, send your request in writing to:
   Sun Life Assurance Company of Canada
   227 King St. S.
   PO Box 1601, Stn Waterloo
   Waterloo ON Canada  N2J 4C5

If you apply to cancel your policy within the first 10 days of receiving it from us, we will treat this as a rescission. This is described under the heading, If you change your mind within 10 days.
If you apply to cancel your policy after the 10th day of receiving it from us, we’ll pay you:
- any amount in the withdrawable premium fund
- minus any unpaid premiums plus interest.

E12056A

When your policy ends

If your policy hasn’t ended for any of the reasons already described, this policy including any additional benefits will automatically end on the date the insured person dies.

When this policy ends, we will pay you any amount in the withdrawable premium fund.

E12059A

Other information about your policy

Information about our contract with you
Once your policy is in effect, the following documents make up our entire contract with you:
- your application for insurance, including any evidence of insurability, and
- this policy, including any amendments.

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

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

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

Transferring your policy (assignment)
You may be able to transfer your rights under this policy to someone else by assigning the policy. We are not responsible for ensuring that the assignment of your policy is legally valid. If you transfer this policy, send a notice of the assignment to:
- Sun Life Assurance Company of Canada
- 227 King St. S.
- PO Box 1601, Stn. Waterloo
- Waterloo ON Canada N2J 4C5

E12061A

Insurance terms

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

Age
Age means a person’s age on their birthday nearest to a particular date. This is known as 'age nearest'. For example, a person’s age at the policy date means their age on their birthday nearest to the policy date.
Benefits
We offer a variety of insurance coverages. The Critical illness insurance benefit is a coverage that is automatically included in your policy. Additional benefits may be available. An example of an additional benefit is the Disability waiver benefit.

Critical illness benefit payee
The person or persons you name in writing to receive the Critical illness insurance benefit.

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 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.

Premium
The amount paid to purchase or maintain an insurance policy.

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

E12065A-CII

Statutory conditions

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

   Waiver
   2) We shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by us.

   Copy of application
   3) We shall, upon request, furnish to you or to a claimant under the contract a copy of the application.

2. Material facts
   No statement made by you or the Insured person at the time of application for this contract shall be used in defence of a claim under or to avoid this contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.
3. **Notice and proof of claim**  
   a) Critical illness insurance benefit  
   Any claim for payment under the Critical illness insurance benefit must be made in writing to our head office within one year of the date a claim first arises. The claimant must provide proof satisfactory to us:  
   · that the Insured person has a Covered critical illness  
   · that all the conditions to qualify for a Critical illness insurance benefit have been satisfied  
   · that the claimant has the right to receive any benefit payable  
   · of the claimant’s date of birth, if required for the claim, and  
   · of the Insured person’s date of birth.  
   
   The claim must be supported by a written diagnosis from a specialist licensed and practising in Canada or the United States or by another physician acceptable to us, stating that the Insured person has experienced a Covered critical illness. The written diagnosis must describe the cause, nature and expected duration of the illness and must refer to specific criteria for the illness as shown in the policy.

4. **Insurer to provide forms for proof of claim**  
   We will provide forms for a claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the illness giving rise to the claim.

5. **Rights of examination**  
   As a condition precedent to recovery of insurance money under this contract, the claimant shall afford to us an opportunity to have the Insured person examined by a health care practitioner appointed by us when and as often as it reasonably requires while the claim is pending.

6. **When is money payable**  
   All money payable under this contract shall be paid by us within 60 days after we have received proof of claim and the conditions in this policy have been satisfied.

7. **Termination of insurance**  
   You may terminate (cancel) your policy at any time as set out earlier in this policy under *Your right to cancel this policy.*