Sun Critical Illness Insurance - Term 10

Policy number: LI-1234,567-8

Owner: John Doe

The following policy wording is provided solely for your convenience and reference. It is incomplete and reflects only some of the general provisions that may be found in some of our insurance policies. We periodically make changes to policy wording and therefore this incomplete sample may not duplicate the wording of any actual issued policy. It is not to be construed or interpreted in any manner as a contract or an offer to contract. The actual policy issued to any given client will govern that relationship.
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Policy 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 - Term 10

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
Risk classification: non-smoker

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.

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

Date this policy ends September 17, XXXX

(optional benefit)
Disability waiver benefit: on Mary Doe
Date this benefit ends: September 17, XXXX

(optional benefit)
Return of premium on cancellation or expiry benefit: If this policy ends on September 17, XXXX or if you cancel this policy, please see the Return of premium on cancellation or expiry benefit - 15 years described later in this policy.

(optional benefit)
Return of premium on cancellation or expiry benefit: If this policy ends on September 17, XXXX or if you cancel this policy, please see the Return of premium on cancellation or expiry benefit - age 65 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.

(optional benefit)
**Long term care conversion option:**
Critical illness insurance may be converted to Long term care insurance as described under the heading, *Long term care conversion option.*

Last date to convert: September 17, XXXX

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

Any Returnable premium amount payable on cancellation or expiry of this policy is paid to the owner of this policy.

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 term insurance policy provides protection for a limited number of years.

The last day you may convert this policy to another Critical illness insurance policy is September 17, XXXX. This is described under the heading, *Your right to convert this policy to another Critical illness insurance policy.*

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.

**Guaranteed premiums**

(1) Critical illness insurance benefit, Additional Group 1 Covered critical illnesses
(2) Disability waiver benefit
(3) Return of premium benefit(s)
(4) Long term care conversion option

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If you change your mind within 10 days

You may send us a written request to cancel your policy within:
· 10 days of receiving it from us, or
· 60 days after the policy is issued, whichever date is earlier.

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

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

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

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

Contesting 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 or expiry 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.

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

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

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

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

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

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

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

**Heart attack**
Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:
- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

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

**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.

**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
· bradykinesia (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.
E12014A  (optional benefit)

**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.

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**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.

**E12021A**

**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. 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.
E12024A (optional benefit)

Disability waiver benefit

The insured person for this benefit and the end date for this benefit are shown under the heading, Policy particulars.

If the insured person becomes disabled as described below, and the disability continues for more than 6 consecutive months they may qualify for this benefit. If they qualify, you don’t have to pay premiums for the duration of their disability. We call this waiving premiums.

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

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

When we will not waive premiums (exclusions and limitations)
We will not waive premiums if the insured person’s disability begins after the policy anniversary nearest the insured person’s 60th birthday.

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

We will not waive premiums if the disability 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 waive premiums if the insured person’s disability is directly or indirectly caused by or associated with the owner committing or attempting to commit a criminal offence while sane or insane.

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

We do not consider the insured person to be disabled unless:
· they are under the active, continuous and medically appropriate care of a physician, or other health care practitioner acceptable to us, and
· they are following the treatment prescribed and any other recommendations made by a physician or health care practitioner.
Making a claim for the Disability waiver benefit
While this benefit is in effect, you may submit a claim if the insured person’s disability began before the policy anniversary nearest their 60th birthday.

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

Before we approve the claim, the insured person’s date of birth must be verified.

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

We’ll consider a late claim exception if we receive proof of disability no later than 1 year following the end date of this benefit. If we receive proof of the disability more than 1 year after it starts and the insured person qualifies for this benefit, we consider the disability to have started 1 year before we received the proof, regardless of when the disability actually started.

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

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

When we waive premiums
You must continue to pay your premiums until we notify you that we’ve waived them. At that time, we waive the premiums from the month the insured person’s disability started.

If any premium is paid and later waived, we credit the same amount to your withdrawable premium fund.

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

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

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

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

We may also require the insured person to authorize us to gather and use information from other insurers or government agencies.
Continuation of a previous disability claim
You may apply to have premiums waived without having to wait another 6 months if there is a
continuation of the previous disability. We consider the disability to be a continuation of the previous
one if:
· premiums had been waived
· the disabled insured person recovers from their disability and then becomes disabled again from the
  same cause within 6 months from the date we stopped waiving premiums, and
· the insured person is disabled as described under the heading, Qualifying for this benefit.

We waive the premiums from the date the disability started again.

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

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

We will put your policy back into effect if it ended:
· while the insured person was disabled and the disability continued for more than 6 consecutive
  months, and
· before the end date of this benefit.

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

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

When this benefit ends
This benefit automatically ends on the earliest of:
· the date the insured person dies
· the date this benefit ends, shown under the heading, Policy particulars, or
· the date this policy ends.
E12026A  (optional benefit)

Return of premium on cancellation or expiry benefit - 15 years

We will pay either the Returnable premium amount or a Critical illness insurance benefit, but not both.

When we make a payment
If you cancel this policy
We will pay you the Returnable premium amount if you cancel this policy after it has been in effect for at least 15 completed policy years. To cancel this policy, refer to Your right to cancel this policy.

If this policy expires
We will pay the Returnable premium amount to you if this policy expires on the policy end date shown under the heading, Policy particulars.

Returnable premium amount for this benefit
The Returnable premium amount is the total of:
· all premiums 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 policy end date.

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 15th policy anniversary
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 15th policy anniversary - 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.

E12027A  (optional benefit)

Return of premium on cancellation or expiry benefit - age 65

We will pay either the Returnable premium amount or a Critical illness insurance benefit, but not both.

When we make a 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 policy anniversary nearest the 65th birthday of the insured person. To cancel this policy, refer to Your right to cancel this policy.

If this policy expires
We will pay the Returnable premium amount to you if this policy expires on the policy end date shown under the heading, Policy particulars.
Returnable premium amount for this benefit
The Returnable premium amount is the total of:
· all premiums 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 65th 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 65th 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.

E12036A (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 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.

If the Critical illness insurance benefit amount is decreased
If you decreased the Critical illness insurance benefit amount, the Returnable premium amount on death is reduced by any Returnable premium amount we transferred to the withdrawable premium fund at the time of the decrease.

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.

**E12042A-ANB  (optional benefit)**

**Long term care conversion option**

You may convert some or all of the Critical illness insurance benefit from this policy to a Long term care insurance policy on the insured person, without giving us new evidence of insurability.

Your application must be in a form acceptable to us and satisfy our administrative rules.

**Converting only a portion of the Critical illness insurance benefit to Long term care insurance**

If only a portion of the Critical illness insurance benefit is converted and this policy remains in effect, the Critical illness insurance benefit is reduced by the amount converted to Long term care insurance. Each policy must have at least the minimum amount of insurance, determined by our rules at the time of conversion. If your application for conversion is approved, the Critical illness insurance converted from this policy ends on the date the new policy takes effect.

**Converting the entire Critical illness insurance benefit to Long term care insurance**

If we approve your application to convert all of the Critical illness insurance benefit from this policy to Long term care insurance, this policy ends on the date the new policy takes effect.

**Amount available to convert is limited by other coverage on the insured person**

On the date you apply to convert, the amount that’s available to convert from this policy is limited by all Long term care conversion options on Critical illness insurance policies we issued on the insured person, that have been exercised.

The amount that’s available to convert will never be more than $250,000. This amount is the lesser of:

- the Critical illness insurance benefit amount in effect for this policy, and
- $250,000 minus any Critical illness insurance benefit amount we issued for the insured person that has already been converted to Long term care insurance.

If a Long term care conversion option has already been exercised on other Critical illness insurance policies, we will tell you the amount eligible to convert, if any.

**When you may apply**

You may only apply to convert on or after the policy anniversary nearest the insured person’s 60th birthday, and no later than the policy anniversary nearest the insured person’s 65th birthday.

The last date to convert this option is shown under the heading, *Policy particulars*.

**If a claim was submitted for a Critical illness insurance benefit**

If a claim was submitted for a Critical illness insurance benefit and we’re assessing that claim, you must wait until after we have made our decision to apply to convert to Long term care insurance.

For a Group 1 Covered critical illness:

- if we approve the claim, this policy ends and the option to convert also ends.
- if we don’t approve the claim, and the last date to convert has passed while we assessed the claim, we will extend the time you may apply for another 30 days, beginning on the date we deny the claim.
For a Group 2 Covered critical illness:
- you may apply to convert after we have made our decision. If the last date to convert has passed while we assessed the claim, we will extend the time you may apply for another 30 days, beginning on the date we approve or deny the claim.

**If the insured person is disabled**
You may convert Critical illness insurance from this policy to a Long term care insurance policy while the insured person is disabled.

The new Long term care insurance policy does not include a Disability waiver benefit. This means if this policy includes a *Disability waiver benefit* and we are waiving premiums on the date you apply to convert, we will not waive premiums on the new policy.

We only pay benefits under the new Long term care insurance policy if the insured person qualifies according to the terms of that policy.

**The new Long term care insurance policy**
We determine the type of Long term care insurance policy you may apply for and the terms and conditions of that policy. The new policy we offer to you will be determined by:
- the information about the insured person in the application for this policy, and
- the age of the insured person at the time of conversion.

A Long term care insurance policy with an unlimited benefit period will be available for conversions. The weekly benefit amount for the new policy is calculated by dividing the Critical illness insurance benefit amount that we've approved for conversion by 200.

*Additional benefits included in the new policy*
Any additional benefits in this policy may only be included in the new policy if:
- you request that benefit when you apply for the new policy
- we offer that benefit on the new policy at the time you apply to convert, and
- that benefit is available when exercising a conversion.

If this policy includes a Return of premium on death benefit at the time of conversion, and the new policy includes a similar benefit we will transfer to the new policy:
- any Returnable premium amount on death for this policy
- minus any Returnable premium amount for cancellation transferred to a withdrawable premium fund.

**Returnable premium amount on cancellation at the time of conversion**
If this policy includes a Return of premium on cancellation benefit at the time this policy is converted and the benefit has been in effect long enough for you to be eligible to receive that Returnable premium amount we will transfer:
- that Returnable premium amount to the withdrawable premium fund in the new policy if this policy ends, or
- a portion of that Returnable premium amount to the withdrawable premium fund in the new policy if this policy remains in effect. The portion we transfer is the premiums paid for the difference between the Critical illness insurance benefit amount on the date you apply to convert and the remaining Critical illness insurance benefit amount.

If at the time of conversion this policy has not been in effect long enough for you to receive a Returnable premium amount on cancellation, you will lose the premiums paid for the difference between the Critical illness insurance benefit amount on the date immediately before the conversion and the remaining Critical illness insurance benefit amount.
Paying for the new policy
The premiums for the new policy will be based on:
- the same evidence of insurability we used to determine the premiums for this policy
- the premium rates we charge for the new insurance at the time you apply for the new policy, and
- the age of the insured person when you apply to convert.

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

When the Long term care conversion option ends
This option automatically ends on the earliest of:
- the date the insured person dies
- the last date to convert this option, shown under the heading Policy particulars
- the date we approve an application to convert to Long term care insurance, or
- the date this policy ends.

E12043A
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.

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.

Your right to convert this policy to another Critical illness insurance policy

This policy has premiums that increase, as shown in the premium schedule. You may convert this policy to a critical illness insurance policy with level premiums, on the life of the insured person, without giving us new evidence of insurability.

The last day you may apply to convert this policy is the policy anniversary nearest the 65th birthday of the insured person. That date is shown under the heading, Policy particulars.

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

The new Critical illness insurance policy

We determine the type of policy you may convert to and the terms and conditions of that policy. The new policy we offer to you will:
· be determined by the information about the insured person in the application for this policy
· depend on our rules about the age of the insured person and the amount of insurance for that age
· exclude any Group 2 Covered critical illness for which we have made a payment
· have a Critical illness insurance benefit that is not greater than the benefit amount under this policy on the date the new application is signed.

If this policy includes an additional benefit on the insured person, that benefit may only be included in the new policy if:
· you request that benefit when you apply for the new policy, and
· we offer that benefit on the new policy at the time you apply to convert.

If this policy includes any Return of premium benefit, and a similar benefit is included in the new policy the Returnable premium amount for that benefit is transferred to the new policy.
If the new policy includes a Return of premium on cancellation benefit the number of years this policy has been in effect will not be transferred to the new policy to determine qualification for a Return of premium benefit.

Any amount in the withdrawable premium fund of this policy will be transferred to the new policy.

**Paying for the new policy**

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

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

**If the insured person is disabled**

If this policy includes a *Disability waiver benefit* on the insured person, you cannot convert this policy while the insured person is disabled. However, if we are waiving your premiums and the insured person remains disabled at the final conversion date for this policy, you may convert at that time. The premiums on the new policy will continue to be waived while the insured person is disabled.

If you do not convert this policy within 30 days of the final conversion date, your right to convert will no longer be available.

**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.
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 earlier of:

· the policy end date shown under the heading, Policy particulars, and
· the date the insured person dies.

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

Other information about your policy

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

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

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

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

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

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

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

Insurance terms

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

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.

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.

   b) Disability waiver provision
   If a Disability waiver provision is included, any claim for waiver of premium must be made in writing to our head office:
   · while the Insured person is alive
   · after the disability continues for more than 6 consecutive months, and
   · within one year of when the disability began.

   We may, from time to time, require proof that the Insured person is still disabled. If this proof is not submitted as requested, the disability will be considered to have terminated on the date of our request.

   Any initial or ongoing claim for benefits under the Disability waiver provision must be supported by written evidence from a physician or other health care practitioner acceptable to us, as to the cause, nature and expected duration of the disability.

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.*