Randstad Affiliation Plan

Critical Illness Insurance

Alberta

Sun Life Financial

Sun Life Assurance Company of Canada agrees to provide the benefits of this policy according to its terms and conditions.

Signed at Toronto, Ontario

Dean Connor
President and Chief Executive Officer
Sun Life Assurance Company of Canada

Dana Easthope
Vice-President, Associate General Counsel
and Corporate Secretary
Sun Life Assurance Company of Canada

If you have any questions or want information on any of our other products or services, please contact us at:

Sun Life Assurance Company of Canada

Client Solutions

225 King Street West 4th Floor

Toronto, ON M5V 3C5

1-800-669-7921

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.

Please read this policy carefully. It describes the benefits payable and exclusions and reductions of coverage. To help you understand insurance terms, refer to the explanations described later in this policy under the heading, *Insurance terms*.

This policy contains a provision removing or restricting the right of the insured (owner) to designate persons to whom or for whose benefit insurance money is to be payable.

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

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If you change your mind within 30 days

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

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

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

You are considered to have received your policy 5 days after it's mailed from our office.

Your decision to cancel your policy is your personal right. The cancellation is binding on you and any beneficiaries you've named, whether the beneficiaries are revocable or irrevocable.

All of our obligations and liabilities under this policy will end immediately when we receive your request to cancel it.

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

Sun Life Assurance Company of Canada
P.O. Box 2001 Stn Waterloo
Waterloo ON Canada N2J 0A3

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.

Covered critical illnesses

This policy covers only the critical illnesses described in this policy. Additional illnesses or procedures that are not specifically mentioned are not covered. To qualify for a Critical illness insurance benefit, all requirements for the Covered critical illness must be satisfied while this policy is in effect.

The diagnosis and treatment of any Covered critical illness must be made by a specialist physician who is licensed in Canada. A specialist physician is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the Covered critical illness for which a benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist physician, a condition may be diagnosed by another qualified medical practitioner as approved by us.

The diagnosis, treatment, tests or examinations performed to satisfy the Covered critical illness definition may not be done by a specialist physician or medical professional who is:

- 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.

Each Covered critical illness describes a survival period. The survival period does not include the number of days on life support*. The insured person must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain.

*Life support means the insured person is under the regular care of a licensed physician or specialist physician for nutritional, respiratory and / or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

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

Exclusion:
No benefit will be 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 physician. The insured person must survive for 30 days following the date of surgery.

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 deficit(s).

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

Exclusions:
No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of the policy.

Moratorium Period Exclusion:
No benefit will be payable for benign brain tumour and the insured person's coverage for benign brain tumour will terminate, if within the first 90 days following the later of:

- the date the application for this policy was signed;
- the policy date, or ,
- the most recent date this policy was put back in effect (reinstatement),

the insured person has any of the following:

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

While the insured person's insurance for benign brain tumour terminates, insurance for all other covered conditions remains in force.

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

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

Exclusions:
No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

No benefit will be payable under this condition for the following non-life threatening cancers:

- carcinoma in situ; or
- 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); or
- any non-melanoma skin cancer that has not become metastasized; or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion:
No benefit will be payable for cancer and the insured person's coverage for cancer will terminate if, within 90 days following the later of:

- the date the application for this policy was signed;
- the policy effective date; or,
- the most recent date this policy was put back into effect (reinstatement),

the insured person has any of the following:

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

While the insured person's insurance for cancer terminates, insurance for all other covered conditions remains in force.

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

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

Exclusion:
No benefit will be payable under this condition for:

- a medically induced coma; or
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

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 physician. 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 physician. 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; or
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- 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 physician. 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.

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

Loss of independent existence

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

Exclusion:
No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

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 physician. The insured person must survive for 180 days following the date of diagnosis.

Exclusion:
No benefit will be 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 enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist physician. 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 physician. The insured person must survive for 30 days following the date of their transplant.

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; or
- 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 physician. The insured person must survive for 30 days following the date of diagnosis.

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 physician. 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 physician. The insured person must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Exclusion:
No benefit will be 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 physician. 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, and,

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

Exclusion:
No benefit will be payable under this condition for:

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

Critical illness insurance benefit

We make a payment if the insured person has a Covered critical illness as defined earlier in this policy. The payment is made to the critical illness benefit payee.

If the insured person qualifies for a Covered critical illness we make a one-time payment. The amount we pay is:

- the Critical illness insurance benefit amount at the time the benefit is payable, as shown on the *Policy particulars* page
- **minus** any unpaid premiums plus interest at the time the benefit is payable.

The policy ends on the date we make the payment.

Your responsibility to report cancer or benign brain tumour

You must report to us, if within the first 90 days following the later of:

- the date the application for this policy was signed
- the policy date, or
- the most recent date this policy was put back into effect (reinstatement),

the insured person has:

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

The information described above must be reported to us within 6 months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for:

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

To report the information, contact us at the toll free phone number shown at the beginning of this policy for the appropriate form. The report must be in writing.

When coverage for cancer or benign brain tumour ends

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

- the date the application for this policy was signed
- the policy date, or
- the most recent date this policy was put back into effect (reinstatement),

the insured person has:

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

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

When we will not make a payment under the Critical illness insurance benefit (exclusions and reductions of coverage)

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.

Making a claim for a critical illness insurance benefit

To make a claim for a Critical illness insurance benefit, 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 must complete the form and give us the information we need to assess the claim.

The form and information must be sent to this address:

Sun Life Assurance Company of Canada
6th Floor, 606E65
Client Solutions Claims
1155 Metcalfe Street
Montreal, QC H3B 2V9

When you may make a claim

You may make a claim for a Critical illness insurance benefit if the insured person has a Covered critical illness as defined earlier in this policy, while this policy is in effect.

A claim must be sent to us while this policy is in effect and within 1 year of the date the insured person has a Covered critical illness.

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

The person making a claim for a Critical illness insurance benefit must give us any 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 conditions and the cause of the illness, and
- the complete medical records of the insured person.

The written diagnosis must:

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

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, neurologists or others. We pay for the cost of these examinations.

The physicians, specialist physicians or health care practitioners who sign the diagnosis or 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.

Before we make a payment, the age of the insured person must be verified. If the age given on the application is incorrect, we'll adjust the amount we pay to reflect the insured person's correct age.

Critical illness developed or diagnosed while outside of Canada.
You may make a claim for a Critical illness insurance benefit if a Covered critical illness develops or is diagnosed while outside of Canada. You will be required to provide us with all of the information described above. 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 person making the claim is responsible for any cost associated with providing the translation.

The translator 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.

Based on the medical records we require, we must be satisfied that the same diagnosis would have been made if the illness developed in Canada.

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 on the *Policy particulars* page. You must pay all premiums monthly by pre-authorized debit or credit card payment by the due date. Payment must be made to Sun Life Assurance Company of Canada.

The premium is determined according to the gender, age and smoking habits of the insured person. If a change in age puts the insured person into another rate category, premiums are adjusted at the next policy anniversary. We may change your premium each year from the date your policy began, effective on the policy anniversary. We will give you 30 days written notice before the change is made.

If premiums are not received (lapse)

Your policy will end if we do not receive the required premium within 31 days after it is due.

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

To prevent your policy from ending, we must receive a minimum 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 (reinstatement)

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

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

- apply within 2 years of the policy ending
- give us new evidence of insurability that we consider satisfactory, and
- make a payment equal to the reinstatement charge set by us.

If we don't approve your application, we'll refund the amount you paid when you applied to put your policy back into effect. If we approve your application, we will reinstate the policy on the date we approve it.

Applying for changes to your policy

You may apply to increase or decrease the critical illness benefit, depending on our rules about the age of the insured person and the amount of insurance.

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

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

Your right to cancel this policy

You may cancel your policy at any time. Your policy will end on the date we receive your request or any later date you indicate in your request. All of our obligations and liabilities under this policy end on that date. The cancellation is binding on you and any beneficiaries you've named, whether the beneficiaries are revocable or irrevocable.

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

Sun Life Assurance Company of Canada
P.O. Box 2001 Stn Waterloo
Waterloo ON Canada N2J 0A3

If you cancel your policy within the first 30 days of receiving it from us, we will treat this as a rescission. This is described earlier in your policy under the heading, *If you change your mind within 30 days*.

When your policy ends

If your policy hasn't ended for any of the reasons already described, it will automatically end on the earlier of the date the insured person dies, or the policy end date shown on the *Policy particulars* page.

There is no benefit payable under this policy after the date your policy ends.

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 (which includes the *Policy particulars* page).

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 limit 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
PO Box 2001 Stn Waterloo
Waterloo ON Canada N2J 0A3

Insurance terms

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

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 life insurance.

Policy anniversary

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

Policy date

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

Premium

The amount paid to purchase or maintain an insurance policy.

Statutory conditions

1. The contract

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.

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 void 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

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 physician licensed and practising in Canada 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 furnish forms for proof of claim

We shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the 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*.