MANULIFE FINANCIAL

THE CRITICAL ILLNESS INSURANCE PLAN

INFORMATION ON YOUR INSURANCE POLICY

PLEASE READ CAREFULLY

The Manufacturers Life Insurance Company (referred to as “we” and “us”) will pay the Critical Illness Benefit to the Policy Owner (referred to as “you”), if we receive proof that you were diagnosed with a covered condition described in this Policy, for the first time in your life and while this Policy is in force. The Covered Condition must be diagnosed by a doctor, and we must receive proof, satisfactory to us, of the diagnosis within the time limits set out in the Policy. The Policy also describes the specific diagnostic methods, test results, symptoms, characteristics and other criteria that must be met for an illness to be considered a Covered Condition.

Benefits under this Policy are paid in a lump sum. For all Covered Conditions, you must survive the diagnosis for at least 30 days in order to qualify for the benefit. In the case of some Covered Conditions, benefits paid to you from another plan for your Covered Condition will not reduce the benefit amount under this Policy.

You may continue this policy until age 70 by paying premiums; however, this Policy will terminate on the date the Critical Illness Benefit becomes payable. Your premiums increase at 5-year intervals after the first premium due date but before the Coverage expiry date.

We will not pay the Critical Illness Benefit (1) if you are diagnosed with any type of cancer, whether it is a Covered Condition or not, at any time before, or within 90 days after, the date we approve your application for: this Policy; or any reinstatement of this Policy (the “qualifying period”); or (2) if a diagnosis of cancer, whether it is a Covered Condition or not, is made as the result of symptoms, signs and/or medical consultation or tests present at any time before, or within 90 days after, the date we approve your application for: this Policy; or any reinstatement of this Policy; or (3) for a subsequent diagnosis of cancer or any other Covered Condition, if such Covered Condition directly resulted from any cancer (covered or excluded under this Policy) or its treatment if benefits would not have been payable under this Policy for such cancer because of exclusion 1) or 2).

Any diagnosis of cancer (covered or excluded under this Policy) or symptoms, signs and/or medical consultation or tests leading to a diagnosis of cancer (covered or excluded under this Policy) occurring within the qualifying period must be reported to us in writing within six months after the diagnosis. If you fail to disclose this information, we have the right to deny any claim under this Policy.

In order to keep this Policy in force, you must pay each premium on or before the premium due date. Premium due dates are described in the Policy. We allow a 30-day grace period for paying each premium after the first.

This Policy does not pay the expenses relating to your Covered Condition. Benefits under this policy are paid only after you have met all the conditions set out in this Policy and we have received, within the time limits set out in the Policy, proof of claim satisfactory to us. It is your responsibility to pay for expenses relating to your Covered Condition.

This Policy provides coverage 24 hours a day.

We will not pay benefits under this policy for a pre-existing condition, whether or not you disclose it to us.

These statements are a brief summary of some of the important provisions of your Policy; however, they are not part of the Policy and are not terms of the insurance contract.

PLEASE REFER TO YOUR POLICY FOR DETAILED PROVISIONS.

You have the right to cancel the Policy and receive a full refund of premiums by notifying us in writing at the following address below, provided the notification is postmarked not later than 30 days after the date of delivery to you of the Policy; however, in the event of cancellation of a reinstated policy, the refund of premiums shall be only the amount of premiums tendered to effect the reinstatement.

The Manufacturers Life Insurance Company
PO Box 670, Stn Waterloo Waterloo,
Ontario N2J 4B8

CRITICAL ILLNESS INSURANCE

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PLEASE NOTE: Some of the terms used in this Policy have been assigned a specific meaning and it is very important that this Policy be read and understood with these specific meanings in mind. A list of these terms is found in the **Definitions** section in **Part H** of the Policy at the back and it is highly recommended that you familiarize yourself with these terms and their associated meanings whenever consulting this Policy.

IMPORTANT: This Policy contains exclusions, limitations, conditions, maximums and definitions. Please read it carefully.

CRITICAL ILLNESS INSURANCE

PART A: PAYMENT OF BENEFITS

1. The Coverage under this Policy provides that the Amount Insured shall be paid to the insured upon the Diagnosis of a Covered Condition while this Policy is in effect as required under the terms of the Policy, provided that the Insured Person Survive s the requisite Waiting Period and meets all other terms or conditions applicable to that Benefit.

2. The Coverage applies only to those illnesses, conditions or procedures defined in the Policy as covered conditions. Any illness, condition or procedure not specifically identified as a covered condition is not covered under this Policy and no Benefit shall be payable. Each Covered Condition has specific requirements which must be satisfied in order for a Benefit to be payable. All Benefits are also subject to the limitations, exclusions and reductions of Coverage which may appear either in the description of a Benefit or in a separate Part dealing with limitations and exclusions of coverage.

PART B: COVERED CONDITIONS

The Amount Insured under this Policy shall be paid to the Insured Person upon the Diagnosis of the first to occur of one of the following covered conditions, provided that the Insured Person Survives the requisite Waiting Period and meets all other terms or conditions applicable to that covered condition:

1. Cancer (Life-Threatening)

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.
Exclusion: No Benefit will be payable 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 of level V invasion), or
- Any non-melanoma skin cancer that has not metastasized, or
- Stage A (T1a and T1b) prostate cancer

Moratorium Period Exclusion
No Benefit will be payable if, within the first 90 days following the later of the Effective Date of the Policy, or the Effective Date of last reinstatement of the Policy, the Insured Person has any of the following:

- signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
- the Diagnosis of cancer (covered or excluded under the Policy).

The medical information described above must be reported to the Insurer within six months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any Claim for cancer or, any Covered Condition caused by any cancer or its Treatment.

The Insured Person must Survive for a period of 30 days following the date the condition is diagnosed in order for the Benefit to be paid.

2. Heart Attack

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; 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.

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

- 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.

The Insured Person must Survive for a period of 30 days following the date the condition is diagnosed in order for the Benefit to be paid.

3. Stroke (Cerebrovascular Accident)

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.

Exclusion: No Benefit will be 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.

The Insured Person must Survive until all of the criteria outlined above have been met in order for the Benefit to be paid.

4. Coronary Artery Bypass Surgery

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 a period of 30 days following the date of the Surgery in order for the Benefit to be paid.

5. Aortic Surgery

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 a period of 30 days following the date of the Surgery in order for the Benefit to be paid.

PART C: ADDITIONAL BENEFITS

The following is a description of additional Benefits available under the Policy. **Please note that the Return of Premium Benefit may not be applicable to all coverage. Reference must be made to the Policy Summary for details of Coverage selected.**

1. Assistance Services Benefit

The Assistance Services Benefit is a comprehensive integrated health information, resource and second opinion service made available to the Insured Person and the Insured Person's eligible family members.

The Assistance Services Benefit provides immediate access to support services for the Insured Person and the Insured Person's eligible family members and is not dependent on making a critical illness Claim. With the Assistance Services Benefit, the Insured Person or Insured Person's eligible family members will be able to receive information, medical coordination services, a medical second opinion service and Treatment options, and resources on how to navigate the Canadian health care system.

2. Return of Premium Benefit (Optional)

In the event that this Policy is still in effect on the Policy Anniversary Date following the date the insured person attains age 75 (the date on which this Policy automatically expires) and the Insured Person has not made a Claim under the Policy, the Insurer will refund an amount equal to the lesser of:

a) 100% of all premiums paid up to that date; or

b) the Amount Insured,

as long as:

c) the Insured Person was between the ages of 18 and 55 at the time the Policy was purchased;

d) the Return of Premium Benefit is still in force on the date the Policy expires; and

e) the Insured Person is not then satisfying a Waiting Period for a covered condition.

If the Insured Person is in the Waiting Period for a Covered Condition on the date the Policy expires, as noted above, this Benefit will remain in effect until the Waiting Period for that Covered Condition

expires. If the Insured Person Survives the Waiting Period and the Benefit for the Covered Condition is payable, the Return of Premium Benefit will not be payable. If the Insured Person Survives the Waiting Period, but the Benefit for the Covered Condition is not payable for any reason, the Return of Premium Benefit will be paid. If the Insured Person does not Survive the Waiting Period, the Return of Premium Benefit will be paid to the Insured Person's estate.

PART D: LIMITATIONS AND EXCLUSIONS

1. In addition to any other exclusions or limitations set out in this Policy, no Benefits will be payable under the Policy if:
   a) the Insured Person suffers a Covered Condition at any time during the 24-month period following the Effective Date of the Policy or the date of the last reinstatement which results, directly or indirectly from, or is in any way associated with, a *pre-existing condition*. A *Pre-Existing Condition* is an illness or condition for which, during the 24-month period *prior to* the Effective Date of the Policy or the date of the last reinstatement, the Insured Person was diagnosed, treated, hospitalized or attended to by a Physician or was advised to seek Treatment or consult a Physician; was prescribed or took medication; showed indications, signs or symptoms or underwent tests or investigations;
   b) the Insured Person, while sane or insane, suffers a Covered Condition which results, directly or indirectly from, or is in any way associated with:
      i) intentional self-inflicted injuries;
      ii) intentional use or intake by the Insured Person of:
         a) any prescription drug or narcotic other than as instructed by a Physician;
         b) any drug or narcotic legally available for sale in Canada without a prescription, other than as recommended by the manufacturer;
         c) any drug or narcotic not legally available in Canada; or
         d) any poisonous substance or intoxicant, including alcohol;
      iii) the commission or attempted commission of a criminal offence by the Insured Person; or
      iv) the operation of a motor vehicle by the Insured Person while the concentration of alcohol in 100 milliliters of his or her blood exceeds 80 milligrams; or
   c) the Insured Person suffers a Covered Condition which is diagnosed in a jurisdiction other than Canada or the United States, unless the Insured Person makes all requested medical records available to the Insurer and the Insurer is satisfied that:
      i) the same Diagnosis would have been made if the Covered Condition had occurred in Canada or the United States;
      ii) the Physician making the Diagnosis was licensed to practice in the jurisdiction in which the Diagnosis was made and had medical credentials equal to those required in Canada or the United States;
      iii) the Diagnosis is fully supported by all appropriate diagnostic tests and other investigation which would normally be undertaken in Canada or the United States (including those required by the Policy); and
      iv) where applicable, the same type of Surgery or procedure as required under the Policy in order for the Benefit to be payable would have been advised if the Diagnosis had been made in Canada or the United States.

   Where the Diagnosis is made in a jurisdiction other than Canada or the United States, the Insurer shall also have the right to request that an Insured Person undergo an independent medical examination by a Physician appointed by the Insurer.

PART E: GENERAL PROVISIONS

Eligibility

In order to be eligible for coverage, the Insured Person must, at time of application for coverage, be a Resident of Canada and be at least 18 years of age but not more than:

55 years of age to purchase an Amount Insured of $75,000.00;

60 years of age to purchase an Amount Insured of $50,000.00; or

65 years of age to purchase an Amount Insured of $25,000.00.

Effective Date

This Policy shall become effective on the date noted on the Policy Summary.

Non-Transferable

This Policy is not transferable or assignable to any other person, including a family member.

Grace Period

For payment of any premium due, a Grace Period of 31 days shall be allowed after the due date. During that time, the Policy will remain in force. If a premium due is not paid by the end of the Grace Period, the Policy will then lapse, all Coverage under it will automatically be cancelled and the liability of the Insurer under the Policy will end. Any partial payments made on the Policy between the start of the Grace Period and the Day all Coverage is cancelled will be refunded, subject to any other provision in this Policy to the contrary. In the event that any Benefit becomes payable during the Grace Period, the Benefit will be paid, but any overdue premiums will be deducted from the amount payable.

Insufficient Funds

In the event that a premium payment, or any other payment which may be owing to the Insurer for any reason, is returned as a result of insufficient funds, a twenty-five (25) dollar administration charge may be levied.

Reinstatement

If this Policy has lapsed, an application to reinstate it can be made during the lifetime of the Insured Person and within one (1) year after the first unpaid premium was due. To reinstate this Policy, proof of insurability satisfactory to the Insurer shall be required, together with the payment of all overdue premiums, and interest at an appropriate rate then set by the Insurer. The reinstated Policy will come into force on the first Day of the month following the date that the application for reinstatement is approved by the Insurer and the preceding terms of this provision have been satisfied.

Change of Premiums

Upon each five (5) year renewal, the Insurer reserves the right to change the premiums.

Release of Information

As a condition precedent to receiving Benefits under this Policy, the Insured Person agrees to authorize the release of any information reasonably necessary for the Insurer to confirm entitlement to Benefits.

Benefit Payments

Benefit payments will be made by cheque to the Insured Person, except as otherwise provided herein

Requesting A Change to Non-Smoker Premiums

An Insured Person who is paying smoker premiums may apply to change to Non-Smoker premiums once such Insured Person meets the definition of a Non-Smoker under this Policy.
That is, such Insured Person must not have used any form of tobacco, nicotine substitutes, tobacco cessation products, or marijuana, within the past twelve (12) months. An Insured Person wishing to change to Non-Smoker premiums must contact the Insurer by telephone, e-mail or mail. The Insurer will advise such Insured Person what information or documents will be required in order to apply for this change. Once such change is approved, all future premiums will be payable on a Non-Smoker basis. The change will take effect on the date the next premium payment is due following the date that the approval of the change is communicated to the Insured Person by the Insurer.

Misstatement of Age or Sex

The Insurer may request satisfactory proof of age and/or sex of the Insured Person. If the date of birth or the sex of the Insured Person was misstated and affects:

a) the date on which Coverage becomes effective, reduces or terminates,

b) the amount or type of coverage, or

c) any rights or Benefits provided under this Policy.

The correct date of birth and/or sex shall govern and premium rates shall be adjusted accordingly, if necessary.

Misrepresentation and Incontestability

If the Insured Person or anyone on the Insured Person 's behalf answered health-related questions, made any declaration as to health status and/or the absence of specified health-related conditions or submitted medical information as part of the application process for Coverage under this Policy, and there was a failure to

disclose, or a misrepresentation of a fact in respect of the application or declaration, Coverage under this Policy shall be voidable, or payment in respect of a Claim denied. In such a case, the liability of the Insurer may be limited to the return of eligible premiums, provided that the Insurer shall have the right to set off against the amount it is required to return, the amount of any Claims it has already paid, as well as any costs which it may have incurred in investigating the misrepresentation and/or any Claim. Where the amount to be returned on account of eligible premiums is not sufficient to set off such costs, both the Insured Person and the Policy Owner (if different from the Insured Person) shall be jointly and severally liable to indemnify the Insurer in this regard and such obligation shall Survive any termination of this Policy. After Coverage has been in force for a period of two years, following the Effective Date or the last reinstatement date, Coverage shall not, in the absence of fraud, be voidable.

No Liability

The Insurer will not be responsible for any act or omission of anyone providing care, services, or supplies to the Insured Person. The liability of the Insurer will be limited solely to the payment of Benefits in accordance with the terms and conditions of this Policy

Notices by Insured Person

Notices to be given by the Insured Person pursuant to this Policy must be sent by prepaid post to:

Manulife Financial
Affinity Markets
P.O. Box 4213, Station A
Toronto, Ontario
M5W 5M3.

Notices by Insurer

Notices to be given by the Insurer pursuant to this Policy will be sent to the Insured Person 's address as it appears on the application for this Policy, or to the last known address as it appears on the Insurer's records.

Provincial Variations

If necessary, the provisions described in this contract will be adjusted to meet the minimum requirements of law within your province or territory.

Limitation Period

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 other applicable legislation.

Limitations of Actions

An action or proceeding against the insurer for the recovery of a claim under this contract shall not be commenced more than one year, or any greater period specified by applicable provincial law, after the date the insurance money became payable or would have become payable if it had been a valid claim.

PART F: TERMINATION

This Policy and all Coverage under it shall terminate automatically on the earliest of the following dates:

a) the Policy Anniversary Date following the Insured Person's 75th birthday;

b) 31 days after the date a premium payment is due under the Policy (the end of the Grace Period), if the required premium remains unpaid;

c) the date that the next premium payment is due following the date the Insurer receives written notification from the Insured Person requesting termination of coverage;

d) the date a Benefit for a Covered Condition becomes payable under the Policy, provided that termination shall not occur until the Insured Person has received payment of the Benefit in full; or

e) the date of death of the Insured Person.

PART G: STATUTORY CONDITIONS

The Contract Between the Parties

The application (or record of the application where it is made over the telephone), this Policy, any document attached to this Policy when issued, and any amendment to the Policy after it is issued, constitute the entire contract between the parties and no other verbal or written information apart from that provided herein shall have any effect.

No agent has authority to change the Policy or waive any of its provisions.

Waiver

The Insurer shall be deemed not to have waived any condition of this Policy, either in whole or in part, unless the waiver is clearly expressed in writing signed by the Insurer.

Material Facts

No statement made by the Insured Person (or any person on the Insured Person's behalf) at the time of application for this Policy shall be used in defence of a Claim or to void this Policy unless it is contained in the application (or record of the application where it is made over the telephone) or in any other written or recorded statements or answers furnished by or on behalf of the Insured Person as part of the application process.

Notice and Proof of Claim

The Insured Person, or a beneficiary entitled to make a Claim, or the agent of any of them, shall:

a) give written notice of Claim to the Insurer,
   i) by delivery thereof to the Insurer, or by sending it by registered mail to the head office or chief agency of the Insurer in the province; or
   ii) by delivery thereof to an authorized agent of the Insurer in the province, not later than thirty (30) days from the date a Claim arises under the Policy;

b) within ninety (90) days from the date a Claim arises under the Policy, furnish to the Insurer such proof as is reasonably possible under the circumstances of the right of the claimant to receive payment, his or her age, and the age of any beneficiary, if relevant; and

c) if so required by the Insurer, furnish a satisfactory certificate as to the cause or nature of the illness, condition or procedure for which Claim may be made under the Policy.

Failure to Give Notice or Proof

Failure to give notice of Claim or furnish proof of Claim within the time prescribed by this statutory condition does not invalidate a Claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one (1) year from the date a Claim arises under the Policy, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of Claim within fifteen (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, condition or procedure giving rise to the Claim.

Rights of Examination

As a condition precedent to recovery of Benefits under this Policy:

a) the claimant shall afford to the Insurer an opportunity to examine the Insured Person when and so often as it reasonably requires while the Claim hereunder is pending; and

b) in the case of death of the Insured Person, the Insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

When Moneys Payable

All moneys payable under this Policy shall be paid by the Insurer within sixty (60) days after it has received satisfactory proof of Claim and all required conditions under the Policy have been satisfied.

Beneficiary Designation

There is no right to name a beneficiary under this Policy.

THE STATUTORY CONDITIONS ABOVE TAKE PRECEDENCE OVER ALL OTHER PROVISIONS AND CONDITIONS IN THIS POLICY.

PART H: DEFINITIONS

Where used in this Policy, the term:

Amount Insured means the amount of insurance Coverage in force under the Policy, as indicated on the Policy Summary.

Benefit means the amount payable when the Insured Person suffers a Covered Condition and satisfies all applicable terms and conditions or, in respect of Part C, the services available under C.1. or the refund of premiums available under C. 2.

Claim means a request by the Insured Person for the payment or provision of a Benefit by the Insurer.

Coverage means the Benefits available under the Policy and the Amount Insured in respect of those Benefits, as selected by the Insured Person.

Covered Condition means an illness, condition, or procedure which is specifically defined in Part B of this Policy and which is not specifically excluded in Part B.

Day means a calendar day, or any part thereof. Where computing any period of time under this Policy, both the first and last Day shall each be counted as a day, whether they are full days or not.

Diagnosis means a written Diagnosis of an illness or condition provided by a Physician.

Effective Date means the Day on which Coverage under this Policy takes effect, as indicated on the Policy Summary.

Grace Period means the period of time following the due date of a premium payment during which the payment can still be made to keep Coverage in force.

Insured Person means a person who is covered under this Policy, so long as premiums continue to be paid.

Insurer means The Manufacturers Life Insurance Company (Manulife Financial).

Manulife Financial means The Manufacturers Life Insurance Company.

Non-smoker means a person who has not used any tobacco, nicotine substitutes, tobacco cessation products, or marijuana within the last twelve (12) months.

Physician means a person duly qualified and legally licensed to practice medicine in Canada or the United States. The Physician must not be a relative or business associate of the Insured Person, or any claimant in respect of the Insured Person. Where used in the context of a covered condition, the Physician must be qualified in the field of medicine relating to the applicable covered condition.

Policy means this insurance Policy and all insurance Coverage provided under it, and any subsequent amendments thereto.

Policy Anniversary Date means the date that is twelve (12) months after the Effective Date and each anniversary of that date thereafter.

Policy Owner means the person who applied for the Coverage and and/or the person who holds the rights under the Policy..

Pre-existing Condition means an illness or condition for which, during the 24-month period prior to the Effective Date or the date of the last reinstatement, the Insured Person was diagnosed, treated, hospitalized or attended to by a Physician or was advised to seek Treatment or consult a Physician; was prescribed or took medication; showed indications, signs or symptoms or underwent tests or investigations.

Resident of Canada means a person who maintains a permanent place of residence in Canada and who has been in the country for a period of not less than 183 days during the past twelve (12) months.

Specialist means a person duly qualified and legally licensed to practice medicine in Canada or the United States, and who has been trained in the specific area of medicine relevant to the covered critical illness condition for which Benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be diagnosed by a Physician.

Specialist includes, but is not limited to, cardiologist, neurologist, oncologist, and internist. The Specialist must not be a relative or business associate of the Insured Person, the Policy Owner or any claimant in respect of the Insured Person.

Surgery means the performance of a surgical procedure by a Physician, in Canada or the United States.

Survive(s) means in respect of the Insured Person, that the Insured Person is still living. Where the Insured Person must Survive a specified number of days in order to be eligible for payment of a Benefit, the Insured Person must be alive at the end of the required survival period and must not be on artificial life support. The Insured Person will no longer be considered to be living on the date the Insured Person experiences irreversible cessation of all functions of the entire brain (including brain stem) as determined by generally accepted medical criteria.

Treatment means any reasonable medical, therapeutic or diagnostic measures, prescribed by a Physician or health care professional in any form, including prescribed medication, reasonable investigative testing, hospitalization, Surgery or other prescribed or recommended medical care.

Waiting Period means the minimum number of days following the date a Diagnosis is made or Surgery is performed which the Insured Person must Survive before a Benefit will become payable.