Manulife

Sample Policy Contract

This sample policy contract is provided for your information only.
It is not a valid contract or an offer of insurance.

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THE CRITICAL ILLNESS INSURANCE PLAN

To make this policy easier to read, we have left out many of the usual cross-references and conditional statements. Therefore, this policy should be read as a whole, from beginning to end.

1. Words and phrases used in this policy

Age at the effective date is your attained age on the effective date.

Amount of insurance is the amount of basic coverage shown on page 1 of this policy. The amount of insurance must be a multiple of $25,000.

Applicant is the person who applied for this policy. The applicant is the owner of this policy.

Approval date is the date we approve:

a) your application for this policy; or
b) your application for reinstatement of this policy.

The approval date of your application for this policy is shown on the *Policy Summary*. If this policy is reinstated, we will send you written notice of the date your application for reinstatement is approved. The qualifying period runs from each approval date.

Attained age is the sum of:

a) your age at the first monthly premium due date; and
b) the number of complete years the coverage has been in effect from the first monthly premium due date to the most recent policy anniversary.

Contract means this policy document and other related documents as referenced in Section 5.

Coverage refers to the insurance provided under this policy.

Coverage expiry date is the date coverage ends.

Covered conditions are the medical conditions described in the Subsection *Critical Illness Benefit* in Section 3.

Critical illness benefit is the amount paid out under this policy after the first diagnosis of a covered condition.

Diagnosis is the certified written diagnosis of a covered condition by a physician. Where the physician is not licensed and practising in Canada,

a) your complete medical records must be made available to us upon request;
b) we must obtain the written opinion of a physician licensed and practising in Canada that
   i) the same diagnosis would have been made in Canada;
   ii) immediate treatment would have been indicated under Canadian standards;
   iii) the same treatment would have been advised if treatment had taken place in Canada;
c) you must undergo any medical examination we request; and
d) in the case of elective surgery relating to the diagnosis, such medical exam must take place before surgery occurs.

The date of the diagnosis shall be the date the diagnosis is first made by a physician as supported by your medical records.

Effective date means the date coverage begins. Refer to the Subsection *When insurance begins (the effective date)* in Section 2.

Evidence of insurability is any information that we require to decide if the person to be insured is insurable and, if so, on what terms. Evidence of insurability means the insurance application; and may include, but is not limited to, medical examination(s), physician's report(s) and blood or fluid tests. We can also request financial information.

In all cases we have the right to decline an application for insurance if the required evidence of insurability is not available or is not provided or if the person to be insured does not satisfy our underwriting requirements for insurance under this policy.

Grace period is the 30-day period following any premium due date while this policy is in force.

In force describes your coverage between the date when insurance begins and when insurance ends. Insurance begins on the effective date. To find out if this policy is in force, refer to Section 2 *When this policy is in force.*

Insured person is the person named on page 1 of this policy but only if he or she:

a) was resident in Canada and at least 18, but not yet 66 years of age on the policy effective date;
b) has applied for this insurance;
c) in the case of coverage where evidence of insurability was required, was approved by us for this insurance; and
d) has not yet reached an attained age of 70 years.

The person who meets the above qualifications is the person whom we have agreed to insure until this policy terminates. Refer to the Subsection *When insurance ends* in Section 2.

Issue date means the date on which this policy is mailed to you.

Non-smoker premiums and **smoker premiums** refer to the premiums for which you are approved based on your smoking status and overall health and our underwriting rules.

Office is The Manufacturers Life Insurance Company, 2 Queen Street East, Toronto, Ontario. If our address changes, we will send you written notification by mail.

Owner means the insured person. See the definition of applicant in this Section.

Physician is a legally qualified medical doctor who is licensed as such in Canada or the United States or any other such region as we may approve, and who is practising within the scope of his or her licensed authority. Your physician must be someone other than yourself, or a member of your immediate family.

Policy anniversary means any anniversary of the first monthly premium due date. For example, if the first monthly premium due date is May 1, 2003, then policy anniversaries would be May 1, 2004, May 1, 2005, etc.

Policy year means a 12-month period that begins on the first premium due date and each policy anniversary after that while this policy is in force.

Premium is the monthly or annual amount that we charge for coverage. The premium for the initial 5-year term and how often it is payable are shown on page 1 of this policy.

Premium due date means:

a) the first day of each month following the effective date (the “monthly premium due date”), if your premiums are paid monthly; or
b) the first day of the month following the effective date and each policy anniversary after that, if your premiums are paid annually.

Qualifying period means the period of 90 consecutive days immediately after each approval date.

Reinstate means to restore full rights under a contract which terminated solely because of a failure to pay a premium, in full, before the end of the grace period. A contract that has terminated can only be reinstated with our approval. To find out the conditions under which we will approve a reinstatement request and how to request reinstatement of this policy, refer to the Subsection *Reinstating your contract* in Section 4.

Renewal dates are policy anniversaries that fall at 5-year intervals after the first premium due date but before the coverage expiry date.

We, **us** and **our** mean The Manufacturers Life Insurance Company (Manulife Financial).

You and **your** refer to the owner.

2. When this policy is in force

When insurance begins (the effective date)
Coverage under this policy begins on the date we receive the application for insurance, provided that:

a) the applicant satisfies our underwriting rules and issue requirements;
b) the applicant is resident in Canada and at least 18 but not yet 66 years of age; and
c) the cheque or credit card charge for the first premium is honoured when first presented for payment to the financial institution.

Term of this policy
The initial term of this policy is 5 years; the initial term ends on the first renewal date. For a definition of renewal dates, refer to Section 1 *Words and phrases used in this policy*.

At each renewal date, we will renew this policy for another 5 years without requesting medical evidence of insurability, if:

a) all premiums have been paid when due; and
b) you are less than 66 years of age.

If you are 66 years or older, we will renew this policy for the number of years remaining to the policy anniversary at which you reach an attained age of 70 years. For example, if you are 69 years old on a renewal date, the renewal term will be one year.

When insurance ends
Insurance under this policy ends on the earliest of the following dates:

a) the date we pay the critical illness benefit to you;
b) the policy anniversary on which you have reached an attained age of 70 years;
c) the first premium due date on which we have your written request to cancel this policy;
d) the date of your death;
e) on any premium due date, if the premium due on that date is not paid in full by the end of the grace period; or
f) the date on which the amount of insurance does not meet our minimum requirements for this policy. Refer to the definition of "Amount of insurance" in Section 1 *Words and phrases used in this policy.*

We may also declare the contract invalid under the conditions described in the Subsection *Contesting the contract (contestability)* in Section 5.

3. Benefits

Critical illness benefit
When we pay the critical illness benefit
We will pay the critical illness benefit to you when we receive at our office within the time limits set out in this policy:

a) proof, satisfactory to us, that you were diagnosed with a covered condition for the first time in your life while this policy was in force;
b) proof, satisfactory to us, of your birth date;
c) proof, satisfactory to us, of the claimant's right to be paid the benefit; and
d) proof, satisfactory to us, of your smoking status.

Refer to the Subsection *Notice and Proof of Claim* in Section 6.

Covered conditions
The following are covered conditions under this policy:

a) **Life-Threatening Cancer**
A tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue as confirmed by histological examination of tissue samples.

Exclusions for cancer
The following are excluded from coverage:

i) Carcinoma in situ;
ii) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion);

iii) any non-melanoma skin cancer that has not become metastatic (spread to distant organs);
iv) Stage A (T1a and T1b) prostate cancer;
v) Any tumour in the presence of any human immunodeficiency virus (HIV).

Furthermore, no critical illness benefit for cancer will be payable:

1) if a diagnosis of any type of cancer (covered or excluded under this policy) is made within the qualifying period; or
2) if a diagnosis of any type of cancer (covered or excluded under this policy) is made as the result of symptoms, signs and/or medical consultations or tests present within the qualifying period; or
3) for a subsequent diagnosis of any cancer or other covered conditions directly resulting from any cancer (covered or excluded under this policy) or its treatment if benefits would not have been payable for such cancer because of exclusion 1) or 2) above.

Duty to report
Any diagnosis of cancer (covered or excluded under this policy) or symptoms, signs and/or medical consultations 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 of diagnosis. If you fail to disclose this information to us within the six-month period, we have the right to deny any claim under this policy.

b) **Heart attack (myocardial infarction)**
The death of a portion of the heart muscle due to atherosclerotic heart disease. The diagnosis must be based on all of the following criteria occurring at the same time:

i) New episode of typical chest pain or equivalent symptoms; and
ii) Resulting from the blockage of one or more coronary arteries; and
iii) New electrocardiographic changes indicative of a myocardial infarction; and
iv) Biochemical evidence of myocardial necrosis including elevated cardiac enzymes and/or troponin; and
v) Excluding minor heart attacks that do not meet all of these criteria.

c) **Stroke**
A cerebrovascular incident causing infarction of your brain tissue, due to intracranial haemorrhage, thrombosis or embolism.

Exclusion for stroke
We will not pay a benefit for stroke unless there is evidence of a new measurable permanent clinical neurological deficit persisting for at least 30 consecutive days following the occurrence of the stroke. Transient ischemic attacks (TIA) and neurological deficits caused by external trauma are specifically excluded.

d) **Coronary artery bypass surgery**
You have undergone heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. This excludes non-surgical techniques such as balloon angioplasty or laser relief of an obstruction.

e) **Major organ transplant**
You have undergone a transplant of a human heart, liver or lung due to irreversible failure of such organ or you receive transplanted human bone marrow.

f) **Kidney failure**
You suffer end-stage renal disease, due to whatever cause or causes, as a result of which you are undergoing peritoneal dialysis or haemodialysis on a regular basis or have received a transplanted human kidney.

Exclusions and limitations
No critical illness benefit will be payable with respect to a covered condition if we determine that:

1) at any time before the effective date shown on page 1 of this policy or the latest reinstatement date of this policy, you had:
   a) any type of cancer, whether it is a covered condition or not; or

b) any symptoms, signs and/or medical consultations or tests and such symptoms, signs, and/or medical consultations or tests initiated any investigations that led to a diagnosis of any type of cancer, whether it is a covered condition or not.

2) within the qualifying period, you had:
   a) any type of cancer, whether it is a covered condition or not; or
   b) any symptoms, signs and/or medical consultations or tests and such symptoms, signs and/or medical consultations or tests initiated any investigations that led to a diagnosis of any type of cancer, whether it is a covered condition or not.

That determination will be based on conditions specifically identified in, or that can reasonably be inferred to have existed at that time from, your application, a related declaration of health, or other information that you authorize or make available to us.

Furthermore, we will not pay benefits under this policy if you, while sane or insane, suffer a covered condition as a direct or indirect result of any of the following:

1) use of intoxicants (including alcohol) or illicit drugs;
2) attempted suicide or intentional self-inflicted injury;
3) committing or attempting to commit a criminal offence;
4) any act of war, whether declared or not; hostile or warlike action in a time of peace or war, whether initiated by a local government, foreign government or foreign group; civil unrest; insurrection; rebellion; civil war; any act of terrorism including but not limited to, bioterrorism; or the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear;
5) operation, or care or control of a motor vehicle, vessel, aircraft or railway equipment, whether or not in motion, while the quantity of alcohol in your blood exceeds 80 milligrams of alcohol in 100 millilitres of blood.

No benefit will be paid unless you survive at least 30 days following the first diagnosis of a covered condition, and you have not experienced irreversible cessation of all functions of the brain. For cancer, heart attack, stroke and kidney failure, the 30-day period will be measured from the date of first diagnosis. For coronary artery bypass surgery and transplants, the 30-day period will be measured from the date the surgery is performed. No benefit shall accrue during this 30-day period.

No more than one benefit is payable to you under this policy.

How to claim a critical illness benefit
To claim a critical illness benefit, you should contact us by telephone, mail or e-mail as shown on page 2 of this policy. We will advise you what documents we require to determine the benefit payable and to ensure that any payment is made to the appropriate person.

We must receive proof of critical illness at our office within the time limits set out in this policy.

We will have the right to investigate the circumstances of the critical illness and, in the event of the death of the insured to require an autopsy unless prohibited by law.

The amount of the critical illness benefit
We calculate the critical illness benefit as of the day of the first diagnosis. The amount of the critical illness benefit is the amount of insurance shown on page 1 of this policy.

When we reduce the critical illness benefit
In some circumstances, a reduced critical illness benefit or no critical illness benefit is payable. These are described in the following Sections or Subsections:

a) When this policy is in force
b) If a benefit is payable during the grace period of an unpaid premium

c) *Contesting the contract (contestability)*
d) *If your age, sex or residence has been stated incorrectly*
e) *If your non-smoker status has been stated incorrectly*
f) *Exclusions for cancer*
g) *Exclusion for stroke*
h) *Exclusions and limitations that apply to all covered conditions*

Who receives the critical illness benefit
The critical illness benefit is payable to you.

Return of Premium on Death Benefit

When we pay the return of premium on death benefit
We will pay the return of premium on death benefit if you die while this policy is in force, and have not received, or are not eligible for, a Critical Illness Benefit payment and provided that we receive the following at our office:

a) a written request for the return of premium on death benefit;
b) proof, satisfactory to us, of the cause of your death; and
c) proof, satisfactory to us, of your birth date.

We may require additional medical information, which must be provided at no cost to us. We reserve the right to make the final decision on whether the above conditions have been met.

The amount of the return of premium on death benefit
The amount of the return of premium on death benefit is the total amount of premiums we received under this policy up to the date of your death.

Who receives the return of premium on death benefit
If the return of premium on death benefit is payable, it will be paid to your estate.

4. Paying your premiums

The amount of your premiums
Premiums for this policy are based on the amount of insurance that you have in force as well as your age, gender and smoking status and the premium frequency you choose.

Premium payable for the first 5 policy years
The premium payable for the first 5 policy years is shown on page 1 of this policy. Your premium is guaranteed not to increase for the first 5 policy years. Renewal rates at the end of each 5-year term are not guaranteed.

Premium changes at renewal dates
Your premium will usually increase at each renewal date until the coverage expiry date, at which time this policy will terminate. Premiums for each renewal term will be based on your attained age on the renewal date. We will send advance notice of any premium changes to the address we have on file for you.

Requesting a change to non-smoker premiums
If you are paying smoker premiums, you can apply to change to non-smoker premiums after you have stopped smoking for 12 consecutive months. You must send us evidence of insurability to support this request.

If you wish to change to non-smoker premiums, please contact us by telephone, e-mail or regular mail. We will tell you what information or documents you need to send to us to request this change.

If you meet our health standards and we approve the change, future premiums will be payable on a non-smoker basis. The change will take effect on the premium due date following the date we approve the change to non-smoker status.

When premiums must be paid

Premium due dates
In order to keep your insurance in effect, you need to pay your premiums when they are due. Your first premium is payable with your application. Your first premium covers the period from the first day of the month following the effective date to the next premium due date. If we do not receive your first premium, or if your first premium is not honoured when first presented for payment, the contract will not go into effect. Subsequent premiums are due on each premium due date.

Grace period
If, on any premium due date after the first, we do not receive enough money to cover your entire premium, you will have 30 days to pay the entire premium. If you do not pay the entire premium within that time, this contract and the coverage it provides will end. This 30-day period is called the grace period.

If a benefit is payable during the grace period of an unpaid premium
If a benefit becomes payable during the grace period of an unpaid premium, we will deduct the overdue premium from the benefit payment.

Missing a payment
At the end of the grace period, the contract is automatically cancelled if you have not paid the full premium owing. We will refund to you any partial payments received, in respect of your policy, between the start of the grace period and the day we cancel your policy.

Reinstating your contract
If your contract is terminated for non-payment of premiums, you may ask us to reinstate your contract. To do this, we must receive the following at our office within 180 days following the grace period but before the policy anniversary on which you reach an attained age of 70 years and during your lifetime:

a) your written application for reinstatement;
b) if required, evidence of insurability, satisfactory to us; and
c) payment from you for:

    i) any amounts that were due on or before the date your policy was cancelled due to non-payment of premium; and
    ii) the total of all payments due from the date your policy was cancelled due to non-payment of premium to the date of reinstatement, plus interest on these amounts. We will determine the interest rate, unless the laws of the legal jurisdiction require a different interest rate.

Provided you qualify based on our underwriting rules, we will reinstate your contract on the day these requirements are met. If this policy is reinstated, the contestability period begins anew.

How premiums can be paid

Method and frequency of payments
You can choose to pay premiums in one of four ways:

a) monthly by pre-authorized withdrawals from your chequing account;
b) annually by charging your premiums to a credit card that is acceptable to us;
c) annually by delivering or mailing your payments to us (cheques should be made payable to Manulife Financial); or
d) by any other payment method or frequency that we make available to you under this policy.

All payments must be in Canadian dollars.

If you wish to change the method or frequency of your premium payments, please contact us by telephone, e-mail or regular mail. We will tell you what information or documents you need to send to us to request this change. If a change in frequency is approved, the premium amount will also change to reflect the new frequency.

5. More information about this policy

Your contract
This insurance policy is part of the legal contract between you and us. The contract commits us to provide insurance coverage and any other benefit(s) described in this policy. We are bound only by the contract's written terms.

Only our president or one of our vice-presidents can agree to any change you request in the contract, and their agreement must be in writing.

How we keep you informed
We will send you a premium notice before each renewal date to notify you that your premium payment is scheduled to change. The amount of your new premium will also be included. Premium notices include a summary of your coverage.

We will send this notice to the address we have on file for you.

How to contact us
Please send payments or documents to our address shown on page 2 of this policy.

Your rights as an owner
Your rights include:

a) varying the frequency of your premium payments, within our administrative limits; and
b) cancelling the contract as a whole.

You must follow the policy's terms and conditions when you use any of these rights. Your rights may also be limited by any applicable laws.

Your beneficiary
There is no right to name a beneficiary under this policy.

Using the contract as security for a loan
You cannot use the contract as security for a loan.

Transferring ownership
You cannot transfer ownership of the contract to another person.

Contesting the contract (contestability)
You have an obligation to disclose every fact that is material to:

a) our decision to issue the coverage for which you have applied; and
b) our decision as to the conditions under which we will issue the coverage, if we decide to issue it.

We have the right to contest the validity of the contract and deny any claim, if you either misrepresent or fail to disclose a material fact.

In issuing this policy, we have relied on the information provided in connection with the application. We will contest the contract if, in any application, or on any medical examination, or in any written or electronic statements or answers provided as evidence of insurability, you have:

a) not disclosed a material fact;
b) incorrectly stated a material fact;
c) misrepresented your age or smoking status; or
d) fraudulently misrepresented a material fact.

A material fact is a fact that, if disclosed, would either influence our decision to issue this policy or affect the conditions under which we would be willing to provide the coverage. The conditions could include limiting the amount of coverage or charging higher premiums.

When we can contest
When there is an indication of fraud, we can, at any time, declare the contract or any insurance coverage invalid. Fraud includes, but is not limited to, a material misrepresentation of smoking status. If the contract is voided for fraud, we will not refund premiums paid under that contract.

Except in the case of fraud, we cannot contest the validity of the coverage after it has been in effect for two years from the latest of the following dates:

a) the effective date;
b) the approval date;
c) the date of the last policy amendment, if any;
d) the date of the last reinstatement, if any; or
e) the date of the last change, if any, where evidence of insurability, satisfactory to us, was provided.

If you die during this two-year period, we can contest at any time.

If your age, sex or residence has been stated incorrectly
If your age or sex has been stated incorrectly, we will adjust the critical illness benefit(s) payable using the correct age or sex and an equitable premium adjustment will be made. However, if we would not have issued the coverage because the correct age or residence does not meet our eligibility rules, we can declare the coverage invalid.

If your non-smoker status has been stated incorrectly
A misstatement of non-smoker status is considered fraud.

Currency
All payments by us or to us under this policy must be in Canadian dollars.

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.

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.

Non-participating policy
This policy is non-participating; it is not eligible to share in our divisible surplus. It has no cash value and receives no dividends.

Legal jurisdiction
This policy is subject to the laws of the Canadian province or territory in which the applicant resided at the time of application.

6. Statutory Conditions

Explanatory note
The following Statutory Conditions apply to this policy. Where this policy is construed according to the laws of Quebec, the Statutory Conditions apply as Policy Conditions and the words "one year" in the Section entitled *Limitation of Actions* shall be replaced by the words "three years".

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 the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Waiver
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 and signed by us.

Copy of Application
Upon your request, we will provide you, or a claimant under this policy, with a copy of your application.

Material Facts
No statement made by you 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.

Notice and Proof of Claim
Any claim for a payment of benefits must be made in writing to our Affinity Markets office or to our principal place of business in your province or to our Head Office. We must receive the notice of claim within 30 days of the date that a claim arises.

Within 90 days of the date a claim arises under the contract, you must provide us with reasonable proof of the happening of the accident or the commencement of the sickness and the resulting loss, the right of the claimant to receive payment and his or her age.

We may also ask you to furnish information, satisfactory to us, as to the cause or nature and duration of the accident or sickness for which you are claiming a benefit under this policy.

Failure to Give Notice or Proof of Claim
If you fail to provide us with notice of claim or proof of claim within the time prescribed in the previous Subsection, you may still make a claim or provide proof if you do so as soon as reasonably possible and if you can provide reasons why it was not reasonably possible to make a claim or provide proof within that prescribed time. In all cases, you must provide proof of claim within one year of the date a claim arises under the policy.

Insurer to Furnish Forms for Proof of Claim
Within 15 days of receiving a notice of claim, we will send you proof of claim forms. If you do not receive the proof of claim forms within 15 days, you may submit the proof of claim to us in a written statement that includes the cause, nature and extent of the accident or sickness that is the basis of this claim.

Rights of Examination
We may require that you be examined when and so often as we reasonably require while the claim is pending. In the case of your death, we may also require an autopsy subject to any law of the applicable jurisdiction relating to autopsies. These conditions must be satisfied before we will pay a claim.

When Moneys Payable Other Than for Loss of Time
If a benefit is payable under this contract, we will pay it within sixty days after we have received proof of claim.

Limitation 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.