LIFE AND HEALTH
INSURANCE

Advisors – Critical illness

Product description

beneva

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1. What is a critical illness insurance?

Progress in medical research currently enables many people who have been diagnosed with critical illnesses to survive and go on to lead a productive life. Critical Illness Insurance is an excellent complement to any financial planning.

Critical Illness Insurance is a protection that provides the necessary tools for insureds to maintain their standard of living and to alleviate their financial obligations following the diagnosis of a critical illness. Indeed, when the insured is diagnosed with a covered critical illness and survives for a minimum period of thirty (30) days, a lump sum tax-free benefit is payable.

The insured can use the benefit as he or she sees fit, for example:

- Cover daily living expenses (mortgage payment, child care expenses, credit cards payments, etc.);
- Choose treatments in a private clinic or abroad;
- Pay for medications or medical expenses not covered by another plan;
- Have the home refitted to his or her medical condition or get nursing care at home;
- Cover business expenses while in recovery;
- Provide income in case of absence from work for an extended period.

2. Why should your client consider critical illness insurance?

Several studies support the importance of this product, confirming that a significant number of Canadians will face the challenge of a critical illness in their lifetime.

Statistics[1] show that:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- There are an estimated 70,000 heart attacks each year in Canada. That is one heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That is one stroke every 10 minutes.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.
- In Canada, approximately 1 in 165 children has autism.
- 1 in every 3,600 children born in Canada has cystic fibrosis.

As we can see, the numbers illustrate the importance of Critical Illness Insurance. Indeed, it is an essential protection at the moment the financial well-being is compromised. It allows insureds to better cope with financial difficulties without having to deplete their savings or their retirement accounts. You can help your clients build a complete protection with the extensive choices and options that we offer.

1. Sources: Canadian Cancer Society, Heart and Stroke Foundation of Canada, Multiple Sclerosis Society of Canada, Autism Society Canada, Canadian Cystic Fibrosis Foundation.

3. Target market

Since critical illness can happen to anyone, it is important to include Critical Illness Insurance in the financial planning process completed with your clients. Recovery can be long and costly. The insurance amount can help them cover additional expenses incurred during their recovery.

This product is tailored to the needs of a diverse client base: families, children, young couples as well as business owners and independent workers. To sum up, this insurance allows clients to meet their needs, regardless of their situation.

4. Product features

4.1 Types of protection

Critical Illness Insurance offers three types of protection:

- **Basic protection** covering the 3 most common critical illnesses
- **Enhanced protection** covering 25 critical illnesses
- **Child protection** covering a total of 29 critical illnesses

4.2 Available plans and issue ages

Several plans are offered to meet the needs of each client. Whether it is for a term or permanent Critical Illness Insurance, you will be able to suggest a plan that suits your clients' profile. Basic and Enhanced protections are available under five plans whereas Child protection is offered under three plans. The insured's age is determined at the nearest birthday.

Plans	Issue ages	Description
T10 – Basic T10 – Enhanced	18 to 65	Term 10 protection, renewable up to age 75 and convertible up to age 65 of the insured. Premiums are level and guaranteed for the initial term and renewal premiums are guaranteed at issue.
T20 – Basic T20 – Enhanced	18 to 55	Term 20 protection, renewable up to age 75 and convertible up to age 65 of the insured. Premiums are level and guaranteed for the initial term and renewal premiums are guaranteed at issue.
T75 – Basic T75 – Enhanced	18 to 65	Protection up to age 75 of the insured. Premiums are level and guaranteed.
T75 – Child	30 days to 17	
T100 – Basic T100 – Enhanced	18 to 65	Protection up to age 100 of the insured. Premiums are level and guaranteed.
T100 – Child	30 days to 17	
T100 paid-up 20 – Basic T100 paid-up 20 – Enhanced	18 to 50	Protection up to age 100 of the insured. Premiums are level and guaranteed. The protection is completely paid up after 20 years of policy.
T100 paid-up 20 – Child	30 days to 17	

4.3 Covered critical illnesses

The table below outlines critical illnesses covered under each type of protection. For a complete definition of covered illnesses, please refer to the appendix at the end of this document.

	BASIC 3 critical illnesses	ENHANCED 25 critical illnesses	CHILD 29 critical illnesses
Cancer	✓	✓	✓
Severe heart attack	✓	✓	✓
Stroke (resulting in severe neurological deficits)	✓	✓	✓
Aortic surgery		✓	✓
Aplastic anemia		✓	✓
Bacterial meningitis		✓	✓
Benign brain tumour		✓	✓
Blindness		✓	✓
Coma		✓	✓
Coronary artery bypass surgery		✓	✓
Deafness		✓	✓
Dementia, including Alzheimer's Disease		✓	✓
Heart valve replacement or repair		✓	✓
Kidney failure		✓	✓
Loss of independent existence		✓	✓
Loss of limbs		✓	✓
Loss of speech		✓	✓
Major organ failure on waiting list		✓	✓
Major organ transplant		✓	✓
Motor neuron disease		✓	✓
Multiple sclerosis		✓	✓
Occupational HIV infection		✓	✓
Paralysis		✓	✓
Parkinson's Disease and Specified Atypical Parkinsonian Disorders		✓	✓
Severe burns		✓	✓
Autism Spectrum Disorder			✓
Cystic fibrosis			✓
Muscular dystrophy			✓
Type 1 Diabetes Mellitus			✓

4.4 Supplementary benefit

In addition to covered critical illnesses listed previously, 15% of the insurance amount, up to a maximum of $50,000, is payable when the insured is diagnosed with one of the following conditions:

- Coronary Angioplasty;
- In situ breast cancer;
- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness that is not ulcerated nor has spread to lymph nodes or other organs;
- Prostate cancer described as AJCC T1 and Gleason grade 6 or less;
- Thyroid cancer, described as AJCC T1 and has not spread to lymph nodes or other organs;
- Chronic lymphocytic leukemia classified as Rai stage 0;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Neuroendocrine tumours classified as AJCC Stage 1.

The payment of the Supplementary benefit is not deducted from the insurance amount and the policy remains in force. Four (4) supplementary benifits are payable, only one payment of this benefit is payable per Medical Condition.

The Supplementary benefit is available free of charge under Enhanced and Child protections only.

For a complete definition of covered conditions, please refer to the appendix at the end of this document.

4.5 Insurance amount

Basic and Enhanced

- Minimum: $25,000
- Maximum: $2,000,000

Child

- Minimum: $25,000
- Maximum: $250,000

4.6 Rate bands

Basic and Enhanced

- $25,000 to $49,999
- $50,000 to $99,999
- $100,000 to $249,999
- $250,000 to $2,000,000

Child

- $25,000 to $49,999
- $50,000 to $99,999
- $100,000 to $249,999
- $250,000

4.7 Renewal option

T10 and T20 plans are renewable up to age 75, without evidence of insurability. The renewal premium is guaranteed at issue and is based on the insured's age at the expiry of each 10-year term or 20-year term, according to the selected plan.

4.8 Conversion privilege

Before age 65, T10 and T20 plans are convertible, under the same type of protection, without evidence of insurability, into T75 or T100 plans.

4.9 Types of policy

Critical Illness Insurance offers the following types of policy:

- Individual; and
- Multi-Life covering up to 6 individuals with maximum of 20 coverages under the same policy.

Policy fees are $60 per year.

4.10 Assistance benefit

The Assistance Benefit is included at no additional cost with all Critical Illness Insurance plans. Consultation services, medical support and assistance are offered through a toll-free number, 24 hours a day, 7 days a week,[2] as soon as the contract is issued, for the insured and his/her family.

- **Second medical opinion:** this service, based on an analysis of medical reports, assesses the key elements of the diagnosis received and produces recommendations from a doctor specializing in the relevant field.
- **Medical referral:** this service provides the insured person with the names of up to three doctors who are best qualified to deal with the case.
- **Administrative services:** this service allows to receive administrative support such as verification of billing, to ensure that bills are justified and free from any duplication, error or over billing.
- **Hospital admission and accommodation assistance outside the province or country:** this service arranges appointments with doctors, hospital admission, hotel reservations, transportation or interpreter services. It also verifies that discounts have been obtained through the Preferred Provider Organization (PPO) of the Excellence Centres.
- **Psychological assistance:** this service, upon request, provides unlimited professional psychological services.
- **Medical assistance:** this service, offered by registered nurses, upon request, provides answers to health, lifestyle and medical related questions.
- **Convalescence assistance:** this service provides with health professional referrals to meet needs in case of convalescence.
- **Concierge services:** this service provides answers to daily questions as well as referrals.
- **Legal assistance:** access to legal advice including legal assistance in the event of identity theft. This service, offered by lawyers, provides with legal information about all legal related matters. The main fields are the following:
  - Civil and common law
  - Property law
  - Family and estate law
  - Consumer law
  - Criminal law

An Assistance Benefit brochure is available for your client (DIND0073A).

2. Legal assistance is offered Monday through Friday from 9 a.m. to 8 p.m. and Saturday from 10 a.m. to 5 p.m. (EST).

5. Return of premiums riders

Different optional return of premiums riders offer clients the possibility to get back the premiums they paid if no critical illness benefit has been paid. Return of premiums riders are offered at issue only.

The table below outlines different return of premiums options and their respective issue ages.

	Return of premiums (ROP) death	Return of premiums (ROP) at expiry	Return of premiums (ROP) on cancellation or at expiry (15 years)	Return of premiums (ROP) on cancellation or at expiry (20 years)
T10 – Basic **T10 – Enhanced**	18 to 65	N/A	N/A	N/A
T20 – Basic **T20 – Enhanced**	18 to 55	N/A	N/A	N/A
T75 – Basic **T75 – Enhanced**	18 to 65	18 to 54	18 to 60	18 to 55
T75 – Child	30 days to age 17	30 days to age 17	30 days to age 17	30 days to age 17
T100 – Basic **T100 – Enhanced**	18 to 65	N/A	N/A	18 to 65
T100 – Child	30 days to age 17	N/A	N/A	30 days to age 17
T100 paid-up 20 years – Basic **T100 paid-up 20 years – Enhanced**	18 to 50	N/A	N/A	18 to 50
T100 paid-up 20 years – Child	30 days to age 17	N/A	N/A	30 days to age 17

5.1 Return of premiums on death

Upon the insured's death, if no benefit in case of critical illness has been paid (except the payment of the Supplementary benefit), this rider allows the beneficiary to receive the sum of all premiums paid, including premiums paid for return of premiums at expiry or return of premiums on cancellation or at expiry (if applicable), as well as rated premiums and policy fees without interest. Premiums paid for other additional benefits are excluded.

If there was a reduction in the insurance amount since the issue or the reinstatement of the Critical Illness Insurance benefit, the premiums paid are based on the insurance amount which is current at the time of the insured's death.

5.2 Return of premiums at expiry

On the anniversary date nearest to the insured's 75th birthday, if no benefit in case of critical illness has been paid (except the payment of the Supplementary benefit), this rider allows the beneficiary to receive the sum of all premiums paid, including premiums paid for return of premiums on death (if applicable), as well as rated premiums and policy fees without interest. Premiums paid for other additional benefits are excluded.

If there was a reduction in the insurance amount since the issue or the reinstatement of the Critical Illness Insurance benefit, the premiums paid are based on the insurance amount which is current at the time of the request of the return of premiums.

Critical Illness Insurance benefit ends following the return of premiums at expiry.

5.3 Return of premiums on cancellation or at expiry (15 or 20 years)

If no benefit in case of critical illness has been paid (except the payment of the Supplementary benefit), the policyowner may request a return of all premiums paid based on a predetermined percentage, including premiums paid for return of premiums on death (if applicable), as well as rated premiums and policy fees without interest. Premiums paid for other additional benefits are excluded.

If there was a reduction in the insurance amount since the issue or the reinstatement of the Critical Illness Insurance benefit, the premiums paid are based on the insurance amount which is current at the time of the request of the return of premiums.

Critical Illness Insurance benefit ends following the return of premiums on cancellation or at expiry.

5.3.1. Return of premiums on cancellation or at expiry (15 years)

The return of premiums may be requested from the fifth (5th) anniversary date of the Benefit according to the following percentages:

Benefit anniversary	Percentage (%)/ return of premium
5th	15%
6th	20%
7th	25%
8th	30%
9th	40%
10th	50%
11th	60%
12th	70%
13th	80%
14th	90%
15th and beyond	100%

5.3.2. Return of premiums on cancellation or at expiry (20 years)

The return of premiums may be requested from the fifth (5th) anniversary date of the Benefit according to the following percentages:

Benefit anniversary	Percentage (%)/ return of premium
5th	15%
6th	17.5%
7th	20%
8th	22.5%
9th	25%
10th	27.5%
11th	30%
12th	35%
13th	40%
14th	45%
15th	50%
16th	60%
17th	70%
18th	80%
19th	90%
20th and beyond	100%

* The policy fees are refunded if at the time of the request of the return of the premiums paid, the benefit in case of critical illness is the only primary coverage under the policy and the insured is the only person who is insured under the policy. In addition, if the policy is issued as a result of a policy split, the policy fees will be refunded only from the date on which this change was made.

6. Additional benefits

6.1 Children's Endorsement (CE)

The Children's Endorsement benefit offers a critical illness protection to all of the insured's dependent children up to age 21 (or 25 if still a full-time student). The insured must be the policyowner to take out this benefit.

Minimum insurance amount: $5,000

Additional protection can be added, up to a maximum of $50,000 per child. The amount insured must be the same for each child under the same policy.

The Assistance Benefit is included with the Children's Endorsement benefit.

Covered illnesses

The following 15 critical illnesses are covered:

- Autism spectrum disorder
- Benign brain tumour
- Blindness
- Cancer
- Cerebral palsy
- Cystic fibrosis
- Deafness
- Down syndrome
- Kidney failure
- Major organ failure on waiting list
- Major organ transplant
- Muscular dystrophy
- Paralysis
- Severe congenital heart disease
- Type 1 diabetes mellitus

Benefit payable following a critical illness diagnosis

If the insured is diagnosed with a critical illness while the benefit is in force and survives at least 30 days following the diagnosis, the insurer will pay the amount insured to the policyowner. Only one claim is payable for each child insured under the benefit.

Benefit in case of death of the parent policyowner

The rider includes a waiver of premium benefit following the death of the policyowner to which this rider is added.

Automatic protection for newborns

This benefit automatically covers all of the policyowner's children born while the benefit is in force. No additional premium is required for this protection.

Limitation

A child born within the 10 months after the Children's Endorsement rider is issued will no longer be covered if they receive a diagnosis of critical illness within 30 days of birth.

Issue ages

Available to insureds between the ages of 18 to 65.

Availability

This rider is available as an additional benefit, for the policyowner's children, from the age of 30 days to 17 years old (depending on the date of issue of the policy).

Termination of benefit

This benefit will terminate for an insured on the earliest of the following dates:

- the benefit anniversary date closest to the insured's 21st birthday (or 25th if still a full-time student);
- the date the insured, born during the first ten (10) months of the benefit, receives a diagnosis of critical illness within 30 days of his or her birth;
- the date on which a benefit following a diagnosis of a critical illness is paid to the insured;
- the date the insured of this benefit dies.

This benefit will terminate on the earliest of the following dates:

- the policy anniversary date closest to the date where all insureds under this benefit have reached age 21 (or age 25 if one or all insureds are full-time students);
- the date the policyowner asks for a payment of the benefit for each insured following a diagnosis of a critical illness;
- the date a written request from the policyowner is received for the cancellation of this benefit or the date indicated in the request, if later;
- the date no insured remains under this benefit;
- the termination date of the benefit to which the present benefit is attached.

6.2 Waiver of Premium (WP)

When the policyowner or the insured is in a state of total disability for a continued period of 4 or 6 months, according to the waiting period selected, premiums due will be waived until the end of the disability period.

Definition of Total Disability

Total disability means a condition of continuous incapacity affecting the insured owing to sickness or accident, that began while this benefit was in effect and that renders the insured:

- Unable to perform any of the duties of his or her principal occupation during the first 24 months of this condition; and
- Unable to engage, while the condition persists, in any occupation that he or she is reasonably fit to engage in based on his or her education, training or experience, whether acquired before or after the start of total disability.

	Issue ages	Premium rate as a percentage (%) of the total premium	
		Male	Female
Waiver of premium 4 months	18 to 55	9.0%	12.0%
Waiver of premium 6 months	18 to 55	5.0%	7.5%

The waiver of premium benefit ends at the policy anniversary nearest to the 60th birthday of the policyowner or the insured.

6.3 Benefit in case of fracture

In the event of accidental fracture or severance, the following benefit is payable:

Fracture	Benefit
Skull, Spine, Pelvis (ilium bone) and Femur	$5,000
Breastbone, Larynx, Windpipe, Shoulder blade, Radius, Humerus, Kneecap, Ulna, Tibia and Fibula	$1,500
Bone not mentioned above	$750

The benefits are doubled when the accident occurs on public transportation or an escalator, in a public elevator, during a fire in a government building, during a hurricane or cyclone or when the insured is hit by lightning.

The premium cost is $45 per year to add the benefit in case of fracture.

The benefit in case of fracture ends at the policy's anniversary date nearest to the insured's 70th birthday.

7. Complementary protection

It is possible to combine Critical Illness Insurance protection with traditional life and universal life products under a single policy for the same insured or any additional insured, at no additional cost.

8. Premiums payment

Premiums can be paid on an annual basis or monthly basis by pre-authorized debit. If monthly option was chosen, the monthly pre-authorized debit premium is calculated as follows:

Monthly premium = Annual premium x 0.09

9. Benefit payable following the diagnosis of a covered critical illness

A lump sum critical illness benefit is paid tax-free when the insured is diagnosed with one of the critical illnesses covered, according to the type of protection chosen. The insured must survive for a minimum period of thirty (30) days before claiming for the insured amount. The benefit payment for certain illnesses is subject to certain conditions or to a different survival period.

The policy ends following the payment of the critical illness benefit.

Limitations

- Cancer: a moratorium period exclusion of 90 days applies after the effective date of the Benefit or after the effective date of the last reinstatement of the Benefit.
- Bacterial meningitis: the condition must result from a neurological deficit documented for at least 90 days from the date of diagnosis.
- Benign brain tumour: a moratorium period exclusion of 90 days applies after the effective date of the Benefit or after the effective date of the last reinstatement of the Benefit.
- Loss of independent existence: cognitive impairment must last for a continuous period of at least 90 days with no reasonable chance of recovery.
- Loss of speech: the condition must be proven for a continuous period of at least 180 days.
- Multiple Sclerosis : a moratoriun period exclusion of 1 year applies after the effective date of the Benefit or after the effective date of the last reinstatement of the Benefit.
- Paralysis: the condition must last for a period of at least 90 days.
- Parkinson's Disease and Specified Atypical Parkinsonian Disorders: a moratoriun period exclusion of 1 year applies after the effective date of the Benefit or after the effective date of the last reinstatement of the Benefit.

For complete definition of covered critical illnesses, please refer to the appendix at the end of this document.

General exclusions

No benefit is payable if the covered condition results, directly or indirectly, from one or many of the following causes or situations:

a) self-inflicted injuries, whether or not the insured was sane or insane;

b) the insured committing or attempting to commit a criminal offence, or being involved in such an offence, or from having provoked such an offence;

c) the insured's service, whether as a combatant or non-combatant, in any armed forces involved in surveillance, peacekeeping or war operations, whether war was declared or undeclared;

d) operating any aircraft, watercraft or land vehicle while exceeding the legal blood alcohol content limit or while under the influence of narcotics;

e) alcoholism, drug addiction or use of hallucinatory agents or illegal drugs, abuse or misuse of medication;

f) war, armed conflict, riot, insurrection or civil commotion, whether or not the insured was actually participating therein;

g) a cancer diagnosed within ninety (90) days following the issue date of the benefit or the date of the last reinstatement of the benefit, if applicable. In such a case, no benefits will be payable for a subsequent diagnosis of any cancer or other covered conditions directly resulting from any cancer or its treatment;

h) a benign brain tumour diagnosed within ninety (90) days following the issue date of the benefit or the date of the last reinstatement of the benefit, if applicable. In such a case, no benefits will be payable for a subsequent diagnosis of any benign brain tumour or other covered conditions directly resulting from any benign brain tumour or its treatment;

i) if, within the first year after the effective date of the Benefit or within the first year after the effective date of last reinstatement of the Benefit, the Insured Person is diagnosed with Parkinson's disease or specified atypical Parkinsonian disorder or develops signs or symptoms that lead to a Parkinson's disease or specified atypical Parkinsonian disorder diagnosis, we will not pay a benefit for this Parkinson's disease or specified atypical Parkinsonian disorder or for any future Parkinson's disease or specified atypical Parkinsonian disorder diagnosis;

j) if, within the first year after the effective date of the Benefit or within the first year after the effective date of last reinstatement of the Benefit, the Insured Person is diagnosed with multiple sclerosis or develops signs or symptoms that lead to a multiple sclerosis diagnosis, we will not pay a benefit for this multiple sclerosis or for any future multiple sclerosis diagnosis.

Termination of benefit

Critical Illness Insurance ends on the first of the following events:

- On the 10th (T10) or the 20th (T20) anniversary of the contract if the benefit is not renewed;
- On the insured's 75th or 100th anniversary, according to the plan selected;
- On the date a covered critical illness benefit is paid;
- On the date the policyowner requests a return of premiums on cancellation or at expiry, if applicable;
- On the date the insured dies;
- On the date a policy's cancellation or at expiry is requested.

10. Appendix

10.1 Definitions of covered critical illnesses under the Basic and Enhanced protections

Dementia, including Alzheimer's Disease

A definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured Person must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The diagnosis of Dementia must be made by a Specialist.

Exclusions

No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

Comments

This condition is difficult to diagnose. The definition is therefore specifically linked to the behaviour and symptoms observed and confirmed by a specialist in the field.

Aortic surgery

The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Exclusions

No benefit will be payable under this condition for:

- Angioplasty;
- Heart valve replacement
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Comments

The thoracic or abdominal aorta (the artery, not the branches) must be surgically replaced.

Aplastic anemia

A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a Specialist.

Comments

Aplastic anemia is a disease that occurs when the bone marrow is no longer able to produce red blood cells, white blood cells, and platelets.

Bacterial meningitis

A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

The neurological deficits must be detectable and measurable by a Specialist. Examples of neurological deficits are measurable weakness in a limb, impaired speech and measurable changes in cognition. Headache or fatigue will not be considered a neurological deficit.

The diagnosis of Bacterial Meningitis must be made by a Specialist.

Exclusion

No benefit will be payable under this condition for viral meningitis.

Comments

Bacterial meningitis is an infection of the brain, caused by bacteria. These deficits must be present for at least 90 days and must be confirmed by a neurologist.

Benign brain tumour

A definite diagnosis of a non-malignant tumour originating in the cranial vault from the brain, meninges, or cranial nerves. The insured must have undergone surgery, radiation treatment or embolization, or the tumour must have caused new irreversible objective neurological deficits on clinical examination. The new neurological deficits must be detectable and measurable by a Specialist and must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of diagnosis. Headache, fatigue, or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

The diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion

No benefit will be payable under this condition for:

- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion

If, within the first 90 days after the effective date of the policy or within the first 90 days after a reinstatement of the policy, the Insured Person is diagnosed with any benign brain tumour or develops signs or symptoms that lead to the diagnosis of a benign brain tumour, we will not pay a benefit for this benign brain tumour or any future benign brain tumour diagnosis.

Comments

A benign brain tumour is a non-cancerous tumour that must be confirmed by diagnostic tests and by a specialist.

Blindness

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.

Comments

Coverage for this disease is intended to cover situations where an insured person loses almost all of the use of both eyes.

Cancer

While most cancers are covered by this policy, the following early-stage cancers are not covered:

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness that is not ulcerated nor has spread to lymph nodes or other organs;
- Skin cancer, other than malignant melanoma, which is confined to the skin (epidermis, dermis). This includes lymphoma which is confined to the skin;
- Prostate cancer unless described as AJCC T2 or higher and/or Gleason grade 7 or higher;
- Thyroid cancer, unless described as AJCC T2 or higher, or has spread to lymph nodes or other organs;
- Chronic lymphocytic leukemia classified as Rai stage 0;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Neuroendocrine tumours classified as AJCC Stage 1;
- Cancers described as carcinoma in situ, Tis or Ta;
- Any pituitary neuroendocrine tumour (PitNET) unless the insured has undergone surgery, radiation treatment or embolization, or the PitNET has caused new, irreversible, objective neurological deficits on clinical examination. The new neurological deficits must be detectable and measurable by a specialist and must be corroborated by diagnostic imaging. Headache, fatigue or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

Tumours (neoplasms) that are classified as uncertain malignant potential, borderline, or that are not classified as cancer (malignant) are not covered under this covered condition. Classification is based on the most current WHO Classification of Tumours series, also known as the ICD-O (International Classification of Diseases for Oncology), published by the International Agency of Research on Cancer (IARC).

Staging or classification refers to the most current (as of date of diagnosis) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

90-Day Exclusion

If, within the first 90 days after the effective date of the Benefit or within the first 90 days after the effective date of last reinstatement of the Benefit, the Insured Person is diagnosed with any cancer or develops signs or symptoms that lead to an eventual cancer diagnosis, we will not pay a benefit for this cancer or for any future cancer diagnosis.

The medical information as described above must be reported to the Company within six (6) months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Comments

Cancer is the growth of abnormal cells that destroy healthy cells. Some cancers are less serious and are not considered life-threatening, according to the definitions of a serious illness product. The excluded cancers are listed above. If a cancer that falls within the exclusions is not cured, progresses, and is subsequently diagnosed as part of a class of covered cancers, then the Critical Illness Benefit becomes payable.

Coma

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 72 hours, and for which period the Glasgow coma score must be 6 or less. The diagnosis of Coma must be made by a Specialist.

Exclusions

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.

Comments

A person may be in a coma for a short period of time and not suffer any aftereffects. This is why it is specified that the coma must last at least 72 hours and must require the use of a life support system.

Coronary artery bypass surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a Specialist.

Exclusions

No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Comments

If one or more arteries leading to the heart are blocked, surgery may be performed to overcome the blockage by substituting a vein or artery from another part of the body. This type of surgery is major and involves a long recovery period.

Deafness

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.

Comments

Temporary hearing loss is more common than permanent hearing loss and can occur after an injury or accident. In order to provide coverage for permanent hearing loss in both (2) ears, the acceptable level of hearing loss must be specified.

Severe Heart Attack (acute myocardial infarction)

A definite diagnosis of death of heart muscle due to obstruction of blood flow, that results in:

Heart attack symptoms, accompanied by a rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- New electrocardiographic (ECG) changes consistent with an acute myocardial infarction;
- New diagnostic imaging changes consistent with an acute myocardial infarction;
- Development of new pathological Q waves on ECG after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

The diagnosis of heart attack must be made by a specialist.

Exclusions

No benefit will be payable under this condition if:

- ECG changes are suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina are diagnosed;
- Elevated cardiac biomarkers and/or symptoms result from medical procedures or diagnoses other than acute myocardial infarction.

The diagnosis of severe heart attack (acute myocardial infarction) must be made by a Specialist.

Comments

When a heart attack occurs, part of the heart muscle dies because blood no longer travels to the heart. In order to confirm the diagnosis of a heart attack, the electrocardiogram must be reviewed to validate the recent cardiac damage related to this cardiac episode. Results of medical imaging may also be reviewed.

Heart Valve Replacement or Repair

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion

No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Comments

The affected valve must be replaced or repaired by surgery.

Kidney failure

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.

Comments

The benefit is payable when both kidneys have ceased to function and the insured requires regular dialysis or a kidney transplant.

Loss of independent existence

A definite diagnosis of the total inability, due to disease or injury, to perform independently (without help), with or without the aid of assistive devices:

- at least 2 of the 5 Activities of Daily Living listed below;
- for a continuous period of at least 90 days;
- and with no reasonable chance of recovery.

The diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

- **Bathing:** washing oneself in a bathtub, shower or by sponge bath;
- **Dressing:** putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances; self grooming, nail and oral care;
- **Bladder and bowel continence:** managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- **Transferring:** being able to stand from a sitting position, as well as getting in and out of bed. The ability to walk independently from one location to another, getting on and off the toilet and maintaining personal hygiene;
- **Feeding:** consuming food or drink that already have been prepared and made available.

Exclusions

No benefit will be payable under this condition if the Loss of Independent Existence is the result of a condition for which the Critical Illness Insurance benefit was declined for the 90-day or 1-Year Exclusion.

Loss of limbs

A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Comments

The amputation must result in the irreversible loss of limbs.

Loss of speech

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.

Exclusions

No benefit will be payable under this condition for all psychiatric related causes.

Comments

Temporary loss of speech is more common than permanent loss of speech and may result from a simple sore throat. For this reason, a number of days is specified in the definition.

Major organ failure on waiting list

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 of America that performs the required form of transplant surgery. For the purposes of the Survival Period, 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.

Comments

The protections for "Major organ transplant" and "Major organ failure on waiting list" reflect two (2) distinct situations. The last one is for the Insured person who is registered on a transplant waiting list.

Major organ transplant

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 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.

Comments

Each of the organs mentioned above must be diseased to the point of requiring a transplant.

Motor neuron disease

A definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of Motor Neuron disease must be made by a Specialist.

Comments

Motor neuron diseases are degenerative diseases of the nerve cells that control the movements of skeletal muscles. In some cases, the Insured has difficulty speaking and swallowing. However, the intellectual functions remain intact.

Multiple sclerosis

The diagnosis of multiple sclerosis as defined by the consensus diagnostic criteria for multiple sclerosis in use in Canada at the time of diagnosis. The diagnosis must be made by a neurologist.

Exclusions

No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion

If, within the first year after the effective date of the policy or within the first year after a reinstatement of the policy, the Insured Person is diagnosed with multiple sclerosis or develops signs or symptoms that lead to a multiple sclerosis diagnosis, we will not pay a benefit for this multiple sclerosis or for any future multiple sclerosis diagnosis.

Comments

Multiple sclerosis is a progressive disease that attacks the nervous system. This condition is difficult to diagnose in its early stages and symptoms may sometimes only be present for a short time. In order to increase the chances of a reliable diagnosis, the diagnosis must therefore be made by a neurology specialist, the Neurologist.

Occupational HIV infection

A definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy.

Payment under this condition requires satisfaction of all the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusions

No benefit will be payable under this condition if:

- The Insured Person has elected not to take any available licensed vaccine offering protection against HIV;
- A licensed cure for HIV infection has become available prior to the accidental injury; or,
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Comments

The conditions listed above must be met for the infection to be considered having been contracted in the workplace.

Paralysis

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.

Comments

A benefit is paid when the Insured cannot voluntarily move at least two (2) limbs, this condition must persist for at least 90 days.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

A definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

1-Year Exclusion

If, within the first year after the effective date of the policy or within the first year after a reinstatement of the policy, the Insured Person is diagnosed with Parkinson's disease or specified atypical Parkinsonian disorder or develops signs or symptoms that lead to a Parkinson's disease or specified atypical Parkinsonian disorder diagnosis, we will not pay a benefit for this Parkinson's disease or specified atypical Parkinsonian disorder or for any future Parkinson's disease or specified atypical Parkinsonian disorder diagnosis.

Exclusions

No benefit will be payable under this condition for all other types of Parkinsonism.

Comments

A specialist in this field should diagnose the disease due to the difficulties in diagnosing this specific condition.

Severe burns

A definite diagnosis of third-degree or full thickness burns over at least 18% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

Comments

Third (3rd) degree burns are the most serious type of burns. Burns must cover at least 18% of the surface of the body to be considered eligible.

Stroke (resulting in severe neurological deficits)

Defined as death of brain tissue, due to an inadequate blood supply or hemorrhage, with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination

The new symptoms and deficits must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of diagnosis.

The neurological deficits must be detectable and measurable by a Specialist. Examples of neurological deficits are measurable weakness in a limb, impaired speech and measurable changes in cognition. Headache or fatigue will not be considered a neurological deficit.

The diagnosis of Stroke must be made by a Specialist.

Exclusions specific to Stroke

No benefit will be payable under this condition for:

- Transient Ischaemic Attacks;
- Trauma causing damage to intracerebral blood vessels;
- Disorders of the blood vessels of the inner ear; or
- Death of the optic nerve or retina unless there is total loss of vision of that eye.

Comments

A stroke occurs when the amount of blood delivered to the brain is significantly reduced, causing neurological aftereffects. The after-effects must be present at least 30 days after the accident.

10.2 Definitions of four additional critical illnesses covered under the Child protection

Autism Spectrum Disorder

A definite diagnosis of autism spectrum disorder based on the DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) or ICD-11 (International Classification of Diseases 11th Revision from the World Health Organization) diagnostic criteria. The diagnosis must be confirmed by a Specialist by the fourth birthday of the insured.

Comments

Autism entails a detachment from reality, including loss of communication with the outside world and the dominance of the inner world of the autistic's imagination.

Cystic fibrosis

A definite diagnosis of cystic fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made by a Specialist before the twenty-fifth (25th) birthday.

Comments

A hereditary disease that leads to progressive respiratory failure and possible liver failure.

Muscular dystrophy

A definite diagnosis of muscular dystrophy with associated symptoms and deficits, confirmed by a Physician specializing in the evaluation and management of muscular dystrophy before the twenty-fifth (25th) birthday..

Comments

Impairment of muscle group functions resulting in anatomical motor changes.

Type 1 Diabetes Mellitus

A definite diagnosis of type 1 diabetes mellitus, characterized by an absolute deficiency of insulin secretion and continued dependence on injectable insulin for survival. Diagnosis must be made by a Specialist. The Diagnosis of Type 1 Diabetes Mellitus must be confirmed by a Specialist before the twenty-fifth (25th) birthday.

10.3 Definitions of eight medical conditions covered under the Supplementary benefit

Coronary angioplasty

The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Comments

Coronary angioplasty is the widening of one coronary artery with a balloon. A balloon-tipped catheter is inserted into an artery (usually in the groin) and threaded up the body to the blockage or narrowing, where the balloon is then inflated. Recovery is short (approximately one day) and the risks of heart attack or emergency bypass surgery as a result of the procedure are low. Nearly 50% of patients with coronary artery disease are treated with this procedure. The medical term for this procedure is PTCA (percutaneous transluminal coronary angioplasty).

Cancers covered for a condition covered under the Supplementary benefit

The diagnosis of one of the following cancers must be made by a Specialist and must be confirmed by a histopathological report.

- In situ breast cancer;
- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness that is not ulcerated nor has spread to lymph nodes or other organs;
- Prostate cancer described as AJCC T1 and Gleason grade 6 or less;
- Thyroid cancer, described as AJCC T1 and has not spread to lymph nodes or other organs;
- Chronic lymphocytic leukemia classified as Rai stage 0;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Neuroendocrine tumours classified as AJCC Stage 1.

Tumours (neoplasms) that are classified as uncertain malignant potential, borderline, or that are not classified as cancer (malignant) are not covered under this covered condition. Classification is based on the most current WHO Classification of Tumours series, also known as the ICD-O (International Classification of Diseases for Oncology), published by the International Agency of Research on Cancer (IARC).

Staging or classification refers to the most current (as of date of diagnosis) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

90-Day Exclusion

If, within the first 90 days after the effective date of the Benefit or within the first 90 days after the effective date of last reinstatement of the Benefit, the Insured Person is diagnosed with any cancer or develops signs or symptoms that lead to an eventual cancer diagnosis, we will not pay a benefit for this cancer or for any future cancer diagnosis.

10.4 Definitions of critical illnesses covered under the Children's Endorsement benefit

Autism Spectrum Disorder

A definite diagnosis of autism spectrum disorder based on the DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) or ICD-11 (International Classification of Diseases 11th Revision from the World Health Organization) diagnostic criteria. The diagnosis must be confirmed by a Specialist by the fourth birthday of the insured.

Comments

Autism entails a detachment from reality, including loss of communication with the outside world and the dominance of the inner world of the autistic's imagination.

Benign brain tumour

A definite diagnosis of a non-malignant tumour originating in the cranial vault from the brain, meninges, or cranial nerves. The insured must have undergone surgery, radiation treatment or embolization, or the tumour must have caused new irreversible objective neurological deficits on clinical examination. The new neurological deficits must be detectable and measurable by a Specialist and must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of diagnosis. Headache, fatigue, or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

The diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusions specific to Benign Brain Tumour: No benefit will be payable under this condition for:

- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion

If, within the first 90 days after the effective date of the policy or within the first 90 days after a reinstatement of the policy, the Insured Person is diagnosed with any benign brain tumour or develops signs or symptoms that lead to the diagnosis of a benign brain tumour, we will not pay a benefit for this benign brain tumour or any future benign brain tumour diagnosis.

Comments

A benign brain tumour is a non-cancerous tumour that has been confirmed by the removal of brain tissue.

Blindness

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.

Comments

The 20/200 rule is aimed at avoiding the situation where the insured is "legally" but not totally blind.

Cancer

The uncontrolled growth of malignant cells and invasion of tissue confirmed by histopathological report.

The diagnosis of Cancer must be made by a Specialist and must be confirmed by a histopathological report.

Exclusions specific to Cancer: While most cancers are covered by this policy, the following early-stage cancers are not covered:

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness that is not ulcerated nor has spread to lymph nodes or other organs;
- Skin cancer, other than malignant melanoma, which is confined to the skin (epidermis, dermis). This includes lymphoma which is confined to the skin;
- Prostate cancer unless described as AJCC T2 or higher and/or Gleason grade 7 or higher;
- Thyroid cancer, unless described as AJCC T2 or higher, or has spread to lymph nodes or other organs;
- Chronic lymphocytic leukemia classified as Rai stage 0;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Neuroendocrine tumours classified as AJCC Stage 1;
- Cancers described as carcinoma in situ, Tis or Ta;
- Any pituitary neuroendocrine tumour (PitNET) unless the insured has undergone surgery, radiation treatment or embolization, or the PitNET has caused new, irreversible, objective neurological deficits on clinical examination. The new neurological deficits must be detectable and measurable by a specialist and must be corroborated by diagnostic imaging. Headache, fatigue or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

Tumours (neoplasms) that are classified as uncertain malignant potential, borderline, or that are not classified as cancer (malignant) are not covered under this covered condition. Classification is based on the most current WHO Classification of Tumours series, also known as the ICD-O (International Classification of Diseases for Oncology), published by the International Agency of Research on Cancer (IARC).

Staging or classification refers to the most current (as of date of diagnosis) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

90-Day Exclusion

If, within the first 90 days after the effective date of the policy or within the first 90 days after a reinstatement of the policy, the Insured Person is diagnosed with any cancer or develops signs or symptoms that lead to an eventual cancer diagnosis, we will not pay a benefit for this cancer or for any future cancer diagnosis.

Comments

Cancer is the growth and spread of abnormal cells that destroy healthy cells. Some cancers are less serious and are not considered life-threatening under the definitions for a critical illness product; these are listed above. When a cancer listed among the exclusions is not successfully treated but grows until it reaches another category, the critical illness benefit becomes payable.

Cerebral palsy

A definite diagnosis of cerebral palsy, characterized by spasticity and incoordination of movements. The diagnosis of cerebral palsy must be made by a Specialist.

Comments

Presence of chronic neuro-motor problems.

Congenital heart disease

A definite diagnosis of any of the following severe congenital heart disease based on appropriate cardiac imaging and confirmed by a cardiologist:

a) Atresia of any heart valve; Coarctation of the Aorta; Double Inlet Ventricle; Double Outlet Left Ventricle; Ebstein's Anomaly; Eisenmenger Syndrome; Hypoplastic Left Heart Syndrome; Hypoplastic Right Ventricle; Single Ventricle; Tetralogy of Fallot; Total Anomalous Pulmonary Venous Connection; Transposition of the Great Vessels; Truncus Arteriosus;.

b) The following conditions are covered only when open heart surgery is performed for their correction: Aortic Stenosis; Atrial Septal Defect; Discrete Subvalvular Aortic Stenosis; Pulmonary Stenosis; Ventricular Septal Defect.

Comments

These defects may occur separately or together and may at any time cause significant deterioration of the cardiovascular or pulmonary systems.

Cystic fibrosis

A definite diagnosis of cystic fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made by a Specialist.

Comments

A hereditary disease that leads to progressive respiratory failure and possible liver failure.

Deafness

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.

Comments

Temporary deafness is more common than permanent deafness and may occur after an injury or accident. To provide coverage for the permanent loss of hearing in both ears, we have specified the acceptable level of deafness.

Down syndrome

A definite diagnosis of Down Syndrome confirmed by a Physician specializing in the evaluation and management of Down Syndrome.

Kidney failure

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.

Comments

The benefit is payable when both kidneys have ceased to function and the insured requires regular dialysis or a kidney transplant.

Major organ failure on waiting list

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. For the purposes of the survival period, 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.

Comments

This coverage is intended for insureds who are enrolled on a transplant waiting list. The coverages in the event of the major organ transplant and of major organ failure on waiting list are determined on this basis.

Major organ transplant

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 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.

Comments

Each of the organs specified above may be diseased to the point that a transplant is required. The benefit is payable when the new organ has been transplanted and the recipient has survived the operation by at least 30 days.

Muscular dystrophy

A definite diagnosis of muscular dystrophy with associated symptoms and deficits, confirmed by a Physician specializing in the evaluation and management of muscular dystrophy.

Comments

Impairment of muscle group functions resulting in anatomical motor changes.

Paralysis

A definite diagnosis of the total loss of muscle function of two (2) 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.

Comments

A benefit is paid when the insured has no feeling in two (2) or more limbs and is unable to move them voluntarily. The condition must have lasted for at least 90 days.

Type 1 diabetes mellitus

A definite diagnosis of type 1 diabetes mellitus, characterized by an absolute deficiency of insulin secretion and continued dependence on injectable insulin for survival. Diagnosis must be made by a Specialist.

Comments

Type 1 diabetes mellitus is caused by a failure of the pancreas to produce insulin, resulting in a daily dependence on insulin injections for survival.

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In 2020, La Capitale and SSQ Insurance, two very solid mutual insurance companies, announced that they would come together to become Beneva.

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