# CRITICAL ILLNESS – LIVING BENEFIT POLICY

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POLICY TERMS AND CONDITIONS

In this Policy, “you”, and “your” means Policy Owner, and “we”, “our”, “us”, the “Company” or “BMO Insurance” mean BMO Life Assurance Company.

GENERAL INFORMATION ABOUT YOUR POLICY

This Policy provides critical illness insurance under the Basic Coverage, which includes a Critical Illness Benefit, an Early Discovery Benefit and a Critical Care Assist Benefit. This Policy may include any optional coverage you have applied for under the Rider Coverage.

You must pay premiums to us for the Policy to remain in force. Your premium will not change for the term of the Plan you have selected. If you have selected a Plan that is renewable, the Policy will be renewed automatically for the same term at the guaranteed renewal rate.

The Policy Information Pages attached to this Policy show important information about your Policy such as the amount of Basic Coverage (Sum Insured), Plan (Living Benefit 10, Living Benefit 20, Living Benefit 75, Living Benefit 100 or Living Benefit 100 15-Pay), optional Rider Coverage, premiums for the Basic Coverage and Rider Coverage and Expiry Date.

WHEN INSURANCE TAKES EFFECT

Insurance under the Policy takes effect on the Policy Date if all the following conditions have been met:

(a) the Policy has been delivered to you, or if you reside in Quebec, we have accepted your application without modification;
(b) we have received the first premium; and
(c) evidence of insurability of the Life Insured has not changed between the date the application was completed and the date the Policy was delivered.

BENEFITS

BASIC COVERAGE

The Basic Coverage is shown on the Policy Information Pages and includes the Critical Illness Benefit, the Early Discovery Benefit and the Critical Care Assist Benefit, all described below.

Critical Illness Benefit

While this Policy is in effect, we will pay the Critical Illness Benefit if the Life Insured:

(a) is Diagnosed with a Critical Illness Covered Condition as defined under “Critical Illness Covered Conditions;
(b) completes the Survival Period applicable to the Critical Illness Covered Condition; and
(c) meets all the other terms of this Policy.

If a Critical Illness Benefit is payable, the amount of the Critical Illness Benefit is the Sum Insured as shown on the Policy Information Pages. Any unpaid premium will be deducted from the Critical Illness Benefit. The Critical Illness Benefit is paid only once regardless of the number of Critical Illness Covered Conditions the Life Insured may have. Once the Critical Illness Benefit is paid, this Policy, including any riders, will terminate.

The Critical Illness Benefit will be paid to you unless you have designated a Beneficiary where applicable or provided us with other payment directions.
**Critical Care Assist Benefit**

Upon Diagnosis of a Covered Condition and consent by the Life Insured, the Life Insured’s medical records will be reviewed by an independent licensed physician(s). The Life Insured will be provided with a written report based on an analysis of the Life Insured’s Covered Condition by a physician(s) whose skills are appropriate for the case. BMO Life Assurance Company may contract with independent third parties to provide this benefit and from time to time, may change service providers without notice.

The Critical Care Assist Benefit is also available to any immediate family member, spouse or dependent child (under eighteen years of age) for one usage (in total for all immediate family members) for all Covered Conditions. The Life Insured will not lose their right to the Critical Care Assist Benefit should an immediate family member elect to use the Critical Care Assist Benefit.

Immediate family members with pre-existing conditions will be excluded for coverage under the Critical Care Assist Benefit on those illnesses. A pre-existing condition is any medical condition which has been diagnosed or for which the Life Insured, spouse or dependent child has received advice or treatment in the 12 months before the Policy Date of this coverage or the last date of Reinstatement.

**Early Discovery Benefit**

While this Policy is in effect, we will pay the Early Discovery Benefit if the Life Insured:

(a) is Diagnosed with an Early Discovery Covered Condition as defined under “Early Discovery Covered Conditions”
(b) completes the Survival Period applicable to the Early Discovery Covered Condition; and
(c) meets all the other terms of this Policy.

If an Early Discovery Benefit is payable, the amount of the Early Discovery Benefit is the lesser of:

(a) 15% of the Sum Insured on the date the Early Discovery Condition is Diagnosed; and
(b) $50,000.00

Any unpaid premium will be deducted from the Early Discovery Benefit.

The Early Discovery Benefit will be paid to you, unless you have designated a Beneficiary where applicable or provided us with other payment directions.

The Early Discovery Benefit is paid only once under this Policy and any other policy resulting from a conversion of this Policy, regardless of the number of Early Discovery Covered Conditions the Life Insured may have.

Payment of the Early Discovery Benefit will not reduce the premium you must pay for this Policy and the amount of Critical Illness Benefit under your Policy.

**Maturity Benefit**

The Maturity Benefit only applies to Living Benefit 100 and Living Benefit 100 15-Pay Plans.

While this Policy is in effect, we will pay the Maturity Benefit to the Policy Owner if:

(a) no Critical Illness Benefit was previously paid under this Policy; and
(b) the Life Insured is living at their Attained Insurance Age 100.
If a Maturity Benefit is payable, the amount of the Maturity Benefit is the Sum Insured as shown on the Policy Information Pages less any Early Discovery Benefit we paid. Any unpaid premium will be deducted from the Maturity Benefit.

Once the Maturity Benefit is paid, this Policy, including any riders, will terminate.

**Rider Coverage**

You may purchase optional coverages under a rider, subject to our approval. If approved, the optional coverage issued to you is indicated on the Policy Information Pages and is subject to the terms and conditions of the rider attached to your Policy.
COVERED CONDITIONS

A Covered Condition is an illness, condition, disorder or Surgery as defined under “Critical Illness Covered Conditions” or “Early Discovery Covered Conditions”. An illness, condition, disorder or Surgery not defined under Critical Illness Covered Conditions and Early Discovery Covered Conditions are not covered under this Policy and no benefit is payable for such illness, condition, disorder or Surgery. Some Covered Conditions have a Survival Period that must be satisfied.

Any tests or examinations that must be performed in order to satisfy the requirements of a Covered Condition must be conducted by a Specialist or Licensed Physician.

CRITICAL ILLNESS COVERED CONDITIONS

Aortic Surgery is defined as 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 and must be performed by a Specialist.

The Life Insured must satisfy the Survival Period.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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

- marrow stimulating agents;
- immunosuppressive agents;
- bone marrow transplantation.

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

Bacterial Meningitis is defined as a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a Specialist.

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

Benign Brain Tumour is defined as a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusions:
No benefit will be payable under this condition if, within the first 90 days following the later of, the Policy - Date of the Policy, or the date of last reinstatement of the Policy, the Insured has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or, any Critical illness Covered Condition caused by any Benign Brain Tumour or its treatment.

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.
Blindness is defined as 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.

Cancer (Life-Threatening) is defined as a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a Specialist.

Exclusions:
No benefit will be payable under this condition if, within the first 90 days following the later of, the Policy -Date of the Policy, or the date of last reinstatement of the Policy, the Life Insured has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for cancer or, any Critical Illness Covered Condition caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.


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

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

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

Coronary Artery Bypass Surgery is defined as 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 and must be performed by a Specialist.

The Life Insured must satisfy the Survival Period.
Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness is defined as 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.

Dementia, including Alzheimer's Disease is defined as 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 Life Insured 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.

Exclusion: 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 Psychiatr Res. 1975;12(3):189.

Heart Attack is defined as a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

The Life Insured must satisfy the Survival Period.

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

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair is defined as 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.

The Life Insured must satisfy the Survival Period.
Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

**Kidney Failure** is defined as 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.

**Loss of Independent Existence** is defined as a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:
- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

**Loss of Limbs** is defined as 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.

**Loss of Speech** is defined as 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.

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

**Major Organ Failure on Waiting List** is defined as 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 Life Insured 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 Life Insured’s enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

**Major Organ Transplant** is defined as 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 Life Insured 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.

**Motor Neuron Disease** is defined as 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.

**Multiple Sclerosis** is defined as a definite diagnosis of at least one of the following:
• two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or,
• well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,
• a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of Multiple Sclerosis must be made by a Specialist.

**Occupational HIV Infection** is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Life Insured’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 Policy - Date, or the effective date of last reinstatement of the Policy.

Payment under this condition requires satisfaction of all of 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;
(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.

Exclusion: No benefit will be payable under this condition if:
• The Life Insured has elected not to take any available licensed vaccine offering protection against HIV; or,
• A licensed cure for HIV infection has become available prior to the accidental injury; or,
• HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

**Paralysis** is defined as 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.

**Parkinson's Disease and Specified Atypical Parkinsonian Disorders**

**Parkinson's Disease** is defined as 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 Life 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.

Exclusion: No benefit will be payable under Parkinson’s Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.
**Parkinson’s Disease and Specified Atypical Parkinsonian Disorders Exclusion Period**

No benefit will be payable for Parkinson’s Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the Policy Date of the Policy, or the date of last reinstatement of the Policy, the Life Insured has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson’s Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson’s Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson’s Disease or Specified Atypical Parkinsonian Disorders or, any Critical Illness covered condition caused by Parkinson’s Disease or Specified Atypical Parkinsonian Disorders or its treatment.

**Severe Burns** is defined as definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

**Stroke** (Cerebrovascular Accident) is defined as a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of Stroke must be made by a Specialist.

The Life Insured must satisfy the Survival Period. The Survival Period runs concurrently with the qualifying period.

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

- Transient Ischaemic Attacks; or,
- Intracerebral vascular events due to trauma; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.
EARLY DISCOVERY COVERED CONDITIONS

**Coronary Angioplasty** is defined as 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. The Life Insured must satisfy the Survival Period.

**Early Breast Cancer** is defined as ductal carcinoma in situ of the breast as confirmed by a biopsy and diagnosed by a Specialist.

**Early Prostate Cancer** is defined as prostate cancer that is either T1A or T1B, without lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.

**Early Skin Cancer** is defined as malignant melanoma skin cancer that is less than or equal to 1.0 mm thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.

**Early Stage Blood Cancer** is defined as chronic lymphocytic leukemia classified less than Rai stage 1, confirmed by appropriate blood tests and diagnosed by a Specialist.

**Early Stage Intestinal Cancer** is defined as malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2, as confirmed by biopsy and diagnosed by a Specialist.

**Early Thyroid Cancer** is defined as papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis, as confirmed by biopsy and diagnosed by a Specialist.


*For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.*

**Exclusions**

No benefit will be payable under the Early Discovery Benefit if:

Within the first 90 days following the later of:
- the Policy Date of the Policy, or
- the effective date of last reinstatement of the Policy,

the Life Insured has any of the following:
- signs, symptoms or investigations that lead to a diagnosis of an Early Discovery Covered Condition, regardless of when the diagnosis is made,
- a diagnosis of an Early Discovery Covered Condition

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for an Early Discovery Covered Condition or, any Critical Illness Covered Condition caused by an Early Discovery Covered Condition or its treatment.
GENERAL EXCLUSIONS AND LIMITATIONS

These general exclusions and limitations apply in addition to the specific exclusions for each Covered Condition under this Policy.

The Critical Illness Benefit or Early Discovery Benefit is not payable if a Critical Illness Covered Condition or Early Discovery Covered Condition results either directly or indirectly from:

(a) a self-inflicted injury or attempted suicide, while a Life Insured is sane or insane;
(b) committing or attempting to commit a criminal offence whether inside or outside Canada, under the laws of the jurisdiction where the offence took place;
(c) the use of any drug, poisonous substance, intoxicant (including alcohol) or narcotic other than as prescribed and administered by or in accordance with the instruction of a Licensed Physician;
(d) war or the act of war whether such war is declared or undeclared; or
(e) the operation of a motor vehicle while the concentration of blood alcohol exceeds 80 milligrams per 100 millilitres of blood (0.08).

CLAIMS

To make a claim, you must provide us with satisfactory evidence of the following:

(a) proof of the Life Insured’s date of birth;
(b) Diagnosis of a Critical Illness Covered Condition or Early Discovery Covered Condition as defined under Critical Illness Covered Conditions and Early Discovery Covered Conditions sections
(c) clinical, radiological, histological and laboratory evidence confirming the date of Diagnosis; and
(d) if applicable, proof of the Life Insured’s death;

In addition to the prior requirements, we reserve the right to:

(a) require that the Life Insured be examined by a Licensed Physician or Specialist we appoint to confirm the Diagnosis
(b) request any information as reasonably necessary to adjudicate the claim.

Specific requirements for a Diagnosis outside of Canada

If a Critical Illness Covered Condition or Early Discovery Covered Condition is Diagnosed outside of Canada, a benefit will be paid only if:

(a) the complete medical records we request are made available to us; and
(b) based on these medical records, we must be satisfied that:
   i. the same diagnosis would have been made if the Critical Illness Covered Condition or Early Discovery Covered Condition had occurred in Canada;
   ii. immediate treatment would have been indicated under Canadian standards; and
   iii. the same treatment regimen would have been administered if treatment had taken place in Canada.
PAYING FOR YOUR POLICY

Premium

The premium is the amount you pay us for the Basic Coverage and any Rider Coverages. Premium includes a policy fee to pay for the administration of the Policy.

The first premium must be paid for your Policy to take effect. Each subsequent premium must be paid when due until the Expiry Date of the Policy. The due date is measured from the Policy Date, considering the payment frequency you have selected.

The Policy Information Pages show the premium amount for the initial and renewal terms for the Basic Coverage and Rider Coverages, if applicable.

Premium by Plan

When you applied for this insurance, you selected a plan that determines the term during which premium stays the same. The plan that applies to your Policy is shown on the Policy Information Pages.

If your Plan is a Living Benefit 10, premiums will stay the same for ten years. For a Living Benefit 20 Plan, premiums will stay the same for twenty years. Premiums increase on the date each term renews. Renewal of each term occurs automatically for the same term until the Expiry Date.

A Living Benefit 75, Living Benefit 100 or Living Benefit 100 15- Pay Plan does not renew and premium remains the same until the Expiry Date

Grace period

After payment of the first premium, you have a 31-day grace period from the due date to pay premium. The Basic Coverage and any Rider Coverage will continue to be in force during this grace period.

If we do not receive the overdue premium before the end of the grace period, your policy will terminate.

REINSTATEMENT

You may apply to put your Policy back into effect (reinstatement) if it was terminated for non-payment of premiums as set out below. If the reinstatement is approved, your Policy and any riders will be put back into effect.

To reinstate a Policy within 30 days of the expiry of the grace period, you must:

(a) give us evidence that the Life Insured is living and has not been Diagnosed with a Covered Condition at the time of the reinstatement application; and

(b) pay all overdue premiums.

If a Policy is not reinstated under the terms above, it may be reinstated within 2 years of the expiry of the grace period provided that you:

(a) give us evidence of insurability, satisfactory to us for the Life Insured, including proof of non-smoking status (if applicable); and

(b) pay all overdue premiums with interest at a rate we set to the extent permitted by law.
TERMINATION

This Policy, including any Riders attached to it, will end on the earliest of the following dates:

(a) the date we receive your request in writing to cancel this Policy;
(b) the date the grace period expires;
(c) the date the Critical Illness Benefit is paid;
(d) the date the Maturity Benefit is paid;
(e) the date the Return of Premium on Surrender Benefit is paid for a Living Benefit 75, Living Benefit 100 and Living Benefit 100 15-Pay plan;
(f) the date conversion takes effect, if the Policy is converted in full;
(g) the date the Life Insured dies; or
(h) the Expiry Date.

No premiums are payable after this Policy terminates. Acceptance of premium after termination does not constitute a waiver of the termination of the Policy. Any payment received will be refunded.

CONVERSION OPTION

If your Policy is a Living Benefit 10 or Living Benefit 20 Plan, you can apply to convert all or part of this Policy to a Living Benefit 75 or a Living Benefit 100 Plan without evidence of insurability. On a full conversion, this Policy terminates. A partial conversion results in a reduction of the Sum Insured of this Policy.

Conditions to exercise the conversion option

(a) The application for conversion is made before the Life Insured’s Attained Insurance Age 60
(b) The Sum Insured is not increased as a result of the conversion;
(c) The new policy meets the age requirements and the required minimum coverage and premium amounts. For a partial conversion, the requirements must be met for this Policy and the new policy;
(d) Premiums under this Policy are not being waived under a total disability premium waiver rider.

If all the conditions are met and your application for conversion is approved, this Policy terminates on the date the new policy takes effect for a full conversion. For a partial conversion, the Sum insured of this Policy will decrease on the date the conversion takes effect.

Information about the new policy

(a) The policy date of the new policy will be the date conversion takes effect;
(b) The first premium for the new policy will be due on the date conversion takes effect;
(c) Premiums for the new policy will be based on:
   i. The Attained Insurance Age of the Life Insured as of the date conversion takes effect;
   ii. The risk classification and insurance rating of this Policy;
   iii. The Living Benefit 75 or Living Benefit 100 rates in effect on the Policy Date of this Policy;
(d) Any evidence of insurability provided for this Policy will be part of the new policy;
(e) Any exclusion or limitation applicable to this Policy will continue to apply to the new policy;
(f) The new policy will provide coverage for the same Covered Conditions as this Policy;
(g) If an Early Discovery Benefit has been paid under this Policy, no Early Discovery Benefit is payable under the new policy;
(h) The addition of riders to the new policy is subject to our approval.
PARTIES TO THE CONTRACT

Life Insured
The Life Insured is the person who is insured under the Policy. The insured person is named in the Policy Information Pages.

Policy Owner
The Policy Owner is the person entitled to all rights and benefits under the Policy. The Policy Owner’s rights may be limited by an irrevocable beneficiary designation, a collateral assignment or a hypothec on the Policy. If there is more than one owner, all owners must exercise their rights unanimously.

Beneficiary
Where permitted, you may name a beneficiary to receive a benefit payable under the Policy. If you named more than one beneficiary, you may tell us how to divide the benefit. If you do not give us this information, the benefit will be divided equally among surviving beneficiaries.

You may change a beneficiary at any time before the Policy terminates. If the beneficiary designation is irrevocable, you cannot change it without the beneficiary’s consent. Some of your rights as owner may not be exercised without the irrevocable beneficiary’s consent, including using the Policy as collateral for a loan.

If you did not designate a beneficiary or if no beneficiary survives the Life Insured, the benefit will be paid to you or your estate.

If you have given this Policy as collateral for a loan, the rights of a collateral assignee or hypothecary creditor may have priority over the rights of a beneficiary.

We are not responsible for any payments made before we receive any change of beneficiary at our Head Office.
GENERAL PROVISIONS

Assignment
You can assign or hypothecate the entire Policy as security for a loan. We are only bound by the assignment or hypothec when we receive written notice of it at our head office. We are not responsible for the validity of the assignment or hypothec.

Changes to tax law
Changes to tax legislation that exists when the Policy takes effect or new tax legislation passed in the future may affect how this Policy is taxed and how premium is charged. In such case, premium will be charged in accordance with the revised tax legislation.

Conformity with Law
This Policy is subject to all applicable laws of Canada, its provinces and territories.

Contract between you and BMO Insurance
All of our obligations to you are set out in the documents or statements that are part of the contract. Our entire contract with you consists of the Policy terms and conditions, the Policy Information Pages, the application for insurance or reinstatement, medical evidence, written statements and answers given as evidence of insurability, riders, and any amendments we agreed to after the Policy is issued. The contract may not be amended or waived except in writing and signed by two authorized officers of BMO Insurance. No agent, broker or financial advisor is authorized to change this contract.

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

Incontestability
We have the right to contest the validity of the Policy and deny any claim if you misrepresent or fail to disclose a material fact. In the absence of fraud, we will not contest the validity of this Policy after it has been in force for two (2) years from the later of (a) the Policy Date; or (b) the date the Policy was last reinstated. There is no time limit to contest a Policy if the misrepresentation or non-disclosure is fraudulent.

If the misrepresentation or failure to disclose is in connection with a Policy increase, additional Rider Coverage or a, change, we have the right to contest the validity of the Policy increase, addition or change within two years such increase, addition or change takes effect.

We will refund premium if a Policy is declared void, except in the case where the misrepresentation or non-disclosure is fraudulent. However, there is no time limit if the misrepresentation or non-disclosure is fraudulent.

Limitation of actions
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 applicable legislation).

Misstatement of Age or Sex
If the age or sex of a Life Insured has been misstated, we will adjust the sum insured or premium based on the correct age or sex. If we would not have issued coverage at the correct age, we can declare the Policy void, within the period allowed by law. All premiums paid will be refunded to you.

Non-participating
This Policy does not participate in the company’s profits or surplus.

Trading in insurance policies
To the extent permitted by law, we can decline your request to record the assignment, transfer, hypothecation or any other change to the Policy if the request is considered to be for trafficking or trading in insurance.

Values
This Policy has no loan, cash surrender, or reduced paid-up values.
DEFINITIONS

In addition to the terms defined earlier, the terms below have the following meanings:

**Annual Base Premium** means the annual premium payable for the purchase of this Policy, including the Policy fee, plus any modal loadings or medical extras, but not including premiums for riders attached to this Policy, unless otherwise specified.

**Attained Insurance Age** is the Insurance Age of the Life Insured as shown on the Policy Information Pages plus the number of Policy Anniversaries that have passed since the Policy Date.

**Diagnosis** refers to the complete fulfillment of all requirements of a Covered Condition as defined under the Critical Illness Covered Conditions and Early Discovery Covered Conditions sections of this Policy.

**Expiry Date** means the date coverage expires under this Policy, as shown on the Policy Information Page. The Policy terminates on the Expiry Date unless terminated earlier.

**Insurance Age** is the age of the Life Insured on their birthday nearest to the Policy Date.

**Licensed Physician** is a legally licensed medical practitioner who practises medicine or performs surgery in Canada or the United States of America (or other such jurisdiction as we may approve). Licensed Physician cannot be the Life Insured, the Policy Owner, a relative or business associate of either the Policy Owner or the Life Insured.

**Life Support** means the Life Insured is under the regular care of a Licensed Physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

**Policy** means this document that the Company has issued as written evidence of a contract of insurance.

**Policy Anniversary** is the annual recurrence of the Policy Date.

**Policy Date** is the date on which the Policy is issued and the date we measure years, months and Policy Anniversaries. The Policy Date is shown on the Policy Information Pages.

**Specialist** is a legally licensed medical practitioner who has been trained in the specific area of medicine relevant to the Covered Condition for which a benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and subject to our approval, the Diagnosis of a Covered Condition may be made by a qualified medical practitioner practising in Canada or the United States of America.

The Specialist cannot be the Life Insured, the Policy Owner, a relative of or business associate of either the Policy Owner or the Life Insured.

**Surgery** means a surgical procedure performed by a Specialist.

**Survival Period** means the period starting on the date of Diagnosis of a Covered Condition and ending 30 days later, except where modified elsewhere under the Policy. The Survival Period does not include the number of days on Life Support. The Life Insured must be alive and must not have experienced irreversible cessation of all functions of the brain at the end of the Survival Period.
STATUTORY CONDITIONS

The Contract
The application, this Policy, any document attached to this Policy when issued, and any amendment to the contract agreed upon in writing after this Policy is issued, constitute the entire contract. Only an authorized officer of the Company can change, modify or waive the provisions of this Policy if requested by the Owner and agreed to by the Company, and then only in writing. No agent, broker or financial advisor is authorized to change this contract.

Waiver
The Company 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 the Company.

Copy of Application
The Company shall, upon request, furnish to the Insured or to a claimant under the contract a copy of the application.

Material Facts
No statement made by the Insured or person Insured 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.

Termination by Owner
The Owner may terminate this contract at any time by giving written notice of termination to the Company by registered mail to its head office or chief agency in the Province, or by delivery thereof to an authorized agent of the Company in the Province, and the Company shall upon surrender of this Policy refund the amount of premium paid in excess of the short rate premium calculated to the date of receipt of such notice according to the table in use by the Company at the time of termination.

Notice and Proof of Claim
The Owner entitled to make a claim, or any agent of the Owner, shall,
(a) give written notice of claim to the Company,
   i. By delivery thereof, or by sending it by registered mail to the head office or chief agency of the Company in the Province; or
   ii. By delivery thereof to an authorized agent of the Company in the Province, not later than thirty (30) days from the date a claim arises under the contract on account of an accident, sickness or disability.
(b) within ninety (90) days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the Company such proof as is reasonably possible in the circumstances of the happening of the accident or the commencement of the sickness or disability, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age; and
(c) if so required by the Company, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such disability.

Company to Furnish Forms for Proof of Claim
The Company shall furnish forms for proof of claim within fifteen (15) days after receiving notice of claim, but where the claimant has not received the forms within that time he may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.
Failure to Give Notice or Proof
Failure to give notice of claim or furnish proof of claim within the time prescribed by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the date of the accident or the date a claim arises under the contract on account of sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Rights of Examination
As a condition precedent to recovery of insurance moneys under this contract:

(a) the claimant shall afford to the Company an opportunity to examine the Insured when and so often as it reasonably requires while the claim hereunder is pending; and
(b) in the case of death of the Insured, the Company may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

When Moneys Payable
All moneys payable under this contract shall be paid by the Company within sixty (60) days after it has received proof of claim.

Limitation of Actions
Every action or proceeding against the insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (or the applicable legislation).