Manulife

Synergy solution document

Sample

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

1 Contents

2 Before you read this document

In this document, *you* and *your* mean the owner of the Synergy solution, and *we*, *our* and *us* mean The Manufacturers Life Insurance Company.

In this document, we occasionally refer to our administrative rules. Administrative rules are the guidelines we set that establish how and in what circumstances you may exercise certain rights under your policies. We change our administrative rules from time to time. When you exercise your rights, you must do so according to the administrative rules in effect at the time you exercise the rights. Any changes we make to our administrative rules will not affect the guaranteed benefits provided by your policies.

We will send any correspondence to the most recent address we have for you in our files. Please advise us of any change in your address by contacting our Canadian head office at:

500 King Street N,
PO Box 1669 STN Waterloo
Waterloo, ON, N2J 4Z6

4 Your Synergy life insurance policy

Your Synergy life insurance policy pays a death benefit if the person insured by your Synergy solution dies before the Synergy solution ends, as described in this life insurance policy.

Your Synergy life insurance policy uses certain terms in specific ways. The definitions of these terms are part of your Synergy life insurance policy. See *Section 9: Terms used in this document* for a complete list of terms.

We use cross-references to make this document easier to use, instead of repeating the same sections in each policy or rider. The following sections are part of your Synergy life insurance policy:

- *Section 3.1: Your Synergy solution summary*
- *Section 3.2: Your Synergy solution premiums*
- *Section 3.3: Your life insurance policy summary*
- *Section 7: About your Synergy solution*

4.1 Your death benefit

When we pay a death benefit

We pay a death benefit if the insured person dies before the Synergy solution ends.

Your death benefit amount

Your death benefit is equal to the available amount of insurance.

Unused premiums

When we pay a death benefit, we add any unused premiums to the death benefit amount.

Who receives the death benefit

We pay the death benefit to you or your estate, unless you've told us that you want your Synergy life insurance benefits paid to someone else.

4.2 Bereavement counselling assistance

When an insured person dies and we pay a death benefit, we will also reimburse up to a total of $1,000 of counselling expenses to the people who receive the death benefit, as described in our administrative rules. We must receive receipts within 12 months of the date of death, and the counselor must be professionally accredited or certified.

4.3 Suicide exclusion

Any death benefit we pay under your life insurance policy is subject to the exclusion defined here.

We don't pay the death benefit under this policy if the insured person, whether sane or insane, commits suicide within two years of the Synergy issue date shown in *Section 3.1*. Instead, we pay a reduced death benefit.

The reduced death benefit is equal to the Synergy premiums you paid since the day we issued or last reinstated your Synergy solution, whichever is later.

4.4 Option to purchase permanent life insurance at expiry

If your available amount of insurance is greater than zero on the Synergy expiry date and we haven't paid a covered condition benefit under your Synergy critical illness insurance policy, you can purchase new permanent life insurance on the insured person without providing any medical evidence.

You must exercise this purchase option within the 60 days before the Synergy expiry date, and your Synergy solution must be in good standing on the Synergy expiry date.

When your new life insurance starts

The new life insurance starts on the day after your Synergy expiry date, once we receive your application and any required premium. If the insured person dies before that date, the new insurance does not go into effect and we refund any premium you paid us for it.

The amount of your new life insurance

The amount of your new life insurance can be any amount between the minimum amount of insurance we allow on the products that we offer under this purchase option and your available amount of insurance on the Synergy expiry date.

If your available amount of insurance is less than the lowest minimum amount of insurance we allow on the products that we offer under this purchase option, the amount of insurance must be the minimum amount of insurance available on the product we choose to offer in this situation.

The new life insurance must have an amount of insurance that doesn't increase over time.

The premium for your new life insurance

The premiums for your new life insurance are based on:

- the amount of the new life insurance,
- the insured person's age on the birthday nearest the day the new life insurance takes effect,
- the insured person's sex, smoking status and insurance rating (shown in *Section 3*), and
- the premium rates in effect on the day the new life insurance takes effect.

Rules that apply to your purchase option

The following rules apply to your purchase option.

We determine which insurance products are available to you when you exercise this purchase option.

The new life insurance must be either:

- a new coverage on an existing insurance policy with us that allows you to add insurance coverage after issue, subject to our administrative rules, or
- a new life insurance policy offered by us on the date you apply for the new life insurance.

The new life insurance must insure only the same insured person as the original Synergy life insurance policy.

The insured person must meet the minimum and maximum age requirements of the new life insurance you want to buy.

The new life insurance will be issued with the same smoker/non-smoker status as the original Synergy life insurance policy or with a comparable risk category.

The new life insurance will include any limitations to our liability contained in your Synergy life insurance policy that apply to the insured person, as well as any limitations we regularly include in policies being issued on the same plan for people of the same age, sex, insurance rating, smoking status, or risk category.

No rider coverages can be carried over to the new life insurance, and the new life insurance cannot include any riders that you qualify for under the new insurance unless you provide evidence of insurability satisfactory to us.

If you provide evidence of insurability satisfactory to us, you can apply for new life insurance with:

- an amount of insurance that increases over time, or
- an amount of insurance that is more than your available amount of insurance on the Synergy expiry date, or
- an improved smoking status or risk category.

If we apply the provisions that relate to suicide and questioning the validity of your insurance to the new insurance, the dates we use will be those that apply to the original Synergy life insurance policy. If the new insurance is reinstated, the dates we use will be those which apply to the new insurance.

If we question the validity of the new insurance, we can rely on any information provided to us to obtain or reinstate the original Synergy life, disability, or critical illness insurance policies or any additional information provided to us at the time you purchased the new insurance. If we are relying on information provided to us at the time you purchased the new insurance, the dates we use will be those of the new insurance.

4.5 What your life insurance contract consists of

The entire life insurance contract consists of:

- the application form(s)
- any information you provided to us for evidence of insurability, including but not limited to:
  - the medical evidence form(s), and
  - the statements and answers you gave us
- the life insurance policy of your Synergy solution, including any endorsements or amendments we issue
- all information you provide if you change or reinstate your life insurance policy, including but not limited to:
  - the application form(s) for those changes,
  - any amendments or endorsements we issue to reflect those changes, and
  - any updated policy summary pages or any tables of guaranteed premiums issued to reflect those changes.

The entire agreement for life insurance between you and us is contained in your life insurance contract.

Your Synergy life insurance policy is non-participating, which means it does not participate in a distribution of surplus or profits that we may declare.

5 Your Synergy disability insurance policy

Your Synergy disability insurance policy pays a disability benefit if the person insured by your Synergy solution becomes totally disabled before your Synergy solution ends, as described in this disability insurance policy.

Your Synergy disability insurance policy uses certain terms in specific ways. The definitions of these terms are part of your Synergy disability insurance policy. See *Section 9: Terms used in this document* for a complete list of terms.

We use cross-references to make this document easier to use, instead of repeating the same sections in each policy or rider. The following sections are part of your Synergy disability insurance policy:

- *Section 3.1: Your Synergy solution summary*
- *Section 3.2: Your Synergy solution premiums*
- *Section 3.4: Your disability insurance policy summary*
- *Section 7: About your Synergy solution*
- *Section 8: Statutory conditions for accident and sickness insurance policies*

5.1 Your monthly benefit

When we pay a monthly benefit

We pay a monthly benefit if the insured person becomes totally disabled and satisfies the waiting period before your Synergy solution ends.

We pay the monthly benefit at the end of each monthly interval, starting from the day the waiting period ends. If a benefit is payable for less than one month, we pay the benefit at a rate of one-thirtieth of the monthly benefit amount for each day of disability.

After your Synergy solution ends, no monthly benefit is payable.

Waiting period for your monthly benefit

The insured person must satisfy the waiting period before we pay a disability benefit. We show your waiting period in *Section 3.4*.

The days that satisfy the waiting period can be accumulated over a longer period of time, but the periods of total disability that make up the waiting period must be:

- related to the same cause, and
- separated by no more than six months.

When we limit the benefit period

We limit monthly benefit payments to a total of 24 months for all total and recurrent disabilities that are caused by psychiatric conditions.

We limit monthly benefit payments to a total of 24 months for all total and recurrent disabilities that are caused by neck or back conditions.

We determine any limited benefit period starting from the day after the waiting period for the first disability has been satisfied and do not extend it as a result of any other injury or sickness suffered during the period of continuous disability.

We waive the 24-month limitation if the disability qualifies as a critical illness covered condition under your Synergy critical illness insurance policy.

Monthly benefit amount

Your monthly benefit amount is 0.5% of the Synergy amount of insurance. Each monthly benefit payment reduces your available amount of insurance. If the available amount of insurance is less than your monthly benefit amount, we pay the available amount of insurance instead. We show your monthly benefit amount in *Section 3.4*.

Who receives the monthly benefit

We pay the monthly benefit to you, unless you've told us that you want your Synergy disability insurance benefits paid to someone else.

Concurrent disability provision

If a disability is caused by any combination of injuries and sicknesses, we treat the claim as one period of disability and the benefit payable each month will not exceed the monthly benefit.

Cooperation

We require the insured person to cooperate, make themselves available, and provide full disclosure of any information or evidence that we require to adjudicate your claim. If the insured person fails to comply with this provision, we will stop processing any new claim or end any existing claim.

5.2 Your vocational rehabilitation benefit

We will consider a request and may agree to pay for the costs of the insured person's participation in an approved vocational rehabilitation program for job retraining.

We may also agree to pay for the cost of approved rehabilitation expenses. These expenses may include:

- necessary office renovations,
- medical equipment, or
- job retraining courses.

When we pay a vocational rehabilitation benefit, we don't reduce your available amount of insurance or monthly benefit.

5.3 Your total disability waiver benefit

While we are paying a monthly benefit, we waive your Synergy premiums and the premiums for any rider coverages month by month. We waive these premiums starting on the day after the waiting period has been satisfied. In the case of a recurrent disability, we waive these premiums starting on the day the recurrent disability starts.

After you submit a disability claim, you must continue to pay your premiums until we approve your claim. When we start waiving your premiums, we retroactively refund all premiums you paid for the exact number of days of your waiting period.

While we are waiving your premiums, you can't make any changes to your Synergy solution or your rider coverages.

5.4 Exclusions and limitations

Any monthly benefit we pay is subject to the exclusions and limitations defined here.

Your disability insurance policy contains three categories of exclusions:
- general,
- out-of-country, and
- pre-existing conditions.

Your disability insurance policy also contains a limitation on reinstatement.

General exclusions

We do not pay disability benefits if a total disability is caused by:
- an act or accident of war, declared or undeclared, or due to any type of military conflict,
- transplant donor surgery or cosmetic surgery, or
- normal pregnancy or childbirth.

However, we pay disability benefits if the total disability is caused by complications of pregnancy or childbirth, including but not limited to:
- extra-uterine pregnancy,
- pernicious vomiting,
- postpartum hemorrhage, and
- toxaemia.

We do not pay disability benefits for any period of time that the insured person is incarcerated in a penal institution or government detention facility.

Out-of-country exclusions

No part of the waiting period can be satisfied while the insured person is outside of Canada or the United States.

We will not pay monthly benefits for any period of disability that occurs while the insured person is outside of Canada or the United States.

Exclusion for pre-existing conditions

We do not pay disability benefits if a total disability begins within 24 months of your Synergy start date and is caused by, contributed to, or results from a pre-existing condition.

Limitation when your Synergy solution has been reinstated

If your Synergy solution has been reinstated, we only pay disability benefits for:

- an injury sustained after the effective date of reinstatement, and
- an illness for which the first indication occurred at least 10 days after the date of reinstatement.

6 Your Synergy critical illness insurance policy

Your Synergy critical illness insurance policy pays a covered condition benefit if the person insured by your Synergy solution satisfies the diagnosis of a covered condition before your Synergy solution ends, as described in this critical illness insurance policy.

Your Synergy critical illness insurance policy also pays an early intervention benefit each time the person insured by your Synergy solution satisfies the diagnosis of an early intervention condition before your Synergy solution ends, as described in this critical illness insurance policy.

Your Synergy critical illness insurance policy uses certain terms in specific ways. The definitions of these terms are part of your Synergy critical illness insurance policy. See *Section 9: Terms used in this document* for a complete list of terms.

We use cross-references to make this document easier to use, instead of repeating the same sections in each policy or rider. The following sections are part of your Synergy critical illness insurance policy:

- *Section 3.1: Your Synergy solution summary*
- *Section 3.2: Your Synergy solution premiums*
- *Section 3.5: Your critical illness insurance policy summary*
- *Section 7: About your Synergy solution*
- *Section 8: Statutory conditions for accident and sickness insurance policies*

6.1 Your covered condition benefit

Your covered conditions

The 24 covered conditions are:

- aortic surgery
- aplastic anemia
- bacterial meningitis
- benign brain tumour
- blindness
- cancer (life threatening)
- coma
- coronary artery bypass surgery
- deafness
- dementia, including Alzheimer's disease
- heart attack
- heart valve replacement or repair
- kidney failure
- 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
- stroke (cerebrovascular accident)

See *Section 6.5: Critical illness covered conditions* for a detailed description of each covered condition, including the criteria of a definite diagnosis. The insured person must meet the criteria of a definite diagnosis before benefits are payable.

When we pay the covered condition benefit

We pay the covered condition benefit if the insured person is diagnosed with a covered condition and meets all the criteria used to define the diagnosis.

We only pay one covered condition benefit.

The covered condition benefit amount

Your covered condition benefit is 25% of the Synergy amount of insurance minus any recovery benefit we've paid. If the available amount of insurance is less than the covered condition benefit, we pay the available amount of insurance instead. We show your covered condition benefit amount and recovery benefit amount in *Section 3.5*.

Who receives the covered condition benefit

We pay the covered condition benefit to you unless you've told us that you want your Synergy critical illness insurance benefits paid to someone else.

6.2 Your recovery benefit

The recovery benefit is designed to help the insured person begin to recover by providing a benefit payment as quickly as possible.

When we pay the recovery benefit

We pay a recovery benefit if you submit a claim for a covered condition benefit and meet all of the following conditions:

- your Synergy solution is in good standing,
- we have not paid a covered condition benefit,
- you provide us with a completed claimant's statement in a form acceptable to us,
- you provide us with an attending physician's statement completed by the appropriate specialist in a form acceptable to us,
- the information you submit to us provides evidence satisfactory to us that the insured person has been diagnosed with the covered condition and is likely to meet all the criteria used to define the diagnosis, and
- we have no evidence at the time that suggests we would not pay the covered condition benefit for that condition.

We only pay the recovery benefit once.

If we pay a recovery benefit, the payment does not necessarily mean that we will pay the associated covered condition benefit. We must complete our investigation of your claim before we can determine if the insured person satisfies our eligibility requirements for the covered condition benefit.

If we decide the insured person is not eligible for the covered condition benefit, we won't ask you to repay the recovery benefit unless we determine that there was misrepresentation or fraud during the underwriting or claims process. In these cases, you must repay the recovery benefit to us.

The recovery benefit amount

Your recovery benefit is 10% of the covered condition benefit amount or $10,000, whichever is less. If the available amount of insurance is less than the recovery benefit, we pay the available amount of insurance instead. We show your recovery benefit amount in *Section 3.5*.

Who receives the recovery benefit

We pay the recovery benefit to you, unless you've told us that you want your Synergy critical illness insurance benefits paid to someone else.

6.3 Your early intervention benefit

Your early intervention conditions

The six early intervention conditions are:

- chronic lymphocytic leukemia (CLL) Rai stage 0
- coronary angioplasty
- ductal carcinoma in situ of the breast
- papillary or follicular thyroid cancer stage T1
- stage A (T1a or T1b) prostate cancer
- stage 1 malignant melanoma

See *Section 6.6: Early intervention conditions* for a detailed description of each early intervention condition, including the criteria of a definite diagnosis that the insured person must meet.

When we pay the early intervention benefit

We pay the early intervention benefit if the insured person is diagnosed with an early intervention condition and meets all the criteria used to define the diagnosis before your Synergy solution ends.

The early intervention benefit can be paid more than once. The early intervention benefit can also be paid even if we have already paid the covered condition benefit, except as described below.

When we don't pay an early intervention benefit

We don't pay an early intervention benefit for:

- chronic lymphocytic leukemia (CLL) Rai stage 0 if we pay a covered condition benefit for CLL Rai stage 1 or greater
- coronary angioplasty that is performed as a treatment for a heart attack if we pay a covered condition benefit for the heart attack
- ductal carcinoma in situ of the breast if we pay a covered condition benefit for breast cancer for that tumour
- papillary or follicular thyroid cancer stage T1 if we pay a covered condition benefit for papillary or follicular thyroid cancer classified as greater than T1, with lymph node or distant metastasis
- stage 1 malignant melanoma if we pay a covered condition benefit for stage 1 malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness that is ulcerated or is accompanied by lymph node or distant metastasis.
- stage A (T1a or T1b) prostate cancer if we pay a covered condition benefit for prostate cancer classified as greater than T1a or T1b, with lymph node or distant metastasis

See *Section 6.4: Exclusions* for details on other exclusions that apply to your early intervention benefit.

The early intervention benefit amount

Your early intervention benefit is 6.25% of the Synergy amount of insurance.

When we pay the first early intervention benefit, we don't reduce your available amount of insurance. Any subsequent early intervention benefit payments reduce your available amount of insurance.

After the first early intervention benefit payment, if the available amount of insurance is less than the early intervention benefit, we pay the available amount of insurance instead. We show your early intervention benefit amount in *Section 3.5*.

Who receives the early intervention benefit

We pay the early intervention benefit to you, unless you've told us that you want your Synergy critical illness insurance benefits paid to someone else.

6.4 Exclusions

Any critical illness insurance benefit we pay is subject to the exclusions defined in:

- *Section 6.3: When we don't pay an early intervention benefit*, and
- *Section 6.5: Critical illness covered conditions*.

Your Synergy critical illness insurance policy also contains four additional categories for exclusions:

- general,
- cancer and related conditions,
- benign brain tumours and related conditions, and
- out-of-country diagnosis.

General exclusions

We don't pay any benefits under your Synergy critical illness insurance policy if the insured person, while sane or insane, suffers a covered condition or an early intervention condition as a result of any of the following:

- intentionally self-inflicted injuries
- committing or attempting to commit a criminal offence
- operating a motor vehicle while the concentration of alcohol in 100 millilitres of blood exceeds 80 milligrams, or
- the insured person's intentional use or intake of:
  - any prescription drug or narcotic other than as instructed by a physician,
  - any drug or narcotic legally available for sale in Canada without a prescription other than as recommended by the manufacturer,
  - any drug or narcotic not legally available in Canada, or
  - any poisonous substance or intoxicant, including alcohol.

Exclusions for cancers and related conditions

The term *any cancer* includes all cancers, even if they would not have been covered under the definitions for cancer for a covered condition or early intervention benefit.

We will not pay a covered condition or early intervention benefit if, within 90 days of the Synergy issue date shown in section 3.1, the insured person has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made, or
- 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 us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

We will not pay a covered condition benefit 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.

For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions for benign brain tumours and related conditions

We will not pay a covered condition or early intervention benefit if, within 90 days of the Synergy issue date shown in section 3.1, the insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under 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 us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

We will not pay a covered condition benefit for pituitary adenomas less than 10 mm.

Exclusions for out-of-country diagnosis

If a covered condition or early intervention condition is diagnosed outside Canada or the United States, we will not pay a critical illness benefit unless the insured person affected by that condition makes all medical records that we request available to us. Based on the medical records, we must be satisfied that all of the following criteria have been met:

- the same diagnosis would have been made if the covered condition or early intervention condition had been diagnosed in Canada or the United States,
- the physician making the diagnosis was licensed to practise in the jurisdiction in which the diagnosis was made and had credentials equal to any defined for that condition in your Synergy critical illness insurance policy,
- the diagnosis is fully supported by all appropriate diagnostic tests and other investigation which would normally be completed in Canada or the United States (including those required by the specific definition of the covered condition or early intervention condition), and
- the same surgery or medically-necessary non-surgical interventional procedure would have been advised if the diagnosis had been made in Canada or the United States.

We also have the right to request that an insured person undergo an independent medical examination by a specialist appointed by us.

6.5 Critical illness covered conditions

This section provides the definitions of the covered conditions for your Synergy critical illness insurance policy.

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

We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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.

Bacterial meningitis

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

We will not pay a covered condition benefit for viral meningitis.

Benign brain tumour

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

See *Section 6.4: Exclusions* for details on other exclusions that apply to the Benign brain tumour covered condition benefit.

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.

Cancer (life threatening)

A definite diagnosis of a tumour 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

See *Section 6.4: Exclusions* for details on exclusions that apply to the Cancer covered condition

benefit.

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 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.

Exclusions

We will not pay a covered condition benefit for the following conditions:

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

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

We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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.

Dementia, including Alzheimer's disease

A definite diagnosis of dementia 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 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 six month period.

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.

The diagnosis of dementia must be made by a specialist.

Exclusions

We will not pay a covered condition benefit for affective or schizophrenic disorders, or delirium.

Heart attack

A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

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

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

Exclusions

We will not pay a covered condition benefit 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

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.

Exclusions

We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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.

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.

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
We will not pay a covered condition benefit for all psychiatric-related causes.

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.

The diagnosis of the major organ failure must be made by a specialist.

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.

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.

Multiple sclerosis

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,
- well-defined neurological abnormalities lasting more than six 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

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 insured person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the Synergy issue date shown in section 3.1.

Payment under this covered condition requires satisfaction of all of the following:
- the accidental injury must be reported to us within 14 days of the accidental injury,
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative,
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive,
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States, and
- the accidental injury must have been reported, investigated and documented in accordance with current workplace guidelines in Canada or the United States.

The diagnosis of occupational HIV infection must be made by a specialist.

Exclusions

We will not pay a covered condition benefit 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 or intravenous (IV) drug use.

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.

Parkinson's disease and specified atypical parkinsonian disorders

A definite diagnosis of primary Parkinson's disease, a permanent neurologic condition characterized by bradykinesia (slowness of movement) and at least one of:
- muscle rigidity, or
- rest tremor

Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

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.

The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist.

Exclusions

We will not pay a covered condition benefit for any other types of Parkinsonism.

We will not pay a covered condition benefit if, within the first year of the Synergy issue date shown in section 3.1, the insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, or a specified atypical parkinsonian disorder, regardless of when the diagnosis is made, or
- a diagnosis of Parkinson's disease, or a specified atypical parkinsonian disorder.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for:

- Parkinson's disease, or
- specified atypical parkinsonian disorders,

or any critical illness caused by:

- Parkinson's disease, or
- specified atypical parkinsonian disorder,

or its treatment.

Severe burns

A definite diagnosis of third-degree burns over at least 20 per cent of the body surface.

The diagnosis of severe burns must be made by a specialist.

Stroke (cerebrovascular accident)

A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, 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.

Exclusions

We will not pay a covered condition benefit for:

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

6.6 Early intervention conditions

This section provides the definitions of the early intervention conditions for your Synergy critical illness insurance policy.

Chronic lymphocytic leukemia (CLL) Rai stage 0

A definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL).

For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Conkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

The condition must be diagnosed by a specialist.

Exclusions

We will not pay an early intervention benefit for Monoclonal Lymphocytosis of Undetermined Significance (MLUS).

See *Section 6.4: Exclusions* for details on exclusions that apply to the Cancer early intervention 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.

Ductal carcinoma in situ of the breast

A definite diagnosis of ductal carcinoma in situ of the breast.

The condition must be diagnosed by a specialist and confirmed by biopsy.

See *Section 6.4: Exclusions* for details on exclusions that apply to the Cancer early intervention benefit.

Papillary or follicular thyroid cancer stage T1

A definite diagnosis of 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.

The condition must be diagnosed by a specialist and confirmed by a biopsy.

See *Section 6.4: Exclusions* for details on exclusions that apply to the Cancer early intervention benefit.

Stage A (T1a or T1b) prostate cancer

A definite diagnosis of stage A (T1a or T1b) prostate cancer.

The condition must be diagnosed by a specialist.

See *Section 6.4: Exclusions* for details on exclusions that apply to the Cancer early intervention benefit.

Stage 1 malignant melanoma

A definite diagnosis of Stage 1A or 1B malignant melanoma that is 1.0 mm or less in depth and non-ulcerated.

The condition must be diagnosed by a specialist.

Exclusion

We will not pay an early intervention benefit for malignant melanoma in situ.

See *Section 6.4: Exclusions* for details on exclusions that apply to the Cancer early intervention benefit.

7 About your Synergy solution

7.1 Your Synergy insurance policies

Your Synergy insurance policies were sold as a Synergy solution. Because of the unique contractual relationship between your Synergy insurance policies, the three policies cannot be separated from your Synergy solution in any way. If you make a change to your Synergy solution, all three policies are affected by that change. Your Synergy life, disability, and critical illness insurance policies must have the same owner and if one policy ends, all three policies end. All three policies are also simultaneously affected by the provisions in this section.

If, at some point in the future, we change our rules and allow you to separate your Synergy insurance policies from your Synergy solution, we reserve the right to determine the terms and conditions under which you may be able to separate your Synergy insurance policies, including changing your premiums.

7.2 Premiums

The premium is the amount we charge for the Synergy insurance policies and the riders on each Synergy insurance policy.

We show your guaranteed premiums in *Section 3*.

Your premium changes if you change your Synergy amount of insurance or your rider coverages, or if your cost type has an increase on a scheduled renewal date. We show your scheduled renewal dates in *Section 3*. If you change your Synergy solution or rider coverages, we will provide you with a new Synergy summary.

Premium guarantee

We guarantee that your Synergy premiums will not exceed the premiums shown in *Section 3*, unless you make a change to your Synergy solution.

How we determine your premium

We determine the premium that applies to your Synergy solution based on:

- the cost type,
- the Synergy amount of insurance, and
- the insured person's age, sex, smoking status and insurance rating (shown in *Section 3*).

The portion of the Synergy premium that applies to each of the Synergy life, disability, and critical illness insurance policies is shown in *Section 3*.

Paying premiums

You need to pay your premiums in order to keep your Synergy solution in effect. Your first premium is due on the Synergy issue date shown in *Section 3.1* and we will apply it to your Synergy solution on that date. We must receive your first premium before your Synergy solution takes effect.

You can choose how often you pay your premiums. Premiums can be paid in the following ways:

- If you choose to pay monthly, you can arrange for us to make automatic monthly withdrawals from a bank account.
- If you choose to pay quarterly, semi-annually or annually, you can mail or deliver your premiums to us at our head office or send them to us electronically. Cheques must be in Canadian dollars, drawn on a Canadian financial institution and made payable to Manulife Financial.

If you change how often you pay your premiums, we calculate your new premium based on the annual rate or discounted annual rate that applies to your new frequency.

If you miss paying a premium

If you miss paying a premium or if we don't receive the full amount of the premium, your Synergy insurance policies enter the grace period as of the date your premium was due. We will cancel your Synergy solution if we don't receive the overdue amount before the end of the grace period. See *Section 7.5: Lapse and reinstatement* for details on the grace period and cancellation.

When we waive your premiums

While we are paying a monthly benefit under your disability insurance policy, we waive the required monthly premiums for your Synergy solution and the required monthly premiums for any rider coverages. See *Section 5.3: Your total disability waiver benefit* for details.

7.3 Currency

All premiums must be in Canadian dollars drawn from an account at a Canadian financial institution, and all payments by us will be in Canadian dollars.

7.4 Claiming a benefit

To claim a benefit, you or a person entitled to make the claim should contact your advisor or contact us directly at the phone number shown in your most recent Synergy statement. We will provide information about which documents we need to process the claim.

When we receive a death claim on your Synergy life insurance policy, we stop processing any other claims and process the death claim instead. We also stop paying any monthly benefits. Your available amount of insurance is reduced by any claims we pay after the date of death but before we receive the death claim.

At any time, we have the right to cancel your Synergy solution if any fraudulent statement of a material fact occurs in any written notice or proof of claim.

7.5 Lapse and reinstatement

If, on any monthly processing day, your premiums are due and not paid in full, your Synergy insurance policies enter the grace period. The grace period ends 31 days after the monthly processing day when your premiums were not paid in full and we cancel your Synergy solution as of the end of the grace period.

All coverage under your Synergy solution continues during the grace period. If a claim becomes payable during the grace period, we will deduct any outstanding premiums from any benefit payable.

At any time during the grace period, you can pay us the outstanding amount to return your Synergy insurance policies to good standing. If you haven't paid the entire outstanding amount by the end of the grace period, we return any partial payments to you when we cancel your Synergy solution.

Reinstatement

You can ask us to reinstate your Synergy insurance policies up to two years after the day it lapses if:

- all of the people insured under your Synergy insurance policies are still alive,
- you pay the reinstatement amount

If you ask us to reinstate your Synergy insurance policies within 30 days of the policies lapsing, we reinstate them without asking for additional information. From the 31st day until two years after the policies lapsed, you must complete and submit an application for reinstatement form. Because of the unique contractual relationship between your Synergy insurance policies, your application for reinstatement must include reinstatement of your Synergy life, disability, and critical illness insurance policies. We also ask you to give us any information we need to make a decision on whether, and under what conditions, we will reinstate the policies. Once we approve your request and receive the reinstatement amount and any other information we need from you, we reinstate your Synergy insurance policies and send you a new *Synergy solution summary*.

The reinstatement amount

The reinstatement amount is:

- the total of all amounts due on the day your Synergy insurance policies went into the grace period, plus
- all premiums due from the day your policies went into the grace period until the day we reinstate your policies, plus
- interest on these amounts, as we describe in our administrative rules.

The effective date of the reinstatement of your Synergy insurance policies is the date on which we determine these requirements have been met. We will reissue your Synergy solution and show these dates in *Section 3.1*.

7.6 How we respond to misrepresentation or nondisclosure

Fraudulent misrepresentation

At any time, we have the right to cancel your Synergy insurance policies and all riders or deny a claim if you or one of the insured people has fraudulently misrepresented a material fact by not disclosing it or by stating it incorrectly in any application or in any medical examination, or in any other information we have used as evidence of insurability.

Misrepresentation or nondisclosure of a material fact

During the contestability period, we have the right to:

- cancel your Synergy life insurance policy, your child protection rider—life, or your term insurance rider, or
- deny a claim on any of these policies or riders

if you or one of the insured people has misrepresented a material fact by not disclosing it or by stating it incorrectly in any application or in any medical examination, or in any other information we have used as evidence of insurability.

During the contestability period (or if an insured person or the insured person's physician notices or becomes aware of any sign, symptom, condition, or medical problem during the contestability period that leads to a diagnosis of a covered condition, early intervention condition, or total disability at any time in the future), we have the right to:

- cancel your Synergy critical illness insurance policy, your Synergy disability insurance policy, or your child protection rider—CI, or
- deny a claim on any of these policies or riders

if you or one of the insured people has misrepresented a material fact by not disclosing it or by stating it incorrectly in any application or in any medical examination, or in any other information we have used as evidence of insurability.

7.7 Making changes to your Synergy solution

You can make the following changes to your Synergy solution at any time, provided that we are not waiving your premiums.

Making changes without providing evidence

You can make the changes described in this section without providing evidence of insurability to us. These changes are also subject to our administrative rules.

Changing your cost type

Synergy offers two cost types: 10-year renewable to 65 and level cost to 65. Each cost type guarantees that your premium remains the same for a certain length of time, provided you don't make a change to your Synergy solution.

Cost type	Your premium stays the same:
10-year renewable to 65	for 10 years or until the Synergy expiry date, if earlier. Every 10 years, we automatically renew your insurance until the Synergy expiry date. Your guaranteed premiums are shown in *Section 3.2*.
level cost to 65	until the Synergy expiry date. Your guaranteed premium is shown in *Section 3.2*.

You can ask us to change your cost type from 10-year renewable to 65 to level cost to 65 if:

- you have not made any claims on your Synergy solution,
- you request the change to your cost type on or after your second Synergy anniversary, and
- the insured person meets our age limit requirements for changing the cost type.

If you change your cost type, your premium for the level cost to 65 cost type is based on the rates in effect at the time you ask us to make the change, and on the personal information shown in *Section 3*. Your premium may increase as a result of this change. The change takes effect on the monthly processing day on or after the day we receive your written request.

You cannot change your cost type from level cost to 65 to 10-year renewable to 65.

Changing your Synergy amount of insurance

You can ask us to decrease your Synergy amount of insurance.

When we reduce your Synergy amount of insurance, we also reduce your available amount of insurance proportionally. Because your benefits are based on a percentage of your Synergy amount of insurance, reducing your Synergy amount of insurance will also change:

- the monthly benefit amount under your disability insurance policy, and
- the covered condition benefit, recovery benefit, and early intervention benefit amounts under your critical illness insurance policy.

We calculate your unused premiums using the new Synergy amount of insurance and return any excess amount to you.

Making changes with evidence

You can make the changes described in this section if you provide evidence of insurability satisfactory to us. These changes are also subject to our administrative rules.

Changing your smoking status or removing exclusions

Once a year, you can ask us to review your smoking status or any exclusions or insurance ratings that are in effect on your Synergy solution at that time.

We calculate your unused premiums using the new smoking status or insurance rating and return any excess amount to you.

Changing your waiting period

If you provide evidence satisfactory to us that you qualify for a shorter waiting period, you can ask us to reduce the waiting period for your disability insurance policy.

7.8 Effective date of changes

Unless otherwise stated, the effective date of any change to your Synergy solution or rider coverages is the monthly processing day on or after the day we approve the change. The monthly processing day is shown in *Section 3.1*. We have the right to delay the effective date of any change:

- if we received your request at our head office after the time stated in our administrative rules, or
- in the event of an unanticipated closure or disruption of our offices.

7.9 Your rights as a Synergy solution owner

Your rights as a Synergy solution owner include the right to name and change any beneficiary or any person you have named to receive a benefit. You can name a separate person to receive benefits for each policy under your Synergy solution.

Your rights as a Synergy solution owner also include the right to:
- name a successor owner for your Synergy solution, called a subrogated policyholder in Quebec,
- transfer ownership of your Synergy solution,
- use your available amount of insurance as security for a loan,
- vary the frequency of your premiums, within our administrative limits, and
- cancel your entire Synergy solution.

Any change you make applies to all of your Synergy insurance policies. You can't exercise these rights on only one Synergy insurance policy.

If you want to exercise any of these rights, you must submit your instructions in writing to our head office. Contact your advisor or us directly for the forms to use to make these changes.

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

7.10 When your Synergy solution ends

Your Synergy solution ends on the earliest of the following dates:
- the business day we receive your written request to cancel your Synergy solution, as described below, or
- the day we cancel any of your Synergy insurance policies or deny a claim under *Section 7.6: How we respond to misrepresentation or nondisclosure*, or
- 31 days after your Synergy solution enters the grace period if you haven't paid the overdue amount, or
- the day the person insured on the Synergy life insurance policy dies, or
- the day on which your available amount of insurance is reduced to zero, or
- your Synergy expiry date.

After your Synergy solution ends, no benefit is payable.

If the insured person is satisfying:
- a waiting period under your disability insurance policy, or
- the criteria for a definite diagnosis of a covered condition under your critical illness insurance policy,

the waiting period or definite diagnosis must be satisfied on or before the Synergy expiry date. No benefits are payable if the waiting period or definite diagnosis is not satisfied before your Synergy solution ends.

Cancelling your Synergy solution

You can ask us to cancel your Synergy solution at any time. If you cancel your Synergy solution, we cancel all insurance policies and riders under your Synergy solution on the business day we receive your written cancellation request. We return any unused premiums to you.

Contact your advisor for more information on the consequences of cancelling your Synergy solution.

8 Statutory conditions for accident and sickness insurance policies

These statutory provisions apply to your Synergy disability insurance policy, your Synergy critical illness insurance policy, and your Synergy child protection rider—CI. If there is a disagreement between the provisions in this section and the provisions in any other section of your Synergy disability insurance policy, your Synergy critical illness insurance policy, or your Synergy child protection rider—CI, the provisions in this section apply.

8.1 The contract

The application, this policy, any document attached to this policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Waiver

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

8.2 Copy of your application

We shall, upon request, furnish to you or a claimant under the contract a copy of the application.

8.3 Material facts

No statement made by you or the person to be insured at the time of the application for this contract can be used in defence of a claim or to avoid this contract unless it is contained in the application or any other written statements or answers provided as evidence of insurability.

8.4 Cancellation by owner

If you choose to cancel your contract, your contract ends on the business day we receive your written request to cancel the contract in our principal place of business in your province or at our Canadian head office. We will refund the unused portion, if any, of the premium paid during the policy year that you request cancellation. If no premium was paid during the policy year you request cancellation, no premium will be refunded.

8.5 Notice and proof of claim

How to claim benefits

You, or a beneficiary entitled to make a claim, or the agent of any of them, shall,

A give written notice of claim to us,

i) by delivery thereof, or by sending it by registered mail to our head office or chief agency in the province, or

ii) by delivery thereof to one of our authorized agents in the province,

not later than thirty days from the date a claim arises under the contract on account of an accident, sickness or disability;

B within ninety days from the date a claim arises under the contract on account of an accident, sickness or disability, furnish to us 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 the age of the beneficiary if relevant; and

C if so required by us, 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.

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 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.

Insurer to furnish forms for proof of claim

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

Rights of examination

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

8.6 Payment of claim

We will pay all benefits payable under this contract within sixty days after we have received proof of claim.

8.7 Limitations of actions

An action or proceeding against us for the recovery of a claim under this contract must begin within one year of the date the insurance money became payable or would have become payable if the claim had been valid.

8.8 Provincial variations

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

9 Terms used in this document

Available amount of insurance – is the amount of insurance available to pay claims made on any of your Synergy insurance policies, and is reduced by any benefit amounts we pay unless a policy specifically states that the payment does not reduce the available amount of insurance. On the Synergy start date, the available amount of insurance is equal to the Synergy amount of insurance.

Business day – is any day our Canadian head office is open for business.

Contestability period – is the period of time when we have the right to question the validity of a policy or any rider coverage under it because a material fact was misrepresented or not disclosed.

For your Synergy insurance policies, the contestability period is two years starting from:

- your Synergy issue date,
- the effective date of a change you made that required updated evidence of insurability, or
- the date your Synergy solution was last reinstated,

whichever is latest.

For your Synergy rider coverages, the contestability period is two years starting from:

- a rider coverage issue date,
- the effective date of a change you made that required updated evidence of insurability for a rider coverage, or
- the date the rider coverage was last reinstated,

whichever is latest.

Cost type – determines how we calculate your insurance costs, the length of time we charge those costs, and the interval when your premium changes. We show the cost type in *Section 3.2*.

Critical illness benefit – is any benefit payable as a covered condition benefit, an early intervention benefit or a recovery benefit.

Death benefit – is the total amount we pay when a person whose life is insured under your Synergy solution dies.

Definite diagnosis – is the written statement by a specialist, supported by the appropriate investigation and medical evidence, that the insured person meets the definition of a covered condition or early intervention condition in this contract.

Disability or **disabled** – is the state of **total disability**, as defined in this section.

Evidence of insurability – is any information that we require to decide if we can provide insurance to a person, and if so, on what terms. Evidence of insurability can include financial information.

Good standing – is the state that your Synergy solution is in when sufficient premiums have been paid to keep your Synergy solution in effect.

Grace period – is a 31-day period that starts on the monthly processing day when premiums are due and not paid in full. During the grace period, your Synergy solution remains in effect. At the end of the grace period, we cancel your Synergy solution if your premiums have not been paid in full.

Healthstyles – are the broad rating categories we use to determine the insurance costs for any rider coverages. We determine the insured person's Healthstyle category for the rider coverages based on their tobacco use, personal and family medical history, recreational risks and an evaluation of health and other personal and lifestyle information. The Healthstyle assigned to each insured person under any rider coverages is shown in *Section 3*.

Injury – is an accidental bodily injury sustained while your Synergy solution is in effect.

Insurance rating – is used in the calculation of the premium rates shown in *Section 3*. We show the insurance rating in *Section 3*. We rate each insured person based largely on their health, family medical history and recreational or employment activities. Our standard rating is 100%, but an insured person may have an insurance rating that is higher than our standard rating if we consider them to be a greater risk to insure. The higher the percentage, the higher the premium. The insurance rating may also be a flat dollar amount.

Insured person – is any person we have agreed to insure under your Synergy solution or any rider coverages. We show the insured people in *Section 3*.

Material fact – is a fact that, if disclosed, would:

- influence our decision to issue the policy or rider, or
- affect the conditions under which we would be willing to provide coverage.

Monthly benefit – is a benefit that you can request if the insured person under your Synergy solution becomes totally disabled. The monthly benefit is described in your disability insurance policy.

Monthly interval – is the time between monthly benefit payments and, depending on the length of the month, can be from 28 to 31 days.

Monthly processing day – is the day most changes take effect on your Synergy solution. The first monthly processing day is on the Synergy start date and subsequent ones are on the same day of each month that follows. For example, if your Synergy start date is April 12, your monthly processing day will be the 12th day of each month. We show this day in *Section 3.1*.

Neck or back conditions – refer to any injury, disease, or disorder of the vertebral column or intervertebral disks and the related muscles, ligaments and nerve roots, and include all associated complications, treatments, and operations.

Permanent life insurance – is protection for the lifetime of the insured person. Permanent life insurance doesn't have an expiry date.

Physician – means a qualified medical doctor (other than you, the insured person, or a relative or business associate of you or the insured person) who gives medical care within the scope of their licensed authority.

Pre-existing condition – is any sign, symptom, condition or medical problem for which medical treatment, diagnosis, investigation, care, services or advice was rendered, prescribed, recommended or received in the 24 months before your Synergy solution or rider coverage started. A condition is considered pre-existing regardless of whether or not the physicians knew or suspected that these signs, symptoms, condition or medical problems were in any way connected to the condition which is ultimately found to have caused, contributed to or resulted in the disability or covered condition leading to a claim.

Premium – is the amount we charge for the Synergy insurance policies and the riders on each Synergy policy.

Psychiatric conditions – are any anxiety or depression, including stress, burnout, fatigue, or any other psychological disorder, and include all manifestations, treatment, and complications of treatment for any of these conditions.

Recurrent disability – is a disability that

- begins within 180 days of a previous disability for which the waiting period has been satisfied, and
- results from the same or related causes.

A recurrent disability is treated as a continuation of the previous claim and doesn't require a waiting period.

Regular care of a physician – means consultations and treatment by a physician which are appropriate in nature and frequency for the condition causing the insured person's disability.

Regular occupation – is the gainful occupation or occupations in which the insured person is engaged when the disability starts.

If the insured person is not engaged in a gainful occupation when the disability starts (i.e. homemaker or laid-off), they qualify as totally disabled if, as a result of injury or sickness:

- they are unable to perform the regular substantial activities they were engaged in before the injury or sickness began, and
- they are not engaged in any gainful occupation, and
- they are under the regular care of a physician and are following the recommended appropriate treatment.

Rider coverage – is additional protection provided by a rider. You can have several rider coverages, each covering one person, under each rider. The benefit provided by each of your rider coverages is shown in *Section 3*.

Rider premium – is what we charge you for the coverage we provide under the riders on your Synergy solution.

Sickness – means a disease or illness which first manifests itself while the Synergy disability insurance policy is in effect.

Specialist – is a licensed medical practitioner who has been trained in the specific area of medicine relevant to a covered condition or early intervention condition related to the benefit that is being claimed, and who has been certified by a specialty examining board. If a specialist is not available and if we approve, a condition may be diagnosed by a qualified medical practitioner practising in Canada or the United States. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, pathologist, burn specialist and internist. The specialist cannot be you, the insured person or a relative or business associate of you or the insured person.

Synergy solution – contains three separate policies: a life insurance policy, a disability insurance policy, and a critical illness insurance policy, and also includes the rider coverages provided under each insurance policy. The benefits offered by each policy are based on a common initial benefit amount called the Synergy amount of insurance.

Term insurance – is insurance protection we provide for a limited number of years.

Total disability or **totally disabled** – is the insured person's inability, due to injury or sickness, to perform the substantial duties of their regular occupation.

For claims which are related to a psychiatric condition or which are contributed to by alcohol or drug use, we may require that the insured person be under the regular care of a psychiatrist and be following recommended appropriate treatment for total disability to exist.

However, total disability will not exist:

- if the insured person is engaged in any gainful occupation, or
- if the insured person is not under the regular care of a physician (or psychiatrist, as described above) or is not following recommended appropriate treatment.

Unused premiums – are premiums that you have paid us that have not yet been used to pay for your insurance protection. We calculate unused premiums starting from the next monthly processing day.