HEATHSURE PREMIUM MEDICAL INSURANCE
Effected with certain Lloyd's Underwriters as scheduled herein ("the Insurers"), through Lloyd's Approved Coverholder ("the Coverholder"):
MSH INTERNATIONAL (CANADA) LTD., Suite 300, 999 – 8th Street S.W., Calgary, Alberta, Canada T2R 1N7

Policyholder: Ashley Renaud
Address:

POLICY NO.: BA1052
BINDING AGREEMENT NO: PM8277418
CERTIFICATE NO.:

POLICY TERM:
March 1, 2019 – February 29, 2020
(Both days inclusive, local standard time at the address of the Insured).

SUMMARY OF ELECTED BENEFITS

HealthSure Premium Medical:	Please refer to policy for details.
Critical Illness:	$25,000
Geographical Area of Coverage:	Canada & United States

The insurance contract consists of this Declarations page, as well as all coverage wordings, riders or endorsements that are attached hereto.

The Insurers Code of Consumer Rights & Responsibilities

The Insurers are committed to safeguarding Your rights when You shop for insurance and when You submit a claim following a loss. Your rights include the right to be informed fully, to be treated fairly, to timely complaint resolution, and to privacy. These rights are grounded in the contract between You and Your Insurers and the insurance laws of Your province/territory. With rights, however, come responsibilities including, for example, the expectation that You will provide complete and accurate information to the Insurers. Your policy outlines other important responsibilities. Insurers and their distribution networks, and governments also have important roles to play in ensuring that Your rights are protected.

Right to Be Informed
You can expect to access clear information about your policy, your coverage, and the claims settlement process. You have the right to an easy-to-understand explanation of how insurance works and how it will meet your needs. You also have a right to know how insurers calculate price based on relevant facts. Under normal circumstances, insurers will advise an insurance customer or the customer's intermediary of changes to, or the cancellation of a policy within a reasonable prescribed period prior to the expiration of the policy, if the customer provides information required for determining renewal terms of the policy within the time prescribed, which could vary by province, but is usually 45 days prior to expiry of the policy.

You have the right to ask who is providing compensation to your broker or agent for the sale of your insurance. Your broker or agent will provide information detailing for you how he or she is paid, by whom, and in what ways.

You have a right to be told about insurers' compensation arrangements with their distribution networks. You have a right to ask the broker or agent with whom you deal for details of how and by whom it is being paid. Brokers and agents are committed to providing information relating to ownership, financing, and other relevant facts.

Responsibility to Ask Questions and Share Information
To safeguard Your right to purchase appropriate coverage at a competitive price, You should ask questions about Your policy so that You understand what it covers and what Your obligations are under it. You can access information through one-on-one meetings with Your broker or agent. You have the option to shop the marketplace for the combination of coverages and service levels that best suits Your insurance needs. To maintain Your protection against loss, You must promptly inform Your broker or agent of any change in Your circumstances.

Right to Complaint Resolution
Insurers, their brokers and agents are committed to high standards of customer service. If you have a complaint about the service you have received, you have a right to access Lloyd's Underwriters' complaint resolution process for Canada. Your agent or broker can provide you with information about how you can ensure that your complaint is heard and promptly handled. Consumers may also contact their respective provincial insurance regulator for information. Lloyd's is a member of an independent complaint resolution office, the General Insurance OmbudService (www.giocanada.org).

Responsibility to Resolve Disputes
You should always enter into the dispute resolution process in good faith, provide required information in a timely manner, and remain open to recommendations made by independent observers as part of that process.

Right to Professional Service
You have the right to deal with insurance professionals who exhibit a high ethical standard, which includes acting with honesty, integrity, fairness and skill. Brokers and agents must exhibit extensive knowledge of the product, its coverages and its limitations in order to best serve You.

Right to Privacy
Because it is important for You to disclose any and all information required by an Insurer to provide the insurance coverage that best suits You, You have the right to know that your information will be used for the purpose set out in the privacy statement made available to you by your broker, agent or insurance representative. This information will not be disclosed to anyone except as permitted by law. You should know that the Insurers are subject to Canada's privacy laws with respect to their business in Canada.

10/12
LSW1565C

LLOYD'S UNDERWRITERS' POLICYHOLDERS' COMPLAINT PROTOCOL

Lloyd's strives to enhance your customer experience with us through superior service and innovative insurance products.

We have developed a formal complaint handling protocol in accordance with the Insurance Companies Act of Canada to ensure your concerns as our valued customer are addressed expeditiously by our representatives. This protocol will assist you in understanding the steps we will undertake to help resolve any dispute which may arise with our product or service. All complaints will be handled in a professional manner. All complaints will be investigated, acted upon, and responded to in writing or by telephone by a Lloyd's representative promptly after the receipt of the complaint. If you are not satisfied with our products or services, you can take the following steps to address the issue:

- Firstly, please contact the broker who arranged the insurance on your behalf about your concerns so that he or she may have the opportunity to help resolve the situation.

- If your broker is unable to help resolve your concerns, we ask that you provide us in writing an outline of your complaint along with the name of your broker and your policy number.

Please forward your complaint to:

Lloyd's Underwriters

Attention: Complaints Officer

1155 rue Metcalfe, Suite 2220, Montréal (Québec) H3B 2V6

Tel: 1-877-455-6937 Fax: (514) 861-0470

Email: lineage@lloyds.ca

Your complaint will be directed to the appropriate business contact for handling. They will write to you within two business days to acknowledge receipt of your complaint and to let you know when you can expect a full response. If need be, we will also engage internal staff in Lloyd's Policyholder and Market Assistance Department in London, England, who will respond directly to you, and in the last stages, they will issue a final letter of position on your complaint.

In the event that your concerns are still not addressed to your satisfaction, you have the right to continue your pursuit to have your complaint reviewed by the following organizations:

General Insurance OmbudService (GIO) assists in the resolution of conflicts between insurance customers and their insurance companies. The GIO can be reached at:

Toll free number: 1-877-225-0446

www.giocanada.org

For Québec clients:

Autorité des marchés financiers (AMF). The regulation of insurance companies in Québec is administered by the AMF. If you remain dissatisfied with the manner in which your complaint has been handled, or with the results of the complaint protocol, you may send your complaint to the AMF who will study your file and who may recommend mediation, if it deems this action appropriate and if both parties agree to it. The AMF can be reached at:

Toll Free: 1-877-525-0337
Québec: (418) 525-0337
Montréal: (514) 395-0311

www.lautorite.qc.ca

If you have a complaint specifically about Lloyd's Underwriters' complaints handing procedures you may contact the Financial Consumer Agency of Canada (FCAC).

Financial Consumer Agency of Canada (FCAC) provides consumers with accurate and objective information about financial products and services, and informs Canadians of their rights and responsibilities when dealing with financial institutions. FCAC also ensures compliance with the federal consumer protection laws that apply to bank and federally incorporated trust, loan and insurance companies. The FCAC does not get involved in individual disputes. The FCAC can be reached at:

427 Laurier Avenue West, 6th Floor, Ottawa ON K1R 1B9

Service in English: 1-866-461-FCAC (3222)
Service in French: 1-866-461-ACFC (2232)

www.fcac-acfc.gc.ca

07/12
LSW1542E

NOTICE CONCERNING PERSONAL INFORMATION

How we use your information

By purchasing insurance from certain underwriters at Lloyd's, London ("Lloyd's"), a customer provides Lloyd's with his or her consent to the collection, use and disclosure of personal information, including that previously collected, for the following purposes:

- The communication with Lloyd's policyholders
- The underwriting of policies
- The evaluation of claims
- The detection and prevention of fraud
- The analysis of business results
- Purposes required or authorized by law

What personal information we collect about you

We collect, process and store the following personal information about you:

- Name
- Address including postcode and country
- Policy number
- Claim number
- Credit card details
- Bank account details

We also collect information about you when you visit www.lloyds.com. Further details can be found on our online Privacy & Cookies policy at http://www.lloyds.com/common/privacy-and-cookies-statement.

We will not use your personal information for marketing purposes and we will not sell your personal information to anybody.

Who we disclose your information to

For the purposes identified, personal information may be disclosed to Lloyd's related or affiliated organizations or companies, their agents/mandataires, and to certain non-related or unaffiliated organizations or companies, including service providers. These entities may be located outside Canada therefore a customer's information may be processed in a foreign jurisdiction (the United Kingdom and the European Union) and there information may be accessible to law enforcement and national security authorities of the jurisdiction.

How to access your information and/or contact us

To access and request correction or deletion of your information or to obtain written information about Lloyd's policies and practices in respect of services providers located outside Canada, please contact the Ombudsman at info@lloyds.ca who will also answer customer's questions about the collection, use, disclosure or storage of their personal information by such Lloyd's service providers.

Further information about Lloyd's personal information protection policy may be obtained from the customer's broker or by contacting Lloyd's on: 514 861 8361, 1 877 455 6937, or through info@lloyds.ca

12/13
LSW1543A

INSURER'S LIABILITY

(Re)insurer's liability several not joint

The liability of a (re)insurer under this contract is several and not joint with other (re)insurers party to this contract. A (re)insurer is liable only for the proportion of liability it has underwritten. A (re)insurer is not jointly liable for the proportion of liability underwritten by any other (re)insurer. Nor is a (re)insurer otherwise responsible for any liability of any other (re)insurer that may underwrite this contract.

The proportion of liability under this contract underwritten by a (re)insurer (or, in the case of a Lloyd's syndicate, the total of the proportions underwritten by all the members of the syndicate taken together) is shown next to its stamp. This is subject always to the provision concerning "signing" below.

In the case of a Lloyd's syndicate, each member of the syndicate (rather than the syndicate itself) is a (re)insurer. Each member has underwritten a proportion of the total shown for the syndicate (that total itself being the total of the proportions underwritten by all the members of the syndicate taken together). The liability of each member of the syndicate is several and not joint with other members. A member is liable only for that member's proportion. A member is not jointly liable for any other member's proportion. Nor is any member otherwise responsible for any liability of any other (re)insurer that may underwrite this contract. The business address of each member is Lloyd's, One Lime Street, London EC3M 7HA. The identity of each member of a Lloyd's syndicate and their respective proportion may be obtained by writing to Market Services, Lloyd's, at the above address or by emailing Market Services, Lloyd's at enquiries@lloyds.com.

Proportion of liability

Unless there is "signing" (see below), the proportion of liability under this contract underwritten by each (re)insurer (or, in the case of a Lloyd's syndicate, the total of the proportions underwritten by all the members of the syndicate taken together) is shown next to its stamp and is referred to as its "written line".

Where this contract permits, written lines, or certain written lines, may be adjusted ("signed"). In that case a schedule is to be appended to this contract to show the definitive proportion of liability under this contract underwritten by each (re)insurer (or, in the case of a Lloyd's syndicate, the total of the proportions underwritten by all the members of the syndicate taken together). A definitive proportion (or, in the case of a Lloyd's syndicate, the total of the proportions underwritten by all the members of a Lloyd's syndicate taken together) is referred to as a "signed line". The signed lines shown in the schedule will prevail over the written lines unless a proven error in calculation has occurred.

Although reference is made at various points in this clause to "this contract" in the singular, where the circumstances so require this should be read as a reference to contracts in the plural.

LMA3333 *(amended)*

PREMIUM PAYMENT CLAUSE

The Insured undertakes that premium will be paid monthly to Underwriters within 30 days of month end in respect of each declaration.

If the premium due under this policy has not been so paid to Underwriters by the 60th day from the inception of this policy (and, in respect of instalment premiums, by the date they are due) Underwriters shall have the right to cancel this policy by notifying the Insured via the broker in writing. In the event of cancellation, premium is due to Underwriters on a pro rata basis for the period that Underwriters are on risk but the full policy premium shall be payable to Underwriters in the event of a loss or occurrence prior to the date of termination which gives rise to a valid claim under this policy.

It is agreed that Underwriters shall give not less than 30 days prior notice of cancellation to the Insured via the Coverholder. If premium due is paid in full to Underwriters before the notice period expires, notice of cancellation shall automatically be revoked. If not, the policy shall automatically terminate at the end of the notice period.

Unless otherwise agreed, the Leading Underwriter (and Agreement Parties if appropriate) are authorised to exercise rights under this clause on their own behalf and on behalf of all Underwriters participating in this contract.

If any provision of this clause is found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability will not affect the other provisions of this clause which will remain in full force and effect.

Where the premium is to be paid through a London Market Bureau, payment to Underwriters will be deemed to occur on the day of delivery of a premium advice note to the Bureau.

11/01
LSW3000 *(amended)*

SERVICE OF SUIT CLAUSE (CANADA)
(Action against Insurer)

In any action to enforce the obligations of the Underwriters they can be designated or named as “Lloyd’s Underwriters” and such designation shall be binding on the Underwriters as if they had each been individually named as defendant. Service of such proceedings may validly be made upon the Attorney In Fact in Canada for Lloyd’s Underwriters, whose address for such service is 1155, rue Metcalfe, Suite 1540, Montreal, Quebec, H3B 2V6.

LMA5028
10/08/06
Form approved by Lloyd’s Market Association

INTENTION FOR AIF TO BIND CLAUSE

Whereas Lloyd's Underwriters have been granted an order to insure in Canada risks under the Insurance Companies Act (Canada) and are registered in all provinces and territories in Canada to carry on insurance business under the laws of these jurisdictions or to transact insurance in these jurisdictions.

And whereas applicants for insurance coverage in respect of risks located in Canada and Canadian Cedants wish that Lloyd's insurance and reinsurance coverage be provided in a manner that requires Lloyd's Underwriters to vest assets in trust in respect of their risks pursuant to the Insurance Companies Act (Canada);

a) This contract shall be in force and shall be the governing contract pending the decision by Lloyd's Underwriters' attorney and chief agent in Canada (the "AIF") to confirm coverage in accordance with both the terms and conditions set out in this contract and applicable Canadian law;

b) The AIF shall confirm Lloyd's Underwriters' coverage by signing in Canada a policy that will contain the terms and conditions set out in this contract (the "Canadian Policy"), and by communicating from Canada the issuance of that policy to the policyholder or its broker;

c) This contract shall cease to have effect upon the communication by the AIF from Canada of the Canadian Policy to the policyholder or his broker, and the Canadian Policy will replace and supersede this contract.

LMA5180
01 November 2011

INSTITUTE CYBER ATTACK EXCLUSION CLAUSE

1.1 Subject only to clause 1.2 below, in no case shall this insurance cover loss damage liability or expense directly or indirectly caused by or contributed to by or arising from the use or operation, as a means for inflicting harm, of any computer, computer system, computer software programme, malicious code, computer virus or process or any other electronic system.

1.2 Where this clause is endorsed on policies covering risks of war, civil war, revolution, rebellion, insurrection, or civil strife arising therefrom, or any hostile act by or against a belligerent power, or terrorism or any person acting from a political motive, Clause 1.1 shall not operate to exclude losses (which would otherwise be covered) arising from the use of any computer, computer system or computer software programme or any other electronic system in the launch and/or guidance system and/or firing mechanism of any weapon or missile.

CL380

10 November 2003

HEATHSURE PREMIUM MEDICAL INSURANCE
Effected with certain Lloyd's Underwriters as scheduled herein ("the Insurers"), through Lloyd's Approved Coverholder ("the Coverholder"):
MSH INTERNATIONAL (CANADA) LTD., Suite 300, 999 – 8th Street S.W., Calgary, Alberta, Canada T2R 1N7

DECLARATIONS

POLICY NO: BA1052

BINDER AGREEMENT NO: PM8277418

POLICYHOLDER:

POLICYHOLDER ADDRESS:

PERIOD OF INSURANCE:
From: March 1, 2019
To: February 29, 2020
(Both days inclusive, local standard time at the address of the Insured).

ANNUAL ESTIMATED PREMIUM*: $ CAD

*The premium listed is an estimated premium based on the census information provided pre-inception and is subject to adjustment at agreed periods based on actual census data.

LIMIT OF LIABILITY OR AMOUNT OF INSURANCE:

HealthSure Premium Medical :	$1,000,000 per lifetime
Critical illness:	$25,000 per lifetime

The insurance contract consists of this Declarations page as well as all coverage wordings, riders, or endorsements that are attached hereto.

IDENTIFICATION OF INSURER / ACTION AGAINST INSURER
This insurance has been effected in accordance with the authorization granted to the Coverholder by the Underwriting Members of the Syndicates whose definitive numbers and proportions are shown in the Table attached to Agreement No. **PM8277418** (hereinafter referred to as "the Underwriters"). The Underwriters shall be liable hereunder each for his own part and not one for another in proportion to the several sums that each of them has subscribed to the said Agreement.

In any action to enforce the obligations of the Underwriters they can be designated or named as "Lloyd's Underwriters'' and such designation shall be binding on the Underwriters as if they had each been individually named as defendant. Service of such proceedings may validly be made upon the Attorney In Fact in Canada for Lloyd's Underwriters, whose address for such service is 1155 rue Metcalfe, Suite 2220, Montreal, Quebec H3B 2V6.

NOTICE
Any notice to the Underwriters may be validly given to the Coverholder.

In witness whereof this policy has been signed as authorized by the Underwriters, by MSH INTERNATIONAL (CANADA) LTD.

Signed	**Date**

The Insured is requested to read this policy, and if incorrect, return it immediately for alteration.

In the event of an occurrence likely to result in a claim under this insurance, immediate notice should be given to the Coverholder whose name and address appears above. All inquiries and disputes are also to be addressed to this Coverholder.

For the purpose of the Insurance Companies Act (Canada), this Canadian Policy was issued in the course of Lloyd's Underwriters' insurance business in Canada.

THIS POLICY CONTAINS A CLAUSE WHICH MAY LIMIT THE AMOUNT PAYABLE

LSW1548B *(amended)*
14 December 2011

List of Insurers not of Open Market Insurers

Syndicate	Coverage(s) Insured	Sum(s) Insured or Percentage
Markel Syndicate under UMR: B0595PM8277418 Markel Syndicate*: 3000	HealthSure Premium Medical	40%
HCC Underwriting Agency under UMR: B0595PM8277418 HCC Underwriting Agency Syndicate: 4141	HealthSure Premium Medical	40%
MS Amlin under UMR: B0595PM8277418 MS Amlin Syndicate: 2001	HealthSure Premium Medical	10%
AmTrust under UMR: B0595PM8277418 AmTrust Syndicate: 1861	HealthSure Premium Medical	10%

*Lead Syndicate

07/05
LSW1546

MSH INTERNATIONAL PRIVACY POLICY

At MSH INTERNATIONAL (CANADA) LTD., we recognize and respect every individual's right to privacy. When You apply for coverage or Benefits, we establish a confidential file of personal information.

We use the information to administer the plan. This includes many tasks, such as:

- Determining an Insured Person's eligibility for coverage under the plan
- Enrolling Insured Persons for coverage
- Assessing an Insured Person's claims and providing them with payment
- Managing an Insured Person's claims
- Verifying and auditing eligibility and claim
- Underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Providing the applicable Regulatory Forms and Tax Receipts, upon request

We limit access to information in the Insured Person's file to MSH INTERNATIONAL (CANADA) LTD. staff or persons authorized by MSH INTERNATIONAL (CANADA) LTD. who require it to perform their duties, to persons to whom the Insured Person has granted access, and to persons authorized by law. MSH INTERNATIONAL (CANADA) LTD., the Insured Person's health care provider, other insurance and reinsurance companies, and the plan administrator of the policyholder may also exchange information when the information is needed to administer the group Benefit plan.

For questions or concerns regarding the collection, use, disclosure or storage of personal information, please contact the Privacy Officer by mail or email. Concerns will be addressed within 30 days.

MSH INTERNATIONAL (CANADA) LTD.
c/o Privacy Officer
Suite 300, 999 - 8th Street S.W.
Calgary, Alberta, Canada T2R 1N7
Email: privacyofficer@americas.msh-intl.com

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INSURING AGREEMENT
In consideration of the payment of the premium, the Insurers agree with the policyholder to reimburse up to the limits detailed in this policy for costs incurred during the policy term subject to all of the exceptions, limitations and provisions of this policy.

Any word explained in the Definitions section herein will have the same meaning throughout this document. The currency of this policy is expressed in Canadian dollars (CAD).

SANCTION LIMITATION AND EXCLUSION CLAUSE
No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade and economic sanctions, laws or regulation of the European Union, United Kingdom or United States of America.

GEOGRAPHICAL AREA OF COVERAGE: Canada and the United States. Coverage outside of Canada and the United States will be considered on a case by case basis and will be subject to the Insurer's approval.

EFFECTIVE DATE AND POLICY TERM
This policy takes effect at 12:00 a.m., local standard time on the date stated in the application for coverage or the date coverage is approved by the Insurer and from which date all insurance months shall be calculated. It continues in force for the period for which premium has been paid. Coverage may be renewed subject to approval by the Insurer for further consecutive terms, not exceeding 12 months, on payment of premium at the rate and in the amount determined at the time of renewal by the Insurer.

GRACE PERIOD
To keep the HealthSure Plus insurance of an Insured Person in force, each premium must be paid no later than 31 days after its Premium Due Date. This 31 day period is known as the **"Grace Period"**. If any premium is not paid within the Grace Period, the applicable HealthSure Plus insurance will terminate on the expiration of the Grace Period effective from the Premium Due Date of the unpaid premium.

HIGH RISK COVERAGE
The Insurers reserve the right to exclude or surcharge coverage in countries deemed to be locations of extreme risk. Locations of extreme risk are subject to change based on the Insurer's assessment. Advance notification of 15 days will be provided by MSH INTERNATIONAL (CANADA) LTD. to employers with employees or Dependants in locations deemed to be of extreme risk before any surcharge becomes applicable.

OTHER INSURANCE
If, at the time of loss, the Insured Person has insurance from another source for Benefits provided under this policy, the policy with the earliest Effective Date will be deemed to be first payor. Any Benefits payable by the following shall not be considered as a covered cost under this policy:

- Any group or individual Hospital or medical plan.
- Any government Hospital or medical plan.
- Any Worker's Compensation Act.
- Any public or tax-supported agency.

PREMIUM PAYMENT

a) Premium Due Dates

Premiums are payable in advance on either an annual basis, or a monthly basis through the pre-authorized payment plan. The **"Premium Due Date"** with respect to premiums paid on i) an annual basis, will be the first day of every Policy Year or alternatively, on ii) a monthly basis, will be the first day of every Policy Month.

b) Computation of Premiums

Premium rates for HealthSure Plus are based on the Member's Age at renewal and the type of plan selected (either Single Plan, Couple Plan, Family Plan or Single with Children Plan). Where the Couple or Family Plan is selected, premium rates will be based on the Age of the older Insured Person.

Premium rates for Critical Illness are based on the Insured Person's Age and smoking status.

Premium rates will increase where the rates are based on Age, as specified in the applicable Table of Premium Rates shown below.

Members who elect to pay premiums on a monthly basis will be required to complete a pre-authorized payment plan form.

The first Premium Due Date for the Insurance Coverage of an Insured Person is the first of the month coincident with the Issue Date (the **"First Premium Due Date"**).

With respect to premiums paid on an annual basis, the first premium payable will be calculated as the product of the applicable monthly premium rate then in effect multiplied by the number of months from the First Premium Due Date to the end of the then current Policy Year stated above. Subsequent annual premiums will be payable on each and every subsequent Premium Due Date.

TABLE OF PREMIUM RATES

Any change in the premium rates set out below will be determined by the Company and effected on any Renewal Date. Notice of any premium rate change will be provided to the Policyholder in writing not less than 30 days prior to the effective date of such change.

All references to Premiums in the Policy are in Canadian dollars.

HealthSure Plus

	Monthly Premium Rates			
Age at Effective date of contract	Single	Couple	Single with Children**	Family
Under 30	$44.69	$71.19	$75.60	$102.10
30 - 39	$51.51	$84.82	$79.01	$112.35
40 - 44	$61.34	$104.47	$90.40	$133.53
45 - 49	$75.49	$132.80	$102.10	$159.40
50 - 54	$85.59	$152.98	$111.33	$178.73
55 - 59	$94.77	$171.36	$120.84	$197.41
60 - 64	$104.42	$190.63	$126.85	$213.08
65 - 69	$118.74	$218.68	$140.81	$241.36

**The Single with Children rate is limited to 2 or less children. Single parents with 3 or more children will be charged the Family rate.

Corporate Rates*:	Single	$51.67
	Couple	$103.34
	Single with 2 Children	$103.34
	Family	$103.34

*A corporate group is considered to be any company with 2 or more lives to be insured.

Critical Illness Insurance

Monthly Premium Rates

NON - SMOKER	
Age at	Benefit Amount
01 January	$25,000
Under 25	$6.61
25-29	$8.92
30-34	$11.23
35-39	$13.65
40-44	$18.69
45-49	$28.55
50-54	$40.41
55-59	$53.74
60-64	$90.36
65-69**	$132.75

SMOKER	
Age at	Benefit Amount
01 January	$25,000
Under 25	$9.65
25-29	$17.63
30-34	$23.83
35-39	$29.49
40-44	$43.25
45-49	$73.56
50-54	$111.56
55-59	$153.63
60-64	$257.43
65-69**	$381.58

* Non-Smoker rates apply to applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum etc) within the last 12 months.

** Renewal rates only, last age to apply is 64.

PREMIUM ADJUSTMENTS

If a notice of termination of HealthSure Plus in respect of an Insured Person is not received by the Company within three months after the date he ceased to be eligible for HealthSure Plus under this Policy, the Company will not be obliged to refund premiums for any period prior to the Premium Due Date coincident with or immediately preceding three months from the date that such notice is received by the Company or the end of the preceding Policy Year, whichever is later. This will not affect the actual date of termination of HealthSure Plus in respect of the Insured Employee which will be governed by the applicable provisions of this Policy.

GROUP ADMINISTRATION OF POLICY

A completed Application Form must be signed by the individual to be insured and received within 30 days of the member's first day of employment in order for coverage to become effective on this date. If an application is received after the 30-day grace period, coverage will be backdated a maximum of 30 days from the date it is received.

The termination of an Insured Person or the addition of a new Dependent must be communicated immediately and may be backdated a maximum of 90 days from the date of receipt. The termination of an Insured Person may only be backdated 90 days provided no claims have been paid during this period.

GROUP PREMIUM ADJUSTMENTS

Any changes received by MSH INTERNATIONAL (CANADA) LTD. by the 15th of the month, prior to the billing month, will appear on the current invoice. Any changes received after the 15th of the month will appear on your next invoice.

Premiums are billed as followed:

- Should an Insured Person become effective on the first of the month, premiums will be due for the entire month.
- Should an Insured Person become effective after the first of the month, premiums will not be charged until the following month.

• Should an Insured Person terminate on the first of the month, premiums will not be charged for the month.

• Should an Insured Person terminate after the first of the month, premiums will be charged for the entire month.

ELIGIBILITY

A Member whom, at the time of application, resides in Canada, is under Age 75 and covered under the provincial health insurance plan of their province of residence, is eligible to apply for HealthSure Premium Insurance which must include Critical Illness Insurance and a minimum of HealthSure Plus, Single Plan coverage.

Provided a Member purchases HealthSure Plus on a Couple Plan or Family Plan basis, the Spouse is also eligible for Critical Illness Insurance.

For the purposes of this policy, Insured Persons shall also be considered as those persons who:

- Have completed and signed the application form in acceptance of the policy terms and conditions;
- Have paid the required premium or had such premium paid on their behalf by the policyholder.

a) HealthSure Plus

HealthSure Plus is available on a Single Plan, Couple Plan, Family Plan or Single with Children Plan basis.

An eligible Member may apply for HealthSure Plus:

1) Under the Couple Plan or Family Plan for a Spouse, who at the time of application, resides in Canada, is under age 75 and covered under the provincial health insurance plan of their province of residence;
2) Under the Family or Single with Children Plan for a Dependent Child, who at the time of application, resides in Canada and is covered under the provincial health insurance plan of their province of residence.

Where a Member and Spouse are both eligible for HealthSure Premium Insurance as a Member, HealthSure Plus coverage is limited to one of the following options:

i) A Single Plan basis for both Members; or
ii) A Couple Plan basis whereby only the oldest Member applies; or
iii) A Single with Children Plan basis for one Member and a Single Plan basis for the other Member ; or
iv) A Family Plan basis whereby only the oldest Member applies.

b) Critical Illness Insurance

Critical Illness Insurance is available to all eligible Members who enroll in a minimum of HealthSure Plus, Single Plan coverage.

A Spouse of an eligible Member who at the time of application, resides in Canada and is also under age 70 is eligible to apply for Critical Illness Insurance provided the Spouse is also enrolled for HealthSure Plus as a Spouse under the Couple Plan or Family Plan.

TERMINATION DATE OF INSURANCE

A. Termination of HealthSure Plus

The HealthSure Plus in respect of an Insured Person will terminate on the earliest of the following dates:

a) the date the Policy terminates;

b) the date the Policyholder discontinues or suspends active operation, is placed in bankruptcy or receivership, loses its business or charter by means of dissolution, merger or otherwise;

c) the Premium Due Date of any unpaid premium as described under the heading Premium Payments;

d) the end of the Policy Month coincident with or the Insured Person's 75th birthday;

e) when the Company determines that material misrepresentation, fraud, substantial breach in contractual duties, conditions or warranties has occurred;

f) the date that the lifetime maximum benefit of $1,000,000 has been paid;

g) the date of death of the Insured Person;

h) the date the Insured Person enters full-time military service;

i) the end of the Policy Month coincident with the date on which the Insured Person no longer qualifies as a Member for insurance under this Policy;

j) the end of the Policy Month coincident with the date the Company receives written notice from the Insured Person requesting cancellation of all of their Critical Illness Insurance or all or part of the HealthSure Plus.

k) with respect to an Insured Spouse, the earlier of the above dates or i) the end of the Policy Month coincident with the date the Insured Spouse no longer qualifies as a Spouse as defined under the Policy, or ii) the end of the Policy Month coincident with the date of death of the Insured Person, or iii) the last day of the month in which the Insured Spouse reaches age 75; and

l) with respect to an Insured Dependent Child, the earlier of the above dates or i) the end of the Policy Month coincident with the date of death of the Insured Person or ii) the end of the Policy Month coincident with the date the Insured Dependent Child no longer qualifies as a Dependent Child as defined under the Policy.

If an Insured Person's Critical Illness Insurance coverage terminates due to attainment of age 70 as described in section B, a), iii) below, the HealthSure Plus in force at the termination date may continue uninterrupted, subject to the provisions of this subsection A.

B. Termination of Critical Illness Insurance

a) The Critical Illness Insurance in respect of an Insured Person will terminate automatically on the earliest of the following dates:

   i) the date the Policy terminates;

   ii) the Premium Due Date of any unpaid premium as described under the heading Premiums and Premium Payments;

   iii) the end of the Policy Month coincident with the Insured Person's 70th birthday;

   iv) the date that the Critical Illness Benefit is paid;

   v) the date of death of the Insured Person;

   vi) the end of the Policy Month coincident with the date the Company receives written notice from the Insured Person requesting cancellation of the HealthSure Plus portion of their HealthSure Premium Insurance; and

   vii) the end of the Policy Month coincident with or next following the date the Company receives written notice from the Insured Person requesting cancellation of all or part of the Critical Illness Insurance coverage. If partial cancellation is requested, only the requested portion of such Critical Illness Insurance will be cancelled.

b) The Critical Illness Insurance in respect of an Insured Spouse will terminate automatically on the earliest of the following dates:

   i) the date the Policy terminates;

   ii) the Premium Due Date of any unpaid premium as described under the heading Premiums and Premium Payments;

   iii) the end of the Policy Month coincident with the Insured Person's 70th birthday;

iv) the end of the Policy Month coincident with the Insured Spouse's 70th birthday;

v) the date that the Critical Illness Benefit is paid;

vi) the date of death of Insured Spouse;

vii) the end of the Policy Month coincident with the death of the Insured Person;

viii) the end of the Policy Month coincident with the date the Company receives written notice from the Insured Person requesting the Critical Illness Insurance portion of their HealthSure Premium Insurance;

ix) the end of the Policy Month coincident with the date the Company receives written notice from the Insured Person requesting cancellation of all or part of the Spouse's Critical Illness Insurance. If partial cancellation of the Spouse's Critical Illness Insurance is requested, only the requested portion of such Insurance Coverage will be cancelled; and

x) the end of the Policy Month coincident with the date on which the Insured Spouse no longer qualifies as a Spouse.

Termination of this Policy and the Insurance in respect of an Insured Person will not prejudice any claim where the Policy has been terminated in accordance with the provisions under the "Claims Provisions" section of this Policy. The Limitations, Exclusions and other terms and conditions of coverage in the Policy will apply.

DEFINITIONS

Accident: Any sudden and unforeseen event occurring during the policy term, resulting in bodily Injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

Age: The attained age of the Insured Person on each and every first day of January in any Policy Year.

Application Form: The application submitted by the Policyholder for HealthSure Plus and HealthSure Premium under this Policy.

Association: An entity, approved by Us, usually chartered, whose members share a common interest or an entity which provides a recognized service. Examples include professions, unions, alumni, and service organizations.

Benefits: Any covered expenses/services that the Insurer will pay under this policy.

Chronic Medical Condition: a disease, Sickness or Injury resulting in the Insured Person having a medical condition which has at least one of the following characteristics:

- the condition continues indefinitely and has no known cure
- the condition comes back or is likely to come back
- the condition is permanent
- the condition results in the Insured Person needing to be rehabilitated or specially trained to cope with it
- the condition results in the Insured Person needing long term medical care which includes continual medication to control, regular monitoring, consultation, check-ups, examinations or tests.

Corrective device: a medical device that supports or corrects the function of a body part.

Couple Plan: Type of plan under HealthSure Plus which provides coverage for an eligible Member and an eligible Spouse.

Date of Diagnosis: Has the meaning set out under the heading "Critical Illness Insurance".

Day Patient: A patient who occupies a Hospital bed or is charged for a Hospital bed for less than 24 hours.

Dependent Child: Any unmarried child of the under the age of 19, who is a child by birth, legal adoption, a stepchild or Member a foster child and for whom the Member provides more than 50% support and maintenance.

An unmarried child who is age 19 but not yet 25 is considered an eligible Dependent Child, if enrolled as a full-time student at an accredited school, college or university, and for whom the Member continues to provide more than 50% support and maintenance.

Diagnosis: The certified diagnosis of the Insured Person with a Covered Critical Illness Condition by a Specialist.

Effective Date: The date on which the coverage under this policy begins.

Emergency: A sudden and unexpected medical condition or Injury that requires immediate medical treatment. The condition or injury must have manifested itself while this policy is in force as to the Insured Person.

Family Member: Any person related to an Insured Person, by blood or by marriage.

Family Plan: The type of plan under HealthSure Plus which provides coverage for an eligible Member, Spouse and Dependent Children.

First Premium Due Date: Has the meaning set out under the heading "Premiums Payments".

Grace Period: Has the meaning set out under the heading "Premiums Payments".

Group Insurance Certificate: The certificate evidencing enrollment of a Member, Spouse and/or Dependent Children in the Insurance Coverage, this certificate is issued to the Member and includes any addendum attached thereto.

Hospital: An institution contracted with Us, located within the Geographical Area of Coverage, when /where services are available. It must maintain organized facilities for medical, diagnostic and surgical care for patients who are Hospital Confined and for which a charge is made that the Insured Person is legally obligated to pay, maintain a staff of one or more duly licensed Physicians, provide 24-hour a day nursing care under supervision of a registered graduate professional nurse (R.N.), have surgical facilities on its premises or have a contract with another institution with a valid license to provide surgical services, and be legally operating in the jurisdiction where it is located.

Except when provided elsewhere in the Policy, "Hospital" does not include an institution that is principally for: rest, nursing, long-term, extended, or custodial care; convalescence; care of the aged, alcoholics, drug addicts, or runaways. Also, it does not include services rendered at a military or veteran's hospital, soldier's home or any Hospital that is contracted for or operated by the federal government or any of its agencies for members or former members of the Armed Forces, unless an Insured Person is legally required to pay for the services.

Injury: Sudden, traumatic accidental or unanticipated damage to the body not of gradual onset. The cause must be external, physically violent, and precede the damage.

Inpatient: A patient who occupies a Hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a Physician or Surgeon.

Insured Dependent Child: An Insured Person who is a Dependent Child.

Insured Person: An eligible person as defined in the eligibility section of this policy.

Insured Spouse: An Insured Person who is a Spouse.

Insurer: Certain Lloyd's Underwriters who provide this insurance.

Issue Date: The date that enrollment of the Insured Person becomes effective.

Maximum Amount Payable: The fee negotiated between the Physician, Hospital or Outpatient Surgical Facility and Us.

Medically Necessary: The shortest, least expensive, or least intense level of treatment, care or service rendered or supply provided, as determined solely by Us, to the extent required to diagnose or treat an Injury or Sickness. The service or supply must be consistent with the Insured Person's medical condition, is known to be safe and effective by most Physicians who are licensed to treat the condition at the time the service is rendered, and is not provided primarily for the convenience of the Insured Person or Physician.

Member: A member in good standing of an Association if the Policyholder is an Association, or a member of a Client Group if the Policyholder is a Client Group, as indicated on the Application Form.

Mental, Nervous and Emotional Disorders: Mental, Nervous and Emotional Disorders are any disorders that are listed in Chapter V (Mental and Behavioral Disorders) of the International Statistical Classification of Diseases and Related Health Problems 10th Revision by the World Health Organization (WHO). *(*http://www.who.int/classifications/icd).

MSH INTERNATIONAL (CANADA) LTD.: The third party administrator and claims administrator appointed by the Insurer.

Non-Smoker: Applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum etc) within the last 12 months before the Effective Date of their policy.

Occurrence: Each treatment plan approved by Us for an Insured Person. A succeeding treatment plan is considered an Occurrence if the treatment plans are separated by both the Insured Person's return to Canada or province of residence and a period not less than twenty-four (24) hours.

Outpatient Surgical Facility: A licensed public or private medical facility located within the Geographical Area of Coverage, when services are available, that is contracted with Us and that has an organized staff of Physicians and permanent facilities equipped and operating primarily to perform surgery. The facility must provide continuous Physician and registered professional nursing services whenever a patient is in the facility.
"Outpatient Surgical Facility" includes a facility that is operated by a Hospital that provides scheduled, non-emergency and outpatient surgical care. It does not include: a Hospital emergency room, trauma centre, Physician's office or clinic.

Physician: A qualified doctor of medicine (M.D.) who is duly registered and licensed in the jurisdiction in which he or she practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his or her licensed authority. The Physician cannot be a Family Member of the Insured Person.

Policy Year: The Policy Term as indicated on the cover page of this policy.

Policyholder: An individual or corporation who purchases this coverage.

Pre-Authorization: The process We employ to ensure We have been notified before services are provided, of an admission or provision of service in order to determine if the admission or provision of service is Medically Necessary and covered by the Policy.

Pre-Existing Condition: Means any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnose or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the Insured Person or would have been received by a prudent individual with in the 24 months immediately preceding the effective date of initial coverage or the effective date of an increase in the amount of an Insured Person's Critical Illness Insurance coverage.

Premium Due Date: Has the meaning set out under the heading "Premium Payment".

Prosthesis: a device, external or implanted, that substitutes for, or supplements a missing or defective part of the body.

Related Medical Condition: Any medical condition for which the Insured Person has experienced symptoms, received medication, advice or treatment in the 24 months prior to the Effective Date of an Insured Person's coverage, whether the condition has been diagnosed or not and which in the opinion of Our chief medical officer, is considered to be an underlying cause of, or directly related to the medical condition which is the subject of the claim.

Sickness: A disorder of an Insured Person's bodily function or structure causing physical symptoms which, if not treated, would result in deterioration of the Insured Person's health.

Single Plan: The type of plan under HealthSure Plus which provides coverage for an eligible Member only.

Single with Children Plan: The type of plan under HealthSure Plus which provides coverage for an eligible Member and their Dependent Children.

Specialist: A physician licensed and practicing in Canada whose practice is limited to the particular branch of medicine relating to the applicable Covered Critical Illness Condition and who is not the Insured Person, a relative or business associate of the Insured Person.

Spouse: A person to whom the Member is married, which marriage was solemnized, authenticated and recorded as required by the province in which the marriage took place.
Spouse also means a person to whom the Member is married, or in common-law, which common-law marriage is fully recognized and sanctioned in the province of residence.

Surgical/Procedural Waiting List: A list of patients who have been recommended for surgical or diagnostic procedure by an appropriate specialist Physician in Canada, and for whom the procedure has not been initiated or completed.

We, Us, Our: means MSH INTERNATIONAL (CANADA) LTD.

DEFINITIONS APPLICABLE TO CRITICAL ILLNESS BENEFITS:

Critical Illness Benefit: Has the meaning set out under the heading "Critical Illness Insurance".

Critical Illness Insurance: The insurance coverage described under the heading "Critical Illness Insurance".

Covered Critical Illness Conditions: for which a Benefit is paid under Critical Illness Insurance are Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Dismemberment, Heart Attack, Kidney Failure, Loss of Speech, Major Burns, Major Organ Failure Requiring Transplant, Multiple Sclerosis, Paraplegia/Quadriplegia/Hemiplegia, Parkinson's Disease and Stroke.

Covered Critical Illness Conditions:

Alzheimer's Disease: A progressive degenerative disease of the brain. The Diagnosis of Alzheimer's Disease must be made by a certified neurologist licensed and practicing in Canada. The Insured Person must exhibit loss of intellectual capacity involving impairment of memory and judgment which results in significant reduction in mental and social functioning such that the Insured Person requires supervision for daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded.

Amyotrophic Lateral Sclerosis (ALS): The unequivocal diagnosis of ALS by a neurologist licensed and practicing in Canada.

Benign Brain Tumour: A benign tumour within the substance of the brain. Excluded are cysts, granulomas, meningiomas, malformations of the intracranial arteries or veins, or tumours of the cranial nerves, pituitary or spinal cord.

Blindness: Permanent loss of sight in both eyes, as confirmed by an ophthalmologist registered and licensed to practice in Canada. The corrected visual acuity must be 20/200 or less in both eyes or the field of vision must be less than 20 degrees in both eyes.

Cancer: A malignancy characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The following conditions are NOT covered: early prostate cancer diagnosed as T1 N0 M0 or equivalent staging; pre-malignant lesions, benign tumours or polyps; non-invasive cancer in-situ; any skin cancer, other than invasive malignant melanoma into the dermis or deeper; and any tumour in the presence of the human immunodeficiency virus (HIV).

Coma: A state of unconsciousness with no reaction to external stimuli, for a continuous period of at least 96 hours. The Diagnosis must be made by a neurologist licensed and practicing in Canada.

Coronary Artery Bypass Surgery: Heart surgery performed to correct narrowing or blockage of one or more coronary arteries with bypass grafts and which has been recommended by a consultant cardiologist registered and licensed to practice in Canada. Non-surgical techniques such as balloon angioplasty, laser embolectomy or other non-bypass techniques are excluded.

Deafness: The permanent and profound loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as confirmed by an otolaryngologist registered and licensed to practice in Canada.

Dismemberment: The total and permanent "loss" of any two limbs. "Loss" as used with reference to arm or leg means complete severance at or above the elbow or knee joint.

Heart Attack: (Myocardial Infarction) means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnostic must be confirmed by both: 1) new electrocardiographic changes indicative of a myocardial infarction or by a new clinical presentation, only in cases where the ECG cannot be interpreted (complete bundle branch block, WPW, pace-maker), and 2) characteristic changes of cardiac biochemical markers (troponine or CPK or CPK-MB) to levels consistent with acute myocardial infarction. *Exclusions:* 1) Heart Attack occurring in the 48 hours following an elective revascularization procedure, unless

it is accompanied by new pathological Q waves. 2) Heart Attack diagnosed by any other method, unless the diagnosis is confirmed as described above.

Kidney Failure: Permanent irreversible failure of both kidneys which necessitates treatment by regular peritoneal dialysis, haemodialysis or kidney transplantation.

Loss of Speech: The total, permanent and irreversible loss of the ability to speak for a continuous period of 180 days due to physical injury or physical disease. The Diagnosis must be made by an appropriate Specialist.

Major Burns: Third degree burns covering at least 20% of the surface area of the body of the Insured Person. The Diagnosis must be made by a plastic surgeon licensed and practicing in Canada.

Major Organ Failure Requiring Transplant: The irreversible failure of the heart, liver, bone marrow, both lungs and both kidneys requiring a transplant of that organ, resulting in the Insured Person being accepted into a recognized transplant program in Canada. The Insured Person must survive at least 30 days following the date of enrollment into the transplant program.

Multiple Sclerosis: A diagnosis by a neurologist of definite Multiple Sclerosis, characterized by well-defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis.

Paraplegia/Quadriplegia/Hemiplegia: Paralysis resulting in complete and permanent loss of use of two or more limbs without interruption for a period of 90 days. At the end of such period, the Specialist must certify that the paralysis is complete and permanent.

Parkinson's Disease: The Diagnosis of primary idiopathic Parkinson's Disease by a neurologist licensed and practicing in Canada and characterized by the clinical manifestation of two or more of the following: rigidity, tremor or bradykinesis. All other types of Parkinsonism are excluded.

Stroke: An acute cerebral vascular accident (CVA) producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least thirty (30) days following the occurrence of the stroke. Transient Ischemic Attacks (TIAs) are not covered.

POLICY EXCLUSIONS

This Policy does not provide HealthSure Plus Benefits for the following:

1. Services and supplies that are:
   a) Not Medically Necessary;
   b) Not recommended or approved by a Physician;
   c) Not rendered within the scope of the Physician's license;
   d) Furnished by a government plan, Hospital or institution unless the Insured Person is legally required to pay for the services;
   e) Charged in excess of the Maximum Amount Payable;
   f) Provided without prior written Pre-Authorization by Us; or
   g) Provided after the termination date of an Insured Person's HealthSure Plus insurance, except as outlined under subsection 18 Effect on Claims of Termination of Insurance, under the heading General Policy Terms.
2. Injury or Sickness occurring during or arising from an Insured Person's course of employment for which benefits are provided or payable under Workers' Compensation or under any Act or Law which provides benefits for such Injury or Sickness for which an Insured Person failed to file a claim for Workers' Compensation benefits for which they were eligible.
3. Injury or Sickness caused by: an act of declared or undeclared war; service in the military forces of any country, including non-military units supporting such forces; the Insured Person committing or attempting to commit civil tort or an indictable offence, taking part in a riot (meaning the Insured Person is taking an active part in common with three or more others by using or threatening to use force or violence without authority of law).
4. Injury or Sickness, while sane or insane, resulting from or related to self-inflicted sickness or injury, flagrant self-abuse such as continued behaviour contrary to a Physician's recommendation, suicide, threatened suicide, alcohol abuse, or drug addiction or abuse. This includes an accident where alcohol or drugs were involved; treatment related to any psychological, mental, Nervous or emotional disorders, treatment of any sexually transmitted disease, except as indicated under sub section 2 c) vi) in this section.
5. Procedures, devices, services, supplies, or drugs that We consider experimental or investigative in the area where service is received.
6. Plastic or cosmetic surgery, unless for reconstruction caused by a covered Injury, Sickness or a mastectomy. Covered expenses are only payable if the Injury happens, or the Sickness is first diagnosed while insured by the Policy, and the covered expenses must be incurred while the Insured Person is insured under the Policy;
7. Treatment to remove a birthmark;
8. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs;
9. Routine physical exams, checkups, and related x-ray and lab expenses, drugs and medicines, except those prescribed in and taken home from the Hospital where permission was Pre-Authorized by Us;
10. Blood products storage where not necessary or not in conjunction with a scheduled covered surgery;
11. Blood products when replaced by donation;

12. Organ or tissue or transplants, including transplants for burns and related services, except corneal transplants;
13. The implant of an artificial organ or any service or supply in connection therewith;
14. Items or devices primarily used for comfort or commonly installed in homes, including but not limited to air purifier, humidifier, dehumidifier, whirlpool, air conditioning, water bed, exercise equipment or ultraviolet lighting;
15. Personal or home-based artificial kidney equipment;
16. Growth hormone treatment, regardless of the reason for prescription;
17. Foot care including but not limited to: shoe inserts, foot care related to corns, calluses, bunions, hallux valgus, flat feet, weak arches or weak feet;
18. Treatment or surgery of bony protuberance of the forefoot and toes, including misalignment of the same (e.g. bunions, spurs, hammertoes);
19. Any dental treatment or services;
20. Treatment of temporomandibular joint dysfunction, craniomandibular joint dysfunction, myofacial pain syndrome and all related conditions, orthognathic reconstructive surgery;
21. Private duty services of a health care provider;
22. Eye exams for corrective lenses, including contact lenses, eye glasses and their fitting, radial keratotomy, corneal modulation, refractive keratoplastry or any similar procedure, speech or vision therapy, including eye exercises, hearing exams, hearing aids and their fitting;
23. Emergency medical care provided through a public or private medical facility;
24. A Chronic Medical Condition;
25. A Related Medical Condition;
26. Sex change operations and complications from that surgery;
27. Artificial insemination, in-vitro or in-vivo fertilization, testing, treatment or medication for the primary purpose of achieving conception, maintaining pregnancy or preventing abortion, infertility and impotency testing and treatment, abortion, voluntary sterilization, reversal procedures or sterilization;
28. Acupuncture, chelation therapy, or laetrile used in form or any derivative or variation thereof;
29. Treatment for weight loss, or for exogenous or morbid obesity, including but not limited to: gastric bypass, gastric stapling, or balloon catheterization, liposuction or reconstructive surgery, any food supplement or augmentation, diet, health or exercise programs, health club dues, or weight reduction clinics;
30. Any treatment related to pregnancy or complications thereof;
31. Prosthesis, Corrective Devices and medical appliances which are not surgically required, unless necessitated by Injury, deformity or Sickness which occurs while the Insured Person is covered under the Policy;
32. Chronic Fatigue Syndrome including, but not limited to diagnostic workups;
33. Sclerotherapy, for the treatment of varicose veins of the extremities;
34. Any treatment relating to birth defects or congenital illnesses;
35. Services and supplies (including but not limited to splints and braces) prescribed or rendered solely to allow for participation in any sports related activity, or solely for strengthening, conditioning or maintaining a muscle, bone or joint function;
36. Injury or Sickness occurring while engaged in any hazardous, high risk or extreme sport activities including but not limited to: sky or scuba diving, parachuting, mountain climbing,

ballooning, hang gliding, bungee cord jumping, stunt flying, crop dusting or the operation of an ultra-light aircraft, racing of any form (other than on foot) and all professional sports.

CRITICAL ILLNESS BENEFIT EXCLUSIONS

This Policy does not provide Critical Illness Benefits for the following:

1. All dementing organic brain disorders and psychiatric illnesses not specifically listed under the Alzheimer's Disease definition.
2. All types of Parkinsonism not specifically listed under the Parkinson's Disease definition.
3. Cysts, granulomas, meningiomas, malformations of the intracranial arteries or veins, or tumours of the cranial nerves, pituitary or spinal cord.
4. The following cancer related conditions are not covered: early prostate cancer diagnosed as T1 N0 M0 or equivalent staging; pre-malignant lesions, benign tumours or polyps; non-invasive cancer in-situ; any skin cancer, other than invasive malignant melanoma into the dermis or deeper; and any tumour in the presence of the human immunodeficiency virus (HIV).
5. Non-surgical techniques such as balloon angioplasty, laser embolectomy or other non-bypass techniques.
6. A Heart Attack occurring in the 48 hours following an elective revascularization procedure, unless it is accompanied by new pathological Q waves.
7. A Heart Attack diagnosed by any other method, unless the diagnosis is confirmed as described in the definition of Heart Attack.
8. Transient Ischemic Attacks (TIAs).

LIMITATIONS

Policy Benefits are subject to limitations described below.

1. LIFETIME MAXIMUM

Benefits under this Policy are provided to an Overall Lifetime Maximum of $1,000,000 per Insured Person. When the total Benefits for an Insured Person reaches the Overall Lifetime Maximum, the coverage afforded the Insured Person under the Policy terminates.

2. PRE-EXISTING CONDITION LIMITATION

Benefits for HealthSure Plus are limited for any Pre-Existing Condition that existed during the 24 months prior to the Insured Person's Effective Date of coverage. HealthSure Plus coverage is not provided for any Pre-Existing Condition until after the Insured Person has been continuously insured for 24 months under this Policy.

This limitation does not apply to a newborn who is insured on the date of birth.

3. BENEFIT MAXIMUM

Benefits payable under this Policy for medical and/or hospital expenses in respect of an Insured Person are limited to the Maximum Amount Payable.

4. HOSPITAL AND INPATIENT SERVICES LIMITATION

Benefits payable under this Policy for Hospital confinement and associated Inpatient charges in respect of an Insured Person are limited to a maximum of 180 days per Insured Person.

5. INCIDENTAL SURGICAL PROCEDURES

Unless approved by Us, the Policy will provide coverage for only the surgery or procedures relating to conditions noted upon referral and Pre-Authorization.

6. WAITING PERIOD FOR SPINE, KNEE OR HIP SURGERIES

Even if diagnosed for the first time, major spine, knee or hip surgeries, including joint replacement, other than arthroscopic procedures, will not be authorized until an Insured Person has been insured under the Policy for 24 consecutive months.

7. BENEFITS NOT PROVIDED IN PROVINCE OF RESIDENCE

An Insured Person is not entitled to receive Benefits under this Policy for services that are prohibited by the Canada Health Act to obtain in your province of residence.

This policy also includes the following exclusion:

NUCLEAR, CHEMICAL, BIOLOGICAL TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes any losses, directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement:

“Nuclear, chemical, biological terrorism” shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical agent and/or biological agent during the period of this insurance by any person or group(s) of persons, whether acting along or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

“Chemical agent” shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants or material property.

“Biological agent” shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

WAR AND TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss if the assured/Insured Person takes an active part therein.

1. War, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; or

2. Any act of terrorism.

   For the purpose of this endorsement an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This endorsement also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to 1 and/or 2 above.

If the Underwriters allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this insurance the burden of proving the contrary shall be upon the assured.

In the event any portion of this endorsement is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

HEALTHSURE PREMIUM

BENEFIT SCHEDULE FOR CRITICAL ILLNESS INSURANCE
Critical Illness Insurance is available to each eligible Member and Spouse up to $25,000. Subject to the eligibility provisions described in section b) of the Eligibility section.

Smoker to Non-Smoker Premium Rates under Critical Illness Insurance

An Insured Person previously ineligible for non-smoker premium rates may request a change to non-smoker rates by completing an application. A change from smoker to non-smoker premium rates for an Insured Person will become effective on the first day of the month coincident with the date the Company approves the application.

If, on the date that the change from smoker to non-smoker premium rates in respect of an Insured Person would otherwise become effective, there has been a change in such person's health or insurability since the date of the request for a change, then the change to non-smoker premium rates will not become effective until satisfactory evidence has been provided to the Company that the change in such person's health or insurability would not affect the approval of the change from smoker to non-smoker premium rates by the Company.

CRITICAL ILLNESS INSURANCE

1. PAYMENT OF BENEFIT

If an Insured Person is diagnosed by a Specialist with a Covered Critical Illness Condition while his Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Critical Illness Conditions, the Company will pay to such Insured Person the amount of Critical Illness Insurance in force with respect to such Insured Person (the **"Critical Illness Benefit"**), subject to the terms and conditions of this Policy. The Date of Diagnosis must be later than the Issue Date of the coverage. If the Insured Person dies before the Critical Illness Benefit is paid, the Critical Illness Benefit will be paid to the estate of such Insured Person. The Company will pay the Critical Illness Benefit for one Covered Critical Illness Condition only.

ALL BENEFIT AMOUNTS, LIMITATIONS AND EXCLUSIONS WITHIN THIS POLICY ARE IN CANADIAN DOLLARS.

2. EXCLUSIONS

The Critical Illness Benefit will not be paid if a Covered Critical Illness Condition results directly or indirectly from any one or more of the following:

(a) a Pre-Existing Condition. This exclusion applies for the 24 months following the effective date and for the first 24 months from the effective date of an increase in the amount of an Insured Person's Critical Illness insurance;

(b) attempted suicide;

(c) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Person;

(d) taking any drug other than as prescribed by a licensed physician;

(e) war or full time active service in the armed forces of any country;

(f) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;

(g) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 milliliters of the Insured Person's blood exceeds 80 milligrams; or

(h) intentionally self-inflicted injury, while sane or insane.

In addition, the Critical Illness Benefit will not be paid if the Insured Person suffers Paraplegia/Quadriplegia/Hemiplegia, Blindness, Deafness, Major Burns, Stroke, Coma, or Dismemberment as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle race or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

3. LIMITATIONS

An Insured Person's Critical Illness Insurance will be void and the Company's liability will be limited to the return of any premiums paid if the Insured Person is diagnosed with Cancer, had any signs and/or symptoms or medical problems commence, or had investigations leading to the Diagnosis of any cancer covered or excluded under the Policy initiated within 90 days following the Issue Date of his Critical Illness Insurance coverage.

4. RIGHTS OF EXAMINATION

As a condition precedent to payment of the Critical Illness Benefit under this Policy:

(a) the Insured Person will afford to the Company an opportunity to examine the Insured Person by a medical practitioner of the Company's choice to confirm the Diagnosis of a Covered Critical Illness Condition; and

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

HealthSure PLUS

1. PAYMENT OF BENEFIT

If an Insured Person is placed on a Surgical/Procedural Waiting List in Canada, the Company will indemnify or pay Benefits for the services described under section 2. Covered Benefits and Services below, subject to Pre-Authorization by Us, and the Limitations, Exclusions and other terms and conditions of coverage in this Policy.

Pre-Authorization by Us means the surgery or diagnostic procedure has been approved by Us based on confirmation from the specialist Physician's office or from the appropriate Canadian facility that:

a) the Insured Person has been placed on a Surgical/Procedural Waiting List; and
b) the surgery(s) or diagnostic procedure(s) cannot be performed earlier than forty five (45) days from the date the Insured Person is placed on the waiting list.

Reimbursement for eligible expenses under this Benefit is 100% with no deductible.

ALL BENEFIT AMOUNTS, LIMITATIONS AND EXCLUSIONS WITHIN THIS POLICY ARE IN CANADIAN DOLLARS.

2. COVERED BENEFITS AND SERVICES

a) SURGICAL AND RELATED MEDICAL SERVICES

Surgical services and other medical care directly related to the approved surgery provided by an approved Physician in an approved Hospital, Outpatient Surgical Facility, or free-standing ambulatory surgical center, including services of an anaesthesiologist and assistant Surgeons when required.
This includes pre-surgical consultations and/or tests to determine if the surgery is Medically Necessary.

b) HOSPITAL AND INPATIENT SERVICES

i) Hospital Accommodation
Room and board charges for up to semi-private room accommodation, unless the Hospital is a private facility which provides private room accommodation only, for Hospital confinement in relation to an approved surgery.

ii) Other Inpatient Services and Supplies
Medically Necessary services, supplies and prescriptions related to an approved surgery in an approved Hospital.

c) OTHER HEALTH SERVICES

i) Diagnostic Procedures
If approved by Us, Medically Necessary diagnostic procedures related to conditions or treatment not otherwise limited or excluded under the Policy. Covered diagnostic procedures are limited to the following:

Magnetic Resonance Imaging (MRI)
Computerized Axial Tomography (CAT or CT scans)
Myelograms
Angiography
Angioplasty
Cardiac Catheterization

ii) Medical and Surgical Support Services
Once treatment for an Insured Person has been approved by MSH INTERNATIONAL (CANADA) LTD., We will assist in locating a provider and coordinate the required surgery or Diagnostic Procedure. Requests for a specific Hospital or Doctor may be considered and must be approved in advance by Us.

iii) Second Opinions
Once an Insured Person has been placed on a Surgical/Procedural Waiting List in Canada for a condition covered under this policy, the Insured Person may be eligible for a second opinion on the recommended surgery or Diagnostic Procedure at no cost to the Insured Person, subject to Pre-Authorization and approval by Us. If determined necessary by Us, We may require a second surgical opinion for any surgery or procedure.

iv) Accommodation and Meals for Family Members

When We determine that a patient requires travelling assistance for a covered surgery only, We may authorize reimbursement of the costs of commercial accommodation and meals for a Family Member, or other person approved by Us.

The maximum daily allowance will be the lesser of the total charges and $150 per day, subject to an overall maximum per Insured Person of $1,500 per Occurrence.

We will only reimburse covered expenses evidenced by original, itemized receipts.

v) Transportation for Covered Services

Transportation costs incurred by an Insured Person while travelling to and from the approved surgical facility, including transportation costs for a follow-up appointment with the performing surgeon, if required, will be reimbursed upon completion of an authorized surgery.

In addition, transportation costs incurred by a Family Member or other person providing travel assistance to the Insured Person, when approved in advance by Us, will also be reimbursed subject to the Benefit maximum per Occurrence.

This Benefit is calculated by measuring the round-trip travel distance from the Insured Person's Canadian residence to the approved surgical facility, according to the most recent Rand McNally geographical data available to Us. The maximum Benefit per surgery is calculated at the rate of 51.5 cents per Kilometer up to a maximum Benefit of $500 per Occurrence.

vi) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Diseases

The Policy will provide coverage for treatment of AIDS or AIDS related diseases, when a positive HIV or Aids diagnosis is made after the Effective Date of an Insured Person's coverage, up to $50,000 per Insured Person per lifetime for all such treatment in total.

3. SPECIALIST CONSULTATIONS

If an Insured Person is referred by their General Practitioner (GP) to a specialist Physician for assessment while insured under this Benefit, and the specialist Physician confirms that the assessment cannot be provided within forty-five (45) consecutive days of the referral by the GP, the Policy will pay Benefits for the cost of an assessment by a specialist Physician approved by Us, subject to the following:

a) the referral by the GP is to a specialist Physician in one of the following medical specialties: Orthopedics; Cardiology; Neurology; General Surgery; Gastroenterology; Ear, Nose and Throat; Ophthalmology; Urology; Rheumatology; Spine Team; and
b) the assessment is for the purpose of determining a condition which may result in a diagnostic test or surgical treatment.

MSH INTERNATIONAL (CANADA) LTD. will make the first available appointment with the appropriate specialist Physician at the geographical location closest to the Insured Person and make every effort to schedule the special Physician assessment within twenty one (21) days from the referral by the GP and/or approval of the request.

Travel expenses to the specialist Physician approved by Us are not included under this Benefit.

An Insured Person's coverage under this Benefit will commence on the first of the month following ninety 90 days from the Effective Date of an Insured Person's HealthSure Plus coverage. No coverage will be provided for specialist Physician referrals for new medical conditions made during this waiting period.

For an Insured Person who has HealthSure Plus Single Plan coverage, the Specialist Consultations Benefit provides for a maximum of two assessments per Insured Person per coverage period.

For an Insured Person who has HealthSure Plus Couple Plan, HealthSure Plus Single with Children Plan, or HealthSure Plus Family Plan coverage, the Specialist Consultations Benefit provides for a maximum of three assessments in total for all Insured Persons per coverage period. Each assessment includes an initial and follow-up consultation.

A coverage period is defined as one Calendar Year from the Effective Date of an Insured Person's HealthSure Plus coverage.

CLAIMS PROCEDURES APPLICABLE TO MEDICAL BENEFITS

To determine eligibility the Insured Person **MUST** provide the following:

- Proof of referral for medical specialist, diagnostic or surgical procedure;

- Proof that the scheduled appointment date for medical specialist, diagnostic or surgical procedure is greater than 45 days from the date that the referral was made;
    - In the event that confirmation of a scheduled appointment date cannot be obtained, documentation from the medical specialist, diagnostic or surgical facility, who will be performing the service, will be required. This document needs to state that you are on a waiting list and unable to get an appointment within 45 days or state the earliest anticipated possible date that an appointment will be scheduled;
    - If the insured is unable to obtain documentation of an appointment, when 45 days from the referral date has elapsed it is assumed that an appointment is unavailable.
- Supporting documents and medical notes from referring medical physician and/or specialist;
- If an Insured member does not have medical specialist, or facility for diagnostic or surgical procedure please contact MSH International for assistance.

To expedite the process to determine claim eligibility, we would suggest that you request copies of the referral, supporting documents and medical notes from your medical practitioner. When information is requested by "us", on your behalf, the average response time is 8 weeks which can cause a significant delay the claims process. When information is requested by the patient the normal turnaround time is typically much faster.

This Policy does not cover expenses directly or indirectly related to;

- Cost of obtaining or copies of
    - Referral for medical specialist, diagnostic or surgical procedure;
    - Documentation of scheduled or anticipated appointment for medical specialist, diagnostic or surgical procedure;
    - Supporting documents;
    - Medical notes;
    - Clinical notes.

Any fees incurred are the responsibility of the claimant.

In the event an insured person obtains diagnostic, specialist, or surgical services without the prior authorization of the Insurer, such service is not eligible for reimbursement.

To obtain authorization please forward the all pertinent information MSH INTERNATIONAL at the following;

MSH INTERNATIONAL
Pre-Certification department
300, 999 – 8th Street S.W.
Calgary, Alberta, CANADA T2R 1N7
Fax: +1 403 265 9425
claimsamerica@msh-intl.com

The Insurers will pay Benefits provided that:

- The required premiums have been paid relative to the Insured Person making the claim.

It is understood that:

- The Insurers can ask for medical information from any Physician or Surgeon as often as required and if necessary examine the Insured Person; and
- The Insurers shall be notified of any circumstances that may lead to a claim against a third party or any other insurance.

All pertinent information shall be sent to
MSH INTERNATIONAL
Suite 300, 999 8th Street S.W.
Calgary, Alberta, Canada T2R 1N7

EFFECT ON CLAIMS OF TERMINATION OF HEALTHSURE PLUS

Termination of this Policy in respect of an Insured Person will not prejudice any claim where:

a) the Policy has been terminated in accordance with the provisions under the Termination of Policy section, and

b) the Insured Person has been placed on a Surgical/Procedural Waiting List prior to the termination date of the Policy.

The Limitations, Exclusions and other terms and conditions of coverage in the Policy will apply.

EFFECT ON CLAIMS OF TERMINATION OF CRITICAL ILLNESS INSURANCE

Termination of this Policy or the Critical Illness Insurance in respect of an Insured Person will not prejudice any claim in connection with a Covered Critical Illness Condition provided that:

a) the Date of Diagnosis is before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person;

b) the existence of the Covered Critical Illness Condition is reported to the Company no later than 30 days following the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person;

c) for Coma, the continuous 96 hour minimum period of unconsciousness must have commenced, but need not be completed, before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person;

d) for Stroke, the 30 day period of paralysis or other measurable objective neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person;

e) for Major Organ Failure Requiring Transplant, the 30 day survival period must have commenced, but need not be completed, before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person;

f) for Paraplegia/Quadriplegia/Hemiplegia, the 90 day period of permanent loss must have commenced, but need not be completed, before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person;

g) for Loss of Speech the 180 day period of permanent loss must have commenced, but need not be completed, before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person; and

h) for Multiple Sclerosis, the 6 month period of episodes of well-defined neurological abnormalities must have commenced, but need not be completed, before the earlier of the termination date of this Policy or of the Critical Illness Insurance in respect of the Insured Person.

The Limitations, Exclusions and other terms and conditions of coverage in this Policy will apply.

GENERAL PROVISIONS AND LIMITATIONS

Arbitration: Any differences with respect to medical opinion will be settled between two medical experts appointed by the two parties. This dispute resolution will be in writing. Any differences of

opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts.

Misrepresentation and Fraud: All Benefits under the policy shall be voidable if the Insurer determines, whether before or after the loss, the Policyholder or Insured Person has concealed or misrepresented any material fact or circumstance concerning the policy or his / her interest therein, or in the case of fraud or false swearing by the Policyholder or Insured Person or if the Policyholder refuses to disclose information or permit the use of such information, pertaining to any of the Insured Persons under the policy. Where a Policyholder or Insured Person makes a material misrepresentation on the signed application form or enrolment form, this will be a breach of the duty of fair representation. In the event of a breach by the Policyholder the Insurer's liability will be suspended. Liability may be restored if the breach is remedied. In the event that the breach is not remedied or cannot be remedied, the Insurer's liability will remain suspended. Where the breach is remedied before a loss, the Insurer will pay the claim, if eligible and according to the terms of this policy. Where the loss occurs after a breach but before the remedy, the Insurer will not be liable for that loss and the Insured Person shall be solely responsible for all expenses relating to their claim, including Emergency Medical Evacuation costs.

Where this contract of group insurance, including renewals thereof, has been in effect continuously for two years with respect to an Insured Person, a failure to disclose or a misrepresentation of a fact with respect to that Insured Person does not, except in the case of fraud, render the contract voidable with respect to that Insured Person.

Where an Insured Person wilfully makes a false statement in respect of a claim under this policy, the claim by the Insured Person will be invalid and the rights of the Insured Person to recover indemnity is forfeited and the Insured Person will be terminated from the plan at the time of the fraudulent act.

Non-disclosure and Misrepresentation by the Insurer: If the Insurer fails to disclose or misrepresents a fact material to the insurance, the contract is voidable by the Policyholder, but in the absence of fraud the contract is not by reason of the failure or misrepresentation voidable after the contract has been in effect for 2 years.

Payment of Benefits: The claims administrator will, on behalf of the Insurers, make payment to the Insured Person or legal representative or directly to the provider of treatment or services. Payment will be made in Canadian currency.

Subrogation: If an Insured Person suffers a loss covered under this policy, the Insurers are granted the right from the Insured Person to take action to enforce all the rights, powers, privileges and remedies of the Insured Person, to the extent of Benefits paid under this policy, against any person or organisation which caused such loss. Additionally, if no fault Benefits or other collateral sources of payment of expenses are available to the Insured Person, regardless of fault, the Insurers are granted the right to make a demand for, and recover those Benefits. If the Insurers institute an action, the Insurers may do so at its' own expense, in the Insured Person's name, and the Insured Person will attend at the place of loss to assist in the action. If the Insured Person institutes a demand or action for a covered loss he or she shall immediately notify the Insurer so that it may safeguard its' rights. The Insured Person shall take no action after a loss that will impair the rights of the Insurers.

STATUTORY CONDITIONS

1. 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.

2. **Waiver**

The insurer 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 the insurer.

3. **Copy of Application**

The insurer shall, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

2. 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.

1. Material change in risk

1. The policyholder must promptly give notice in writing to the Insurer or its agent of a change that is
   (a) material to the risk, and
   (b) within the control and knowledge of the policyholder.
2. If an Insurer or its agent is not promptly notified of a change under subparagraph (1) of this condition, the contract is void as to the part affected by the change.
3. If an Insurer or its agent is notified of a change under subparagraph (1) of this condition, the Insurer may
   (a) terminate the contract in accordance with the Statutory Condition: termination by Insurer, **or**
   (b) notify the policyholder in writing that, if the policyholder desires the contract to continue in force, the policyholder must, within 15 days after receipt of the notice, pay to the Insurer an additional premium specified in the notice.
4. If the policyholder fails to pay an additional premium when required to do so under subparagraph (3) (b) of this condition, the contract is terminated at that time and the Statutory Condition: termination by Insurer (2) (a) applies in respect of the unearned portion of the premium.

4. Termination by Policyholder

The policyholder may terminate this contract by giving written notice of termination to MSH INTERNATIONAL (CANADA) LTD. by mail, fax, or email provided that notice is received at least 30 days in advance of the requested termination date. In the event that the notice is sent by mail, the notice must be mailed to MSH INTERNATIONAL (CANADA) LTD.

MSH INTERNATIONAL
300, 999 – 8th Street SW
Calgary, Alberta T2R 1N7
Canada

5. Termination by Insurer

The Insurer may terminate this contract by giving written notice of termination to the policyholder by mail, fax, or email provided that notice is received at least 30 days in advance of the requested

termination date. In the event that the notice is sent by mail, the notice will be mailed to the latest address of the policyholder in the records of MSH INTERNATIONAL (CANADA) LTD.

6. Notice

(1) Written notice to the insurer may be delivered at, or sent by registered mail to, the chief agency or head office of the insurer in the province.

(2) Written notice to the insured may be personally delivered at, or sent by registered mail addressed to, the insured's last known address as provided to the insurer by the insured.

7. Failure to Give Notice or Proof of Claim

Failure to give notice of claim or furnish proof of claim within the time prescribed by this policy 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.

8. Insurer to Furnish Forms for Proof of Claim

The Insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time the claimant may submit his 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.

9. Rights of Examination

As a condition precedent to recovery of insurance moneys under this contract,

a) the claimant shall afford to the insurer an opportunity to examine them when and so often as it reasonably requires while the claim hereunder is pending; and

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

10. Limitation of Actions

An action of proceeding against the Insurer for the recovery of a claim under this contract shall not be commenced until 60 days after a claim had been correctly submitted and no such action shall be brought unless commenced within three years* after the date the insurance money became payable or would have become payable if it had been a valid claim.

This policy is governed by the Laws of Canada and the province of Alberta and any dispute arising out of this policy shall be settled in the courts of Alberta.

* Two years in the Northwest and Yukon Territories.
Saskatchewan Statutory Condition 12 is repealed. See The Limitations Act, S.S. 2004, c.L -16.1.