Policy Wording

Table of Contents

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 losses occurring 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.

LMA 3100

Important Notice Regarding the Patient Protection and Affordable Care Act

This insurance is not subject to and does not provide certain of the insurance Benefits required by the United States Patient Protection and Affordable Care Act (ACA). This insurance does not provide and Insurers may not intend to provide minimum essential coverage under ACA. In no event will Benefits be provided in excess of those specified in the Policy documents. This insurance is not subject to guaranteed issuance or renewability other than as specified in the Policy.

ACA requires certain US citizens and US residents to obtain ACA compliant health insurance coverage. In some circumstance's penalties may be imposed on persons who do not maintain ACA compliant coverage. You should consult Your attorney or tax professional to determine if ACA's requirements are applicable to You. Should the coverage provided under this plan be altered by the Insurer and subsequently be deemed to be exempt from the requirements of ACA we will notify You immediately.

Zone of Coverage: Worldwide*

***Worldwide:** as applicable to the Geographical Area of Coverage, Worldwide comprises all countries throughout the world.

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 twelve (12) months, on payment of premium at the rate and in the amount determined at the time of renewal by the Insurer.

Termination of Policy

The Policy may be cancelled within 10 days of purchase for a full refund if there is no claim in process.

Eligibility

Insured Person:

To be eligible for coverage, the Insured must be:

a. at least 6 months old;
b. under the age of 27;
c. residing in Canada;
d. named on file with the plan administrator as being Insured under this Policy during the coverage period;

If over the age of 18 years, the Insured Person must be a full time student or have been a full time student within the last 12-months prior to making any claim.

Coverage Period

Coverage commences on the latest of:

a. the date the plan administrator confirms that the Insured is Insured under the Policy;
b. the Effective Date shown on the Insured's Confirmation of Coverage documents.

This Policy terminates on the earliest of:

a. the expiry date indicated on the Insured Confirmation of Coverage documents;
b. the date the required premium is due and unpaid and appropriate statutory notice has been given to the Insured;
c. the date the Insured attain age 28;
d. the date we obtain reasonable evidence of fraudulent use of the coverage card;

Refunds

The Insured shall be entitled to a full refund of the insurance premium, less administration fees, if cancellation is received within ten (10) days after purchase, provided that there is no claim in process.

Definitions

Accident: an unexpected event that is beyond the Insured's control.

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

Confirmation of Coverage: the document that identifies the names Insured.

Dentist: A person, other than a family member, who is legally qualified to practice dentistry in the place where services are provided.

Diagnostic Services: Laboratory tests and x-ray services, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions.

Disability: The inability to perform the principal duties of any occupation in relation to the Insured Person's education, skills, training and experience.

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

Emergency Treatment: Any immediate medical care provided by a Physician that is necessary to prevent or reduce existing danger to life or health.

Home Country*: The country for which the Insured Person holds a passport*. Where the Insured Person holds more than one passport, the Home Country will be taken to mean the country that the Insured Person has declared on the application form. Where a family is to be covered by the Policy there will be deemed to be one Home Country for that family, which will be the Home Country declared on the application form.

**Third Country Nationals may use their resident Country as Home Country.*

Hospital or **Hospitalized:** a licensed institution that is staffed and operated for the care and treatment of in-patients. Treatment must be supervised by Physicians and registered nurses must be on duty 24 hours a day. A laboratory and an operating room must also exist on the premises or in facilities controlled by the establishment. A Hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa.

Injury or **Injured:** sudden bodily damage due to an Accident causing the Insured to seek Emergency Treatment.

Insured: the person whose name is on the Confirmation of Coverage, who is eligible for coverage and for whom the required premium has been paid.

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

Medical Assistance Provider*:* MSH Assistance will be operating as Student Accident Insurance by StudyInsured Assistance

Medical Expenses: Those medical and related expenses for which coverage is provided under the Benefit Section of this Policy which are necessarily incurred as a result of Injury or Sickness while coverage is in force under this Policy as to the Insured Person.

Mountaineering: means the ascent or descent of a mountain requiring the use of specialized equipment, including crampons, pick-axes, anchors, bolts, carabineers and lead-rope or top-rope anchoring equipment.

MSH INTERNATIONAL (CANADA) LTD.: The third-party administrator and claims administrator appointed by the Insurer. Claims will however be administered by MSH Assistance.

Physician: a person, other than a family member, who is legally qualified to practice medicine in the place where medical services are provided.

Policy: this document and the Confirmation of Coverage which we issue when the required premium is paid.

Pre-existing Medical Condition: a medical or related condition for which treatment or prescribed medication was needed at any time in the 90 days before the Insured's trip began.

Prescription Drugs: Drugs, medicines, serums and vaccines which must, by federal law or regulation in the country where incurred, be dispensed only pursuant to a prescription from a licensed Physician or Dentist. For geographical areas where there are no regulatory laws for such substances, eligibility will be determined by Canadian standards as defined by the Canadian Food and Drugs Act and Regulations.

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

Scheduled airline: an airline with a license to transport fare–paying passengers. It has a regular published schedule and includes chartered flights or licensed tour companies.

Sick or **Sickness:** an illness or disease that needs Emergency Treatment or Hospital care. Sickness does not include emotional or mental disorders unless Hospitalized.

Totally and Permanently Disabled: the Insured cannot ever be employed.

You or **Your:** the Insured person

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 bradykinesia. 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

General Exclusions

This Policy does not cover expenses caused or contributed to directly or indirectly by:

1. Intentionally self-inflicted injuries.
2. Sickness, except under the Counselling Benefit, the Critical Illness Benefit and Travel Benefit.
3. 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).
4. The purchase, repair or replacement of eyeglasses, contact lenses, orthotic devices, trusses, braces or prescription medication except as described in Schedule of maximum Benefits
5. Loss caused directly or indirectly, in whole or in part if the Insured
    a. Commits a crime or malicious act;
    b. Uses drugs, alcohol or medication

In addition, exclusions that apply to the Travel Benefit.

Conditions & limitations:

1. The Insured can only be covered under one plan with us. Benefits will only be paid under one Policy.

2. The Benefits we pay under the Policy are in excess of the Insured's coverage from any other source.
3. Except for the "10 Day Free Look", there are no premium refunds.
4. The Policy only covers the Insured if they attend school in Canada.
5. If the Insured files a claim with us, we have the right to have a Physician approved in our sole discretion examine them.
6. If the Insured files a claim with us, we are automatically subrogated to their right to collect from third parties and can act on their behalf to enforce this right.
7. If the Insured files a claim for similar Benefits with us and another excess Insurer, we coordinate the payment of Benefits with the other Insurer to settle the actual eligible loss.
8. The Policy is subject to the statutory conditions of the Insurance Act of the province or territory where the Insured lives. If the Policy and the Insurance Act disagree, the Insurance Act prevails

Critical Illness 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).

Travel Benefit Exclusions

The Travel Benefit does not cover:

1. Pre-existing medical conditions
2. Travel to Cuba, Iran, and/or North Korea
3. Medical conditions that would make a normally prudent person decide not to travel;
4. Declared or undeclared war, hostile acts, civil war, riot, insurrection, invasion or terrorism;
5. Taking part in military forces training, exercises or manoeuvres, professional sporting events or motorized races;
6. Taking part in Mountaineering, parachuting, skydiving, parasailing, bungee jumping, gliding or piloting an aircraft or professional underwater activities;
7. Any claim that is against the law of a government plan or political subdivision in Canada;
8. Pregnancy, miscarriage, childbirth or complications within 2 months of the expected delivery date;
9. Trips taken to arrange or receive medical, Hospital, or dental services;
10. Expenses inside the province or territory where the Insured lives;
11. Any claim that happens more than 30 days after the Insured leaves the Province or territory where they live;
12. Therapy for a medical condition the Insured has;
13. Hospital or medical services when there is no emergency;

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 one (1) and/or two (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.

08/10/01

NMA2918

Medical Schedule of Maximum Benefits

	Plan Benefit Maximum
Medical Treatment and Transportation	
Hospital Accommodation	Full Cost
Ambulance	Full Cost
Emergency taxi to nearest medical facility	$350
Paramedical	$800
Counselling	$1,000
Special Training	$10,000
Confinement	$30,000
Travel for Special Treatment	$3,000
Travel for Parent/Guardian	$1,000
Tutoring	$6,000
Critical Illness	
Nursing expenses	$12,500
Accommodations, meals, laundry, parking	$3,000
Critical Illness Insurance	$5,000
Medical Equipment	
Damage to eyeglasses and contact lenses	$350
Eyeglasses and contact lenses needed due to Injury	Full Cost
Medical Appliances	$1,500
Purchase of Prosthetic Device or Hearing Aids	$5,500
Fix or Replace Prosthetic Device or Hearing Aids	$500
Special Clothing	$400
Travel	
Out of Province Emergency Medical Expenses	$200,000
Trip Cancellation	$1,000
Air flight Accidental Death	$5,000
Emergency Return Flight	$1,000
Repatriation or Burial	$5,500

Benefits

Notwithstanding the limits stated in the separate sections of this Policy, based on the Plan Benefit Maximum.

It is recommended that Insured Persons obtain pre-authorization from MSH INTERNATIONAL (CANADA) LTD. for pre-authorization of scheduled services. These requests should be submitted at least ten (10) days prior to the anticipated service date to avoid delays.

In the case of an Emergency it is required that the Insured Person contact MSH INTERNATIONAL (CANADA) LTD. within forty – eight (48) hours of the Emergency occurring.

Hospital Accommodation

If the Insured is Injured as a result of an Accident and is admitted to a Hospital in Canada for more than 24 continuous hours within 30 days of that Accident, we will cover:

a. Hospital charges for room and board in a Canadian Hospital, limited to the semi-private accommodation level up to 1 year;
b. Emergency room fees;
c. Hospital charges for out-patient services when medically required
d. Up to $25 a day for television and Wi-Fi service

The Insured must have Canadian government health insurance coverage to receive this benefit.

Hospital Cash

This benefit of one hundred dollars ($100) per day applies to a maximum of one thousand $1,000 dollars. This is available on an Accident basis only.

Ground Transportation

Up to overall Policy limit for licensed ground ambulance service (or taxi fare up to $350 in lieu of ambulance) to the nearest medical facility for medical treatment as the result of a covered emergency.

Paramedical

When deemed essential on an emergency basis and accompanied by a written referral from a Physician, the services of a licensed chiropractor, osteopath, physiotherapist, athletic therapist, or registered nurse to a maximum of $100 per visit up to the amount stated in the Schedule of Maximum Benefits for all providers.

Counselling

Expenses incurred for trauma counselling sessions from a licenced psychologist for the Insured, the Insured's parents, legal guardian and/or siblings up to the amount stated in the Schedule of Maximum Benefits if the Insured dies or suffers a loss under Accidental Death & Dismemberment or is diagnosed with a Critical Illness.

Special Training

When required by the Insured as a result of a covered Accident, we cover special employment training up to $150 per day for accommodation in a hotel and meals up to the amount stated in the Schedule of Maximum Benefits.

Benefit only applies if training is delivered at a location more than 160 km from where the Insured lives.

Confinement

If the Insured is Injured due to an Accident and is continuously confined to Hospital or to the Insured's home except for attending medical appointments, starting on the 31st day of continuous confinement we will pay:

a. $750 per full month up to the amount stated in the Schedule of Maximum Benefits.

This benefit ends whichever comes first be it:

a. the Insured's continuous confinement ends, or
b. after 40 months.

Travel Expenses for Specialized Treatment

When specialized treatment is required by the Insured within one (1) year of a covered Accident, we will pay $60 per day for their travel expenses up to the amount stated in the Schedule of Maximum Benefits.

Benefit only applies if treatment is administered at a location more than 160 km from where the Insured lives.

Travel Expenses for Parent/Legal Guardian

Up to a maximum of $1,000 for single round-trip economy airfare by the most direct and economical route an immediate family member to be with the Insured if the Insured is Hospitalized as the result of a covered emergency and the attending Physician provides written certification that the situation was serious enough to warrant the visit.

Tutoring

If the Insured is confined to a Hospital for a minimum period of thirty (30) consecutive days due to a covered Sickness or Injury, the Insurer will pay up to $30 per hour to the amount stated in the Schedule of Maximum Benefits for:

a. the actual expenses incurred for a qualified private tutorial service.
b. the cost to rent necessary equipment and software that the school board recommends.

Fracture or Dislocation

	Plan Benefit Maximum
Skull (depressed), Spine (3 or more vertebrae)	$1,000
Skull (not depressed, Pelvis, Spine (1 or 2 vertebrae)	$500
Hip, Femur, Shoulder, Humerus, Scapula	$300

Collar bone (clavicle), Elbow, Kneecap, Leg, Forearm, Hand, Wrist or Foot	$250
Jaw (except the alveolar process), Sacrum, Coccyx, Sternum, Two or more toes, fingers or ribs	$200
One toe, finger, rib, or any bone not specified above	$150

Up to the amount stated in the Schedule of Maximum Benefits we pay the benefit that corresponds to the Injury as indicated if the Insured is Injured due to an Accident and fractures or dislocates a body part. We cover the Injury that pays the highest benefit only if the Insured has more than one Injury from the same Accident.

Critical Illness

If the Insured is newly diagnosed with a listed Critical Illnesses during the Coverage Period, we cover up to the amount, per student as stated in the Schedule of Maximum Benefits:

a. a registered nurse; and
b. $125 a day for hotel, meals, laundry services and parking expenses if the Physician recommends that the Insured's parent or legal guardian be with the Insured while they are Hospitalized.

Benefits are covered for up to 3 years from the Physicians first diagnosis.

Critical Illnesses		
AIDS (Acquired Immune Deficiency Syndrome)	Leukaemia	Poliomyelitis
Cancer	Meningitis	Rabies
Cardiomyopathy	Multiple Sclerosis	Scarlet Fever
Diphtheria	Muscular Dystrophy	Tetanus
Encephalitis	Myocarditis	Tularaemia
Haemolytic Uremic Syndrome (Renal failure caused solely by E-coli bacterial infection)	Necrotizing Fasciitis	Typhoid

Medical Equipment

Eyeglasses and Contact Lenses

If the Insured damages or breaks their eyeglasses or contact lenses or needs eyeglasses or contact lenses for the first time, due to an Accident that results in Injury, we pay up to the amount stated in the Schedule of Maximum Benefits to fix or replace them or to buy new ones. The Insured must receive treatment from a Physician within 30 days. We do not cover the normal replacement of eyeglasses or contact lenses if a prescription changes or if they are lost.

Medical Appliances

When approved in advance, and prescribed by the attending Physician as the result of a covered Accident for therapeutic treatment we cover up to the amount stated in the Schedule of Maximum Benefits the cost of:

a. minor appliances such as crutches, casts, splints, orthotic truss, braces;
b. Prescription Drugs;
c. the temporary rental of a Hospital type bed or wheelchair.

Prosthetic Device and Hearing Aids

If the Insured is Injured and as a result requires a Physician to prescribe an artificial limb, artificial eye and/or hearing aid, we cover the purchase of the device within 3 years after the Accident, up to the amount stated in the Schedule of Maximum Benefits. Repair or replacement Benefits of the Insured's artificial limb, artificial eye and/or hearing aid up to the amount stated in the Schedule of Maximum Benefits if, during the coverage period, it is damaged or breaks which rendering it unusable.

Special Clothing

When required by the Insured as a result of a covered Accident and deemed essential and referred from a Physician, we cover the cost up to the amount stated in the Schedule of Maximum Benefits for special protective clothing.

Travel

Out of Province Emergency Medical Expenses

Emergency treatment from a Physician, registered nurse, Hospital, x-ray clinic is covered if the Insured suffers a Sickness or Injury while travelling outside of their province during the coverage period. Emergency transportation is included up to overall Policy limit for licensed ground ambulance service (or reasonable alternative ambulance to a max of $1,000 to the nearest medical facility for medical treatment as the result of a covered emergency. Services provided by family members are excluded.

Pre-existing conditions are excluded from coverage while travelling outside of Canada.

In the event of a medical emergency, the Insured or someone acting on their behalf must call the emergency assistance provider immediately. The Insured must call emergency assistance to ensure coverage of certain expenses. If the Insured fails to contact emergency assistance, the Insured may be responsible for a portion of the expenses.

24-HOUR EMERGENCY ASSISTANCE
1-833-561-0370 (Canada/USA) or elsewhere Collect 1-416-916-0982

The emergency assistance provider on behalf of the Insurer reserves the right, as reasonably required and at its expense, to transfer the Insured to where the trip began following an emergency. If the Insured refuses to be transferred or transported when declared medically fit to travel by the medical director, any continuing costs incurred after the Insured's refusal will not be covered and the payment of such costs becomes the Insured's sole responsibility. Coverage ceases upon the Insured's refusal and no coverage will be provided to the Insured for the remainder of the coverage period. If the Insured decides to go back to the trip destination or rejoins the trip or tour itinerary after we return the Insured to the place where the trip began the Policy will not cover the Insured. The overall maximum are as follows:

a. $200,000 if the Insured has government health insurance coverage or
b. $5,000 if they do not have government health insurance coverage

The company and the emergency assistance provider we appoint are at the Insured’s service according to the conditions, limitations and exclusions of the Policy. Neither the Insurer nor the emergency assistance provider shall be responsible for the availability or quality of any medical treatment (including the results thereof) or the Insured’s failure to obtain medical treatment during the coverage period.

Trip Cancellation

If an Insured person is unable to travel due to a Sickness, Injury or death that occurs before the scheduled departure date, the Insurer will pay up to $1,000 or the penalty to cancel within 72 hours whichever is less. A Physician must provide in writing a report explaining why the Sickness or Injury is preventing the Insured from travelling. We do not cover cancellation for any other reason including cancellations due to emotional or mental disorders unless the Insured is Hospitalized.

Air Flight Accident Death

Should the Insured incur death within 90 days as a result of an Injury sustained while riding as a fare paying passenger on a common carrier, Benefits shall be paid in accordance with the Accidental Death benefit plus $5,000. We do not cover pilots, operators or crew members.

Emergency Return Flight

If the trip is interrupted due to Sickness or Injury that occurs on or after the scheduled departure date, the Insurer will pay:

a. the lesser of one-way economy airfare to return to the point of departure, or
b. the fee to change the existing ticket, or
c. $1,000 if the Insured received a refund on the existing ticket, we subtract the refund from the benefit we pay.

Repatriation or Burial

In the event of the Insured's death as a result of a covered Sickness or Accident we pay up to the amount stated in the Schedule of Maximum Benefits toward:

a. the actual cost incurred for the preparation of remains and transportation (including a standard shipping container) to the place where the Insured's trip began; or
b. cremation and/or burial at the place of death.

The cost of the casket, urn or funeral is not covered.

Dental Treatment

	Plan Benefit Maximum
Treatment within 10 years of Accident	Dental Association Fee Guide
Treatment after 10 years of Accident (per tooth)	$1,650
Implants (up to 2 implants per Accident)	$2,000
Orthodontics	$2,500
Dentures and removable teeth	$500

When performed by a legally qualified Dentist or oral surgeon, Emergency Treatment or orthodontic treatment for whole or sound natural, crowned or capped, teeth damaged as a result of an Accident.

Treatment must be initiated within sixty (60) days from the time date of the Accident. Follow-up dental treatment for Insureds under the age of 21 is covered for up to 10 years following the Accident unless the attending Dentist contacts us within 90 days after the Accident to report why the treatment will take longer to complete. If the Insured is 21 years or older, only one year of dental treatment will be covered.

If the Insured's permanently attached artificial teeth, dentures, or removable teeth are broken due to an Accident, repair or replacement must be initiated within thirty (30) days.

Payment will not exceed the amount stated in the Schedule of Maximum Benefits and will not exceed the minimum fee specified in the General Practitioner Schedule of Fees and Treatment Services of the Provincial Dental Association in the province or territory in which the Insured receives such treatment.

Conditions

a. we will only cover the least expensive of any one treatment that is professionally acceptable for the same Accident
b. we cover up to 2 dental implants per Accident and pay up to the maximum amount as stated in the Schedule of Maximum Benefits per implant.
c. There is no coverage for routine dental visits or dental maintenance including but not limited to cleanings and fillings;
d. There is no coverage for artificial teeth or dentures except as specifically provided;
e. There is no coverage for cosmetic or aesthetic treatment

Claims Procedures Applicable to Medical and Dental Benefits

The Insurers will pay Benefits provided that:

- Written details of all claims (including supporting documents) must be received by the claims administrator as soon as possible and in any event not later than ninety (90) days from the beginning of the treatment, ninety (90) days after the Insured Person's date of termination, or ninety (90) days after the group Policy has been terminated, whichever is earlier;
- All documentation relating to the claim including the claim form and accounts must be provided. Copies of original documents are only authorized for claims in which the total cost of services submitted does not exceed ten thousand dollars ($10,000) CAD*. The original documents of the copies initially submitted must be retained by the Insured Person for a period of twenty-four (24) months from the date the claim was incurred during which time MSH INTERNATIONAL (CANADA) LTD. may request these documents to validate any claim at any time. The original documents must be received within thirty (30) days of the date of request. In the event the original copy cannot be produced, the Insured Person will be responsible for any claim payments made in regard to that receipt. The claim payment reimbursement made by the Insured Person must

be received within sixty (60) days of the date of request. Additionally, Insured Persons who fail to provide original documents to MSH INTERNATIONAL when requested, will be required to submit original documents for all future claim's submissions.

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

*Invoices received directly from a provider will be considered to be an original document including but not limited to facsimiles, scans, PDF documents, direct portal submissions or digital copies.

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;
- 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

Accidental Death & Dismemberment (AD&D)

Benefit Sections	Plan Benefit Maximum
Total and Permanent Disability	$350,000
Loss of Limb or Loss of Use	$150,000
Accidental Death	$30,000
Double Benefit for Accidental Death	$60,000

Eligibility

All primary Insured Persons are eligible for Accidental Death & Dismemberment coverage.

Aggregate Limit of Liability: ten million dollars ($10,000,000) per plan aggregate

The Insurer shall not be liable for any amount in excess of the above stated aggregate limit of liability.

Total and Permanent Disability

We will pay Benefits according to the Plan Benefit Maximum if within 12 months of the date of an Accident, which occurred during the coverage period, an Injury to the Insured caused by the Accident results total and permanent Disability. Benefit applies only after a Physician approved in the company's sole discretion confirms that the Insured is Totally and Permanently Disabled due to the Accident. We will subtract the amount paid for other Benefits from the Total and Permanent Disability Benefit if other Benefits have been paid under the Policy. If the Total and Permanent Disability Benefit is paid, no further Benefits are payable under the Policy. If the Insured dies within 12 months of the date of an Accident, the Total and Permanent Disability Benefit is not payable.

Loss of Limb or Loss of Use

If Injury results in the loss of a limb or use of a limb, or loss of sight, hearing or speech within 12 months after the date of the Accident and a Physician approved in the company's sole discretion has confirmed that the loss of use of a limb, or the loss of sight, hearing or speech is permanent and continuous for at least one (1) year after the Accident, we will pay in accordance with the TABLE OF INJURIES subject to the following:

Conditions:

1. we cover the Injury that pays the highest benefit only should more than one Injury occur as a result of the same Accident.
2. there is no coverage under this benefit if death occurs as a result of the Accident within 90 days.
3. we subtract other Benefits that have been paid under the Policy from this benefit, except for Prosthetic devices.

TABLE OF INJURIES

Loss	Plan Benefit Maximum
Both hands or both feet at or above the wrist or ankle	$150,000

One hand and one foot at or above the wrist or ankle	$150,000
One hand or one foot at or above the wrist or ankle and the sight of one eye	$150,000
Sight in both eyes	$150,000
One arm or one leg at or above the elbow or knee or the hearing in both ears or speech	$45,000
One hand or one foot at or above the wrist or ankle, or the sight in one eye	$30,000
Thumb and index finger at or above the knuckle (metacarpal- phalangeal joint)	$15,000
Part or all of one or more fingers or toes	$ 1,500

Accidental Death

If the Insured is Injured and dies due to an Accident, we pay the death benefit for the plan chosen. Benefits are payable if death occurs within one (1) year of the Accident.

Double Benefit for Accidental Death

The amounts payable under the Accidental Death Benefit will be doubled if an Insured person suffers an Injury and dies as the result of an Accident occurring while riding as a passenger in or on, including boarding or alighting from, or being struck by any public conveyance licensed for the conveyance of passengers for hire. Benefits are payable when death occurs within one (1) year of the Accident.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the Benefits afforded an Insured Person.

If the body of an Insured Person has not been found within one (1) year of the disappearance, stranding, sinking or wrecking of the conveyance in which the Insured Person was riding at the time of the Accident, it shall be presumed subject to all other conditions of the Policy, that the Insured Person suffered loss of life resulting from bodily injuries sustained in the Accident and covered under this Policy.

PROVISIONS

Notice of Claim: Written notice of claim must be given to the Insurer within thirty (30) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice by or on behalf of the claimant to the Insurers or to any authorized agent of the Insurer, with information sufficient to identify the Insured Person, shall be deemed notice to the Insurer.

Claim Forms: The Insurers, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time of Payment of Claim: Indemnities payable under this Policy shall be paid by the Insurer within sixty (60) days after it has received proof of claim.

Payment of Claims: Indemnity for Accidental loss of life will be payable to the beneficiary of record in a lump sum. The lump sum payment shall be paid by the Insurer within sixty (60) days after it has received proof of claim.

If, at the death of the Insured Person, there is no surviving beneficiary, the Accidental loss of life indemnity shall be payable in one sum to the estate of the Insured Person.

All other indemnities will be payable to the Insured Person.

Physical Examinations and Autopsy: The Insurers at its own expense shall have the right and opportunity to examine the body of any Insured Person whose Injury is the basis of claim when and as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Designation or Change of Beneficiary: Subject to any statutory restrictions, an eligible Insured Person may designate a beneficiary to receive death Benefits payable under this Policy or may change any beneficiary already appointed, by filing written notice. No

designation or change of beneficiary under the Policy shall be binding upon the Insurer until the original or a duplicate thereof is received by the designated custodian of beneficiary records. No assignment of interest shall be binding upon the Insurer until the original or a copy thereof is received by the Insurer. The Insurer assumes no responsibility for the validity or legal sufficiency of such designation or change of beneficiary assignment.

Conformity with Provincial Statutes: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the province in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such province.

Workers' Compensation Laws: This Policy is not in lieu of and does not affect any requirements for coverage under any Workers' Compensation Law.

GENERAL PROVISIONS AND LIMITATIONS

Arbitration: Any differences with respect to medical opinion will be settled between two (2) medical experts appointed by the two (2) parties. This dispute resolution will be in writing. Any differences of opinion between the two (2) medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two (2) 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 an Insured Person willfully 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 Policy is voidable by the policyholder, but in the absence of fraud the Policy is not by reason of the failure or misrepresentation voidable after the Policy has been in effect for two (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 dollars 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 organization 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 their 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 Policy**

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

   2. **Waiver**

   The Insurer shall be deemed not to have waived any condition of this Policy, 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 Policy a copy of the application.

2. **Material Facts**

   No statement made by the Insured or person Insured at the time of application for this Policy shall be used in defence of a claim under or to avoid this Policy unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

3. **Termination by Policyholder**

   Please refer to the Termination of Policy section of this Policy.

4. **Termination by** Insurer

   Please refer to the Termination of Policy section of this Policy.

5. 1. **Notice and Proof of Claim**

   The policyholder or an Insured Person, or a beneficiary entitled to make a claim, or the agent of any of them, shall,

   a. give written notice of claim to the Insurer,
      i. by delivery thereof, or by sending it by registered mail to the head office or chief agency of the Insurer in the Province, or
      ii. by delivery thereof to an authorized agent of the Insurer in the Province,

      not later than the number of days allowed, as indicated within this Policy, from the date a claim arises under the Policy on account of an Accident, Sickness or Disability;

   b. within the number of days allowed, as indicated within this Policy, from the date a claim arises under the Policy on account of an Accident, Sickness or Disability, furnish to the Insurer such proof as is reasonably possible in the circumstances of the happening of the Accident or the commencement of the Sickness or Disability, and the loss occasioned thereby, the right of the claimant to receive payment, his age, and the age of the beneficiary if relevant; and
   c. if so required by the Insurer, furnish a satisfactory certificate as to the cause or nature of the Accident, Sickness or Disability for which claim may be made under the Policy and as to the duration of such Disability.

   2**. Failure to Give Notice or Proof**

   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 Policy 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.

6. **Insurer to Furnish Forms for Proof of Claim**

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

7. **Rights of Examination**

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

   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.

8. **When Money Payable Other Than for Loss of Time**

   All money payable under this Policy, other than Benefits for loss of time, shall be paid by the Insurer within sixty (60) days after it has received proof of claim.

9. **Limitation of Actions**

   An action of proceeding against the Insurer for the recovery of a claim under this Policy shall not be commenced until sixty (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 an dispute arising out of this Policy shall be settled in the courts of Alberta.

   * Two (2) years in the Northwest and Yukon Territories.

   Saskatchewan Statutory Condition 12 is repealed. See The Limitations Act, S.S. 2004, c.L -16.1.

LSW1540

Statutory Conditions

(Alberta)

1. **Misrepresentation**

   If a person applying for insurance falsely describes the property to the prejudice of the Insurer, or misrepresents or fraudulently omits to communicate any circumstance that is material to be made known to the Insurer in order to enable it to judge the risk to be undertaken, the contract is void as to any property in relation to which the misrepresentation or omission is material.

2. **Property of others**

   The Insurer is not liable for loss or damage to property owned by a person other than the Insured unless

   a. otherwise specifically stated in the contract, or
   b. the interest of the Insured in that property is stated in the contract.

3. **Change of interest**

   The Insurer is liable for loss or damage occurring after an authorized assignment under the *Bankruptcy and Insolvency Act* (Canada) or a change of title by succession, by operation of law or by death.

4. **Material change in risk**
   1. The Insured 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 Insured.
   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 Statutory Condition 5, or
      b. notify the Insured in writing that, if the Insured desires the contract to continue in force, the Insured must, within 15 days after receipt of the notice, pay to the Insurer an additional premium specified in the notice.
   4. If the Insured 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 Statutory Condition 5 (2) (a) applies in respect of the unearned portion of the premium.

5. **Termination of insurance**

    1. The contract may be terminated
        a. by the Insurer giving to the Insured 15 days' notice of termination by registered mail or 5 days' written notice of termination personally delivered, or
        b. by the Insured at any time on request.
    2. If the contract is terminated by the Insurer,
        a. the Insurer must refund the excess of premium actually paid by the Insured over the prorated premium for the expired time, but in no event may the prorated premium for the expired time be less than any minimum retained premium specified in the contract, and
        b. the refund must accompany the notice unless the premium is subject to adjustment or determination as to amount, in which case the refund must be made as soon as practicable.
    3. If the contract is terminated by the Insured, the Insurer must refund as soon as practicable the excess of premium actually paid by the Insured over the short rate premium for the expired time specified in the contract, but in no event may the short rate premium for the expired time be less than any minimum retained premium specified in the contract.
    4. The 15-day period referred to in subparagraph (1) (a) of this condition starts to run on the day the registered letter or notification of it is delivered to the Insured's postal address.

6. **Requirements after loss**

    1. On the happening of any loss of or damage to Insured property, the Insured must, if the loss or damage is covered by the contract, in addition to observing the requirements of Statutory Condition 9,
        a. immediately give notice in writing to the Insurer,
        b. deliver as soon as practicable to the Insurer a proof of loss in respect of the loss or damage to the Insured property verified by statutory declaration,
            i. giving a complete inventory of that property and showing in detail quantities and cost of that property and particulars of the amount of loss claimed,
            ii. stating when and how the loss occurred, and if caused by fire or explosion due to ignition, how the fire or explosion originated, so far as the Insured knows or believes,
            iii. stating that the loss did not occur through any willful act or neglect or the procurement, means or connivance of the Insured,
            iv. stating the amount of other insurances and the names of other Insurers,
            v. stating the interest of the Insured and of all others in that property with particulars of all liens, encumbrances and other charges on that property,
            vi. stating any changes in title, use, occupation, location, possession or exposure of the property since the contract was issued, and
            vii. stating the place where the Insured property was at the time of loss,
        c. if required by the Insurer, give a complete inventory of undamaged property showing in detail quantities and cost of that property, and
        d. if required by the Insurer and if practicable,
            i. produce books of account and inventory lists,
            ii. furnish invoices and other vouchers verified by statutory declaration, and
            iii. furnish a copy of the written portion of any other relevant contract.
    2. The evidence given, produced or furnished under subparagraph (1) (c) and (d) of this condition must not be considered proofs of loss within the meaning of Statutory Conditions 12 and 13.

7. **Fraud**

    Any fraud or willfully false statement in a statutory declaration in relation to the particulars required under Statutory Condition 6 invalidates the claim of the person who made the declaration.

8. **Who may give notice and proof**

    Notice of loss under Statutory Condition 6 (1) (a) may be given and the proof of loss under Statutory Condition 6 (1) (b) may be made

    a. by the agent of the Insured, if
        i. the Insured is absent or unable to give the notice or make the proof, and
        ii. the absence or inability is satisfactorily accounted for, or

b. by a person to whom any part of the insurance money is payable, if the Insured refuses to do so or in the circumstances described in clause (a) of this condition.

9. **Salvage**

    1. In the event of loss or damage to Insured property, the Insured must take all reasonable steps to prevent further loss or damage to that property and to prevent loss or damage to other property Insured under the contract, including, if necessary, removing the property to prevent loss or damage or further loss or damage to the property.
    2. The Insurer must contribute on a prorated basis towards any reasonable and proper expenses in connection with steps taken by the Insured under subparagraph (1) of this condition.

10. **Entry, control, abandonment**

    After loss or damage to Insured property, the Insurer has

    a. an immediate right of access and entry by accredited representatives sufficient to enable them to survey and examine the property, and to make an estimate of the loss or damage, and
    b. after the Insured has secured the property, a further right of access and entry by accredited representatives sufficient to enable them to appraise or estimate the loss or damage, but
        i. without the Insured's consent, the Insurer is not entitled to the control or possession of the Insured property, and
        ii. without the Insurer's consent, there can be no abandonment to it of the Insured property.

11. **In case of disagreement**

    1. In the event of disagreement as to the value of the Insured property, the value of the property saved, the nature and extent of the repairs or replacements required or, if made, their adequacy, or the amount of the loss or damage, those questions must be determined using the applicable dispute resolution process set out in the *Insurance Act*, whether or not the Insured's right to recover under the contract is disputed, and independently of all other questions.
    2. There is no right to a dispute resolution process under this condition until
        a. a specific demand is made for it in writing, and
        b. the proof of loss has been delivered to the Insurer.

12. **When loss payable**

    Unless the contract provides for a shorter period, the loss is payable within 60 days after the proof of loss is completed in accordance with Statutory Condition 6 and delivered to the Insurer.

13. **Repair or replacement**

    1. Unless a dispute resolution process has been initiated, the Insurer, instead of making payment, may repair, rebuild or replace the Insured property lost or damaged, on giving written notice of its intention to do so within 30 days after receiving the proof of loss.
    2. If the Insurer gives notice under subparagraph (1) of this condition, the Insurer must begin to repair, rebuild or replace the property within 45 days after receiving the proof of loss, and must proceed with all due diligence to complete the work within a reasonable time.

14. **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.

01/07/12

LSW1814

Statutory Conditions

(British Columbia)

1. **Misrepresentation**

   If a person applying for insurance falsely describes the property to the prejudice of the Insurer, or misrepresents or fraudulently omits to communicate any circumstance that is material to be made known to the Insurer in order to enable it to judge the risk to be undertaken, the contract is void as to any property in relation to which the misrepresentation or omission is material.

2. **Property of others**

   The Insurer is not liable for loss or damage to property owned by a person other than the Insured unless
   a. otherwise specifically stated in the contract, or
   b. the interest of the Insured in that property is stated in the contract.

3. **Change of interest**

   The Insurer is liable for loss or damage occurring after an authorized assignment under the *Bankruptcy and Insolvency Act* (Canada) or a change of title by succession, by operation of law or by death.

4. **Material change in risk**

   1. The Insured 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 Insured.
   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 Statutory Condition 5, or
      b. notify the Insured in writing that, if the Insured desires the contract to continue in force, the Insured must, within 15 days after receipt of the notice, pay to the Insurer an additional premium specified in the notice.
   4. If the Insured 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 Statutory Condition 5 (2) (a) applies in respect of the unearned portion of the premium.

5. **Termination of insurance**

   1. The contract may be terminated
      a. by the Insurer giving to the Insured 15 days' notice of termination by registered mail or 5 days' written notice of termination personally delivered, or
      b. by the Insured at any time on request.
   2. If the contract is terminated by the Insurer,
      a. the Insurer must refund the excess of premium actually paid by the Insured over the prorated premium for the expired time, but in no event may the prorated premium for the expired time be less than any minimum retained premium specified in the contract, and
      b. the refund must accompany the notice unless the premium is subject to adjustment or determination as to amount, in which case the refund must be made as soon as practicable.
   3. If the contract is terminated by the Insured, the Insurer must refund as soon as practicable the excess of premium actually paid by the Insured over the short rate premium for the expired time specified in the contract, but in no event may the short rate premium for the expired time be less than any minimum retained premium specified in the contract.
   4. The 15 day period referred to in subparagraph (1) (a) of this condition starts to run on the day the registered letter or notification of it is delivered to the Insured's postal address.

6. **Requirements after loss**

   1. On the happening of any loss of or damage to Insured property, the Insured must, if the loss or damage is covered by the contract, in addition to observing the requirements of Statutory Condition 9,
      a. immediately give notice in writing to the Insurer,
      b. deliver as soon as practicable to the Insurer a proof of loss in respect of the loss or damage to the Insured property verified by statutory declaration,

i. giving a complete inventory of that property and showing in detail quantities and cost of that property and particulars of the amount of loss claimed,
ii. stating when and how the loss occurred, and if caused by fire or explosion due to ignition, how the fire or explosion originated, so far as the Insured knows or believes,
iii. stating that the loss did not occur through any willful act or neglect or the procurement, means or connivance of the Insured,
iv. stating the amount of other insurances and the names of other Insurers,
v. stating the interest of the Insured and of all others in that property with particulars of all liens, encumbrances and other charges on that property,
vi. stating any changes in title, use, occupation, location, possession or exposure of the property since the contract was issued, and
vii. Stating the place where the Insured property was at the time of loss,

c. if required by the Insurer, give a complete inventory of undamaged property showing in detail quantities and cost of that property, and
d. if required by the Insurer and if practicable,
i. produce books of account and inventory lists,
ii. furnish invoices and other vouchers verified by statutory declaration, and
iii. furnish a copy of the written portion of any other relevant contract.

2. The evidence given, produced or furnished under subparagraph (1) (c) and (d) of this condition must not be considered proofs of loss within the meaning of Statutory Conditions 12 and 13.

7. **Fraud**

Any fraud or willfully false statement in a statutory declaration in relation to the particulars required under Statutory Condition 6 invalidates the claim of the person who made the declaration.

8. **Who may give notice and proof**

Notice of loss under Statutory Condition 6 (1) (a) may be given and the proof of loss under Statutory Condition 6 (1) (b) may be made

a. by the agent of the Insured, if
I. the Insured is absent or unable to give the notice or make the proof, and
II. the absence or inability is satisfactorily accounted for, or
b. by a person to whom any part of the insurance money is payable, if the Insured refuses to do so or in the circumstances described in clause (a) of this condition.

9. **Salvage**

1. In the event of loss or damage to Insured property, the Insured must take all reasonable steps to prevent further loss or damage to that property and to prevent loss or damage to other property Insured under the contract, including, if necessary, removing the property to prevent loss or damage or further loss or damage to the property.
2. The Insurer must contribute on a prorated basis towards any reasonable and proper expenses in connection with steps taken by the Insured under subparagraph (1) of this condition.

10. **Entry, control, abandonment**

After loss or damage to Insured property, the Insurer has

a. an immediate right of access and entry by accredited representatives sufficient to enable them to survey and examine the property, and to make an estimate of the loss or damage, and
b. after the Insured has secured the property, a further right of access and entry by accredited representatives sufficient to enable them to appraise or estimate the loss or damage, but
i. without the Insured's consent, the Insurer is not entitled to the control or possession of the Insured property, and
ii. without the Insurer's consent, there can be no abandonment to it of the Insured property.

11. **In case of disagreement**

    1. In the event of disagreement as to the value of the Insured property, the value of the property saved, the nature and extent of the repairs or replacements required or, if made, their adequacy, or the amount of the loss or damage, those questions must be determined using the applicable dispute resolution process set out in the *Insurance Act*, whether or not the Insured's right to recover under the contract is disputed, and independently of all other questions.
    2. There is no right to a dispute resolution process under this condition until
        a. a specific demand is made for it in writing, and
        b. the proof of loss has been delivered to the Insurer.

12. **When loss payable**

    Unless the contract provides for a shorter period, the loss is payable within 60 days after the proof of loss is completed in accordance with Statutory Condition 6 and delivered to the Insurer.

    Repair or replacement

    1. Unless a dispute resolution process has been initiated, the Insurer, instead of making payment, may repair, rebuild or replace the Insured property lost or damaged, on giving written notice of its intention to do so within 30 days after receiving the proof of loss.
    2. If the Insurer gives notice under subparagraph (1) of this condition, the Insurer must begin to repair, rebuild or replace the property within 45 days after receiving the proof of loss, and must proceed with all due diligence to complete the work within a reasonable time.

13. **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.

01/07/12

LSW1815