Group Insurance Benefits Summary

Term Life, Accidental Death & Dismemberment, and Critical Illness Insurance

This Insurance Benefits Summary is designed to outline the benefits which are available to you (and your dependents, when insured) under the Goose Insurance Services Inc. Group Policy issued by Industrial Alliance Insurance and Financial Services Inc. ("**the Company**") which is available to you upon request. This Group Policy contains a provision removing or restricting the right of the Insured Person to designate persons to whom or for whose benefit insurance money is payable. In the event of any variation between the Group Insurance Certificate, this Insurance Benefits Summary and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Policy which may be amended from time to time.

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Policy Definitions

"Accident" means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while the Group Policy is in force and be the basis of claim.

"AdvanceCare Benefit Conditions" are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Member or Insured Spouse. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

"Covered Conditions" with respect to an Insured Member or Insured Spouse are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, Coma, Coronary Artery Bypass Surgery, Deafness, Dementia including Alzheimer's Disease, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Severe Burns and Stroke, as defined in the section titled *Definitions of Covered Conditions.*

"Date of Diagnosis" means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

"Diagnosis" means the certified diagnosis of the Insured Person with a Covered Condition or AdvanceCare Benefit Condition by a Specialist.

"Dependent Child" means any natural child, step-child or legally adopted child of a Member who is over 14 days of age and under 21 years of age, unmarried and receives full parental support and maintenance; or 21 years of age or over but under 25 years of age, unmarried and receives full parental support and maintenance for reason of full-time attendance at a recognized school, college or university.

"Insured Member" means an Insured Person who is a Member.

"Insured Person" means a person who is eligible for coverage under the Policy and who is insured under the Policy.

"Insured Spouse" means an Insured Person who is a Spouse.

"Loss" as used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and index finger means complete severance at or above the metacarpophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; and as used with reference to hearing means the total and irrecoverable loss thereof and with reference to quadriplegia, paraplegia and hemiplegia means the total and irrecoverable paralysis of such limbs.

"Loss of Use" means permanent, total and irrecoverable Loss which is continuous for a period of twelve months from the date of the Accident.

"Member" means a person who, at the time of application, has downloaded and registered on the Goose Insurance Services Inc. mobile application.

"Special Offer" (when applicable) means Voluntary Group Insurance to eligible Members and/or their Spouses on a guaranteed issue basis during a specified open enrolment period offered by Goose Insurance Services Inc.

"Specialist" means a licensed medical practitioner who:

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America.

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

"Spouse" means the legal or common-law spouse of a Member. Legal spouse is a person who is legally married and cohabiting with the Member and with whom there is no formal or informal agreement of separation. Common-law spouse is a person who has been cohabiting in a marriage-like relationship with the Member for a period of not less than 12 consecutive months.

"You" or **"Your"** refers to the Insured Member.

Benefit Schedule

You, your Spouse and Dependent Children are insured for those benefits indicated on the Group Insurance Certificate.

Term Life Insurance

This insurance pays a benefit in the amount indicated on your Group Insurance Certificate on the death of an Insured Person (the "**Death Benefit**").

Compassionate Living Benefit

In the event of an Insured Person's terminal illness with a prognosis of death within 12 months from the date of written proof, the Company will pay to such Insured Person an amount equal to 50% of the Term Life Insurance in force for that Insured Person up to a maximum of $25,000 provided such insurance has been in force for at least two full years at the time of prognosis.

Daycare Benefit

If an Insured Person dies while his Term Life Insurance is in force, the Company will pay the reasonable and necessary expenses incurred for Dependent Children, under age 13, who are either enrolled in a legally licensed daycare centre at the date of death or enrol within 12 months of the Insured Person's death. This benefit is subject to a limit equal to the lesser of 5% of the Insured Person's Term Life Insurance in force or $2,500 per year, for up to 4 consecutive years, for each Dependent Child.

Education Benefit

If an Insured Person dies while his Term Life Insurance is in force, the Company will pay the reasonable and necessary post-secondary education expenses incurred for Dependent Children who are either enrolled as a full-time post-secondary student at the date of death or enrol in a full-time post-secondary program within 12 months of the Insured Person's death. This benefit is subject to a limit equal to the lesser of 5% of the Insured Person's Term Life Insurance in force or $2,500 per year, for up to 4 consecutive years for each Dependent Child.

Retraining Benefit

If an Insured Person dies while his Term Life Insurance is in force, the Company will pay the reasonable and necessary retraining expenses incurred within 3 years from the date of death, by the surviving Member or Spouse where such person engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which they would not otherwise have sufficient qualifications. This benefit is subject to a maximum of $10,000 for all such expenses.

Repatriation Benefit

If an Insured Person dies while his Term Life Insurance is in force, the Company will pay the reasonable and necessary expenses incurred for transportation of the body of the Insured Person to the city of residence, including preparation of the body for such transportation subject to a maximum of $10,000.

Exclusions

The Death Benefit is not payable if an Insured Person commits suicide within two years of the initial effective date of such person's coverage.

With respect to Term Life Insurance issued to a Member or Spouse as a result of a Special Offer, if the cause of death is non-accidental, no benefit is payable, but premiums will be refunded with 5% interest, compounded annually. This exclusion does not apply to Term Life Insurance purchased outside of a Special Offer. If the cause of death is suicide, no benefit is payable, and premiums will not be refunded. This exclusion applies for the first 24 months following the effective date of an Insured Person's Term Life Insurance coverage under the Special Offer.

Conversion Privilege

If the Group Term Life Insurance of an Insured Member or Insured Spouse terminates as a result of termination of the master Group Policy between Goose Insurance Services Inc. by the Company, the Insured Person may convert their terminated Term Life Insurance to an individual policy for the lesser of $50,000 or the amount of such Insured Person's insurance reduced by any amount for which they may be eligible under any replacing group policy, provided such Insured Person is under age 65 at the date of termination. This may be done without further evidence of health at smoker rates applicable to such Insured Person's age at the time of conversion.

You must apply to the Company in writing, within 31 days of the date the master Group Policy terminates.

Accidental Death & Dismemberment ("AD&D") Insurance

Insurance is issued on a Member Only Plan as indicated on your Group Insurance Certificate. Your insurance covers you on a 24 hour basis, anywhere in the world.

Schedule of Losses

If injury results in any of the following Losses, within 365 days after the date of the Accident causing such injury, the Company will pay for the Loss or permanent and total Loss of Use of:

Loss	Percentage of Benefit
Life	100%
Both Hands, Both Feet or the Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand or Foot and the Entire Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Arm or One Leg	75%
One Hand, One Foot or the Entire Sight of One Eye	66.66%
Speech or Hearing in Both Ears	50%
Thumb and Index Finger of Either Hand	33.33%
Hearing in One Ear	16.66%
Quadriplegia (Complete paralysis of both upper and lower limbs)	100%
Paraplegia (Complete paralysis of both lower limbs)	100%
Hemiplegia (Complete paralysis of upper and lower limbs of one side of body)	100%

Daycare Benefit

If an Insured Member dies as a result of injury sustained in an Accident for which the Company pays the AD&D loss of life benefit, the Company will also pay the reasonable and necessary expenses incurred for each of the Member's Dependent Children, under age 13, who are enrolled in a legally licensed daycare centre at the date of death or enrol within 12 months of the Insured Member's death. This benefit is subject to a limit equal to the lesser of 5% of the Insured Member's AD&D Insurance or $5,000 per year, for up to 4 consecutive years, for each Dependent Child.

Education Benefit

If an Insured Member dies as a result of injury sustained in an Accident for which the Company pays the AD&D loss of life benefit, the Company will also pay the reasonable and necessary expenses incurred for Dependent Children who are either enrolled as a full-time post-secondary student at the date of death or enrol in a full-time post secondary program within 12 months of the Insured Member's death. This benefit is subject to a limit equal to the lesser of 5% of the Member's AD&D Insurance or $5,000 per year, for up to 4 consecutive years for each Dependent Child.

Home Alteration & Vehicle Modification Benefit

If an Insured Person sustains an injury which results in a Loss or Loss of Use in accordance with the Schedule of Losses and such person is subsequently required to use a wheelchair to be ambulatory, the Company will pay the reasonable and necessary expenses incurred within 3 years of the accident for the alteration of the person's home and/or modification of one motor vehicle for wheelchair accessibility, subject to a maximum amount of $10,000 as a result of any one Accident.

Rehabilitation Benefit

If an injury due to an Accident requires that an Insured Member undergo special training to engage in an occupation in which they would not engage except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training by the Insured Person within 3 years of the Accident subject to a maximum amount of $10,000 as a result of any one Accident.

Repatriation Benefit

If an Insured Person dies as a result of injury sustained in an Accident for which the Company pays the AD&D loss of life benefit, the Company will also pay the reasonable and necessary expenses incurred for transportation of the body of the Insured Person to the city of residence, including preparation of the body for such transportation subject to a maximum amount of $10,000.

Retraining Benefit

If an Insured Member dies as a result of injury sustained in an Accident for which the Company pays the AD&D loss of life benefit, the Company will also pay the reasonable and necessary retraining expenses incurred within 3 years from the date of death, by the Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which the Spouse would not otherwise have sufficient qualifications. This benefit is subject to a maximum amount of $10,000.

Exclusions

Benefits are not payable for any Loss which is contributed to, resulting from or caused by:

a. suicide or any attempt thereat, regardless of any impairment, illness or state of mind;

b. intentionally self-inflicted injury, regardless of any impairment, illness or state of mind;

c. injury sustained while a pilot or member of a crew in any aircraft;

d. full-time active service in the armed forces of any country;

e. declared or undeclared war or any act thereof;

f. committed, attempted or provoked assault or criminal offence, including without limitation the operation of a vehicle while under the influence of any intoxicant or while the Insured Person's blood alcohol concentration is in excess of 80 mg of alcohol per 100 ml of blood; or

g. any drug, poison, gas, intoxicant or controlled substance as defined by federal or provincial law which is taken, administered, absorbed or inhaled, voluntarily or otherwise, unless related to the Insured Person's occupation or administered on the advice of a Physician.

Critical Illness Insurance

You and/or your Spouse are insured for Critical Illness Insurance in the amount(s) indicated on the attached Group Insurance Certificate (the **"Benefit Amount"**).

Covered Condition Benefit

If an Insured Member or Insured Spouse is diagnosed by a Specialist with a Covered Condition while the 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 Conditions, the Company will pay such Insured Member or Insured Spouse the Benefit Amount in force with respect to such Insured Person (the "**Covered Condition Benefit**"). The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies before the approved Covered Condition Benefit is paid, the Company will pay the Covered Condition Benefit to the Insured Person's estate.

Payment of the Covered Condition Benefit for Critical Illness Insurance is limited to only the first Covered Condition to occur.

AdvanceCare Benefit

If an Insured Member or Insured Spouse is diagnosed by a Specialist with an AdvanceCare Benefit Condition while his Voluntary Group Critical Illness Insurance is in force, the Company will pay to such Insured Member or Insured Spouse a benefit equivalent to 10% of the Benefit Amount in force with respect to such Insured Person (the **"AdvanceCare Benefit"**). The Date of Diagnosis of the AdvanceCare Benefit Condition must be later than the effective date of coverage. If the Insured Person dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to the estate of such Insured Person. The AdvanceCare Benefit is a one-time benefit which the Company will pay for one AdvanceCare Benefit Condition only.

Payment of the AdvanceCare Benefit in respect of an Insured Person will not affect the amount of benefit payment under a subsequent Covered Condition Benefit for such person.

Critical Illness Insurance for an Insured Person will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit providing premiums continue to be paid as required.

Multiple Event Coverage Benefit

If an Insured Member or Insured Spouse receives a Covered Condition Benefit under the Group Policy, and then diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**"MEC Grouping"**) the Company will pay to such Insured Member or Spouse the Benefit Amount in force with respect to such Insured Member or Spouse (the **"Multiple Event Coverage Benefit"**), subject to the terms and conditions of the Group Policy. The Insured Member must survive for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions to qualify for this benefit. If the Insured Member or Spouse dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to the estate of such Insured Member or Spouse.

MEC Grouping	Covered Condition
Group 1	Cancer
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure On Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

Limitations

a. Cancer

An Insured Member or Insured Spouse will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Cancer in MEC Grouping 1 will no longer be considered a Covered Condition for such Insured Person.

b. Benign Brain Tumour

An Insured Member or Insured Spouse will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Benign Brain Tumour, or has any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all

Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

c. Multiple Sclerosis

An Insured Member or Insured Spouse will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Multiple Sclerosis, or has any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

d. Parkinson's Disease and Specified Atypical Parkinsonian Disorders

An Insured Member or Insured Spouse will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, or has any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

e. AdvanceCare Benefit

An Insured Member or Insured Spouse will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Voluntary Group Critical Illness Insurance will remain in force, but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Insured Person.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply:

a. No benefit will be paid if a Covered Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;
b. No benefit will be paid if an AdvanceCare Benefit Condition results from any AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;
c. No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

    1. a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, Diagnosis 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 within the 24 months immediately preceding the effective date of such Insured Person's coverage. This exclusion applies for the 24 months following the effective date of the Insured Person's Voluntary Group Critical Illness Insurance coverage;

    2. attempted suicide;

    3. taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Member or Insured Spouse;

    4. taking any drug other than as prescribed by a licensed physician;

    5. war or full-time active service in the armed forces of any country;

    6. flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;

    7. 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 millilitres of the Insured Member's or Insured Spouse's blood exceeds 80 milligrams; or

    8. intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.

In addition, no benefit will be paid if the Insured Member or Insured Spouse suffer Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Definitions of Covered Conditions

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

Exclusion: No benefit will be payable under this condition for

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

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

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

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

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

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

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

Benign Brain Tumour means a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

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

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty

with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- *Pituitary adenomas less than 10 mm;*
- *Vascular malformations;*
- *Cholesteatomas; or*
- *Infectious or inflammatory tumours.*

90-Day Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms, or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Group Policy), regardless of when the Diagnosis is made; or*
- *A Diagnosis of Benign Brain Tumour (covered or not covered under the Group Policy).*

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

Blindness means a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer means the definite Diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The Diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the Group Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
  - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF; or
  - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm2, or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- *Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;*
- *Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;*
- *Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;*
- *Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;*
- *Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;*
- *Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;*
- *Gastro-intestinal stromal tumours classified as AJCC Stage 1;*
- *Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or*
- *Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.*

90-Day Exclusion : No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the Group Policy), regardless of when the diagnosis is made; or*
- *A diagnosis of any cancer (covered or not covered under the Group Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or any critical illness caused by any cancer or its treatment.

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

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

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

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

Exclusion: No benefit will be payable under this Covered Condition for:

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

Deafness means a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease means a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

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

The Insured Person must exhibit:

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

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

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

Heart Attack (acute myocardial infarction) means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

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

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

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

- *ECG changes suggestive of a prior myocardial infarction;*
- *Other acute coronary syndromes, including angina pectoris and unstable angina; or*

- *Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.*

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

Exclusion: No benefit will be payable under this Covered Condition for

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

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already has been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

The Diagnosis of Loss of Speech must be made by a Specialist.

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

Major Organ Failure on Waiting List means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the survival period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease means a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

- Two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

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

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- *Solitary sclerosis;*
- *Clinically isolated syndrome;*
- *Radiologically isolated syndrome;*
- *Neuromyelitis optica spectrum disorders; or*
- *Suspected multiple sclerosis or probable multiple sclerosis.*

1-Year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the Group Policy) regardless of when the diagnosis is made; or*
- *A diagnosis of multiple sclerosis (covered or not covered under the Group Policy).*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

Payment under this condition requires satisfaction of all of the following:

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

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

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

Paralysis means a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of primary Parkinson's Disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease. Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

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

1-Year Exclusion: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- *Signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or*
- *A Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.*

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism with:

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

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- *Transient Ischaemic Attacks;*
- *Intracerebral vascular events due to trauma;*
- *Ischaemic disorders of the vestibular syndrome;*
- *Death of tissue of the optic nerve or retina without total loss of vision of that eye; or*
- *Lacunar infarcts which do not meet the definition of stroke as described above.*

Definitions of AdvanceCare Benefit Conditions

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

Early Stage Cancer refers to one of the following conditions:

- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- gastrointestinal stromal tumours classified as AJCC Stage 1;
- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- Ductal Carcinoma in situ of the Breast

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

Claims at TuGo

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. Claims at TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons, and arranges travel and lodging, if required, at special pricing discounts.

For assistance in accessing this service, please visit www.tugo.com/tms. Note that utilization fees may apply.

General Provisions

Beneficiary

Term Life Insurance: You may designate a beneficiary of your choice. Unless otherwise specified in writing, you are the beneficiary for your Spouse's insurance under this benefit.

Accidental Death and Dismemberment Insurance: In the event of your accidental death, the benefit will be paid to the beneficiary you have designated under your Term Life Insurance. All other AD&D benefits are payable to you.

Termination of Insurance

An Insured Person's insurance will terminate automatically on the earliest of the following dates:

a. the termination date of the Group Policy;

b. the end of the policy year coincident with or next following a Member's 70th birthday for Term Life Insurance coverage and Critical Illness Insurance;

c. the end of the policy year coincident with or next following a Member's 85th birthday for Accidental Death and Dismemberment ("AD&D") Insurance;

d. the due date of any unpaid premiums;

e. the end of the month coincident with or next following the date Goose Insurance Services Inc. receives written notice from you requesting cancellation of all or part of the insurance;

f. with respect to a Spouse's insurance, the earliest of the above, or the end of the policy year coincident with or following an insured Spouse's 70th birthday for Term Life Insurance coverage and Critical Illness Insurance and 85th birthday for Accidental Death & Dismemberment Insurance; or the end of the month coincident with or next following the date on which they no longer qualify as a 'Spouse' and have not elected to continue coverage as a Member;

Coordination of Benefits

In the event that an Insured Person is entitled to one of the benefits listed below under Term Life Insurance and AD&D Insurance under this policy or under any other policy issued by the Company, the Company's total liability will be limited to the lesser of the actual expense incurred and the maximum amount of benefit provided:

- Daycare Benefit
- Education Benefit
- Repatriation Benefit
- Retraining Benefit

Special Continuation for Insured Spouses

An Insured Spouse who ceases to be eligible as a Spouse as defined in the Policy may apply within 31 days of Spouse coverage termination to continue existing coverage as a Member. Member coverage will be issued on a guaranteed-acceptance basis, subject to continuation of any and all exclusion and/or limitation timeframes applicable to the original coverage.

Money Back Guarantee

Goose Insurance Services Inc. offers you 30 days from the effective date of your coverage to decide if the coverage meets your needs. If the coverage does not meet your needs, simply contact Goose Insurance Services Inc. through its mobile application or email refunds@gooseinsurance.com with your certificate information. A Goose Insurance agent will cancel from the effective date and refund any premium paid. If you send your cancellation request outside of the 30 days from the effective date of your coverage, you are not entitled for a refund of premium.

Claims Procedures

Before paying a benefit under the Group Policy, we will require the claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at **1.800.266.5667** or email **sms-claims@ia.ca** to obtain the appropriate forms and for details on claims procedures.

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

Note: With respect to Critical Illness Insurance**,** all claims will be adjudicated according to the definition of the Covered Condition or the applicable AdvanceCare Benefit Condition at the time of Diagnosis.

Send Claims forms to:

iA Financial Group
400 – 988 West Broadway Vancouver, BC V5Z 1K7

Questions?

Contact Goose Insurance Services Inc:

We are here to help Monday to Friday 6am to 6pm PST except statutory holidays.

1.888.374.6673 (toll free)

support@gooseinsurance.com