Manulife

Certificate of Insurance

OMA Priority Insurance Program (OPIP) Critical Illness

Benefits are provided by:

The Manufacturers Life Insurance Company (Manulife)

We administer this certificate and pay benefits to the person named in the *Summary of Information*, according to the terms, conditions, and limitations of Group Policy #50130, which we have issued to the

Ontario Medical Association (OMA)

This document contains all details about your coverage and how to use it. Your contract includes this certificate, *Summary of Information*, applications for insurance submitted by you, and any schedules, riders, attachments, amendments and/or endorsements to this certificate executed by us. If there is any conflict between the terms and conditions of this certificate and the group policy, the terms of the group policy will take precedence, to the extent required by law.

The effective date, also known as the start date, of this certificate appears on your *Summary of Information*. Read this certificate carefully to become familiar with the features of coverage so you can take full advantage of the benefits it offers.

This certificate contains a provision removing or restricting the right of the insured to designate persons to whom or for whose benefit insurance money is to be payable.

Signed for The Manufacturers Life Insurance Company (Manulife) at Toronto by:

Roy Gori,

President and Chief Executive Officer

30-day satisfaction guarantee

The first 30 days from the start date of your insurance is known as the free-look period. If you decide that you don't want your certificate, simply mail it to the address below for cancellation. We will cancel your certificate as of the start date shown on your *Summary of Information* and send you a full refund of premiums, minus any claims we've paid. If the claims we paid are more than your premium payments, you must repay the difference. This right of cancellation expires 30 days after the certificate is received by you. The rights of any beneficiary under the certificate are also subject to this right of cancellation.

The Manufacturers Life Insurance Company
Affinity Markets
P.O. Box 17001, Station Waterloo,
Waterloo, Ontario N2J 0G5

Visit our website: manulife.ca
Email us: am_service@manulife.ca
Call us toll-free: 1- 888-596-8881

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Before you begin

This certificate indicates that your application for insurance under the group policy has been accepted by us and, as of the start date shown on your *Summary of Information*, your insurance is in force under the terms and conditions of the certificate.

To be eligible to submit claims, this certificate must be in good standing, which means the certificate premiums must be paid in full to the current date.

We may update our terms and conditions without notice to reflect corporate policies, economic changes, or legislative changes, including changes to income tax legislation. Any changes we make to the terms and conditions may affect the benefits provided by this certificate. We reserve the right to change premiums or benefits required for this certificate for any reason.

All benefits outlined in this certificate apply to you. This certificate contains information about your insurance coverage, including exclusions, limitations, conditions, deductibles, maximums, and definitions. Please read it carefully and be sure to keep it in a safe place.

Some of the terms used in this certificate have been assigned a specific meaning. It's very important this certificate is read and understood with these specific meanings in mind. Refer to *Section 8: Words and phrases used in this certificate* to familiarize yourself with these terms and their associated meaning whenever consulting this certificate.

You can view the current version of this certificate online at manulife.ca/secureserve.

1 How your coverage works

Benefit amount

The Critical Illness benefit amount is $50,000. Coverage under this plan is only available for you.

The combined amount of insurance under this OMA Priority Insurance Program coverage (Group Policy #50130) and the OMA Critical Illness group coverage (Group Policy #17862) cannot exceed $300,000.

Eligibility

To be eligible for this coverage, you must be:

- a Canadian resident who has submitted the application in a province or territory other than Quebec, and not a resident of Quebec at the time the application is submitted after the group policy has come into force;
- licensed with the College of Physicians and Surgeons of Ontario to practice medicine in Ontario;
- actively engaged in providing medical services in the province of Ontario for at least 15 hours per week on average and is remunerated by the Ministry through OHIP or by an employer for providing insured clinical services;
- a member in good standing of the OMA or, if not a member, have paid any OMA dues and assessments owing under the Ontario Medical Association Dues Act, 1991;
- not a medical resident; and
- insurable under a contract of insurance for the program.

This certificate indicates that your application for insurance under the group policy has been approved by us and, as of the start date shown on your *Summary of Information*, your insurance is in force under the terms and conditions of the group policy.

Government-subsidized premium

If you are eligible for the government-subsidized Physician Health Benefit Program (PHBP), your premium cost is subsidized by the Ministry of Health and Long-Term Care through Ontario Physicians Services Inc., with the remainder paid by you. The subsidy amount is not guaranteed and is subject to change. To continue to qualify for this subsidy, at each renewal you must be residing in a province or territory of Canada, other than Quebec, and you must meet the above eligibility requirements, except that you do not become ineligible if you are absent from practice due to disability or parental leave of up to 18 months. If you do not return to practice after the disability or parental leave ends, you may elect to continue your coverage, at your own expense, as set out in the continuation of coverage provision in Section 3.

Premiums

The premium, also known as the cost of insurance, is the amount we charge you to maintain this insurance and is shown on your *Summary of Information*. The cost of insurance is based on rates agreed to by us and the OMA. The *Summary of Information* shows your cost, including any applicable taxes.

The premium rate is subject to change if you change your coverage selection or if the coverage you chose has a rate change on a scheduled renewal date. We'll send you a notice when your premium is scheduled to change. We reserve the right to change premiums required for this certificate. If we do, we'll give you 30 days' written notice.

The first premium payment is due at the time of your initial insurance application and covers you from your start date until your next premium due date. If we do not receive the first premium, or if the first premium is not honoured when first presented for payment, the insurance will not go into effect. Afterwards, premiums can be paid either monthly on the 1st of each month following your start date, or annually on the group policy anniversary date.

For the first year, premiums are pro-rated based on the number of full months remaining from your start date until the next group policy anniversary date. Your insurance remains active from month to month if the required premiums are paid when due. You may request to change the premium payment frequency.

Grace period

Following payment of your first premium, if you don't pay your subsequent premiums, you have a 31-day grace period to pay the overdue amount to maintain your coverage. Your insurance will remain active during this grace period, subject to the conditions of Section 6. Your insurance ends on the last day of the grace period if we don't receive your full payment. We will refund you any partial payments made during the grace period.

Reinstatement

Your insurance coverage under this certificate may be reinstated within 60 days after the end of the grace period. To be eligible for reinstatement, you must have had in force coverage under this certificate for at least 12 consecutive months prior to the start of the grace period.

To reinstate your insurance coverage, we must receive your:

- written application for reinstatement;
- satisfactory medical evidence; and
- payment of the reinstatement amount.

The reinstatement amount is the total of all outstanding required premiums that were due on or before the end of the grace period, plus all premiums due from the end of the grace period to the effective date of the reinstatement.

Once your reinstatement request is approved by us, your certificate will be reinstated as of the start of the grace period.

2 What is covered

We provide protection for covered critical illness conditions while your coverage is in force and subject to the terms of this certificate. The details of each covered condition are listed below.

Aortic surgery

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 physician. You must survive for 30 days following the date of surgery.

Exclusion:

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

Aplastic anemia

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 physician. You must survive for 30 days following the date of diagnosis.

Bacterial meningitis

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days following the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist physician. You must survive for 90 days following the date of diagnosis.

Exclusion:

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

Benign brain tumour

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).

The diagnosis of benign brain tumour must be made by a specialist physician. You must survive for 30 days following the date of diagnosis.

Exclusions:

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

No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Moratorium Period Exclusion*:*

No benefit will be payable under this condition and your coverage for benign brain tumour will terminate if within the first 90 days following the later of:

- the date the enrolment for this coverage was signed; or
- the effective date of your coverage,

you have 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 excluded under the group policy).

While your insurance for benign brain tumour terminates, insurance for all other covered conditions remains in force.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within 6 months of the date of diagnosis. If this information is not provided within this period, we have the right to deny any claim for benign brain tumour, or any critical illness caused by any benign brain tumour or its treatment.

Blindness

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 physician. You must survive for 30 days following the date of diagnosis.

Cancer (Life-threatening)

Cancer (Life-threatening) means a definite diagnosis of a tumour which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma.

The diagnosis of cancer must be made by a specialist physician. You must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

No benefit will be payable under this condition for the following:

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

Moratorium Period Exclusion:

No benefit will be payable under this condition and your coverage for cancer will terminate if within the first 90 days following the later of:

- the date the enrolment for this coverage was signed; or
- the effective date of your coverage,

you have any of the following:

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

While your insurance for cancer terminates, insurance for all other covered conditions remains in force.

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

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

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

Coma

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 physician. You must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

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

Coronary artery bypass surgery

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 physician. You must survive for 30 days following the date of surgery.

Exclusion:

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

Deafness

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 physician. You must survive for 30 days following the date of diagnosis.

Dementia, including Alzheimer's disease

Dementia, including Alzheimer's disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour), which is affecting daily life.

You must exhibit:

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

The diagnosis of dementia must be made by a specialist physician. You must survive for 30 days following the date of diagnosis.

Exclusion:

No benefit will be payable under this 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

Heart attack 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; or
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist physician. You must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

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

Heart valve replacement or repair

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 physician. You must survive for 30 days following the date of surgery.

Exclusion:

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

Kidney failure

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 physician. You must survive for 30 days following the date of diagnosis.

Loss of independent existence

Loss of independent existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;

- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.

Loss of limbs

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 physician. You must survive for 30 days following the date of diagnosis.

Loss of speech

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

The diagnosis of loss of speech must be made by a specialist physician. You must survive for 180 days following the date of diagnosis.

Exclusion:

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

Major organ failure on waiting list

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, you must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

For the purposes of the Survival Period, the date of diagnosis is the date of your enrolment in the transplant centre.

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

Major organ transplant

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, you 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 major organ failure must be made by a specialist physician. You must survive for 30 days following the date of the transplant.

Motor neuron disease

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 physician. You must survive for 30 days following the date of diagnosis.

Multiple sclerosis

Multiple sclerosis means a definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than 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 physician. You must survive for 30 days following the date of diagnosis.

Occupational HIV infection

Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of your normal occupation, which exposed you to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of:

- the date the enrolment for this coverage was signed; or
- the effective date of your coverage.

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

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

The diagnosis of occupational HIV infection must be made by a specialist physician. You must survive for 30 days following the date of the second serum HIV test described above.

Exclusions:

No benefit will be payable under this condition if:

- you have elected not to take any available licensed vaccine offering protection against HIV;
- a licensed cure for HIV infection has become available prior to 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

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 physician. You must survive for 90 days following the precipitating event.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by Bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. You 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 means a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's disease or a specified atypical Parkinsonian disorder must be made by a neurologist. You must satisfy the above conditions and survive for 30 days following the date all these conditions are met.

Exclusions:

No benefit will be payable for Parkinson's disease or specified atypical Parkinsonian disorders if, within the first year following the later of:

- the date the enrolment for this coverage was signed; or
- the effective date of your coverage,

you have 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.

No benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders for any other type of Parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within 6 months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorders or, any critical illness caused by Parkinson's disease or specified atypical Parkinsonian disorders or its treatment.

Severe burns

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 physician. You must survive for 30 days following the date the severe burn occurred.

Stroke (cerebrovascular accident)

Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

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

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist physician. You must survive for 30 days following the date of diagnosis.

Exclusions:

No benefit will be payable under this condition for:

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

3 Continuation of coverage

If your subsidy should end due to no longer meeting the eligibility requirements in Section 1, you may elect to continue your coverage, by paying the full amount of the required premium, provided you:

- have had insurance coverage under this certificate in force for 12 consecutive months;
- are a member in good standing of the OMA or, if not a member, have paid any OMA dues and assessments owing under the *Ontario Medical Association Dues Act, 1991*;
- are under the age of 70;
- made a written request for continuation of coverage to us within 60 days of the end of the month in which you no longer met this certificate's eligibility requirements; and
- are not a resident of Quebec, Canada.

The continuation of coverage is subject to the same terms of this certificate.

Portability

If your coverage is continued under the terms of the continuation of coverage provision above, you will be covered anywhere worldwide, provided you maintain your membership in the OMA, premiums continue to be paid, and, if possible, you return to Canada for diagnosis.

4 How benefits are paid

A lump-sum benefit amount will be paid in accordance with the terms and conditions of this certificate. Except as provided under the cancer and benign brain tumour conditions in Section 2, the critical illness benefit is payable only on the first covered critical illness condition for which a diagnosis is made while your coverage is active, or surgery is performed while your coverage is active, and then your insurance ends. You will not be able to become insured again under this certificate.

Any benefit payment for a covered condition is subject to the survival period, moratorium period exclusions, and pre-existing condition limitations required to be completed under the terms of this certificate. No benefit payment is due or accrues during any survival period. If a benefit becomes payable, the amount of any premiums due which were paid during the survival period will be refunded to you.

We reserve the right to require medical examination of you when a claim is made. Confirmation of any diagnosis of or surgery for any covered condition is required by a physician or specialist physician of our choosing in order for any benefit to become payable.

Claims

Written notice of claim must be given to us no later than 30 days, and proof no later than 90 days, from the date of diagnosis of, or surgery for, a covered critical illness condition. Notice given by you or on your behalf to us, with information sufficient to identify you and your group policy, will be considered notice to us. We will provide you with the appropriate claim forms on receipt of notice.

Failure to give notice of claim or provide proof of claim within the time prescribed does not invalidate the claim if the notice or proof is given as soon as reasonably possible, and in no event, later than one year from the date of diagnosis or surgery.

We will notify you in writing whether a claim is payable. Any benefit payable will be made directly to you or, in the event of your death, your estate.

5 What is not covered

We will not pay benefits resulting directly or indirectly from any of the following:

- **Self-inflicted injury** – suicide, attempted suicide, or intentionally self-inflicted injury, regardless of whether medical evidence establishes that the injuries are related to a mental health illness;
- **Terrorism, war, or insurrection** – declared or undeclared war, or any act of war, riot or insurrection or terror;
- **Criminal offence or imprisonment** – attempt, provocation, or commission of a criminal offense or assault, or participation in a riot or civil commotion; or any period of incarceration or confinement in a similar institution;
- **Drugs** or **alcohol** – the misuse of alcohol or use of any medication, narcotics, toxic substances, or drugs of any nature, unless administered by or taken as prescribed or as recommended by an authorized health care professional or licensed physician;
- **Death** – your death during the required survival period; or
- **Non-covered conditions** – any illness, disorder, or surgery excluded by or omitted from the covered conditions listed in Section 2.

6 When your coverage ends

Your insurance will end on the earliest of the following:

- the date any critical illness benefit is paid to you;
- the date the group policy terminates;
- the date any premium due has not been paid, subject to the grace period;
- the last day prior to the group policy anniversary date that is on or immediately following your 70th birthday;
- the last day of the period for which premiums have been paid, which is on or immediately following the date you cease to be a member of the OMA;
- the last day of the month coinciding with the date you no longer meet the eligibility requirements in Section 1, except as provided under the continuation of coverage provisions in Section 3;
- the first of the month on or immediately following the date we receive written notice from you requesting the insurance be terminated; or
- the date of your death.

7 General provisions

Entire contract

This certificate, together with the *Summary of Information and* any applications for insurance submitted by you and any schedules, riders, amendments, and/or endorsements to this certificate executed by us, constitutes the entire contract between the parties.

This certificate is subject in all respects to the terms and conditions of the group policy. If there is any conflict between the terms and conditions of this certificate and the group policy, the terms of the group policy take precedence to the extent permitted by applicable law. The certificate will govern any matter requiring determination. It supersedes any previously issued certificate.

Summary of Information

The *Summary of Information* is a separate document issued to you accompanying this certificate outlining the benefits for which you have been approved, along with any applicable provisions, and forms part of this certificate.

Currency

All payments by us or to us under this certificate must be in Canadian dollars.

Facility of payment

If for any reason, you are not competent to give a valid release for payments to which you are entitled, we may, at our discretion, make payment, to the extent permitted by law, to any person related to you, or to any other individual appearing to us to be equitably entitled to such payment. Any payment made by us in good faith pursuant to this provision fully discharges us to the extent of such payment.

Non-waiver

If we waive our rights in a specific instance or fail to insist on performance of any of the provisions of this certificate, that will not be construed as a subsequent waiver of the performance of, or any subsequent breach of, the same provision.

Governing law

This certificate will be subject to the laws of the Canadian province or territory in which you resided at the time of application for insurance.

Provincial variations

We reserve the right to adjust the provisions described in this certificate to meet the minimum requirements of law within your province or territory.

Non-participating

This certificate is non-participating and is not eligible to share in our divisible surplus. It has no cash value and receives no dividends.

Assignment

The insurance coverage evidenced by this certificate may not be assigned.

Limitation of action

No legal action may be taken on claims until 60 days after due proof of claim has been submitted.

Limitation period

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 *Limitations Act, 2002*, in Ontario, if applicable, or such other applicable legislation of your province or territory.

Requesting copies of documents

Upon request and on reasonable notice, you may, at any time, obtain copies of:

- your application for insurance;
- any written statements or other record, not otherwise part of the application for insurance, that you have provided to us as evidence of insurability; and
- the group policy.

The first copy will be provided at no cost, but a fee may be charged for subsequent copies. All requests for copies of documents should be directed to us.

Clerical error

Clerical error by the OMA or by us in administering this certificate will not:

- invalidate coverage that is otherwise in force;
- render insurance valid which would, but for such error, not validly be in force; or
- continue coverage otherwise validly terminated.

We or the OMA will not refund premiums for any period which is more than 12 months prior to the date we or the OMA receive proof in writing of your right to a refund.

Changes and amendments

We may at any time, by agreement with the OMA, amend the provisions of this certificate. You will be provided with written notification of any changes to this certificate. Your consent is not required. No such amendment will in any way affect our liability in respect of any loss that occurs prior to the start date of the amendment.

We may also change the benefits, terms, and conditions of this certificate at any time, in response to changes in provincial, territorial, or federal legislation or regulations, retroactive to the date of such changes.

Misstatement of non-smoker status

If your status as a non-smoker has been misstated, your insurance will be cancelled retroactive to the date we determined your status as a smoker, with a refund of premium paid since that date.

Misstatement of age

If due to the misstatement of your age or the age of any of your eligible family members:

- we would not have issued the insurance coverage because the true age at issue does not meet the eligibility requirements in effect when the coverage was issued, then we may declare the insurance void and our liability will be limited to the refund of all premiums paid for the coverage.
- the coverage has been in effect longer than it would have been based on the true age at issue, we will terminate the coverage effective on the date the coverage would have ceased according to the true age and, if we accepted a premium for a period beyond that date, our liability will be limited to the refund of all premiums paid for the period during which coverage would not have been in effect.

Otherwise, if the amount of insurance for any insured person in accordance with the terms and conditions of this certificate has been affected by a misstatement of age, the amount of insurance will be adjusted to the amount to which an insured person would have been entitled as determined using the true age, and an equitable premium adjustment will be made.

If the amount of premium applicable to you has been affected by such misstatement of age, the amount of premium applicable to you will be adjusted to the amount determined by the true age, and an equitable premium adjustment will be made.

We may request proof of age for any person insured under this certificate. If a date of birth is misstated, it will be corrected, and the following may occur:

- rates may be adjusted;
- the date coverage starts may change;
- the amount and type of coverage may be reduced or cancelled; and/or
- any rights or benefits provided under this certificate may be changed.

Misrepresentation, adjustments, and incontestability

Any failure to disclose or misrepresentation of a fact material to the insurance could render your insurance voidable by us.

Where there are multiple people insured under the certificate, we may either cancel the entire certificate, modify, or cancel only the coverage of the individuals insured to whom the failure to disclose relates.

In addition, we have the right to subtract any claims we've paid from any premiums we refund. However, after coverage has been in force for a period of 2 years, we can't cancel any coverage, unless a fraud is committed.

8 Words and phrases used in this certificate

Some of the terms used in this certificate have a specific meaning. It's very important this certificate is read and understood with these specific meanings in mind. Please familiarize yourself with these terms and their associated meaning whenever consulting this certificate.

age – is your age in completed years on the start date of coverage and on each subsequent certificate calendar year.

benefit amount – is the amount of insurance stated on your most recently signed application on file with us, which was accepted by us.

Certificate – is the certificate of insurance issued by us to you as evidence that we have granted you insurance under the policy.

critical illness – means only an illness, disorder or surgery that is defined under the covered critical illness conditions listed in Section 2 of this certificate. Any illness, disorder or surgery not specifically defined under the covered critical illness conditions listed in Section 2 will not be insured under this certificate and no benefit will be payable.

diagnosis *or* ***diagnosed*** – means a written diagnosis by a physician or specialist physician of the covered critical illness condition. Any diagnosis will be effective as of the date it is established by the physician or specialist physician, as supported by your medical records. Any diagnosis of a covered critical illness condition that was made prior to the start date of coverage will not be covered.

group policy – is Group Policy #50130, issued by us to the OMA, and any associated amendments made to it.

immediate family member – the spouse, children (natural, adopted or step-relations), parents, siblings, grandparents, grandchildren, or in-laws of an insured person.

member – a physician who meets the eligibility requirements under the group policy.

non-smoker – is when you have not used any tobacco, tobacco cessation products, nicotine in any form or nicotine replacement products in the past 24 months.

OMA – is the Ontario Medical Association.

physician – is a physician or surgeon who is licensed as such in Canada or the United States or any such other region as we may approve, and who is practicing within the scope of the physician's licensed authority. The treating physician may not be you or an immediate family member, or anyone who resides with you.

Physician Health Benefit Program (PHBP) – means the OMA's benefits program underwritten by us under this certificate. PHBP assists physicians to secure benefits through a group plan option that will ensure broad appeal and access, encourage participation in the plans, and provide benefits to eligible physicians that they may have difficulty arranging on their own. The Ontario government subsidizes PHBP through a Funding Agreement with Ontario Physician Services Inc. (OPSI), which then arranges with the OMA for delivery of the program. A physician receiving government subsidization through PHBP must meet funding criteria as established between OPSI and the Ontario government.

policy anniversary date – is January 1st of each year.

specialist physician – means a legally and professionally qualified medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which a benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist physician, and as approved by us, a condition may be diagnosed by a legally

and professionally qualified medical practitioner practicing in Canada or the United States. The specialist physician providing the diagnosis or treatment may not be you, your relative, or a person who normally resides in your household.

surgery – means a medical operation performed on you and recommended by a physician or specialist physician licensed and practicing in Canada, the United States, or any such other region as we may approve.

survival period – means the period starting on the date of diagnosis of the covered critical illness condition and ending 30 days following the date of diagnosis of the covered condition, except where modified elsewhere under the coverage. The survival period does not include the number of days on life support. You must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain. *Life support* means you are under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

you*, **your** and **the insured*** – means the member who is the person named on the *Summary of Information,* whose application for insurance has been accepted and is in force under the group policy.

we*, **our**, or **us*** – is The Manufacturers Life Insurance Company (Manulife).