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RIGHT TO EXAMINE POLICY

- Please read **Your** policy carefully before **You** travel. If **You** are not completely satisfied with this policy, **You** may return it by registered mail to the **Company** within 10 days after purchase and any premium paid will be refunded.
- Travel insurance is designed to cover **Emergency** losses arising from sudden and unforeseeable circumstances. It is important that **You** read and understand **Your** policy before **You** travel as **Your** coverage may be subject to certain terms, conditions, limitations and exclusions.
- Benefits - This policy covers up to a maximum aggregate of **\$200,000** unless **You** have purchased a lesser amount as shown on **Your Policy Receipt**.
- Exclusions for any **Pre-existing Condition** will apply to medical conditions and/or symptoms that existed on or prior to **Your Effective Date** unless **You** have selected to cover any **Pre-existing Condition** and paid the corresponding additional premium. (Exclusion # 1).
- Application to be covered for **Pre-existing Conditions** may be made with **Your** agent's assistance.
- Diabetes: If **You** have been diagnosed with diabetes, losses or expenses incurred for or as the result of **Treatment** for heart or stroke conditions will not be covered unless **You** have obtained an underwriting endorsement, which discloses **Your** medical history and **You** have paid the required additional premium.
- Application Process - There is no Medical information required unless **You** want coverage for **Your Pre-existing Conditions**. If **You** have completed an application to cover any **Pre-existing Conditions**, please check **Your** medical declaration in **Your Application for**

Insurance. If there are discrepancies in **Your** medical declaration or changes in **Your** health status or medication, between the time **You** answered the qualifying questions and **Your Effective Date**, please contact the office where **You** purchased this policy to make the necessary amendments to **Your Application for Insurance** in writing. If **Your Application for Insurance** contains a material mistake **You** run the risk of **Your** policy being null and void for non-disclosure or misrepresentation, **Your** claim being declined, and **Your** premium refunded.

- This policy document must be accompanied by a **Policy Receipt** to complete the policy.
- **Start of Coverage:** Coverage starts on the **Effective Date**.
- **Waiting Period:** Coverage for losses resulting from any **Sickness** or **Injury** will begin five days after the **Effective Date** if **You** purchased **Your** policy after the **Termination Date** of an existing policy; or after **You** exit **Your** Country of residence. Any **Sickness** that manifests itself during the five day waiting period is not covered even if expenses are incurred after the five day waiting period.
- **End of Coverage:** Coverage ends on the **Termination Date**.
- **Emergency:** In the event of hospitalization or any **Medical Emergency**, **You** are required to contact the **Emergency** assistance operator for prior approval of **Treatment** or within 24 hours of admission to **Hospital** at **1-855-883-6479** or **416-467-4587** (collect). Please refer to **V Limitations and Exclusions**, #32.

I ELIGIBILITY FOR COVERAGE

You are eligible for coverage if on the **Effective Date**:

1. **You** are at least 15 days old and **You** are age 89 or under and not insured or eligible for benefits under a Canadian Government Health Insurance Plan; and
2. **You** are currently in good health and know of no reason why **You** would require **Treatment** during **Your Insured Trip**; and
3. **You** are not residing in a nursing home, rest home, convalescent home, rehabilitation centre or home for the aged unless **You** receive written approval from the **Company**.

II HOW THIS POLICY WORKS

INSURING AGREEMENT

In consideration of *Your Application for Insurance* and payment of the appropriate premium and subject to the terms, conditions, limitations and exclusions of this policy, the *Company* will pay the benefits of this policy, up to the maximum aggregate limit as shown on *Your Policy Receipt* (less any applicable *Deductible*) for eligible expenses incurred by *You* which are in excess of any other insurance or other amounts; and

- (a) Payments are limited to the amounts specified under each coverage option.
- (b) Losses incurred as the result of any *Pre-existing Condition* are excluded unless *You* have completed a medical questionnaire, received underwriting approval, paid the necessary premium and received a written endorsement and *Policy Receipt*.
- (c) No *Deductible* will apply to claims unless *You* select a *Deductible* for *Your* coverage and the premium will be adjusted accordingly.
- (d) If *Your* health changes or does not remain *Stable* between the date *You* submitted *Your Application for Insurance* and the *Effective Date* of coverage, *You* may not be covered if a claim occurs. *You* may be required to reapply for coverage and if so please contact *Your* agent.
- (e) Limitations and Exclusions apply (See Section V)

III INSURANCE COVERAGE

SINGLE TRIP COVERAGE

You may apply for coverage for a single *Trip* up to 365 days. The *Application for Insurance* may be completed before or after *You* arrive in Canada. A *Waiting Period* for coverage will apply if *You* applied for insurance after *Your* arrival in Canada.

EXTENDING YOUR COVERAGE

You may apply for an Extension of *Your* health insurance coverage providing *You* have not incurred a claim in the period prior to the *Effective Date* of the Extension coverage *You* wish to purchase. Coverage will be extended at the option of the *Company*. Extension coverage will be void and of no force or effect if a claim has occurred in the period immediately prior to *Your* application for Extension coverage. Minimum premium levels apply. Extension coverage is effective on the date immediately following the *Termination Date* of *Your* existing coverage provided *You* have paid the correct premium prior to the *Termination Date* of *Your* existing coverage.

PLEASE NOTE:

(1) **Sports coverage** endorsements are available by application, and

(2) **Pre-existing Condition coverage** is available through an application with medical underwriting.

The specific details of *Your* plan are outlined on *Your Policy Receipt*, medical declaration and if applicable, *Your Application for Insurance*, all of which forms a part of this policy. *You* will be responsible for expenses that are not payable by the *Company* and no coverage is provided under this policy for losses resulting from a *Sickness* or *Injury* if *Your Period of Stability* for that *Sickness* or *Injury* is less than 3 months (See Exclusion # 3).

IV WHAT IS COVERED

Reimbursement will be made for benefits listed in the event of a *Medical Emergency* when not excluded under "**What is Not Covered**", only to the extent that:

1. Reimbursement is not prohibited by law, nor is it available or covered under any Canadian Government Health Insurance Plan, Worker's Compensation Act or Similar law or legislation or any other insurance Policy or plan; and
2. The care, services or supplies were provided or obtained on the written authorization or prescription of a *Physician* or Dentist.
3. *Pre-existing Conditions* may be covered if *You* have completed the medical questionnaire, paid the required premium, and received written confirmation of coverage from the *Company*. Individual benefit maximums apply where specified.

HEALTH INSURANCE BENEFITS

This plan provides *Emergency Hospital* and Medical coverage, up to the maximum aggregate limit *You* selected at the time of application per any one *Sickness* or *Injury* and subject to any *Deductible* per *Insured*. Individual benefit maximums apply. Losses incurred outside of Canada are not covered.

1. **EMERGENCY HOSPITAL/MEDICAL TREATMENT**
- Up to the maximum aggregate limit purchased and shown on *Your Policy Receipt*.
Emergency Hospital and *Medical Treatment* which is *Medically Necessary* and all other related expenses resulting from an *Injury* (accident) or new *Sickness* or disease that first manifests itself during the *Insured Trip* are covered and *Pre-existing Conditions* are covered if *You* have completed the medical questionnaire, paid the required premium, and received written confirmation of coverage from the *Company*.

2. EXTENDED HEALTH CARE

The following services or *Treatment* must be supported by a written order from the attending *Physician*.

- a) Prescription Drugs (limited to a 30 day supply up to \$5,000)
- b) Diagnostic-rays & Laboratory Services up to \$10,000
- c) Local licensed Ambulance services up to \$5,000
- d) Private Duty Nursing services performed by a registered Nurse (R.N.) or Registered Medical Attendant, other than a relative up to \$10,000
- e) Wheelchair rental, crutches, braces and other necessary medical appliances up to \$5,000
- f) 50% of the costs for the services of a chiropractor, chiropodist, osteopath and physiotherapist when referred by a doctor following a covered *Injury* up to \$1,000.

3. DENTAL ACCIDENT - Up to \$1,000 per Trip

The *Company* will pay up to a maximum of \$1,000 for dental expenses during the policy period when *Your* sound natural teeth are damaged as the result of a direct accidental blow to the mouth.

4. OUT-OF-POCKET EXPENSES - Up to \$100 per Trip

Up to \$100 for additional out-of-pocket expenses (i.e., telephone, television rental) are covered when *You* are hospitalized for a covered *Medical Emergency*. Expenses must be supported by an original receipt.

5. EMERGENCY RETURN HOME BY REGULAR FLIGHT OR AIR AMBULANCE - Up to \$25,000

In the event of a *Medical Emergency*, the *Company* will pay the costs to transport *You* to the nearest appropriate medical facility. If *You* must be transported to *Your* Country of residence for immediate medical attention following a covered *Emergency*, the *Company* will pay to transport *You* to *Your* Country of residence by Air Ambulance, provided *You* are unable to return by regular flight, and prior written approval is obtained from the *Medical Director*. If *You* must be transported to *Your* Country of residence for immediate medical attention following an *Emergency*, the *Company* will pay up to a maximum of \$25 000, for the extra cost (i.e., one-way economy fare, accommodation for a stretcher, and a medical attendant) to return *You* by regular flight when approved by the *Medical Director*.

6. RETURN OF DEPENDENT(S) - Up to \$2,000 per Trip

If *You* return home under the terms of Benefits 5 or 9, the *Company* will pay up to \$2,000 per *Trip* for the return of *Your Dependent(s)* who are travelling with *You* at the time of the *Medical Emergency* if they are named on the same *Application for Insurance*.

7. ESCORT OF DEPENDENT(S) - Up to \$1,000 per Trip

The *Company* will pay up to \$1,000 per Trip to reimburse *You* for the cost of the services of a care giver (other than a relative) contracted by *You* to escort *Your Dependent(s)* (under the age of 16) to their Country of residence in the event *You* are Hospitalized or must be repatriated (See Benefit 9) when such services are arranged by the *Company* and approved in advance.

8. TRANSPORTATION OF RELATIVE - Up to \$2,000 per Trip

If *You* are hospitalized for a covered *Injury* or *Sickness*, for more than three days, the *Company* will pay the cost (up to a maximum of \$2,000) of transporting one relative or other person who is not travelling with *You* to *Your* bedside. (Insurance should be purchased separately for this person). The *Company* will also pay for meals and accommodation for up to a maximum of \$100 a day.

9. REPATRIATION - Up to \$5,000 per Trip

This *Company* will pay up to a maximum of \$5,000 for the necessary cost of returning *You* to *Your* Country of residence by regular flight if *You* are totally disabled as the result of an *Emergency* necessitating Hospitalization of three days or more.

In the event of *Your* death the *Company* will pay a maximum of \$5,000 for the cost of returning *Your* remains to *Your* Country of residence or burial or cremation at the place of death. The *Company* will not pay for the cost of a burial coffin or urn.

10. MEALS & COMMERCIAL ACCOMMODATION - Up to \$1,500 per Trip

The *Company* will pay up to \$100 a day when the return portion of an *Insured Trip* is delayed beyond the scheduled date due to a *Medical Emergency* or death of *Your* family member.

V LIMITATIONS & EXCLUSIONS

WHAT IS NOT COVERED FOR: HEALTH INSURANCE

No coverage shall be provided under this contract and no payment shall be made for any Loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of, any of the following excluded risks:

1. Any **Pre-existing Condition**, unless **You** have been approved for **Pre-existing Condition** coverage and received a **Policy Receipt** from the **Company**. The **Pre-existing Condition** exclusion will apply to a loss or expenses resulting from a medical condition and a loss to **Treat** symptoms that existed on or prior to **Your Effective Date**, unless **You** have selected underwriting to cover **Your Pre-existing Conditions** and paid the corresponding additional premium.

Any condition that was not **Stable** at any time during the 365 days immediately before the **Effective Date** unless **You** have paid the additional premium required to reduce the **Period of Stability**; or

Any condition listed under “Exclusions” on **Your Policy Receipt**; or

Any condition listed under “Notes” on **Your Policy Receipt** as an excluded condition; or

Check to see how this exclusion applies in **Your** policy and how it relates to **Your Effective Date**, date of purchase and **Termination Date**. In the event of an accident, **Injury** or **Sickness**, **Your** prior medical history will be reviewed when a claim is reported. **You** must notify the **Company** prior to any **Treatment**. **Your** policy may limit benefits should **You** not contact the **Company** within a specific time period.

2. Diabetes: if **You** have been previously diagnosed with diabetes, **Treatment** for cardiovascular or cerebrovascular conditions is not covered (excluded) unless **You** have disclosed **Your** complete medical history, submitted it for underwriting approval and obtained an endorsement issued by the **Company** to cover **Your** specified **Pre-existing Conditions**.
3. Any loss, **Sickness** or **Injury** which occurred outside of Canada or any loss, **Sickness** or **Injury** occurring while this policy is not in effect;
4. **Hospital** or **Treatment**, where this policy is specifically purchased to obtain such services, whether or not authorized by a **Physician**;
5. Expenses incurred as a result of asymptomatic or symptomatic HIV infection, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions (ARC) or the presence of HIV, including any associated diagnostic tests or charges or other sexually transmitted disease;

6. A **Sickness**, **Injury** or related condition during a **Trip** undertaken;
 - a. with the knowledge that **You** will require or seek **Treatment** or surgery for that **Sickness**, **Injury** or related condition, or
 - b. for the purpose of obtaining **Treatment** or surgery.
7. Non-**Emergency Treatment** or investigation, check-ups, cosmetic surgery, chronic care, rehabilitation, or any complications directly or indirectly related thereto, or **Treatment** which can be reasonably delayed until **You** can return to **Your** Country of residence by the next available means of transportation. The delay to receive **Treatment** in **Your** Country of residence has no bearing on the application of this exclusion;
8. **Sickness** or **Injury** when travel is booked or commenced contrary to medical advice, with prior knowledge of an **Unstable Condition**, or after determination of a **Terminal Prognosis**;
9. Major medical or surgical procedures, including but not limited to cardiac surgery, which are not approved in advance by the **Medical Director**;
10. Expenses arising from **Sickness** or **Injury** related to a change in a pre-approved **Pre-existing Condition** if **You** failed to notify the **Company** of that change prior to **Your Effective Date**;
11. Any **Treatment**, investigation, or hospitalization which is a continuation of or subsequent to a **Medical Emergency**, unless **You** are declared medically unfit to return to **Your** Country of residence by the **Medical Director**;
12. Childbirth, miscarriage, deliberate termination of pregnancy or any complications incident to pregnancy;
13. Mental, nervous or emotional disorders, misuse of medication, abuse of drugs or intoxicants, any **Sickness** related to and/or induced by alcohol, medication, drug and/or toxic substance abuse, any accident related to and/or induced by an excessive consumption of alcohol (determined by a blood-alcohol level in excess of eighty (80) milligrams per one hundred (100) milliliters of blood) or **Treatment** therefor;
14. Suicide or attempt thereat, or self-inflicted injury, whether sane or insane;
15. **Sickness** or **Injury** arising from civil disorders, war or act of war, declared or not, or willful exposure to peril except in an attempt to save human life;
16. Committing or attempting to commit any criminal or illegal activity;
17. Air travel other than as a passenger in a commercial aircraft with a seating capacity of six people or more, licensed to carry passengers for hire;
18. An automobile accident where **You** are entitled to benefits under an automobile insurance policy (including but not limited to no-fault benefits), or under an applicable Insurance Act;

19. Participation in sanctioned competitive sports, professional sports or, participation in aerobatic or stunt flying, hang gliding, mountaineering, skydiving, parachuting, bungee jumping, scuba diving without being properly certified, extreme fighting, any racing or speed contests unless the **Company** has accepted the risk and issued a Rider;
20. For children under two (2) years of Age: Any **Sickness** or medical condition related to a birth defect;
21. **Treatment** or surgery for a specific condition, or a related condition, which:
 - a. had caused **Your Physician** to advise **You** not to travel, or
 - b. **You** contracted in a country during **Your Trip** when, before **Your Effective Date**, a written formal notice was issued by the Department of Foreign Affairs and International Trade of the Canadian government, advising Canadians not to travel to that country, region or city;
22. Noncompliance with prescribed medical therapy or **Treatment**;
23. a. cardiac catheterization, angioplasty and/or cardiovascular surgery including any associated diagnostic test(s) or charges unless approved in advance by the **Company** prior to being performed, except in extreme circumstances where such surgery is performed as a **Medical Emergency** immediately upon admission to **Hospital**;
- b. magnetic resonance imaging (MRIs), computerized axial tomography (CAT) scans, sonograms, ultrasounds or biopsies unless approved in advance by the **Company**;
- c. The replacement of an existing prescription, whether by reason of loss, renewal or inadequate supply, or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada;
24. Services in connection with general health examinations, routine prenatal care, regular care of a chronic condition;
25. The continuing care and/or **Treatment** of an acute **Sickness** or **Injury** after the initial **Medical Emergency** has ended (as determined by Our **Medical Director**) or a medical consultation where the **Physician** observes no change in a previously noted condition, symptom or complaint;
26. Medical care or surgery that is cosmetic in nature;
27. Cataract surgery or services provided by a naturopath or an optometrist or in a convalescent home, nursing home, rehabilitation centre or health spa;
28. Air ambulance services unless approved in advance and arranged by the **Company**;
29. Damage to or loss of hearing devices, eye examinations, eyeglasses, sunglasses, contact lenses, or prosthetic teeth or limbs, and resulting prescription thereof;
30. Expenses for which no charge would normally be made in the absence of insurance or expenses which exceed the **Reasonable and Customary** charges for the region where the services were provided or any loss, **Sickness** or **Injury** if the expense is incurred in **Your** Country of residence.
31. The **Company** reserves the right to transfer **You** to an appropriate **Hospital** within our network, provided **You** are medically fit to be transferred or to arrange transportation to return **You** to **Your** Country of residence following a **Medical Emergency**. If **You** decline to return to **Your** Country of residence when declared medically fit to travel by the **Medical Director**, any continuing expenses for such **Sickness** or **Injury** shall not be covered.
32. Failure to contact the **Company** within the first 24 hours of hospitalization for a **Medical Emergency** will limit benefits under this policy to 50% of any gross eligible expenses incurred or the maximum liability under this policy will be limited to \$25,000 should you select a maximum aggregate of \$50,000 or greater.

VI GENERAL TERMS AND CONDITIONS

1. The required premium is due and payable at the time of application (Application Date). Premium will be calculated according to the schedule of premium rates in effect on the Application Date based on **Your** age on the **Effective Date**.
2. Policy Terms and Conditions are subject to change with each new policy purchase, without prior notice, to reflect actual experience.
3. This policy is void if the **Insured** makes any false or fraudulent statements in the **Application for Insurance**, the medical declaration, a claim for insurance benefits or if the **Insured** is covered under insurance benefits from any other insurer for this **Injury** or **Sickness** claim.
4. Coverage will be null and void if the premium is not received, if a cheque is not honoured for any reason, if credit card charges are invalid, if no proof of **Your** payment exists or if **You** did not answer the qualifying medical questions truthfully, accurately or completely. The **Company** reserves the right to decline an application, or any request for extensions of coverage.
5. No payment is provided for expenses incurred in **Your** Country of residence.
6. Benefit limits and premium payments made under this policy shall be in Canadian currency and no sum payable shall carry interest.
7. This policy shall be governed by the laws of Canada in all respects including matters of construction, validity and performance. All legal actions or proceedings must be brought in the Canadian Province in which **Your** medical services were provided.

8. Co-ordination of benefits and subrogation with other insurance plans: This policy is designed to pay in excess of any existing coverage held by **You** and shall not substitute for any other coverage which would have been in effect and would have reimbursed for expenses incurred if this insurance was not in effect, including but not limited to, homeowners insurance, tenants insurance, multi-risk insurance, extended health care insurance, automobile insurance, credit card Policy or any other Insurer's individual Plan. Benefits payable under all policies or plans shall not exceed 100% of the eligible expenses incurred. If **You** acquire any right of action against any individual, firm, or corporation for a covered loss for which a payment has been made under this policy, then if requested by the **Company**, **You** shall transfer such claim or right of action to the **Company**. The **Company** shall reserve the right to subrogate to the extent of the payment made to all of **Your** rights of recovery against any third party who is liable.
9. Notwithstanding any other provision contained herein, this contract is subject to Statutory Conditions in the Insurance Act.

VII DEFINITIONS

"**Application for Insurance**" means the document which is completed by **You** or **You** were consulted when it was completed and where **You** have confirmed **Your** personal information as well as the coverage chosen by **You** for which **You** have paid the full and correct premium. This document forms part of the policy.

"**Company**" means Industrial Alliance Insurance and Financial Services Inc. or any party contracted to service this policy.

"**Deductible**" means the amount in Canadian dollars, which the **Insured** person must pay before any remaining covered expenses, are reimbursed under this policy. The **Deductible** applies once per **Insured** per **Trip**.

"**Dependent(s)**" means any unmarried children residing at home, who are at least 15 days of age but under age 19 and who are living with and rely upon **You** for their sole means of support.

"**Effective Date**" means the date, indicated on **Your Policy Receipt**, provided the **Company** or its **Representative** has received the appropriate premium. If coverage is purchased after **You** arrive in Canada, benefits shall become effective five days after the date and time the required premium is received by the **Company**.

"**Emergency**" means an unexpected or unforeseeable **Sickness** or **Injury** which requires immediate non-discretionary medical attention, **Treatment** or care for the immediate relief of acute symptom, which upon the advice of a **Physician** cannot be delayed until **You** return to **Your** Country of residence.

"**Hospital**" means a facility equipped to perform surgery, on a **Medical Emergency** in-patient and out-patient basis, but in no event shall this include a nursing home, rest home, convalescent home, rehabilitation centre, or home for the aged, a place for the **Treatment** of alcohol or drug addiction.

"**Injury**" means physical hurt or damage sustained accidentally after the policy **Effective date** and requiring immediate medical **Treatment**.

"**Insured**" means any person(s) named on the **Application for Insurance** form for which insurance coverage is in effect under this policy.

"**Insured Trip**" means a **Trip** on which **You** are travelling outside **Your** Country of residence and for which coverage is in effect. Coverage on a **Trip** begins on **Your Effective Date** and ends on the earlier of the date (i) **You** return to **Your** Country of residence, or (ii) the number of days of coverage **You** purchased expires.

"**Medical Director**" means the medical doctor acting for the **Company**.

"**Medical Emergency**" means an unexpected or unforeseeable **Sickness** or **Injury** not related to a **Pre-existing Condition** (unless a rider has been issued to cover specified **Pre-existing Conditions**) which requires immediate medical attention, **Treatment** or care during **Your Insured Trip**.

"**Medically Necessary**" in reference to a given service or supply, means such service or supply:

- a) is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;
- b) is not experimental or investigative in nature;
- c) cannot be omitted without adversely affecting **Your** condition or quality of medical care;
- d) cannot be delayed until **You** return to **Your** Country of residence; and
- e) is delivered in the most cost effective manner possible, at the most appropriate level of care and not primarily by reason of convenience.

"**Period of Stability**" means that, during the period selected in **Your Application for Insurance**, there has been: (i) no increase in symptoms or development of new symptoms; (ii) no reduction, increase or stoppage in medication dosage or its frequency; (iii) no new medications prescribed; (iv) **You** have not been hospitalized or required medical consultation (other than a routine examination); and (v) no medical, therapeutic or diagnostic procedure has been prescribed, received or performed, or recommended by a **Physician**, including but not limited to investigative testing and surgery, during the period selected on **Your Application for Insurance**.

"**Physician**" means a person, other than a relative, who is legally qualified and licensed to practice medicine or perform surgery.

"**Policy Receipt**" means the document sent to **You** confirming the coverage **You** have selected on **Your Application for Insurance**. It forms part of the policy.

"**Pre-existing Condition**" means a medical or physical condition, symptom, illness or disease, whether diagnosed or not, for which **Treatment** has been received or taken, or which exhibited symptoms, at any time preceding **Your Effective Date** and includes a medically recognized complication or **Recurrence** of a medical condition.

"Reasonable and Customary" means the costs customarily charged for covered benefits, which are not in excess of the standard fee in the geographical area where the charges are incurred for comparable **Treatment**, services or supplies for a similar **Sickness** or **Injury**.

"Recurrence" means the appearance of symptoms caused by or related to a medical condition which was previously diagnosed by a **Physician** or for which **Treatment** was previously received.

"Representative" means the insurance agent, broker or advisor that accepted **Your Application for Insurance** and payment arrangements for this insurance.

"Sickness" means the onset of an ailment, illness or disease requiring **Treatment**, care or advice.

"Stable" or "Stability" means that within three months immediately preceding **Your Effective Date** **Your** condition is not worsening and there has been:

- a. No change in symptoms or development of new symptoms;
- b. No reduction, increase or stoppage in medication dosage or its frequency;
- c. No new medications prescribed;
- d. **You** have not been hospitalized or required medical consultation (other than a routine examination); and
- e. No medical, therapeutic or diagnostic procedure has been prescribed, received or performed, or recommended by a **Physician**, including but not limited to investigative testing or surgery.

"Terminal Prognosis" means a clinical assessment performed by a licensed **Physician** who determines that an existing medical condition, **Sickness** or **Injury** is expected to result in the premature death of the **Insured** within the twelve (12) month period following the **Effective Date**.

"Termination Date" means the date any coverage ends, being the earlier of the date (i) **You** return to **Your** Country of residence, or (ii) the number of days of coverage **You** purchased expires.

"Treatment, Treat or Treated" means advice, a medical, therapeutic or diagnostic procedure, prescribed, performed or recommended by a **Physician**, including but not limited to prescribed medication, investigative testing, or hospitalization, surgery or recommended action that is related to the **Sickness** or **Injury**.

"Trip" means travel outside **Your** Country of residence which commences on or after **Your Effective Date** and which terminates on **Your Termination Date**.

"Unstable Condition" means a **Sickness** or **Injury** which would cause an ordinarily prudent person to expect the need for **Treatment** or investigation following departure.

"You" or **"Your"** means each **Insured** Person.

VIII REFUNDS

You may apply for a refund if **You** become insured under a Canadian provincial or territorial health/medical plan as long as **You** are not required to maintain the coverage for work permit or other immigration purposes. Requests for premium refund will be considered, in the case of non-departure from **Your** Country of residence due to a **Medical Emergency**, failure to meet visa requirements, or departure from Canada provided this policy is signed and returned to the **Company** and no claim has been paid or is pending on **Your** behalf. A full refund will be provided for policies which are returned within 10 days of purchase and before the **Effective Date** of the policy.

A refund will be calculated from the date of receipt of written notification, subject to an administration fee of 12% of refund calculated plus \$25 per **Application for Insurance** and a minimum refund amount of \$10 per policy.

Important Notes

Premium refunds, regardless of method of payment, must be obtained from the agent where coverage was originally purchased.

IX EMERGENCY PROCEDURE

Call **Emergency** Assistance immediately at 1-855-883-6479 or 416-467-4587 (collect).

If **You** require medical or dental services, **You** must call **Emergency** Assistance. Failure to notify **Emergency** Assistance within 24 hours of Hospitalization, as directed will delay the processing and payment of **Your** claim and may limit the **Company's** liability. Please refer to **V Limitations and Exclusions**, #32.

X CLAIM PROCEDURE

For general information regarding **Your** policy call **Your** agent. For information regarding a claim made on **Your** policy call 1-855-883-6479 or 416-467-4587 (collect).

Claim Notification: **You** must notify the **Company** at 1-855-883-6479 or 416-467-4587 (collect) within 24 hours of any claim for medical or dental **Treatment**. Failure to do so will result in a penalty where **You** will be responsible for 50% of any gross eligible expenses incurred or the maximum liability under this policy will be limited to \$25,000 should you select a maximum aggregate of \$50,000 or greater. **You** must call unless **Your** condition prevents **You** from doing so and in this case **You** must contact the **Company** as soon as medically possible or have someone call on **Your** behalf.

The payment to a medical provider by the *Company* for any eligible expense is at their option. In the event that they choose not to pay the medical facility directly, or the facility will not accept payment from the *Company* directly, they will reimburse *You* for any eligible expenses that *You* have paid provided that *You* provide a valid original receipt for such services, including original itemized bills, invoices and receipts. *You* will be required to pay *Your Deductible* (if any) directly to the provider at the time the claim is incurred.

Claim Documentation: Once *Your Emergency* is over, *You* must submit all claims to the *Company* within 90 days from the date of loss. Failure to furnish proof of claim within 90 days does not invalidate *Your* claim if proof is furnished as soon as reasonably possible and in no event later than 1 year from the date of loss. If applicable law provides for a longer period, *You* must submit *Your* claim within the longer period provided for by law. For *Your* claim to be valid, *You* must provide all of the documents that the *Company* requires to support *Your* claim. Failure to complete the required claim and authorization forms in full will delay the assessment of *Your* claim.

When submitting a claim, please include a brief explanation of the medical situation, e.g., how, where and when the loss, *Sickness* or *Injury* took place. Claims cannot be considered unless the claim form is fully completed and signed by the claimant or an authorized person and submitted along with all required documentation including original receipts. All documentation must be supplied free of expense to the *Company*.

Claim Form: Call the *Company* for a claim form at 1-855-883-6479 or 416-467-4587 (collect). In the event that the *Company* pays any medical expense on *Your* behalf for which there is coverage through any other insurance plan, they have full rights to recover any amount due to *You*, with respect to these expenses.

Claim Inquiries: call 1-855-883-6479 or 416-467-4587 (collect) **within 24 hours of any medical or dental Treatment.**

Mail or Deliver Claims to:
Ardent Assistance Inc.
4-160 Pony Drive
Newmarket, Ontario,
L3Y 7B6

For General Inquires: Please call *Your Representative*.

XI APPEAL PROCEDURE

In the event of a concern with the sales process or an issue about a claim, *You* may request that the circumstances be reviewed. Any new information provided will be taken into consideration and a decision will be given in writing outlining our findings based on the terms, conditions, limitations and exclusions of the policy. Requests to review *Your* particular circumstances must be made in writing no later than 30 days after the date *You* receive our decision. Send *Your* request for review including the reason for *Your* concern and any new information supporting it to:
ombudsman@ardentassistance.com

or send *Your* request to review to:
Review Committee
Ardent Assistance Inc.
4-160 Pony Drive,
Newmarket, Ontario, L3Y 7B6

THIS POLICY IS UNDERWRITTEN BY:
Industrial Alliance Insurance and Financial Services Inc.