

**Lifecheque[®] Basic Critical Illness
Insurance Plan
Product Guide**

Plan At a Glance

Eligibility

- Resident of Canada
- Termination age: 75 years
- Coverage amounts: \$25,000 issue ages 18-65, \$50,000 issue ages 18-60 and \$75,000 issue ages 18-55

Product Highlights

- Benefits: payment of the sum insured upon the first diagnosis of Cancer, Heart Attack, Stroke, Coronary Bypass surgery, and Aortic Surgery
- Signed Health Declaration with no family history question
- Pre-existing condition clause: 24 month period prior to the effective date of policy
- Each condition has exclusions and additional requirements specified in its definition.
- Best Doctors® Solutions Services included.
- 30 Days at No Cost: the offer includes one month at no cost to the insured, provided payment is made monthly.

Return of Premium Option

- Issue ages: 18-55 years
- Refund of 100% of all premiums paid at the expiry of policy, up to 100% of the benefit amount
- Available for purchase at the issue date of the policy only

Premiums

- Monthly premiums are gender and smoker status distinct.
- The premiums are level, single scale renewable term five rates. The premiums are guaranteed not to change for the first five years. The renewal rates (at each 5th year duration) are not guaranteed. Once the renewal rate is determined (at each 5th year duration) they are guaranteed not to change for another five years.
- Ages are based on age at last birthday
- Premiums are payable until the policy anniversary date following the insured's 75th birthday at which time the policy will terminate.

Underwriting

- Approval for coverage for cancer, stroke, heart attack, coronary bypass surgery and aortic surgery is subject to signed/confirmed declaration of good health and providing Manulife Financial with payment information.
- No medical questionnaire is required and no family history

Modal factors and Policy Fees

The annual premium is 12 times the monthly premium. There is no policy fee.

Payment options

The premium modes available are monthly by PAC, monthly by credit card (MC, AMEX and Visa) and annually by credit card (MC, AMEX and Visa).

The Lifecheque Basic Solution

Lifecheque Basic critical illness insurance offers a one-time lump sum payment upon diagnosis of one of the five most common and major disorders: cancer, stroke, heart attack, coronary bypass surgery and aortic surgery. It includes Best Doctors® Solutions Services and, a 30-Day Satisfaction Guarantee. Return of Premium Option ensures the return of all premiums paid up to 100% of the benefit amount should the policy continue until expiry date – the anniversary date following the policyholder’s 75th birthday.

The plan’s unique selling features are simplicity, accessibility and affordability. With Lifecheque Basic critical illness insurance, completion of a medical questionnaire is not required nor is family history requested. Premiums are guaranteed not to increase for the first five years, with the first month of coverage at no cost to the insured, provided payment is made monthly.

Surviving a critical illness

During the recovery of a critical illness, your client may have to pay for healthcare services, special drugs and supplements, and homecare expenses not covered by their government health insurance plan or their group plan. Add to all of this the regular household bills, and the financial consequences of surviving a serious illness could add up very quickly.

Lifecheque Basic offers basic Critical Illness protection, providing the right amount of coverage to protect the insured during recovery. Use the funds to pay the mortgage for a year or two, cover unexpected costs of care and caregiving – for yourself and your family.

How long will it take to get approved?

If your applicant can sign the Health Declaration, then he or she is approved for Lifecheque Basic critical illness insurance. The effective date of coverage is the first of the month following the date the application is received.

Plan Details

Covered Conditions Definitions

Cancer (Life-Threatening)

A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

- carcinoma in situ, or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion), or
- any non-melanoma skin cancer that has not metastasized, or
- Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion

No benefit will be payable within the first 90 days following the later of the effective date of the policy, or the effective date of last reinstatement of the policy, the Insured Person has any of the following:

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

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, the Company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

The insured must survive for a period of 30 days following the date the condition is diagnosed in order for the benefit to be paid.

Heart Attack

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.

Exclusion: 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.

The insured must survive for a period of 30 days following the date the condition is diagnosed in order for the benefit to be paid.

Stroke (Cerebrovascular Accident)

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,

and 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.

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

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

The insured must survive until all of the criteria outlined in Stroke above have been met in order to the benefit to be paid.

Coronary Artery Bypass Surgery

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist.

The insured must survive for a period of 30 days following the date of the surgery in order for the benefit to be paid.

Aortic Surgery

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

The insured must survive for period of 30 days following the date of the surgery in order for the benefit to be paid.

Assistance Services Benefit

Best Doctors connects seriously ill Canadians and their treating physicians with world renowned specialists to confirm the right diagnosis and right treatment options without ever having to leave home. Best Doctors delivers certainty to claimants facing uncertainty about their medical conditions and delivers a complete and methodical understanding of a claimant's medical condition giving actionable and educative information to both the claimant and their treating physician. Services include:

Interconsultation™

This provides an in-depth review of the insured's medical files to assist in the development and confirmation of the diagnosis and to help develop a treatment plan, with access to the latest technologies and opinions of world-class specialists. Fast and detailed turnaround of results can reduce potentially serious complications that can result from a misdiagnosis and help your treating physician determine the proper course of action.

Findbestdoc®

Sometimes the medical care required for a specific diagnosis goes beyond borders so this exclusive global database of more than 50,000 specialists can prove to be an invaluable. A detailed report containing information on up to three specialists including their educational background and training, and their relevant experience to your particular case is prepared. If the insured decides to see one of the best doctors in Canada, the report is provided to the insured and their local family physician so they can make a referral. Should you choose to go outside of Canada for treatment, the concierge service will book all appointments and even take care of travel arrangements.

Findbestcare®

If an insured decides to be treated by a physician identified by Best Doctors, FindBestCare helps take the worry out of making travel arrangements for them and their family, reducing stress so that they can concentrate on getting well again. It includes a full concierge service to help make all arrangements such as booking airfare, hotel accommodations, ground transportation, translation services, medical appointments, hospital admissions, etc. And if the insured chooses to go to the United States for medical care, Best Doctors manages a cost containment process to help protect against over charges or incorrect billing. We'll provide you with a full report outlining all the charges, what discounts were applied, and the final amount to be paid.

BEST DOCTORS 360

Designed to deliver information that is individually tailored to meet the needs of each individual, this unique program allows Best Doctors to become the insureds personal advocate by providing resources needed to offer one-on-one support, customized advice and guidance, personally delivered – helping to bridge the knowledge gap in healthcare.

Return of Premium Option

We will refund premiums paid up to 100% of the face amount, if:

- the insured has not made a claim by the expiry date of the policy on the policy anniversary date following the insured's attaining age 75
- his/her coverage including the return of premium rider is still in force on that date, and the insured is not then satisfying a waiting period for a Covered Condition.
- This rider is available at the issue date of the policy only for issue ages 18 to 55.

If the insured person is in the waiting period for a Covered Condition Benefit, this rider coverage will not expire until the first day the insured person is no longer satisfying the waiting period required by that Covered Condition.

If the insured person survives the waiting period for a Covered Condition Benefit, but that benefit is not payable, we will pay the Return of Premium on Expiry Benefit described above.

If the Insured Person survives the waiting period for a Covered Condition Benefit, and the benefit is payable, no Return of Premium on Expiry Benefit will be payable.

Exclusions and Limitations

The following exclusions and limitations contained in this policy are in addition to the exclusions and limitations set out within the Covered Conditions Definitions.

No benefit will be paid if the Insured suffers a covered condition at any time during the 24-month period following the effective date of the policy or the date of the last reinstatement which results, directly or indirectly from, or is in any way associated with a pre-existing condition. A **pre-existing condition** is an illness or condition for which, **during the 24-month period prior to the effective date** of the policy or the date of the last reinstatement, the insured was diagnosed, treated, hospitalized or attended to by a physician or was advised to seek treatment or consult a physician; was prescribed or took medication; showed indications, signs or symptoms or underwent test or investigations.

No benefits are payable if the insured, while sane or insane, suffers a covered condition which results, directly or indirectly from, or is in any way associated with:

- Intentional self-inflicted injuries,
- Intentional use or intake of:
- Any prescription drug or narcotic other than as instructed by a physician;
- Any drug or narcotic legally available for sale in Canada without a prescription, other than as recommended by the manufacturer;
- Any drug or narcotic not legally available in Canada; or
- Any poisonous substance or intoxicant, including alcohol,
- Committing or attempting to commit a criminal offence,
- Operating a motor vehicle while the concentration of alcohol in 100 milliliters of blood exceeds 80 milligrams.

If the insured suffers a covered condition which is diagnosed in a jurisdiction other than Canada or the United States, we must be satisfied that:

- The same diagnosis would have been made if the covered condition had occurred in Canada or the United States.;
- The physician making the diagnosis was licensed to practice and had medical credentials equal to those required in Canada or the United States.;
- The diagnosis is fully supported by all appropriate diagnostic tests and other investigation which would normally be undertaken in Canada or the United States (including those required by the policy); and

- Where applicable, the same type or surgery or procedure as required under the policy in order for the benefit to be payable would have been advised if the diagnosis had been made in Canada or the United States.

Where the diagnosis is made in a jurisdiction other than Canada or the United States, the insurer shall have the right to request that an insured undergo an independent medical examination by a physician appointed by the insurer.

Underwriting basis

Coverage is available based on a declaration by the insured, as follows:

I declare that I am a Canadian resident. I understand that my coverage will come into effect on the first day of the month following the date my application is received and approved by Manulife Financial.

I declare that during the past 10 years I have not been diagnosed with, had any signs and/or symptoms of, or had any medical consultations and/or abnormal tests for the following disorders:

- Cancer, Intracranial Tumour
- Heart Disease (including but not limited to Angina and Heart Attack), Stroke, Transient Ischemic Attack (TIA), Peripheral Vascular Disease or Diabetes
- Hepatitis, including Hepatitis Carrier State, Chronic Kidney Disease, AIDS or HIV
- Alcoholism or Drug Abuse

I declare that I have not had, during the last 10 years, Coronary Artery Bypass surgery and/or Aortic surgery.

I also declare that I have not undergone any tests for which I am currently awaiting results and I have not been advised to undergo any tests which have not yet been completed.

I agree that any material misrepresentation, including smoking status, will render the insurance voidable by Manulife Financial at any time.

I acknowledge receipt of and agree with the Notice on Privacy and Confidentiality.

In addition to the above language, direct to client offers of this product (i.e. where a licensed agent has not presented the product to the applicant) will include the following language:

I acknowledge receipt of the [Product Name] Critical Illness insurance brochure and declare that I have read and understand the information concerning the terms of coverage under the plan and the limitations and exclusions applicable to such coverage, including those related to pre-existing conditions.

A Non-Smoker must not have used any form of tobacco, nicotine substitutes, tobacco cessation products or marijuana in the last twelve (12) months.

Termination

Insurance under the policy shall terminate automatically on the earliest of the following dates:

- At the policy anniversary date following an insured's 75th birthday
- 31 days after the premium due date if the required premium remains unpaid for the policy;
- on the premium due date following the date Manulife receives written notification by an Insured of his or her desire to terminate coverage;
- on the premium due date next following the date the Insured ceases to qualify as an Insured as defined under the policy;
- on the date a benefit becomes payable under the policy;
- on the date of death of the Insured.