GROUP INSURANCE

KEEWATIN-PATRICIA DISTRICT SCHOOL BOARD

Policy No. 641013

Senior Management

Desjardins
Financial Security

Money working for people

Life, health, retirement

Your Group Insurance

KEEWATIN-PATRICIA DISTRICT SCHOOL BOARD

Policy No. 641013

Senior Management

For information regarding Claims, Administration or Billing Inquiries, you may contact our:

Group Customer Contact Centre

Toll-Free number: 1-800-263-1810

You may also access Claim forms and other information online at:

www.desjardinsfinancialsecurity.com

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

Use of masculine is intended to include both women and men.

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Information on benefits that are not insured by Desjardins Financial Security Life Assurance Company has been inserted into this booklet for convenience and reference purposes only. Inclusion of such wording does not imply nor impart any liability upon Desjardins Financial Security Life Assurance Company for the coverages in question.

BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation: Mandatory

Eligibility Requirements

Number of hours worked per week: A minimum of 15 hours per week on a regular basis for the Employer.

Eligibility Period: Nil

Waiver of Premium

Benefits for which premiums are waived in the event of Total Disability:

- Basic Participant Life Insurance Benefit
- Participant Optional Life Insurance Benefit
- Dependent Optional Life Insurance Benefit
- Participant Long Term Disability Benefit

Beginning of Waiver of Premium: At the end of the Elimination Period of the Participant Long Term Disability Benefit, retroactive to the initial date of Total Disability.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Underwritten by Desjardins Financial Security Life Assurance Company

Amount of Insurance: $150,000

Non-Evidence Maximum of Insurability: $150,000

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

Underwritten by Desjardins Financial Security Life Assurance Company

Amount of Insurance: Any multiple of $10,000 with a minimum of $10,000 and a maximum of $300,000. This maximum amount combined with the Amount of Insurance under the Basic Participant Life Insurance cannot exceed $1,000,000.

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

DEPENDENT OPTIONAL LIFE INSURANCE BENEFIT

Underwritten by Desjardins Financial Security Life Assurance Company

Amount of Insurance: Spouse $20,000

Child $10,000

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

PARTICIPANT LONG TERM DISABILITY BENEFIT

Underwritten by Desjardins Financial Security Life Assurance Company

Percentage and Maximum of Benefit:	70% of monthly Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $8,000.
Non-Evidence Maximum of Insurability:	$7,200
Elimination Period:	180 days or the expiration of sick leave credits, whichever is later.
Maximum Benefit Period:	To age 65
Cost-of-Living Adjustment following the Consumer Price Index:	Up to 5%. First increase after the end of the Elimination Period plus one year
Taxability of Benefits:	Taxable

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

EXTENDED HEALTH CARE BENEFIT

Self-Insured by Keewatin-Patricia District School Board and administered by Desjardins Financial Security Life Assurance Company

Drug Co-pay: **(with payment card)**	Dispensing fee with an $8 cap (and standard maximum on mark-up).
Hospitalization Expenses in province of residence:	Nil
Travel Insurance Emergency Expenses outside province of residence:	Nil
Vision Care, Eyeglasses, Lenses and Eye surgery:	Nil
Other Eligible Expenses:	Nil
Percentage of Reimbursement	
Drugs:	100%
Hospitalization Expenses in province of residence:	100%
Travel Insurance Emergency Expenses outside province of residence:	100%
Referral Treatment Expenses outside province of residence:	80%
Other Eligible Expenses:	100%
Vision Care, Eyeglasses, Lenses and Eye surgery	
Vision Care, Eyeglasses, Contact Lenses and Eye surgery:	100%
Contact Lenses: (Special conditions)	100%

Limits for Eligible Expenses

Drugs:	Unlimited. In some provinces, a dispensing fee cap and a mark-up fee cap apply to all prescriptions. Should the dispensing fee and the mark-up at the pharmacy exceed the caps, the individual is responsible for the difference.
Short-Term Hospitalization Expenses:	The cost of a private or semi-private room for each day of Hospitalization with no limit as to the number of days.
Long-term Hospitalization Expenses:	
• **Palliative Care Establishment:**	Payable amount of $40 per day and a maximum of 60 days.
• **Convalescent / Rehabilitation Centre:**	Payable amount of $40 per day and a combined maximum of 180 days per hospitalization period.
Travel Insurance Emergency Expenses outside province of residence:	Lifetime maximum payable amount of $5,000,000 per Insured Person.
Nursing Care:	Payable amount of $25,000 per Covered Person each Calendar Year.
Paramedical Services:	Payable amount of $300 for each discipline per Covered Person each Calendar Year.
Vision Care, Eyeglasses, Lenses and Eye surgery:	Payable amount of $300, including eye exams, per Covered Person once in any 24 month period for adults and any 12 month period for children under 21. Exams will be limited to a maximum of $50 per Covered Person for any period of 24 consecutive months.

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

DENTAL CARE BENEFIT

Self-Insured by Keewatin-Patricia District School Board and administered by Desjardins Financial Security Life Assurance Company

Guide Year:	Current year
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	100%
Basic Services, Endodontics and Periodontics:	100%
Major Restorative Services:	75%
Orthodontics:	50%. Eligible Expenses for children and adults.
Maximum Benefit	
Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Unlimited
Orthodontics:	Lifetime Maximum of $2,000 per Covered Person.
Frequency:	6 months
Limitations:	Reimbursement of fees for composite restorations performed on posterior teeth are not limited to the fees for amalgam restorations.
Payment Card:	Yes
Benefit Termination	
Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

1) is more than 24 hours, but less than 21 years of Age, and for whom the Participant or the Spouse of the Participant has legal guardianship or had legal guardianship until he reached the Age of majority; or

2) has no spouse, is less than 25 years of age and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant would have legal guardianship if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would have legal guardianship of him as if he were a minor.

   It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular compensation paid to the Employee by the Employer, including dividends, compensation for regular overtime and bonuses that are part of the regular compensation. Occasional overtime and occasional bonuses are not considered Earnings.

Employee means a person who is domiciled in Canada and who is:

1) employed by the Employer on a permanent full-time basis for not less than the number of hours specified in the Benefit Schedule, or

2) retired, having been immediately prior to retirement a person specified in 1) above (Retiree).

However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any companies listed on the application of the Policyholder for the policy or specified in the Benefit Schedule.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean birth). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means a person who is domiciled in Canada and who is

1) the legal Spouse of the Participant by virtue of a religious or civil marriage ceremony; or

2) the common-law Spouse of the Participant with whom the Participant has been living in a conjugal relationship continuously for a period of at least 12 months.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EXEMPTION PRIVILEGE

A Participant may decline to be insured under the Extended Health Care Benefit or Dental Care Benefit, if included in the policy, if such Participant is insured as a Dependent under the policy or another similar group insurance plan. However, if the other plan terminates or the Spouse ceases to be a member of an eligible class, the Participant will be eligible for insurance under the Benefit he previously opted out of as of the date of such termination, provided written application is made within 31 days of such eligibility.

If the written application is received more than 31 days after the eligibility date, the following conditions apply:

1) the Insured Person will have to submit evidence of insurability for the Extended Health Care Benefit and insurance will not take effect until the date on which the insurability of the individuals concerned is approved by the Insurer;

2) the Dental Care Benefit will be effective on the date on which the written application is signed by the Participant and evidence of insurability is replaced by a limitation of payment, as indicated in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under the Dental Care Benefit.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days after the date of his eligibility.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

With respect to the Dental Care Benefit, if included in the policy, if the Employee applies more than 31 days after the date of his eligibility, evidence that the insurability of an Employee is satisfactory will not be required; however, his dental coverage will be limited as set forth in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS section of the Dental Care Benefit.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

1) the date on which the insurance of a Participant first becomes effective under the policy,

2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible,

4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

WAIVER OF PREMIUM

1) For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

   a) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

   b) the date on which the Participant ceases to be Totally Disabled,

   c) for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

   d) the date on which the Participant attains Age 65 or retires, if earlier,

   e) in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or the policy terminates except for the Basic Participant Life Insurance Benefit and the Participant Long Term Disability Benefit (if applicable).

2) Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

3) A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

4) In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

   a) the Participant became Totally Disabled while insured under this Benefit,

   b) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

   c) the Participant dies within 12 months from the onset of his Total Disability,

   d) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

   e) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.

5) To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

   In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

1) the date the Participant no longer qualifies as an Employee, as defined in the policy,

2) the date the Participant ceases to belong to a class of Participants eligible for insurance,

3) the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

4) the end of the period for which required premiums were paid on behalf of the Participant,

5) the date the Participant ceases to be Actively At Work, except as an eligible Retiree,

6) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

1) the date the insurance of the Participant terminates,

2) the date the Participant no longer has any Dependents,

3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

4) the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

No action or proceedings may be brought against the Insurer for the recovery of any claim within 60 days or after 3 years following the expiration of the time in which proof of claim is required.

BENEFICIARY

Subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, the death benefit is paid as follows:

1) in the event of the Spouse's death:

   to the Spouse's legal heirs;

2) in the event of the death of the Participant's Dependent Child:

   a) to the Spouse, if alive, or

   b) if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

CO-ORDINATION OF BENEFITS

If an individual, who is insured for a Benefit that is subject to the CO-ORDINATION OF BENEFITS provision, is also insured under another Plan that provides similar benefits, the amount of benefits payable during any calendar year will be co-ordinated and the amount payable under the policy will be pro-rated so that the benefits payable under all Plans will not exceed 100% of the incurred expenses.

As used in this provision, "Plan" means the policy and any plan providing benefits or services under

1) group insurance other than the policy, family insurance or creditor's group insurance,

2) service-type group plans or other group prepayment coverage,

3) labour-management trusteed plans, union welfare plans, employer organization plans or participant benefit organization plans, and

4) government programs or any coverage required or provided by any statute including an automobile no fault law or the Workers' Compensation Act.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT PAYMENT

The payment of benefits will be determined in the following manner:

1) If the other Plan does not contain a Co-ordination of Benefits provision, the benefits of such Plan will be deemed payable prior to the application of benefits under the policy.

2) If the other Plan contains a Co-ordination of Benefits provision, the benefits of such Plan will be co-ordinated with the benefits under the policy as follows:

   Priority will be attributed to the Plan under which the individual is eligible to receive the benefits in the following order:

   a) other than as a Dependent, priority will be attributed to the plan where the Participant is

      i) an active full-time employee

      ii) an active part-time employee

      iii) a retiree

      If the Participant is an active part-time employee under more than one Plan, priority will be attributed to the plan for which the Participant works the higher number of hours per week;

   b) as a Spouse;

   c) as a Child, priority will be attributed as follows:

      i) the Plan of the parent with the earlier day and month of birth in the calendar year, or

      ii) the Plan of the parent whose first name begins with the earlier letter in the alphabet;

d) as a Child where the parents are separated or divorced, priority will be attributed as follows:

i) the Plan of the parent with custody of the Child,

ii) the Plan of the Spouse of the parent with custody of the Child,

iii) the Plan of the parent not having custody of the Child, or

iv) the Plan of the Spouse of the parent not having custody of the Child.

If priority cannot be established in the above manner, benefits will be pro-rated between or amongst the Plans in proportion to the amounts that would have been paid under each Plan had there been coverage by just that Plan.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation

   a) for which he would earn 60% or more of his Earnings in effect immediately prior to commencement of Total Disability; and

   b) for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;

3) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

1) $200,000; or

2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Participant Optional Life Insurance.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Optional Life Insurance Benefit is payable in respect of a Participant who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer’s liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Optional Life Insurance of a Participant aged 65 or younger terminates under any of the conditions specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit and not solely the Participant's request, the Participant will be entitled to convert that insurance to an individual policy, without evidence of insurability.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit will apply to any individual policy available under this Benefit except that the maximum amount that may be converted under this Benefit will be the maximum specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit, minus the amount of any Basic Participant Life Insurance that may be converted.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Optional Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

DEPENDENT OPTIONAL LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Dependent applying for any amount of Dependent Optional Life Insurance.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Dependent Optional Life Insurance Benefit is payable in respect of an insured Dependent who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer's liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

SPOUSE CONVERSION PRIVILEGE

If the Optional Life Insurance of a Spouse age 65 or younger terminates for any reason other than at the Participant's request, the Participant, or the Spouse in the event of the death of such Participant, may convert this insurance to an individual policy, without evidence of insurability.

The amount of individual life insurance for the Spouse will be limited to the lesser of:

1) $200,000; or

2) the difference between the amounts of Spouse Optional Life Insurance in force on the date the insurance is terminated and the amount of insurance for which the Spouse is eligible under another group life insurance at the time of exercising the conversion right.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Spouse under this Benefit;

2) The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

3) The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

4) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Spouse's Age at nearest birthday and the class of risk to which the Spouse belongs;

5) If the amount of Spouse Optional Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Spouse may convert;

6) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Spouse under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Spouse dies within 31 days of the termination of his insurance under this Benefit, the amount of Spouse Optional Life Insurance payable will be the amount that the Participant or the Spouse, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

If a Participant decides to continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described under the CONTINUATION OF INSURANCE provision of the TERMINATION OF INSURANCE section, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active full-time employment.

Net Monthly Earnings means the monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled means

1) during the Elimination Period and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, that wholly prevents the Participant from working in any occupation

   a) for which he would earn 60% or more of his Earnings in effect immediately prior to commencement of Total Disability; and

   b) for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered Totally Disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and

2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

1) the end of Elimination Period;

2) the scheduled date of return to work.

The amount of Long Term Disability Benefit payable will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to the initial date of Total Disability.

Long Term Disability Benefits are payable at the end of each month following the completion of the Elimination Period.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

COST-OF-LIVING ADJUSTMENT

During a continuous period of Total Disability, the Long Term Disability Benefit payable to a Participant under this Benefit will be increased by an amount equal to the percentage, as specified in the Benefit Schedule, of that monthly Benefit payable immediately prior to such increase, subject to the following conditions:

1) the initial increase will become effective in accordance with the COST-OF-LIVING ADJUSTMENT section of the Benefit Schedule;

2) subsequent increases will become effective on each anniversary of the initial increase; and

3) for any year in which the Consumer Price Index (CPI) is less than the percentage specified in the Benefit Schedule, the increase for that specific year will be equal to that of the CPI.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Direct Offset

   Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

   a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and

   b) any disability benefit the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding

      i) benefits payable on behalf of his Dependents; and

      ii) any increase in benefits due solely to cost-of-living, after benefit payments commence; and

   c) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis;

   d) any disability benefit payable by a private pension plan.

2) Indirect Offset

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

a) 85% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

b) 85% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Participant from all sources, whether he receives or is eligible to receive this income, will include all of the following:

a) any Long Term Disability payments under this Benefit;

b) any monthly Earnings or payments from the Employer;

c) any disability benefits payable under the Quebec Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

d) any disability benefits payable under the Canada Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

e) any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;

f) any disability benefits payable under any other group or association insurance plan;

g) any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;

h) any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

3) In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

4) Limitations

No benefits are payable for a period of Total Disability

a) during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;

b) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a total disability occurring during this period;

c) during a Parental or Family-related Leave taken by a Participant, as provided for under provincial or federal legislation, for Total Disability occurring during this period;

d) during the imprisonment of the Participant due to conviction of an offence;

e) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

5) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

a) intentionally self-inflicted injuries while sane or insane;

b) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

c) committing, or attempting to commit a criminal offence;

d) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Participant was insured under this Benefit;

e) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

f) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

1) 30 days of active full-time employment during the Elimination Period; or

2) 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

1) co-ordination of access to health care services;

2) support program for returning to work;

3) negotiations for a gradual return to work,

4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

1) the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;

2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

4) if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity
B = Monthly Earnings of the Participant immediately prior to the commencement of Total Disability
C = Long Term Disability Benefits otherwise payable under this Benefit

5) while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

1) the date the Participant ceases to be Totally Disabled;

2) the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

3) the date set by the Insurer the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;

4) the date payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;

5) the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

6) the date the Participant attains the Age Limit specified in the Benefit Schedule.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

If a Participant is not Totally Disabled on the date this Benefit terminates but was receiving Long Term Disability Benefits under this Benefit less than 6 months prior to such date, such Participant will be eligible to a resumption of Long Term Disability Benefits if he again becomes Totally Disabled from the same or related causes prior to

1) 90 days after the termination of this Benefit; or

2) 180 days after the last day he was Totally Disabled.

The reinstated Long Term Disability Benefits will be equal to those which the Participant was previously eligible to receive and will continue for the remainder of the Maximum Benefit Period.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period extending from January 1st to December 31st inclusive.

Convalescent/Rehabilitation Centre means any facility or institution in Canada which is licensed as a convalescent hospital by the licensing body having jurisdiction for the care and treatment of sick and injured persons who require supervision of either a Physician or a registered nurse. This institution must provide nursing care 24 hours a day by a registered nurse and maintain a daily record of each patient under the care of a Physician. However, it does not include a nursing home, home for the aged, or the chronically ill, home for the mentally ill, rest home, or an institution for the care and treatment of alcoholism or drug addiction.

Day Surgery means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Dispensing fee cap means a maximum amount applied to the part of the price of each prescription sold by a drugstore which corresponds to the standard amount covering the cost of the pharmacist's services. This maximum amount varies by province.

Hospitalization means

1) to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or

2) any Hospital stay in order to receive Day Surgery.

In-patient means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.

Mark-up fee cap means a maximum amount applied to the part of the price of each prescription sold by a drugstore which corresponds to the profit made on the drug. This maximum amount varies by province.

Medical Emergency means any acute and unexpected condition, Illness or injury requiring immediate medical treatment.

Medical Recommendation means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of his profession.

Orthesis means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Palliative Care Establishment means any establishment in Canada designated as such by law that provides, under the supervision of a Physician, care and treatment to patients, mainly during the terminal phase of their Illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a Physician. An active treatment Hospital designated as such by law, extended care facility, rest home, Convalescent or Rehabilitation Centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a Palliative Care Establishment.

Period Of Hospitalization means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Covered Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.

Prosthesis means an appliance used to replace all, or part, of a limb or organ.

Sound Tooth means a natural tooth that is not afflicted with any pathology either itself or in the adjacent structures. In addition, a tooth that has been treated or repaired and restored to normal function will be considered sound.

Total Disability or Totally Disabled means a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, training and experience.

Vehicle means a car, a motor home or a van with a maximum load of 1,000 kilograms.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to Desjardins Financial Security that a Participant, or one of his Dependents, while covered under this Benefit, incurred Eligible Expenses, Desjardins Financial Security will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and this Plan.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

1) which is medically necessary to treat the Covered Person;

2) which is generally provided for an Illness or injury of similar type or seriousness; and

3) which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the reasonable and customary charges generally paid in the area where the services are provided.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

COMMENCEMENT OF DEPENDENT COVERAGE

If a Dependent is hospitalized on the day his coverage would normally become effective, the effective date of coverage will be delayed, and his coverage will commence 24 hours after his discharge from the hospital. However, the newborn Child of a Participant, with Dependents who are already covered, will become covered at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

CO-PAY

The Co-pay is the portion of Eligible Expenses that the Participant must pay for each drug for which expenses were incurred before reimbursement will be made under this Benefit. The Co-pay is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by Desjardins Financial Security, in accordance with the provisions of this Benefit.

DRUG EXPENSE LIMITS

The maximum amount specified in the BENEFIT SCHEDULE is applicable to all drug expenses incurred by each Covered Person, per Calendar Year.

ELIGIBLE EXPENSES - IN PROVINCE OF RESIDENCE

Eligible Expenses in the Participant's normal province of residence include charges for the following:

HOSPITALIZATION EXPENSES

Hospital: Hospital charges for active treatment for each day of Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

Palliative Care Establishment: Hospital charges for palliative care up to the maximum specified in the Benefit Schedule.

Convalescent/Rehabilitation Centre: semi-private accommodation and meals in a licensed Convalescent or Rehabilitation Centre, provided that the Covered Person was admitted within 14 days of discharge from a Hospital to which he was confined as an In-patient and that this stay was primarily required for rehabilitation and not custodial care, up to the maximum specified in the Benefit Schedule.

DRUGS

1) Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium of Pharmaceuticals and Specialities) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

   Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialities is directly linked to the treatment of the following pathological conditions:

   cardiac problems;

   pulmonary problems;

   diabetes;

   arthritis;

   Parkinson's disease;

   epilepsy;

   cystic fibrosis;

   glaucoma.

   For a Covered Person domiciled in British Columbia, Saskatchewan or Manitoba, expenses for prescribed drugs must not exceed the Deductible and Co-payment percentage prescribed from time to time under the British Columbia or Manitoba Pharmacare program, or under the Saskatchewan Prescription Drug Plan.

2) Oral contraceptives prescribed by a Physician.

3) Injectable drugs, serums and vaccines prescribed by a Physician for preventing or treating an Illness. Preventive vaccines are limited to a payable amount of $100 per Calendar Year per Covered Person.

4) Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to an eligible amount of $20 per visit per Covered Person.

5) Reagent strips and syringes for the treatment of diabetes.

6) Anaesthetic administered during surgery that is not performed in a Hospital, up to a maximum payable amount of $20 per operation.

7) Smoking cessation aids (products only), up to a lifetime payable amount of $500 per Covered Person.

8) Drugs used for fertility treatment, up to the combined maximum amount specified in Fertility treatment paragraph.

HEALTH PROFESSIONALS

Nursing Care: Services of a registered nurse, a licensed practical nurse or a registered nursing assistant are eligible, up to the payable amount specified in the Benefit Schedule per Covered Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship and psychotherapy, and come within the competence of such nurse. In addition, the nurse must not be related to the Participant or to any of his Dependents by birth or marriage, and must not ordinarily reside in his or his Dependent's home.

Paramedical Services: Services of the following practitioner disciplines, provided that the practitioner is operating within his recognized field, that he is a member in good standing of his professional association, and that the association is recognized by Desjardins Financial Security, up to the payable amount specified in the Benefit Schedule per Covered Person:

1) Services that do not require prior Medical Recommendation:

- chiropractor
- naturopath
- podiatrist or chiropodist *
- psychologist, social worker or guidance counsellor *
- physiotherapist, physiatrist, physical rehabilitation therapist , sports therapist or acupuncturist *
- osteopath
- speech therapist
- dietician
- massage therapist, orthotherapist or kinesiologist *

* The maximum benefit amount specified in the Benefit Schedule applies to all specialists of this discipline.

Imaging techniques ordered by a chiropractor, a podiatrist, an osteopath or chiropodist are covered, up to a payable amount of $40 per Covered Person each Calendar Year for each of these specialists.

In the province of Ontario, the charges of a podiatrist or a chiropodist that exceed the fee covered under the provincial health insurance plan are reimbursed as of the first treatment, subject to the maximum applicable for each treatment. Proof that the per visit maximum has been exhausted will be required.

In all other provinces, reimbursement will be made as allowed under the relevant provincial health plan. If applicable, proof that the benefit has been exhausted will be required.

AMBULANCE

In the event of a Medical Emergency, or if the Covered Person must be transferred to another Hospital, transportation by a licensed ground ambulance

1) from the place of the Accident or Illness to the nearest Hospital where adequate medical treatment is available;

2) between Hospitals; and

3) from the Hospital to the place of residence of the Covered Person, when his condition warrants it.

Medical Emergency transportation by a licensed air ambulance to the nearest Hospital where adequate treatment is available, or to another Hospital when certified as medically necessary by the attending Physician.

MOBILITY AIDS

Conventional wheelchair: Rental or purchase, at the discretion of Desjardins Financial Security, of a wheelchair, up to a lifetime payable amount of $1,500 per Covered Person.

Walkers or crutches: Purchase or rental, at the discretion of Desjardins Financial Security.

ORTHOPAEDIC SUPPLIES

Spinal brace: Purchase, but not repair.

Brace for a limb, truss and plaster: Purchase, but not the repair or replacement.

Conventional hospital bed: Purchase or rental, at the discretion of Desjardins Financial Security.

Orthopaedic shoes: Purchase of one pair each Calendar Year, up to a payable amount of $400 per Covered Person each Calendar Year. Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces. The cost of modifications or adjustments to stock item footwear is also eligible; in-depth shoes and off-the-shelf shoes that are regular stock are excluded.

ORTHESIS AND PROSTHESIS

Podiatric Orthesis or arch support: Purchase, limited to 1 pair and a maximum payable amount of $400 per Covered Person each Calendar Year:

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Covered Person.

External breast Prosthesis: Purchase of an external breast Prosthesis when required because of total or radical mastectomy that has been performed while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, including the purchase of 2 surgical brassieres, up to a payable amount of $200 per Covered Person for any period of 24 consecutive months.

Hearing aids: Purchase on the written prescription of a licensed otolaryngologist, up to a payable amount of $375 each 5 Calendar Years per Covered Person.

Wigs: Purchase of wigs required as a result of chemotherapy, up to a lifetime payable amount of $200 per Covered Person.

THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon medical recommendation, up to a payable amount of $200 and one device for any period of 36 consecutive months.

Oxygen and equipment required for its administration: Purchase or rental, at the discretion of Desjardins Financial Security.

Apnea monitor: Purchase or rental, at the discretion of Desjardins Financial Security.

Drainage pump and chest percussion accessories: Purchase.

TENS nerve stimulators: Purchase or rental, at the discretion of Desjardins Financial Security, up to a lifetime payable amount of $700 per Covered Person.

Other therapeutic equipment: Purchase or rental, at the discretion of Desjardins Financial Security, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime payable amount of $10,000 per Covered Person. This category of equipment includes, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines.

MEDICAL SUPPLIES

Colostomy, ileostomy or uretherostomy supplies: Purchase.

Elastic support stockings: Purchase of medium or firm (over 20 mm/Hg) support stockings dispensed in a pharmacy or a medical facility, up to a payable amount of $500 each Calendar Year, per Covered Person.

Intra-uterine devices: Purchase, up to a payable amount of $50 per Covered Person each Calendar Year.

Supplies for paraplegics: Purchase, provided such supplies are required for the treatment and the care of a paraplegic Covered Person.

Catheter: Purchase.

Medical supplies for gavage: Purchase.

Medical supplies necessary following a tracheotomy: Purchase

Opaque glass necessary during radiotherapy or psoriasis treatments: Purchase

Compressive garments for the treatment of burns: Purchase.

Medicated dressings: Purchase.

DIAGNOSTIC SERVICES

Imaging techniques (including X-ray, ultrasound or MRI examinations), diagnostic laboratory tests and radiotherapy or radium therapy, up to a payable amount of $500 per Covered Person each Calendar Year. Such procedures do not include services received in a Hospital.

DENTAL TREATMENT DUE TO AN ACCIDENT

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in his mouth. Dental services must be rendered within 12 months of the accident; otherwise, a treatment plan deemed satisfactory by Desjardins Financial Security will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident.

OTHER TREATMENTS

Fertility treatment: All medical treatment, including drugs, directly referable to infertility, subject to a payable amount of $2,000 per cycle and a lifetime payable amount of $12,000 per Covered Person.

VISION CARE, EYEGLASSES, LENSES AND EYE SURGERY

Eye examinations: Including eye refraction provided they are performed by a qualified ophthalmologist or a licensed optometrist. Exams will be counted towards the VISION CARE, EYEGLASSES, LENSES AND EYE SURGERY maximum specified in the Benefit Schedule.

Eyeglasses or contact lenses and their replacement, provided they are prescribed in writing by a qualified ophthalmologist or a licensed optometrist and dispensed by a qualified ophthalmologist, a licensed optometrist or a qualified optician; or surgery to correct myopia, hypermetropia and astigmatism.

Contact lenses: Purchase of one pair, up to a payable amount of $250 per Covered Person per period of 24 consecutive months, provided that they are required as a result of cataract surgery and that vision can be improved to at least 20/40.

Artificial crystalline lenses: Purchase of crystalline lenses implanted surgically as a replacement for natural crystalline if the Covered Person has cataracts, up to a payable amount of $200 per Covered Person each Calendar Year.

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day enabling the Covered Person to speak with experienced health care professionals and to obtain information immediately.

This telephone service provides the Covered Person with information on the following topics:

- health
- nutrition
- physical fitness
- availability of local resources
- immunization
- lifestyle
- child care

Health Assistance should be considered as a complement to medical consultations and emergency medical services (911 or other); it is not intended to replace the regular health care provider of the Covered Person, nor the emergency medical services of a municipality.

This information service may be of use in improving the quality of life of the Participant and of his Dependents.

The Insured Person may contact HEALTH ASSISTANCE at any time.

Calls from	**Dial**
Anywhere in Canada	1 877 875-2632

ELIGIBLE EXPENSES - OUTSIDE PROVINCE OF RESIDENCE

All Eligible Expenses incurred on an emergency or referral basis outside the normal province of residence of the Insured Person are limited to the reasonable and customary charges in the area in which they are incurred and the charges in excess of the amounts reimbursed by the provincial hospital and/or health insurance plan of the normal province of residence of the Insured Person.

REFERRAL TREATMENT

Eligible Expenses incurred outside the province of residence of the Insured Person as a result of a referral include those provided for in the TRAVEL INSURANCE section below, subject to the following provisions:

1) This service or treatment must not be available in Canada or in the normal province of residence of the Insured Person;

2) The Insured Person must provide the Insurer with a letter of referral from a Physician in his normal province of residence, indicating that he is being referred to another Physician;

3) The Insurer must give prior written approval;

4) The provincial health and/or hospital insurance plans must pay a portion of the Eligible Expenses.

The maximum amount payable by the Insurer under this provision is limited to the percentage specified in the Benefit Schedule and the following Eligible Expenses:

1) Expenses incurred outside the province of residence, but in Canada - no maximum limitation;

2) Expenses incurred outside Canada - up to a payable amount of $50,000 per Insured Person each Calendar Year.

TRAVEL INSURANCE

If an Insured Person covered under government health and hospital insurance plans incurs Medical Emergency expenses as a result of an Accident or Illness that occurs while travelling outside his province of residence, Eligible Expenses will be reimbursed in accordance with the Benefit Schedule, provided they are eligible under this section and not payable by a government body or under another private insurance plan.

1) Eligible Health Care Expenses

   a) Hospital services and room and board charges in a semi-private room;

   b) Services of a Physician, a surgeon and an anaesthetist;

   c) All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Insured Person, excluding Hospital and Convalescent Care Eligible Expenses, if insured.

2) Eligible Transportation Expenses

   a) Expenses incurred for the repatriation of the Insured Person to his place of residence by a suitable means of public transportation to receive appropriate care as soon as his state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Insured Person declines, his insurance under the Travel Insurance provision will terminate.

   b) Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member insured under this Benefit, if he cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".

   c) Round-trip economy transportation for a qualified medical attendant, who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".

   d) Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Insured Person must be confined for at least 7 days (expenses will be reimbursed only if the Insured Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Insured Person is not accompanied by an Immediate Family member age 18 or over, and that such visit is considered by the attending Physician to be beneficial to the patient and prior approval is obtained from "Voyage Assistance".

e) Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents him from operating this Vehicle and none of the Immediate Family members accompanying him are able to return it. A commercial agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage Assistance". The amount reimbursed is limited to $1,000 per Participant.

f) If the Insured Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Insured Person was accompanied by an Immediate Family member age 18 or over.

g) If the Insured Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to $5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".

3) Eligible Daily Allowance

The cost of meals and accommodations for an Insured Person who must delay his return because of an Illness or bodily injury suffered by the Insured Person himself, an accompanying member of his Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to $150 per day per Participant for a maximum of 7 days and the Illness or injury must be certified by a Physician.

4) Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Insured Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Insured Person is not accompanied by an Immediate Family member age 18 or over - up to $50 per day, and up to an overall maximum of $200 per Period Of Hospitalization.

5) Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

6) Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Insured Person who requires them:

a) 24 hour toll-free telephone assistance;

b) referral to Physicians or health-care facilities;

c) assistance for Hospital admission;

d) cash advances to the Hospital when required by the facility;

e) repatriation of the Insured Person to his home city, as soon as his state of health permits it;

f) establishing and staying in contact with the Insurer;

g) handling arrangements in the event of death;

h) repatriation of the Children of the Insured Person, if the Insured Person cannot be moved;

i) delivery of medical assistance and drugs to an Insured Person who is too far from health care facilities to be transported there;

j) arrangements to bring a member of the Immediate Family to the bedside of the Insured Person if he must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician;

k) assistance in replacing lost or stolen travel documents so that the Insured Person can continue his trip;

l) referral to lawyers if legal problems arise;

m) translation services for emergency calls;

n) transmission of urgent messages to close friends or family in case of emergency; or

o) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the insured must contact the travel assistance firm immediately.

Calls from	**Dial**
Montreal area	(514) 875-9170
Canada and United States	1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code + 800 29485399 (toll-free)
Collect call (Anywhere worldwide)	(514) 875-9170

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

1) No reimbursement will be made under this Benefit for the following:

a) services or treatment that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount;

b) services, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, Desjardins Financial Security will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Covered Person's province of residence;

c) services, treatment or supplies which are experimental in nature;

d) expenses incurred for surgically implanted prostheses, except for crystalline lenses if covered under this Plan;

e) services, treatment or supplies provided to the Participant by the Employer;

f) wheelchairs adapted or designed for sports activities;

g) electric beds;

h) monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;

i) equipment such as "Obus form" type;

j) training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;

k) diapers for incontinence;

l) dental services, except those provided for in this Benefit;

m) dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;

n) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;

o) services, treatment or supplies not included in the list of Eligible Expenses;

p) Eligible Expenses which result directly or indirectly from the following:

   i) intentionally self-inflicted injuries while sane or insane;

   ii) cosmetic treatment;

   iii) committing, or attempting to commit a criminal offence;

   iv) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

   v) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

   vi) driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment are not subject to this exclusion;

q) services, treatment or supplies for the treatment of alcoholism and drug addiction;

r) sunglasses or safety glasses.

3) Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

a) products and drugs, including hormones and injections, used in the treatment of obesity;

b) contraceptives (prophylactics and contraceptive jellies and foams) except those provided for under this Benefit;

c) the following products, whether or not prescribed:

i) shampoos and other scalp care products, including hair growth products;

ii) beauty-care products;

iii) cosmetics;

iv) so-called "natural" products and homeopathic preparations;

v) sun-tan emulsions (sunscreens);

vi) soaps;

vii) over-the-counter laxatives;

viii) over-the-counter antacids;

ix) skin softeners;

x) disinfectants and ordinary dressings;

xi) mineral water;

xii) any infant milk formulas;

xiii) proteins and food supplements (i.e. products used to supplement or complement a diet);

d) sclerosing injections used in the treatment of varicosities, telangiectasia and minor dilation when this treatment is primarily for cosmetic and not therapeutic purposes;

e) products and drugs used in the treatment of sexual dysfunctions.

4) Drug restrictions

Any one prescription for drugs or medicines must not be in excess of a 34 day supply and a 100 day supply in the case of maintenance drugs.

5) Exclusions applicable to Travel Insurance

If an Insured Person fails to contact "Voyage Assistance" immediately when he requires Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

a) if the Insured Person is not covered under government health and hospital insurance plans;

b) if the purpose of the trip is to receive medical or paramedical treatment or hospital services, unless the Insured Person was referred to another Physician, in accordance with the provisions of the REFERRAL TREATMENT section of this Benefit; or

c) for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering his life or health, even if such service is provided as a result of a sudden Illness or an Accident requiring emergency treatment;

d) if the Insured Person does not agree to repatriation as recommended by "Voyage Assistance".

Travel Insurance benefits are limited to the lifetime maximum specified in the Benefit Schedule.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of the policy, and to the provisions below.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

BENEFIT EXTENSION AFTER TERMINATION

If a Participant is Totally Disabled or a Dependent is confined to a Hospital on the date the insurance of the Participant terminates for any reason other than policy termination, Eligible Expenses incurred as a result of such disability or confinement will continue to be reimbursed as if the insurance had not ended for such Insured Person, until the earliest of the following dates:

1) the date the Participant ceases to be Totally Disabled;

2) the date the Dependent is no longer confined in a Hospital;

3) the 91st day after the date the insurance of the Participant terminated;

4) the date this Benefit terminates.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1) 24 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent insurance would have terminated if the Participant had not died; or

4) the date on which this Benefit or policy terminates.

NOTICE AND PROOF OF CLAIM

All claims, other than drug claims must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expense was incurred. In the event of an Accident for which the Participant must submit a claim, written notice must be sent to the Insurer within the 30 days immediately following the Accident.

DRUG CLAIMS

When incurring drug expenses, the Insured Person must show his payment card to the pharmacist. With this method of payment, which is referred to as “direct”, the Insured Person only pays the pharmacist for the uninsured portion of the drug expenses incurred and, therefore, the Participant is not required to submit a claim to the Insurer.

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period from January 1st to December 31st inclusive.

Dental Hygienist means a person licensed by an accredited dental faculty to perform dental prophylaxis.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Fee Guide means the Dental Association Fee Guide for General Practitioners of the Province in which the service is provided to the Covered Person, for the Calendar Year mentioned in the BENEFIT SCHEDULE.

LATE APPLICATION

With respect to this Benefit, if the Participant applies for coverage for himself or his Dependents more than 31 days after the date of his eligibility, evidence of good health will not be required by Desjardins Financial Security. However, in all cases, Desjardins Financial Security will limit the amount of Eligible Expenses in accordance with the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under this Benefit.

PAYMENT OF BENEFIT

On receipt of Proof of Claim satisfactory to Desjardins Financial Security that an Covered Person, while covered under this Benefit, incurred Eligible Expenses which were necessary and which were for services recommended by a Dentist, Desjardins Financial Security will reimburse the expenses in excess of the Deductible, if any, subject to the Percentage of Reimbursement and maximums specified in the Benefit Schedule, and in accordance with other applicable Plan provisions.

To be eligible, the expenses must have been performed

1) by a Dentist; or

2) by a Dental Hygienist under the supervision of a Dentist; or

3) by a licensed denturist when such services are within the scope of his licence.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided. However, with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred, and with respect to root canal therapy, the date of the final treatment will be the date that expense was incurred.

COMMENCEMENT OF DEPENDENT COVERAGE

If a Dependent is hospitalized on the day his coverage would normally become effective, the effective date of coverage is delayed, and his coverage will commence 24 hours after his discharge from the Hospital. However, the newborn Child of a Participant with Dependents who are already covered becomes covered at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by Desjardins Financial Security, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA

PREVENTIVE SERVICES

EXAMINATIONS

- Complete oral examination, once every 24 months
- Recall oral examination, according to the frequency specified in the Benefit Schedule
- Specific oral examination, once every 6 months
- Emergency oral examination

RADIOGRAPHS (X-RAYS)

- Complete series of periapical films or panoramic radiographs, limited to one series in any 24 months
- Intra oral films, including bitewing films, and radiographs to diagnose a symptom or examine progress of a particular course of treatment
- Interpretation of radiographs from another source
- Photography
- Radiograph of the hand and wrist as a diagnostic aid for dental treatment

LAB TESTS AND EXAMINATIONS

- Bacteriologic cultures/smears to determine pathological agents
- Biopsies
- Pulp vitality tests
- Unmounted diagnostic casts

CASE PRESENTATION AND EXPLANATION

- Consultation with a patient (a day other than the examination date)

PREVENTIVE SERVICES

- Polishing, according to the frequency specified in the Benefit Schedule
- Light scaling for preventive purposes rather than therapeutic, according to the frequency specified in the Benefit Schedule
- Topical application of fluoride, according to the frequency specified in the Benefit Schedule
- Finishing restorations
- Pit and fissure sealants, for Children under Age 16
- Interproximal discing
- Space maintainers for missing primary teeth, for Children under Age 16
- Prophylactic odontotomy/enameloplasty

BASIC SERVICES, ENDODONTICS AND PERIODONTICS

RESTORATIONS

- Amalgam (silver)
- Composite restorations in accordance with the LIMITATIONS provision of the Dental Care section in the Benefit Schedule
- Retentive pins for amalgam and composite restorations
- Preformed stainless steel and polycarbonate crowns, for Children under Age 16
- Caries / trauma / pain control, separate procedure from restoration

ENDODONTICS

- Treatment of disease of the pulp chamber and pulp canals (root canal therapy)

PERIODONTICS

Treatment of the soft tissue (gums) and bone supporting the teeth. However the following expenses are limited:

a) post-operative visits, 4 visits per Calendar Year

b) curettage performed by a Dentist, once per period of 60 months

c) scaling for therapeutic purposes limited to a maximum of 12 units per Calendar Year

d) adjustments to periodontal appliance to control bruxism only, limited to one adjustment per Calendar Year

MAINTENANCE OF REMOVABLE DENTURES

- Repair
- Structure addition
- Relining
- Rebasing
- Adjustments to dentures, 3 months after insertion
- Denture adjustments including minor adjustments, once every 6 months.

ORAL SURGERY

- Extractions - uncomplicated and complex
- Removal of residual roots
- Surgical exposure of teeth
- Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty
- Alveolar ridge reconstruction
- Extension of mucous folds
- Excisions
- Incisions
- Frenectomy
- Miscellaneous surgical procedures

OTHER SERVICES

Only general anaesthesia and conscious sedation are covered. These expenses are eligible if they are administered in conjunction with extractions.

MAJOR RESTORATIVE SERVICES

PROSTHODONTICS

Expenses incurred for a permanent initial prosthodontic appliance, such as partial or full removable denture or fixed bridge, are covered if such appliance was necessary because of the extraction of at least one natural tooth while the covered is covered under this Benefit or a comparable benefit held by the Plan Sponsor in force immediately before the effective date of this Benefit.

Replacement of an existing denture or bridge by a permanent denture or bridge:

a) if the replacement was necessary because of the extraction of one or more natural teeth while the covered is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, or

b) if the existing denture or bridge is at least 5 years old; or

c) if the existing denture or bridge is temporary and is being replaced with a permanent denture or bridge within 12 months of the installation of the temporary appliance. With respect to a permanent appliance that replaces a temporary one, the amount eligible for reimbursement will be reduced by the amount previously reimbursed by Desjardins Financial Security for the temporary appliance.

A temporary appliance which is at least 12 months old will be considered to be a permanent denture or bridge for the purposes of this provision.

REMOVABLE DENTURES

- Complete denture
- Immediate complete denture
- Complete or partial overdenture
- Transitional denture
- Partial denture including cast in chrome (but not in gold)
- Partial denture remake
- Remount with occlusal equilibration
- Therapeutic tissue conditioning

FIXED PROSTHODONTICS (bridges)

- Abutments and pontics
- Repairs
- Bridge removal
- Recementation

OTHER SINGLE RESTORATIONS

- Onlays, veneers applications, inlays, crowns

  a) for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite

  b) temporary crowns are considered to be part of the final restoration

  c) replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old

- Porcelain repair
- Retentive pins, pivots, cast posts
- Recementation
- Removal of an inlay or crown

ORTHODONTICS

If an individual, while covered under this Benefit, incurs Eligible Expenses that are for necessary dental treatment, which has as its objective the correction of malocclusion of the teeth, as listed below, Desjardins Financial Security will reimburse such expenses, in accordance with the provisions of this Plan and subject to any maximum specified in the Benefit Schedule.

- services for diagnostic purposes
- preventive orthodontic treatment
- comprehensive orthodontic treatment
- appliances to control harmful oral habits

ELIGIBLE EXPENSES OUTSIDE CANADA

Payment will be made for dental treatment rendered while travelling outside Canada, but only to the extent that payment would have been made under this Benefit if such treatment had been rendered in the normal province of residence of the Covered Person and provided that such treatment was rendered for emergency purposes only.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

In the event of late application of the Participant or his Dependents, in accordance with the Late Application provision under this Benefit, reimbursement will be limited to $250 per Covered Person for the first 12 months of coverage and Orthodontics (if applicable) will not be covered during the first 24 months of such coverage.

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule. When there are two or more courses of treatment available to adequately correct a dental condition, this plan will provide reimbursement for the treatment that incurs the lowest cost consistent with good dental care.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 50% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

Reimbursement of fees for composite restorations performed on posterior teeth may be limited to the fees for amalgam restorations as specified in the LIMITATIONS provision of the Dental Care section in the Benefit Schedule.

No reimbursement will be made under this Benefit for the following:

1) any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;

2) charges for nutritional counselling, oral hygiene and dental plaque control programs;

3) any dental services or supplies, including X-rays, provided for full mouth reconstruction, for vertical dimension correction, for the restoration of occlusion, for the correction of temporomandibular joint dysfunction or for permanent splinting of teeth;

4) charges levied by a Dentist for broken appointments, completion of claim forms or advice by telephone;

5) expenses incurred for bacteriologic cultures/smears followed by a Chlorzoïn treatment;

6) expenses incurred for implants;

7) expenses incurred for duplicate diagnostic casts (unmounted);

8) expenses incurred for anaesthesia administered by acupuncture;

9) any dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes;

10) dental services, treatment or supplies that the individual received without charge or that a government health plan prohibits from being paid;

11) services, treatment or supplies provided to the Participant by the Employer;

12) any dental treatment rendered outside Canada except as specifically provided under the ELIGIBLE EXPENSES OUTSIDE CANADA provision;

13) dental services and supplies not included in the list of Eligible Expenses;

14) Eligible Expenses that result directly or indirectly from the following:

    a) intentionally self-inflicted injuries while sane or insane;

    b) committing, or attempting to commit a criminal offence;

    c) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

    d) war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

EXCLUSIONS RELATED TO PROSTHESES AND CROWNS

No reimbursement will be made under this Benefit for the following:

1) expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen;

2) prosthetics with precision attachments or stress breakers;

3) precision attachments and telescoping crown units for fixed bridgework;

4) preformed stainless steel or polycarbonate crowns, except in the case of primary teeth;

5) transfer coping for crowns.

EXCLUSIONS RELATED TO ORTHODONTIC TREATMENT

No reimbursement will be made under this Benefit for the following:

1) myofunctional therapy;

2) replacement or repair of an orthodontic appliance;

3) patient motivation (psychological evaluation and progress, per visit);

4) procedure requiring the insertion of an adjustable orthodontic appliance before the person is covered under this Benefit.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of this Plan.

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for a Covered Person is expected to exceed $500, the Participant should submit a detailed treatment plan to Desjardins Financial Security before treatment commences. Desjardins Financial Security will then advise the Participant of the amount of reimbursement for which the Covered Person is eligible in accordance with the provisions of this Plan. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

The treatment plan submitted must be completed by the Dentist who first proposed the treatment; otherwise the Participant will be required to submit a new treatment plan to Desjardins Financial Security for re-assessment.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant reaches the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT COVERAGE provision.

No benefits are payable for expenses incurred after the date the coverage of the Participant terminates, even if a detailed treatment plan under the PRE-DETERMINATION OF BENEFIT provision was filed and benefits were determined by Desjardins Financial Security prior to such termination date.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to Plan provisions, coverage under this Benefit will continue for covered Dependents, without premium payment, until the earliest of the following dates:

1) 24 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent coverage would have terminated if the Participant had not died;

4) the date on which this Benefit or Plan terminates.

PROOF OF CLAIM

If the Dentist uses the Electronic Data Interchange (EDI), the Participant is not required to submit a claim to Desjardins Financial Security. EDI allows the Dentist to validate the Covered Person's eligibility, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Participant, or the Dentist, by Desjardins Financial Security, and the amount payable by the Covered Person. The Dentist submits the benefit claim through EDI and gives a copy of the confirmation to the Covered Person. If the Dentist does not use the Electronic Data Interchange (EDI), the Covered Person must submit a benefit claim to Desjardins Financial Security.

All claims must be submitted to Desjardins Financial Security along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expenses were incurred.

Desjardins Financial Security reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

PAYMENT OF ORTHODONTIC CLAIMS

Notwithstanding anything to the contrary under the CLAIMS provision of this Plan, the payment of orthodontic claims will be made on one of the following bases:

1) If a single charge is estimated for the entire course of treatment and the Covered Person pays this charge to the orthodontist in prearranged instalments over an estimated period of treatment or in one lump sum, Desjardins Financial Security will reimburse the Participant each time he submits a bill, certificate or receipt that specifies the amount of expenses, the date and the nature of the treatment received; or

2) If in lieu of a single charge, a charge is made for each treatment as it is performed, the Insurer will reimburse the Participant as each charge is incurred.

BASIC A.D.&D. INSURANCE

Policy No.100004378 issued by Industrial Alliance Pacific Insurance and Financial Services Inc.

COVERAGE

Any accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

ELIGIBILITY

All active, permanent, full-time employees of the Policyholder, working a minimum of 15 hours per week, as described below, are eligible immediate upon employment:

Senior Management

AMOUNT OF INSURANCE

Your amount of insurance (Principal Sum) is:

$100,000.00

BENEFITS

Accidental Death and Dismemberment Benefits

If injury shall, within 365 days of the date of the accident causing such injury, result in any of the following losses, the Company will pay for loss of or permanent and total loss of use of:

LIFE	THE PRINCIPAL SUM
BOTH HANDS	THE PRINCIPAL SUM
BOTH FEET	THE PRINCIPAL SUM
ENTIRE SIGHT OF BOTH EYES	THE PRINCIPAL SUM
ONE HAND AND ONE FOOT	THE PRINCIPAL SUM
ONE HAND AND THE ENTIRE SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE FOOT AND THE ENTIRE SIGHT OF ONE EYE	THE PRINCIPAL SUM
SPEECH AND HEARING	THE PRINCIPAL SUM

ONE ARM	THREE-QUARTERS OF THE PRINCIPAL SUM
ONE LEG	THREE-QUARTERS OF THE PRINCIPAL SUM
ONE HAND	TWO-THIRDS OF THE PRINCIPAL SUM
ONE FOOT	TWO-THIRDS OF THE PRINCIPAL SUM
ENTIRE SIGHT OF ONE EYE	TWO-THIRDS OF THE PRINCIPAL SUM
SPEECH OR HEARING	TWO THIRDS OF THE PRINCIPAL SUM
FOUR FINGERS OF EITHER HAND	ONE-THIRD OF THE PRINCIPAL SUM
ALL TOES OF ONE FOOT	ONE-QUARTER OF THE PRINCIPAL SUM
THUMB AND INDEX FINGER OF EITHER HAND	ONE-THIRD OF THE PRINCIPAL SUM
HEARING IN ONE EAR	ONE-THIRD OF THE PRINCIPAL SUM

PARALYSIS BENEFITS

QUADRIPLEGIA (COMPLETE PARALYSIS OF BOTH UPPER AND LOWER LIMBS).	TWO TIMES THE PRINCIPAL SUM
PARAPLEGIA (COMPLETE PARALYSIS OF BOTH LOWER LIMBS)	TWO TIMES THE PRINCIPAL SUM
HEMIPLEGIA (COMPLETE PARALYSIS OF UPPER AND LOWER LIMBS OF ONE SIDE OF BODY)	TWO TIMES THE PRINCIPAL SUM

"Injury" wherever used in the policy means bodily injury caused by an accident occurring while the policy is in force as to the Insured Person and resulting directly and independently of all other causes in loss covered by the policy.

"Loss" as above used with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof.

Any indemnity payable for Loss of Use shall be paid only if such loss is permanent, total and irrecoverable and shall have been continuous for a period of 12 months from the date of the accident.

“Loss” as above used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

Indemnity provided under this Part will not be paid under any circumstances for more than one of the losses, the greatest, sustained by any one Insured Person as the result of any one accident.

Day Care Benefit

If Injury results in the loss of your life within 365 days of the date of the accident, the Company will pay the lesser of five percent of your Principal Sum or a maximum of $5,000.00 for each year your Dependent Child is enrolled in a legally licensed Day Care (not to exceed four years) for each of your Dependent Children who are under 13 years of age and are enrolled in a legally licensed Day Care Centre on the date of the accident or are enrolled in a legally licensed Day Care Centre within 12 months after your death.

Eyeglasses, Contact Lenses and Hearing Aids Benefit

If you receive an injury which requires and receives treatment by a physician and results in the purchase of eyeglasses, contact lenses or hearing aids within 365 days of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expense therefor not to exceed $1,000.00.

Family Transportation Benefit

When, as a result of loss covered by the policy, you are confined as an inpatient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the Company will pay the reasonable expenses actually incurred by any member of your immediate family for hotel accommodation and transportation by the most direct route to you, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Home Alteration and Vehicle Modification Benefit

In the event you sustain a loss for which indemnity becomes payable under the part titled “Accidental Death and Dismemberment Benefits” and subsequently require the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to your principal residence and/or the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $15,000.00.

Occupational Training Benefit

In the event you lose your life as the result of an injury, the Company will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

Rehabilitation Benefit

If injury requires that you undergo special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum amount of $15,000.00 as the result of any one accident.

Repatriation Benefit

If injury results in your loss of life, the Company will pay the actual expense incurred for the transportation of your body to your city of residence, including the preparation of your body for such transportation, subject to a maximum amount of $15,000.00.

Seat Belt Benefit

In the event you sustain an injury which results in a Loss payable under “Accidental Death and Dismemberment Benefits” of the policy, your amount of Principal Sum will be increased by 10% to a maximum of $25,000.00 if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt.

Special Education Benefit

If injury results in your loss of life, the Company will pay, in addition to all other benefits, five percent of your Principal Sum to a maximum of $5,000.00 to your Dependent Child, who on the date of the accident was enrolled as a full-time student in any institution of higher learning above the secondary school level, or was enrolled as a full-time student at the secondary school level and enrolls as a full-time student in any institution of higher learning within 365 days after your death, but not to exceed four consecutive annual payments.

EXPOSURE AND DISAPPEARANCE

If due to accident you are unavoidably exposed to the elements and if, as a result of such exposure and within 365 days after the date of the accident, you suffer a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 365 days after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of injury.

AGGREGATE LIMIT OF INDEMNITY

The policy is subject to an Aggregate Limit of Indemnity of $2,500,000.00 for all losses resulting from any one *aircraft* accident. This means that in the event of an *aircraft* accident that results in an accumulation of losses exceeding $2,500,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

EXCLUSIONS

Cover does not apply to any loss caused or contributed to by:

- flying as a pilot or crew member in any aircraft;
- suicide or self-destruction;
- full-time, active service in the armed forces;
- war or act of war;
- flying in owned, operated or leased aircraft of the Policyholder.

BENEFICIARY

The beneficiary or beneficiaries of an Insured Person shall be that person or those persons designated by the Insured Person under the Policyholder's current Group Life policy. If no such designation has been filed, the beneficiary in respect of loss of life of an Insured Person shall be the estate of the Insured Person. All other indemnities payable will be payable to the Insured Person.

This brochure is for illustrative purposes only and carries no contractual or other rights. All rights with respect to the benefits of an Insured Person will be governed by the Group Master policy, a copy of which is filed with your Employer.

GROUP INSURANCE

Our Commitment to Our Plan Members

| VANCOUVER

| CALGARY

| WINNIPEG

| TORONTO

| OTTAWA

| MONTREAL

| QUEBEC

| HALIFAX

As one of our valued Plan Members, you are entitled to our attention and respect. We make it a point to be available to provide you with any assistance you may require. You can rely on our knowledgeable team that is committed to settling your claims objectively and diligently, thereby delivering the kind of service you have come to expect.

At Desjardins Financial Security, the needs of the Plan Members are at the heart of the organization. Your financial security is vital to us and, as such, we will provide financial support in the event of illness, an accident or death.

Please accept this brochure which summarizes our financial obligations toward you.

Desjardins
Financial Security

Money working for people

www.dfs.ca

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