The following are definitions of some of the terms used in your EquiLiving Critical Illness Insurance Policy. If you need additional information or clarification, please call the Equitable Life of Canada Customer Service Line at 1−800−668−4095.

Beneficiary: The Beneficiary of the Covered Condition Benefit(s) is the Person Insured, unless otherwise specified by the Policy Owner.

Birthday: The anniversary of the day on which a person was born, which does not include the day the person was born.

Covered Condition: A Covered Condition is an illness, condition, disorder or Surgery as defined under, and that meets all requirements of the Definitions of Covered Critical Conditions or Definitions of Early Detection Benefit Covered Conditions in this Policy. Any condition, illness, disorder, or Surgery not specifically defined under the Definitions of Covered Critical Conditions or Definitions of Early Detection Benefit Covered Conditions is not insured under this Policy and no Covered Condition Benefit shall be payable for such conditions, illnesses, disorders, or Surgeries.

Covered Condition Benefit: A Covered Condition Benefit means an EquiLiving Benefit or an Early Detection Benefit.

Company: The terms "we", "our", "us", "Equitable Life" and "Company", mean The Equitable Life Insurance Company of Canada and its Head Office located in Waterloo, Ontario, Canada.

Currency: All amounts payable to or by the Company under the terms of this Policy are payable in the lawful currency of Canada.

Diagnosis (Diagnosed): The Diagnosis of any Covered Condition or the advice to undergo Surgery for any Covered Condition requiring Surgery must be made by a Specialist. In the absence of a Specialist, a condition may be diagnosed by another qualified medial practitioner as approved by us. The date of Diagnosis shall be the date the Specialist makes the Diagnosis of the Covered Condition. The Diagnosis must be supported by objective medical evidence and the date of Diagnosis must occur while this Policy is in effect.

Effective Date: This Policy takes effect on the Effective Date as shown on the Policy Specification page of this Policy, provided that:

a) the full amount of the first premium has been paid to the Company, and
b) no change has taken place in the insurability of the Person Insured under this Policy between the date the application was completed, and the date specified in the insurance legislation that applies.

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

Owner: The Owner of this Policy refers to the Owner indicated on the Policy Specifications page of this Policy. The terms "you", "your" and "Owner" refer to the Owner of this Policy. The Owner may or may not be the Person Insured under this Policy.

Person Insured: The Person Insured is the person we have agreed to insure under this Policy and who is named as a person insured on the Policy Specifications page of this Policy. The Person Insured may or may not be the Owner of this Policy.

Policy: Policy means this EquiLiving Critical Illness Insurance policy.

Policy Anniversary (ies): In this Policy, "Policy Anniversaries" are measured yearly from the Effective Date on which the first Policy year begins.

Rider: A Rider is an additional benefit applied for and issued by us as shown on the Description of Benefits page(s). The terms and conditions of any Riders applicable to this Policy are stated in the Rider pages attached to this Policy.

Specialist: A licensed medical practitioner practicing medicine in Canada or the United States or any other region as approved by Equitable Life who has been trained in the specific area of medicine relevant to the Covered Condition for which benefit is being claimed and who has been certified by a specialty examining board. The Specialist may not be the Owner, the Person Insured, or a relative by blood or marriage or a business associate of the Owner or of the Person Insured.

Specialist includes but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist.

Any tests or examinations that must be performed in order to satisfy the requirements of the Covered Condition must be conducted by a medical professional who is not the Owner, the Person Insured, or a relative by blood or marriage or business associate of the Owner or of the Person Insured.

Sum Insured: The Sum Insured is the amount of critical illness insurance shown on the Description of Benefits page of this Policy.

Surgery: Surgery refers to the undergoing of surgery, on the written advice of a Specialist practicing medicine in Canada or the United States or any other region approved by Equitable Life, whose practice is restricted to the particular branch of medicine relating to the applicable surgery. Surgery must be performed by a Specialist.

Survival Period: Some Covered Conditions require a 30-day Survival Period as specified within their definitions. The Survival Period begins on the date of Diagnosis of, or Surgery for, a Covered Condition and ends 30 days following the date of Diagnosis of, or Surgery for, a Covered Condition, unless otherwise specified in the definition of the Covered Condition. The Person Insured must be alive at the end of the Survival Period and must not have experienced irreversible cessation of all brain functions during the Survival Period. If such irreversible cessation occurs, no Covered Condition Benefit is payable. If artificial life support is used to sustain the Person Insured during the Survival Period, the date the Person Insured experiences irreversible cessation of all brain functions shall be deemed to be the date of death of the Person Insured. Determination of irreversible cessation of all brain function shall be by generally accepted medical criteria.

During the Survival Period, no premium payment is required. If a Covered Condition Benefit becomes payable, the amount of any premiums paid during the Survival Period will be added to any Covered Condition Benefit amount due.

For Covered Conditions that do not have a Survival Period, the Person Insured must be alive at the time the Diagnosis is made.

COVERED CONDITION BENEFITS

EquiLiving Benefit

The EquiLiving Benefit is the Sum Insured as shown on the Description of Benefits page of this Policy.

If, while this Policy is in effect, the Person Insured is alive when Diagnosed with one of the Covered Critical Conditions as defined in the Definitions of Covered Critical Conditions and survives any applicable Survival Period following the date of Diagnosis of, or Surgery for, the Covered Critical Condition, the EquiLiving Benefit will, subject to applicable limitations and exclusions set out in this Policy, become payable.

The EquiLiving Benefit shall be payable to the Person Insured (or other Beneficiary as designated) provided this Policy is in effect on the first day following the satisfaction of all requirements of the Covered Critical Condition as defined in the Definitions of Covered Critical Conditions of this Policy. Any condition, illness, disorder, or Surgery not specifically defined as a Covered Critical Condition in the Definitions of Covered Critical Conditions in this Policy is not an insured condition and no EquiLiving Benefit will be payable for such condition, illness, disorder or Surgery.

The EquiLiving Benefit is payable only once and only for one Covered Critical Condition. Once the EquiLiving Benefit is paid, this Policy terminates, regardless of how many additional Covered Critical Conditions the Person Insured may be diagnosed with. Payment of the EquiLiving Benefit represents the total fulfillment of all claims, insurance coverages, Riders, and benefits under this Policy. Payment of the EquiLiving Benefit is subject to the exclusions set out in the definitions of Covered Critical Conditions, the exclusions and limitations in the section entitled “Exclusions and Limitations”, as well as other limitations, conditions, and exclusions in this Policy.

If this Policy has a Return of Premiums on Surrender/Expiry Rider, the EquiLiving Benefit payable will be the greater of the Sum Insured or the eligible Premiums to be Returned as defined in the Rider.

Early Detection Benefit

If, while this Policy is in effect, the Person Insured is alive when Diagnosed with one of the Early Detection Benefit Covered Conditions as defined in the Definitions of Early Detection Benefit Covered Conditions and survives any applicable Survival Period following the date of Diagnosis of, or Surgery for, the Early Detection Benefit Covered Condition, the Early Detection Benefit will, subject to applicable limitations and exclusions set out in this Policy, become payable.

The Early Detection Benefit shall be payable to the Person Insured (or other Beneficiary as designated) provided this Policy is in effect on the first day following the satisfaction of all requirements of the Early Detection Benefit Covered Condition as defined in the Definitions of Early Detection Benefit Covered Conditions of this Policy. Any condition, illness, disorder, or Surgery not specifically defined as an Early Detection Benefit Covered Condition in the Definitions of Early Detection Benefit Covered Conditions in this Policy is not an insured condition and no Early Detection Benefit will be payable for such condition, illness, disorder or Surgery.

The Early Detection Benefit is equal to the lesser of:

a) 15% of the then current Sum Insured; or
b) $ 50,000.

The Early Detection Benefit can be paid multiple times during the lifetime of this Policy, but only once for each of the Early Detection Benefit Covered Conditions.

Any payment of the Early Detection Benefit will not reduce the Policy premium, the Sum Insured or any Premiums to be Returned for a Return of Premium Rider.

DEFINITIONS OF EARLY DETECTION BENEFIT COVERED CONDITIONS

The following are the definitions of the Early Detection Benefit Covered Conditions that are applicable to this this Policy.

In the following definitions: (i) the terms Tis, Ta, T1a, T1b, T1, and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018; and (ii) the term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pastermack: Clinical staging of chronic lymphocytic leukemia, Blood 46:219, 1975.

Coronary Angioplasty:

The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

A 30-day Survival Period following the date of the procedure applies. The procedure must be determined to be medically necessary by a Specialist.

Ductal Breast Cancer:

A definite Diagnosis of the presence of ductal carcinoma in-situ of the breast.

The Diagnosis of Ductal Breast Cancer must be made by a Specialist and confirmed by pathological examination of the tissue.

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the “Exclusions and Limitations” section of this Policy.

Early Prostate Cancer:

A definite Diagnosis of either stage T1a or T1b prostate cancer, confirmed without lymph node or distant metastasis.

The Diagnosis of Early Prostate Cancer must be made by a Specialist and must be confirmed by pathological examination of the tissue.

For purposes of this Policy, Stage T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the “Exclusions and Limitations” section of this Policy.

Gastrointestinal Stromal Tumours (AJCC Stage 1) :

A definite Diagnosis of malignant gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1.

The Diagnosis of Gastrointestinal Stromal Tumours (AJCC Stage 1) must be made by a Specialist and confirmed by pathological examination of the tissue.

For purposes of this Policy, gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:

- Gastric and omental GISTs that are less than or equal to 10.0 cm in greatest dimension with five or fewer mitoses per 5.0 mm2, or 50 per HPF; or
- Small intestinal, esophageal, colorectal, mesenteric and peritoneal GIST that are less than or equal to 5.0 cm in greatest dimension with five or fewer mitoses per 5.0 mm2, or 50 per HPF.

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.

Grade 1 Neuroendocrine Tumours (Carcinoid):

A definite Diagnosis of Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with Surgery alone and requiring no additional treatment other than medication to counteract the effects from hormonal oversecretion by the tumour.

The Diagnosis of Grade 1 Neuroendocrine Tumours (Carcinoid) must be made by a Specialist and confirmed by biopsy.

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.

Papillary or Follicular Thyroid Cancer Stage T1:

A definite Diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 centimetres in greatest diameter and classified as T1, without lymph node or distant metastasis.

The Diagnosis of Papillary or Follicular Thyroid Cancer Stage T1 must be made by a Specialist and confirmed by pathological examination of the tissue.

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.

Rai Stage 0 Chronic Lymphocytic Leukemia (CLL):

A definite Diagnosis of chronic lymphocytic leukemia (CLL) classified as Rai Stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts.

The Diagnosis of Rai Stage 0 Chronic Lymphocytic Leukemia (CLL) must be made by a Specialist and confirmed by appropriate blood tests.

Exclusions: No benefit will be payable under Rai Stage 0 Chronic Lymphocytic Leukemia (CLL) for Monoclonal Lymphocytosis of Undetermined Significance (MLUS)

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.

Superficial Malignant Melanoma:

A definite Diagnosis of stage 1A or 1B malignant melanoma of the skin that has not ulcerated into the dermis and is less than or equal to 1.0 mm in thickness.

The Diagnosis of Superficial Malignant Melanoma must be made by a Specialist and confirmed by pathological examination of the tissue.

Exclusions: No benefit will be payable under Superficial Malignant Melanoma for any malignant melanoma in situ.

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.

The following are the definitions of the Covered Critical Conditions that are applicable to this Policy.

In the following definitions: (i) the terms Tis, Ta, T1a, T1b, T1, and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018; (ii) the term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pastermack: Clinical staging of chronic lymphocytic leukemia, Blood 46:219, 1975; and (iii) the term Mini Mental State Exam refers to MF Folstein, SE Forstein, PR McHugh, J Psychiatry Res. 1975; 12(3): 189.

Acquired Brain Injury:

A definite Diagnosis of new damage to brain tissue as result of traumatic injury, anoxia (an absence of oxygen) or encephalitis, resulting in one or more signs and symptoms of Neurological Deficits that:

- are present and verifiable on clinical examination or neuro-psychological testing;
- are corroborated by imaging studies of the brain such as Magnetic Resonance Imaging (MRI) or Computerized Tomography (CT) showing changes that are consistent in character, location and timing with the new damage, and
- persist for more than 180 days following the date of Diagnosis.

The Diagnosis of Acquired Brain Injury must be made by a Specialist.

Exclusions: No benefit will be payable under Acquired Brain Injury for:

- an abnormality seen on brain scans without definite related clinical impairment;
- neurological signs occurring without symptoms of abnormality.

Aortic Surgery:

The undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

A 30-day Survival Period following the date of Surgery applies. The Surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under Aortic Surgery for:

- angioplasty,
- intra-arterial procedures,
- percutaneous trans-catheter procedures, or
- non-surgical procedures.

Aplastic Anemia:

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

- marrow stimulating agents;
- immunosuppressive agents; or
- bone marrow transplantation.

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

Bacterial Meningitis:

A definite Diagnosis of meningitis confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective Neurological Deficit persisting for at least 90 days from date of Diagnosis.

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

Exclusion: No benefit will be payable under Bacterial Meningitis for viral meningitis.

Benign Brain Tumour:

A definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The Person Insured must have undergone Surgery or radiation treatment or the tumour must have caused irreversible objective Neurological Deficits. These Neurological Deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the Neurological Deficits.

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

Exclusions: No benefit will be payable under Benign Brain Tumour for pituitary adenomas less than 10.0 mm, vascular malformations, Cholesteatomas, or infectious or inflammatory tumours.

90-day exclusion period: No Covered Condition Benefit will be provided for any benign brain tumour or any Covered Condition defined under this Policy contributed to or caused by any type of benign brain tumour (covered or not covered under this Policy) if within the first 90 days following the Effective Date of this Policy, or 90 days from the date of last Reinstatement of this Policy, the Person Insured has any of the following:

- a Diagnosis of benign brain tumour (covered or not covered under this Policy); or
- one or more signs, symptoms, tests, investigations and/or medical consultations that lead directly or indirectly to a Diagnosis of benign brain tumour (covered or not covered under this Policy), regardless of the date of Diagnosis.

Requirement to report: The Owner or Person Insured must give written notification to Equitable Life's Head Office in Waterloo, Ontario, within 180 days if, following the later of 90 days from the Effective Date of this Policy or 90 days from the date of last Reinstatement of this Policy, the Person Insured has any Diagnosis or one or more signs, symptoms, tests, investigations and/or medical consultations for benign brain tumour (covered or not covered under this Policy). If the Owner or Person Insured under this Policy fails to disclose this information, Equitable Life reserves the right to deny a claim for Benign Brain Tumour, or any Covered Condition caused by any benign brain tumour or treatment of any benign brain tumour.

The Owner may, by writing request to maintain this Policy in effect, provided the written request is received in Equitable Life's Head Office in Waterloo, Ontario, within 30 days of the date Equitable Life confirms that the 90-Day Benign Brain Tumour Exclusion and Requirement to Report applies. Upon receipt of the written request, Equitable Life may in the absence of fraud or misrepresentation, maintain this Policy in effect, with the condition that no Covered Condition Benefit will be payable for any:

- subsequent Diagnosis of any form of benign brain tumour (covered or not covered under this Policy);
- Covered Condition directly resulting from any benign brain tumour (covered or not covered under this Policy); and
- Covered Condition directly resulting from the treatment of any benign brain tumour (covered or not covered under this Policy).

If no written request is received as described above, this Policy will terminate, and Equitable Life will return all premiums paid for this Policy and no Covered Condition Benefit will be payable.

Blindness:

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

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

The Diagnosis of Blindness must be made by a Specialist.

Cancer:

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

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

Exclusions: No benefit will be payable under Cancer for the following:

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

Cancer Exclusion and Requirement to Report: A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.

Coma:

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

The Diagnosis of Coma must be made by a Specialist.

Exclusions: No benefit will be payable under Coma for:

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

Coronary Artery Bypass Surgery:

The undergoing of heart Surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

A 30-day Survival Period following the Surgery applies. The Surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under Coronary Artery Bypass Surgery for:

- angioplasty;
- intra-arterial procedures;
- percutaneous trans-catheter procedures; or
- non-surgical procedures.

Deafness:

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

The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease:

A definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

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

The Person Insured must exhibit:

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

The Diagnosis of Dementia must be made by a Specialist.

Exclusions: No benefit will be payable under Dementia, including Alzheimer's Disease for affective or schizophrenic disorders, or delirium.

Heart Attack (Acute Myocardial Infarction):

A definite Diagnosis of death of heart muscle due to obstruction of blood flow, that results in a rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

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

A 30-day Survival Period following the date of Diagnosis applies. The Diagnosis of Heart Attack (Acute Myocardial Infarction) must be made by a Specialist.

Exclusions: No benefit will be payable under Heart Attack (Acute Myocardial Infarction) for:

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair:

The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

A 30-day Survival Period following the date of the procedure applies. The procedure must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under Heart Valve Replacement or Repair for:

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

Kidney Failure:

A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

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

Loss of Independent Existence:

A definite Diagnosis of the total inability, due to disease or injury, to perform independently:

- with or without the aid of assistive devices;
- at least 3 of 6 Activities of Daily Living listed below;
- for a continuous period of at least 90 days; and
- with no reasonable chance of recovery.

The Diagnosis of Loss of Independent Existence must be made by a Specialist or other person as approved by Equitable Life and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

- Bathing-washing oneself in a bathtub, shower, or by sponge bath;
- Dressing−putting on and removing necessary clothing including braces, artificial limbs or other surgical appliances;
- Toileting−getting on and off the toilet and maintaining personal hygiene;
- Bladder and bowel Continence−managing your bowel and bladder function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- Transferring−moving in and out of a bed, chair or wheelchair; and
- Feeding−consuming food or drink that has already been prepared and made available.

Loss of Limbs:

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

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

Loss of Speech:

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

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

Exclusion: No benefit will be payable under Loss of Speech for all psychiatric related causes.

Major Organ Failure on Waiting List:

A definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary.

To qualify under Major Organ Failure on Waiting List, the Person Insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant Surgery. The date of Diagnosis is the date of the Person Insured's enrollment in the transplant centre.

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

Major Organ Transplant:

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

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

Motor Neuron Disease:

A definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy.

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

Multiple Sclerosis:

A definite Diagnosis of at least one of the following occurring after the later of the Effective Date, or the date of last Reinstatement of this Policy:

- Two or more separate clinical attacks, confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective Neurological Deficits lasting more than 180 days, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

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

Exclusions: No benefit will be payable under Multiple Sclerosis for the following:

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

One-Year exclusion period: No benefit will be payable for Multiple Sclerosis if, within the first year following the later of the Effective Date of this Policy or the date of the last Reinstatement of this Policy, the Person Insured has any of the following:

- One or more signs, symptoms or investigations that lead directly or indirectly to a Diagnosis of multiple sclerosis (covered or not covered under this Policy) regardless of when the Diagnosis is made; or
- A Diagnosis of multiple sclerosis (covered or not covered under this Policy).

Requirement to report: Medical information about the Diagnosis of Multiple Sclerosis and one or more signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis must be reported to Equitable Life's Head Office in Waterloo, Ontario, within 180 days of the date of Diagnosis. If this information is not provided within this period, Equitable Life has the right to deny any claim for Multiple Sclerosis or any Covered Condition caused by Multiple Sclerosis or its treatment.

Occupational HIV Infection:

A definite Diagnosis of infection with the Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Person Insured's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the Effective Date of this Policy, or the date of the last Reinstatement of this Policy.

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

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

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

Exclusions: No benefit will be payable under Occupational HIV Infection if:

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

Paralysis:

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

The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders:

Parkinson's Disease is defined as a definite Diagnosis of primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of muscular rigidity, or rest tremor. The Person Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.
The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

Exclusion: No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for all other types of Parkinsonism.

One-Year exclusion period: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the Effective Date of this Policy, or the date of last Reinstatement of this Policy, the Person Insured has any of the following:

- one or more signs, symptoms or investigations that lead directly or indirectly to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or
- a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Requirement to report: Medical information about the Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorders and one or more signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorder must be reported to Equitable Life's Head Office in Waterloo, Ontario, within 180 days of the date of the Diagnosis. If this information is not provided within this period, Equitable Life has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any Covered Condition caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or their treatment.

Severe Burns:

A definite Diagnosis of third degree burns over at least 20% of the body surface.

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

Stroke (Cerebrovascular Accident):

A definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, hemorrhage, or embolism with:

- acute onset of new neurological symptoms; and
- new objective Neurological Deficits on clinical examination

persisting for more than 30 days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new Neurological Deficits.

A 30-day Survival Period following the date of Diagnosis applies. The Diagnosis of Stroke (Cerebrovascular Accident) must be made by a Specialist.

Exclusions: No benefit will be payable under Stroke (Cerebrovascular Accident) for:

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

90-Day Cancer Exclusion and Requirement to Report:

No Covered Condition Benefit will be provided for any cancer or any Covered Condition defined under this Policy contributed to or caused by any type of cancer (covered or not covered under this Policy) if within the first 90 days following the Effective Date of this Policy, or 90 days from the date of last Reinstatement of this Policy, the Person Insured has any of the following:

a) a Diagnosis of any form of cancer (covered or not covered under this Policy); or
b) one or more signs, symptoms, tests, investigations and/or medical consultations that lead directly or indirectly to a Diagnosis of cancer (covered or not covered in this Policy), regardless of the date of Diagnosis.

The Owner or Person Insured must give written notification to Equitable Life's Head Office in Waterloo, Ontario, within 180 days, if, following the later of 90 days from the Effective Date of this Policy or 90 days from the date of last Reinstatement of this Policy, the Person Insured has any Diagnosis or one or more signs, symptoms, tests, investigations and/or medical consultations for any form of cancer (covered or not covered under this Policy). If the Owner or Person Insured under this Policy fails to disclose this information, Equitable Life reserves the right to deny a claim for any cancer, or any Covered Condition caused by any cancer or treatment of cancer.

The Owner may, by writing, request to maintain this Policy in effect, provided the written request is received in Equitable Life's Head Office in Waterloo, Ontario, within 30 days of the date Equitable Life confirms that the 90-Day Cancer Exclusion and Requirement to Report applies. Upon receipt of the written request, Equitable Life may in the absence of fraud or misrepresentation, maintain the Policy in effect, with the condition that no Covered Condition Benefit will be payable for any:

- subsequent Diagnosis of any form of cancer (covered or not covered under this Policy);
- Covered Condition directly resulting from any cancer (covered or not covered under this Policy); and
- Covered Condition directly resulting from the treatment of any cancer (covered or not covered under this Policy).

If no written request is received as described above, this Policy will terminate, and Equitable Life will return all premiums paid for this Policy and no Covered Condition Benefit will be payable.

Exclusions:

In addition to any exclusions noted in this Policy, no Covered Condition Benefit will be paid if the Person Insured is diagnosed with a Covered Condition which arises directly or indirectly from:

- intentionally self-inflicted injuries, regardless of the state of mind of the Person Insured;
- war, or any act or incident of war, whether declared or not, or any conflict between the armed services of countries or international organizations;
- the Person Insured's intentional use or intake of any:
  - prescribed drug or narcotic other than as instructed by a physician;
  - legally available drug or narcotic for sale in Canada or the United States without a prescription, in a manner other than as recommended by the manufacturer;
  - drug or narcotic not legally available in Canada or the United States; or
  - any poisonous substance or intoxicant, including inhalation of toxic gases or fumes;
- committing or attempting to commit a criminal offence; or
- operating a motor vehicle while the concentration of alcohol in 100 milliliters of blood exceeds 80 milligrams.

Covered Condition Outside of Canada:

If the occurrence or Diagnosis of one of the Covered Conditions occurs outside of Canada, the Covered Condition Benefit will be payable only if all the following conditions are satisfied:

a) The complete medical records are made available and provided to Equitable Life's Head Office in Waterloo, Ontario; and
b) The medical records provide evidence, satisfactory to Equitable Life that;
   1. the same Diagnosis would have been made if the illness or accident had occurred in Canada; and
   2. immediate treatment would have been indicated under Canadian standards; and
   3. the same treatment, involving the particular surgical procedure, would have been advised if treatment had taken place in Canada; and
c) The Person Insured must undergo an independent medical examination by a Specialist appointed by Equitable Life if we make such request. In the case of elective Surgery, such an examination must be undergone before Surgery takes place.

PREMIUMS

Premiums:

All premiums are payable to Equitable Life and must be received in our Head Office in Waterloo, Ontario.

Premiums are payable for this Policy, for the period specified in the Premium Schedule/Table of Charges of this Policy. With Level to Age 100 as your premium type, your premiums are guaranteed for the life of your Policy. At the Policy Anniversary nearest the Person Insured's 100th Birthday, premiums will cease, and no further premiums for this Policy will be required.

Premium Tax: The premiums shown in the Premium Schedule include a provision for Premium Tax. Equitable Life remits the Premium Tax to the Government(s) on your behalf.

Grace Period: A Grace Period of 31 days is allowed for the payment of renewal premiums, during which time this Policy will remain in effect.

This Policy will lapse, and all liability of the Company under the Policy will terminate at the end of the 31-day Grace Period following an unpaid renewal premium.

If the Person Insured is Diagnosed with a Covered Condition during the Grace Period, and survives the applicable Survival Period, the Covered Condition Benefit, once approved, will become payable, less the premiums past due. If the Person Insured dies during the Grace Period the benefit under Return of Premiums at Death will become payable, if applicable, less the premiums past due.

Reinstatement:

a) If this Policy lapses at the end of the Grace Period because a premium due at the beginning of the Grace Period was not paid, this Policy may be reinstated by payment of the overdue premium within a further period of 30 days after the end of the Grace Period, but only if the Person Insured under this Policy is alive at the time payment is made.

b) If this Policy lapses and it is not reinstated under subsection (a), you may apply to have this Policy reinstated within two years following lapse of the Policy.

The requirements for Reinstatement are:

i. evidence of ongoing good health and insurability of the Person Insured satisfactory to the Company; and
ii. payment of all premiums, with interest (at a rate determined by the Company from time to time) from the date of lapse of this Policy.

The effective date of Reinstatement will be the date all of the above requirements for Reinstatement are met.

CHANGE PRIVILEGE

You may change your EquiLiving Level to Age 100 Policy, without evidence of insurability to a 20 Pay coverage for Life critical illness plan, provided such plan is available pursuant to the Company's then current administrative rules, at any time up to and including the Policy Anniversary nearest the Person Insured's 60th Birthday.

To make a change:

a) your notice to the Company must be received by the Company prior to the Policy Anniversary nearest the Person Insured's 60th Birthday; and
b) no increase in Sum Insured is requested; and
c) the Policy is in effect at the time the change is requested and at the effective date that the change takes place.

If this Policy has a Return of Premiums at Surrender/Expiry Rider in effect at time of change, any Premiums to be Returned that have accumulated for the Rider will be carried over to the new plan if the new plan has a Return of Premiums at Surrender/Expiry Rider. Policy anniversaries will be deemed to start at the date of the change for the purposes of calculating policy anniversaries under the Return of Premiums at Surrender/Expiry Rider.

If this Policy has a Return of Premiums on Death Rider in effect at time of change, any Premiums to be Returned that have accumulated for the Rider will be carried over to the new plan only if the new plan has a Return of Premiums on Death Rider.

The changed critical illness plan will be the 20 Pay coverage for Life critical illness plan that was available when this Policy was put into effect. The premium rates for the changed critical illness plan will be the rates in effect for that plan on the date of the change and will be based on the Person Insured's age on their Birthday nearest to the effective date of the changed critical illness plan and for the same class of risk and smoking status as this Policy. The 20-year payment period will start at the date of the change.

TERMINATION

In addition to any other termination or expiry provisions contained within this Policy, your Policy will terminate on the earliest of:

a) the lapse of the Policy;
b) the written cancellation request by the Owner, effective on the date the notice is received by Equitable Life at its Head Office in Waterloo, Ontario;
c) the date the EquiLiving Benefit under this Policy becomes payable;
d) the date of death of the Person Insured.

The following are General Provisions applicable to your EquiLiving Policy.

Assignment: This Policy may be assigned by the Owner as permitted by law. The Assignment will not be binding on Equitable Life unless the Assignment is made in writing and filed with our Head Office in Waterloo, Ontario. Equitable Life is not responsible for the validity of any Assignment.

Incontestability: Failure to disclose every fact or the misrepresentation of any fact in the application for insurance, medical examination, and any written statement or answers given as evidence of insurability within the Person Insured's or Owner's knowledge that is material to the insurance being applied for, will cause this Policy, including any Riders, to be voidable by Equitable Life. Where the Policy has been in effect for two years from the Effective Date, or in the case of Reinstatement, two years from the date of last Reinstatement, with the exception of Misstatement of Age which is described below, the failure to disclose or the misrepresentation, except in the case of fraud, will not cause this Policy including any riders to become voidable.

Any additional insurance coverages effective after the Effective Date or date of last Reinstatement of this Policy will be considered to be incontestable only after the additional insurance coverage or the Reinstated Policy has been in effect from its effective date for two years, except in the case of fraud.

Non-Participation: This Policy and any Riders that may be attached to it are Non-Participating, and therefore will not be eligible for dividends, nor participate in any divisible surplus of the Company.

Misstatement of Age: If the date of birth of the Person Insured has been misstated and a Covered Condition Benefit is payable, it will be the amount of EquiLiving Benefit or Early Detection Benefit that the premium would have purchased had the premiums been calculated based on the correct Age.

Notice/ Correspondence: Any notice or correspondence that is required to be provided to you by the Company will be in writing and sent by regular mail, facsimile, or electronic mail. The notice and/or correspondence will be deemed to be received by you on the seventh business day following the mailing or transmission.

Any notice or correspondence from you will be in writing and sent by regular mail, facsimile, electronic mail (provided a signature is not required) or personal delivery and will be deemed to be received by us on the date we receive it at our Head Office in Waterloo, Ontario.

Proof of Age: Equitable Life requires satisfactory proof of the date of birth of the Person Insured before making any payment payable under this Policy.

Right of Rescission: You will have 10 calendar days from the date you receive this Policy to cancel it provided you have given us written notice of your request to cancel within the 10 days. If for any reason during that time you want to cancel this Policy, any premiums received will be refunded as of the date Equitable Life's Head Office in Waterloo, Ontario, receives your notice requesting cancellation. This Policy will then be considered void from inception.

Smoker Classification: If the Person Insured has been classified as a smoker, at any time, subject to our administrative rules and guidelines, you may request that the Smoker Classification be changed to a non-smoker classification by providing a written declaration to Equitable Life's Head Office in Waterloo, Ontario, that provides satisfactory evidence to qualify the Person Insured as a non-smoker. Equitable Life reserves the right to require evidence of good health before approving a change in Smoker Classification.

Compliance with Provincial Legislation: If any terms, conditions or provisions of this Policy conflict with the legislation of the province where the Person Insured resided on the date of application, the term, condition or provision shall be amended to meet the minimum requirement of such legislation.

Limitation Period: Every action or proceeding against an insurer for the recovery of insurance money payable under this Policy is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

The Contract: The application, this Policy, any Riders and any document attached to this Policy, when issued and any amendment to the contract agreed upon in writing after the Policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions. The Company shall, upon request, furnish to the Owner or to a claimant under the Contract a copy of the application.

Waiver: Equitable Life will be deemed not to have waived any condition of the Contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by us. (If the insurance legislation that governs the Contract does not include this condition, this condition does not apply).

Material Facts: No statement, made by the Owner or the Person Insured at the time of application for the Contract, shall be used in defense of a claim under or to avoid the Contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

Notice and Proof of Claim: The Owner or the Person Insured, or a Beneficiary entitled to make a claim, or the agent of any of them, shall;

a) give written notice of claim to Equitable Life:
   i. by delivery of the notice of claim, or by sending it by registered mail to our Head Office in Waterloo, Ontario, or chief agency of Equitable Life in the Province; or
   ii. by delivery of the notice of claim to an authorized agent of Equitable Life in the Province;
   not later than 30 days from the date a claim arises under the Contract for a Covered Condition;

b) within 90 days from the date a claim arises under the Contract for a Covered Condition, furnish to Equitable Life's Head Office in Waterloo, Ontario, such proof as is reasonably possible in the circumstances of the happening of the Covered Condition, the right of the claimant to receive payment, the claimant's age, and the age of the Beneficiary if relevant; and

c) if required by Equitable Life, furnish us with a satisfactory certificate as to the cause or the nature of the Covered Condition for which claim may be made under the Contract.

Failure to Give Notice or Proof: Failure to give notice of claim or furnish proof of claim within the time prescribed/required by this statutory condition does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one (1) year from the date the claim arises under the Contract if it is shown that it was not reasonably possible to give notice or furnish proof within the time prescribed/required by this condition.

Insurer to Furnish Forms for Proof of Claim: Equitable Life will furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time, the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the Covered Condition giving rise to the claim.

Rights of Examination: As a condition precedent to recovery of insurance money under the Contract, the claimant will furnish Equitable Life with an opportunity to examine the person of the Person Insured when and so often as we reasonably require while the claim under the Contract is pending.

When Money is Payable: All money payable under the Contract will be paid by us within 60 days after we have received proof of claim.

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