Sun Life CHOICES

We're here to help – with Choices Critical Illness Insurance

Critical Illness insurance plans that fit your life today and in the future

Sun Life

Life's brighter under the sun

We understand that you might have lots on your mind when changing jobs. The good news is that leaving your workplace doesn't mean having to leave your critical illness insurance coverage behind.

Choices Critical Illness Insurance – a smart way to plan for the unexpected

Did you, your spouse or your children had critical illness coverage with Sun Life through your employer? You may be able to transfer it when you leave your workplace plan. We've made it easy to make sure you're prepared financially in case of a life-changing illness. The benefits of Choices Critical Illness Insurance include:

- **Guaranteed coverage for you and your family in minutes – with no health questions or medical tests**

  Call us **within 60 days** of when your workplace coverage ends and you can transfer you, your spouse and children's critical illness insurance coverage. We can do everything over the phone and there won't be any health questions or medical tests. You and your spouse must be age 18 to 69 (or age 65 if that was the maximum under your former employer's plan). Your children must be under age 21 (or age 25 if they're a full-time college or university student and age 26 for Quebec residents).

Over 70 or looking for more coverage? We have solutions for you. Give us a call at 1-877-893-9893 to learn about your options.

- **Three plans to match your workplace coverage**

  We have three plans available – coverage for 3, 11, or 25 illnesses – depending on what your workplace plan covered. For coverage that you transfer, the group coverage effective date will apply to the:

  - moratorium period exclusion for benign brain tumor, cancer and Parkinson's disease; and
  - pre-existing condition provision.

  If you are transferring coverage from a 19- or 20-illness workplace plan, we will place you into the 25-illness plan. The coverage start date for the additional 5 or 6 illnesses will be the start date of your Choices Critical Illness Insurance plan, and a pre-existing condition exclusion will apply.

- **Keep the same amount of coverage**

  You can keep the amount of your existing workplace critical illness insurance. That's up to $100,000 for adults and $20,000 for each child you had covered under your workplace plan.

- **Options for children when they've outgrown their coverage**

  Your children's coverage doesn't have to end when they turn age 21 (or age 25 if they're a full-time college or university student) and age 26 for Quebec residents. You can convert your children's Choices Critical Illness Insurance coverage into an adult policy with the same amount of coverage.

Our team of licensed financial services consultants (registered as financial security advisors in Quebec) can assess your coverage needs and recommend solutions that match your budget. We can also refer you to a local Sun Life advisor. An advisor can discuss other insurance options to make sure you get the right coverage.

Call us today to get started. 1-877-893-9893 8 a.m. to 8 p.m. ET | Monday to Friday

We have you covered

Critical illness insurance offers you financial help to pay the costs of dealing with a life-changing illness. If you become sick with a covered illness and survive the waiting period, you'll get a lump-sum cash payment upon approval of claim. You can use this money for anything you want, including:

- paying down debt
- replacing lost income
- buying specialized equipment
- considering new medical treatments not covered by private or government health plans
- hiring a nurse, housekeeping, or child care provider

We have three plans available. If you'd like to get a sample Choices Critical Illness Insurance policy, call us at **1-877-893-9893** from 8 a.m. to 8 p.m. ET, Monday to Friday. We'll be happy to walk you through all the details.

Plan	Covered illnesses		
Basic (3 illnesses)	• Cancer (Life-threatening)	• Heart Attack	• Stroke
Enhanced (11 illnesses) Includes the conditions from the Basic plan, plus 8 more	• Multiple sclerosis • Major organ transplant • Kidney failure	• Loss of independent existence • Paralysis • Coronary artery bypass surgery	• Deafness • Blindness
Comprehensive (25 illnesses) Includes the conditions from the Enhanced plan, plus 14 more	• Aortic surgery • Coma • Parkinson's disease and specified atypical parkinsonian disorders • Aplastic anemia • Bacterial meningitis	• Benign brain tumour • Loss of speech • Major organ failure on waiting list • Heart valve replacement or repair • Motor neuron disease	• Dementia, including Alzheimer's disease • Severe burns • Occupational HIV infection • Loss of limbs
Child illnesses Your children are covered for the conditions in the plan you choose, plus these 6 child-specific conditions	• Cerebral palsy • Congenital heart disease	• Cystic fibrosis • Down's syndrome	• Muscular dystrophy • Type 1 diabetes mellitus

Teladoc Medical Experts

You, your spouse, dependent children, parents and parents in law will have access to Teladoc Medical Experts, a medical consultation service. Teladoc Medical Experts will provide an in-depth medical review of your case and/or information about resources within or outside of Canada, including availability, referral process and cost. In addition, if you get critically ill, you'll be connected with a leading expert to review your diagnosis and your treatment plan, and provide you with recommendations for moving forward. What's more, you can use Teladoc Medical Experts' services up to 4 months from the time your critical illness claim is paid.

For more information about Teladoc Medical Experts, call **1-877-419-2378** or visit **teladoc.ca/medical-experts**.

What you need to know – Choices Critical Illness Insurance

Question	Answer
Do I need critical illness insurance if I already have long-term disability (LTD) insurance?	Each insurance covers you for something different. Long-term disability (LTD) insurance helps replace your lost income so you can pay those bills that don't stop coming when you stop working due to a serious illness or injury. With critical illness insurance, you get a lump-sum payment to use on anything you want if: › you're diagnosed with a covered condition or had surgery for a covered condition; › survive the waiting period; and › we've approved your claim.
Can I make more than one claim under my policy?	Your policy covers you for one critical illness claim. After you've made a claim, your policy ends.
What happens to my spouse's or children's coverage if I make a claim?	As long as your spouse and children are still eligible for coverage, they'll still be covered. Remember, when your children outgrow their policy, they're also eligible to convert their coverage into an adult policy.
What do we mean by spouse and children?	Your spouse can be either by marriage or someone you've been living with for at least one year and refer to as your spouse or partner in public. If you live in Quebec, the one year minimum period does not apply if a child is born out of the relationship. Children include your and your spouse's children (other than foster children) who aren't married and are under age 21. If your child is a full-time student in a recognized school, they're covered until the age of 25 (age 26 in Quebec) as long as they are entirely dependent on you for financial support. We also cover children who are physically or mentally incapable of self-support if they became so while they were entirely dependent on you for financial support under one of the two same age eligibility rules.
What is a pre-existing condition?	Any injury, illness, disease or sickness of which there are symptoms. Or for which medical treatment, care, advice or diagnosis was recommended or received before the date the application was signed.
How does a pre-existing condition work?	A pre-existing condition limitation applies to Choices Critical Illness Insurance. For illnesses that your workplace plan covered, we use your coverage start date from that plan. For any new illnesses that your workplace plan didn't cover, we use the start date of your Choices Critical Illness Insurance coverage. This pre-existing condition limitation means that we won't pay a claim for a specific illness if: › the insured has any medical conditions, whether diagnosed or not, in the 12 months before your coverage start date; and › those medical conditions turn into a covered illness within 12 months of your coverage start date.
When will my coverage begin?	Coverage for this policy will begin the day after your workplace coverage ends.
What is the 30-day free look period?	You can cancel your policy at any time. If you would like a refund on your premiums you have to cancel within 30 days of receiving your policy from us or 60 days after we issue it (whichever date is earlier).
When can I cancel my policy?	You can cancel your policy at any time.

Question	Answer		
When will my coverage end?	**Your coverage will end on the earlier of the:**	**Your spouse's coverage will end on the earlier of the:**	**Your child's coverage will end on the earlier of the:**
	date you cancel your policy;	date you or your spouse cancels your spouse's policy;	date you cancel your child's policy;
	date you reach age 70;	date your spouse reaches age 70;	date your child reaches age 21, or 25 and attending college or university full time (26 in Quebec);
	date you are no longer a resident of Canada;	date your spouse is no longer a resident of Canada;	date your child is no longer a resident of Canada;
	date we pay your critical illness benefit;	date we pay your spouse's critical illness benefit;	date we pay your child's critical illness benefit (coverage will continue for the rest of your eligible children);
	end date of the period for which premiums have been paid; or	end date of the period for which premiums have been paid; or	end date of the period for which premiums have been paid; or
	date of your death.	date of your spouse's death.	date of your/your spouse's death (under whom your child is covered under this plan) or the date of your child's death; or
			date that you and your spouse no longer have coverage.
Will my premiums change over time?	Yes. Premiums are the monthly fee a person pays for insurance. The plans renew every year and your premium could change, as well your premium will change as you move into a new age group (every 5 years or so). This means that you'll receive a renewal notice each year, 30 days before your renewal date. The premium on the renewal notice is based on: › the coverage amount and number of covered illnesses you've chosen; › your age and/or the age of your spouse covered by your policy; › your gender and/or the gender of your spouse covered by your policy; and › your smoker status and/or the smoker status of your spouse covered by your policy. Coverage for children is available at a per-child flat rate, per $5,000 unit of coverage, and it doesn't change upon renewal.		
How will I be billed?	We charge premiums monthly, which means that we won't charge you for partial months. If there's an amount owing once we process your application, we'll charge your first bill to you as soon as possible. After that, we'll charge you for all following premiums on the 1st of each month.		

Question	Answer
How does the plan work?	Sun Life will pay a critical illness benefit if an insured person meets the following conditions: › their coverage is in effect; › they are diagnosed with or have surgery for a covered illness; › they survive a period of time (typically 30 or 90 days) after diagnosis; and › their claim has been approved. Sun Life will pay a critical illness benefit for one covered illness for each insured person. Once an insured person receives a benefit payment, their coverage ends. They will not become covered again under the plan. The coverage start date will determine if an insured person qualifies for a benefit payment. We'll also apply this date to any exclusions and limitations. The definitions of critical illness conditions could change based on a number of factors such as medical advances and industry guidelines. We'll assess your claim based on the definition of the critical illness condition on the date of your diagnosis or surgery. If a definition changes, we will contact you.
What is Teladoc Medical Experts?	Access to Teladoc Medical Experts is included in your coverage. It's a valuable service available to you, your spouse, dependent children, parents and parents-in-law at any point during the lifetime of your policy. You can access Teladoc Medical Experts to get answers to any of your medical questions. Teladoc Medical Experts will provide an in-depth medical review of your case and/or information about resources within or outside of Canada, including availability, referral process and cost. In addition, if you get critically ill, you'll be connected with a leading expert that will review your diagnosis and your treatment plan and provide you with recommendations for moving forward. What's more, you can still use Teladoc Medical Experts services up to 4 months from the time your claim is paid. For more information about Teladoc Medical Experts, call **1-877-419-2378** or visit **teladoc.ca/medical-experts**.
Portability of critical illness coverage	The coverage start date from your workplace plan will apply to all illnesses you were previously covered for. If you are transferring coverage from a 19- or 20-illness workplace plan, we will place you into the 25-illness plan. The coverage start date for the additional 5 or 6 illnesses will be the start date of your Choices Critical Illness Insurance plan, and a pre-existing condition exclusion will apply.
Definition of diagnosis	Diagnosis means a written diagnosis of the covered condition by a physician or specialist physician, who is licensed and practicing in Canada. A diagnosis is valid from the date the physician or specialist physician establishes it, as supported by the covered person's medical records. We won't pay a benefit for a covered condition if the diagnosis was made before the coverage start date.
Pre-existing condition exclusion	For any amount of coverage that: › did not require proof of good health, and › has been in effect for less than 12 months under your workplace critical illness plan, no benefits are payable for any covered condition that results from any injury, sickness or medical condition (whether or not diagnosed) for which the covered person, during the 12 months prior to the effective date of such amount of coverage: ° had signs, symptoms, consulted a physician or any other health care practitioner; ° was provided any health-related care, advice or treatment; or ° would have consulted a physician or any other health care practitioner, acting as a reasonably prudent person with such injury, sickness, medical condition, signs or symptoms. If coverage ends but the person is covered again under this benefit, Sun Life will use the latest date the person's coverage began when applying the above limitation. The pre-existing condition exclusion does not apply where the child coverage moratorium period exclusion applies.

Question	Answer
Waiting periods for cancer, benign brain tumour and Parkinson's disease	We won't cover cancer, a benign brain tumour of any type, or Parkinson's disease if, within the first 90 days (1 year for Parkinson's disease) after the workplace coverage start date, the covered person: › is diagnosed with cancer, benign brain tumour, or Parkinson's disease; or › has any signs, symptoms or tests that lead to a diagnosis of cancer, benign brain tumour, or Parkinson's disease. However, coverage will stay in effect for all of the other covered conditions.
Child coverage moratorium	This is defined as the period starting 90 days before the workplace coverage start date for the Child Critical Illness coverage, and continuing until 10 months after. During this period, your child will not be covered if, on or within 90 days after that child's birth: › your child is diagnosed with any of the covered illness; or › your child has any signs, symptoms or tests that lead to a diagnosis of a covered illness within 5 years of their birth.
Consequences for insured non-disclosure or misstatements	If you don't provide accurate information when you apply, Sun Life could cancel your coverage or deny your claims.

Definitions of covered conditions

The definitions of critical illness conditions are subject to change based on a number of factors that include medical advances and industry guidelines. We will review your claim based on the definition of the critical illness condition on the date of your diagnosis or surgery. You will be informed of any definition changes.

Covered condition	Definition
Aortic surgery	Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of surgery. **Exclusion:** No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
Aplastic anemia	Aplastic anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: • marrow stimulating agents; • immunosuppressive agents; or • bone marrow transplantation. The diagnosis of aplastic anemia must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Covered condition	Definition
Bacterial meningitis	Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist. The insured person must survive for 90 days following the date of diagnosis. **Exclusion:** No benefit will be payable under this condition for viral meningitis.
Benign brain tumour	Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis. **Exclusions:** No benefit will be payable under this condition for pituitary adenomas less than 10 mm. No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the policy date. **Moratorium period exclusion:** If, within 90 days following the later of: • the group coverage effective date; or • the date this policy was put back in effect (reinstatement), the insured person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this policy), regardless of when the diagnosis is made; or • a diagnosis of benign brain tumour (covered or excluded under this policy), no benefit will be payable for benign brain tumour and the insured person's coverage for benign brain tumour will terminate. All other Covered critical illnesses remain in force. The information described above must be reported to us within 6 months of the date of diagnosis. If this information is not provided, we have the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.
Blindness	Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by: • the corrected visual acuity being 20/200 or less in both eyes; or • the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Covered condition	Definition
Cancer (Life-threatening)	Cancer (Life-threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of cancer must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis. **Exclusions:** No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the policy date. No benefit will be payable under this condition for the following: • lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta; • malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis; • any non-melanoma skin cancer, without lymph node or distant metastasis; • prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; • papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis; • chronic lymphocytic leukemia classified less than Rai stage 1; or • malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2. **Moratorium period exclusion:** If, within 90 days following the later of: • the group coverage effective date; or • the date this policy was put back in effect (reinstatement), the insured person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this policy), regardless of when the diagnosis is made; or • a diagnosis of cancer (covered or excluded under this policy), no benefit will be payable for cancer and the insured person's coverage for cancer will terminate. All other Covered critical illnesses remain in force. The information described above must be reported to us within 6 months of the date of diagnosis. If this information is not provided, we have the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment. For the purposes of this policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. For the purposes of this policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975

Covered condition	Definition
Coma	Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of coma must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis. **Exclusions:** No benefit will be payable under this condition for: • a medically induced coma; • a coma which results directly from alcohol or drug use; or • a diagnosis of brain death.
Coronary artery bypass surgery	Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.The insured person must survive for 30 days following the date of surgery. **Exclusion:** No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
Deafness	Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.
Dementia, including Alzheimer's disease	Dementia, including Alzheimer's disease means a definite diagnosis of a progressive deterioration of memory and at least one of the following areas of cognitive function: • aphasia (a disorder of speech); • apraxia (difficulty performing familiar tasks); • agnosia (difficulty recognizing objects); or • disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life. The insured person 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. The insured person must survive for 30 days following the date of diagnosis. **Exclusion:** No benefit will be payable under this condition for affective or schizophrenic disorders or delirium. For purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Covered condition	Definition
Heart attack	Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: • heart attack symptoms; • new electrocardiogram (ECG) changes consistent with a heart attack; or • development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. The diagnosis of heart attack must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis. **Exclusions:** No benefit will be payable under this condition for: • elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or • ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.
Heart valve replacement or repair	Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of surgery. **Exclusion:** No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
Kidney failure	Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Covered condition	Definition
Loss of independent existence	Loss of independent existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery. Activities of daily living are: • **Bathing** – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices; • **Dressing** – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices; • **Toileting** – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices; • **Bladder and bowel continence** – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained; • **Transferring** – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and • **Feeding** – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices. The diagnosis of loss of independent existence must be made by a specialist. No additional survival period is required once the conditions described above are satisfied.
Loss of limbs	Loss of limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.
Loss of speech	Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist. No additional survival period is required once the conditions described above are satisfied. **Exclusion:** No benefit will be payable under this condition for any psychiatric related causes.
Major organ failure on waiting list	Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the insured person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.
Major organ transplant	Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of major organ failure must be made by a specialist. The insured person must survive for 30 days following the date of their transplant.

Covered condition	Definition
Motor neuron disease	Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.
Multiple sclerosis	Multiple sclerosis means a definite diagnosis of at least one of the following: • two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; • well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or • a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart. The diagnosis of multiple sclerosis must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.
Occupational HIV infection	Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the insured person'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 date the application for this policy was signed; • the policy date, or • the date this policy was put back in effect (reinstatement). Payment under this condition requires satisfaction of all of the following: • the accidental injury must be reported to us within 14 days of the accidental injury; • a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; • a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; • all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and • the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines. The diagnosis of occupational HIV infection must be made by a specialist. The insured person must survive for 30 days following the date of the second serum HIV test described above. **Exclusions:** No benefit will be payable under this condition if: • the insured person 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.

Covered condition	Definition
Paralysis	Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist. The insured person must survive for 90 days following the precipitating event.
Parkinson's disease and specified atypical parkinsonian disorders	Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The insured person 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 or a specialist physician. The insured person must satisfy the above conditions and survive for 30 days following the date all these conditions are met. **Moratorium period exclusion:** If, within 1 year following the later of: • the group coverage effective date; or • the date this policy was put back in effect (reinstatement), • the insured person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism (covered or excluded under this policy), 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 (covered or excluded under this policy), no benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders and the insured person's coverage for Parkinson's disease or specified atypical parkinsonian disorders will terminate. All other Covered critical illnesses remain in force. No benefit will be payable under Parkinson's disease and specified atypical parkinsonian disorders for any other type of parkinsonism. The information described above must be reported to us within 6 months of the date of diagnosis. If this information is not provided, we have the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.
Severe burns	Severe burns means a definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist. The insured person must survive for 30 days following the date the severe burn occurred.

Covered condition	Definition
Stroke	Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with: • acute onset of new neurological symptoms; and • new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis. **Exclusions:** No benefit will be payable under this condition for: • transient ischaemic attacks; • intracerebral vascular events due to trauma; or • lacunar infarcts which do not meet the definition of stroke as described above.

We can help

- We're here to help if you have questions or need advice. Call one of our financial services consultants at **1-877-893-9893**, Monday to Friday from 8 a.m. to 8 p.m. ET. If you prefer in-person guidance and support, we can refer you to a Sun Life advisor in your area.

Life's brighter under the sun

Sun Life

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