ALLSTATE INSURANCE COMPANY OF CANADA

HOME OFFICE:
27 ALLSTATE PARKWAY, SUITE 100
MARKHAM, ONTARIO, L3R 5P8
1-844-436-1105

A Stock Company

CERTIFICATE OF INSURANCE

This certificate explains the policy of insurance underwritten by Allstate Insurance Company of Canada (called "we", "our", or "us"). It is not the contract of insurance. The policy (called “the policy”), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. Your coverage is governed by the laws of your province or territory of residence at the time your coverage becomes effective. Upon request and reasonable notice, we shall permit an insured, debtor insured, or claimant under the contract to examine, and shall furnish to that person, a copy of the policy and enrolment form.

CONSIDERATION

Your coverage under the policy is issued to you in consideration of your enrolment form and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

INSURING CLAUSE

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

THIS IS A SPECIFIED CRITICAL ILLNESS CERTIFICATE WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED ILLNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

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ALLSTATE INSURANCE COMPANY OF CANADA

27 Allstate Parkway, Suite 100 Markham, Ontario, L3R 5P8

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	
GCICNP0119	COMPREHENSIVE CRITICAL ILLNESS BENEFIT	BASIC BENEFIT AMOUNT
	INSURED MEMBER	***$25,000***
	INSURED CHILD(REN)	***$12,500***
	SECOND EVENT CRITICAL ILLNESS BENEFIT	
GCIERAC	CRITICAL ILLNESS ENHANCEMENT RIDER	
GCIALSAC	AMYOTROPHIC LATERAL SCLEROSIS (ALS) BENEFIT RIDER – SAME AS BASIC BENEFIT AMOUNT	
	SINGLE COVERAGE	

The effective date of each benefit is the Effective Date unless otherwise specified.

INSURED:

ISSUE AGE:

EFFECTIVE DATE:

CERTIFICATE NUMBER:

POLICY NUMBER: ***255-0027***

BENEFICIARY: ***AS NAMED ON ENROLMENT FORM OR OTHER BENEFICIARY DESIGNATION FORM***

GROUP CRITICAL ILLNESS COVERAGE

GENERAL PROVISIONS

This certificate, your application for enrolment, and your Certificate Specifications page constitute your evidence of coverage under the policy.

COVERAGE SUBJECT TO POLICY
The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice.

EFFECTIVE DATE OF COVERAGE
Your coverage will be effective at 12:01 a.m. on the effective date shown on the certificate of insurance issued to you.

CERTIFICATE OF INSURANCE
This certificate of insurance provides a description of the insurance provided by the policy issued to the policyholder. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

GENERAL PROVISIONS (*continued*)

ELIGIBILITY OF DEPENDENTS
Eligible dependents are your children.

A child is a person who is your natural or adopted son or daughter, a son or daughter of your current spouse, or a child otherwise in a parent-child relationship with you. The child must be dependent upon you for maintenance and support and be:
1. under twenty-one (21) years of age; or
2. under twenty-five (25) years of age and in attendance at an institution of higher learning on a full-time basis.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the certificate if we are notified within thirty-one (31) days after they become eligible.

A child born to you or your current spouse will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under this coverage.

An adopted child or child pending adoption will be covered as follows:
1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within thirty-one (31) days after the date of birth.
2. If adoption proceedings have been instituted by you within thirty-one (31) days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. Coverage shall begin from the moment of placement.

Coverage will be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

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TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is terminated;
2. the last day of the period for which any required premium payments were made;
3. the last day you are in membership;
4. the date you are no longer in an eligible class;
5. the date your class is no longer eligible;
6. the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under the policy.

We will pay covered claims arising from events that occur after the effective date of your coverage and before the termination of your coverage.

Coverage for your child will end on the issue day of the month that follows when the child: (a) reaches age twenty-one (21) or twenty-five (25) if a full-time student; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity;
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the policy/certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to the plan administrator when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the two (2) year period following the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age, or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate as of the date, age, or event so specified, and claims will not be paid.

Coverage may be eligible for continuation as outlined in the PORTABILITY PRIVILEGE provision.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

GENERAL PROVISIONS (*continued*)

INCONTESTABILITY
After two (2) continuous years from the effective date of coverage, no failure to disclose or misrepresentation of a fact, made in writing by you, can be used to void coverage or deny a claim, absent fraud.

LEGAL ACTION
No action may be brought to obtain benefits under the policy:
1. for at least sixty (60) days after proof of loss has been furnished; or
2. after the later of two (2) years from the time written proof of loss is required to have been furnished or such longer period as is afforded under applicable provincial/territorial statutory limitations currently in force.

(***FOR ONTARIO***) Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Limitations Act, 2002.*

(***FOR BC & ALBERTA***) Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act*.

CLERICAL ERROR
Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

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PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:
1. coverage under the policy terminates under the GENERAL PROVISION entitled TERMINATION OF COVERAGE;
2. we receive a written request and payment of the first premiums for the portability coverage not later than thirty (30) days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

PORTABILITY COVERAGE
The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS
Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate is the rate in effect for all covered persons of your rate class who have the same coverage. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least thirty-one (31) days before the change is to take effect.

GRACE PERIOD
The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE
Insurance under this portability privilege will automatically end on the earliest of the following dates:
1. the date you again become eligible for insurance under the policy;
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
   a. the date your insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY
If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

EXCLUSIONS AND LIMITATIONS

The policy does not pay benefits for an illness due to, or resulting (directly or indirectly) from:

1. any act of war, whether or not declared, participation in a riot, insurrection or rebellion;
2. intentionally self-inflicted injuries;
3. injury incurred while engaging in an illegal occupation or committing or attempting to commit a criminal act;
4. attempted suicide;
5. any injury resulting directly or indirectly from the use of alcohol, narcotics, or any other controlled substance or drug unless administered upon the advice of a physician;
6. participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
7. alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

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BENEFIT INFORMATION

COMPREHENSIVE CRITICAL ILLNESS BENEFIT

We pay the benefits, described below, subject to the conditions described for each benefit and all other provisions of the policy. Only the critical illnesses described below are covered. No benefits are payable for any other disease, sickness or incapacity, unless specifically stated. The amount payable for each critical illness is the percentage shown below next to that critical illness multiplied by the basic benefit amount shown on the Certificate Specifications page applicable to each covered person.

A covered person can receive benefits for each critical illness shown below only once, unless the Second Event Critical Illness Benefit is included. Once a covered person is diagnosed with a critical illness and a Comprehensive Critical Illness benefit has been paid for that critical illness, no other critical illness benefits for separate and subsequently diagnosed critical illnesses will be payable for that covered person unless the diagnoses are separated by a period of at least ninety (90) days.

Coverage remains in force until the basic benefit amount shown on the Certificate Specifications page times the percentage shown below has been paid for each Comprehensive Critical Illness individually. Once that occurs, no additional Comprehensive Critical Illness benefits are payable for that covered person, unless the Second Event Critical Illness Benefit is included.

Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. All covered critical illnesses must be diagnosed by a physician. Emergency situations that occur while the covered person is outside Canada may be reviewed and considered for approval by a Canadian physician on foreign soil or when the covered person returns to Canada.

1. **Heart Attack.** We will pay a benefit for a heart attack for a covered person provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured;
   c. the heart attack is not excluded by name or specific description; and
   d. we have not paid a Comprehensive Critical Illness benefit for a heart attack before.

Critical Illness	**Percentage of Basic Benefit Amount**
Heart Attack	100%

   Heart attack (acute myocardial infarction or AMI) means the diagnosis of the death of a portion of heart muscle as a result of inadequate blood supply as evidenced by:
   a. new electrocardiographic (ECG) changes, indicative of a myocardial infarction; and
   b. elevation of cardiac biochemical markers to levels considered diagnostic for acute infarction.

   The date of diagnosis is the date that death (infarction) of a portion of the heart muscle occurs.

   Exclusions: No benefit will be paid under this condition for:
   a. an incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroborating event; or
   b. elevation of cardiac markers to coronary angioplasty unless there are diagnostic changes of new Q wave infarction on the ECG.

2. **Stroke.** We will pay a benefit for a stroke for a covered person provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured;
   c. the stroke is not excluded by name or specific description; and
   d. we have not paid a Comprehensive Critical Illness benefit for a stroke before.

Critical Illness	**Percentage of Basic Benefit Amount**
Stroke	100%

   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:
   a. acute onset of new neurological symptoms; and
   b. new objective neurological deficits on clinical examination persisting for more than thirty (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.

COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

2. **Stroke** (*continued*)
   The date of diagnosis is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

   Exclusions: No benefit will be payable under this condition for:
   a. transient ischemic attacks;
   b. intra-cerebral vascular events due to trauma; or
   c. lacunar infarcts which do not meet the definition of stroke as described above.

3. **Major Organ Failure (Transplant or Waiting List).** We will pay a benefit if a covered person, due to a major organ failure, receives a major organ transplant or is enrolled on a major organ transplant waiting list provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured; and
   c. we have not paid a Comprehensive Critical Illness benefit for a major organ transplant or being enrolled on a major organ transplant waiting list before.

Critical Illness	Percentage of Basic Benefit Amount
Major Organ Failure (Transplant or Waiting List)	100%

   Major organ means the heart, lung, liver, kidney, or bone marrow.

   Major organ failure means a definite diagnosis of the irreversible failure of a major organ, and transplantation must be medically necessary. The diagnosis of the major organ failure must be made by a specialist.

   Major organ transplant means to undergo, due to a major organ failure, a transplantation procedure as the recipient of a major organ.

   Enrolled on a major organ transplant waiting list means to be enrolled, due to a major organ failure, as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of major organ transplant surgery.

   The date of diagnosis is the earlier of either the date the covered person: (i) undergoes the actual major organ transplant surgery; or (ii) is enrolled in the transplant centre.

4. **Kidney Failure.** We will pay a benefit for a covered person with kidney failure provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured;
   c. the kidney failure is not excluded by name or specific description; and
   d. we have not paid a Comprehensive Critical Illness benefit for kidney failure before.

Critical Illness	Percentage of Basic Benefit Amount
Kidney Failure	100%

   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. Kidney failure does not include failure of both kidneys to function caused by a traumatic event, including surgical traumas.

   The date of diagnosis is the date regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

5. **Carcinoma In Situ.** We will pay a benefit for a covered person with carcinoma in situ provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured;
   c. the cancer is not excluded by name or specific description; and
   d. we have not paid a Comprehensive Critical Illness benefit for carcinoma in situ before.

Critical Illness	Percentage of Basic Benefit Amount
Carcinoma In Situ	25%

   Carcinoma in situ means a cancer wherein the tumour cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in situ includes melanoma not invading the dermis.

(Comprehensive CI Benefit)

COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

5. **Carcinoma In Situ** (*continued*)

Carcinoma in situ must be diagnosed in one of two ways:

a. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be made by a specialist.
b. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:
   i. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
   ii. there is medical evidence to support the diagnosis.

The date of diagnosis is the date the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

As used in this section, the terms listed below have the following meanings:

First diagnosis of cancer includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is symptom and treatment-free for the twelve (12) consecutive months immediately preceding the effective date of coverage or any twelve (12) consecutive months thereafter.

Maintenance drug therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

Symptom and treatment-free means free of any symptoms (the subjective evidence of disease or physical disturbance observed by a medical professional or the patient) and treatment (medical care, prevention and management of illnesses or injuries by a physician, including the professional services of a radiologist, pathologist or other medical specialist acting within the scope of his or her medical license). For the purposes of this benefit, the treatment does not include: maintenance drug therapy and routine follow-up office visits to verify if the cancer critical illness has returned.

Exclusion: No benefit will be payable under this condition for skin malignancies other than melanoma not invading the dermis.

6. **Invasive Cancer.** We will pay a benefit for a covered person with invasive cancer provided that:

a. the date of diagnosis is after the effective date of coverage;
b. the date of diagnosis is while insured;
c. the cancer is not excluded by name or specific description; and
d. we have not paid a Comprehensive Critical Illness benefit for invasive cancer before.

Critical Illness	**Percentage of Basic Benefit Amount**
Invasive Cancer	100%

Invasive cancer means a malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Invasive cancer includes invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic.

Invasive cancer must be diagnosed in one of two ways:

a. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be made by a specialist.
b. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:
   i. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
   ii. there is medical evidence to support the diagnosis.

The date of diagnosis is the date the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

As used in this section, the terms listed below have the following meanings:

First diagnosis of cancer includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is symptom and treatment-free for the twelve (12) consecutive months immediately preceding the effective date of coverage or any twelve (12) consecutive months thereafter.

COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

6. **Invasive Cancer** (*continued*)

Maintenance drug therapy means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

Symptom and treatment-free means free of any symptoms (the subjective evidence of disease or physical disturbance observed by a medical professional or the patient) and treatment (medical care, prevention, and management of illnesses or injuries by a physician, including the professional services of a radiologist, pathologist, or other medical specialist acting within the scope of his or her medical license). For the purposes of this benefit, the treatment does not include: maintenance drug therapy and routine follow-up office visits to verify if the cancer critical illness has returned.

Exclusion: No benefit will be payable under this condition for skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic.

7. **Alzheimer's Disease.** We will pay a benefit for a covered person with Alzheimer's disease provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured; and
   c. we have not paid a Comprehensive Critical Illness benefit for Alzheimer's disease before.

Critical Illness	Percentage of Basic Benefit Amount
Alzheimer's Disease	100%

Alzheimer's disease means a definite diagnosis of a progressive degenerative disease of the brain. The covered person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning and requires a minimum of eight (8) hours of daily supervision. The diagnosis of Alzheimer's disease must be made by a specialist.

The date of diagnosis is the date a specialist establishes the diagnosis of Alzheimer's disease based on clinical and/or diagnostic findings as supported by medical records.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

8. **Parkinson's Disease.** We pay a benefit for a covered person with Parkinson's disease provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured; and
   c. we have not paid a Comprehensive Critical Illness benefit for Parkinson's disease before.

Critical Illness	Percentage of Basic Benefit Amount
Parkinson's Disease	100%

Parkinson's disease means primary idiopathic Parkinson's disease, which is characterized by a minimum of two (2) or more of the following clinical manifestations:
   a. muscle rigidity;
   b. tremor; and
   c. bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).

The covered person must require substantial physical assistance from another adult to perform at least two (2) of the following activities of daily living (ADL):
   a. Bathing—the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment;
   b. Dressing—the ability to put on, remove, fasten and unfasten all necessary clothing, braces, artificial limbs or other surgical appliances;
   c. Toileting—the ability to get to and from the toilet and complete related personal hygiene;
   d. Bladder and bowel continence—the ability to manage bowel and bladder functions, with or without any protective undergarments or surgical appliances, so that a reasonable level of hygiene is maintained;
   e. Transferring—the ability to move into and out of a bed, chair or wheelchair, with or without the use of equipment; and
   f. Feeding—the ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils.

The date of diagnosis is the date the psychiatrist or neurologist establishes the diagnosis of Parkinson's disease based on clinical and/or diagnostic findings as supported by medical records.

Exclusion: No benefit will be payable under this condition for all other types of Parkinsonism.

(Comprehensive CI Benefit)

COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

9. **Coronary Artery By-Pass Surgery.** We will pay a benefit if a covered person undergoes coronary artery by-pass surgery provided that:
   a. the date of diagnosis is after the effective date of coverage;
   b. the date of diagnosis is while insured;
   c. the surgery is not excluded by name or specific description; and
   d. we have not paid a Comprehensive Critical Illness benefit for a coronary artery by-pass surgery before.

Critical Illness	Percentage of Basic Benefit Amount
Coronary Artery By-Pass Surgery	100%

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

The date of diagnosis is the date the actual coronary artery by-pass surgery occurs.

Exclusions: No benefit will be payable under this condition for:
a. balloon angioplasty;
b. laser embolectomy;
c. atherectomy; stent placement; or
d. other non-surgical procedures.

10. **Multiple Sclerosis.** We pay a benefit for a covered person with multiple sclerosis provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for multiple sclerosis before.

Critical Illness	Percentage of Basic Benefit Amount
Multiple Sclerosis	100%

Multiple sclerosis means a definite diagnosis of at least one of the following:
a. two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
b. well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
c. a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

The diagnosis of multiple sclerosis must be made by a specialist.

The date of diagnosis is the date a specialist establishes the diagnosis of multiple sclerosis based on clinical and/or diagnostic findings as supported by medical records.

11. **Paralysis.** We will pay a benefit for a covered person with paralysis provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for paralysis before.

Critical Illness	Percentage of Basic Benefit Amount
Paralysis	100%

Paralysis means the definite diagnosis of the total and permanent loss of muscle function of two (2) or more limbs as a result of accidental injury or disease to the nerve supply of those limbs. The diagnosis of paralysis must be made by a specialist.

The date of diagnosis is the date a specialist establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

(Comprehensive CI Benefit)

COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

12. **Deafness.** We will pay a benefit for a covered person with deafness provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for deafness before.

Critical Illness	Percentage of Basic Benefit Amount
Deafness	100%

Deafness means the definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of ninety (90) decibels or greater within the speech threshold of five hundred (500) to three thousand (3,000) hertz. The diagnosis of deafness must be made by a specialist.

The date of diagnosis is the date a specialist makes an accurate certification of total and permanent hearing loss.

13. **Blindness.** We will pay a benefit for a covered person with blindness provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for blindness before.

Critical Illness	Percentage of Basic Benefit Amount
Blindness	100%

Blindness means the definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:
a. the corrected visual acuity being twenty over two hundred (20/200) or less in both eyes; or
b. the field of vision being less than twenty (20) degrees in both eyes.

The diagnosis of blindness must be made by a specialist.

The date of diagnosis is the date a specialist makes an accurate certification of total and permanent blindness.

14. **Aortic Surgery.** We will pay a benefit if a covered person undergoes aortic surgery provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured;
    c. the aortic surgery is not excluded by name or specific description; and
    d. we have not paid a Comprehensive Critical Illness benefit for aortic surgery before.

Critical Illness	Percentage of Basic Benefit Amount
Aortic Surgery	100%

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

The date of diagnosis is the date the actual aortic surgery occurs.

15. **Benign Brain Tumour.** We will pay a benefit for a covered person with a benign brain tumour provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for a benign brain tumour before.

Critical Illness	Percentage of Basic Benefit Amount
Benign Brain Tumour	100%

Benign brain tumour means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

The date of diagnosis is the date a physician determines a benign brain tumour is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Exclusions: No benefit will be payable under this condition for:
a. pituitary adenomas less than 10mm;
b. tumours of the skull; or
c. germinomas.

COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

16. **Coma.** We will pay a benefit for a covered person in a coma provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for a coma before.

Critical Illness	**Percentage of Basic Benefit Amount**
Coma	100%

Coma means the 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 ninety-six (96) hours, and for which period the Glasgow coma score must be four (4) or less. The diagnosis of coma must be made by a specialist.

The date of diagnosis is the date a specialist confirms a coma has lasted for fourteen (14) or more consecutive days.

Exclusions: No benefit will be payable under this condition for:
a. a medically-induced coma;
b. a coma which results directly from alcohol or drug use; or
c. a diagnosis of brain death.

17. **Severe Burns.** We will pay a benefit for a covered person with severe burns provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for severe burns before.

Critical Illness	**Percentage of Basic Benefit Amount**
Severe Burns	100%

Severe burns mean the definite diagnosis of third degree burns over at least twenty percent (20%) of the body surface. The diagnosis of severe burns must be made by a specialist.

The date of diagnosis is the date the severe burns occurred.

18. **Loss of Speech.** We will pay a benefit for a covered person with loss of speech provided that:
    a. the date of diagnosis is after the effective date of coverage;
    b. the date of diagnosis is while insured; and
    c. we have not paid a Comprehensive Critical Illness benefit for loss of speech before.

Critical Illness	**Percentage of Basic Benefit Amount**
Loss of Speech	100%

Loss of speech means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of accidental injury or disease. The diagnosis of loss of speech must be made by a **specialist**.

The date of diagnosis is the date a specialist makes accurate certification of total and permanent loss of speech.

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COMPREHENSIVE CRITICAL ILLNESS BENEFIT (*continued*)

19. **Heart Valve Replacement or Repair.** We will pay a benefit if a covered person undergoes heart valve replacement or repair provided that:
    1. the date of diagnosis is after the effective date of coverage;
    2. the date of diagnosis is while insured;
    3. the heart value replacement or repair is not excluded by name or specific description; and
    4. we have not paid a Comprehensive Critical Illness benefit for a heart value replacement or repair before.

Critical Illness	**Percentage of Basic Benefit Amount**
Heart Valve Replacement or Repair	100%

Heart valve replacement or repair means undergoing surgery to replace or repair any heart valve with either a natural or mechanical valve.

20. **Hip or Knee Replacement Surgery.** We will pay a benefit if a covered person undergoes hip or knee replacement surgery provided that:
    1. the date of diagnosis is after the effective date of coverage;
    2. the date of diagnosis is while insured;
    3. the surgery is not excluded by name or specific description; and
    4. we have not paid a Comprehensive Critical Illness benefit for a hip or knee replacement surgery before.

Critical Illness	**Percentage of Basic Benefit Amount**
Hip or Knee Replacement Surgery	20%

Hip or knee replacement surgery means surgery to replace either the hip or the entire knee through the procedures set out below:

1. Hip replacement qualifies if the femoral stem is replaced. This procedure is performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar); or
2. Knee replacement qualifies if all three compartments of the knee (medial, lateral, and patellofemoral compartments) are replaced. This procedure is also known as total knee replacement.

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WAIVER OF PREMIUM BENEFIT. We will waive premiums if, while this coverage is in force, the insured member is accepted and approved under the policyholder's current group life policy for total disability waiver of premium.

We will waive premiums beginning with the date the total disability waiver of premium under the policyholder's group life policy begins, and until the earliest of:

1. the date the insured member attains age sixty-five (65);
2. the date the insured member is no longer disabled due to death or recovery;
3. the date the insured member is no longer eligible for total disability waiver of premium under the policyholder's group life policy;
4. two (2) years from the date the waiver of premium under this coverage began; or
5. the date insurance ends according to the TERMINATION OF COVERAGE provision.

At the end of the period for which premiums are waived, premiums must be resumed for coverage to remain in force, if such coverage would still be in force had premiums not been waived.

This benefit is only provided for the insured member. It does not apply to any other covered person.

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OPTIONAL BENEFIT INFORMATION

SECOND EVENT CRITICAL ILLNESS BENEFIT

We will pay this benefit if a covered person is diagnosed more than once with the same critical illness for which a Critical Illness benefit was previously paid if:

1. there is more than twelve (12) months between each diagnosis;
2. the covered person did not receive treatment for that critical illness during that twelve (12) month period; and
3. the subsequent date of diagnosis is while insured.

For purposes of the cancer critical illness benefit, “treatment” does not include maintenance drug therapy or routine follow-up visits to verify if the cancer critical illness has returned.

We will pay an amount equal to one hundred percent (100%) of the Critical Illness basic benefit amount previously paid for that specified critical illness. We will only pay one Second Event Critical Illness benefit per previously paid Critical Illness.

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(Second Event CI Benefit)

CLAIM INFORMATION

NOTICE OF CLAIM
We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within twenty (20) days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at Group CI Claims, Allstate Benefits, PO Box 8100 Stn T, Ottawa, Ontario K1G 3H6, or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received from us within fifteen (15) days of the request, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM
You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF YOUR CLAIM
Written proof must be furnished to us within ninety (90) days of diagnosis of or treatment for each illness. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than one (1) year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY
We have the right, at our own expense, to have you examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

PAYMENT OF CLAIMS
After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payment to you. Any amounts unpaid at your death will be paid to the named beneficiary or, if no beneficiary is named, to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM
We have the right to recover any overpayments due to:
1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid you.

CLAIM REVIEW
If a claim is denied, we will give written notice of:
1. the reason for denial;
2. the policy provision that relates to the denial;
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

APPEALS PROCEDURE
Prior to filing any lawsuit and within sixty (60) days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial. You or your beneficiary may review our complaint handling process available on our website.

GLOSSARY

Covered person. Means any of the following:
1. you;
2. any eligible dependent named on the enrolment and acceptable for coverage by us;
3. any eligible dependent added by endorsement after the effective date; or
4. a newborn child.

Enrolment form. Means your application and any written statement or other record, not otherwise part of the application, provided to us as evidence of your insurability under the policy.

Family coverage. Means coverage that includes you and your eligible children. May also mean coverage that includes only you, as defined.

Grace period. Means a period of thirty-one (31) days following the premium due date during which premium payment may be made.

Illness. One of the specified critical illnesses listed in the certificate.

Injury. Means accidental bodily injury sustained by a covered person while coverage under the policy is in force.

Insured member. Means a member accepted for coverage by us who has completed and signed the enrolment form and whose name appears on the Certificate Specifications page.

Material and substantial duties. Means duties that:
1. are normally required for the performance of your regular occupation; and
2. cannot be reasonably omitted or modified, except that if you are required to work on average in excess of forty (40) hours per week. We will consider you able to perform that requirement if you are working or have the capacity to work forty (40) hours per week.

Member. Means a member in good standing in a labor union, association, or other entity named as the policyholder and who is:
1. a citizen or permanent resident of Canada; and
2. is engaged in, or able to engage in and currently seeking, active employment.

Payable claim. Means a claim for which we are liable under the terms of the policy.

Physician. Means:
1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the province he or she practices in.

We will not recognize you, or your spouse, children, parents, or siblings as a physician for a claim.

Policyholder. Means the legal entity to whom the policy is issued.

Sickness. Means an illness or disease that must begin while covered person is covered under the policy.

Single coverage. Means coverage that includes only you, as defined. May also mean coverage that includes only you, as defined, and eligible children.

Specialist. A licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist, and as approved by us, a condition may be diagnosed by a qualified medical practitioner practising in Canada or the United States of America. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, and burn specialist.

We will not recognize you, or your spouse, children, parents, or siblings as a specialist for a claim.

Treatment. Means consultation, care, or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

We, us, and **our.** Means Allstate Insurance Company of Canada.

You, your, and **yours.** Means the insured member covered under the policy and for whom a certificate of insurance has been issued.

ALLSTATE INSURANCE COMPANY OF CANADA

Home Office: 27 Allstate Parkway, Suite 100, Markham, Ontario, L3R 5P8

CRITICAL ILLNESS ENHANCEMENT RIDER

This rider is issued in consideration of the rider premium and your request for this rider. Benefits are subject to all of the terms, conditions and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Continuous hospital confinement. Means one continuous confinement or two or more hospital confinements not separated by more than thirty (30) days. If there are more than thirty (30) days between confinements, they are considered separate confinements.

Hospital. Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and twenty-four (24) hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Non-local. Means more than one hundred twenty-five (125) kilometres one-way from the covered person's home to the treatment facility using the most direct route possible.

Rider date. Means the certificate's effective date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

BENEFIT INFORMATION

Second Consultation
If surgery or treatment is recommended by a physician for a covered critical illness and the covered person chooses to obtain a consultation with a second physician, we pay $1,000. This consultation must be: rendered prior to surgery or treatment being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

Non-Local Transportation
We pay the following benefit for transportation to receive treatment for a covered critical illness at a non-local hospital (inpatient or outpatient) or any other non-local specialized freestanding treatment centre: (1) $500 for round trip airfare; or (2) $0.30 per kilometre, up to one thousand five hundred (1,500) kilometres, for round trip personal vehicle transportation. Distance is measured from the covered person's home to the treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment. This benefit is limited to $5,000 per twelve (12) month period beginning with the first day of benefit under this provision.

Outpatient Lodging
We pay a daily lodging benefit when a covered person receives treatment for a covered critical illness on an outpatient basis at a non-local treatment facility. The benefit is $100 per day during treatment for a single room in a motel, hotel, or other accommodations acceptable to us. This benefit is limited to $1,000 per twelve (12) month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than one hundred twenty-five (125) kilometres from the covered person's home.

BENEFIT INFORMATION (*continued*)

Family Member Lodging and Transportation

We pay the following benefits for one adult member of the covered person's family to be near the covered person, when they are confined in a non-local hospital for specialized treatment for a covered critical illness:

1. *Lodging* - $100 per day for a single room in a motel, hotel, or other accommodations acceptable to us. This benefit is limited to $1,000 per twelve (12) month period beginning with the first day of benefit under this provision; and
2. *Transportation* - $500 for round trip airfare or a personal vehicle allowance of $0.30 per kilometre, up to one thousand five hundred (1,500) kilometres per continuous hospital confinement. Distance is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the personal vehicle allowance in the Family Member Transportation benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit, when the family member lives in the same city or town as the covered person. This benefit is limited to $5,000 per twelve (12) month period beginning with the first day of benefit under this provision.

EXCLUSIONS

The Exclusions provision in the certificate applies to this rider.

TERMINATION

This rider terminates at the earliest of:

1. the date the certificate is canceled;
2. the date the group policy is canceled;
3. the last day of the period for which any required premium payments were made;
4. the last day you are in membership;
5. the date you are no longer in an eligible class;
6. the date your class is no longer eligible; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this rider.

Secretary

President

ALLSTATE INSURANCE COMPANY OF CANADA

Home Office: 27 Allstate Parkway, Suite 100, Markham, Ontario, L3R 5P8

AMYOTROPHIC LATERAL SCLEROSIS BENEFIT RIDER

This rider is issued in consideration of your request for this rider. Benefits are subject to all of the terms, conditions, and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Rider date. Means the certificate's effective date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by us in accordance with our coverage dating rules in effect at the time this rider is issued.

BENEFIT INFORMATION

We pay this benefit subject to the conditions described for the benefit and all other provisions of the certificate. Only the critical illness described below is covered under this rider. No benefits are payable for any other disease, sickness, or incapacity, unless specifically stated. The amount payable for this benefit is the percentage shown below multiplied by the basic benefit amount shown on the page 3 applicable to each covered person.

Amyotrophic Lateral Sclerosis (ALS). We will pay a benefit for a covered person with ALS provided that:

1. the date of diagnosis is after the rider date;
2. the date of diagnosis is while insured; and
3. we have not paid a benefit for ALS before.

Critical Illness	Percentage of Basic Benefit Amount
ALS	100%

ALS means a progressive neuromuscular disease which causes the death of neurons controlling voluntary muscles, characterized by muscle stiffness, twitching, and progressively worsening weakness. The diagnosis of ALS must be made by a specialist.

The date of diagnosis is the date a specialist establishes the diagnosis of ALS based on clinical and/or diagnostic findings as supported by medical records.

Exclusion: No benefit will be payable under this condition for all other motor neuron diseases.

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations provision in the certificate applies to this rider.

TERMINATION

This rider terminates at the earliest of:

1. the date the certificate is canceled;
2. the date the group policy is canceled;
3. the last day of the period for which any required premium payments were made;
4. the last day you are in membership;
5. the date you are no longer in an eligible class;
6. the date your class is no longer eligible; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this rider.

Secretary

President

GCIMALSAC