RBC Life Insurance Company

Underwriting Guidelines for Individual Disability Insurance and Critical Illness Insurance (12/04)

RBC Insurance

UNDERWRITING GUIDELINES

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INTRODUCTION TO THE UNDERWRITING GUIDELINES (04/04)

This manual is a reference for key underwriting guidelines, limits and requirements. It contains a wealth of information pertaining to most aspects of underwriting including new applications, policy changes and reinstatements.

Just as each applicant is unique, so is each application for disability and critical illness insurance. It is expected that this manual will provide guidelines that are useful in most situations. However, each application will be assessed based on all aspects of the case and an appropriate underwriting decision will be determined by the underwriter.

The process of underwriting disability and critical illness applications is dynamic. Should you encounter a situation that is not referenced in these guidelines, we encourage you to discuss it with your sales representative or with our underwriting department prior to submitting an application.

Throughout this book, you will notice dates after the title for each section. This represents the date that particular section was last updated. For instance: “Medical Underwriting Requirements (03/04)”, this section was updated in March 2004.

PRODUCT INFORMATION (04/04)

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SUMMARY - BUSINESS PRODUCTS (04/04)

Plan & Plan Number	Benefit Period (B/P)	Occupation Classes	Maximum Issue Ages*	Elimination Periods (E/P)	Available Optional Benefits**
Business Overhead Expense (906)	15, 24 months (AMI to 180th day is also available using H721)	4A, 3A, 2A, A	60	15***, 30, 60 or 90 days ***15 day E/P not available to class A	Additional Covered Overhead Expense Rider (H721) Future Covered Monthly Expense Option Benefit - FCEO (H862) Health Care Profession Benefit - HCP (H1134) Extended Partial Disability Injury and Sickness Benefit (H782) **OR** Residual Disability Benefit (H856)
Disability Buy Sell	Monthly Instalments or Flex Funding	4A, 3A, 2A	60	360, 540, 720 days	Business Insurance Option -BIO
Business Loan Protector (958, 958L)	24 months Lump sum paid at 365, 540, 730 days	4A, 3A, 2A, A Lump sum not available to class A	55	30, 60, 90 days (Periodic Pay) 365 days (Lump sum pay-out at 365, 540, 730 days)	Health Care Professional Benefit - HCP (H1134)
Key Person Protector (933)	12 months	4A, 3A, 2A	55	60, 90 days	Health Care Professional Benefit - HCP (H1134)

* For details of Overage Limits, please refer to the Application Completion and Policy Delivery section.
** For full details regarding eligibility, please refer to the Underwriting Optional Benefits section.

SUMMARY - INDIVIDUAL DISABILITY PRODUCTS (04/04)

Plan & Plan Number	Benefit Period (B/P)	Occupation Classes	Maximum Issue Ages*	Elimination Periods (E/P)	Available Optional Benefits**
Professional Series Level Premiums (964) Step-Rate (965)	2 years 5 years to age 65	4A, 3A, 2A	60 for level premiums 35 for step-rate	30, 60, 90, 120, 180, 365, 730*** days ***not available with 2 year B/P	Future Income Option Benefit - FIO (H899) Future Income Option Benefit for Young Professional - FIO (H1145) Cost of Living Adjustment Benefit – COLA (H1001) Disability in Your Occupation Benefit (H897) Accidental Death and Dismemberment Benefit (H702) First Day of Hospitalization Benefit (H880) Health Care Profession Benefit - HCP (H1134 or H1135 if included with H897) Additional Monthly Indemnity (AMI)
Quantum Level Premiums (918) Step-Rate (919)	2 years 5 years to age 65	4A, 3A, 2A	60 for level premiums 35 for step-rate	30, 60, 90, 120, 180, 365, 730*** days ***not available with 2 year B/P	Future Income Option Benefit - FIO (H899) Cost of Living Adjustment Benefit – COLA (H1006) Health Care Profession Benefit - HCP (H1136) Additional Monthly Indemnity (AMI)
Foundation Series Level Premiums (966) Step-Rate (967)	2 years 5 years to age 65 (10 years also available for classes A & B only)	4A, 3A, 2A, A, B for level premiums 4A, 3A, 2A for step-rate	60 for level premiums 35 for step-rate	30, 60, 90, 120, 180, 365, 730*** days ***not available with 2 year B/P	Future Income Option Benefit - FIO (H899) Cost of Living Adjustment Benefit – COLA (H1002) Enhanced Definition of Disability Benefit (H884) Partial Disability Benefit: short-term partial (H892) or long-term partial (H893) Accidental Death and Dismemberment Benefit (H702) First Day of Hospitalization Benefit (H880) Health Care Profession Benefit (H1134) Additional Monthly Indemnity (AMI)
Bridge Series	2 years 5 years to age 65	4A, 3A, 2A, A, B	60	30, 60, 90, 120, 180, 360, 720*** days ***not available with 2 year B/P	Cost of Living Adjustment Rider (COLA) Future Insurance Option Benefit (FIO) Partial Disability Benefit (short-term partial or long-term partial benefit) Regular Occupation Extension Hospitalization Benefit Additional Monthly Indemnity (AMI)
Retirement Protector (945)	10 years (classes A, B only) to age 65 (classes 4A, 3A, 2A only)	4A, 3A, 2A, A, B	55	90 days only	Health Care Profession Benefit (H1134)

* For details of Overage Limits, please refer to the Application Completion and Policy Delivery section.
** For full details regarding eligibility, please refer to the Underwriting Optional Benefits section.

SUMMARY - CRITICAL ILLNESS INSURANCE PRODUCTS (04/04)

Plan Type	Plan Code	Issue Ages
Term 10 (non-cancellable) convertible to age 65, renewable to age 75	936	18 - 64
Level premiums to age 65 (guaranteed renewable)	957	2 - 60
Level premiums to age 75 (guaranteed renewable)	959	2 - 65
Level premiums to age 75 (guaranteed renewable) - for voluntary GSI only	979	18 - 65
Level premiums to age 75 (non-cancellable)	947	2 - 65
Level premiums to age 100 (non-cancellable)	980	2 - 65

Optional Benefit	Issue Ages	Availability
Return of Premium on Expiry Rider	2 - 60 except 18 - 60 for Term 10 plan	Available on all Plans except the Term 100 Plan – see Return on Death provision built-in to the policy
Scheduled Increase Benefit Rider	2 - 45	Available on all Plans with an original benefit amount that is less than $500,000, except Term 10 Plan
Disability Waiver of Premium Rider	18 - 55	Available on all Plans
Functional Independence Rider	18 - 55	Available on all Plans except Term 10 Plan

APPLICATION COMPLETION AND POLICY DELIVERY GUIDELINES (05/04)

The following pages provide important information concerning application completion and how business can be processed correctly and within the shortest time-frame possible. The purpose of this section is to establish a common ground of understanding regarding rules and principles involved in processing of applications. Please read this section carefully. The information will be of great assistance.

Proper application completion is one of the most important factors in the processing and ultimate issuance of a policy. The underwriter must make decisions based on the information contained in the application. The quality and detail of the information supplied has a direct impact on the need to obtain additional underwriting requirements and contributes greatly to resulting time service delays and expenses. The application is the most important reference document and in many instances, provides all the information needed. It is important to make sure that complete, accurate, first hand information is provided.

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APPLICATION (05/04)

The application identifies the proposed insured, specifies the type of policy and benefits applied for, and supplies certain underwriting information such as details of other coverage in force and recently applied for and basic financial data in addition to the medical history of the proposed insured. The application also contains more specific details required for underwriting specialized plans or unusual situations. The application has been designed to contain the fewest questions possible within the bounds of reasonable selection. All application questions must be asked of the applicant and all answers provided must be faithfully and completely recorded. Any statement made to the producer that is not recorded in the application will not bind the company.

An application is valid for 120 days.

APPLICATION & ANSWERS TO QUESTIONS (05/04)

- It is preferable that the application be completed at the time of the producer's direct interview with the applicant.
- The producer must ask all questions with care and the answers must be inserted in full.
- The application may be completed in the course of a telephone conversation between the producer and the applicant. The producer must complete the application by recording the responses of the applicant to the questions on the application; the producer then sends the application to the Proposed Insured/Proposed Owner. Upon receipt of the application, the Proposed Insured/Proposed Owner reviews the application, signs as Proposed Insured/Proposed Owner and completes the first signature section. An adult who is not related to the Proposed Insured/Proposed Owner must witness the signature(s) of the Proposed Insured/Proposed Owner. The application is then returned to the producer who signs and completes the Producer Declaration. If an application is completed by mail, the Producer must be licensed in the province or territory where the applicant is located on the date the application is taken.
- All questions must be answered before the application is signed. Any change, addition or deletion to the applicant's part of the application must be made in the presence of the applicant and **initialled by the applicant in acceptance of these changes**.
- No one may add to, delete, alter or amend any information on those pages after the application is signed.
- Under no circumstances may blank applications be signed.

Conscientious attention to these factors will speed up policy issue and help avoid problems at claim time. No application may be taken in a province or country in which the producer is not licensed to write business at the date the application is taken. Also, we cannot accept applications on a non-resident of Canada.

AUTHORIZATION (05/04)

It is essential that the authorization portion of the application be signed and dated on both trial and regular applications. We are unable to process any application where the authorization has not been signed, nor can we process any application where the authorization has been restricted, or amended in any way.

CONCURRENT GSI AND FIO APPLICATIONS OR CONCURRENT GSI AND FULLY UNDERWRITTEN APPLICATIONS (04/04)

CONCURRENT FIO AND GSI APPLICATIONS:

We occasionally receive a new GSI application either concurrent with or shortly after receiving an FIO application on the same individual. Usually, the GSI application qualifies for a larger discount than the original policy with the FIO. Often, the broker submitting the new application is different than the one requesting the FIO election. The new GSI application is usually accompanied by a request from the broker/client to cancel the recent FIO election as the client does not qualify for both the FIO option amount and the new GSI policy.

Our guidelines state that 'a make-over is required if applying for additional coverage within six months of reducing coverage on an existing policy, including the reversal of any FIO increase which was exercised within the six months immediately preceding the application for more coverage'.

These situations will be dealt with based on the following guidelines:

- If the FIO has been approved and placed (most are placed upon 'issue'), we will not cancel/reverse the FIO. If the GSI application includes a Large Case Discount, we cannot make-over the existing policy. If the Insured qualifies for coverage in addition to the FIO, a new GSI policy for this amount can be issued with the higher discount. Otherwise, the GSI application will be declined. We can change the agent of record, if requested by the insured.

- If the FIO is still pending when we receive the new GSI application, we will use the 'second application in' rule. Generally this would mean the FIO application takes precedence as it was received first. However, if we receive a letter of direction from the client indicating that they do not wish to proceed with the FIO and want to proceed with the GSI, change the broker etc., we will honour that request.

FULLY UNDERWRITTEN APPLICATIONS SUBMITTED TO MAKE-OVER A GSI APPLICATION:

We often receive applications for fully underwritten coverage either concurrently or very shortly after a GSI has been applied for on the same individual. This new application is often intended to replace the GSI with a fully underwritten policy containing more coverage or optional benefits not available under the GSI offer.

These situations will be dealt with based on the following guidelines:

- The GSI policy will be issued first and allowed to place.

- The fully completed non-GSI application will then be underwritten and issued as a make-over of the GSI policy.

- Underwriting can begin on the fully underwritten application prior to placement of the GSI policy but the GSI policy must be placed before the fully underwritten policy can be issued.

CONDITIONAL INSURANCE AGREEMENT (CIA) (05/04)

INDIVIDUAL DISABILITY INSURANCE PRODUCTS

If at least a minimum payment is paid with the application, the applicant is covered under the Conditional Insurance Agreement if the applicant is an insurable risk. In other words, if the applicant is a decline for any reason (income, occupation or medical history) on the date of application, there is no coverage under the CIA.

Minimum payment is defined as an initial deposit of one month's premium for monthly premium mode and 10% of the annual premium for all other modes. The cheque or money order must be made payable to **RBC Life Insurance Company** and collected at the time of application.

Coverage under the CIA is effective on the later of:

- The date we receive the minimum payment; or
- The date of completion of the application and all medical examinations and supplementary tests which we may require according to our underwriting guidelines and practices; or
- The date of issue requested by the proposed owner at the time of application.

Coverage under the CIA is subject to the following:

- We must receive at least the minimum required deposit; and
- Completion of the application and all medical examinations and supplementary tests which we may require according to our underwriting guidelines and practices; and
- The proposed insured is insurable, according to our underwriting guidelines and practices, under any policy we currently offer; and
- A licensed producer or agent has signed the producer declaration.

There is no coverage under the CIA, if:

- Either question 11a or 11b of "Part 2: Medical History" of the application is answered "yes" or left blank; or
- There is any material misrepresentation on the application; or
- Death is by suicide; or
- The applicant is not insurable according to our underwriting guidelines and practices under any policy currently offered by us.

Application with no routine medical requirements:

If an applicant is insurable on a standard or substandard basis, he is covered under the CIA (subject to its terms and conditions) from the date of the application if there are no routine age & amount medical requirements, subject to the conditions outlined above.

Application with routine medical requirements:

If the amount of coverage applied requires a urine/HIV, blood profile or paramedical according to our published medical requirements, the CIA coverage does not begin until the date the necessary requirement(s) are completed. If more than one requirement is needed (urine/HIV & a paramedical) and these are completed on different days, coverage under the CIA starts when the final requirement is completed by the applicant. The reason for this is that coverage under the CIA is only available to insurable risks as stated above. Until all the routine requirements have been completed, we cannot determine if the applicant is an insurable risk.

Examples (assuming minimum payment has been made):

- If a 53 year old applies for $2,000/mth, there are no routine requirements published; therefore, the coverage under the CIA begins on the application date.
- If a 35 year old applies for $4,500/mth, we routinely require a urine specimen; therefore, the coverage under the CIA begins on the date the urine specimen is collected from the client.

Termination of the Conditional Insurance Agreement:

If conditional insurance becomes effective, it will terminate on the earliest of the following:

- The date that any policy issued as a result of the application is delivered to the applicant and comes into effect; or
- 90 days from the effective date; or
- The date that we write to advise that we are unable to approve the issuance of a policy.

The terms of the CIA are NOT affected by discretionary requirements such as a PHI, MVR or APS.

Please refer to the Receipt and Conditional Insurance Agreement sections of the applications for exact wording of the terms and conditions of the Conditional Insurance Agreement.

CRITICAL ILLNESS RECOVERY PLANS

The wording and conditions attached to this agreement provide a limited amount of temporary insurance during the underwriting process.

The Conditional Insurance Agreement on Critical Illness Insurance does not protect an applicant's insurability, as is the case with Disability Insurance.

Coverage is not conditional upon completing routine age and amount medical requirements to satisfy the Conditional Insurance Agreement as it is for Disability Insurance.

An applicant must meet the eligibility criteria set out in the Application for Conditional Insurance and temporary coverage is subject to the terms and conditions of the Conditional Insurance Agreement.

When an application is submitted as a make-over, unlike Disability Insurance, there is no Conditional Insurance in effect unless the applicant meets the eligibility criteria set out in the Application for Conditional Insurance and a premium deposit is collected. The temporary coverage is subject to the terms and conditions of the Conditional Insurance Agreement.

Please refer to the Application for Conditional Insurance on Critical Illness Applications and the Conditional Insurance Agreement and receipt on Critical Illness Applications for complete details of all terms and conditions.

DATING (04/04)

- The date shown on the application must be the date that the application was taken. This date may not be changed under any circumstances. All policies are issued with a current date unless an alternate specific date is requested (such as 'to save age' dating or replacement dating).

- Current dating is defined as 5 business days from the date the policy is issued by us except for the Bridge Series and Disability Buy Sell contracts where the issue date is the same date that we issue the policy. Bridge and Buy Sell contracts cannot be future dated.

- We do not date policies the 29th, 30th or 31st of the month. To avoid these dates, coverage will be dated the first of the next month.

- Money will not be accepted on a COD application after the application date.

- All COD policies will require signed statements before delivery of the policy to confirm that there has been no change in the applicant's health and no changes to the answers given to the questions on the application.

- If the minimum payment, or more, is paid with the application, the policy will also be currently dated. If the applicant becomes disabled while we are underwriting and is covered under the Conditional Insurance Agreement, that policy will be dated in accordance with the terms of the Conditional Insurance Agreement.

- There is great value in obtaining a deposit at the time of application in order to provide maximum protection to the applicant under the terms of the Conditional Insurance Agreement.

- A make-over will be dated "on-cycle" with the policy being made-over. Except for Critical Illness (see CI Guidelines), applications for make-overs are considered paid for applications as any unearned premium on the existing policy is considered to be a deposit on the new application. A lapsed make-over will be dated currently as outlined above.

- Specific dating requests must be provided at the time of application or at least prior to approval of the policy. In order to save a younger age, we will backdate a policy a maximum of 30 days before the application date. We will currently date coverage unless we are specifically requested to save age.

- An application which is to replace existing coverage with another carrier will be dated the replacement date of the existing policy to avoid any duplication of premium or any lapse of coverage. Replacement dating must be requested on the application and the exact replacement date must be indicated. Replacement dating cannot be more than 90 days from the application date.

- All applications will be filed incomplete 90 days after the application date and any premium deposit will be refunded to the proposed policy owner. Any filed incomplete application which is subsequently reopened will be COD as any initial deposit has already been refunded. A filed application which is reopened and approved will be dated currently unless save age dating or replacement dating has been requested.

INSURANCE AGE (05/04)

Except for the Bridge Series and Disability Buy Sell contracts, where age is calculated based on the last birthday, age is calculated based on the nearest birthday rather than the last birthday. For example, if an applicant's date of birth is December 24, 1960 and he/she applies for insurance on July 29, 2004, insurance age is 44 (even though the applicant will not turn 44 until the following birthday). It may be helpful to remember that if an applicant applies for coverage six months and one day after his/her last birthday, the age at the next birthday should be used to calculate rates.

It is possible to date coverage as much as 30 days before the actual application date for the purposes of retaining the younger age. A request to "save age" should be indicated on the application.

LACK OF CANDOUR (05/04)

Non-disclosure of material information at the time of application is a serious underwriting concern.

These situations require a substantial investment of time, resources and expense, to ensure that all relevant facts are developed prior to making an offer for insurance coverage. As a result, these situations can negatively effect underwriting resources, which could otherwise be devoted to processing quality business. Additionally, they can present an increased risk, as any significant omission at time of underwriting calls into question the legitimacy of all information contained in the application for insurance. To deter this practice, cases where an applicant has failed to disclose significant information on their application will be declined for lack of candour.

To ensure consistent and fair treatment, prior to communication of a decline, all cases where significant non-disclosure is discovered during the underwriting process are reviewed by senior members of the Underwriting Department.

LEGAL DOCUMENT (06/95)

The application forms part of the policy contract, which is a legal document. The legal rights of both the proposed insured and the company are governed by the application if legal problems subsequently arise.

LEGIBILITY (10/99)

Applications must be completed in ink, preferably blue or black. Legible handwriting speeds underwriting by avoiding the need for clarification. Typewritten applications or applications completed in different pens cannot be accepted. Answers must never be whited out or written over. An answer too lengthy for the space provided may be continued on a clearly identified separate piece of paper attached to the application or continued in the remarks/comments section which should be signed and dated by the applicant.

MEDICAL HISTORY (06/95)

The applicant's medical history is one of the largest contributors to total underwriting time. In answering the questions, it is absolutely essential that the information be complete and clear. The medical history should identify not only the medical problem, but also the symptoms, diagnosis, treatment, date of occurrence, duration of symptoms, time lost from work and name and address of all physicians.

MIB PRE-NOTICE AND CONSUMER'S FACT SHEET (06/95)

The Medical Information Bureau (MIB) pre-notice and consumer's fact sheet must be detached from the application and given to the applicant when the application is signed. This must be done in all cases even though it may not be anticipated that an investigative consumer report or some other type of investigation will be completed during underwriting. The pre-notice & fact sheet provides the proposed insured with written notice concerning the MIB and our personal history interview (PHI) process.

MINIMUM AND MAXIMUM AGE LIMITS (05/04)

Please refer to the details of the specific plans in the product Profiles. The availability of rates indicates the minimum and maximum ages at which each of our disability products is available.

MINIMUM POLICY SIZE (05/04)

INDIVIDUAL DISABILITY POLICIES

The minimum individual disability policy we issue is $450 of total monthly indemnity. This amount may be made up of a basic indemnity of $450 only or a minimum basic indemnity amount of $150 plus an additional monthly indemnity (with benefit period longer than six months). After the minimum policy size requirement has been met, indemnities may be considered in increments of $25.

CRITICAL ILLNESS RECOVERY PLAN POLICIES

The minimum critical illness policy we issue is $10,000. After the minimum policy size requirement has been met, indemnities may be considered in increments of $1,000.

NAMES (05/04)

The name of the Proposed Insured must be printed clearly, accurately and shown as the person is legally known. Proper titles must be given. The contract and all records pertaining to it are written as the name appears on the application. The policy, when issued, will generally show the name in the usual form: first name, middle initial, last name. Ensure that all former name(s) are indicated. Note in the remarks section of the application any name change since the last application.

OCCUPATION AND DUTIES (06/95)

The applicant's eligibility for certain types of policies and benefits, and the resulting premium charged, are directly influenced by the occupational class. Occupational duties more accurately describe an applicant's work and position than just an occupational title, and should be described carefully. A clear, complete, and accurate description will, in most cases, give the underwriter sufficient information to make the proper occupational classification without having to ask for further details.

OVERAGE LIMITS (05/04)

We recognize that occasionally the need may arise to prepare a proposal for an applicant who is beyond the maximum issue age of our published rates. To accommodate these situations, your local office has been provided with rates that may be quoted in competitive sales situations involving quality business.

The rates our local offices have are available subject to the following criteria:

- There must be other supporting, non-exceptional business being written (e.g. other partners, a family member, other select group members);
- The business must originate from an established producer; and
- There must be no concerns regarding the health, finances or employment stability of the applicant.

A written summary must accompany the application covering these points and any other reasons for considering coverage on an overage applicant.

No optional benefits are available on overage coverage. Additional Monthly Indemnities (AMI's) are allowed, they are not considered to be an optional benefit.

An overage rate quote does not commit us to issue coverage. A final decision will depend on the results on the complete underwriting file.

THE ONLY PLANS CONSIDERED FOR OVERAGE PROPOSALS ARE:

Plan	Issue Age	Benefit Period	Elimination Period (days)	Occupation Class	Issue & Participation Limits
Business Overhead (906)	61 - 63	15 months	30, 60, 90	4A 3A	$20,000 $15,000
Professional Series (964)	61 - 63	2 years	30, 60, 90, 120	4A 3A 2A	$8,000 $6,000 $3,000
Quantum (918)	61 - 63	2 years	30, 60, 90, 120	4A 3A 2A	$8,000 $6,000 $3,000
Foundation Series (966)	61 - 63	2 years	30, 60, 90, 120	4A 3A 2A A B	$8,000 $6,000 $3,000 $2,500 $1,500
Bridge Series	61 - 63	2 years	30, 60, 90, 120	4A 3A 2A A B	$8,000 $6,000 $3,000 $2,500 $1,500

POLICY DELIVERY (05/04)

When the policy is delivered, any outstanding balance of premium and other specified delivery requirements such as a signed statement, etc., must be collected and submitted to the Company in order to place the policy.

If the Proposed Insured is unable to sign the signed statement as issued or if there is any alteration made to the signed statement, the policy and the altered signed statement must be returned to the Company with full details. The Underwriting Department will advise whether this new information has any impact on the coverage originally issued.

With COD applications, the policy must be delivered on or after the policy date. This rule also applies to replacement policies that have advanced dating.

VERIFICATION THAT THERE HAS BEEN NO CHANGE IN THE INSURABILITY OF THE PROPOSED INSURED SINCE THE DATE OF APPLICATION:

A policy may only be delivered if, following the date of application, there has been no change in the applicant's health and no change to the answers given in response to the application questions. If any change has occurred, the policy cannot be left with the applicant nor can any premiums be collected. The policy must be returned to the Company immediately, along with full details of the new information, including the full names and addresses of any medical practitioners or medical facilities consulted. The underwriting department will advise whether the new information has any impact on the coverage originally issued.

In signing the application, the producer agrees that prior to delivery of the policy the producer will confirm with the owner/insured that "there have been no changes in the insurability of the Proposed Insured since completing [the] Application". This replaces the former requirement for the producer to physically meet with the insured/owner at the time of delivery of the policy to certify that there has been no change of insurability at the time of delivery. The producer declares that he/she will only deliver the policy to the insured/owner after **asking** if, since the date of completion of the application:

- the Proposed Insured has experienced **a change in health**; or
- there are **any changes to the answers given in response to the questions** on the application.

This verification is required whether a policy is delivered in person or by mail. It is in the best interest of the client and the producer to address this matter prior to delivery rather than much later in the event of a claim.

DELIVERY OF THE POLICY BY MAIL:

If the policy is **issued as applied for with no delivery requirements** such as a signed statement on delivery, the producer may deliver the policy by mail.

If the policy is **issued with amendments or other delivery requirements**, such as a signed statement on delivery, the producer may choose to:

- meet with the insured/owner to fulfill the delivery requirements and deliver the policy at that time; or
- send the delivery requirements **first** to the insured/owner for completion/return and **then** deliver the policy by mail only after the producer has received the completed delivery requirements.

Regardless of the method of delivery, the producer must verify that there has been no change in the insurability of the Proposed Insured prior to delivery of the policy.

POLICY NOT TAKEN (06/95)

The policy must be delivered as soon as possible. If the policy has not been delivered and all placement requirements received by us within sixty days of the mailing date, the policy will be automatically marked "not taken". Once a policy has been marked "not taken", a current application may be required before we can consider issuing a new policy, depending on the date of the original application.

PREPAYMENT WITH APPLICATION (05/04)

One of the surest ways to avoid "not taken" policies is to collect the first premium with the application. Obtaining a deposit with the application also provides coverage in accordance with the terms of the Receipt and Conditional Insurance Agreement while the application is pending. Please refer to the Conditional Insurance Agreement section of the Guidelines.

The minimum prepayment is one month's premium for pre-authorized cheque (PAC) mode or 10% of the annual premium for all other payment methods.

The deposit must be made by personal cheque or money order. It is advisable that the pre-authorization form be submitted along with the application and one month's deposit. If sufficient premium is on deposit, and no other requirements are needed to place the policy, the policy will be considered placed upon issue for purposes of releasing commissions.

Except for Critical Illness, if a make-over application is taken, any unearned premium will bind the Company under the terms of the Conditional Insurance Agreement. Whenever a make-over application is taken or prepayment is made with the application, the Receipt and Conditional Insurance Agreement must be used, signed by the producer and given to the applicant.

All premium cheques must be made payable to **RBC Life Insurance Company**. They must not be made payable to the producer nor may the payee section be left blank.

A producer may not advance his or her own funds as prepayment on behalf of the applicant for insurance.

If the application is rejected or filed incomplete, the premium will be returned directly to the Proposed Policy Owner immediately with a letter of explanation. A copy of the letter is also sent to the producer.

PRIVACY (05/04)

Privacy is important and we are committed to protecting personal information we collect, use and disclose. Except where allowable or required by law, we adhere to the following principles:

We will be accountable for our personal information practices.

We will identify the purpose(s) for which personal information is collected at or before the collection of information.

We will obtain appropriate consent prior to the collection, use or disclosure of personal information.

We will limit our collection of personal information to that which is necessary to fulfill the purposes identified.

We will not use or disclose personal information for a purpose other than a purpose for which it was collected unless we have appropriate consent.

We will retain personal information as long as necessary for the fulfillment of the specific purposes(s) for which it was collected.

We will maintain personal information as accurate, complete and up-to-date as is necessary and appropriate.

We will protect personal information by security safeguards that are appropriate to the sensitivity of the personal information and our business environment.

We will be open about our personal information practices.

We will, upon appropriate written request, inform an individual of the existence, use and disclosure of their personal information and will provide an individual with appropriate access to their personal information. If access to personal information is refused, we will provide a written explanation of the refusal.

We will investigate all complaints about our personal information practices.

PRODUCER REPORT (06/95)

The producer should bring to the attention of the Company all information, which might affect the liability of the Company, or its judgement, in making an underwriting decision. The producer must not omit histories or facts that may seem unimportant, if required by the wording of a question. In addition, the producer may be aware of information not specifically asked for on the application, such as home or work environment, avocation or unusual work hazard, etc., but which may affect the underwriting decision. This should be included on the application. To a large extent, the quality of business and producer's claim rate will depend on the field selection standards. The Company expects the producer to report both unfavourable and favourable features of the risk.

REPLACEMENT (06/95)

The replacement questions on the application must be answered in all cases. The producer must include the date by which the in force coverage will be discontinued. Note that "upon issue" is not an acceptable answer; the underwriter will have to ask for a specific date. In many cases, this will delay issue of the policy.

Overinsurance has been an area of concern for the Company for many years. In replacement cases, the failure of an applicant to discontinue existing coverage often results in an overinsurance situation. In order to minimize this problem the following guidelines are to be followed in replacement situations:

- The date by which the other coverage will be discontinued must be noted on the application in the section entitled "existing and pending coverage".
- A replacement policy will be dated to coincide with the cancellation of other coverage. This dating may not be more than ninety days from the application date.

REPLACEMENT AND DISCLOSURE FORMS FOR INDIVIDUAL DISABILITY AND CRITICAL ILLNESS COVERAGE (03/05)

Province of Quebec

In the Province of Quebec, insurance representatives must complete replacement forms where the purchase of an insurance contract is likely to result in the termination, cancellation or reduction in benefits of another Individual Life, Individual Disability or Critical Illness contract.

This provision of the Quebec Regulation Respecting the Pursuit of Activities as a Representative applies to all representatives licensed in Quebec and applies whenever a producer takes an application in the Province of Quebec, regardless of the province of residence of the applicant or the policy owner or the producer.

Replacement forms must be submitted in all cases, even if the coverage being replaced is with our company. Submission of the replacement forms will be an underwriting requirement.

Province of British Columbia

Disclosure forms have been designed for use in the Province of British Columbia to comply with the British Columbia Financial Institutions Act. It is the responsibility of the producer to complete these forms with the client. A copy of this form is not considered an underwriting requirement.

Province of Newfoundland

The Province of Newfoundland requires that replacement forms be completed for all applications for life and disability insurance when, within a six month period, any existing life or disability insurance has been or is likely to be replaced.

These guidelines apply when existing coverage is being lapsed, surrendered, partially surrendered, forfeited or otherwise terminated, changed or modified in any way. Such changes include the type of insurance, its value, benefits, or the period of time the existing contract will continue in force.

This requirement also includes the replacement of policies issued by the same insurer. Replacement does not include contractual conversions. Newfoundland does not require replacement forms for Critical Illness coverage.

SECOND APPLICATION IN (04/97)

Occasionally, multiple applications are received from an applicant through different producers for the same type of coverage. These situations are handled based on the following guidelines:

- the first application received and registered is considered the viable application, regardless of whether a deposit was paid with the application or not. That application will be underwritten in the usual way.
- any subsequent application received will be filed incomplete and any deposit submitted will be refunded directly to the Proposed Policy Owner. The appropriate sales office will be notified that the second application received has been filed incomplete and no wastage will be charged in this situation.
- if the first application is approved but subsequently marked 'not taken', the underwriter will, upon request, re-open the second application and proceed to issue a policy for placement on a COD basis.

The only exception to these guidelines would be a situation where we have received a written request from the applicant requesting that we not proceed with the first application. The written request from the applicant must include the following:

- the identity of the producer on both the first and second application received; and
- the applicant's reason for not proceeding with the first application; and
- the applicant's reason for their request to process the second application instead.

SIGNATURES (05/04)

Proper and authentic signatures of the producer, applicant, and proposed owner, where applicable, must be obtained on both the application and authorization. Tracings or copies of any kind are strictly forbidden. It is important that the producer signs the application and prints his/her name legibly to ensure that proper credit is given. It is also imperative to indicate the city/town and province where the application is signed by the applicant and proposed owner.

TRIAL APPLICATION (05/04)

We will underwrite, and where possible offer coverage on the basis of a trial application.

When there is any serious question about the eligibility of a proposed insured, send a trial application for an underwriting opinion. This consists of a regular, fully completed and signed application marked "Trial" on the Receipt and Conditional Insurance Agreement that must remain attached to the application when submitted. The application should be completed in full, including the authorization and provide a detailed explanation of the reasons for submitting it on a trial basis.

Trial applications must be submitted on a COD basis. To keep costs at a minimum, medical requirements must not be ordered. If required, the underwriter will order an Attending Physicians Statement (APS). The Underwriting Department will advise whether further consideration can be given. A favourable opinion cannot be considered as a guarantee that a policy will be issued, as a final decision will be subject to any further underwriting requirements specified at the time of a tentative offer. A trial application is not included in wastage figures unless a policy is issued and later marked not taken.

MEDICAL UNDERWRITING REQUIREMENTS (03/04)

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AUTOMATIC MEDICAL REQUIREMENTS FOR INDIVIDUAL DISABILITY INSURANCE (03/04)

Close attention should be paid to the limits for medical requirements to assure that the appropriate requirements are ordered. This will enable us to provide the best possible time service while avoiding the delays and expense resulting from unnecessary requirements or the failure to order all necessary requirements.

All requirements are based on the TOTAL AMOUNT OF COVERAGE with us (see Notes Regarding Individual Disability Requirements):

MEDICAL REQUIREMENTS FOR INDIVIDUAL DISABILITY INSURANCE COVERAGE: use tables listed below as appropriate for applicant's occupation.

TABLE 1: All Non-Health Care Workers

TABLE 2: Surgeons (Cardiac Surgeons, General Surgeons, Neurosurgeons, Obstetricians & Gynecologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologists, Pediatric General Surgeons, Plastic Surgeons, Thoracic Surgeons, Urologists, Vascular Surgeons), Dentists (including Orthodontists, Periodontists, Endodontists), Dental Surgeons (including Oral and Maxillofacial Surgeons), Dental Hygienists, Dental Assistants

TABLE 3: all other Physicians, Chiropodists, Podiatrists, Professional Lab Technicians, RN's, RNA's, LPN's, Respiratory Therapists, Respirologists, Paramedics, Acupuncturists (MD and non-MD), Massage Therapists doing acupuncture, Physiotherapists doing acupuncture, Denture Therapists, Denturists, Denturologists

TABLES 2 & 3: HEALTH CARE WORKERS TESTING LIMITS

A blood profile with a hepatitis screen is a mandatory requirement for health care workers at the testing limits indicated. Any increase in risk for health care professionals will automatically require testing as indicated in these tables. **This applies to make-overs, internal replacements, policy changes and reinstatements**. If a client has had a blood profile with a hepatitis screen done for us within the preceding six months, a current blood profile with a hepatitis screen should not be arranged unless requested by the underwriter. **Testing limits apply to all products except Critical Illness Insurance and Long Term Care Insurance**.

TABLE 1: ALL NON-HEALTH CARE WORKERS

MONTHLY INDEMNITY			
AGE	URINE/HIV PROFILE	URINE/HIV PROFILE and PARAMED	BLOOD PROFILE and URINE PROFILE and PARAMED
18 - 50	$2,501 - $6,000	$6,001 - $10,000	Over $10,000
51 - 60 and overage	N/A	N/A	Over $2,500

LUMP SUM (excluding Critical Illness Insurance)			
AGE	URINE/HIV PROFILE	URINE/HIV PROFILE and PARAMED	BLOOD PROFILE and URINE PROFILE and PARAMED
18 - 50	$100,001 - $200,000 (monthly equivalent – using factor of 36 = $2,777 - $5,555)	$200,001 - $400,000 (monthly equivalent – using factor of 36 =$5,556 - $11,111)	Over $400,000 (monthly equivalent – using factor of 36 = Over $11,111)
51 - 60 and overage	N/A	N/A	Over $100,000 (monthly equivalent- using factor of 36 = Over $2,777)

TABLE 2:

Surgeons (Cardiac Surgeons, General Surgeons, Neurosurgeons, Obstetricians & Gynecologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologists, Pediatric General Surgeons, Plastic Surgeons, Thoracic Surgeons, Urologists, Vascular Surgeons), Dentists (including Orthodontists, Periodontists, Endodontists), Dental Surgeons (including Oral and Maxillofacial Surgeons), Dental Hygienists, Dental Assistants

Note: for this group of Health Care Workers, a blood profile with a hepatitis screen is required at $0.

MONTHLY INDEMNITY		
AGE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE and PARAMED
18 - 50	$0 - $6,000	Over $6,000
51 - 60 and overage	$0 - $2,500	Over $2,500

LUMP SUM (excluding Critical Illness Insurance)		
AGE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE and PARAMED
18 - 50	$0 - $200,000	Over $200,000
51 - 60 and overage	$0 - $100,000	Over $100,000

TABLE 3:

All other Physicians, Chiropodists, Professional Lab Technicians, RN's, RNA's, LPN's, Respiratory Therapists, Respirologists, Paramedics, Podiatrists, Acupuncturists (MD and non-MD), Massage Therapists doing acupuncture, Physiotherapists doing acupuncture, Denture Therapists, Denturists, Denturologists

For this group of Health Care Workers, a urine/HIV is required at $0 and hepatitis screening at $4,001. For applicants who have in force coverage for which they were not tested for Hepatitis B/C, the amount of that in force coverage must be added to the current amount of coverage applied for, to determine current testing requirements.

MONTHLY INDEMNITY			
AGE	URINE/HIV PROFILE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE and PARAMED
18 - 50	$0 - $4,000	$4,001 - $6,000	Over $6,000
51 - 60 and overage	$0 - $2,500	N/A	Over $2,500

LUMP SUM (excluding Critical Illness Insurance)			
AGE	URINE/HIV PROFILE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE	BLOOD PROFILE and HEP SCREEN and URINE PROFILE and PARAMED
18 - 50	$0 - $150,000	$150,001 - $200,000	Over $200,000
51 - 60 and overage	$0 - $100,000	N/A	Over $100,000

NOTES REGARDING INDIVIDUAL DISABILITY INSURANCE REQUIREMENTS

› Urine/HIV, blood profile, hepatitis screen, paramedical, exam by a MD are considered current for six months.

› ECG is considered current for one year.

› TOTAL AMOUNT OF COVERAGE

Includes:
- › Total current amount applied for, **plus**
- › Any AMI, short and long term coverage, and retirement protector rider, **plus**
- › Any coverage issued by us, including all personal and business plans, any AMI, long and short term coverage and retirement protector riders, fully underwritten or GSI, since medical requirements were last satisfied.

Does not include:
- › FIO, FCEO & BIO benefits applied for at time of original application, **or**
- › Any exercised FIO, FCEO, FBIO, BIO, GPI, AIB or Update, **or**
- › AD & D coverage, **or**
- › Any pending or in force group coverage with us or another company, **or**
- › LTC coverage

› Each time the applicant has an automatic medical requirement completed (Urine/HIV profile, paramedical, blood profile) resulting in our issuing standard coverage, eligibility for non-medical insurance is renewed. The next time the applicant applies, in force coverage is disregarded for purposes of determining medical requirements and only the current amount is calculated to determine requirements. Exception: see note in Health Care Workers Testing Limits section above.

Example:
A 37 year old applicant (not a health care worker) has $2,000/mth. of in force coverage, issued standard, non-medically. Applicant is requesting additional $1,500/mth. Current requirement: Urine/HIV profile (based on $3,500/mth. total coverage).

A 37 year old applicant (not a health care worker) has $2,800/mth. of in force coverage issued standard after routine requirements were obtained (Urine/HIV profile) at the time of underwriting. Applying currently for $500/mth. Current requirement: none (based on $500/mth).

› The underwriter may request these or other medical requirements for any amount depending on medical history and current findings, in order to make the most favourable decision.

› For IDI, if both a monthly indemnity and lump sum benefits (other than Critical Illness Insurance) are applied for at the same time, divide the lump sum amount by 36 and add this amount to the monthly indemnity to determine medical requirements.

› If applying for individual disability insurance coverage along with Critical Illness Insurance coverage, please consult both the Critical Illness Insurance medical requirements chart and the individual disability coverage medical requirements charts to determine the overall medical requirements. The highest level of automatic requirements will apply.

Example:
A 57 year old carpenter is applying for $2,000 of disability coverage and $200,000 Critical Illness coverage. Current medical requirements: blood profile, urine profile, paramedical and ECG (based on the CI requirements).

› If the underwriter requests additional urine tests to confirm a result, these additional tests should be ordered as "urine re-test" from the paramedical facility.

MEDICAL REQUIREMENTS FOR CRITICAL ILLNESS INSURANCE (see CI Notes below) (01/04)

AGE	BLOOD PROFILE, URINE PROFILE and PARAMED	BLOOD PROFILE, URINE PROFILE, PARAMED and ECG	BLOOD PROFILE, URINE PROFILE, EXAM and ECG
18 - 40	Over $249,999	N/A	N/A
41 - 50	$100,001 - $250,000	Over $250,000	N/A
51 - 55	$25,001 - $100,000	Over $100,000	N/A
56 - 60	0 - $100,000	Over $100,000	N/A
61 - 65	N/A	$0 - $250,000	Over $250,000

NOTES REGARDING CRITICAL ILLNESS INSURANCE MEDICAL REQUIREMENTS

› Urine/HIV, blood profile, hepatitis screen, paramedical, exam by an MD are considered current for six months

› ECG is considered current for one year

› TOTAL AMOUNT OF COVERAGE

Includes:
- › Current amount of Critical Illness Insurance applied for, **plus**
- › Current amount of Scheduled Increase Benefit Rider applied for, **plus**
- › Any previous amount of Critical Illness coverage issued, including any Scheduled Increase Benefit Rider amount and GSI, since medical requirements were last satisfied.

› **If applying for the Scheduled Increase Benefit Rider**, the sum of all future increases must be added to the base Critical Illness indemnity to obtain the total amount of coverage for the purposes of determining the medical requirements.

› **There are no routine medical requirements for ages 17 or under**, however they may be requested at time of underwriting, based on the information provided on the application.

› Each time the applicant has automatic medical requirement completed resulting in our issuing standard coverage, eligibility for non-medical insurance is renewed. The next time the applicant applies for coverage, the in force coverage issued as a result of the automatic medical requirements is disregarded for the purposes of determining medical requirements and only the current amount is used to determine requirements.

Example:
A 45 year old has $200,000 of Critical Illness coverage in force, with the Scheduled Increase Benefit Rider, issued standard; at the time of application, a blood profile, urine profile, paramedical and ECG were submitted. He is now applying for an additional $100,000 of Critical Illness coverage. Current medical requirements: none.

› If applying for Critical Illness Insurance along with individual disability coverage, please consult both the Critical Illness Insurance medical requirements chart and the individual disability coverage medical requirements charts to determine the overall medical requirements. The highest level of automatic requirements will apply.

Example:
A 42 year old cardiac surgeon is applying for Critical Illness Insurance in the amount of $200,000 and Individual Disability coverage in the amount of $3,000 per month. Medical requirements: blood profile with hepatitis screen, urine profile and paramedical (based on both Health Care Worker's DI requirements chart and the CI requirements chart).

› Testing for hepatitis is not a routine requirement for Critical Illness Insurance unless applying in conjunction with a request for disability coverage where a hepatitis screen is an automatic requirement.

DETAILS REGARDING MEDICAL REQUIREMENTS (03/04)

Urine/HIV Profile (01/04)

Urine/HIV profile includes all the tests for a Urine Profile as well as an HIV-1 antibody screen;

HIV-1 antibody screen - indicator of infection by the Human Immunodeficiency Virus 1;

Urine Profile (01/04)

Urine profile - is a non-invasive method of testing applicants; a specimen consists of a urine sample;

Glucose - indicator for diabetes mellitus;

Protein - indicator for kidney diseases;

Red blood cells and white blood cells - indicators for infection, genito-urinary diseases and kidney diseases;

Hyaline casts - originate in kidneys - indicator of kidney diseases;

Antihypertensive medications - detect presence of medications used in control of elevated blood pressure;

Oral hypoglycaemic medications - detect presence of medications used in the control of diabetes mellitus;

Beta blockers - detect presence of medications used in control of elevated blood pressure and cardiac arrhythmia;

Cotinine - detects a metabolite of nicotine, used to detect individuals who use tobacco products;

Cocaine - detects usage of cocaine;

Creatinine, chloride Ph and temperature are used to detect adulterants to a urine specimen;

Blood Profile (01/04)

Blood profile - is an intravenous method of blood collection; the blood test results obtained by this method include:

HIV antibody status - indicator of infection by the Human Immunodeficiency Virus;

Glucose - a blood sugar measure; indicator of diabetes mellitus;

GGTP - a liver enzyme measure; indicator of liver disorders, alcohol abuse;

SGPT - a liver enzyme measure; indicator of liver disorders, alcohol abuse;

SGOT - a liver enzyme measure; indicator of liver disorders, alcohol abuse;

Fructosamine - a blood sugar measure; indicator of diabetes mellitus, pancreas and liver disorders;

Creatinine - a kidney function measure; indicator of kidney disorders;

HgbA1C - only performed if glucose and fructosamine are elevated; indicator of diabetes mellitus;

Cholesterol - elevated levels associated with risk for atherosclerosis and coronary artery disease;

Triglycerides - elevated levels may be associated with diabetes mellitus and may be a risk factor for coronary artery disease;

PSA - performed on males age 51 and over; a measure of prostate specific antigen; indicator for prostate cancer;

A urine specimen (HOS) is also collected when a blood profile is requested.

The list of results indicators provided above is not a complete list. For simplicity, only the most prominent indicators have been included.

For optimum test results with any urine or blood test being performed for us, the client should not eat for at least 12 hours before the test.

Hepatitis Screen (10/99)

Shown as “Hep Screen” on the above medical requirement charts. This is an intravenous blood test for Hepatitis B Surface Antigen and Hepatitis C antibodies.

Paramedical Examination (10/99)

Shown as “Paramed” on the above medical requirement charts. A nurse from an approved facility for blood and urine collection takes the medical history and completes the height/weight, pulse, blood pressure & dipstick urine sections of the Medical Examiner’s Report.

Exam (10/99)

A medical doctor takes the medical history and completes the Medical Examiner’s Report.

ECG (01/04)

A 12-lead electrocardiogram is done by a nurse or medical doctor.

Vitals (01/04)

A nurse from an approved paramedical facility records the applicant's height, weight, pulse and blood pressure.

APPROVED PARAMEDICAL FACILITIES (01/04)

Quality Underwriting Services / Bodimetric Profiles

Hooper Holmes / Portamedic

Medisys Health Group

Exam*One* Canada

All medical requirements must be arranged through an approved paramedical facility. Unless it is a medical requirement, a physician's examination will be used only if these paramedical facilities are unavailable, with pre-approval from underwriting, or if the underwriter specifically requests a physician's examination. Medical examinations by the applicant's attending physicians, family members or business associates are not acceptable.

USE OF OTHER COMPANY'S EVIDENCE (01/04)

We will accept results from other companies if their evidence is consistent with our requirements and if the results have been obtained within six months of our application date. If you wish us to obtain requirements from another company, please indicate this request in the Remarks section of the application and the underwriter will request the required information directly from the other company.

We are unable to accept another company's paramedical if our application is for CI.

ATTENDING PHYSICIANS STATEMENT (APS) (01/04)

A report from an attending physician or physicians may be ordered at the underwriter's discretion based on underwriting information available.

Attending Physicians Statements are ordered directly from the underwriting department. Attending Physicians Statements that are obtained by the producer or applicant are not acceptable.

UNUSUAL SITUATIONS (01/04)

We are very occasionally faced with a situation where an applicant's medical history is such that we are unable to make an offer of coverage without knowing the current medical status or without a diagnosis having been made. This information may not be available and/or may require additional investigation to obtain.

In these situations, we would not recommend any particular medical investigation or test. Any such investigations or tests are the responsibility of the applicant and would be the result of further consultations with his medical doctor.

Should there be any subsequent investigations or tests, we would be willing to review the results when they become available.

FINANCIAL UNDERWRITING GUIDELINES AND REQUIREMENTS (03/04)

INDEX

FINANCIAL UNDERWRITING (03/04)

The purpose of disability income insurance is to replace a portion of the income lost when a disability due to injury or sickness prevents the insured from working. To provide financial incentive for the insured to return to work as soon as he or she is physically able, it is necessary to limit the total amount of disability income coverage available. For this purpose, we look at public and private sources of compensation to determine an amount that is less than gross earnings from employment. The amounts of coverage available at various income levels reflect this fundamental principle.

Public sources of benefits would include Canada Pension Plan, Quebec Pension Plan, no-fault automobile insurance plans, Workers' Compensation and Employment Insurance (EI) benefits.

Privately, benefits might be obtained from salary continuation plans (short and/or long term benefits), association coverage available to members of a common association or organization, group insurance benefits or disability benefits on a life insurance contract.

We also consider accident only insurance at full dollar value and program our coverage accordingly.

Please note that we always program our coverage around the benefit period of other coverage. If existing coverage has a benefit period to age 65, for example, with a two-year regular occupation definition, we will not consider this to be coverage with a two-year benefit period. Until a disability occurs, there is no way to determine whether or not the in force coverage will pay beyond the two-year regular occupation definition period.

EARNED INCOME (02/04)

Income that results from the applicant's ability to work at his or her occupation is considered “earned income”. This would include salary, wages, commissions and fees. In certain circumstances, bonuses as well as pension plan or profit sharing plan contributions made by the employer may also be considered as earned income, see **Note** below. To be considered as earned, any of these amounts must be received as the result of vocational activities.

DETERMINATION OF EARNED INCOME AMOUNT FOR INSURANCE PURPOSES (02/04)

- For an **employee** of any type of business (no ownership interest): earned income consists of salary, bonus (see **Note**), commissions (net of employment expenses), pension (pension adjustment amount found on line 206 of T1 or in box 52 of T4) and/or profit sharing plan contributions made by the employer on the employee's behalf.
- For the **owner or shareholder of an incorporated business:** earned income consists of salary, bonus, commissions (net of employment expenses) and pension and/or profit sharing contributions made by the company on the shareholder's behalf. Management fees (amounts received without payroll withholdings being deducted) may be received in lieu of or in addition to salary. The earned income of a shareholder (owner) of a corporation must also include their percentage-of-ownership share of the net income (or loss) before corporate income tax of the corporation for the last complete fiscal year-end. The ownership of the voting shares of a corporation confirms "ownership" for our purposes.
- For the **partner** in an unincorporated partnership: earned income consists of the partner's share of the fiscal year's net partnership profits or losses as declared for income tax purposes and reported on each partner's personal tax return.
- For the **sole owner** of an unincorporated business: earned income consists of the net business profit or loss which is reported as taxable personal income (or loss) on the owner's personal tax return.

Note: Bonuses, commissions (net of employment expenses), fees and pension/profit sharing contributions are included in earned income as shown above only if there is a consistent, regular pattern of payment of these items established for at least two years with no indication of decreased amount for the current year.

One-time bonus and other non-recurring payments are not included when determining earned income. If a particular situation warrants exceptional consideration, full details should be submitted in writing for underwriting review.

DRAW (02/04)

A “draw” does not necessarily constitute earned income. This is dependent upon the organization of the business, as shown below. The word "draw" is used to mean a payment from the business without payroll deductions being made.

DRAW FROM CORPORATIONS (02/04)

An owner may take a draw from the corporation. On a corporation's financial statements, the draw may be recorded as a “management fee” or “bonus”. The draw is, therefore, deducted from the corporation's profits like any other expense. In this situation, if a draw is taken, then earned income will consist of the draw plus profits, or the draw minus any business loss.

Repayments made by the corporation of a loan from a shareholder, which are being called “draws”, are not included as part of earned income.

DRAW FROM UNINCORPORATED BUSINESSES (02/04)

The only way in which an unincorporated business owner can pay themselves money from their business is to “draw” it, as the owner is not legally allowed to be on the payroll as an employee. The profit/loss of the business for the year is reported on the owner's personal tax return, and that is what we consider as earned income for insurance purposes. **The "draw" is not considered as income as the owner is considered to be “drawing” from the profit of the business**. It is not uncommon to see unincorporated business owners draw out more than they made in the year. The owner may run up an overdraft or take out a bank loan and use those funds to live on. For this reason, a draw is not a good representation of earned income for an unincorporated business and we do not, therefore, rely on the amount of the draw for insurance purposes. Also, the draw and the business profit for the year are NOT added together as this would be double-counting (the draw is a portion of the profits). If the business shows a loss and a draw has been taken, the amount of the loss is the “earned income” (loss) for the year, and the draw is irrelevant.

RETAINED EARNINGS (06/95)

As shown on the financial statements, retained earnings represent the cumulative net earnings of a company since its inception. Including “retained earnings” in the applicant's earned income has the effect of adding in the total of the company's lifetime earnings.

It is, therefore, inappropriate to include the retained earnings figure on the financial statement as part of an applicant’s earned income. Profits for only one year at a time are considered part of earned income as explained earlier. Therefore, each year's portion of “retained earnings” has already been attributed to the appropriate year and including “retained earnings” and profits would be double-counting.

DIVIDENDS (02/04)

Dividends are not counted as earned income because we underwrite using the corporation’s annual profit or loss. The payment of a dividend can be viewed as the release of all or part of the accumulated profits to the shareholders. For this reason, dividends may or may not reflect income generated in a single business year. Including dividends as part of the applicant's earned income, as well as the profits, has the effect of double-counting the company's profits.

DETERMINATION OF WHICH YEAR'S INCOME TO USE (04/04)

The insurable income is the earned income from the last full business fiscal year (or calendar year for employees) for which financial documentation is available.

Acceptable forms of financial documentation are personal tax returns and business financial statements (to include the income statement and additional parts of the financial statements when available).

All documentation must be for the last complete business fiscal year for which a tax return and/or final version business financial statements have been prepared. On any application dated after May 15 of each year, the financial documentation from the preceding year is required. To minimize any confusion or delay that could occur at time of claim, we only underwrite income that can be proven at the time of underwriting coverage. Therefore, income amounts that are “projected” or “annualized” based on current earnings cannot be considered. Any requests for benefits in excess of what the proven income would allow must be accompanied by a detailed explanation of the unusual circumstances that would warrant exceptional consideration.

It is also important to note that the benefits approved may not be the amount that the proven insurable earnings will support if the pattern of earnings for that year is inconsistent with previous years, or if the earnings for the current year appear to be less.

To achieve our expected morbidity results, the level of benefits that are approved must be based on a stable and consistent pattern of insurable income. If the income pattern is questionable, if the income for the last year is inconsistent with previous years or is declining, the amount of coverage approved, in some situations, may be less than what the last full business year would support, or coverage may be denied entirely. Any significant fluctuations in income should be fully explained in writing and submitted with all available income documentation to support these remarks in order to assist the underwriter in making the most favourable decision possible.

INCOME SPLITTING (02/04)

T4'd salary or a management fee (net of expenses) that a **self-employed** applicant pays to a spouse or minor children under the age of 18* for taxation purposes will be considered as earned income of the **self-employed** applicant if:

- The amount of income split is generated by the applicant's personal services and would cease if the applicant became disabled; **and**
- The spouse and/or children work **less than** 20 hours per week in the business; **and**
- The spouse does not have the same occupation or profession as the applicant, regardless of the number of hours worked in the business.

We do not put a maximum limit on the amount of the income split that can be considered as earned income to the applicant. However, if the amount exceeds $30,000, both the T4 and T1 General forms of the spouse and/or the minor children will be required in addition to the income documentation required for the applicant.

Family trusts are becoming common as an income splitting device. The profit or loss of the business owned by a family trust and operated by the applicant will be attributed back to the applicant, as an income split. Dividend payments received by family members from the family trust are not part of an applicant's insurable earned income.

Income splitting is not available under the farmer's issue limits.

* Individual consideration may be given to dependent children over age 18 if they are full-time students, the hours worked in the business over the course of a year average less than 20 hours per week and they otherwise qualify based on the above criteria.

BUSINESS EXPENSES (06/95)

All expenses that have been deducted by the applicant for the purpose of filing an income tax return will be considered as business expenses for the purpose of determining insurable income. Expenses cannot be added back to insurable income, regardless of the nature of the expense.

ITEMS WHICH ARE NOT CONSIDERED AS EARNED INCOME (04/04)

The following are not considered to be **earned income**: pension benefits, family allowance payments, social assistance payments, Employment Insurance benefits, Workers' Compensation payments, dividends, interest from investments, rental income (unless the applicant's primary occupation is that of a property owner and lessor), royalties, capital gains, alimony, separation allowance payments, child support payments, retirement savings plan income, retained earnings, depreciation/capital cost allowance (CCA)*, automobile expenses deducted as a business expense for tax purposes, entertainment or travel expenses deducted as a business expense for tax purposes, repayment of shareholder loans to the owner, stock option payroll benefit amounts, wages paid to a spouse or child working 20 or more hours a week in the business, payments received from no-fault automobile insurance plans, severance or early retirement payments. This is not intended to be an all-inclusive list but does include some of the more commonly seen sources of income to an applicant.

Also excluded from insurable income are any earnings that are not reported to Canada Revenue Agency ("off the books") or any earnings obtained from other illegal activity.

* Refer to the Issue Limits for Farmers section for the only exception to this rule.

PERK ALLOWANCE (03/05)

The unique circumstances of self-employed occupations and those who are commissioned sales persons create a greater loss of income when disability strikes than for other applicants. For this reason, a perk allowance is added to the insurable income of these individuals. The perk allowance is 20% of the net earned self-employed income or the net commission income, to a maximum of $40,000 annually. The perk allowance should not be included in the income figures provided on the application. Only actual income figures should be indicated on the application and the perk allowance will be calculated by the underwriter to determine the eligible coverage amounts. If a sales person receives both salary and commission, the perk allowance will be calculated based only on that portion of insurable income derived from net commission income.

For the Bridge Series and Quantum policies, we suggest that you do not use the perk allowance to determine the coverage amount. These products contain an integration of benefits provision that, when used in conjunction with the perk allowance, may result in the client paying for benefits they may never receive as a result of that provision.

MINIMUM INSURABLE EARNED INCOME (01/04)

The minimum insurable earned income required to determine eligibility for coverage is $12,000 annually (after deducting business expenses, but before taxes) for all products except the Critical Illness Recovery Plan and the Retirement Protector benefit.

An employee must have a minimum earned income of $12,000. For a self-employed individual or commissioned sales person, the $12,000 earned income amount includes the appropriate perk allowance. The only exceptions are farmers using the Issue Limits for Farmers.

Any applicant (other than a farmer using farmer's issue limits for coverage under the Foundation or Bridge Series) who does not meet the $12,000 minimum amount is ineligible for any disability product. We would not allow the purchase of any product because of the anticipated poor persistency in such a situation.

To qualify for a Retirement Protector benefit, an applicant must have a minimum earned income of at least $18,000. This rule applies whether the benefit is issued as a rider or as a stand-alone policy.

For the Critical Illness Recovery Plan, please refer to the Financial Underwriting section of the Critical Illness Underwriting Guidelines.

ISSUE & PARTICIPATION LIMITS (03/04)

The maximum issue and participation limits by occupational class and age, are found on the following charts. Both in force and pending coverage from all sources are to be included, in addition to any pending group coverage for which the applicant will automatically become eligible upon completion of probationary employment or a waiting period. Use the Issue Limits chart to determine exactly what the applicant may be eligible for based on their specific income, subject to the limits shown in the Issue and Participation charts.

ID Issue Limit: this is the maximum amount of individual disability insurance coverage we will issue.

Combo Limit: this is the maximum total individual disability insurance and group LTD coverage that we will consider, subject to the restrictions listed in the Combo Limits section of the Underwriting Guidelines. The individual disability insurance portion may not exceed the ID Issue Limit shown in the charts. The group coverage may be with any company, not just with us.

Participation: this is the maximum total amount of disability coverage that we will participate in. This amount may be made up of individual coverage with us, to the maximum shown under the ID Issue Limit, plus our group coverage and/or group, association or individual coverage with another company.

Retirement Protector: coverage will be allowed over and above the company's issue and participation limits up to a maximum of $1,500 but not to exceed 20% of the monthly earned income. Please refer to the Underwriting Optional Benefits section.

Over Age 60: please refer to the Overage Limits section for the criteria for consideration of overage applicants and the Plan restrictions that apply.

INDIVIDUAL DISABILITY INCOME - ISSUE AND PARTICIPATION LIMITS CHART (06/03)

Class 4A	Age	ID Issue Limit	Combo Limit	Participation
Non-taxable	18 - 55	$25,000*	$35,000	$35,000
	56 - 60	$10,000 non-combo $15,000 combo	$25,000	$10,000 non-combo $25,000 combo (amount above $15,000 must be group)
	61 - 63	$8,000	$10,000	$8,000 non-combo $10,000 combo (amount above $8,000 must be group)
Taxable	18 - 55	$25,000*	$35,000	$50,000**
	56 - 60	$10,000 non-combo $15,000 combo	$25,000	$10,000 non-combo $25,000 combo (amount above $15,000 must be group)
	61 - 63	$8,000	$10,000	$8,000 non-combo $10,000 combo (amount above $8,000 must be group)

* Individual consideration will be given to requests to issue up to and including $35,000 per month for otherwise standard cases subject to an established need based on full review of all financial documentation for the last two complete tax years, including full evaluation of unearned income and net worth. In these cases, the maximum participation limit will continue to be $35,000 or $50,000 as per the above chart.

** Coverage through us for multi-life cases associated with Advanced Underwriting only, otherwise participation only.

Classes 3A to B	Age	ID Issue & Participation Limit
3A	18 - 55 56 - 60 61 - 63	$15,000 $6,000 $6,000
2A	18 - 55 56 - 60 61 - 63	$7,000 $3,000 $3,000
A	18 - 55 56 - 60 61 - 63	$5,000 $2,500 $2,500 Foundation or Bridge contract only
B	18 - 55 56 - 60 61 - 63	$3,500 $1,500 $1,500 Foundation or Bridge contract only

BUSINESS PRODUCTS - ISSUE AND PARTICIPATION LIMITS CHART (03/04)

The Issue and Participation Limits for business products are over and above the regular issue and participation limits for income protection coverage. However, if income protection coverage already in force exceeds our issue and participation limits, additional coverage cannot be approved. Also, if the applicant does not have a net earned income of at least $12,000 or if overinsured for any other disability product, coverage is not available.

<table>
<tr><td>Business Overhead Expenses
Age 18 - 60**</td><td>Class 4A *
$20,000</td><td>Class 3A
$15,000</td><td>Class 2A
$7,000</td><td>Class A
$5,000</td><td>Class B
not available</td></tr>
<tr><td rowspan="2">Disability Buy Sell
Age 18 - 60</td><td rowspan="2">Classes 4A,
3A, 2A only</td><td colspan="3">Maximum Purchase Amount if IDI with maximum 120 day EP is not with us
Elimination period / Amount
360 days - $1,000,000
540 days - $1,500,000
720 days - $2,000,000</td><td colspan="2" rowspan="2">Monthly pay out
divide maximum business purchase amount by 60</td></tr>
<tr><td colspan="3">Maximum Purchase Amount if IDI of at least $450 with Maximum 120 day EP is in force with us
Any EP - $2,000,000</td></tr>
<tr><td>Business Loan Protector
Age 18 - 55</td><td>Class
4A
3A
2A
A</td><td colspan="3">Periodic Pay ***
$10,000
$8,000
$6,000
$5,000</td><td colspan="2">Lump Sum****
$250,000
$250,000
$250,000
not available</td></tr>
<tr><td>Key Person Protector
Age 18 - 55</td><td colspan="2">Classes 4A, 3A, 2A only</td><td colspan="4">1/12th the of applicant's annual salary, to max. $15,000</td></tr>
</table>

* Amounts in excess of $20,000, up to a maximum of $30,000, will be considered on an individual case basis subject to financial justification and underwriting approval of the complete file.

** For classes 4A and 3A only, age 61 - 63 will be considered for coverage with a benefit period of 15 months only and a minimum 30 day elimination period, subject to the criteria set out in the Overage Limits section of the Underwriting Guidelines.

*** 100% of the business loan plus interest to the maximum shown above.

**** 75% of the business loan to the maximum shown above.

GUIDELINES FOR THE USE OF ISSUE LIMITS CHART (02/04):

Column A represents the amount of coverage available with a 30, 60 or 90 day elimination period (EP) if programming with Employment Insurance (EI) is necessary.

Column B represents the amount of coverage available with an elimination period (EP) of 120 days or greater if programming with Employment Insurance (EI) is necessary.

Column C represents the amount of coverage available with any elimination period (EP) if no programming with Employment Insurance (EI) is necessary.

Column D replaces Column C in situations where Combo Limits apply - see Combo Limits guidelines for more information. If programming with Employment Insurance (EI) is required, see column B for the minimum amount required with a 120 day elimination period (EP). The difference between Column D and Column B would be available with a 30, 60 or 90 day elimination period.

It is appropriate to interpolate within the ranges provided on the chart. Each income band reflects a range of income, but provides only one benefit amount for this range. Thus, if an individual's income falls in the lower part of this range, it is appropriate to move the benefit amount applied for closer to the amount offered in the next income range.

Example:

For the income range of $100,000 to $109,999, the non-taxable issue limit offered is $4,425/month. At $110,000 we offer $4,725/month; we would expect the range to be interpolated as follows (rounded to the nearest $25 after interpolation):

Formula: ($4,725 - $4,425) / 10 = $30 x each thousand dollars of income over $100,000

Income	Non-taxable issue limit
$100,000	$4,425
$103,000	$4,500
$106,000	$4,600
$109,000	$4,700

GUIDELINES FOR THE USE OF COMBO LIMITS (02/05)

Combo limits allow certain individuals to obtain a higher total amount of disability insurance coverage when purchasing individual insurance coverage in addition to in force group long-term disability (LTD) coverage.

› **Maximum Individual Coverage:** the maximum amount of individual disability coverage issued under combo limits cannot exceed our regular individual non-combo limit.

› **Eligible Plans:** Professional Series and Foundation Series only.

› **Eligible Occupations in Classes 4A and 3A:** accountants (C.A., C.M.A., C.G.A.), actuaries, architects, business owners, computer professionals, consultants, engineers, executives (per Occupation Schedule), general office workers, optometrists, medical doctors, notaries (in Quebec) and lawyers. Individuals in these occupations who qualify for class 3A using the occupational upgrade guidelines also qualify for combo limits.

› **Ineligible Employment Situations:** regardless of their occupation or occupational classification, combo limits are not available to part-time workers, contract workers, individuals who are working out of their homes (home based workers), seasonal employees or newly self-employed individuals.

› **Minimum Group Coverage:** to qualify for combo limits, an applicant must have group LTD coverage in force. The group coverage can be with another insurer or with us. The applicant must be maintaining the group LTD coverage in force. **Association coverage is not considered group LTD** and does not allow an individual to qualify for combo limits.

› **Group Offset:** all policies issued under the combo limits will include a group/association offset amendment (A707GIO). Any amount that exceeds the "individual combo limit less all in force and applied for individual coverage including GSI" will be offset. This amendment will have to be signed for upon delivery of the policy. No discount applies to this group offset.

› **Discount:** any applicant who has coverage issued under the combo limit guidelines qualifies for a 15% select discount (select no. D09285-01). Upon request, the discount will be extended to the insured's other in force policies except for plans that are ineligible for a select discount (i.e. CI). When the select discount is extended to an insured's other in force policies, the change will be current dated and only apply to future premiums payable.

› **Top up to Guarantee Standard Issue (GSI):** even if their occupation is not one that is eligible for combo limits, individuals who are offered combo limits under a GSI will be allowed combo limits for any additional, fully underwritten coverage applied for, subject to the following:

- › The applicant is still part of the group or employed by the company that was offered the GSI.
- › The GSI offer allowed for combo limits.
- › Group LTD coverage remains in force.

If the applicant is no longer part of the group or no longer has group LTD in force, non-combo limits apply.

› **FIO's and Combo Limits:** combo limits will be allowed when exercising an FIO in the following situations:

1) **Policies issued originally with combo limits, subject to the following:**
   - › Group LTD coverage remains in force

2) **Policyholders who now qualify for combo limits based on our current guidelines for the use of combo limits.**

3) **Policyholders of in force GSI contracts who are exercising FIO's on fully underwritten policies, subject to the following:**
   - › The insured is still part of the group or employed by the company that was offered the GSI.
   - › The GSI offer allowed for combo limits.
   - › Group LTD coverage remains in force.

The request for combo limits should be included on the FIO application.

› FIO's, Combo Limits & Group Offsets:

1) **Policies issued originally with 10/99 or 05/00 combo limits:** these policies should include the required GIO group offset and combo limits can be used for any FIO exercised, as long as they qualify as indicated above. The offset amount will be adjusted as required.

2) Po**licies issued without a group offset:** for policies issued originally with non-combo limits or with the combo limits from the early 1990's, we will allow combo limits on the current FIO if the insured qualifies as indicated above. A group/association offset amendment (A707GIO) will be included with any increase approved.

3) **Policies issued with A670 group/association offset (or earlier versions):** if a policy was originally issued with non-combo limits or issued with the combo limits from the early 1990's, we will allow combo limits on the current FIO, if the insured qualifies as indicated above. The group/association offset amendment version will not be changed. However, if the policy includes the A670 group/association offset amendment that specifies an offset amount, the amount will be adjusted as required.

ISSUE LIMITS – subject to the Issue and Participation Limits (03/04)

	Non-Taxable				Taxable			
Annual Net Earned Income	Column A	Column B	Column C	Column D	Column A	Column B	Column C	Column D
	Covered by EI Amount available with 30, 60, 90 day EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***	**Covered by EI** Amount available with 30, 60, 90 day EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***
12,000 - 12,999	400	450	850	850	400	450	850	850
13,000 - 13,999	425	475	900	900	425	500	925	925
14,000 - 14,999	425	500	925	925	450	525	975	975
15,000 - 15,999	450	550	1,000	1,000	550	550	1,100	1,100
16,000 - 17,999	475	575	1,050	1,050	575	575	1,150	1,150
18,000 - 19,999	500	650	1,150	1,150	625	650	1,275	1,275
20,000 - 21,999	525	725	1,250	1,250	675	725	1,400	1,400
22,000 - 23,999	550	800	1,350	1,350	725	800	1,525	1,525
24,000 - 25,999	575	875	1,450	1,450	800	875	1,675	1,675
26,000 - 27,999	600	950	1,550	1,550	875	950	1,825	1,825
28,000 - 29,999	625	1,025	1,650	1,650	950	1,025	1,975	1,975
30,000 - 32,999	675	1,100	1,775	1,775	1,000	1,100	2,100	2,100
33,000 - 35,999	725	1,175	1,900	1,900	1,050	1,175	2,225	2,225
36,000 - 37,999	750	1,275	2,025	2,025	1,075	1,275	2,350	2,350
38,000 - 39,999	800	1,325	2,125	2,125	1,225	1,325	2,550	2,550
40,000 - 43,999	900	1,350	2,250	2,250	1,425	1,350	2,775	2,775
44,000 - 47,999	1,075	1,325	2,400	2,400	1,725	1,325	3,050	3,050
48,000 - 51,999	1,300	1,300	2,600	2,600	2,075	1,300	3,375	3,375
52,000 - 55,999	1,525	1,300	2,825	2,825	2,400	1,300	3,700	3,700
56,000 - 59,999	1,750	1,275	3,025	3,025	2,675	1,275	3,950	3,950
60,000 - 64,999	1,975	1,275	3,250	3,250	2,950	1,275	4,225	4,225
65,000 - 69,999	2,175	1,250	3,425	3,425	3,275	1,250	4,525	4,525
70,000 - 74,999	2,375	1,225	3,600	3,600	3,575	1,225	4,800	4,800
75,000 - 79,999	2,525	1,225	3,750	3,750	3,875	1,225	5,100	5,100
80,000 - 89,999	2,725	1,200	3,925	3,925	4,200	1,200	5,400	5,400
90,000 - 99,999	2,975	1,175	4,150	4,150	4,750	1,175	5,925	5,925
100,000 - 109,999	3,275	1,150	4,425	4,425	5,275	1,150	6,425	6,425
110,000 - 119,999	3,575	1,150	4,725	4,800	5,875	1,150	7,025	7,100
120,000 - 129,999	3,875	1,125	5,000	5,175	6,425	1,125	7,550	7,800
130,000 - 139,999	4,150	1,125	5,275	5,550	6,925	1,125	8,050	8,500
140,000 - 149,999	4,450	1,100	5,550	5,925	7,450	1,100	8,550	9,150
150,000 - 159,999	4,725	1,100	5,825	6,300	7,975	1,100	9,075	9,825

*Some restrictions apply. Please consult the "Guidelines for the use of Combo Limits" section.

ISSUE LIMITS – subject to the Issue and Participation Limits (03/04)

	Non-Taxable				Taxable			
Annual Net Earned Income	Column A	Column B	Column C	Column D	Column A	Column B	Column C	Column D
	Covered by EI Amount available with 30, 60, 90 day EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***	**Covered by EI** Amount available with 30, 60, 90 day EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***
160,000 - 169,999	5,075	1,100	6,175	6,675	8,475	1,100	9,575	10,500
170,000 - 179,999	5,350	1,100	6,450	7,050	8,950	1,100	10,050	11,250
180,000 - 189,999	5,650	1,075	6,725	7,425	9,400	1,075	10,475	12,000
190,000 - 199,999	5,800	1,075	6,875	7,800	9,850	1,075	10,925	12,700
200,000 - 209,999	6,000	1,075	7,075	8,175	10,150	1,075	11,225	13,400
210,000 - 219,999	6,200	1,075	7,275	8,550	10,575	1,075	11,650	14,225
220,000 - 229,999	6,450	1,075	7,525	8,925	11,200	1,075	12,275	15,050
230,000 - 239,999	6,650	1,075	7,725	9,300	11,550	1,075	12,625	15,900
240,000 - 249,999	6,900	1,050	7,950	9,675	11,900	1,050	12,950	16,600
250,000 - 259,999	7,100	1,050	8,150	10,050	12,300	1,050	13,350	17,325
260,000 - 269,999	7,275	1,050	8,325	10,425	12,775	1,050	13,825	18,050
270,000 - 279,999	7,500	1,050	8,550	10,800	13,150	1,050	14,200	18,750
280,000 - 289,999	7,725	1,050	8,775	11,150	13,525	1,050	14,575	19,400
290,000 - 299,999	7,975	1,050	9,025	11,500	13,900	1,050	14,950	20,075
300,000 - 309,999	8,175	1,050	9,225	11,850	14,300	1,050	15,350	20,750
310,000 - 319,999	8,350	1,050	9,400	12,275	14,675	1,050	15,725	21,400
320,000 - 329,999	8,525	1,050	9,575	12,700	15,050	1,050	16,100	22,050
330,000 - 339,999	8,700	1,050	9,750	13,100	15,425	1,050	16,475	22,700
340,000 - 349,999	8,875	1,050	9,925	13,475	15,800	1,050	16,850	23,350
350,000 - 359,999	9,050	1,050	10,100	13,800	16,125	1,050	17,175	24,000
360,000 - 369,999	9,225	1,050	10,275	14,150	16,475	1,050	17,525	24,650
370,000 - 379,999	9,425	1,050	10,475	14,500	16,825	1,050	17,875	25,300
380,000 - 389,999	9,600	1,050	10,650	14,850	17,200	1,050	18,250	25,950
390,000 - 399,999	9,775	1,050	10,825	15,200	17,525	1,050	18,575	26,550
400,000 - 409,999	9,975	1,025	11,000	15,500	17,925	1,025	18,950	27,150
410,000 - 419,999	10,150	1,025	11,175	15,875	18,325	1,025	19,350	28,000
420,000 - 429,999	10,325	1,025	11,350	16,250	18,650	1,025	19,675	28,750
430,000 - 439,999	10,500	1,025	11,525	16,625	18,950	1,025	19,975	29,500
440,000 - 449,999	10,675	1,025	11,700	17,000	19,300	1,025	20,325	30,300
450,000 - 459,999	10,850	1,025	11,875	17,375	19,625	1,025	20,650	31,000
460,000 - 469,999	11,025	1,025	12,050	17,750	19,975	1,025	21,000	31,750
470,000 - 479,999	11,200	1,025	12,225	18,125	20,300	1,025	21,325	32,400

* Some restrictions apply. Please consult the "Guidelines for the use of Combo Limits".

ISSUE LIMITS – subject to the Issue and Participation Limits (03/04)

	Non-Taxable				Taxable			
Annual Net Earned Income	Column A	Column B	Column C	Column D	Column A	Column B	Column C	Column D
	Covered by EI Amount available with 30, 60, 90 day EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***	**Covered by EI** Amount available with 30, 60, 90 EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***
480,000 - 489,999	11,375	1,025	12,400	18,500	20,625	1,025	21,650	33,050
490,000 - 499,999	11,550	1,025	12,575	18,875	20,950	1,025	21,975	33,650
500,000 - 509,999	11,725	1,025	12,750	19,250	21,325	1,025	22,350	34,375
510,000 - 519,999	11,900	1,025	12,925	19,700	21,675	1,025	22,700	34,900
520,000 - 529,999	12,075	1,025	13,100	19,950	22,025	1,025	23,050	35,425
530,000 - 539,999	12,250	1,025	13,275	20,250	22,325	1,025	23,350	35,950
540,000 - 549,999	12,425	1,025	13,450	20,600	22,675	1,025	23,700	36,475
550,000 - 559,999	12,600	1,025	13,625	20,900	23,000	1,025	24,025	36,975
560,000 - 569,999	12,775	1,025	13,800	21,125	23,350	1,025	24,375	37,475
570,000 - 579,999	12,950	1,025	13,975	21,375	23,675	1,025	24,700	37,975
580,000 - 589,999	13,125	1,025	14,150	21,650	24,025	1,025	25,050	38,475
590,000 - 599,999	13,300	1,025	14,325	21,900	24,350	1,025	25,375	38,975
600,000 - 609,999	13,475	1,025	14,500	22,200	24,700	1,025	25,725	39,475
610,000 - 619,999	13,650	1,025	14,675	22,450	25,000	1,025	26,025	39,975
620,000 - 629,999	13,825	1,025	14,850	22,650	25,325	1,025	26,350	40,450
630,000 - 639,999	14,000	1,025	15,025	22,850	25,650	1,025	26,675	40,925
640,000 - 649,999	14,175	1,025	15,200	23,050	25,975	1,025	27,000	41,400
650,000 - 659,999	14,350	1,025	15,375	23,275	26,275	1,025	27,300	41,875
660,000 - 669,999	14,525	1,025	15,550	23,500	26,625	1,025	27,650	42,350
670,000 - 679,999	14,700	1,025	15,725	23,750	26,925	1,025	27,950	42,825
680,000 - 689,999	14,875	1,025	15,900	24,000	27,250	1,025	28,275	43,300
690,000 - 699,999	15,050	1,025	16,075	24,250	27,550	1,025	28,575	43,775
700,000 - 709,999	15,225	1,025	16,250	24,475	27,900	1,025	28,925	44,225
710,000 - 719,999	15,400	1,025	16,425	24,725	28,200	1,025	29,225	44,675
720,000 - 729,999	15,575	1,025	16,600	25,000	28,550	1,025	29,575	45,150
730,000 - 739,999	15,750	1,025	16,775	25,250	28,850	1,025	29,875	45,625
740,000 - 749,999	15,925	1,025	16,950	25,425	29,175	1,025	30,200	46,100
750,000 - 759,999	16,100	1,025	17,125	25,625	29,525	1,025	30,550	46,550
760,000 - 769,999	16,275	1,025	17,300	25,725	29,875	1,025	30,900	46,675
770,000 - 779,999	16,450	1,025	17,475	25,825	30,225	1,025	31,250	46,800
780,000 - 789,999	16,650	1,025	17,675	25,925	30,550	1,025	31,575	46,925
790,000 - 799,999	16,800	1,025	17,825	26,025	30,875	1,025	31,900	47,050
800,000 - 809,999	17,000	1,025	18,025	26,125	31,225	1,025	32,250	47,175

* Some restrictions apply. Please consult the "Guidelines for the use of Combo Limits".

ISSUE LIMITS – subject to the Issue and Participation Limits (03/04)

	Non-Taxable				Taxable			
Annual Net Earned Income	Column A	Column B	Column C	Column D	Column A	Column B	Column C	Column D
	Covered by EI Amount available with 30, 60, 90 day EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***	**Covered by EI** Amount available with 30, 60, 90 EP	**Covered by EI** Amount subject to 120 day EP	**No EI** Amount available with any EP	**Combo Limits***
810,000 - 819,999	17,175	1,025	18,200	26,225	31,600	1,025	32,625	47,550
820,000 - 829,999	17,350	1,025	18,375	26,325	31,925	1,025	32,950	47,675
830,000 - 839,999	17,525	1,025	18,550	26,425	32,275	1,025	33,300	47,800
840,000 - 849,999	17,700	1,025	18,725	26,500	32,625	1,025	33,650	47,925
850,000 - 859,999	17,875	1,025	18,900	26,575	32,975	1,025	34,000	48,050
860,000 - 869,999	18,050	1,025	19,075	26,650	33,325	1,025	34,350	48,175
870,000 - 879,999	18,225	1,025	19,250	26,725	33,650	1,025	34,675	48,300
880,000 - 889,999	18,400	1,025	19,425	26,800	34,000	1,025	35,025	48,425
890,000 - 899,999	18,575	1,025	19,600	26,875	34,350	1,025	35,375	48,550
900,000 - 909,999	18,750	1,025	19,775	26,950	34,700	1,025	35,725	48,675
910,000 - 919,999	18,925	1,025	19,950	27,025	35,025	1,025	36,050	48,800
920,000 - 929,999	19,100	1,025	20,125	27,100	35,375	1,025	36,400	48,925
930,000 - 939,999	19,275	1,025	20,300	27,175	35,700	1,025	36,725	49,050
940,000 - 949,999	19,450	1,025	20,475	27,225	36,025	1,025	37,050	49,175
950,000 - 959,999	19,625	1,025	20,650	27,275	36,375	1,025	37,400	49,300
960,000 - 969,999	19,800	1,025	20,825	27,325	36,700	1,025	37,725	49,425
970,000 - 979,999	19,975	1,025	21,000	27,375	37,050	1,025	38,075	49,550
980,000 - 989,999	20,150	1,025	21,175	27,425	37,375	1,025	38,400	49,675
990,000 - 999,999	20,325	1,025	21,350	27,475	37,700	1,025	38,725	49,800
1,000,000 - 1,099,999	20,500	1,025	21,525	27,550	38,100	1,025	39,125	50,000
1,100,000 - 1,199,999	22,575	1,025	23,600	29,500	42,275	1,025	43,300	50,000
1,200,000 - 1,299,999	24,450	1,025	25,475	31,100	46,025	1,025	47,050	50,000
1,300,000 - 1,399,999	26,125	1,025	27,150	32,575	48,975	1,025	50,000	50,000
1,400,000 - 1,499,999	27,625	1,025	28,650	33,800	48,975	1,025	50,000	50,000
1,500,000 - 1,599,999	28,950	1,025	29,975	34,775	48,975	1,025	50,000	50,000
1,600,000 - 1,699,999	30,125	1,025	31,150	35,000	48,975	1,025	50,000	50,000
1,700,000 - 1,799,999	31,125	1,025	32,150	35,000	48,975	1,025	50,000	50,000
1,800,000 - 1,899,999	31,950	1,025	32,975	35,000	48,975	1,025	50,000	50,000
1,900,000 - 1,999,999	32,700	1,025	33,725	35,000	48,975	1,025	50,000	50,000
2,000,000 - 2,099,999	33,375	1,025	34,400	35,000	48,975	1,025	50,000	50,000
2,100,000	33,975	1,025	35,000	35,000	48,975	1,025	50,000	50,000

* Some restrictions apply. Please consult the "Guidelines for the use of Combo Limits".

PROOF OF INCOME REQUIREMENTS (02/05)

Following is a chart of the financial documentation that constitutes proof of income for underwriting purposes. Financial documentation is required with every application submitted, except as follows:

Quantum Policy (excluding farmers): There are no routine financial requirements for the Quantum policy unless the in force and applied for coverage exceeds $3000 per month*. However, we do recommend that documentation be submitted to help ensure the appropriate amount of coverage is approved. Proof of earnings is required at claim time.

The Bridge Series Policy (excluding farmers): There are no routine financial requirements for the Bridge Series unless the in force and applied for coverage exceeds $3000 per month*. However, we do recommend that documentation be submitted to help ensure the appropriate amount of coverage is approved. Proof of earnings is required at claim time.

Business Overhead Expense (BOE): There are no routine financial requirements for stand-alone BOE applications unless the in force and applied for coverage exceeds $3000 per month*, or for selected 4A professionals, unless the in force and applied for coverage exceeds $10,000 per month*. Selected 4A professionals are: accountants (CA, CGA, CMA only), actuaries, architects, chiropodists, professional engineers, lawyers, notaries (Quebec), optometrists, osteopaths, pharmacists, physicians and surgeons, podiatrists, orthodontists, and psychologists (with a Ph.D. only). Proof of earnings and expenses is required at claim time.

The Underwriting Department reserves the right to request any financial evidence necessary to accurately assess an applicant for coverage.

* Provided this documentation is not required for any other types of coverage applied for concurrently.

FINANCIAL DOCUMENTATION REQUIREMENTS CHART (02/05)

INDIVIDUAL DISABILITY COVERAGE (INCLUDING RETIREMENT PROTECTOR, BUSINESS LOAN AND KEY PERSON)
* SEE EXCEPTIONS BELOW

Business/Employment Status	Applied for and In Force less than $11,000 (lump sum $400,000)	Applied for and In Force $11,000 and over (lump sum $400,001 and over)
Employee, no ownership share of business	T4 or **T1	T4 +**T1
Employee with business expense deductions or commissioned employee deducting expenses	**T1	T4 + **T1
Owner/shareholder of incorporated business	T4 or **T1 + Income Statement of business (farmers: **T1 + income statement)	T4 + **T1 + ***Complete Business Financial Statements
Owner/shareholder of incorporated business deducting expenses on personal tax return	**T1 + Income Statement of business	**T1 + ***Complete Business Financial Statements
Unincorporated professional, business owner or partner (see note 6)	**T1 + Income Statement	**T1 + ***Complete Business Financial Statements
Unincorporated Farmer (see note 10)	**T1	**T1

** **T1** means all pages up to and including lines 260 of the most recent T1 General federal tax return.
*** **The Business Financial Statement** includes the income statement (profit & loss statement), balance sheet and notes for the last complete fiscal year end.

* EXCEPTION FOR 4A EXECUTIVES WHO ARE PART OF A MULTI-LIFE SALE:

4A Executive - Part of a multi-life sale of 3 or more individuals	All Amounts
Employee, no ownership share of business	Census or letter on company letterhead, signed by appropriate company official, with their title. Document must include clear breakdown of all applicants' salary, bonus and any other compensation for the last 2 years. If original document not available or not submitted, census can be submitted as an e-mail from appropriate company official, not from producer or applicant.
Corporate owner/shareholder - share of profit of business is not required to justify the indemnity requested	Same as above plus the census or letter must also state that for corporate income tax purposes the business has not shown a net pre-tax loss for the last two fiscal years.
Corporate owner/shareholder - share of profit of business is required to justify the indemnity requested	Same as 'employee, no ownership' plus the Income Statement of the business for the last complete fiscal year end.

BUSINESS OVERHEAD EXPENSE COVERAGE****

Business Structure	Requirement at $0
Unincorporated professional, business owner or partner	**T1 and Income Statement of business
Owner/shareholder of an incorporated business	**T1 and Income Statement of business

** **T1** means all pages up to and including lines 260 of the most recent T1 General federal tax return.

**** Provided this documentation is not required for any other types of coverage applied for concurrently, there are no routine financial requirements for Business Overhead Expense applications except:

- Where the in force and applied for coverage exceeds $3000 per month. Proof of earnings and expenses is required at claim time.
- For selected 4A professionals except where the in force and applied for coverage exceeds $10,000 per month. Selected 4A professionals are: accountants (CA, CMA, CGA only), actuaries, architects, chiropodists, professional engineers, lawyers, notaries (Quebec), optometrists, osteopaths, pharmacists, physicians and surgeons, podiatrists, orthodontists, and psychologists (with a Ph.D. only). Proof of earnings and expenses is required at claim time.

DISABILITY BUY SELL COVERAGE

Business Structure	Amount applied for $500,000 or less	Amount applied for over $500,000
Unincorporated professional, business owner or partner (see note 6)	**T1 and complete ***Business Financial Statements, for the past two years	**T1 and complete ***Business Financial Statements, for the past two years
Owner/shareholder of incorporated business	**T1 or T4 and complete ***Business Financial Statements, for the past two years	**T1 or T4 and complete ***Business Financial Statements, for the past two years

** **T1** means all pages up to and including lines 260 of the most recent T1 General federal tax return.

*** **The Business Financial Statement** includes the income statement (profit & loss statement), balance sheet and notes for the last complete fiscal year end.

NOTES REGARDING ALL FINANCIAL REQUIREMENTS CHARTS

1. All financial documentation must be for the last complete tax year for which a tax return and/or business financial statements have been prepared. On any application dated after May 15 of each year, the financial documentation required is that from the immediately preceding tax year. For example: after May 15, 2004, we require a 2003 T4 and T1 for an employee applying for $12,000 per month Individual Disability coverage.

2. ** "T1" means all pages up to and including line 260 of the most recent T1 General federal tax return.

3. *** Business Financial Statements generally include the following: income statement (profit & loss statement), balance sheet plus all notes.

4. Farm owners can be incorporated or unincorporated. In all cases, we require the complete T1 General and for the incorporated farmer, we also require the income statement of the business. Please refer to the Issue Limits for Farmers section of the guidelines for additional information.

5. Fee for service professionals include the following: Actuaries, Engineers with consulting duties, Lawyers, Optometrists, Dentists, Veterinarians and Physicians, etc.

6. Unincorporated businesses may submit the following Canada Revenue Agency forms instead of business financial statements:

   a) Professionals: the Statement of Professional Activities - T2032
   b) Business owners: the Statement of Business Activities - T2124

7. Students and first-year professionals: We provide benefit limits without income justification and without financial documentation for specified students and first-year professionals. Please refer to the Student Limits section for further details.

8. Refer to the "Earned Income" section to determine the appropriate earned income to be recorded in the appropriate section of the application. Any difference between the documented income amount and the earned income stated on the application should be explained.

9. **A Notice of Assessment is not an acceptable proof of income.** A notice of assessment reports the total of all taxable income, and does not provide the sources or nature of the income. Consequently, it is impossible for us to distinguish between earned and unearned income using a notice of assessment.

10. Please refer to the Issue Limits for Farmers. If the applicant qualifies for use of the special adjusted net earned income method for farmers, proof of the capital cost allowance is required in addition to the routine financial documentation that must be submitted for consideration under the Issue Limits for Farmers. The additional documentation required is as follows:

    a) Unincorporated farmer: Form T2042 (Statement of Farming Activities) - all pages, or Form T1175 (Farming - Calculation of Capital Cost Allowance) - all pages (formerly Form T1163CCA), for the tax year being underwritten
    b) Incorporated farmer: Schedule 8 Capital Cost Allowance (CCA) for the tax year being underwritten

11. The business owners' salaries are a factor in calculating the value of the business for Buy Sell coverage. Consequently, details of the wages of all owners, for the last complete fiscal year, should be provided.

BANKRUPTCY (10/99)

If an applicant has a history of bankruptcy that has not been discharged, we must decline coverage. Following discharge of a single bankruptcy, coverage may be considered with a minimum 90 day EP and for short-term coverage, subject to stability of earned income following discharge, and no other underwriting concerns.

The amount of coverage available may also be limited.

GROUP/ASSOCIATION OFFSET AMENDMENT (A670) (01/04)

This amendment may be used on coverage issued under the Foundation Series and the Professional Series policies.

Group/Association Offset Amendments are not required on Bridge Series or Quantum policies due to contract provisions regarding the integration of group and association benefits.

If an applicant has group and/or association coverage in force or pending (including a probationary employment or waiting period), this amendment may allow us to offer additional individual coverage where income limits and in force and pending coverage might otherwise reduce or prohibit any more coverage. The amendment can also be used if an applicant can opt in and out of a group plan. Only the amount of coverage that exceeds our issue limits will be offset, thus preventing overinsurance.

A signed statement included in the policy will indicate the amount of the monthly benefit that will be affected by the Group/Association Offset Amendment.

GROUP AND ASSOCIATION DISABILITY COVERAGE INTEGRATION CLAUSE:
Even if an applicant advises that his group and/or association disability coverage contain an integration clause or an all source maximum, a group offset must be used when the total amount of coverage, group/association and individual, exceeds our issue limits.

DISCOUNT:
For new policies, if the amount of the offset is $1,000 per month or greater, or the full amount of the policy, and the group LTD or association coverage being offset has a benefit period of longer than one year, a 10% premium discount is given on the entire policy. If the offset amount is less than $1,000 per month or the group LTD or association coverage being offset has a benefit period of one year or less, no premium discount applies. No discount is available if the group or association coverage being offset is short-term disability coverage.

Example:
Applicant is eligible for $6,000 per month by our issue limits. The in force group insurance amount is $3,500 per month and coverage requested is $5,000 per month for a total of $8,500 per month. We would approve with a Group/Association Offset Amendment and the signed statement would indicate that the offset applies to $2,500 per month which is the amount of coverage the applicant has in excess of the $6,000 issue limit. The premium for the entire $5,000 per month benefit is discounted by 10%.

TERMINATION OF GROUP OR ASSOCIATION COVERAGE:
If this amendment is included in the policy and the 10% premium discount is given, the insured is required to notify us in writing if the group or association coverage terminates. On the first premium due date thereafter, the full premium without any group/association offset discount is payable. If the insured does not notify us of the termination of the group or association coverage, any monthly disability or recovery benefit provided under our policy will be reduced by 10%. Although the discount will be removed, the **offset amendment will remain on the policy**. If the insured subsequently becomes covered for group or association coverage in an equal or greater amount, we will reinstate the 10% discount upon receiving written notification from the insured and satisfactory evidence of such coverage.

A discount is not available if the group offset is added as a result of a policy change or to exercise an FIO option on an in force policy.

ADDING A GROUP/ASSOCIATION OFFSET AMENDMENT TO EXERCISE A FUTURE INCOME OPTION BENEFIT:
Professional and Foundation series policies: if a policy was originally issued without a group offset and one is now required in order for the insured to qualify for an FIO increase, we will offer to approve the FIO with the addition of a group offset. As long as there has been no past misrepresentation with regards to in force coverage, the amount of the offset will not exceed the amount of the FIO being approved.

Old Unum and Provident portfolio policies: if a policy was issued initially without a group offset, we do not offer to add a group offset amendment in order to approve an FIO increase. This is because the offset amendment available for use on these contracts would apply to the entire policy amount, not just the FIO coverage being approved.

REQUESTS TO REMOVE THE GROUP/ASSOCIATION OFFSET AMENDMENT:

Upon termination of group or association coverage, any group offset discount will no longer apply, however, the offset amendment will remain on the policy as it is in no way detrimental to the insured to do so.

REVISION OF THE GROUP/ASSOCIATION OFFSET AMENDMENT AMOUNT:

Up to once per calendar year, but no later than 90 days after becoming and remaining disabled, the insured can request a review of the amount of offset referred to in the amendment. If permitted by our financial underwriting guidelines in effect at the time of such request and subject to satisfactory documentation of current income and group and/or association coverage, we will reduce the amount of offset accordingly.

GUIDELINES FOR CONVERSION OF TAXABLE AND NON-TAXABLE COVERAGE (INDIVIDUAL AND GROUP) (04/04)

The existing and pending coverage section of the application must include details of all group coverage, in force or pending. If dealing with a combination of taxable and non-taxable coverage, the following chart explains how to convert taxable and non-taxable coverage to determine the amount of coverage an individual is eligible for.

Note: Remember to use Column D on the Issue Limits chart if you are using Combo limits.

Conversion factors to be applied to taxable coverage in order to obtain the non-taxable equivalent, at different income levels:

- › less than $30,000 total income 85%
- › $30,000 to $50,000 total income 80%
- › $50,001 to $100,000 total income 70%
- › greater than $100,000 total income 60%

(Note: when converting taxable coverage for a U.S. resident, i.e. for an F.I.O., a conversion factor of 80% is to be used at all income levels; this rate takes into consideration the lower rates of taxation in the U.S.)

CONVERSION OF TAXABLE GROUP BENEFIT TO NON-TAXABLE EQUIVALENT:

1. Based on the applicant's total income, determine which conversion factor to use.
2. Multiply the taxable group coverage by the % in step # 1 to obtain the non-taxable equivalent.
3. Find the maximum non-taxable amount of coverage available for the total income, based on the issue limits.
4. Subtract the amount in step # 2 (non-taxable equivalent) from the amount in step # 3 to determine the additional non-taxable coverage available (if negative, no coverage is available).

Example #1: applicant has $28,000 income and $1,500 taxable group coverage in force
1. Use 85% conversion factor
2. $1,500 x 85% = $1,275 non-taxable equivalent
3. At $28,000 = $1,650 available on a non-taxable basis
4. $1,650 - $1,275 = $375 additional non-taxable coverage available

Example #2: applicant has $90,000 income and $5,500 taxable group coverage in force
1. Use 70% conversion factor
2. $5,500 x 70% = $3,850 non-taxable equivalent
3. At $90,000 = $4,150 available on a non-taxable basis
4. $4,150 - $3,850 = $300 additional non-taxable coverage available

CONVERSION OF NON-TAXABLE GROUP COVERAGE TO TAXABLE EQUIVALENT:

1. Based on the applicant's total income, determine which conversion factor to use.
2. Divide the non-taxable group coverage by the % in step # 1 to obtain the taxable equivalent.
3. Find the maximum taxable amount of coverage available for the total income, based on the issue limits.
4. Subtract the amount in step # 2 (taxable equivalent) from the amount in step # 3 to determine the additional taxable coverage available (if negative, no coverage is available).

Example #3: applicant has non-taxable group coverage of $1,000 and $40,000 income
1. Use 80% factor
2. $1,000 / 80% = $1,250 taxable equivalent
3. At $40,000 = eligible for $2,775 taxable coverage
4. $2,775 - $1,250 = $1,525 additional taxable coverage still available

Example #4: applicant has non-taxable group coverage of $2,000 and $80,000 income
1. Use 70% factor
2. $2,000 / 70% = $2,857 taxable equivalent
3. At $80,000 = eligible for $5,400 taxable coverage
4. $5,400 - $2,857 = $2,543 additional taxable coverage still available

INCOME LIMITS (01/04)

No policy will be issued if the total disability income benefits from all sources exceed the amount listed on the Issue Limits chart or the limit specified for the applicant's occupational class and age on the Issue and Participation chart, whichever is less.

Bridge Series and Quantum contracts contain an integration of benefits provision that, when used in conjunction with some limits, may result in the client paying for benefits they may never receive under the provisions of the policy. This is most likely to occur at incomes under $100,000. Consequently, it may be prudent to reduce the benefit amount by 5% or 10% in these situations.

INTEGRATION OF BENEFITS (02/04)

EMPLOYMENT INSURANCE (EI) (02/04)

Our Issue Limits are designed to integrate with EI sickness benefits. If an applicant is eligible for EI benefits, the taxable aspect of these benefits has been taken into consideration in determining the amount of coverage shown on our Issue Limits chart. Programming around EI benefits is accomplished by using the "With EI" column (120 day EP or longer) as an Additional Monthly Indemnity (AMI) amount in conjunction with any shorter elimination period for which the applicant may qualify for on the basic amount.

CANADA/QUEBEC PENSION PLAN (04/97)

Our Issue Limit chart is based on an allowance for minimum Canada/Quebec Pension Plan benefits (on a taxable basis), thus eliminating the need to program individual disability insurance coverage around these benefits.

PROGRAMMING BENEFITS AROUND IN FORCE COVERAGE (02/04)

In order to facilitate programming benefits around in force coverage, an Additional Monthly Indemnity (AMI) can be added to the basic coverage. An AMI can have the same or a longer elimination period than the basic coverage and have a benefit period that is the same or shorter than the basic coverage. Consequently, the AMI offers many alternatives that can be used to properly accommodate an applicant's needs.

CREDITOR INSURANCE (02/04)

We require that all forms of disability insurance be fully disclosed on our application for insurance, including creditor disability insurance. However, we will disregard creditor insurance when determining the amount of disability coverage we will allow.

LUMP SUM DISABILITY BENEFITS (02/04)

It may not be possible to program around coverage that provides Lump Sum Disability benefits, however such coverage cannot be ignored. Discuss any situation where the applicant has Lump Sum Disability benefits with the Underwriting Department.

ISSUE LIMITS FOR FARMERS (02/04)

There can be unique aspects to a farmer's financial circumstances. In recognition of this fact, the following farmer's issue limits are available for self-employed farmers with a minimum 25% ownership applying for disability insurance.

These farmer limits are available using the Foundation Series policy only. The Professional Series contract is not available under the special farmer's issue limits.

Optional benefits are available subject to usual underwriting approval.

Special farmer's issue limits are also available using the Bridge Series. For this product, the farmer's limit is $1,500 per month, without an AMI. The Bridge contract will include a Farmer's Amendment # A710 to amend the Integration of Benefits clause of the policy.

Regular underwriting rules apply to any farmer applying for one of our other products.

Refer to the Notes at the end of this section for additional guidelines.

ISSUE LIMITS FOR FARMERS EXCLUDING QUEBEC AND THE MARITIME PROVINCES

SPECIAL ADJUSTED NET EARNED INCOME METHOD FOR FARMERS – not available to farmers in Quebec and the Maritime Provinces:

If the applicant wishes, an adjusted net earned income method can be used to develop a higher annual earned income, even if their annual earned income is below $0. A percentage of their ownership share of the capital cost allowance (CCA), claimed for the tax year being used to determine their insurable income, can be added to their net earned income. Proof of this capital cost allowance is required **in addition** to the routine financial documentation required for consideration under the farmer's issue limits. The **additional documentation** required is as follows:

- *Unincorporated farmer*: Form T2042 (Statement of Farming Activities) - all pages, or Form T1175 (Farming - Calculation of Capital Cost Allowance) - all pages (formerly Form T1163CCA), for the tax year being underwritten
- *Incorporated farmer*: Schedule 8 Capital Cost Allowance (CCA) for the tax year being underwritten

Calculation of adjusted net income:

- Determine the net earned income before taxes, and
- Add 100% of the applicant's ownership share of the Capital Cost Allowance (CCA) from farm buildings (CCA classes 1, 3 and 6), and
- Add 25% of the applicant's ownership share of the Capital Cost Allowance (CCA) from all other items (CCA classes 8, 10, etc.).
- This total is the adjusted net earned income that can be used as 'income' to determine the amount of disability coverage for which the applicant is eligible.

DAIRY, CHICKEN AND EGG FARMERS EXCLUDING QUEBEC AND THE MARITIME PROVINCES:

- With an annual earned income from farming of $0 - $47,999, we will consider a maximum monthly indemnity amount of $2,500 with any elimination period (EP) and any benefit period (BP)*.
- If the annual earned income from farming is $0 - $47,999, an additional monthly indemnity (AMI) up to a maximum of $1,250 will also be allowed. The AMI must have an EP that is equal to or longer than the EP on the basic coverage and a maximum BP* of 2 years.
- With an annual earned income of $48,000 or more, we will consider coverage based on our regular issue limits.
- The farmer must work full-time on the dairy, chicken or egg farm.
- Dairy, chicken or egg production must be the primary function of the farm, representing the largest percentage of gross revenue.

* a 2-year benefit period is not available with a 730 day elimination period.

ALL OTHER FARMERS EXCLUDING QUEBEC AND THE MARITIME PROVINCES:

- With an annual earned income from farming of $0 - $25,999, we will consider a maximum monthly indemnity amount of $1,500 with any elimination period (EP) and any benefit period (BP)*.
- If the annual earned income from farming is $0 - 25,999, an additional monthly indemnity (AMI) up to a maximum of $750 will also be allowed. The AMI must have an EP that is equal to or longer than the EP on the basic coverage and a maximum BP* of 2 years.
- With an annual earned income of $26,000 or more, we will consider coverage based on our regular issue limits.
- The farmer must work full-time on the farm.

* a 2-year benefit period is not available with a 730 day elimination period.

ISSUE LIMITS FOR FARMERS IN QUEBEC AND THE MARITIME PROVINCES

DAIRY, CHICKEN AND EGG FARMERS:

- With an annual earned income from farming of $0 - $35,999, we will consider a maximum monthly indemnity amount of $2,000 with any elimination period (EP) and any benefit period (BP)*.
- With an annual earned income of $36,000 or more, we will consider coverage based on our regular issue limits.
- The farmer must work full-time on the dairy, chicken or egg farm.
- Dairy, chicken or egg production must be the primary function of the farm, representing the largest percentage of gross revenue.

* a 2-year benefit period is not available with a 730 day elimination period.

ALL OTHER FARMERS:

- With an annual earned income from farming of $0 - $15,999, we will consider a maximum monthly indemnity amount of $1,000 with any elimination period (EP) and any benefit period (BP)*.
- If the annual earned income from farming is $0 - $15,999, an additional monthly indemnity (AMI) up to a maximum of $500 per month, will also be allowed. The AMI must have an EP that is equal to or longer than the EP on the basic coverage and a maximum BP of 365 days.
- With an annual earned income of $16,000 or more, we will consider coverage based on our usual issue limits.
- The farmer must work full-time on the farm.

* a 2-year benefit period is not available with a 730 day elimination period.

NOTES REGARDING ISSUE LIMITS FOR FARMERS (01/04)

- For the purpose of qualifying for the farmer's issue limits, perks are not available. Perks can be included when a farmer qualifies for coverage under our regular issue limits.
- The farmer must work full-time on the farm.
- Working farmers with no ownership or less than 25% ownership must qualify under our regular issue limits as would a farm owner's child or spouse who has no current ownership in the farm.
- Spouses who each have a minimum of 25% ownership of a farm, and who both actively work full-time on the farm, may each qualify for the farmer's issue limits, subject to financial documentation for each applicant.
- Income splitting will not be considered for purposes of using the farmer's issue limits. Income splitting will be considered when a farmer qualifies for coverage under our regular issue limits.
- The children and/or spouse who have no ownership or less than 25% ownership of the farm will be considered at class 2A based on the following criteria:
  - they work full-time, year-round on the farm.
  - their parent(s)/spouse own the farm.
  - they have a minimum insurable income of $12,000 per year.
  - proof of income (T1 or T4) is provided (if employed less than a full year, we will consider copies of cheque stubs or some other acceptable proof of employment income).

  Note: the special Issue Limits for Farmers do not apply and any future ownership of the farm is not a consideration for this situation.
- Any applicant who is currently or has in the past year, collected employment insurance, social assistance and/or Workers' Compensation benefits is ineligible for the farmer's issue limits. These individuals will only be considered under our regular underwriting rules.
- An applicant with an earned income (or 'adjusted net earned income', for those who qualify) below $0 (a negative or minus income) is ineligible for coverage on any basis, except under the following situation:
  Should the financial documentation for the most recent complete tax year result in a loss or negative income figure, we will consider an average of the last three years of income to determine eligibility under the farmer's issue limits. Complete financial documentation must be provided for each of the last three years if averaging is to be used. Coverage is not available if the income averaged over the three years shows a loss.
  Note: Averaging income over the last three years is only available for the purpose of using the farmer's issue limits.
- To qualify for any business product, a farmer must have a minimum net earned income of $12,000. The Special Adjusted Net Earned Income Method does not apply in establishing this minimum amount.
- To qualify for Retirement Protector, either as a rider or a stand-alone policy, a minimum net earned income of $18,000 is required. The Special Adjusted Net Earned Income Method does not apply in establishing this minimum amount.
- When a farmer also has another occupation, both incomes are taken into consideration when determining insurable income, however, to qualify for farmer limits, the earned income (or 'adjusted net earned income' for those who qualify) from farming must not show a loss and farming must be a full-time occupation. A dual occupation situation may affect the applicant's occupational classification.
- Medical requirements will be based on the total amount of coverage applied for. Please refer to the Medical Requirements section of the Underwriting Guidelines.
- Proof of income is a mandatory requirement. Please refer to the Financial Documentation chart for details of the income documents required.
- Except for those applicants using the 'adjusted net earned income method' to calculate eligible income, earned income is based on the following:
  Incorporated farm owner: includes the wage, shown on the Federal T1 General, plus the applicant's ownership share of the profit/loss of the farm.

  Unincorporated farm owner: is the net farming income shown on the applicant's Federal T1 General.

Example #1: earned farming income less than $16,000

A farmer has an earned farming income of $9,800 per year and wishes coverage with 30 day EP to age 65 for the maximum amount available. The financial documentation confirms the earned income of $9,800.

An Alberta egg farmer would be eligible for $2,500/month coverage with 30 day EP to age 65 plus an AMI of $1,250/month with a 2 year BP. A New Brunswick egg farmer would be eligible for $2,000/month coverage with 30 day EP to age 65.

An Alberta beef farmer would be eligible for $1,500/month coverage with 30 day EP to age 65 plus an AMI of $750/month with a 2 year BP. A beef farmer from New Brunswick would be eligible for $1,000/month coverage with 30 day EP to age 65 plus an AMI of $500/month with a 30 day EP to the 365th day of disability.

Example #2: earned farming income more than $16,000

A farmer has an earned farming income of $28,000 per year from farming and wishes coverage with 30 day EP to age 65 for the maximum amount available. The financial documentation confirms the earned income of $28,000.

An Alberta egg farmer would be eligible for $2,500/month coverage with 30 day EP to age 65 plus an AMI of $1,250/month with a 2 year BP. A New Brunswick egg farmer would be eligible for $2,000/month coverage with 30 day EP to age 65.

To calculate the maximum coverage available for a beef farmer, perks are added to the earned income ($28,000 + 15% = $32,200).

For a beef farmer resident in any Province, the maximum coverage available, based on $32,200 earned income, would be $1,775/month with 30 day EP to age 65.

Example #3: earned farming income more than $36,000 and Capital Cost Allowance (CCA) deduction of $50,000

A farmer has an earned farming income of $38,000 per year and wishes coverage with 30 day EP to age 65 for the maximum amount available. The financial documentation confirms the earned income of $38,000 and a Capital Cost Allowance deduction of $50,000. The CCA amount is made up of $10,000 from farm buildings and $40,000 from other items.

To calculate the maximum coverage available for a farmer not residing in Quebec or the Maritimes, 100% of the CCA deduction of $10,000 and 25% of the CCA deduction of $40,000 would be added back to the $38,000 net farming income, to obtain an adjusted net earned income of $58,000. Perks are added to the net adjusted income ($58,000 + 15% = $66,700). This amount would allow for $3,425/month coverage with 30 day EP to age 65.

To calculate the maximum coverage available for a farmer from Quebec or the Maritimes, perks are added to the earned income ($38,000 + 15% = $43,700). This amount would allow for $2,250/month coverage with 30 day EP to age 65.

Example #4: earned farming income plus other source of earned income

A farmer has an earned income of $30,000 per year from farming plus a salary of $14,000 per year from working in a feed mill. Maximum coverage with 30 day EP to age 65 is requested. The financial documentation confirms the earned income figures.

To calculate the maximum coverage available, perks are added to the earned income from farming ($30,000 + 15% = $34,500).

The perked farming income and salaried income are totalled ($34,500 + $14,000 = $48,500) to determine the applicant's total earned income. This amount allows for $2,600/month coverage to age 65 for all farmer's, regardless of their Province of residence.

OVERINSURANCE (03/04)

Please refer to the Individual Disability Income and Business Products Issue and Participation Limits Charts.

Any applicant who is over-insured by our limits for any single disability product will not be insurable for any other disability product.

Such overinsurance presents a risk of adverse experience that we are unable to assume even under another type of product.

For example, an applicant who is overinsured on his or her business overhead plan will not be eligible for a disability insurance policy.

STUDENT LIMITS (02/05)

The following indemnities are available without income justification for certain professionals:

Profession	Benefit Amount	Eligibility for Enhanced Prior Earnings Definition Amendment * – Professional Series Contract Only
Accountants (C.A., C.G.A., C.M.A. only)		
Starting or within first year of practice	$3,500	*PED - other
Articling	$3,500	*PED - other
Last year students	$2,000	*PED - other
Actuaries, ASA, FSA		
Starting or within first year of practice	$3,500	*PED - other
Architects		
Starting or within first year of practice	$3,000	*PED - other
Articling	$2,500	*PED - other
Last year students	$2,000	*PED - other
Chiropodists		
Starting or within first year of practice	$3,500	*PED - other
Last year students	$1,500	*PED - other
Chiropractors		
Starting or within first year of practice	$2,000	not available
Last year students	$1,000	not available
Computer Industry Professionals (4A – Executives, Consultants, Engineers, Designers, Analysts, Programmers)		
Starting or within first year of business, started within first 12 months of graduation** only	$3,000	not available
Last year students**	$1,500	not available
**Note: must have a university degree in computer science or must be a computer science major.		
Dentists (including endodontists, periodontists, oral surgeons, maxillofacial surgeons, etc. excluding orthodontists, listed below)		
Starting or within first year of practice	$2,000	not available
Interns/Residents	$1,500	not available
Third and fourth year dental students	$1,000	not available
Lawyers, Notaries (Quebec only)		
Starting or within first year of practice	$2,500	*PED - other
Articling	$1,500	*PED - other
Last year students	$1,000	*PED - other
Master of Business Administration (MBA) Students or Graduates (see "Notes" below for restrictions and special underwriting considerations)		
Within first 12 months of graduation	$2,500	not available
Second year students	$2,500	not available
First year students	$1,500	not available

Profession	Benefit Amount	Eligibility for Enhanced Prior Earnings Definition Amendment * – Professional Series Contract Only
Medical doctors		
Specialists starting or within first year of practice (see notes)	$7,500	*PED - other
Others starting or within first year of practice	$6,000	*PED - other
Fellowship	$5,000	*PED - MED
Residents	$3,500	*PED - MED
Interns	$2,500	*PED - MED
Medical students - fourth year	$2,500	*PED - MED
Medical students - third year	$1,500	*PED - MED
Medical students - first and second year	$1,000	*PED - MED
Optometrists		
Starting or within first year of practice	$3,500	*PED - other
Last year students	$2,000	*PED - other
Third year students	$1,500	*PED - other
Second year students	$1,000	*PED - other
Orthodontists		
Starting or within first year of practice	$4,000	*PED - other
Residents	$3,000	*PED - other
Interns - see dentists		
Third & fourth year dental students - see dentists		
Osteopaths		
Starting or within first year of practice	$2,500	*PED - other
Last year students	$1,500	*PED - other
Pharmacists		
Starting or within first year of practice	$2,000	*PED - other
Third and fourth year students	$1,000	*PED - other
Physiotherapists		
Starting or within first year of practice	$1,500	not available
Podiatrists		
Starting or within first year of practice	$3,500	*PED - other
Last year students	$1,500	*PED - other
Professional engineers (see notes)		
Starting or within first year of practice	$3,000	*PED - other
Last year students	$2,000	*PED - other
Third year students	$1,000	*PED - other
Psychologists (with Ph.D. only)		
Starting or within first year of practice	$1,500	*PED - other
Veterinarians		
Starting or within first year of practice	$2,000	not available
Last year students	$1,000	not available

* Prior earnings are used to establish the amount of income loss that has occurred during a period of residual disability. The higher the prior earnings amount, the greater the loss that can be demonstrated during residual disability. The **Enhanced Prior Earnings Definition Amendment** replaces the prior earnings definition in the contract with a more favourable definition.

The amendment applies to the Professional Series contracts only. The basic contract caps the "6 out of 24 months" at 125% of the average earnings in the last fiscal year. The amendment recognizes the low level of earnings of a student or those in the first year of practice. The amendment allows those applicants to use a "6 out of the last 24 months" definition at claim time to establish their earnings loss without the cap.

PED - MED refers to amendment A701. PED - other refers to amendment A702. The amendment is only available on new business (not available as a policy change), to the specific 4A occupations as indicated above. Medical doctors starting in practice do not get a PED - MED amendment, they get the PED - other amendment.

NOTES REGARDING STUDENT LIMITS

- **Projected income:** the amount of coverage offered to students, first year professionals or those changing their employment status cannot be based on projected income.
- **Professional engineers:** we will allow class 4A and the limits stated above, for applicants who are in their last year of studies for a Bachelor of Science degree and those who have a B.Sc. and are working to obtain practical experience prior to attaining their Professional Engineer designation.
- **Starting or within first year of practice:** can include the last three months of education if plans have been made to go directly from school into practice. In addition, these limits may be used if an already established professional, such as a doctor, returns to school for a specialty and then returns to active practice.
- The Student Limits do not apply if the applicant has completed the first year of practice.
- If a professional who was an employee becomes self-employed, the Student Limits do not apply. The amount of coverage available will be based on the prior established and documented income.
- If the policy applied for is part of a Wage Loss Replacement Plan, the taxable equivalent to the above limit is available.
- Eligible university MBA programs are as follows:

DeGroote (McMaster University)
Molson (Concordia University)
Richard Ivey (University of Western Ontario)
Schulich (York University)
University of Alberta
University of Calgary
University of Victoria
McGill University
Queens University
Rotman (University of Toronto)
Simon Fraser University
University of British Columbia
University of Manitoba

Minimum Occupation Class of 3A with upgrade available based on our "Executive" occupational guidelines. An upgrade to class 4A may also be available based on our consideration of the prior occupational classification to students or applicants who are within 12 months of graduation and who are not currently employed or made arrangements for employment in the near future.

On our Professional and Foundation Series products, the regular group offset (A670) will be applied if there is group coverage in place or if it is known that group coverage will be available in the future. The 10% group offset discount is available, subject to our regular group offset amendment rules. Otherwise, the non-discounted offset amendment (A707GIO) will be applied if the applicant is not yet employed full-time, and there is no group coverage in place at the time of underwriting. The A707GIO offset amount will be zero (0).

UNEARNED INCOME AND NET WORTH (02/04)

While eligibility for disability income coverage is based upon an applicant's earned income, significant unearned income and/or net worth must also be considered. When an applicant has substantial financial resources, it may be necessary to consider these resources as a form of "self-insurance". Unless such resources are taken into account, a situation similar to Overinsurance may exist, leaving an individual with reduced incentive to return to work in the event of a disability.

UNEARNED INCOME:

Unearned income is defined as any income which is not dependent on the applicant's ability to work and which would continue in the event of disability. Examples of such income would include pension income, interest and investment income, royalties, and rental income.

The total amount of unearned income and the percentage relationship of unearned to earned income determine how coverage may be approved. Although we do not usually require additional details when unearned income is less than $30,000 annually, applicants with unearned income greater than $30,000 annually must provide a detailed breakdown of the sources and types of unearned income received. Normally, the amount of coverage allowed in our Issue Limits chart would be reduced when the unearned income exceeds 20% of the earned income.

Unearned income up to a level of 20% of earned income is usually ignored when determining the level of benefits available. Unearned income in excess of that amount will usually require that a deduction be made in the indemnity amount offered. An example of such a calculation is shown below. Our calculation takes into consideration the applicant's estimated tax rate.

Depending on the relationship between the dollar amount of earned and unearned income, coverage may be considered with a longer elimination period and/or short benefit period or not be available on any basis. In a situation, for example, where unearned income is in excess of 50% of earned income, coverage would usually be denied. The specifics of each situation are considered on a case by case basis.

Example:

Earned income of $100,000 annually including perks
Unearned income of $35,000 annually from rental income
Total indemnity available based on earned income: $4,425 non-taxable limits

Calculation of excess unearned income:

Earned income:		$100,000
Allowable unearned income %:	20% or	$20,000
Total unearned income:		$35,000
Excess unearned income:		$15,000 ($35,000 less $20,000)
Indemnity reduction %, allowing for estimated rate of taxation:		x 50% $7,500 divided by 12 months equals $625 per month which is the monthly indemnity reduction required

Eligible indemnity: $4,425 less $625 unearned income reduction results in an allowable indemnity amount of $3,800 per month (rounded).

NET WORTH:

Net worth is also a consideration in order to preserve adequate incentive to return to work after a period of disability. Net worth that provides easily accessible funds or that has been inherited rather than accumulated through the applicant's own efforts presents more of an underwriting concern. Any applicant nearing usual retirement age who has significant unearned income and/or net worth bears closer scrutiny.

When net worth is an underwriting consideration, we are usually concerned only with amounts in excess of $4,000,000. Personal use assets such as residential and vacation homes, automobiles, works of art, coin collections, etc. are not usually included in our net worth evaluation. If we have already calculated an unearned income deduction as explained above, we will exclude from the net worth calculation any assets which generate such unearned income.

The value (net worth) of an applicant's business may or may not be considered in our net worth evaluation depending on the overall merits of the case, the size of the business, the applicant's age, medical history, etc.

A reduction of the usual monthly indemnity available on our income chart will be calculated by deducting $400 of indemnity per $100,000 of net worth in excess of $4,000,000. An AMI with a short benefit period may be considered for the amount deducted due to the net worth.

Depending on the specifics of the case (net worth compared to earned income, unearned income, nature of assets), we may consider coverage with one or more of the following: a reduced indemnity, short benefit period or an AMI with a 12, 24 or 60 month benefit period. In situations where the net worth is unusually high, coverage may be declined.

WAGE LOSS REPLACEMENT PLAN AMENDMENT (A692) (02/04)

A Wage Loss Replacement Plan (WLRP) groups individual disability income policies together for the purpose of providing employer-paid, disability income coverage to employees. At least two employees of the same "classification" (e.g. executive classification or clerical classification) must be insured. Under a WLRP, any claim benefits are taxable to the employee. For this reason, higher taxable limits are used to determine the benefit amount for each employee covered by the plan. Since benefits offered through Employment Insurance (EI) are considered second payer to a WLRP policy, it is not necessary to program a WLRP policy around EI sickness benefits.

The WLRP amendment outlines what happens to the policy benefit amount in the event that the insured is no longer part of a valid WLRP.

Because of the wording in the WLRP amendment, we do not require that a letter of intent or a board resolution be submitted as underwriting requirements prior to the approval of WLRP coverage.

If a policy ceases to be part of a valid WLRP and ownership is transferred to the insured that will now pay the premiums for the policy, the benefits are no longer taxable. Therefore, the higher taxable benefit amount issued initially would no longer be appropriate. Employment Insurance eligibility will be taken into consideration in determining the non-taxable benefit limit. If we are not advised when a policy is no longer part of a valid WLRP, any claim benefit will be reduced to the benefit amount that the insured would have qualified for based on either the non-taxable issue limits in effect on the date of issue of the policy or when the policy ceases to be part of a valid WLRP, whichever is more favourable to the insured. Again, eligibility for Employment Insurance will be considered in determining the non-taxable benefit limits.

Any over payment of premiums between the time the insured left the plan and the time the new premium for the non-taxable benefit amount has been established will be refunded to the owner. Any over payment of claim benefits prior to notification that the policy is no longer part of a valid WLRP must be repaid to us.

Bridge Series and Quantum policies contain an integration of benefits provision that, when used in conjunction with some limits, may result in the client paying for benefits they may never receive under the provisions of the policy. This is most likely to occur at incomes under $100,000. It may be prudent to reduce the Income Limits by 5% or 10% in these situations.

ADDING AN IN FORCE POLICY TO AN EXISTING WLRP REQUIRES:

- An Application for Reinstatement and/or Policy Change (form # 83536 English (formerly # 12010) or form # 83537 French (formerly # 12011), signed and dated by the insured, requesting that we change the policy to a WLRP is required. The requested change can be indicated in Section D, under "other changes". The benefits will now be taxable, however, the benefit amount will not be increased. Any increase in coverage requires full underwriting and is subject to a new application.
- A WLRP amendment, signed and dated by the insured and the policy owner, if the policy ownership is being transferred to the employer. If this is not included with the policy change request, a signed amendment will become a delivery requirement.
- If there is a change of ownership to the employer, an Absolute Assignment form is required.
- If there is a change in banking, please submit the new banking information.

REMOVING AN IN FORCE POLICY FROM A WLRP REQUIRES:

- If a WLRP amendment was included in the policy, we require a fully completed Application for Removal of Wage Loss Replacement, (form # 12043 English or # 12044 French), signed and dated by the insured. This request authorizes us to remove the WLRP amendment from the policy and, under the terms of the amendment, to reduce the indemnity to the non-taxable equivalent of the monthly benefit, based on the non-taxable limits in effect at the time of original issue or our current issue limits, whichever is more favourable to the insured. The benefit amount will also be programmed around EI benefits, if applicable.

- If no WLRP amendment was included in the policy originally, an Application for Reinstatement and/or Policy Change signed and dated by the insured requesting that the policy be removed from the WLRP is required. The request can be indicated in Section D, under "other changes".
- If the insured wishes to retain the same amount of monthly benefit on a non-taxable basis, we require that proof of income confirming that their current income justifies this amount. This request would also be subject to the following:
  1. The insured must currently be employed full-time in an occupation whose occupational class is the same or better than the one at the time of the original issue of the policy (full-time is defined based on the type of contract).
  2. The insured is not becoming self-employed.
- We require notification that the employer or current owner will no longer pay the policy premiums. If the policy is corporately owned and ownership is to revert back to the insured, we do not require an Absolute Assignment form. Instead, the insured can simply advise us in writing or verbally that they are no longer employed by the company or that the employer or owner has stopped paying the premiums.
- All requirements are to be submitted to Customer Service along with any change in banking. Customer Service will process the change in banking and resume monthly withdrawals. Customer Service will forward the remaining documentation to Underwriting to handle. After underwriting review, any reduction in coverage will be processed and any excess premiums paid will be refunded.

CHANGE FROM ONE WLRP TO ANOTHER WLRP REQUIRES:

- An application for Reinstatement and/or Policy Change signed and dated by the insured to authorize us to change the policy from one employer's WLRP to another employer's WLRP. The requested change can be indicated in Section D, under "other changes".
- A new WLRP amendment signed and dated by the insured and the new policy owner. If not submitted with the change request, the signed amendment will become a delivery requirement.
- If the ownership is changing from the prior employer to the new employer, an Absolute Assignment form is required.
- Please submit any new banking information.

CHANGE OF OWNER'S NAME (SAME CORPORATE ENTITY) REQUIRES:

- An Absolute Assignment (form # 517DI English or # 517DIF French) specifying that it is only the employer's legal name that has changed.

WORKERS' COMPENSATION OFFSET AMENDMENT (A700) (01/04)

Except for the professions listed below, the Workers' Compensation offset amendment will be included on any Professional Series or Foundation Series policy issued to an applicant who is **eligible** for Workers' Compensation coverage. Amendment A700 is not used on the Bridge Series or Quantum policies because the contracts contain an integration of benefits provision.

Please note that it is the applicant's **eligibility to obtain Workers' Compensation (WCB) coverage** that determines whether or not an amendment is applied, not whether or not they actually have WCB coverage at the time of application. This amendment may be used on coverage issued to classes 4A, 3A, 2A, A and B. If WCB coverage is optional or if an applicant qualifies for WCB coverage on some contracts and not on others, the offset will be applied.

EXCEPTIONS:

The following professions do **not** require a Workers' Compensation offset amendment even if they are eligible for WCB coverage: accountants with C.A., C.M.A., C.G.A. designation, acupuncturists with M.D. degree, actuaries (A.S.A, F.S.A.), architects, chiropodists, chiropractors, dentists (including third and fourth year dental students, residents), lawyers (including last year law students and articling students), medical doctors (including students, interns, residents), notaries (Quebec), optometrists (including last year students), osteopaths, pharmacists, podiatrists, psychologists (Ph. D.), professional engineers (including last year students), veterinarians (including last year students).

REQUEST TO REMOVE THE WCB OFFSET:

The Workers' Compensation offset amendment will not be removed after issue even if the insured is no longer eligible for WCB coverage; leaving the offset on the policy is not detrimental to the insured if there is no WCB benefit received.

HOW THE OFFSET IS APPLIED:

At the time of claim, if the insured is entitled to receive Workers' Compensation benefits, the amendment provides that a calculation is done to determine if any offset is required. If so, the amount offset is based on the insured's "net" income level (defined as gross earnings less business expenses but before personal income tax) and the amount of WCB benefit for which the insured is eligible at the time of claim. If the total amount of benefits from both our policy and WCB does not exceed the limits shown below, no offset is applied.

Income up to $36,000	total benefits cannot exceed 70% of income
Income of $36,001 - $75,000	total benefits cannot exceed 60% of income
Income of $75,001 - $150,000	total benefits cannot exceed 50% of income
Income over $150,000	total benefits cannot exceed 45% of income

Example #1 with Workers' Compensation offset included in the policy:

At time of claim, the insured has an income of $28,700. The amount of Workers' Compensation to which she is entitled is $2,150 per month. Her policy provides a monthly benefit amount of $1,500. Based on her income, total benefits cannot exceed 70% of income or $1,675 per month. Since the amount of Workers' Compensation benefits exceeds $1,675, no benefits would be payable for this claim. Should this insured be injured in a non-job related accident for which she is not entitled to Workers' Compensation benefits, the full $1,500 per month which she purchased would be payable.

Example #2 with Workers' Compensation offset included in the policy:

At time of claim, the insured has an income of $43,000. The amount of Workers' Compensation to which he is entitled is $500 per month. His policy provides a monthly benefit amount of $1,900. Based on his income, total benefits cannot exceed 60% of income or $2,150 per month. Since the amount of the Workers' Compensation benefit is $500 per month, the policy would provide benefits in the amount of $1,650 per month for a total of $2,150 per month. In the event of a claim for which the insured was not entitled to Workers' Compensation benefits, the insured would receive $1,900 per month from his policy.

OTHER UNDERWRITING REQUIREMENTS (03/04)

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INSPECTION REQUIREMENTS (01/04)

Underwriting reserves the right to request either an inspection report (IR) or a personal history interview (PHI) at any time.

In order to provide the best possible time service with the least inconvenience to the applicant, it is crucial that the producer pre-notify every applicant that an IR or PHI may be necessary during the underwriting process. The application must always indicate the preferred time and place for the telephone interview to be conducted.

An inspection report or PHI may be ordered at the underwriter's discretion on any case based on underwriting information available.

When an IR or PHI is required, the underwriter will order the report.

INSPECTION REPORT (IR) (06/95)

At our request, an independent firm provides an inspection report. This type of report obtains information from the applicant as well as from other sources such as business associates, family members, accountants, etc. Public records may also be accessed depending on the type of report required.

PERSONAL HISTORY INTERVIEW (PHI) (01/04)

At our request, specially trained interviewers at an independent firm conduct a personal history interview. The questions asked by the interviewers amplify the information on the application relating to personal, financial and health issues. The PHI can also be used to gather details that have been omitted or partially completed on the application. Because of the nature of the information obtained, the PHI interview will only be conducted directly with the applicant. If a client is unwilling or unable to participate in a PHI interview, coverage will not be offered.

MOTOR VEHICLE REPORTS (01/04)

Motor vehicle reports (MVR's) may be ordered at the underwriter's discretion based on underwriting information available. Driver's license numbers should be provided on all cases where any driving offense is declared on the application.

Motor vehicle reports are ordered directly by the Underwriting Department.

REPLACEMENT FORMS (03/05)

Province of Quebec

In the Province of Quebec, insurance representatives must complete replacement forms where the purchase of an insurance contract is likely to result in the termination, cancellation or reduction in benefits of another Individual Life, Individual Disability or Critical Illness contract.

This provision of the Quebec Regulation Respecting the Pursuit of Activities as a Representative applies to all representatives licensed in Quebec and applies whenever a producer takes an application in the Province of Quebec, regardless of the province of residence of the applicant or the policy owner or the producer.

Replacement forms must be submitted in all cases, even if the coverage being replaced is with our company. Submission of the replacement forms will be an underwriting requirement.

Province of British Columbia

Disclosure forms have been designed for use in the Province of British Columbia to comply with the British Columbia Financial Institutions Act. It is the responsibility of the producer to complete these forms with the client. A copy of this form is not considered an underwriting requirement.

Province of Newfoundland

The Province of Newfoundland requires that replacement forms be completed for all applications for life and disability insurance when, within a six month period, any existing life or disability insurance has been or is likely to be replaced.

These guidelines apply when existing coverage is being lapsed, surrendered, partially surrendered, forfeited or otherwise terminated, changed or modified in any way. Such changes include the type of insurance, its value, benefits, or the period of time the existing contract will continue in force.

This requirement also includes the replacement of policies issued by the same insurer. Replacement does not include contractual conversions. Newfoundland does not require replacement forms for Critical Illness coverage.

SPECIFIC UNDERWRITING CONSIDERATIONS (03/04)

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ASSOCIATION MARKETING (03/04)

Marketing to associations represents a real opportunity for our producers and our Company. It is essential that our products be promoted to association members in a consistent and professional manner. We offer a discount of 15% to approved associations. In order to obtain the benefits from offering a discount and soliciting business from associations, approval by Advanced Underwriting is required before any discount will be considered.

If approved, a letter acknowledging approval of a discount will be provided. Enrollment for successful participation will be monitored.

PROCESS FOR DISCOUNT APPROVAL

To ensure successful marketing, consistency and a professional presentation to associations, the following is required prior to approving a discount for association business.

1. Completed Association Endorsement Request Form:

› This form must be completed and submitted along with the marketing plan before the company will commit to the consideration of a discount for any association.

2. A comprehensive marketing plan as follows:

› The plan should outline actions to be taken to enroll members of the association. The greater the level of detail, the greater chances of success and the increased likelihood of approval of a discount. The producer will be expected to reach an agreed upon level of participation in a set period of time (e.g. 100 cases in 4 months).
› A solid plan is essential to ensure we have strong commitment from the producer and the association.
› Provincial and national associations require very extensive plans. Consideration must be given to the assignment of producers across the province and across the country.

3. A copy of the association's constitution and bylaws:

› The association must have a constitution and bylaws. These are required to confirm the validity of the association. The association must have been in existence for at least 2 years.

4. A census of association members:

› A complete census of association members may be required to determine the size and demographics of the group.

APPROVAL BY HEAD OFFICE

Advanced Underwriting will provide approval of the association discount and marketing plan. They will confer with Sales Management and the Marketing Department as necessary.

EXCLUSIVE ENDORSEMENT BY THE ASSOCIATION

Once the initial requirements have been reviewed and approval of the discount has been granted, we will require a letter from the association president or chief administrator, addressed to the association members, endorsing the offer from our Company. The letter must exclusively endorse our Company as the insurance provider. This letter forms part of the marketing plan, and must be distributed to the association membership.

MARKETING SUPPORT

Before any association is approached, it is important to confirm that we will support the producer's presentation. Specific marketing material and assistance is available through your local sales office.

ENROLLMENT PERIOD

Discounts will be granted for a defined period of time, usually 90 or 180 days. The length of time will depend on the strength of the endorsement and the marketing plans. We also require a commitment by the producer, or producers, to write a certain number of applications within the initial enrollment period. At the end of the designated enrollment period, we will assess the success of the marketing efforts. If we do not receive the anticipated result from the marketing effort, we will re-evaluate extending the availability of the discount to the association. If the marketing efforts have not produced the anticipated level of participation (number of applications), we will terminate the availability of the association discount.

ELIGIBLE ASSOCIATIONS

- Member occupations must be homogeneous in nature (i.e. Computer Programmers, Lawyers, Accountants, and Engineers).
- The association should be at the local (county or city) or provincial level. We may consider national associations with a very comprehensive marketing plan. National efforts will require advance approval and the involvement of Head Office Sales Management.
- All associations must possess a constitution and bylaws.
- The association must have been active for at least two years.
- Associations must be formed for the purpose of promoting the interests of the profession. Professionals who come together on a social, fraternal or alumni basis are generally not eligible.
- Preference is given to 4A Professional Associations.

AVIATION (04/04)

The Company's disability insurance policies contain no restrictions on aviation, except for the accidental death and dismemberment benefit (AD&D).

The AD&D benefit **excludes** coverage for travel in an aircraft that is being operated for any training, testing, or experimental purpose or travel in any aircraft as a crew member or pilot, unless extended aviation coverage is approved, with or without an extra premium. For further details, please refer to the AD&D section of the Underwriting Optional Benefits of the Guidelines.

In some situations, depending on whether the applicant is a student or licensed pilot, the individual's experience, the type of aircraft flown and the nature of the flying done, coverage may require an exclusion. In some cases, where high risk is involved, coverage may be declined.

When the aviation question on the application is answered "Yes", an aviation questionnaire should be completed and submitted along with the application.

Commercial Pilots

Commercial pilots applying for coverage will be subject to the following maximum benefit period:

- Up to age 50 – 5 year benefit period
- Over age 50 – 2 year benefit period

Any unusual or questionable situation should be referred to the Underwriting Department to obtain an opinion prior to submission of an application.

CURRENTLY DISABLED OR COLLECTING DISABILITY BENEFITS (03/04)

- A person who is currently disabled is not eligible for disability insurance.
- A person who is currently collecting disability benefits under an "own occupation" definition of disability and is employed on a full-time basis will not be considered for any type of disability coverage. Such an individual is considered to be disabled for our purposes and therefore, is not eligible for coverage.
- An individual who is working on a full-time basis but is currently collecting Workers' Compensation benefits for a permanent injury may be considered for coverage, depending on the specifics of the situation and the severity of the limitations. However, if insurable, a full exclusion will apply, with no offer of reconsideration, regardless of the severity of the residuals.

DEFINITION OF FULL-TIME AND PART-TIME EMPLOYMENT (04/04)

For all of our individual disability income or business protection plans except for Bridge Series policies, an applicant must be actively at work on a full-time basis in order to qualify for coverage. Full-time employment is defined as being actively at work for at least 30 hours per week on a year-round basis.

Individuals working on a part-time basis may qualify for Bridge Series policies. Part-time employment means that an individual is actively and regularly at work for 20 to 29 hours per week on a year-round basis.

FOREIGN RESIDENCE AND TRAVEL (03/04)

If an applicant travels outside of Canada and the United States with unusual frequency or more than 25% of their job duties, or if they take up temporary residence and/or travel to high risk areas or developing countries, coverage may be considered with a foreign residence or travel exclusion.

Individual consideration is required on these cases because of the ever-changing situation in these countries.

Any other situation where an applicant intends to move to the United States or any other country, either temporarily or permanently at some time in the future, is not generally insurable in Canada.

Least Restrictive Exclusion:

Some applicants may be considered for coverage with a foreign residence or travel exclusion that excludes any cause while residing or travelling outside of Canada or the United States. This exclusion is designed to allow claim consideration once the individual returns to Canada or the United States. This exclusion will be used with the following criteria:

- Canadian citizen or landed immigrant, and
- Maintains a permanent residence in Canada, and
- Travels or takes up temporary residence outside Canada with the intent of returning to Canada permanently, and
- Travels to politically and economically stable, developed countries, and
- Works in a non-hazardous work environment.

We would not use the least restrictive exclusion when travel is to politically unstable countries, where there is significant risk of disease or where medical facilities and treatment are inadequate or unavailable.

Most Restrictive Exclusion:

Some applicants may be considered for coverage with a foreign residence or travel exclusion which excludes any disability incurred while travelling or residing outside Canada or the United States or any disability, regardless of cause or where incurred, while travelling outside Canada or the United States. This exclusion is designed to exclude consideration of a claim even if the individual returns to Canada or the United States. This exclusion will be used with the following criteria:

- Not a Canadian citizen or landed immigrant, or
- Does not maintain a permanent residence in Canada, or
- Travels to politically or economically unstable country or under developed country, or
- Hazardous work environment.

Foreign travel to high-risk countries such as those countries that are remote or hazardous, where there is civil unrest or where the threat of war is imminent, may be considered with the most restrictive exclusion or may be declined.

Temporary Residence in the U.S. (Doctors & Dentists)

Doctors or dentists who are moving to the United States to pursue further education for a **limited** period of time (usually a year or two) **with the intention of returning to Canada following completion of their studies**, may be considered for coverage within the following guidelines:

- medical doctors will be considered at class 3A and dentists will be considered at class 2A rates and limits;
- loss-of-time coverage is the only product we will offer in these situations (Retirement Protector is not available);
- the supplementary benefits available will be those appropriate to the occupation class and those available in the U.S. (Disability in Your Occupation benefit and Health Care Profession benefit are not available);
- credit for benefit amounts or exchange in consideration of U.S. dollars is 30%;
- we reserve the right to limit the amount of benefit offered to applicants moving to the U.S.;
- upon returning to Canada, and if eligible, the Insured can request the addition of the Health Care Profession benefit by submitting a request for policy change; a class upgrade can also be requested by policy change within two years of the original policy issue date; disability in Your Occupation benefit can be obtained through a make-over.

In any situation where there are unusual factors or doubt about the applicant's insurability because of foreign residence or travel, the details should be discussed with the Underwriting Department before taking or submitting the application.

Applications & Medical Requirements:
Applications must be completed and signed in Canada. All medical requirements must be completed in Canada.

Cross-Border Situations:
Canadian citizens, or landed immigrants, who are permanent residents of Canada and travel across the border to work in the U.S., are insurable in Canada.

U.S. citizens or residents, who are permanent residents of the U.S. and travel across the border to work in Canada, must obtain coverage with a U.S. based insurer.

Claims and Benefit Payments:
All claims will be administered in Canada with benefits paid in Canadian dollars.

GUARANTEE STANDARD ISSUE (10/99)

Most individual products are available on a guarantee standard issue (GSI) basis on either an individual, stand-alone sale basis or as part of a combination group LTD sale. Advanced Underwriting or the local sales office should be consulted for further details regarding the process to request a GSI as well as the requirements, guidelines, restrictions, considerations and administration of a GSI sale.

GUIDELINES FOR NEWLY SELF-EMPLOYED INDIVIDUALS (02/04)

Underwriting and assessing employment stability and income for applicants who have recently become self-employed is particularly challenging. While we recognize their need to obtain quality disability insurance, it is difficult to determine how successful an individual will be in the early years of self-employment.

The following guidelines have been designed to assist you in determining the appropriate level of benefit for these situations. The more information that can be provided to us with the application, the more accurately we will be able to assess the risk.

FACTORS TO CONSIDER FOR NEWLY SELF-EMPLOYED APPLICANTS:

Favourable Factors	Unfavourable Factors
› Prior experience and/or related occupation	› No prior experience and/or related occupation
› Working on a contract basis with former employer	› No contracts or short-term contract only
› Secured current, long-term, renewable contract	› EI funds exhausted leading to a self-employment situation
› In business at least 6 months	› In business less than 6 months
› Professional or skilled occupation	› Non-professional or non-skilled occupation
› Solid past employment and earnings	› Sporadic employment and earnings history
› Has employees	› No employees
› Year-to-date business income operating at a profit and financial statements available	› Year-to-date business income operating at a loss
	› Past financial problems or bankruptcy
› No history of financial problems	› Medical concerns
› No medical concerns	› Working from home
› Business established away from home	› Severance and/or retirement package(s) from former employers(s)
› Full-time, year-round employment	
› Purchased an existing, profitable business	› Seasonal occupation

Each situation is evaluated on its own merits and some may not fall clearly into either of the above categories. The Underwriting Department can provide assistance in assessing any borderline or questionable situation, prior to submission of an application.

NEWLY SELF-EMPLOYED INDIVIDUALS WITH PRIOR INDUSTRY EXPERIENCE:

If, in addition to prior industry experience, the newly self-employed applicant demonstrates:

- Past employment stability, and
- At least $50,000 earned income in the last calendar year, supportable by financial documentation, and
- Works at least 30 hours per week on a year-round basis in an insurable occupation, and
- Favourable factors as indicated above.

We may consider a limited amount of coverage until earnings from the new, self-employed situation can be verified. In these situations, amounts of coverage **up to** $2,500 per month can be considered under a Professional Series or Foundation Series policy. We will reconsider the amount of coverage once the applicant is able to provide us with financial documentation for a full year that supports a higher amount of indemnity. Alternatively, we may consider a higher amount with a benefit period of 5 years or less, or for coverage under the Bridge Series or the Quantum policies. Longer elimination periods may also be necessary until the business is firmly established. Each case will be evaluated on its own merits.

Applicants who are employed under a long-term contract (minimum of 6 months), who have prior experience in the industry plus a stable pattern of employment and earnings may be considered for amounts in excess of the $2,500 specified above. To consider such a situation, we require a copy of their contract or an employment letter outlining their compensation, hours and the length of the contract. As well, we will require complete details of any expenses that will be deducted for tax purposes. These situations will also be evaluated individually. Coverage may be reduced because of the large amount of personal expenses that can be deducted from gross earnings. We will consider additional amounts of coverage once a stable pattern of earnings has been established and the individual can provide proof of income for a full year.

Optional benefits are available subject to our regular underwriting rules.

NEWLY SELF-EMPLOYED INDIVIDUALS WITHOUT PRIOR INDUSTRY EXPERIENCE:

We will consider up to $1,000 per month with any Elimination Period (EP) or Benefit Period (BP) under the Bridge Series policy for the following newly self-employed applicant:

- Past stable employment history
- Had $12,000 earned income in the last calendar year, supported by proof of income
- Works at least 20 hours per week on a year-round basis, in an insurable occupation

We will consider up to $500 per month with any Elimination Period (EP) or Benefit Period (BP) under the Bridge Series policy for those who do not qualify for the above, provided they:

- Had $12,000 earned income in the last calendar year.
- Work at least 20 hours per week on a year-round basis.

In both situations, optional benefits are available subject to our regular underwriting rules.

In situations where the applicant has an unstable employment history, prior income below our minimum insurable income or other unfavourable factors, coverage may be postponed until the applicant has been in business at least one full year and can provide complete financial documentation for their new self-employment situation.

If newly self-employed and working in home, please refer to the Working in Home Guidelines for additional information.

GUIDELINES FOR THOSE WORKING IN HOME (02/05)

We are seeing an increasing trend towards more people working in their homes. The following guidelines have been developed to assist you in determining the insurability of these individuals. Please note that these guidelines assume that the occupation of the applicant is an insurable occupation, as per our occupation schedule. If our occupation schedule indicates that the occupation in home is a "No", then the following guidelines do not apply.

SELECT 4A PROFESSIONALS

Eligible Select 4A Professionals: accountants (C.A., C.M.A., C.G.A. only), actuaries, acupuncturists with M.D. degree, architects, chiropodists, professional engineers, lawyers, notaries (Quebec), optometrists, orthodontists, osteopaths, pharmacists, physicians and surgeons, podiatrists and psychologists (with a Ph.D. only).

Working up to 100% of the time in home, in the absence of any other underwriting issues

Will be considered for:
- Any Plan
- Benefit period to age 65
- Any elimination period
- Optional benefits, including Disability in Your Occupation, if desired

OTHER INSURABLE OCCUPATIONAL CLASSES

Working up to 50% of the time in home, in the absence of any other underwriting issues

Will be considered for:
- Any Plan
- Any benefit period requested, including to age 65
- Any available elimination period
- Optional benefits as requested

Working up to 75% of the time in home, in the absence of any other underwriting issues

Subject to meeting all of following criteria:
- Minimum net earned income $25,000 before perks for each of the past 2 years
- Minimum 2 years in current business
- Proof of income for the past 2 years submitted for review Interim income statements are not acceptable proof
- Full details and copies of current contracts, client lists and all other information concerning their business submitted for review
- Mandatory Personal History Interview (PHI)

Will be considered for:
- Any Plan
- Any benefit period requested, including to age 65
- Minimum 90 day elimination period
- No optional benefits

Those that do not meet all of the above criteria will be considered for:
- A maximum benefit period of 2 or 5 years (depending on the merits of the case) under the Professional or Foundation Series **OR** a benefit to age 65 under a Bridge or Quantum policy
- A minimum 90 day elimination period
- No optional benefits

Working more than 75% of the time in home, in the absence of any other underwriting issues

Subject to meeting all of the following criteria:	**Will be considered for:**
› Minimum net earned income of $25,000 before perks for each of the last 2 years › Minimum of 2 years in current business › Proof of income for the past 2 years submitted for review. Interim income statements are not acceptable proof.	› Maximum 2 or 5* year benefit period (depending on the merits of the case) under the Professional or Foundation Series **OR** a benefit period to age 65 under a Bridge or Quantum policy › Minimum 90 day elimination period › No optional benefits

***Individual consideration for a benefit period to age 65 (minimum 90 ep's and no optional benefits) will be given to the following individuals who, in addition to the above criteria, also:**

› Have business premises that are separate from the living area of their residence.
› Have separate business and residence phone numbers.
› Have a separate business entrance that is sign-posted.
› Maintain a business that requires the coming and going of clients.

Examples: psychologist, registered massage therapist, hairdresser/barber, mechanic

Those that do not meet all of the above criteria will be considered for:

› Coverage under a Bridge contract only, with a benefit period to age 65
› Minimum 90 day elimination period
› No optional benefits

If working in home and newly self-employed, please refer to the Guidelines for Newly Self-Employed Individuals for additional information.

IMMIGRANTS (04/04)

Immigrants who have landed immigrant status, have a verifiable, full-time, steady employment pattern and who intend to remain in Canada indefinitely may be considered for coverage after they have filed a tax return demonstrating at least one full year's income.

In addition, those immigrants who intend to remain permanently in Canada, who have verifiable full-time employment **and** who have either invested in a Canadian business in which they are employed full-time, year-round **or** who have established stable, long-term employment with an established Canadian business may be considered for coverage immediately. **Proof of income, investment, and employment will be required**.

If the applicant is not a landed immigrant, any coverage approved will require a foreign residence exclusion (the most restrictive travel exclusion). This excludes any disability incurred while travelling or residing outside the United States or Canada or any disability, regardless of cause or where incurred, while travelling or residing outside the United States or Canada.

We reserve the right to request appropriate medical evidence, regardless of the amount of coverage, if, in the underwriter's opinion, we are unable to develop adequate medical history. A minimum 90 day EP will usually be required. The amount of coverage, the benefit period and optional benefits may be restricted, particularly if the applicant has resided in Canada for a very short time, if there is any question about the stability of employment and income or if other aspects of the application are unfavourable.

Even if the applicant has landed immigrant status, a foreign residence exclusion may be required if there are specific travel concerns.

If income documentation cannot be provided, coverage may be considered under a Bridge or Quantum contract.

MILITARY (10/99)

Generally, members of the regular armed forces or those expecting to enter the service cannot be considered for disability insurance. In addition to the risks that may be inherent in the duties as a member of the military, there is the additional difficulty that a dual occupation ("major/dentist") represents at time of claim.

We will consider coverage on medical residents and doctors in the military provided a group/association offset amendment is included on any coverage issued. (Required if the Professional Series or Foundation Series policy applied for. Group/association offset amendments are not required on Bridge Series or Quantum policies due to contract provisions regarding the integration of group benefits.) This is necessary because the residents/doctors will have group benefits while in the military. The offset amendment will guard against Overinsurance while the insured is in the military and covered by group coverage.

Members of the reserves are usually insurable unless their service presents unusual hazards or there is a possibility of being called to active duty in the foreseeable future. Full details should be provided to underwriting either with the application or before an application is taken, if there is any doubt about the insurability of a specific applicant.

We will underwrite an application within the 90 days preceding discharge from the military if the applicant has a specific insurable employment situation to commence upon discharge.

NON-SMOKER DEFINITION FOR DISABILITY INSURANCE (02/04)

To qualify for non-smoker rates, the following criteria must be met:

- The applicant must have refrained from using any tobacco product, smoking cessation therapy (including Nicorettes, any transdermal patch or other form of tobacco cessation product) or marijuana, for at least twelve months preceding the application date.
- We reserve the right to obtain an HOS on any case to verify non-smoker status. In all cases, the HOS must be negative for cotinine.

Non-smoker rates are also available when all of the following criteria are met:

- Maximum of 12 cigars/year.
- An HOS negative for cotinine.
- No health concerns exist that would be impacted by, or related to smoking.
- Cigar use is admitted on the application.

This consideration for cigar smoking does not apply to GSI applications.

It is essential that the producer and the applicant carefully establish the applicant's qualification for non-smoker rates at the time the application is taken. In accordance with industry practices, we consider an inaccurate response to the smoking question to be material misrepresentation and therefore, grounds for rescission of the contract.

Requests to change from smoker to non-smoker rates subject to the following guidelines:

- The Insured meets the criteria for consideration as a non-smoker.
- We are in receipt of a fully completed Application for Reinstatement and/or Policy Change (Form 83536, formery 12010).
- Since the policy was issued, the Insured has not developed medical history that is smoking-related (i.e. coronary artery disease, chronic obstructive pulmonary disease, emphysema); in such a case, the request would be denied with no future reconsideration of non-smoker rates.
- We reserve the right to obtain an HOS or any other underwriting requirements in order to evaluate the Insured's eligibility for non-smoker rates.

SEASONAL EMPLOYMENT (04/04)

APPLICANTS EMPLOYED ON A SEASONAL BASIS

Applicants employed on a seasonal basis may be insurable if they are employed full-time (at least 30 hours per week) for at least nine months each year. Any coverage offered will require a minimum elimination period of 90 days and will be subject to a stable pattern of insurable income. (Benefits received from EI are not insurable income.)

APPLICANTS WHO WORK LESS THAN NINE MONTHS PER YEAR DUE TO SEASONAL LAY-OFFS

Applicants who work less than nine months per year due to seasonal lay-off are usually ineligible for disability coverage as are any persons collecting unemployment insurance benefits at the time of application.

COMMERCIAL FISHERMEN

Individual whose primary occupation is commercial fishing and who have periods of seasonal employment, and collect Employment Insurance during the year may be considered on the following basis:

Minimum number of months worked per year	Minimum number of hours worked per week	Maximum number of months collecting EI	Product Available	Minimum EP required
9	30	3	The Foundation, The Bridge	90 days
8	30	4	The Foundation, The Bridge	120 days

The above table is a guideline for situations where the applicant does not work year-round. There may be situations where a longer EP is required, based on the circumstances of the overall case (medical history or other unfavourable factors).

Fishermen working less than 8 months of the year or collecting EI at the time of application are not insurable.

PERSONS WHO WORK FULL-TIME ON A YEAR-ROUND BASIS AT MORE THAN ONE OCCUPATION

Persons who work full-time on a year-round basis at more than one occupation due to seasonal conditions would usually be considered for coverage as a “dual occupation” situation. Please refer to the “Dual occupations” section of the Occupation schedule for further details.

Note:

The above details are guidelines only. Each situation will be considered individually and there may be situations where a minimum elimination period of 120 or 180 days will be required or where coverage cannot be offered at all. Financial and medical history and all other factors of the case will affect the ultimate decision.

SELF-EMPLOYMENT ASSISTANCE (SEA) PROGRAM (02/04)

We will consider for disability insurance some applicants who are currently participating in the SEA program.

To be eligible for coverage, the SEA participants must have been approved for full SEA benefits initially and they must still be eligible for SEA benefits at the time of application. This means that SEA has not discontinued benefits to the applicant prior to the application due to poor earnings or failure to provide the required income verification to SEA. "Full" SEA benefits means that SEA approved benefits for the remaining duration of time, up to a total of 52 weeks, or the maximum benefits available when the applicant was initially approved for the SEA program. The underwriter may require verification that these conditions are met.

We will consider $500 per month coverage under the Bridge series regardless of income in the last twelve months. We will consider $1,000 per month coverage under the Bridge series with proof of prior earned income of at least $12,000 in the last calendar year.

These offers are available with any Elimination Period (EP) or Benefit Period (BP) and optional benefits are available subject to our regular underwriting rules.

Otherwise, our normal underwriting rules apply. All questions on the application must be answered fully and accurately. The producer should note in the Remarks section of the application that the applicant is a qualifying SEA participant.

An applicant who can provide proof of income that justifies a higher indemnity may be considered subject to our normal underwriting rules and issue and participation limits.

Note: All policy definitions and limitations apply. It is important that a low-earning policyholder understand that he/she may receive reduced or no benefits at claim time under the Integration of Benefits section of the Bridge contract.

We reserve the right to discontinue this offer of coverage to SEA applicants at any time.

SPORTS AND AVOCATIONS (04/04)

Avocations or activities, in which individuals participate outside of, and in addition to their regular work, often become significant when considering an applicant for disability insurance. Risks beyond the usual hazards of daily life include, for example, hang gliding, auto racing, ballooning, karate, motorcycle riding, mountain climbing, scuba diving below 100 feet*, snowboarding, sky diving, motorboat racing, rock climbing, helicopter skiing, rodeo activity participation, snowmobile racing, bungie jumping, kayaking.

To properly evaluate insurability, the underwriter should know the extent of the applicant's training, level of experience, frequency of participation, equipment used, safety precautions, club affiliations and details of any competitive activity. For some of these activities, we have prepared a specific questionnaire to be completed along with the application, in order to provide all necessary details of the activity for evaluation. If there is no specific questionnaire available, the producer's assistance in providing all details with the application is needed.

Any sport that is a source of financial gain, directly or indirectly, must be declared and described in detail.

*Note: scuba diving, without any unusual hazards or adverse risk factors, to 100 feet or less will generally be underwritten on a standard basis.

UNDERWRITING OPTIONAL BENEFITS (03/04)

This section contains summaries of our current Optional Benefits.
Please refer to the actual contract wording for full details.

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ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (H702) (03/04)

The accidental death and dismemberment benefit (AD&D) is available as an optional benefit on some personal disability insurance policies.

Eligible Ages: 18 - 60
Eligible Plans: Professional Series and Foundation Series (not available on Quantum or Bridge policies)
Minimum Amount: $20,000
Maximum Amount: no more than $10,000 for each $100 of the policy's monthly disability coverage, in increments of $1,000, up to the maximum Issue and Participation Limits.
Issue & Participation Limits: Participation Limits include any Accidental Death Benefits and Accidental Death and Dismemberment coverage with us and any other company.

Class	Issue Limit	Participation Limit
Classes 4A & 3A	$300,000	$300,000
Class 2A	$225,000	$250,000
Class A	$100,000	$150,000
Class B	$50,000	$150,000

Beneficiary Designation: the beneficiary section of the application should be completed so that the appropriate benefits are payable in the event of death. If this section is not completed, benefits will be payable to the insured's estate.

Aviation Risks and AD&D

The AD&D benefit excludes coverage for training, testing, or experimental flying, or as a crew member or pilot of an aircraft, unless extended aviation coverage is approved, with or without an extra premium. The schedule of annual extra premiums below shows the extra charges per $1,000 AD&D in the categories listed, assuming full flying coverage is wanted. In addition, in certain categories where high risk is involved, an exclusion may be added to the entire policy, or coverage refused entirely.

When the aviation question on the application is answered "Yes", an aviation questionnaire should be submitted. The application will be treated as if extended aviation coverage is being requested on any AD&D benefit applied for, unless it is specifically indicated that this coverage is not required.

If the aviation risk is to be covered by the AD&D benefit, the underwriter will include a special letter with the policy, confirming the extended aviation coverage.

Schedule of Additional Premiums for AD&D Extended Aviation Coverage:

1. Civilian commercial flying (for pay):
   - Multi-engine, company-owned planes, business flying only, pilot qualification and aircraft maintenance comparable with scheduled airlines: AD&D will be considered at standard rates.
   - Student instruction, freight carrying, non-scheduled passenger, charter, sightseeing, photographic and business-type flight not included above: AD&D will be considered at $3.50 per thousand extra premium.
   - Crop dusting or prospecting activities: These are uninsurable occupations.
   - Inspection Flying, not prototype planes: AD&D will be considered at $5.00 per thousand extra premium.

2. Civilian non-commercial flying (private license, not paid for flying and not working toward commercial license):
   - Experience over 100 solo flying hours, flying less than 300 hours per year, under age 27: AD&D will be considered at $2.50 per thousand extra premium.
   - Experience over 100 solo flying hours, flying less than 300 hours per year, age 27 or older: AD&D will be considered at standard rates.
   - Experience over 100 solo flying hours, flying 300 hours per year or more, under age 27: AD&D will be considered at $3.50 per thousand extra premium.
   - Experience over 100 solo flying hours, flying 300 hours per year or more, age 27 or older: AD&D will be considered at $2.50 per thousand extra premium.
   - Experience less than 100 solo flying hours or student pilot: AD&D will be considered at $2.50 per thousand extra premium.

3. Civilian glider, helicopter, and lighter-than-air pilots are usually classified the same as other pilots.

4. Parachutists: A full exclusion will be required.

5. Crop dusting, fire bombing and other hazardous flying: These are uninsurable occupations.

6. Ultra-light pilots: A full exclusion will be required.

Any unusual or questionable situation should be referred to the Underwriting Department to obtain an opinion.

ADDITIONAL MONTHLY INDEMNITY (AMI) (03/04)

Additional coverage may be added to the base coverage with longer or the same elimination periods and the same or shorter benefit periods as the basic coverage. This benefit is used to program around other in force coverage or benefits the Insured may receive such as Employment Insurance or short-term disability coverage. AMI's are also available with benefit periods of 120, 180 and 365 days (360 or 720 days on the Bridge).

ADDITIONAL COVERED OVERHEAD EXPENSE RIDER (H721) (03/04)

Additional coverage payable to the 180th day is available in flexible amounts provided it is added to a base policy of at least $100 per month. The elimination period on this benefit must be the same as on the basic coverage. The purpose of the benefit is to allow the Insured to provide an additional amount of coverage during the first six months of total disability when expenses will be greater. The benefit does not increase the partial disability indemnity otherwise payable under the policy.

BUSINESS INSURANCE OPTION (BIO) - DISABILITY BUY SELL (10/99)

This benefit protects the Insured partner's medical insurability and allows the owner to purchase additional Disability Buy Sell coverage as the value of the business grows.

This benefit provides that at each option date (every second policy anniversary date), the owner can purchase up to 18% of the Maximum Business Purchase Amount available. Increases in coverage are subject to financial underwriting only.

When an option is exercised, the additional premium is based on the insured partner's current age and current rates. This option amount will be for the same type of coverage and subject to the same terms, conditions and exclusions as provided in the Disability Buy Sell policy.

A special option may be exercised 90 days after the date we begin paying a disability benefit to any other insured partner. This gives the non-disabled business owners the additional opportunity to increase their coverage by up to 18% of the Maximum Business Purchase Amount.

Eligible Ages: 18 - 50
Minimum BIO amount: $5,000
Maximum BIO Amount: the total amount of BIO that can be purchased is based on the age of the Insured at the time of application and is a percentage of the Maximum Business Purchase Amount.

Age	Maximum Business Purchase Amount
On or before age 42	Up to 100%
Age 43 to 44	Up to 93%
Age 45 to 46	Up to 64%
Age 47 to 48	Up to 39%
Age 49 to 50	Up to 18%

For the monthly installment pay out option, monthly payments can be calculated by dividing the maximum business purchase amount by 60.

When added together, the Maximum Business Purchase Amount and the BIO benefit cannot exceed the Issue Limit for the elimination period chosen.

COST OF LIVING ADJUSTMENT (COLA) (03/04)

Eligible Ages: 18 – 55 (to age 60 on Bridge Series)
Rider H1001 - Professional Series
Rider H1002 - Foundation Series
Rider H1006 - Quantum
COLA - Bridge Series

This rider increases the amount of benefit payable on each anniversary of an insured's continuing total, partial or residual disability (depending on the policy series). Benefits begin on the 366th day of disability. Benefit increases will match the actual rise in the Consumer Price Index over the period of disability. The cumulative adjustment is not less than 2% compounded per year and the maximum cumulative adjustment per year is 10% compounded. There is no cap on the total increase.

Benefit Purchase Option
The insured has the option to purchase the increased amount of the monthly benefit applied during disability without medical or financial evidence, based on the following criteria:

- the Insured has returned to a gainful full-time occupation; and
- the Insured has not attained 60 years of age; and
- the Insured submits a written request to exercise the increase option within 90 days of the end of the period of disability for which COLA benefits were received.

Rates for the increased coverage are based on current age and current rates. The increase will take effect within 31 days after we receive the Insured's request.

The increase will not apply if the Insured is receiving benefits under the Recurrent Disability provisions of their policy and will apply to new total disabilities that occur after the effective date.

Any questions regarding this option should be directed to the Customer Care Centre or Customer Service.

DISABILITY IN YOUR OCCUPATION BENEFIT (H897) (02/05)

The Disability in Your Occupation benefit begins on the commencement date for total disability. It changes the definition of total disability **from:**
a. as a result of injury or sickness, the Insured is unable to perform the important duties of their occupation; and
b. the Insured is not engaged in any gainful occupation; and
c. the Insured is receiving appropriate physician's care.
to:
a. as a result of injury or sickness, the Insured is unable to perform the important duties of their occupation; and
b. the Insured is receiving appropriate physician's care.

Eligible Ages: 18 - 55
Eligible Plan: Professional Series
Eligible Occupations: select class 4A professionals only - accountants (C.A., C.M.A., C.G.A. only), actuaries, acupuncturists with M.D. degree, architects, chiropodists, professional engineers, lawyers, notaries (Quebec), optometrists, orthodontists, osteopaths, pharmacists, physicians and surgeons, podiatrists and psychologists (with a Ph.D only).

ENHANCED DEFINITION OF DISABILITY BENEFIT - FOUNDATION SERIES (H884) AND THE REGULAR OCCUPATION EXTENSION RIDER – BRIDGE SERIES (10/99)

Subject to any plan limitations, these riders extend the regular occupation definition of disability in the contract from 24 months to the end of the benefit period.

The Enhanced Definition of Disability benefit is available on the Foundation Series 966 plan (all classes), and the Foundation step-rate 967 plan (classes 4A, 3A and 2A).

The Regular Occupation Extension rider is available with the Bridge Series contracts (all classes).

FIRST DAY OF HOSPITALIZATION BENEFIT (H880) (03/04)

Eligible Plans: Professional Series and Foundation Series
Provides for payment of the total disability benefit from the 1st day of hospitalization as long as the Insured satisfies the definition of total disability and has been hospitalized for 72 hours. The elimination period must be equal to or less than 90 days.

HOSPITALIZATION BENEFIT (03/04)

Eligible Plan: Bridge Series
Covers expenses while the Insured is hospitalized. Coverage can be purchased in amounts from $50 to $200 per day. Benefits will be paid for each day the Insured is hospitalized after being admitted to and remaining in the hospital for 24 hours following admission. There is a total 120 day maximum per occurrence.

This coverage includes an intensive care benefit that pays a total of five times the basic daily hospital benefit amount for each day the Insured is in intensive care – up to a 30 day maximum.

Pre-existing conditions, pregnancy and childbirth are covered if this rider has been in force for at least six months. Exclusions of the Bridge Series plan also apply.

The total of our payment, plus the payment made by any other hospital coverage, cannot be more than $400 per day.

FUTURE INCOME OPTION BENEFIT (H899) - (03/04)

This benefit allows an insured to purchase additional coverage in the future, regardless of their health or occupation, as long as they have adequate income to qualify for the increased amount at the time they decide to exercise the option.

Eligible Ages: 18 to 50

Eligible Plans: Professional Series, Foundation Series and Quantum

Maximum Option Amounts

Class	Option Amount
4A	$1,500
3A	$1,000
2A	$500
A and B	$200

Maximum Total Option Amount
The maximum total option amount (increase) available by class under the Future Income Option benefit is automatically calculated and is equal to **the lesser of:**
1. 2.5 times the monthly base and long-term AMIs (1 year or longer);
2. 55 less insurance age (age nearest) x FIO option amount chosen; and
3. Class maximums 4A - $15,000, 3A - $10,000, 2A - $7,000, A - $5,000, B - $3,500 less base and long-term AMI.

EXERCISING AN FIO
On each policy anniversary, up to age 55, the Insured may exercise all or part of a unit of increase, subject to financial verification and our maximum issue and participation limits. Up to one unit of increase may be carried over to the next anniversary date if any or all of it is not exercised. However no more than two units can be obtained at one time. One additional unit of increase may be purchased on any anniversary date up to age 50. The total amount of all of the units of increase exercised cannot exceed the maximum total option amount. Increases are available in multiples of $50.

When options are exercised, the premiums for the additional amount are based on the Insured's age nearest and our current rates.

The FIO option will be underwritten based on the Insured's earned income for the last complete tax year.

If the policy includes a Partial Disability Rider, the amount of benefits under the rider will be increased by one half of the amount of any increase in the maximum monthly amount of benefit.

Application Date: the application form must be completed and returned to us within 31 days of the option date.

FIO OPTION WHILE DISABLED
While disabled, a financially eligible insured may exercise one FIO option.

If the option date upon which an increase is elected occurs while the Insured is disabled, the increase will be **the lesser of** an amount not exceeding:
- one half of the amount of the FIO Option amount; or
- $750

The increased policy benefits will be payable on the 91st day of continuous disability after the Option date.

SPECIAL OPTION INCREASE

In addition to the annual options, a single Special LTD (long-term disability) increase is available under the following circumstances:

- the Insured terminates employment with an employer which has a group long-term disability insurance plan in force under which the Insured is covered at the time of termination; or
- long-term disability insurance plan benefits are no longer available to a class of employees to which the Insured belongs; or
- the Insured's group long-term disability insurance plan terminates.

Option Amount: the maximum amount of increase that will be allowed is **the lesser of:**

- the amount of lost LTD coverage; or
- the remaining future income option benefit amount.

Option Date: the date on which the Insured ceases to have coverage under the LTD policy will be deemed to be the option date.

Application Date: applications for additional disability coverage under the Special Option must be made in writing, within 91 days of the date on which the Insured ceases to have coverage under the LTD policy.

Requirements: proof of the loss of group long term disability benefits is required and may take the form of a letter of termination of benefits from either the insurer or the employer, or a letter of resignation to the employer where benefits were provided.

The Special Option is not available:

- during any period of disability.
- if the Insured is not working full-time, at least 30 hours per week, in a Reasonable Occupation (refer to rider wording for additional details).

Integration of Benefits: if the policy does not offset or integrate with group long-term disability benefits, we have the right to add a Group/Association Offset Amendment to the policy, in accordance with our underwriting rules and the Issue and Participation Limits in effect at the time the Special Option is applied for.

This special option amount can only be exercised once and may not exceed the total FIO benefit amount. The Special LTD option is subject to the other terms of this rider including financial verification.

Note: the Special Option may also be used when a medical student, as defined in our Student Limits section, leaves their residency and loses their professional resident's association disability coverage. It is available on all FIO riders, regardless of whether the rider contains the Special Option.

FUTURE INCOME OPTION BENEFIT FOR YOUNG PROFESSIONALS (H1145) – (03/04)

The future income option for young professionals is available to those professionals (classes 4A and 3A) who qualify for our Student Limits as indicated in our Underwriting Guidelines.

This rider is similar in design to our standard future income option (H899). Its distinguishing feature is that it uses a higher factor of 5 times the monthly benefit (vs. the 2.5 times used in the standard FIO) to determine the maximum total option amount that is available under this rider. This allows the Insured to purchase a smaller monthly benefit, when their income is low, but retain a higher amount of FIO that they may apply to exercise and increase their monthly benefit as their income grows.

Eligible Ages: 18 - 40
Eligible Plan: Professional Series
Maximum Option Amounts

Class	Option Amount
4A	$1,500
3A	$1,000

Maximum Total Option Amount for Young Professionals:
The maximum total option amount (increase) available by class under the Future Income Option benefit is automatically calculated and is equal to **the lesser of:**

1. **FIVE** times monthly base and long-term AMIs (1 year or longer);
2. 55 less insurance age (age nearest) x FIO option amount chosen; and
3. Class maximums 4A - $15,000, 3A - $10,000 less base and long-term AMI.

EXERCISING AN FIO
On each policy anniversary, up to age 55, the Insured may exercise all or part of a unit of increase, subject to financial verification and our maximum issue and participation limits. Up to one unit of increase may be carried over to the next anniversary date if any or all of it is not exercised. However no more than two units can be obtained at one time. One additional unit of increase may be purchased on any anniversary date up to age 50. The total amount of all of the units of increase exercised cannot exceed the maximum total option amount. Increases are available in multiples of $50.

When options are exercised, the premiums for the additional amount will be based on the Insured's age nearest and our current rates.

The FIO option will be underwritten based on the Insured's earned income for the last complete tax year.

Application Date: the application form must be completed and returned to us within 31 days of the option date.

FIO OPTION WHILE DISABLED
While disabled, a financially eligible insured may exercise one FIO option.
If the option date upon which an increase is elected occurs while the Insured is disabled, the increase will be **the lesser of** an amount not exceeding:

- one half of the amount of the FIO Option amount; or
- $750

The increased policy benefits will be payable on the 91st day of continuous disability after the Option date.

SPECIAL OPTION INCREASE

In addition to the annual options, a single Special LTD (long-term disability) increase is available under the following circumstances:

- the Insured terminates employment with an employer which has a group long-term disability insurance plan in force under which the Insured is covered at the time of termination; or
- long-term disability insurance plan benefits are no longer available to a class of employees to which the Insured belongs; or
- the Insured's group long-term disability insurance plan terminates.

Option Amount: The maximum amount of increase that will be allowed is **the lesser of:**

- the amount of lost LTD coverage; or
- the remaining future income option benefit amount.

Option Date: the date on which the Insured ceases to have coverage under the LTD policy will be deemed to be the option date.

Application Date: applications for additional disability coverage under the Special Option must be made in writing, within 91 days of the date on which the Insured ceases to have coverage under the LTD policy.

Requirements: proof of the loss of group long-term disability benefits is required and may take the form of a letter of termination of benefits from either the insurer or the employer, or a letter of resignation to the employer where benefits were provided.

The Special Option is not available:

- during any period of disability.
- if the Insured is not working full-time, at least 30 hours per week, in a Reasonable Occupation (refer to rider wording for additional details).

Integration of Benefits: if the policy does not offset or integrate with group long-term disability benefits, we have the right to add a Group/Association Offset Amendment to the policy in accordance with our underwriting rules and Issue and Participation Limits in effect at the time the Special Option is applied for.

This special option amount can only be exercised once and may not exceed the total FIO benefit amount. The Special LTD option is subject to the other terms of this rider including financial verification.

Note: the Special Option may also be used when a medical student, as defined in our Student Limits section, leaves their residency and loses their professional resident's association disability coverage. It is available on all FIO riders, regardless of whether the rider contains the Special Option.

FUTURE INSURANCE OPTION BENEFIT (FIO) – BRIDGE SERIES (03/04)

Allows the Insured to purchase additional coverage in the future, regardless of their health or occupation, as long as they have adequate income to qualify for the increased amount at the time they decide to exercise the option.
Eligible Ages: 18 to 50
Eligible Plan: Bridge Series
Maximum Total Option Amount: the total FIO benefit amount is determined by the Insured and is based on the total amount of indemnity (additional monthly benefit amount plus basic monthly benefit), age and class.

The maximum total option amount (increase) available by class under this benefit is equal to **the lesser of:**

1. FIO factor as multiplied by the total indemnity applied for;
2. FIO maximum benefit amount; and
3. Total class maximums.

Class	FIO Factor	FIO Maximum Benefit	Total Class Maximum
4A	2 X	$9,000	$15,000
3A	2 X	$6,000	$10,000
2A	1.5 X	$3,000	$7,000
A	1 X	$1,250	$5,000
B	1 X	$1,000	$3,500

EXERCISING AN FIO
During the first six years that this rider is in force, on every anniversary date, the Insured may exercise an option for all, part, or the balance of the total FIO benefit amount. After six years, the Insured will have the option, on every policy anniversary date up to age 55, to exercise an option of up to $1/5^{th}$ of the total FIO benefit amount. All requests for FIO increases are subject to financial underwriting and to our issue and participation limits at the time the FIO is exercised.

When options are exercised, the premiums for the additional amount are based on the Insured's attained age and the rates in effect on that option date.

The benefit period and elimination period of the FIO will normally be the same as the original policy though a shorter benefit period or a longer elimination period may be requested.

Application Date: the application form must be completed and returned to us within 30 days of the option date.

Eligibility: on the option date (except for the provision regarding disabilities existing as at the option dates), the Insured must:

- be regularly working at least 20 hours per week and 35 weeks per year, and receiving earnings; and
- the Insured's earnings for the 12 months preceding the option date must justify an increase based on our published financial underwriting guidelines in effect on the option date.

Minimum FIO: the minimum amount that can be exercised on an option date is $100.

FIO OPTION WHILE DISABLED

The insured can only exercise a single option amount if disabled. The option amount cannot exceed 1/5th of the FIO benefit amount.

The additional coverage obtained in relation to an option date when the Insured is disabled only applies to new disabilities that are incurred after the option date and after the application for the additional coverage. Premiums for additional coverage obtained in relation to an option date when the Insured is disabled will be waived if, and for as long as, premiums for the policy are waived.

SPECIAL OPTION FOR LOSS OF LTD COVERAGE

A special LTD (long-term disability) option is available if the Insured has lost group LTD for one of the following reasons:

- the Insured's employment terminates; or
- the LTD policy terminates and is not replaced by the Insured's employer; or
- coverage for the class of employee that includes the Insured is cancelled and is not replaced by the employer.

Option Amount: the option amount under the Special Option may not exceed the lesser of:

- the monthly amount of the benefit which the Insured was eligible under the LTD policy on the option date; and
- the remaining portion of the FIO benefit amount that has not already been exercised through earlier options.

Option Date: the date on which the Insured ceases to have coverage under the LTD policy will be deemed to be the option date.

Application Date: applications for additional disability coverage under the Special Option must be made in writing, within 90 days of the date on which the Insured ceases to have coverage under the LTD policy.

Requirements: proof of loss is required and may take the form of a letter of termination of benefits from either the insurer or the employer, or a letter of resignation to the employer where benefits were provided.

The Special Option is not available if:

- the Insured has obtained or has applied for individual coverage; or
- the Insured has become covered under another group LTD policy or has become eligible for such coverage and must satisfy a waiting period as qualification period before coverage becomes effective.

The Special LTD option may only be exercised once and may not exceed the total FIO option amount. The Special LTD option is subject to the other terms of the rider including financial verification.

Note: the Special Option may also be used when a medical student, as defined in our Student Limits section, leaves their residency and loses their professional resident's association disability coverage. It is available on all FIO riders, regardless of whether the rider contains the Special Option.

FUTURE COVERED MONTHLY EXPENSE OPTION BENEFIT – FCEO (H862) (10/99)

This benefit allows an insured to purchase additional coverage in the future, regardless of their health or occupation, as long as they have adequate expenses to qualify for the increased amount at the time they decide to exercise the option.

Eligible Ages: 18 to 50
Eligible Plan: Business Overhead Expense (Plan 906)
Eligible Occupational Classes: 4A, 3A, 2A, A
Maximum Option Amounts

Class	Option amount
4A	$1,500
3A	$1,000
2A	$500
A	$200

Maximum Total Option Amount
The maximum total option amount (increase) available by class under the FCEO benefit is automatically calculated and is equal to **the lesser of:**
1. 2 times monthly base;
2. 55 less insurance age (age nearest) x FCEO option amount chosen; and
3. Class maximums 4A - $20,000, 3A - $15,000, 2A - $7,000, A - $5,000, less the base

EXERCISING AN FIO
On each policy anniversary, up to age 55, the Insured may exercise all or part of a unit of increase. Up to one unit of increase may be carried over to the next anniversary date if all or part of it is not exercised. However no more than two units can be exercised at one time. One additional unit of increase may be purchased on any anniversary date up to age 50. The total amount of all of the units of increase exercised cannot exceed the maximum total option amount. Increases are available in multiples of $50.

When options are exercised, the premiums for the additional amount will be based on the Insured's age nearest and our current rates.

All increases are subject to financial verification and our maximum Issue and Participation Limits. The combined total of all in force coverage and future expense options cannot exceed Maximum Issue and Participation Limits. Financial verification will be based on the Insured's financial documentation for the last complete tax year.

Application Date: the application form must be completed and returned to us within 31 days of the option date.

FIO OPTION WHILE DISABLED
While disabled, an insured may exercise one FCEO option amount. This increase will be effective on the 91st day of continuous disability after the Option date.

HEALTH CARE PROFESSION BENEFIT (H1134/H1135/H1136) (02/01)

This benefit expands the definition of "sickness" contained in the policy to which it is attached.

Under this benefit, if the Insured meets one of the following conditions, they are not required to be under the care of a physician in order to qualify for disability benefits provided they are HIV impaired or Hepatitis impaired and due to their impairment,

- they are restricted or prohibited from performing the important duties of their occupation by law or by a written policy of general application of a medical regulatory body or medical licensing body; or
- their patients refuse treatment from them because they have to disclose to their patients their impairment as required by law or by a written policy of general application of a medical regulatory body or medical licensing body.

For the purpose of this benefit, "your occupation" means the occupation or occupations in which the Insured is regularly engaged at the time that they become disabled.

This benefit has the same elimination period, benefit period and benefits as the base coverage. If the future income option is included in the Insured's policy, the Health Care Profession benefit amount will increase automatically as this benefit is applied.

Eligible Ages: age 18 - 55
Eligible Plans: Professional Series, Foundation Series, Quantum, Business Overhead Expense, Key Person Protector, Retirement Protector and Business Loan
Ineligible Plans: Bridge Series, Disability Buy Sell, Critical Illness Recovery Plan
Rider H1136 - Quantum
Rider H1135 - The Professional Series policies that include Disability in Your Occupation rider H897; the "Own Occupation" definition of total disability is replaced with a "Regular Occupation" definition for the purposes of this benefit.
Rider H1134 - all other eligible policies
Mandatory Coverage: unless declined for underwriting reasons, the Health Care Profession benefit is mandatory for the following health care professionals:

> Medical doctors, dentists, dental surgeons, chiropodists, podiatrists, professional lab technicians, dental hygienists, dental assistants, denture therapists, denturists, denturologist, acupuncturists (MD and non-MD), nurses (RN's, RNA's, LPN's, including nursing directors, instructors and nurse practitioners), respiratory therapists, respirologists, massage therapists doing acupuncture, physiotherapists doing acupuncture and paramedics

Premium: there is currently no premium charged for this rider. A premium for the Health Care Profession benefit can be introduced at any time, however once implemented, the premium is locked in for five years.
Requirements: please see Health Care Worker Testing Limits in the Medical Requirements section of the Underwriting Guidelines for testing requirements for Health Care Workers.

PARTIAL DISABILITY BENEFIT (03/04)

FOUNDATION SERIES

Provides either short or long-term partial disability benefits.
Partial disability means that:

1. the Insured is not totally disabled; and
2. the Insured is engaged in his occupation or any gainful occupation; and
3. due directly to continuing injury or sickness, the Insured is unable to perform either:
   (i) one or more important duties of their occupation; or
   (ii) the important duties of their occupation at least one half the time normally required; and
4. the Insured is under the care of a physician.

The partial disability benefit is equal to 50% of the base indemnity, plus AMIs with benefit periods of five years or longer. In the case of the long-term partial benefit rider, this percentage reduces to 25% after 24 months for the remainder of the benefit period. The partial disability benefit will never be greater than the base indemnity.

Short-Term Partial Disability Benefit (H892)

Partial disability does not have to follow a period of total disability. It can start when an injury or sickness occurs. This benefit is payable for 6, 12 or 24 months (classes 4A, 3A, 2A) or for six or 12 months (classes A, B), as requested at time of application.

Long-Term Partial Disability Benefit (H893)

Partial disability does not have to follow a period of total disability. It can start when an injury or sickness occurs. This benefit is payable for five years, or to age 65 (classes 4A, 3A, 2A) or for five or 10 years or to age 65 (classes A, B). The longer-term partial benefit period cannot be longer than the benefit period of the policy.

Built-in recovery benefit: an insured will be eligible for up to two additional months of partial disability benefits by returning to work in any occupation after a period of partial disability. A physician's care is not required.

BRIDGE SERIES

Provides either short or long-term partial disability benefits.
Partial disability or partially disabled mean that, solely because of an injury or sickness:

1. the Insured is under the regular care of a physician and receiving appropriate treatment; and
2. the Insured is unable to perform one or more of the essential duties of their regular occupation; or
3. the Insured is unable to perform the essential duties of their regular occupation for at least half of what were their normal work hours as of the starting date of total disability.

The insured must be working full-time (30 hours a week or more) at the start of a disability to qualify for partial disability benefits.

Occupational Classes 4A and 3A: partial disability does not have to follow a period of total disability, it can start when an injury or sickness occurs and days of partial disability can be used to satisfy the elimination period.
Occupational Classes 2A, A and B: partial disability must follow a period of total disability.

Short-Term Partial Disability Benefit

This benefit pays up to 50% of the maximum monthly benefit (base indemnity plus AMIs) for up to 12 months.

Long-Term Partial Disability Benefit

This benefit pays up to 50% of the maximum monthly benefit (base indemnity plus AMIs) for the first 24 months and 25% thereafter, for the balance of the benefit period. The long-term partial benefit period cannot be longer than the benefit period of the policy.

BUSINESS OVERHEAD EXPENSE - applicant can request one or the other of the following:

Extended Partial Disability Injury and Sickness Benefit (H782)
When the Insured is partially disabled, either from the date of injury or sickness or after a period of total disability, he or she will receive 50% of the maximum monthly benefit for a maximum of six months. This replaces the partial disability benefit in the policy.

Available to classes 4A, 3A and 2A.

OR

Residual Disability Benefit (H856)
Provides long-term residual benefits when the Insured is receiving care and treatment by a physician and when covered fixed expenses plus cost of sales or service exceed the Insured's business monthly gross income by at least $200.

The benefit begins after a period of total disability ends or after the elimination period has been satisfied, whichever is later. During the first six months of residual disability, the benefit will not be less than 50% of the maximum monthly benefit. The maximum amount payable is the covered monthly expenses plus the monthly amount of "cost of sales and services items" less the business' monthly gross income.

The benefit paid cannot exceed the maximum monthly benefit payable. Benefits can be extended beyond the benefit period until either the maximum total benefit has been paid or the Insured's 65th birthday, whichever is first. If residual disability begins within three months of the Insured's 65th birthday, benefits will be payable for three months.

Available to classes 4A and 3A.

RETIREMENT PROTECTOR (03/04)

The Retirement Protector is available as both a stand-alone policy or rider to the Professional Series or the Foundation Series policies. This coverage helps individuals maintain a retirement savings program in the event of total disability.

Plan Code: 945 - issued as a stand-alone policy or H945 - issued as a rider

Eligible Occupational Classes: 4A, 3A, 2A, A, B

Minimum Earned Income: $18,000

Minimum Monthly Benefit: $300

Maximum Monthly Benefit: 20% of applicant's monthly earned income to a maximum of $1,500

Maximum Issue & Participation Limit: $1,500

Issue Ages and Benefit Periods:

Age	Class	Benefit Period*
18 - 55	4A, 3A, 2A	to age 65
18 - 55	A, B	10 years

* If included as a rider, the benefit period is limited to the benefit period of the plan to which it is added.

Elimination Period for the Plan: 90 days

Elimination Period for the Rider: the greater of 90 days or the elimination period of the base plan

Additional Benefit if issued as a stand-alone plan:

Health Care Profession Rider (H1134)

Mandatory coverage (unless denied for underwriting reasons) to the following health care professionals: medical doctors, dentists, dental surgeons, chiropodists, podiatrists, professional lab technicians, dental hygienists, dental assistants, denture therapists, denturists, denturologists, acupuncturists (MD and non-MD), nurses (RN's, RNA's, LPN's), respiratory therapists, respirologists, massage therapists doing acupuncture, physiotherapists doing acupuncture and paramedics.

Please refer to details in Health Care Profession Benefit section above for additional details.

UNDERWRITING GUIDELINES FOR BUSINESS PRODUCTS (03/04)

This section contains summaries of our current business products. Please refer to the actual contract wording for full details.

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DISABILITY BUY SELL (03/04)

PURPOSE/MARKET

The Disability Buy Sell policy is designed to provide funds for the purchase of an insured's share of ownership in a business in the event of his or her total disability.

The policy is designed primarily for partnerships and professional corporations comprised of two to five principals. Consideration may also be given to corporations and partnerships with six to ten principals. The Disability Buy Sell policy is most effectively used with partnerships and closely held corporations that employ less than 50 people, have up to $10 million in annual sales and are in stable industries.

The best prospects include: Accounting firms, advertising agencies, architectural firms, high-tech and computer firms, medical practices and clinics, engineering firms, law practices, employment agencies, small manufacturers.

REQUIREMENT

All eligible partners must apply for Buy Sell coverage or have Buy Sell coverage already in force.

INELIGIBLE RISKS

- Public corporations, husband-wife combinations, parent-child combinations and other relationships that do not meet the "arms length" test are ineligible for Disability Buy Sell coverage.
- Any business that has not been in operation for at least three years prior to the application.
- Any partnership where the partners have not been associated for at least three years prior to the application.
- Any business that does not have a net worth of at least $50,000.
- Any applicant who does not have a minimum annual earned income of $12,000.
- Any applicant who is not active in the business.
- Silent partners
- One-person Buy Sell situations
- Any risk where we are asked to participate with another insurer.

ELIGIBLE OCCUPATIONAL CLASSES

Classes 4A, 3A and 2A (including individuals who qualify for class 2A using the occupational upgrade guidelines).

ISSUE AGES

18 to 60

OWNERSHIP SHARE

The applicant must own at least 10% of the business and the need must be apparent based on his or her specific situation. We will exceptionally consider less that 10% ownership subject to prior underwriting approval. The applicant must not own more than 90% of the business as coverage terminates once the Insured's share of the business exceeds 90%.

OTHER COVERAGE

Personal disability income protection for the proposed insured should be in force or have been requested as personal coverage is considered a primary need. Furthermore, the partners of the business should be covered by Buy Sell life to protect the business from a partner's death.

MINIMUM ISSUE LIMITS

Monthly Installments: $45,000 lump sum
Flexible Funding: $25,000 lump sum

MAXIMUM ISSUE LIMITS

Maximum Purchase Amount if IDI with maximum 120 day EP is not with us	Maximum Purchase Amount if IDI of at least $450, with Maximum 120 day EP, is in force with us
360 days Elimination Period - $1,000,000 540 days Elimination Period - $1,500,000 720 days Elimination Period - $2,000,000	Any Elimination Period - $2,000,000

For the monthly installment pay out option, monthly payments can be calculated by dividing the maximum business purchase amount by 60.

Issue limits for the Disability Buy Sell are over and above the regular limits for disability insurance coverage. However, Disability Buy Sell will not be considered if an applicant's in force individual disability insurance exceeds the individual issue and participation limits or if the applicant is over-insured under any other disability product.

ELIMINATION PERIODS

360, 540, 720 days
Disability Buy Sell coverage for all insured owners or partners must have the same elimination period.

MEDICAL REQUIREMENTS

Please refer to the Medical Requirements section of the Underwriting Guidelines.

INCOME DOCUMENTATION

Please refer to the Financial Documentation chart in the Financial Underwriting and Requirements section of the Underwriting Guidelines.

An inspection report (IR) is not an automatic requirement, however, the underwriter reserves the right to order one depending on the specifics of a case.

OTHER UNDERWRITING REQUIREMENTS

The Disability Buy Sell Valuation Worksheet will be completed at the time of underwriting.

CO-INSURANCE FACTORS APPLIED

Flex Funding	-	90%
Monthly Installments (60 months)	-	100%

OPTIONAL BENEFIT (please refer to the product Profile for additional details)

Business Insurance Option (BIO)

At each option date, every second policy anniversary date, the owner can purchase up to 18% of the maximum option amount available. When an option is exercised, the additional premium is based on the Insured partner's current age.

Minimum BIO amount: $5,000.

Maximum BIO amount: the total amount of BIO that can be purchased is based on the age of the Insured at the time of application and is a percentage of the maximum business purchase amount.

Age	Maximum Purchase Amount
On or before age 42	Up to 100%
Age 43 to 44	Up to 93%
Age 45 to 46	Up to 64%
Age 47 to 48	Up to 39%
Age 49 to 50	Up to 18%

For the monthly installment pay out option, monthly payments can be calculated by dividing the maximum business purchase amount by 60.

When added together, the maximum business purchase amount and the BIO benefit cannot exceed the issue limit for the elimination period chosen.

OWNERSHIP

The owner of the policy can be the corporation or partnership (entity purchase), or alternatively, each owner or partner can own a policy on each of the other owners or partners (cross purchase). The entity purchase may be preferred when there are more than two owners involved as it reduces the number of policies issued.

DISABILITY BUY SELL AGREEMENT

Although a formal Buy Sell agreement or letters of intent are not required to issue a policy, such agreements should be in effect and may be requested by the underwriter to assess any case prior to approval. The contract provides that they will be required at time of claim. It is important that the provisions of the Buy Sell agreement parallel those of the Disability Buy Sell policy.

TRANSFER PRIVILEGE PROVISION

If the person insured under the Buy Sell policy stops active full-time work in the business, we will issue a new policy providing identical coverage, without medical underwriting, if:

- The insured is under age 55 when his policy coverage terminates; **and**
- The insured is not totally disabled and has not received benefits under the policy; **and**
- The insured begins full-time work in a business and owns no more than 90% of that business; **and**
- The new business and the Insured meet our underwriting requirements (except for medical insurability); **and**
- The proposed new owner and the Insured complete an application for coverage within 90 days after the policy terminates.

The maximum business purchase amount will be the lesser of the amount for which the Insured's interest in the new business qualifies him or her, or the amount of the policy being terminated. The elimination period for the new policy cannot be less than the policy being terminated. The new policy will contain all the same exclusions and limitations as the terminated policy.

The new policy will be issued at the original age and original rates of the terminated policy.

CONVERSION PRIVILEGE

This is an underwriting guideline and is not a contractual obligation.

If the Insured partner becomes more than 90% owner of the business, he or she may request an exchange of his or her Disability Buy Sell policy for a disability insurance policy, such as the Professional Series, Foundation Series, Quantum or Bridge Series.

The conversion is subject to the following:

- A regular application, without the medical section completed, is required;
- The exchange must be requested prior to the Insured's 60^{th} birthday and while the policy is still in force;
- The request is financially underwritten and all financial underwriting rules apply. In no event can the monthly amount of the benefit and all other in force disability coverage exceed our issue and participation limits in effect at the time of the request;
- The monthly benefit cannot exceed $1,000;
- The benefit period will be 24 months;
- The elimination period will be a minimum of 90 days but a longer elimination period may be requested;
- The premiums will be based on our rates in effect on the date of exchange for the Insured's attained age and the policy issued with current dating;
- The insured's occupational classification will be the same as for the replaced Buy Sell policy;
- The new policy will only cover disability or other loss that begins after the new policy takes effect;
- The new policy will contain all the same exclusions and limitations as the replaced Buy Sell policy;
- The owner of the policy will be the Insured.

BUSINESS OVERHEAD EXPENSE (BOE) (02/05)

PLAN: 906

PURPOSE/MARKET

The Business Overhead Expense policy is designed for principals of closely held businesses or practices and owners of small businesses. It is an expense reimbursement policy that covers those fixed monthly business overhead expenses required to keep the business viable until the return of the partially or totally disabled owner.

INELIGIBLE RISKS

- **Income:** Applicants who do not have a minimum annual earned income of $12,000 are ineligible for Business Overhead Expense coverage.

- **Business Address Same as Residence:** Business Overhead Expense coverage is not available to individuals whose business and residence addresses are the same except for the following select 4A professionals: accountants (C.A., C.M.A., C.G.A. only), actuaries, architects, chiropodists, professional engineers, lawyers, notaries (Quebec), optometrists, orthodontists, osteopaths, pharmacists, physicians and surgeons, podiatrists and psychologists (with Ph.D. only).

  When allowing BOE coverage for select 4A professionals whose business and residence addresses are the same, certain expenses may be limited or excluded (e.g. utilities, rent or mortgage interest, property taxes).

- **Ineligible Occupations:** Farmers; truck drivers and all other class B risks

- If it is determined that a business can continue to function under the management of the other partners, owners or employees and the profit of the business will not suffer as the result of the applicant's disability, coverage will be denied.

ELIGIBLE OCCUPATIONAL CLASSES

4A, 3A, 2A, A

Eligible Class 4A Professionals

- Self-employed professionals whose income depends on personal and regular attention to professional duties and who are responsible for the cost of maintaining their own office (this applies to sole proprietorships or partnerships).
- Shareholders of a professional corporation, if they agree to indemnify the corporation for overhead expenses which are incurred during a period of disability. In this situation the corporation should be the owner of the policy.
- Partnership and professional corporations with 5 or less partners or shareholders: are generally eligible for business overhead coverage. The key measure for eligibility is the clear and significant loss of income to the business should one of the partners or shareholders become disabled.
- Partnerships or professional corporations consisting of six to ten partners or shareholders: are generally ineligible for business overhead coverage. They may be considered for amounts up to $15,000 if the need for coverage can be demonstrated and provided the corporation or partnership does not employ other individuals of the same or similar professions or in supporting occupations.

All other eligible Class 4A, 3A, 2A and A

- Sole proprietorships or two-person partnerships with no more than 3 full or part-time employees: are eligible for business overhead coverage if they are engaged in a business requiring their special, personal services.
- Sole proprietorships or two-person partnerships with up to six employees: may be considered only if the need for business overhead coverage can be established. A detailed letter must accompany the application clearly establishing that the applicant's personal services are essential to the continuation of the business.
- Class 4A and 3A business owners with up to 10 employees: may be considered if the need for business overhead coverage can be established and provided that no more than three employees or other owners have similar duties to those of the applicant. A detailed letter must accompany the application establishing clearly the essential services of the applicant that will be lost in the event of disability and the economic impact of that loss.

Applicants in the following occupations are ineligible for consideration in the "up to ten employees" category and no exceptions will be considered: construction industry, real estate development and retail sales.

- Insurance representatives will be considered for business overhead expense coverage if:
  a) Their business and residence address are not the same; and
  b) They are not receiving full or partial financing from their affiliated company; and,
  c) They do not have more than three full or part-time employees.

MINIMUM MONTHLY BENEFIT

$450 - may use a base of $100 plus an Additional Covered Overhead Expense rider

ISSUE AGES, BENEFIT PERIODS AND ELIMINATION PERIODS

Age	Class	Benefit Period	Elimination Period
18 - 60*	4A, 3A, 2A	15, 24 months	15, 30, 60, 90 days
18 - 60	A	15, 24 months	30, 60, 90 days

* For classes 4A and 3A only, age 61 - 63 will be considered for coverage with a benefit period of 15 months only and a minimum 30 day elimination period, subject to the criteria set out in the Overage Limit section of the Underwriting Guidelines.

ISSUE AND PARTICIPATION LIMITS FOR BOE

Class:	4A*	3A	2A	A
Age 18 - 60	$20,000	$15,000	$7,000	$5,000

* Amounts in excess of $20,000 up to a maximum of $30,000 will be considered on an individual case basis, subject to financial justification and underwriting approval of the complete file.

The issue and participation limits for Business Overhead Expense coverage are over and above the regular issue and participation limits for income protection coverage. However, Business Overhead Expense coverage will not be considered if an applicant's in force individual disability coverage exceeds our issue and participation limits or if the applicant is over-insured under any other disability product.

MEDICAL REQUIREMENTS

Please refer to the Medical Requirements section of the Underwriting Guidelines.

INCOME DOCUMENTATION

Please refer to the Financial Documentation chart in the Financial Underwriting and Requirements section of the Underwriting Guidelines.

A breakdown of overhead expenses is required on the application unless income documentation, including an expense breakdown, has been submitted with the application. If not included on the application, a signed statement will be required upon delivery of the contract, confirming the amount of monthly overhead expenses.

The following financial information should be clear on the application or included in a covering memo:

- the applicant's share of current eligible expenses must be correctly recorded on the application
- ineligible expenses should not be included
- unstable and unusually high expenses should be clarified
- if other professionals are employees, do not include their salaries

Proof of earnings and expenses are required at time of claim.

OPTIONAL BENEFITS (please refer to the product Profile for additional details)

Extended Partial Disability Injury and Sickness benefit (H782)

When the Insured is partially disabled either from the date of injury or sickness or after a period of total disability, he or she will receive 50% of the maximum monthly benefit for a maximum of six months. This replaces the partial disability benefit in the policy.

Available to classes 4A, 3A, 2A only.

OR

Residual Disability benefit (H856)

Provides long-term residual benefit when the Insured is receiving care and treatment by a physician and when covered fixed expenses plus cost of sales or service exceed the Insured's business monthly gross income by at least $200.

Available to classes 4A, 3A only.

Future Covered Monthly Expense Option benefit - FCEO (H862)

Allows an insured to purchase additional coverage in the future, regardless of their health or occupation, as long as they have adequate expenses to qualify for the increased amount at the time they exercise the option.

Available to classes 4A, 3A, 2A, A, and ages 18 to 50.

Maximum total option amount is **the lesser of:**

- 2 times the monthly base benefit;
- 55 less insurance age (age nearest) x FCEO option amount chosen; **and**
- Occupational class maximums 4A - $20,000, 3A - $15,000, 2A - $7,000, A - $5,000, less the base benefit.

Maximum option amounts:

Class 4A	$1,500
Class 3A	$1,000
Class 2A	$500
Class A	$200

Health Care Profession benefit (H1134)

Mandatory coverage (unless denied for underwriting reasons) to the following health care professionals: medical doctors, dentists, dental surgeons, chiropodists, podiatrists, professional lab technicians, dental hygienists, dental assistants, denture therapists, denturists, denturologists, acupuncturists (MD and non-MD), nurses (RN's, RNA's, LPN's), respiratory therapists, respirologists, massage therapists doing acupuncture, physiotherapists doing acupuncture and paramedics.

Additional Covered Overhead Expense rider (H721)

Additional coverage payable to the 180th day can be added to a base policy of at least $100 per month. The elimination period on this benefit must be the same as on the basic coverage. The benefit does not increase the partial disability indemnity otherwise payable under the policy.

CO-ORDINATION WITH OTHER BOE PLANS

If an overhead policy is issued in addition to an existing BOE policy, either with us or with another company, a signed statement will be required on delivery, acknowledging the inclusion of a non-duplication rider in the policy.

BENEFICIARY DESIGNATION

If the beneficiary section of the application is not completed, the survivor benefit in the event of death will be paid to the Estate.

OWNERSHIP

The owner is the Insured unless otherwise designated. If the business is a corporation, it should be the owner of the policy.

EXCHANGE PRIVILEGE

Prior to age 60, an individual insured under our current Business Overhead Expense plan can request an exchange of his or her policy to a substantially equivalent individual policy subject to the following:

- the policy is then in force, and
- a new application is completed (without the Part 2 medical section), and
- the Insured is not disabled at the time.

The insured can elect the monthly amount of the benefit under the new policy but that monthly benefit amount cannot exceed the lesser of:

- $5,000 or
- the Maximum Covered Monthly Expense Benefit shown on the Policy Schedule.

The request is financially underwritten and all financial underwriting rules apply. In no event can the monthly amount of the benefit and all other in force disability coverage exceed our issue and participation limits in effect at the time of the request.

Coverage will be issued with the original age, rates and class as of the date of issue of the BOE policy, however, it will be dated currently.

Any exclusions and/or ratings on the original policy apply to the new policy.

BENEFIT PERIOD
2 years.

ELIMINATION PERIOD
The elimination period will be the same, unless the original policy had a 15 day EP, in which case the policy will be issued with a 30 day elimination period. A longer elimination period can be requested.

ADDITIONAL MONTHLY INDEMNITY
If the BOE has an Additional Covered Overhead Expense rider, then this portion will be converted to an additional monthly indemnity (AMI) with a six month benefit period.

RENEWABILITY
After age 65, the policy is conditionally renewable, while the Insured is actively and regularly employed at least 30 hours per week and responsible for the expenses of maintaining an office or business. The insured may continue the policy for the total disability benefit up to age 75. After age 75, the Insured's total disability benefit will be reduced by 50%.

BUSINESS LOAN PROTECTOR (10/99)

PLANS: 958 - Periodic Pay; 958L - Lump Sum

PURPOSE/MARKET

The Business Loan Protector policy has been developed to make the funds available to pay outstanding business loans and loan interest when the business owner becomes totally disabled.

Examples of eligible loans include loans for equipment, property and buildings used for the sole purpose of operating a business. The lump sum plan also covers lines of credit and account overdrafts.

INELIGIBLE RISKS

- Loans that are not payable to a recognized financial institution
- Public corporations, husband-wife combinations, parent-child combinations and other relationships that do not meet the "arms length" test, except for farm situations
- Investment loans, share purchase and personal property mortgage protection do not meet the eligibility criteria for this contract
- Any business that has not been in operation for at least three years prior to the application
- Any partnership where the partners have not been associated for at least three years prior to the application
- Any business that does not have a net worth of at least $50,000
- Any applicant with less than 25% ownership in the business
- Any applicant who does not have a minimum annual earned income of $12,000
- Any applicant who is not active in the business
- Silent partners
- Any risk where we are asked to participate with another insurer

ELIGIBLE OCCUPATIONAL CLASSES

4A, 3A, 2A, A - Periodic
4A, 3A, 2A - Lump Sum

OTHER COVERAGE

Personal income protection coverage for the proposed insured should be in force or have been requested as personal coverage is considered a primary need.

MINIMUM ISSUE LIMITS

$600 - Periodic Pay.
$10,000 - Lump Sum.

MAXIMUM ISSUE LIMITS

Class	Periodic Pay*	Lump Sum**
4A	$10,000	$250,000
3A	$8,000	$250,000
2A	$6,000	$250,000
A	$5,000	not available

* 100% of the business loan plus interest to the maximum shown above
** 75% of the business loan

We will allow both the lump sum and the periodic pay plans to cover the same loan. The total amount may not exceed the $250,000 lump sum limit per person. The periodic pay portion may not exceed the occupation class limits with the balance of coverage desired sold as a lump sum up to the overall maximum of $250,000. Class A is ineligible for lump sum coverage.

Issue limits for Business Loan Protector coverage are over and above the regular limits for disability insurance coverage. However, Business Loan Protector coverage will not be considered if an applicant's in force individual disability insurance exceeds the individual issue and participation limits or if the applicant is over-insured under any other disability product.

ISSUE AGES AND BENEFIT PERIODS

Age	Class	Benefit Period
18 - 55	4A, 3A, 2A, A	24 months (periodic pay)
18 - 55	4A, 3A, 2A	Three installments paid at 365, 540, 730 days *(lump sum)

* Total disability must exist throughout the 730 day period to receive all three payments.

ELIMINATION PERIODS

30, 60, 90 days - Periodic Pay
365 days - Lump Sum

MEDICAL REQUIREMENTS

Please refer to the Medical Requirements section of the Underwriting Guidelines.

INCOME DOCUMENTATION

Please refer to the Financial Documentation chart in the Financial Underwriting and Requirements section of the Underwriting Guidelines.

At time of claim, a letter from the lender will be required as evidence of the existence of a business loan.

OTHER UNDERWRITING REQUIREMENTS

When the amount of coverage applied for exceeds $50,000, we require a letter from a recognized financial institution outlining the amount that the business is liable for with respect to its business loans and the purpose of the loan.

OPTIONAL BENEFIT

Health Care Profession benefit (H1134)

Mandatory coverage (unless denied for underwriting reasons) to the following health care professionals: medical doctors, dentists, chiropodists, podiatrists, professional lab technicians, dental hygienists, dental assistants, denture therapists, denturists, denturologists, acupuncturists (MD and non-MD), nurses (RN's, RNA's, LPN's), respiratory therapists, respirologists, massage therapists doing acupuncture, physiotherapists doing acupuncture and paramedics.

OWNERSHIP

The ownership section of the application must be completed in full.

ASSIGNMENT

The policy can be assigned to the lender.

KEY PERSON PROTECTOR (03/04)

PLAN: 933

PURPOSE/MARKET

The Key Person Protector policy has been developed to provide coverage for a financial loss to an employer due to the disability of a key person.

A key person is an employee whose services are of such a nature that the owner would suffer substantial financial loss due to the employee's total disability. These employees offer their employer knowledge, skills or talent that few others can imitate or duplicate. The industry they work in or the nature of their work may be so specialized that there are few others with the skills needed. Many of these occupations have a component of design or research to them. Typically, the unique skills possessed by a key person are not totally acquired through education or even experience but are attributable in part to their own creativity, talents and interests.

People in the following businesses or professions are considered excellent prospects for the Key Person Protector policy:

Advertising account executives
Architects
Auctioneers
Biologists
Research scientists
Scriptwriters or directors in the motion picture, video, recording or television industry
Computer industry designers
Curators of museums
Curators of large art galleries (not involved with sales)
Industrial designers
Interior designers
Jewellery designers
Fashion industry designers
Other designers in the manufacturing industry
Engineers (industrial, research, civil)
Physicists
Columnists who work for a single newspaper (employee basis)
Publicity agents
Super-salespersons with an established stable pattern of high sales who contribute a significant portion of their employer's total revenue

INELIGIBLE BUSINESSES

Real estate (commercial and residential)
Construction/development companies
Stockbrokers/investment/commodity firms
Insurance sales
Entertainment industry
Retail sales

INELIGIBLE RISKS

- Public corporations, husband-wife combinations, parent-child combinations and other relationships that do not meet the "arms length" test are ineligible for Key Person coverage
- Any business that has not been in operation for at least three years prior to the application
- Any partnership where the partners have not been associated for at least three years prior to the application
- Any business that does not have a net worth of at least $50,000
- Any proposed insured who is not a key person

- Individuals hired under contract or on a fee-for-service basis
- Any proposed insured who has not been in his or her present occupation for at least one year and does not have an annual earned salary of at least $30,000
- Any proposed insured who does not have in force individual disability insurance, group LTD or association coverage
- Any proposed insured who owns more than 50% of the business
- Large corporations with many employees and very large profits do not qualify
- Any risk where we are asked to participate with another insurer

ELIGIBLE OCCUPATIONAL CLASSES

4A, 3A, 2A

OTHER COVERAGE

Personal income protection coverage for the proposed insured should be in force or have been requested as personal coverage is considered a primary need.

MINIMUM ISSUE LIMIT

$2,500 per month ($30,000/12)

MAXIMUM ISSUE LIMIT

Maximum $1/12^{th}$ of proposed insured's annual salary to a maximum of $15,000 per month.

Issue limits for Key Person coverage are over and above the regular limits for disability insurance coverage. However, Key Person coverage will not be considered if an applicant's in force individual disability insurance exceeds the individual issue and participation limits or if the applicant is overinsured under any other disability product.

ISSUE AGES

18 - 55

BENEFIT PERIOD

12 months

ELIMINATION PERIODS

60, 90 days

MEDICAL REQUIREMENTS

Please refer to the Medical Requirements section of the Underwriting Guidelines.

INCOME DOCUMENTATION

Please refer to the Financial Documentation chart in the Financial Underwriting and Requirements section of the Underwriting Guidelines.

OTHER UNDERWRITING REQUIREMENTS

Key Person Supplement, completed and signed by the proposed owner.

OPTIONAL BENEFIT

Health Care Profession benefit (H1134).

Mandatory coverage (unless denied for underwriting reasons) to the following health care professionals: medical doctors, dentists, chiropodists, podiatrists, professional lab technicians, dental hygienists, dental assistants, denture therapists, denturists, denturologists, acupuncturists (MD and non-MD), nurses (RN's, RNA's, LPN's), respiratory therapists, respirologists, massage therapists doing acupuncture, physiotherapists doing acupuncture and paramedics.

OWNERSHIP

The employer, company or corporation is the owner of the policy. This is designated on the policy schedule page. Benefits are paid to the owner. The Ownership Section of the application must be completed in full. The proposed owner or an authorized representative of the business must sign the application and the Key Person Supplement form.

ASSIGNMENT

The policy cannot be assigned.

UNDERWRITING NOTES

- Any unusual situation where the Underwriting Guidelines are not clearly met may be referred to underwriting for an opinion or may be submitted on a preliminary basis for an underwriting assessment of the facts.
- Key Person coverage will not be approved if Buy Sell or Business Overhead Expense coverage seems more appropriate.

EXAMPLES OF FAVOURABLE CHARACTERISTICS OF A POTENTIAL KEY PERSON

- The key employee is employed in a business separate from the residence;
- The key employee works on project type work, often on an independent basis;
- The key employee is employed in a field that is innovative, "cutting edge" or state of the art;
- The key employee originates or designs processes or products;
- The skills of the key employee have a direct impact on the profits and day to day activities of the rest of the company; an example of this could be a situation where without the designer, the manufacturing processes would come to a stop;
- The key employee is the only one within the company with his/her skills;
- The key employee is often the most highly paid employee in the organization other than the owner;
- The loss of the key employee would result in a difficult and lengthy search to hire a replacement;
- It would not be possible to hire a temporary or replacement worker to fill in for an absent key employee;
- The key employee might be a recognized authority in their field.

EXAMPLES OF UNFAVOURABLE CHARACTERISTICS OF A POTENTIAL KEY PERSON

- The key employee is a sole proprietor;
- The key employee owns more than 50% of the business;
- The key employee and the employer are not in an arms length relationship;
- The key employee is employed by a large and profitable corporation;
- The key employee works for a home-based business;
- The key employee's absence has an adverse effect on the business but there is no significant financial impact on the company;
- The key employee could be replaced internally by the organization;
- There is a successor within the organization for the key employee;
- The responsibilities of the key employee are shared or duplicated by others within the organization.

ACTUAL CASE EXAMPLES WE HAVE SEEN OF KEY PERSONS INCLUDE:

- A shoe designer working for a manufacturer employing 200 persons; the key person was the only designer working for the firm;
- A designer of a unique hockey stick employed by the manufacturer;
- A building envelope inspector; there are very few of these in Canada;
- The inventor of a hydroponic gardening method employed by the distributor who had purchased the rights to the system.

CRITICAL ILLNESS RECOVERY PLAN UNDERWRITING GUIDELINES (03/04)

INDEX

REVIEW THE QUALIFYING CHECKLIST (01/04)

The Qualifying Checklist provides a list of illnesses and conditions that indicate when a client is not eligible for Critical Illness coverage. If the applicant has any of the illnesses or conditions listed, do not submit an application. If you are unsure if your client can be considered for Critical Illness coverage, contact the underwriting department before submitting an application.

Individuals are uninsurable if they have a history of:

AIDS (AIDS related disease or HIV positive)
Alcohol abuse (within past 2 years)
ALS (Amyotrophic lateral sclerosis); known as Lou Gehrig's disease
Alzheimer's disease
Angina
Angioplasty
Blindness (may be excluded)
Cancer *
Chronic hepatitis (other than type A)
Chronic kidney disease
Colon polyps **
Coronary artery bypass surgery
Cystic fibrosis
Deafness (may be excluded)
Diabetes (insulin dependent)
Heart attack
Huntington's Chorea
Kidney failure
Major organ transplant
Multiple Sclerosis (MS)
Parkinson's disease
Peripheral vascular disease
Permanent paralysis
Polycystic kidney disease
Primary lateral sclerosis
Progressive bulbar palsy
Progressive pseudo bulbar palsy
Sickle cell disease
Stroke
Systemic lupus erythematosis
Transient ischemic attack (TIA)
Valvular heart surgery

* Applicants with certain skin cancers other than melanoma, or certain early stage cancers may be eligible for coverage. Consult with the Underwriting Department before submitting an application.

* Some forms of testicular cancer may be considered for coverage 5 years after successful completion of treatment. Any request for coverage where the client has a history of testicular cancer should be reviewed with the Underwriting Department prior to submission of an application.

** If colon polyps are present, coverage is not available. Once they have been removed and biopsied, coverage may be available depending on the medical details. Consult the Underwriting Department prior to submitting an application.

Also uninsurable:

Individuals on Welfare or Social Assistance.

Individuals who are not permanent residents of Canada regardless of whether they are Canadian citizens or not.

Individuals who do not have landed immigrant status.

Individuals who intend to reside outside of Canada.

Children, if all eligible siblings are not applying for CI coverage or whose parents do not have CI coverage in force or applied for (refer to the Financial Underwriting section of the following Underwriting Guidelines for additional details).

APPLICATION COMPLETION (04/04)

APPLICATIONS TO COMPLETE FOR CRITICAL ILLNESS INSURANCE (CI) (01/04)

Critical Illness Insurance may be applied for using:

- The stand-alone CI application (Form # 83550 - English, # 83551 - French); **or**
- A fully completed regular application (Form # 83530 - English, # 83531 - French); **or**
- For applicants at attained age 2 to 17, the only acceptable application is the Child Critical Illness Recovery Plan application (Form # 83552 - English, # 83553 - French); up to 3 children can apply per application.

BACKDATING TO SAVE AGE (01/04)

Due to the 90 day cancer clause in the contract and other application provisions, we cannot backdate a Critical Illness Insurance contract unless the Insured agrees to sign a Backdating Amendment. The amendment specifies that the Issue Date has been backdated for the purpose of reducing the premium rate only and that all references to "Issue Date" in the policy, riders, etc., refer to the True Issue Date, not the Issue Date stated on the Policy Schedule. The temporary insurance under the CIA provides limited coverage between the date the application was signed and the 'actual' date the policy becomes effective.

We will not backdate to save age in order to enable an applicant to obtain coverage or optional benefits that would not otherwise be available because of age restrictions.

CONDITIONAL INSURING AGREEMENT (CIA) 04/04)

The wording and conditions attached to this agreement provide a limited amount of temporary insurance during the underwriting process.

The Conditional Insurance Agreement on Critical Illness Insurance does not protect an applicant's insurability, as is the case with Disability Insurance.

Coverage is not conditional upon completing routine age and amount medical requirements to satisfy the Conditional Insuring Agreement as it is for Disability Insurance.

An applicant must meet the eligibility criteria set out in the Application for Conditional Insurance and temporary coverage is subject to the terms and conditions of the Conditional Insurance Agreement.

When an application is submitted as a make-over, unlike Disability Insurance, there is no Conditional Insurance in effect unless the applicant meets the eligibility criteria set out in the Application for Conditional Insurance and a premium deposit is collected. The temporary coverage is subject to the terms and conditions of the Conditional Insurance Agreement.

Please refer to the Application for Conditional Insurance on Critical Illness Insurance Applications and the Conditional Insurance Agreement and Receipt on Critical Illness Insurance Applications for the exact wording.

DISCOUNTS (04/04)

LARGE CASE DISCOUNTS

This discount program is designed for large employer/employee groups. Prior underwriting approval is required and an employer census should be submitted with any enquiry to the Underwriting Department. Large case discounts are mandatory for large groups in excess of 25 lives. Please refer to the Policy Administration of the Underwriting Guidelines for more details.

SELECT DISCOUNT

This discount is only available to children aged 2 - 17 if at least one parent or grandparent has an in force or pending Critical Illness Recovery Plan policy with us.

ISSUE AGES (01/04)

Term 10 (non-cancellable) convertible to age 65; renewable to age 75 . . . . 18 - 64
Level premiums to age 65 (guaranteed renewable) . . . . . 2 - 60
Level premiums to age 75 (guaranteed renewable) . . . . . 2 - 65
Level premiums to age 75 (guaranteed renewable for voluntary GSI) . . . . . 18 - 65
Level premiums to age 75 (non-cancellable) . . . . . 2 - 65
Level premiums to age 100 with options at age 75 (non-cancellable) . . . . . 2 - 65

ISSUE AND PARTICIPATION LIMITS (01/04)

- Minimum policy size is $10,000.
- Maximum policy size is $1,000,000 *.
- Maximum participation with other companies is $1,000,000 *.
- Coverage is issued in increments of $1,000.

* Amounts in excess of $1,000,000, to a maximum of $2,000,000, may be considered on an exceptional basis, subject to underwriting approval.

OCCUPATIONAL CLASSES (01/04)

The Critical Illness Recovery Plan is not class specific.

RATES (10/99)

- Rates are age dependent, calculated at age nearest.
- Rates are gender specific and smoker/non-smoker specific.
- Rates are banded by benefit amount ($0-$49,999; $50,000 - $99,999; $100,000+).

MEDICAL UNDERWRITING (04/04)

MEDICAL REQUIREMENTS (01/04)

AGE	BLOOD PROFILE, URINE PROFILE and PARAMED	BLOOD PROFILE, URINE PROFILE, PARAMED and ECG	BLOOD PROFILE, URINE PROFILE, EXAM and ECG
18 - 40	Over $249,999	N/A	N/A
41 - 50	$100,001 - $250,000	Over $250,000	N/A
51 - 55	$25,001 - $100,000	Over $100,000	N/A
56 - 60	$0 - $100,000	Over $100,000	N/A
61 - 65	N/A	$0 - $250,000	Over $250,000

NOTES REGARDING CRITICAL ILLNESS INSURANCE MEDICAL REQUIREMENTS

- Urine/HIV, blood profile, hepatitis screen, paramedical, exam by an MD are considered current for six months.
- ECG is considered current for one year.
- TOTAL AMOUNT OF COVERAGE

  Includes:
  - Current amount of Critical Illness Insurance applied for, **plus**
  - Current amount of Scheduled Increase Benefit Rider applied for, **plus**
  - Any previous amount of Critical Illness coverage issued, including any Scheduled Increase Benefit Rider amount and GSI, since medical requirements were last satisfied.

- **If applying for the Scheduled Increase Benefit Rider**, the sum of all future increases must be added to the base Critical Illness indemnity to obtain the total amount of coverage for the purposes of determining the medical requirements.

- **There are no routine medical requirements for ages 17 or under**, however they may be requested at time of underwriting, based on the information provided on the application.

- Each time the applicant has an automatic medical requirement completed resulting in our issuing standard coverage, eligibility for non-medical insurance is renewed. The next time the applicant applies for coverage, the in force coverage issued as a result of the automatic medical requirements is disregarded for the purposes of determining medical requirements and only the current amount is used to determine requirements.

  Example:
  A 45 year old has $200,000 of Critical Illness Insurance coverage in force, with the Scheduled Increase Benefit Rider, issued standard; at the time of application, a blood profile, urine profile, paramedical and ECG were submitted. He is now applying for an additional $100,000 of Critical Illness Insurance coverage. Current medical requirements: none.

- If applying for Critical Illness Insurance along with Individual Disability coverage, please consult both the Critical Illness Insurance medical requirements chart and the Individual Disability coverage medical requirements charts to determine the overall medical requirements. The highest level of automatic requirements will apply.

Example:
A 42 year old cardiac surgeon is applying for Critical Illness Insurance in the amount of $200,000 and Individual Disability coverage in the amount of $3,000 per month. Medical requirements: blood profile with hepatitis screen, urine profile and paramedical (based on both Health Care Workers' DI requirements chart and the CI requirements chart).

› Testing for hepatitis is not a routine requirement for Critical Illness Insurance unless applying in conjunction with a request for disability coverage where a hepatitis screen is an automatic requirement.

FAMILY HISTORY (01/04)

Due to the strong statistical correlation between family history and the risk of another family member developing the same condition, family history is an important aspect of Critical Illness Insurance underwriting.

The impact of family history on underwriting varies based on the specific medical condition of the family member, the age of onset in the affected family member, the age of the applicant and the overall medical history of the applicant. Due to these variables, it is not possible to create simple guidelines to address the issue of family history.

Examples of family histories that are of particular concern are: early onset cardiovascular disease, early onset diabetes, early onset of certain cancers, any history of motor neuron disease and any strong family incidence of a same medical condition or an unusually early onset of some conditions such as Alzheimer's disease.

NON-SMOKER DEFINITION (02/04)

To qualify for non-smoker rates, the following criteria must be met:
› The applicant must have refrained from using any tobacco product, smoking cessation therapy (including Nicorettes, any transdermal patch or other form of tobacco cessation product) or marijuana, for at least twelve months preceding the application date.
› We reserve the right to obtain an HOS on any case to verify non-smoker status. In all cases, the HOS must be negative for cotinine.

Non-smoker rates are also available when all of the following criteria are met:
› Maximum of 12 cigars/year
› An HOS negative for cotinine
› No health concerns exist that would be impacted by, or related to smoking
› Cigar use is admitted on the application
This consideration does not apply to GSI applications.

It is essential that the producer and the applicant carefully establish the applicant's qualification for non-smoker rates at the time the application is taken. In accordance with industry practices, we consider an inaccurate response to the smoking question to be material misrepresentation and therefore, grounds for rescission of the contract.

Requests to change from smoker to non-smoker rates are subject to the following guidelines:
› The Insured meets the criteria for consideration as a non-smoker.
› We are in receipt of a fully completed Application for Reinstatement and/or Policy Change (Form 83536, formerly 12010).
› Since the policy was issued, the Insured has not developed medical history that is smoking-related (i.e. coronary artery disease, chronic obstructive pulmonary disease, emphysema); in such a case, the request would be denied with no future reconsideration of non-smoker rates.
› We reserve the right to obtain an HOS or any other underwriting requirements in order to evaluate the Insured's eligibility for non-smoker rates.

SUBSTANDARD RISK (01/04)

In Critical Illness Insurance underwriting, substandard refers to some modification of coverage due to medical history, physical condition, laboratory findings, family history or some non-medical situation (e.g. avocation) that exists or has existed in the past.

The objective of substandard underwriting is to modify the coverage being approved so that the experience results (morbidity) of the substandard group to which the applicant belongs are the same as a standard group.

The underwriter has several actions available that allow us to offer coverage to as many applicants as possible. These actions include:

- Extra premium (a rating): the maximum rating for CI is + 150
- Exclusions* for self-limiting conditions that do not lead to other covered conditions (e.g. blindness, multiple sclerosis)
- Exclusions* for a specific risk (thyroid cancer) or avocation (aviation)
- Reductions of indemnity and/or deletion of optional benefits
- Any combination of the above

* Why not a cancer or diabetes exclusion? Because we cannot apply an exclusion for a condition that would impact more than one covered condition or would be difficult to evaluate at the time of a claim. Example: diabetes is a significant risk factor that can lead to a number of covered conditions: blindness, kidney failure, major organ transplant, loss of limbs.

SIGNIFICANT UNDERWRITING DIFFERENCES BETWEEN DISABILITY PRODUCTS AND CRITICAL ILLNESS INSURANCE

Medical condition:	Difference:
Asthma	Less severe
High blood pressure	More severe
Breast disease	More severe
Build – overweight and underweight	More severe
Colon: ulcerative colitis	More severe
polyps	More severe
Chronic obstructive pulmonary disease	Less severe for non-smokers
Diabetes: insulin dependent	Decline
non-insulin dependent	More severe - maximum rate +100
Epilepsy	More severe
Family history	More severe
Heart disease	More severe - most abnormalities = decline
Hyperlipidemia	More severe
Kidney disease	More severe
Mental illness	Less severe
Musculo-skeletal disorders	Less severe
Peripheral vascular disease	Decline
Rheumatoid arthritis	Less severe
-if on steroid medication	More severe
Smoking	More severe
Soft tissue injuries	Less severe
Urinary abnormality	More severe

SIGNIFICANT UNDERWRITING DIFFERENCES BETWEEN LIFE PRODUCTS AND CRITICAL ILLNESS INSURANCE

Medical condition:	Difference:
Asthma	Less severe
High blood pressure	More severe
Breast disease	More severe
Build – overweight and underweight	More severe
Colon: ulcerative colitis	More severe
polyps	More severe
Chronic obstructive pulmonary disease	Less severe for non-smokers
Diabetes: insulin dependent	Decline
non-insulin dependent	More severe - maximum rate +100
Epilepsy	More severe
Family history	More severe
Heart disease	More severe - most abnormalities = decline
Hyperlipidemia	More severe
Kidney disease	More severe
Mental illness	Less severe
Peripheral vascular disease	Decline
Rheumatoid arthritis	Less severe
- if on steroid medication	More severe
Smoking	More severe
Urinary abnormality	More severe

FINANCIAL UNDERWRITING (01/04)

INDIVIDUAL COVERAGE:

1. **There are no routine financial requirements.** The underwriter reserves the right to request income documentation depending on the specifics of a case. Any request for coverage in excess of our Issue & Participation limits will require income documentation and an Inspection Report.

2. **Issue Limits for personal coverage:**
   - Up to age 50 - will allow up to 9 times the net earned income *
   - Age 51 to 59 - will allow up to 7 times the net earned income *
   - Age 60 to 65 - will allow up to 5 times the net earned income * at age 60, decreasing yearly by one multiple (20%) to a minimum amount of not less than $100,000

   * plus the amount of personal mortgage on either the house and/or cottage (if applicable)

3. **Non-working spouse:** we will allow 50% of the income multiple amount * on the wage earner, plus the mortgage on either the house and/or the cottage (if applicable). Confirmation of the Critical Illness Insurance amount in force or applied for on the wage earner is required. The amount of Critical Illness coverage on the non-working spouse's life generally should not exceed the spouse's coverage.
   * The income multiple amount on the wage earner is the net earned income of the wage earner, multiplied by the factor (1 to 9) used in determining the amount of Critical Illness coverage in # 2 above.

4. **Children aged 2 - 17:** in order to avoid anti-selection and to protect the welfare of the child, all children in the family must apply for (or have) the same amount of Critical Illness coverage, based on their age grouping. Parents are also expected to have Critical Illness coverage in force or applied for in amounts that are equal to or exceed that of any one child. Exceptions to this rule will be considered on an individual basis, depending on the reasons given for such consideration.

5. **Children aged 2 - 4:** allowed up to $100,000.

6. **Children aged 5 - 17:** allowed up to $100,000. Amounts up to $250,000 may be considered subject to the parent who is the main wage earner carrying at least 2 x the child CI amount and the spouse at least as much as the child. Any amount in excess of $100,000 will be subject to a Personal History Interview.

7. **Farm owners:** Up to 10 times the net earned income; farm owners with annual earned income of $0 to $9,999 are allowed up to $100,000; farmer's with a net earned loss are ineligible for coverage.

8. **Medical Doctors, Lawyers, Notaries (Quebec) and Dentists starting in practice:** allowed up to $500,000. **Other new professionals (see occupations listed under Student Limits in the Financial Underwriting and Requirements section of the Underwriting Guidelines):** allowed up to $250,000.

9. **University students:** allowed up to $250,000.

10. **Applicants on welfare or social assistance are not eligible for coverage.**

11. **Unemployed or on disability:** Individual consideration but likely uninsurable, submit as a trial application.

Note: the amount of coverage is based on an applicant's actual net income, after expenses but before taxes, earned in the previous year. In using this figure to calculate the maximum amount of coverage considered, no "perk allowance" is added to this income. For employees, the income figure used is based on their salary or hourly wages.

BUSINESS COVERAGE:

1. **Business Key Person coverage:** can allow up to 3 times the net earned income of the key person.

   Critical Illness coverage should be applied for or in force for all key persons of a firm. Individual consideration to exceed this amount only with full documentation of how the amount was calculated. Explanation of the key person's value should be included.

2. **Business Loan:**
   - We will cover up to 50% of an owner's share of a business loan subject to our Issue and Participation limits.
   - The loan must be a long-term liability with a minimum 5 year payback.
   - All active owners must be insured or there must be a reasonable explanation why they are not.
   - Full loan or financing details including reason for loan, amount, name of lender and terms must be provided.

3. **Coverage for Line of Credit, Overdraft and Partnership/Shareholder Buy Sell is not available.**

4. **Financial requirements:** coverage in the amount of $500,000 and over will require financial documentation including the most recent financial statement of the business and likely an Inspection, Business Beneficiary Report. Any request for coverage in excess of our Issue & Participation limits will require an Inspection, Business Beneficiary Report and a financial statement of the business.

GROUP/ASSOCIATION OFFSET AMENDMENT

Not applicable.

WAGE LOSS REPLACEMENT PLAN AMENDMENT

Not applicable.

SPECIFIC UNDERWRITING CONSIDERATION (04/04)

AVIATION (01/04)

Aviation risks may be standard depending on the type of aircraft flown, type of license held, experience and certification of the applicant. An exclusion may be substituted for a rating, if one is required.

AVOCATIONS AND SPORTS (01/04)

Certain avocations and sports can represent a significantly increased risk of traumatic injury leading to one of the covered Critical Illnesses such as loss of limbs, coma, paralysis, blindness or burns. Consequently, some avocations and sports may require a rating and/or exclusion. Examples: boxing, race car driving.

CHILD COVERAGE (01/04)

› **Application Form:** until the child has attained age 18 (or the age of majority in province of residence), the only acceptable application is the Child CI application (Form # 83552 - English, #83553 - French).

› **Minimum Insurable Age:** Attained age 2 years

› Maximum Issue Limits:

Ages 2 - 4	$100,000
Ages 5 - 17	$100,000
	(Coverage up to $250,000 subject to underwriting approval)

› **Available Plans:** All except the Term 10 plan

› **Optional Benefits Available:** Return of Premium on Expiry rider
Scheduled Increase Benefit Rider – the total of the base benefit amount and all future Scheduled Increase Benefits cannot exceed the maximum Issue and Participation limits.

Note: the Functional Independence rider and/or Disability Waiver of Premium rider can be added within the first 2 years after the Insured has reached age 18 (or the age of majority in province of residence), as a policy change. The policy change will be medically underwritten and subject to our policy change guidelines in effect at that time.

› **Ownership & Benefit Payment:** Only a parent or legal guardian of a minor can be the Owner of the policy. Ownership can be transferred to the Insured upon reaching the age of majority (18 or 19 depending on the province of residence), subject to our regular change of ownership guidelines. While the Insured is a minor, all benefits payable are paid to the Owner. The Owner can be one or both parents or legal guardian(s). Even if both parents or more than one guardian are Owners of the policy, only one parent or guardian needs to sign the application agreement and authorizations.

DRIVING RECORD (01/04)

A significantly adverse driving record may require a rating because of the increased risk of traumatic injury leading to one of the covered Critical Illnesses such as loss of limbs, coma, paralysis, blindness or burns. Any rating is dependent on the nature and number of violations in addition to the age of the applicant.

FOREIGN RESIDENCE OR TRAVEL (01/04)

Critical Illness Recovery Plan underwriting guidelines and pricing are based on Canadian incidence rates for the covered conditions. Incidence rates for Critical Illness Insurance related conditions vary greatly from country to country. Consequently, our policies are not priced appropriately for residents of other countries.

Although geographically close, the experience between Canada and the U.S.A. for Critical Illness Insurance related conditions could differ significantly. As a result, Canadians who intend to move to the U.S.A. or any other country cannot be considered for coverage.

Extended travel to countries that are politically unstable or where medical facilities and treatment are inadequate or simply unavailable represents increased risks of injury, disease and infection. This increased risk may result in coverage being declined or offered with a rating.

We cannot consider Critical Illness coverage for anyone who is not a permanent resident of Canada. Additionally, those who have not resided in Canada for a minimum of 1 full year, or have not yet obtained landed immigrant status, cannot be considered for coverage.

OCCUPATIONAL RISKS (01/04)

There are some occupations where the inherent risk of injury is unusually high or there is an increased risk of developing cancer through exposure to toxic substances. Certain unusually hazardous occupations may not be acceptable or may require a rating. Examples: asbestos workers, explosive handlers, hazardous chemical workers, commercial deep-sea divers.

OPTIONAL BENEFITS (01/04)

This section contains summaries of our current Optional Benefits. Please refer to the actual contract wording for full details.

RETURN OF PREMIUM ON EXPIRY RIDER

Eligible Ages: 2 - 60 (except 18 to 60 for Term 10 Plan)
Eligible Plans: all Plans except Term 100 Plan (see Return on Death provision built-in to the policy)
Rider H1154 – Plan 957
Rider H1155 – Plans 959, 947, 979
Rider H1153 – Plan 936

This benefit provides that we will pay a return of premium on expiry benefit to the owner, if the Critical Illness Recovery Plan policy is in force on the expiration date of the policy (65^{th} or 75^{th} birthday) and there is no critical illness benefit or functional independence rider benefit payable or pending. For the purpose of the Term 10 Plan, the expiration date is the 75^{th} birthday.

The return of premium benefit is equal to the lesser of:
- The face amount of the policy; and
- The premiums paid under this policy (including riders and ratings) while this rider was in force.

It will be reduced by any premiums waived or refunded (if disability waiver of premium rider is purchased) and any benefits paid under the functional independence rider (if purchased).

SCHEDULED INCREASE BENEFIT RIDER

Eligible Ages: 2 - 45
Eligible Plans: all Plans, except Term 10 Plan (936), with an original benefit amount that is less than $500,000
Rider H1152

The Scheduled Increase Benefit Rider provides that the amount of Critical Illness Benefit coverage is automatically increased by 20% of the original amount on every 2^{nd} policy anniversary of the effective date of the policy, while the policy is in force.

These increases occur during the first 10 years that the policy is in force.

The increases cannot be declined; however, if the Insured no longer needs to increase their benefit, the benefit can be terminated.

All increases under this rider are subject to any exclusion that applies to the base Critical Illness contract.

The amount of increase under this rider is equal to 100% of the base Critical Illness Benefit.

The total of the base Critical Illness Benefit amount and all future Scheduled Increase Benefits **cannot exceed the lesser of:**
a) our published financial underwriting guidelines; or
b) our maximum Issue and Participation limits.

Any automatic increase in benefit that occurs during the waiting period for Critical Illness or elimination period for the Functional Independence rider (where applicable), will not apply to that claim.

DISABILITY WAIVER OF PREMIUM RIDER

Eligible Ages: 18 - 55
Eligible Plans: all Plans
Rider H1157 – Plan 957
Rider H1159 – Plan 959
Rider H1158 – Plan 947
Rider H1156 – Plan 936
Rider H1161 – Plan 980
Rider H1160 – Plan 979

This rider provides that after the Insured has been disabled for 90 consecutive days, we will pay premiums that come due while the Insured is disabled. We will also refund premiums paid during those first 90 days.

Disabled means the Insured is unable to perform any occupation for which they are reasonably suited by education, training or experience. However, if the Insured owns any other individual accident and sickness policy of ours, we will waive the Critical Illness premiums when the premiums under their individual accident and sickness policy are being waived.

Provided policy premiums are not being waived under this rider on the Insured's 65th birthday, this rider will terminate on that date. If the premiums are being waived on the Insured's 65th birthday, we will continue to waive the premiums until the earlier of the termination of the policy or when the Insured no longer meets the definition of disability under this rider (and premiums are no longer being waived under their individual accident and sickness policy insured with us).

This rider is subject to any exclusion that applies to the base critical illness contract.

FUNCTIONAL INDEPENDENCE RIDER

Eligible Ages: 18 - 55
Eligible Plans: all Plans except Term 10 Plan (936)
Rider H1148 – Plan 957
Rider H1149 – Plan 959
Rider H1147 – Plans 947 & 980
Rider H1151 – Plan 979

This rider provides benefits for some of the on-going costs that may be associated with severely debilitating medical problems that are not caused by one of the covered critical illnesses.

After satisfying the 60 day elimination period, we will pay 1/60th of the Total Benefit Amount each month that the Insured is:

a) unable to perform two or more of the six Activities of Daily Living (ADL) in their normal living environment without substantial daily physical assistance from another person. If home modifications and/or adaptive devices or equipment enable them to perform an ADL without assistance, they will not be considered unable to perform that ADL; or
b) Cognitively Impaired, meaning they have suffered a severe impairment of cognitive functioning or intellectual capacity that has left them dependent on another adult person's continuous presence, stand-by assistance and verbal cueing to ensure their safety or the safety of others.

The six Activities of Daily Living are: bathing, toileting, continence, dressing, transferring (i.e. from chair to bed), eating.

Any amounts paid under this rider will reduce the Critical Illness benefit that is payable. Once the Total Benefit Amount has been paid under this rider or the policy, the policy and all riders will terminate.

Provided the Insured is not satisfying the elimination period or receiving Functional Independence benefits, this rider will terminate on the Insured's 65th birthday.

POLICY ADMINISTRATION (04/04)

POLICY CHANGES (01/04)

The following changes are available on all non-GSI* plans EXCEPT the Term 10 (T10) **, but only if the original policy was issued from a Plan version that permitted these benefits.

Type of Change	Availability	Form Required	Underwritten	Modify or Make-Over	Rates – Current Age Nearest
Add Return of Premium Rider	Anytime – on Plans issued under Version Control date Oct. 2, 2000 or later	Application for Reinstatement and/or Policy Change – Part 1 (name & address) and Section-D **OR** A request, signed by the policy owner, to add this benefit	No	Modify	Yes, premium is a percentage of the current annualized premium.
Add Functional Independence Rider	Two years from original issue date of the policy.	Application for Reinstatement and/or Policy Change – Part 1 (name & address), Sections B & D, and Part 2	Yes	Modify	Yes – on the FI Rider portion only
Add Waiver of Premium Rider	Two years from original issue date of the policy Plans with Version Control date Oct. 2, 2000 or later.	Application for Reinstatement and/or Policy Change – Part 1 (name & address), Sections B & D, and Part 2	Yes	Modify	Yes – on the Waiver Rider portion only
Add Scheduled Increase Benefit	Not available by policy change – requires a make-over.	Full Application	Yes	Make-Over	Yes – on entire new policy

* The above are available on GSI issued cases subject to approval from Advanced Underwriting.

**** Term 10 (T10) Policies**

Optional benefits are not available post issue on any T10 policy. In order to acquire any optional benefits on a T10 plan, the T10 plan must be made-over to a new policy at attained age and rates. This make-over is subject to a new application with full underwriting, with one exception:

If the benefit requested is the Return of Premium Rider and the policy is from our most current product offering (i.e. current version control date), we will permit the make-over without underwriting. See the following chart.

T10 Plan	Form Required	Underwritten	Rates - Current Age Nearest
Current version and Portfolio Plan only	Application for Reinstatement and/or Policy Change - Part 1, Section D only	No	Yes - on the entire new policy
Any previous version or Portfolio Plan	Full Application	Yes	Yes - on the entire new policy

MAKE-OVERS AND ADDITIONS (01/04)

Other than the policy changes indicated above, requests for additions and changes to Critical Illness Insurance coverage for an applicant who currently has existing coverage are only available via a make-over or by issuing an additional contract.

- An existing policy can be maintained in its current form and additional coverage can be applied for under a new policy. The client will have two separate CI policies, which may or may not have different policy provisions.

- An individual can apply for a make-over to the most current version of the Critical Illness Insurance policy. In this situation, the existing provisions and coverage available under the in force policy will be maintained during the underwriting period as long as payments continue to be made. The contestable period will only apply to increases and improvements to the original contract, and to the remaining time frame within the contestable time period, if any, between the issue date of the original policy and the date of the make-over. Limitations in the policy, such as the 90 day cancer clause and any other built in exclusions, will only apply to the additional features and increased coverage applied for, assuming these limitations have already been satisfied on the previous policy.

MELDING CREDIT (01/04)

A melding credit may be available if switching from in force Individual Disability Insurance (IDI) to a Critical Illness Recovery Plan policy (i.e. at retirement). The availability of a melding credit will be dependent upon the IDI Plan in force at that time. Refer to Melding Credit Rules in the Policy Administration section of the Underwriting Guidelines.

RECONSIDERATIONS AND REINSTATEMENTS (01/04)

Due to the nature of the coverage provided by this product, the Application for Reinstatement and/or Policy Change (Form # 83536 - English (formerly #12010), Form # 83537 - French (formerly # 12011) does not provide the level of information required to fully assess an individual's insurability. As a result, we require a complete Critical Illness Recovery Plan application (Form # 83550 - English, # 83553 - French or, if applicable, Child CI # 83552 - English, # 83553 - French) to consider reinstatement of any lapsed Critical Illness policy or to reconsider any substandard action originally taken.

POLICY ADMINISTRATION

APPENDIX

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About RBC Insurance

RBC Insurance, through its operating entities, including RBC Life Insurance Company, provides a wide range of creditor, life, health, travel, home, auto and reinsurance products to more than five million North American clients. As one of the top 10 life insurance producers and the leading provider of individual living benefits in Canada, RBC Life Insurance Company offers a comprehensive portfolio of individual and group life and health insurance solutions. These products are distributed through more than 17,000 independent brokers affiliated with producer groups, financial planning firms and stock brokerage firms, as well as through direct sales and a network of career sales representatives.

For more information, please visit **www.rbcinsurance.com**

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