NATIONAL BANK INSURANCE Life | Health

10-Year Term Life Insurance Policy

Part I of this *Policy* includes the conditions specific to your situation and that of the insured.
Part II (this document) indicates the general conditions of your *Insurance Contract*.

Part II – General terms and conditions

We recommend that you read this document carefully to ensure your *Insurance Contract* effectively meets your needs.

You have 30 days to read the document. If you cancel your *Insurance Contract* in the 30 days after it is delivered to you, any premiums that you paid will be refunded and your *Insurance Contract* will be considered to have never been in effect. You can cancel your *Insurance Contract* at any time by contacting us.

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1-877-871-7500

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In this *Policy*, "you" designates the *Policyholder* and "us" designates the *Insurer*, National Bank Life Insurance Company. The words in italics are defined and explained in Section 2 (Definitions).

In this *Policy*, the *Policyholder* may also be the *Insured*. In this case, "you" and the "*Insured*" designate the same person.

Part II includes what you must know about your *Insurance Contract*. You will find the description of the coverage, exclusions and how your *Insurance Contract* works. It is important for you to fully understand these provisions. Do not hesitate to contact us if you require additional explanations.

1. About this Policy

1.1 COVERAGE

This section describes the different types of coverage offered by the *Insurer*. The different benefit amounts are indicated in Part I (Specific Conditions).

1.1.1. Life Insurance

Upon the *Insured*'s death, we will pay the life insurance benefit to the beneficiary, based on the terms and conditions in your *Insurance Contract*.

1.1.2. Additional Insurance in the Event of Accidental Death

Upon the *Insured*'s death, we will pay the additional benefit to the beneficiary in the event of accidental death if the *Insured*'s death is the result of an *Accident*. This benefit is payable in addition to the life insurance benefit, according to the terms and conditions set out in your *Insurance Contract*.

1.1.3. Critical Illness diagnosis Insurance

Your *Insurance Contract* states that a benefit will be paid following the diagnosis of a cancer (life threatening), a heart attack or a stroke that meets the criteria set out in Section 1.6 (Critical Illnesses Covered).

The benefit amount for the insurance in the event of a *Critical Illness* diagnosis is determined based on the amount of the life insurance benefit set out in your *Insurance Contract* and is indicated in Part I (Specific Conditions). The maximum amount payable is $30,000 per *Insured*, regardless of the number of Term Life Insurance contracts held with us.

The payment of a benefit in the event of a *Critical Illness* has no impact on the amount of the premiums payable, as these are guaranteed for the duration of your *Insurance Contract*.

1.2 ELIGIBILITY, INSURABILITY AND DURATION OF THE INSURANCE

For your *Insurance Contract* to be valid, the insured must meet certain conditions when submitting the *Insurance Application*. To accept the insurance application, the *Insurer* also has certain rights that are explained in this section.

The *Insurance Contract* has a start and an end, and there are certain rules during the coverage period. This section contains explanations and some examples.

1.2.1. Conditions to be Eligible for Insurance (eligibility)

To be eligible, the *Insured* must fulfill the following three conditions:

- Be between the ages of 18 and 60
- Be a Canadian citizen or permanent resident
- Be domiciled in and have been present in Canada for more than six months over the 12 months preceding the date on which the *Insurance Application* is submitted to us.

1.2.2. State of Health (insurability)

In order to assess the *Insurance Application*, we request certain information from the *Insured* on his or her state of health and lifestyle. We can also, at our expense, request a medical examination (e.g., electrocardiogram, blood tests or screening tests) in order to assess the risk that the *Insurance Application* presents. Analyzing this information helps us make a decision.

1.2.3. Start of Insurance

The date that the *Insurance Contract* takes effect is indicated in Part I (Specific Conditions) and is applicable only if the following three conditions are met:

- We have accepted your *Insurance Application*
- We have received the total amount of the first monthly premium or valid banking information for the electronic withdrawal of premiums
- No major change has occurred concerning the *Insured*'s state of health since the *Insurance Application* date.

1.2.4. Initial Period and Automatic Renewal

The initial period of your *Insurance Contract* start on its effective date as indicated in Part I (Specific Conditions) and ends on the renewal date. The renewal date corresponds to the 10th anniversary of the effective date.

At the end of the initial 10-year period, if your *Insurance Contract* is still in effect, we will automatically renew it for a new 10-year period without the *Insured* having to provide proof of his or her state of health. The automatic renewal of your *Insurance Contract* will then take place every 10 years, until the *Insured* reaches 70 years of age.

If your *Insurance Contract* is renewed after the *Insured* has reached 60 years of age, your *Insurance Contract* will end on the date of the *Insured*'s 70th birthday.

The renewal dates and the expiry date of your *Insurance Contract* are indicated in Part I (Specific Conditions).

1.2.5. Termination of the Insurance Contract

Your *Insurance Contract* terminates on the earliest of the following:

- Death of the *Insured*
- The date when the voluntary termination of your *Insurance Contract* takes effect, without the need of the beneficiary consent, irrevocable or not
- The date when your *Insurance Contract* is cancelled by the *Insurer* (see clause 1.7.4)
- On the 70th birthday of the *Insured*
- The day after the last day of the grace period granted for the non-payment of premiums.

1.2.6. End of Critical Illness diagnosis Insurance

Coverage in the event of *Critical Illness* diagnosis ends when either one of the following situations occurs:

- The benefit in the event of *Critical Illness* diagnosis is paid by the *Insurer*
- Your *Insurance Contract* ends.

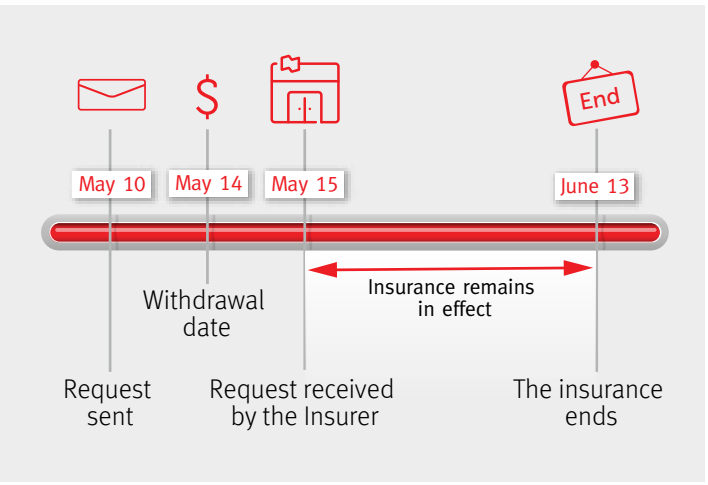
1.2.7. Voluntary Termination (if you wish to end your *Insurance Contract*)

You may, at any time, terminate your *Insurance Contract* without charge by contacting us at 1-877-871-7500.

Your *Insurance Contract* will end on the premium withdrawal date that follows the later of the following dates:

- The date on which you choose to terminate your *Insurance Contract*
- The date on which we receive your notice of voluntary termination.

For example, if you advise us that you wish to terminate your *Insurance Contract* effective on May 10 but we only receive your request on May 15, if the withdrawal date is the 14th of each month, your *Insurance Contract* will remain in effect until June 13.



If you terminate your *Insurance Contract*, no premiums will be refunded and no grace period will be granted.

1.3 PREMIUMS AND REINSTATEMENT

For your *Insurance Contract* to be in force, premiums must be paid to the *Insurer*. See below for the rules explaining the payment of premiums.

1.3.1. Payment of Premiums

The *Policy* premiums are payable monthly to the *Insurer* in Canadian dollars. The dates and premium amounts payable are indicated in Part I (Specific Conditions).

1.3.2. Guarantee of Premium Amounts

We guarantee that the premium amounts indicated in Part I (Specific Conditions), including the renewal premiums, will not be modified.

1.3.3. Period during which your insurance contract remains in effect, even if the premium is late (Grace Period)

If the premium is not paid on its payment date, we will grant you a grace period of 30 days to pay it, except for the first premium.

If an insured event occurs during this 30-day period, the unpaid premium amount will be deducted from the benefit payable.

If the premium is still unpaid after the grace period, your *Insurance Contract* will be terminated.

1.3.4. Reinstatement within 30 Days after the end of the grace period

If your *Insurance Contract* is terminated because the premiums have not been paid, it can be reinstated within 30 days after the end of the grace period by payment of the overdue premium, but only if the Insured is alive at the time payment is made.

1.3.5. Reinstatement more than 30 days after the end of the grace period

If your *Insurance Contract* is terminated because the premiums have not been paid, and it is not reinstated within 30 days after the end of the grace period, it can be reinstated only if the following four conditions are met:

- You must complete a reinstatement form in the two years following the end of your *Insurance Contract*
- The *Insured* must present all the evidence of insurability that we request
- The *Insured* must still be insurable based on our criteria
- You must pay all the unpaid premiums, including interest calculated at a rate determined by us, as well as the reinstatement fees for your *Insurance Contract*, if applicable, at the time the reinstatement is accepted.

We can change the *Insured*'s risk category and modify the future payable premiums on your *Insurance Contract* if the *Insured*'s insurability (lifestyle, health, smoker status) has changed.

When your *Insurance Contract* is reinstated, a new two-year period applies during which we can refuse a claim because of suicide or misrepresentation (see Section 1.7 (Exclusions and Limitations)).

1.4 BENEFICIARY

The beneficiary is the person who will receive payment under the *Insurance Contract* if the benefit is payable. This section indicates who the beneficiary is and the procedures for changing the beneficiary.

1.4.1. Life Insurance and Additional Insurance in the Event of Accidental Death

The beneficiary of the life insurance and additional insurance in the event of accidental death is the *Policyholder*, or his estate if the policyholder is a natural person, unless the *Policyholder* indicates otherwise.

1.4.2. Critical Illness diagnosis Insurance

If the policyholder is a natural person, the beneficiary in the event of a *Critical Illness* diagnosis is the *Insured*. If the *Insured* is deceased when the benefit is paid, the benefit will be payable to the beneficiary of the life insurance, as set out in Section 1.4.1.

If the policyholder is a legal person, the beneficiary in the event of a Critical Illness diagnosis is the policyholder.

1.4.3. Change of Beneficiary

You can, at any time, change the beneficiary by completing a change of beneficiary form provided by us. If a beneficiary is appointed irrevocably, his or her written consent is required in order to make the change.

The information and regulations concerning the change of beneficiary and the percentages to be paid to each beneficiary are described in the form that we provide.

Under no circumstances can we be held liable for the validity of a designation of beneficiary.

1.5 SETTLEMENT CLAIM

This section explains the process to follow to make a claim, as well as the documents needed and the maximum timeframes applicable.

1.5.1. Settlement claim in the Event of Death

Upon the death of the *Insured*, the claim must be sent to us as soon as it is reasonably possible, using the forms that we provide and accompanied by the following supporting documents:

- Death certificate of the *Insured*
- Document indicating the cause and circumstances of the *Insured*'s death
- Proof indicating the age or date of birth of the *Insured*
- Proof confirming the beneficiary's right to receive the benefits payable (identity documents, will, etc.), if applicable.

A benefit in the event of death is payable only when the required supporting documents and all other documents have been presented to us and deemed sufficient.

1.5.2. Settlement claim in the Event of Critical Illness diagnosis

In the event that the *Insured* is diagnosed with a *Critical Illness*, we must be informed within 30 days of the *Date of Diagnosis*. The benefits in the event of *Critical Illness* diagnosis are payable only when all the supporting documents and the results of all tests or medical examinations required have been presented to us and deemed sufficient. All the tests and examinations must be done by a *Specialist*.

All documents, including the claim form that we will provide and the supporting documents that we require must be submitted to us within one year after the *Date of Diagnosis*. After this date, we will no longer be required to pay the benefit.

1.6 CRITICAL ILLNESSES COVERED

Only certain *Critical Illnesses* are covered by the *Critical Illness* diagnosis insurance. These are named and described in this section.
This section also contains the exclusions and situations where the coverage does not apply.

The following *Critical Illnesses* are covered by the *Insurance Contract*: cancer (life threatening), heart attack and stroke, which meet the criteria explained in this *Policy*. The diagnosis of a *Critical Illness* must be made by a *Specialist* licensed to practice medicine in Canada or the United States.

If a *Specialist* is not available, the *Critical Illness* diagnosis can be made by a qualified doctor practicing in Canada or in the United States, but only if the *Insurer* agrees.

Any *Critical Illness* diagnosis must be confirmed by objective medical proof.

1.6.1. Stroke

Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the *Date of Diagnosis*. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a *Specialist*.

Exclusions

No benefit will be payable in the following situations:

- Transient Ischaemic Attacks
- Intracerebral vascular events due to trauma
- Lacunar infarcts which do not meet the definition of stroke as described above.

1.6.2. Cancer (Life Threatening)

Definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of cancer must be made by a *Specialist*.

Exclusions

No benefit will be payable if, within the first 90 days following the later of the effective date of your *Insurance Contract* or the effective date of the last reinstatement, the *Insured*:

- has presented signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded by your *Insurance Contract*), regardless of when the diagnosis is made, or
- has received a diagnosis of cancer (covered or excluded by your *Insurance Contract*).

No benefit will be payable in the following situations:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis
- any non-melanoma skin cancer, without lymph node or distant metastasis
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis
- chronic lymphocytic leukemia classified less than Rai stage 1
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For purposes of the *Policy*, the terms "Tis, Ta, T1a, T1b, T1 and AJCC Stage 2" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual (7th edition, 2010).

For purposes of the *Policy*, the term "Rai staging" is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia, Blood 46:219, 1975.

1.6.3. Heart Attack

Definite diagnosis of a heart attack resulting from the death of part of the heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a *Specialist*.

Exclusions

No benefit will be payable in the following situations:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described in this *Policy*.

1.7 EXCLUSIONS AND LIMITATIONS

There are exclusions that apply to some of the coverage. There are time-related exclusions, situations that are excluded and exclusions set out in the applicable legislation. This section explains these exclusions in detail.

1.7.1. Suicide

During the two years following the effective date of your *Insurance Contract*, no life insurance benefits in the event of death will be paid if the *Insured*'s death is due to suicide or is related to self-inflicted injuries, regardless of the *Insured*'s mental health. In such event, a benefit will not be payable but we will refund all the premiums paid, without interest.

This exclusion also applies when your *Insurance Contract* is reinstated, as indicated in Section 1.3.5. In such event, a benefit will not be payable but we will refund all the premiums paid since the date of reinstatement of your *Insurance Contract*, without interest.

1.7.2. Exclusions in the Event of Accidental Death

No additional benefits are paid in the event of accidental death if the death of the *Insured* results directly or indirectly from one of the following causes:

- **War:** war or any act of war, whether or not the *Insured* was involved
- **Terrorism:** any terrorist act
- **Riot:** active participation by the *Insured* in an uprising, riot or insurrection
- **Aircraft:** active participation of the *Insured* in a flight in an airplane or any other type of aircraft, whether as a pilot, a member of the crew, an instructor or a student
- **Dangerous activities:** participation of the *Insured* in a dangerous activity such as motor vehicle racing, scuba diving deeper than 30 metres, parachuting, free flight, bungee jumping, rock or mountain climbing, ultralight glider or hang-gliding
- **Criminal offence:** injuries suffered while the *Insured* is committing or attempting to commit a criminal offence
- **Alcohol and drugs:** abuse of prescription drugs or alcohol or use of narcotics. Prescription drug abuse means surpassing the recommended dosage. Alcohol abuse means having a blood alcohol content greater than or equal to 80 mg of alcohol per 100 ml of blood
- **Medical or surgical treatments:** medical or surgical treatment, where complications arose following this type of treatment, unless the treatment is required as a direct result of an *Accident* suffered by the *Insured*
- **Suicide and self-inflicted injury:** suicide of the *Insured* or complications from a suicide attempt, or complications from self-inflicted injury, regardless of the *Insured*'s mental health.

Also, additional benefits in the event of accidental death are not payable if the death of the *Insured* occurs more than 365 days after the date of the *Accident*.

1.7.3. Exclusions Regarding Critical Illnesses Covered

The benefits in the event of *Critical Illness* will not be payable if the irreversible cessation of brain function of the *Insured* occurs within 30 days of the *Date of Diagnosis*. In this case, only the life insurance benefit will be payable.

This *Policy* also sets out specific exclusions applicable to each *Critical Illness* and for which the benefit in the event of *Critical Illness* will not be payable, as indicated in Section 1.6 (Critical Illnesses Covered).

1.7.4. Misrepresentation and Dispute of Statements

If a material fact is omitted from a statement that is part of the *Insurance Application* or if a statement is false, your *Insurance Contract* will automatically be cancelled and the premiums paid will be refunded without interest, except if the age or sex was misstated.

However, in the absence of fraud, we will not contest the validity of this *Policy* after it has been continuously in force for at least two years during the lifetime of the Insured, unless the statement concerns the age or the sex of the *Insured*.

If your *Insurance Contract* was rescinded then reinstated, or if your *Insurance Contract* was modified and new evidence of insurability was presented, the two-year timeframe in which we may exercise our right to contest validity (as referenced in the previous paragraphs) applies to all the statements that would be required for this reinstatement or modification.

Not declaring the use of tobacco, electronic cigarettes or nicotine replacement products in any form in the *Insurance Application* is considered a material fact and constitutes a misrepresentation.

1.7.5. Misstatement of Age or Sex

If the premiums you pay are too low due to an error in terms of sex or age of the *Insured* at the time the *Insurance Application* is made, we will reduce the insured amount based on the real age or sex of the *Insured* at the time of the *Insurance Application* and the premiums that have been paid.

Example:

At the time of the *Insurance Application*, the amount of insurance chosen is $300,000 with a monthly premium of $50.

However, considering the real age of the *Insured* at the time of the *Insurance Application*, the $50 premium is actually equivalent to an insured amount of $254,000. This is the amount that will be paid.

If you pay premiums that are too high based on an error in terms of sex or age of the *Insured* at the time the *Insurance Application* is made, the insured amount will stay the same but the excess premiums paid will be refunded without interest.

If the *Insured*'s real age is greater than 70 years old, no benefits will be payable and only the excess premiums paid will be refunded without interest.

When the *Insurance Application* is submitted to us, if the *Insured*'s true age does not meet the eligibility criteria (between 18 to 60 years old), we will cancel your *Insurance Contract* and refund the premiums paid without interest.

1.8 POLICYHOLDER'S RIGHTS AND OPTIONS

Your rights concerning your *Insurance Contract* are described in this section.

1.8.1. Ownership

As long as the *Insured* is alive, you are the owner of your *Insurance Contract*, and only you can ask the *Insurer* to make changes to it, without the need of the beneficiary consent, irrevocable or not.

If you are a natural person and you are not the insured, your estate will become the owner of your *Insurance Contract* if you die, unless you have designated a substitute owner. You can designate a substitute owner at any time by submitting a written request to us.

1.8.2. Transfer Rights

You can transfer the ownership of your *Insurance Contract* to another person. If you choose to do this, you must inform us in writing. We will not under any circumstances be liable for the validity of this transfer.

1.8.3. Participation Rights

Your *Insurance Contract* is a non-participating insurance contract. It does not entitle the *Policyholder* to receive dividends from the surplus or profit declared by the *Insurer*.

1.8.4. Conversion

You cannot convert your *Insurance Contract* into a permanent insurance contract or any other type of insurance policy.

1.8.5. Cash Value and Advances

Your *Insurance Contract* has no cash value and does not permit you to receive advances on the *Policy* nor obtaining paid-up or extended insurance.

1.8.6. Copy of the Insurance Contract

You may obtain a copy of your insurance policy, including riders attached to it if any, by sending us a written request. Only the insured may ask us in writing to obtain a complete copy of the insurance contract.

1.9 ADDITIONAL CLAUSES

1.9.1. Applicable Legislation

Your *Insurance Contract* is governed by the applicable laws in Canada.

1.9.2. Amendments to the Policy

After your *Insurance Contract* has taken effect, we may make changes that we deem appropriate to respond to any changes to laws or regulations. To be in force, these changes must be communicated in writing to the *Policyholder*. These changes will become an integral part of the *Insurance Contract*.

1.9.3. Notice

Any notice that must be sent in writing to the *Insurer* must be sent to the address indicated on the next page. We recommend that you send us any important documents by registered mail or courier, being sure to keep a copy of the notice with the proof of mailing.

1.9.4. Period for the Limitation of Actions

Any action or proceeding against the *Insurer* for the recovery of amounts payable under your *Insurance Contract* must be commenced within the period set out in the applicable provincial legislation.

1.9.5. Provincial Specifications

Depending on your province of residence, a document entitled Provincial Specifications could form part of your *Insurance Contract*.

2. Definitions

The following definitions are applicable to this *Policy* and will help you to understand some of the terms used in the insurance industry and in this *Policy*.

Accident An event brought about by external causes of a violent, sudden and involuntary nature resulting in bodily injury, directly and independently of all other causes and illnesses. The injury must be certified by a physician who is a licensed medical practitioner in Canada or the United States.

Critical Illness Means exclusively the following Critical Illnesses: stroke, cancer (life-threatening) and heart attack, as set out in section 1.6 (Critical Illnesses Covered).

Date of Diagnosis Date on which the *Specialist* makes the diagnosis for the first time, as shown in the *Insured*'s medical file.

Insurance Application Application for insurance to the *Insurer*. The form is completed in writing, electronically or orally. All statements with respect to insurability made by the *Policyholder* and the *Insured*, including health declarations, form a part of the Insurance Application.

Insurance Contract Legal agreement entered into with your *Insurer* setting out the terms and conditions of your coverage. The *Insurance Contract* contains the following items:

- The *Insurance Application*
- Part I — Specific conditions of the *Policy*
- Part II — General conditions of the *Policy*
- All riders (changes made to your *Policy* after it takes effect) and the document entitled Provincial Specifications
- Any statement presented as part of the *Insurance Application*, sent to the *Insurer* or one of its mandataries.

Insured Person insured under the *Insurance Contract*. This person is designated in Part I (Specific Conditions).

Insurer National Bank Life Insurance Company.

Policy The main document indicating the terms and conditions of your insurance coverage with your *Insurer*, including the General Conditions and Specific Conditions of your coverage.

Policyholder Owner of the *Insurance Contract* and the only person (natural or legal) who can ask the *Insurer* to make changes to it. The *Policyholder* may also be the *Insured*. The name of the *Policyholder* appears in Part I (Specific Conditions).

Specialist Medical specialist who is a licenced medical practitioner who has been trained in the specific area of medicine relevant to the covered *Critical Illness* condition for which benefit in the event of *Critical Illness* diagnosis is being claimed, and who has been certified by a specialty examining board. The specialist cannot be the *Policyholder*, the *Insured* or a beneficiary of the *Insurance Contract*, or a member of the family, the spouse or a business partner of the *Policyholder*, of the *Insured* or of a beneficiary of the *Insurance Contract*.

For more information, contact us:

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