Business Overhead Expense - INJURY

SAMPLE

POLICY BOOKLET

Simply Safeguarding Your Lifestyle™

BUSINESS OVERHEAD EXPENSE
INJURY ONLY POLICY

(underwritten by Co-operators Life Insurance Company)

IMPORTANT NOTE: You are only covered for those benefits applied for, which Co-operators Life Insurance Company has approved and for which premium has been received.

Please see your Schedule of Benefits for confirmation of the plan purchased.

POLICY INDEX

SECTION 1 GENERAL DEFINITIONS 2

SECTION 2 BUSINESS OVERHEAD EXPENSE BENEFIT 4

SECTION 3 ACCIDENT MEDICAL TREATMENT BENEFIT.......... 6

SECTION 4 EXCLUSIONS AND LIMITATIONS.......... 6

SECTION 5 GENERAL, TERMINATION & PREMIUM PROVISIONS.......... 9

SECTION 6 STATUTORY CONDITIONS 11

PRIVACY STATEMENT (Co-operators Life Insurance Company) 13

HOW TO MAKE A COMPLAINT (Co-operators Life Insurance Company).......... 15

ABOUT THE EDGE BENEFITS INC.......... 17

PRIVACY STATEMENT (The Edge Benefits Inc.).......... 17

SAMPLE

This policy contains a provision removing or restricting the right of the insured to designate persons to whom or for whose benefit insurance money is to be payable.

V20 APR22

Co-operators Life Insurance Company
(Herein referred to as "We", "Us", "Our" and the "Company")

"Administrator" refers to The Edge Benefits Inc.

We agree to provide insurance coverage and pay benefits as described in this Policy. Our agreement to pay is subject to the provisions on the attached pages, which together with the application, the Schedule of Benefits, and any amendments or endorsements to this Policy, and any other declaration affecting insurability make up this Policy.

This is a limited Policy, which provides insurance against losses as defined in this Policy. The insurance coverage is subject to specified exclusions, and certain reductions and limitations of benefits as described in this Policy's provisions. Please read this policy booklet fully (including Section 4 – Exclusions and Limitations) to make sure you are aware of all exclusions and limitations which will affect your insurance coverage. If you have any questions or are unclear about any exclusions or limitations, please contact us for clarification.

Premiums are subject to change by Class Grouping. (Please see the Termination and Change of Premium Provisions in Section 5.)

24 HOUR OR NON-OCCUPATIONAL INJURY COVERAGE

Subject to the definitions, and the exclusions and limitations, this Policy provides coverage for Disability caused by an Injury that is not Work Related. In addition, when "24 Hour" coverage is indicated on the Schedule of Benefits, this Policy also provides coverage for Disability caused by an Injury that is Work Related. If the Schedule of Benefits indicates "Non-Occupational" coverage, there is no coverage for Disability caused or contributed to by an Injury that is Work Related. Injury coverage is guaranteed renewable to the Insured Person's 75th birthday.

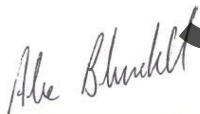
ILLNESS COVERAGE

This policy does not provide any coverage for Disability due to Illness of any type. If Illness coverage is identified on your Schedule of Benefits, please refer to your Business Overhead Expense Illness policy booklet.

EFFECTIVE DATE OF COVERAGE

Coverage for Disability or other loss due to Injury is effective on the Effective Date specified on the Schedule of Benefits provided premiums have been paid.

SAMPLE



Alec Blundell
Executive Vice-President and Chief Operating Officer

SECTION 1 GENERAL DEFINITIONS

Accident or Accidental means an unexpected and sudden event due exclusively to an external force of a violent nature beyond the Insured Person's control, occurring while this Policy is in force.

Class Grouping means a group of Insured Persons by occupation, plan type (which includes, but is not limited to, Elimination Period and benefit period), gender and/or province or territory.

Day, for the purposes of this Policy, a 'day' is a continuous 24 hour period.

Disability or Disabled means a state of Total Disability or Partial Disability.

Effective Date means any of the date(s) shown on the Schedule of Benefits.

Elimination Period (EP) means the number of consecutive days of Disability specified on the Schedule of Benefits or in an endorsement or amendment to this Policy that must pass for each period of Disability before the payment of any benefit payments begin.

He/his/him applies to both sexes unless the context clearly indicates otherwise.

Illness means a disease or sickness, which is first Manifested while this Policy is in effect. Disability that results, directly or indirectly from Illness, regardless of the date of First manifestation, is not covered for benefits under this Policy.

Injury means Accidental physical harm or damage sustained by the Insured Person while this Policy is in effect. No Disability or loss shall be considered as due to Injury if it results, directly or indirectly, from disease or sickness. Soft Tissue Injuries include Contusions, Sprains or Strains and are deemed to be an Injury.

Physical harm or damage that results, directly or indirectly, from any of the conditions or activities listed in any exclusions provision of this Policy are deemed not to be an Injury and are not covered for the applicable benefits under this Policy.

Insured Person means the individual named in the Schedule of Benefits, who has applied and is insured for coverage by the Company. The Insured Person may or not be the PolicyOwner.

Leave of Absence means an arranged period of absence from work that has been agreed to with the Insured Person's employer and which has a specific return to work date.

Manifest (Manifestation, Manifested) means the disease or sickness does not merely exist, but a symptom or symptoms have appeared, regardless of whether or not any medical treatment or advice has been sought or received or whether a correct diagnosis has been made.

Month, for the purpose of this Policy, a 'month' refers to a calendar month.

Partially Disabled or Partial Disability means that:

1) The Insured Person is not Totally Disabled; and
2) The Insured Person is engaged in his Regular Occupation or any gainful occupation; and
3) Due directly to continuing Injury, the Insured Person is unable to perform either:
    a) One or more important duties of his Regular Occupation; or
    b) The important duties of his Regular Occupation at least one-half of the time normally required; and
4) The Insured Person is receiving Physician's Care.

No period of Disability shall be considered as due to Injury if it begins more than 120 days after the date of the Accident.

SAMPLE

The availability of work does not affect the determination of Partial Disability.

Physician means an individual who is not related by blood or marriage to the Insured Person or ordinarily resident with the Insured Person or a business associate of the Insured Person and who is legally licensed to practice medicine or surgery in the jurisdiction where such an individual is practicing. Treatment by a chiropractor is acceptable provided the treatment is authorized and monitored by a Physician.

Physician's Care means the regular and personal care of a Physician, which under prevailing medical standards is appropriate for the condition(s) causing the Disability.

PolicyOwner means the individual named in the Schedule of Benefits who retains all rights to the policy, and may or may not be the same as the insured person.

Policy means the insurance coverage described in this document that the Company has issued as evidence of the contract of insurance coverage between it and the Insured Person. Unless otherwise stated in writing to the contrary, this Policy includes insurance coverage under any amendment, rider or endorsement that the Company has issued for intended attachment to this document. It does not refer to any other insurance coverage that has not been issued by the Company.

Regular Occupation, unless modified by the Unemployment/Minimal Work or Leave of Absence Provisions in Section 4, means the occupation or occupations the Insured Person is actively involved in for compensation at the date he becomes Disabled.

Soft Tissue Condition Injury means physical harm or damage resulting from Soft Tissue Condition that occurs over time, and is sustained by the Insured Person while this Policy is in effect. No Disability or loss shall be considered as due Soft Tissue Condition Injury if it results, directly or indirectly, from disease or sickness.

Soft Tissue Conditions include the following:

1) bursitis;
2) carpal tunnel syndrome
3) epicondylitis (medial & lateral);
4) patellofemoral syndrome
5) palmar fasciitis
6) plantar fasciitis;
7) rotator cuff injury
8) tarsal tunnel syndrome;
9) tendonitis or
10) concussion
11) disc bulge.

Sprain means a joint Injury, in which some fibers of a supporting ligament are ruptured, but the continuity of the ligament remains intact.

Strain means an Injury to a muscle caused by over-stretching or over-exertion.

Totally Disabled or Total Disability means that:

1) Due directly to Injury the Insured Person is unable to perform the important duties of his Regular Occupation; and
2) The Insured Person is not engaged in any gainful occupation; and
3) The Insured Person is receiving Physician's Care.

No period of Disability shall be considered as due to Injury if it begins more than 120 days after the date of the Accident.

The availability of work does not affect the determination of Total Disability.

Unemployed for an Insured Person who is or was an employee means that the Insured Person is not currently working and has been or is entitled to be issued a Record of Employment by his employer; and, for an Insured Person who is self-employed, Unemployed means that the Insured Person is not actually working at least 20 hours per week on a regular basis and at least 35 weeks per year.

Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat.

SAMPLE

Work Related means arising out of, or in the course of:
1) Any employment or business in which the Insured person was engaged; or
2) Any other work which the Insured Person was performing for financial gain.

SECTION 2 BUSINESS OVERHEAD EXPENSE BENEFIT

There is no coverage under this benefit, unless it is shown on the Schedule of Benefits or any endorsement or amendment to this Policy.

Definition of Terms Used In This Section

Business Overhead Expenses mean the fixed contractual operating expenses of a business, where the Insured Person is an owner, generates the sales or revenue, and is involved in the day to day operation of that business. If a premium is accepted for any period during which the Insured Person is no longer responsible for the Business Overhead Expenses, this Policy will remain in effect but the Business Overhead Expense Benefit will be limited to the return of premium accepted during that period for this benefit.

Business Overhead Expenses are limited to the Insured's share of the fixed contractual operating expenses of the business and include:
- scheduled installment payments of principal of debt allocated to business use;
- rent, leased and rented equipment, business property liability insurance premiums, dues for professional associations, interest on debt, accounting fees;
- other fixed contractual business expenses, which are normal and customary in the operation the business;
- wages, fees or other compensation for any employee if that employee is involved in administrative support and is not engaged in any revenue producing or sales generating activities for the business and was continuously employed in the business for a period of not less than six months prior to the Insured Person's date of Disability. For an Independent Transport Owner-Operator, a replacement driver is included as a Business Overhead Expense. For a farm owner, a replacement farmer is included as a Business Overhead Expense.

Business Overhead Expenses Do NOT Include:
- wages, fees or other compensation payable to staff or any person who generates revenue for the business;
- any expense for which the Insured Person is not liable, any expenses for which the Insured Person was not regularly liable before the start of Disability;
- travel and entertainment expenses;
- any business or office supplies, fuel or repairs and maintenance;
- Business Overhead Expenses for which the business is reimbursed through any other source.

Independent Transport Owner-Operator means a person:
1) whose occupation is truck driver; and
2) who is the owner of the truck and/or is responsible for paying for the truck used in their occupation; and
3) who has discretion to enter contracts to transport goods with any organization and is not exclusively bound to carry goods for one organization.

Maximum Benefit Period means the maximum length of time for each period of Disability, for which benefits are payable under this Business Overhead Expense Benefit. The Maximum Benefit Period begins on the date benefits become payable and ends on the earliest of:

1) the date the Insured Person ceases to be Disabled according to the definition of Disability as defined in this Policy;
2) the date benefits cease in accordance with the Benefit Limitations or Exclusions of this Policy;

SAMPLE

3) the Insured Person's 75th birthday;
4) the date the Maximum Total Benefit is paid; or
5) the date the Insured Person fails to provide proof of claim in accordance with the requirements of the Proof of Claim provisions in Section 5.

Maximum Monthly Benefit means the greatest dollar amount the Company will pay each month while the Insured Person is Disabled subject to the terms of this Policy. The Maximum Monthly Benefit is shown on the Schedule of Benefits or in an endorsement or amendment to this Policy.

Maximum Total Benefit

- Injury Only Policies: means 24 times the Maximum Monthly Benefit.

The cumulative total of Monthly Expense Benefits paid for a single claim cannot under any circumstances exceed the Maximum Total Benefit.

Monthly Expense Benefit means the dollar amount which is payable while the Insured Person is Disabled. It is equal to the lesser of the actual Business Overhead Expenses incurred for the month or the Maximum Monthly Benefit.

BENEFIT PROVISIONS

Total Disability Benefit
If an Insured Person is Totally Disabled after the Elimination Period applicable to this Business Overhead Expense Benefit, the Company will reimburse to the PolicyOwner of this Policy, upon submission of receipts or other proof satisfactory to the Company, the Business Overhead Expenses incurred for each month during which the Insured Person is Totally Disabled, subject to the Monthly Expense Benefit, Maximum Benefit Period, Maximum Monthly Benefit, Maximum Total Benefit and benefit limitations and exclusions.

Partial Disability Benefit
If an Insured Person is Partially Disabled after the Elimination Period applicable to this Business Overhead Expense Benefit, the Company will reimburse to the PolicyOwner of this Policy, upon submission of receipts or other proof satisfactory to the Company, 50% of the Monthly Expense Benefit for each month during which the Insured Person is Partially Disabled, for up to a maximum of three (3) months, subject to the Maximum Benefit Period, Maximum Total Benefit and benefit limitations and exclusions.

Recurrent Disability
If, within six months of the end of a prior period of Disability for which Business Overhead Expense Benefits were paid, Disability results again from the same or a related medical cause(s) which caused the prior Disability, then any subsequent period of Disability will be deemed to be a continuation of the previous period of Disability in determining the Maximum Benefit Period and Maximum Total Benefit.
A Business Overhead Expense Benefit will be payable from the first day of such subsequent Disability. Each period of Disability separated by six months or more will be considered as a separate Disability, even if such Disabilities are due to the same or related causes.

Concurrent Disability
If a Disability is caused by more than one Injury or by one or more injuries and/or Illnesses the Company will pay benefits as if the Disability was caused by only one Injury (or Illness if an Insured person has a separate policy that provides coverage for Disability due to Illness).

Limitations and Exclusions
See Section 4 for the exclusions and limitations applicable to benefits under this Section.

SAMPLE

SECTION 3 ACCIDENT MEDICAL TREATMENT BENEFIT

Benefit Provisions

If an Insured Person incurs any of the following expenses because of an Accidental Injury and the Insured Person provides the Company with proof of payment for the expenses, the Company will reimburse the Insured Person for the reasonable and customary amounts of those expenses, up to a cumulative total of $10,000:

1) qualified Physician (including surgeon and anesthetist) fees;
2) necessary care and services from a hospital, including x-rays and medicines, (but not including room ward, semi-private or private) charges;
3) fees for the services from a registered graduate nurse who is not related by blood or marriage to the Insured Person or ordinarily resident with the Insured Person or a business associate of the Insured Person;
4) ambulance fees;
5) fees for the services of any of the following licensed practitioners: physiotherapist, osteopath, chiropractor, chiropodist, podiatrist, speech therapist, psychologist, and, when recommended by a physician, massage therapist;
6) rental of a wheel chair or other approved durable equipment for temporary therapeutic treatment, but not to exceed the purchase price prevailing at the time such rental became necessary;
7) purchase of hearing aids, crutches, trusses, braces, casts and splints, but not including the cost of replacements;
8) orthopedic appliances;
9) drugs or medicines dispensed by a licensed pharmacist, which requires the prescription from the attending Physician; or
10) services by a qualified dentist for dental treatment to natural teeth or replacement of natural teeth, but not to exceed the cost of the least expensive treatment that will provide a professionally adequate treatment.

EXCLUSIONS

Please see Section 4 of this Policy.

LIMITATIONS

Benefits are subject to the following limitations:

1) Expenses covered by any governmental health insurance plan in the Insured Person's province or territory of residence will not be covered.
2) Expenses must be solely and directly as a result of an Accident to the Insured Person, and substantiated by submission of original receipts. Physician's Care must be sought within 30 days of the Accident and the first such expense must be incurred within 90 days of the Accident. All other expenses must occur within 365 days of the Accident.

In no event shall any individual be insured for an amount of Accident Medical Treatment Benefit in excess of $10,000, either through a single policy or a combination of coverage through multiple policies whether Individual or group, issued by Co-operators Life Insurance Company.

SECTION 4 EXCLUSIONS AND LIMITATIONS

****Important: Please review****

EXCLUSIONS

A. The following exclusion applies to claims for benefits provided under Section 2 & 3 of this Policy. Benefits are not payable or provided under this Policy, and no premiums will be waived, for any portion of any period of Disability, nor for any other loss covered by this Policy, that results, directly or indirectly, from any disease or sickness (including any medical or surgical treatment thereof).

   This exclusion does not apply however to Disability, or any other loss covered by this Policy, that results directly from a septic infection caused through a wound Accidentally sustained.

B. The following exclusions apply to claims for all benefits provided under this Policy:

SAMPLE

I. Benefits are not payable or provided under this Policy, and no premiums will be waived, for any portion of any period of Disability, nor for any other loss covered by this Policy, that results, directly or indirectly, from, any Injury which occurs while the Insured Person:
   1) is traveling or flying in (including the descent from) any kind of aircraft, other than as a fare paying passenger in a certified passenger aircraft provided by a commercial airline on a regular scheduled or non-scheduled special or chartered flight, operated by a properly certified pilot, flying between duly established and maintained commercial airports;
   2) participates, in any type of professional athletics activity, or professional underwater activities, including scuba diving;
   3) engages in any of the following activities: mountaineering, rock climbing, caving, parachuting, sky diving, hang gliding, bungee jumping, racing (for example, but not limited to automobile, motorcycle, or horse) or racing of any water device (e.g. seadoo);
   4) is operating a Vehicle while under the influence of any drugs (other than as prescribed and taken in accordance with the instructions of a physician), or while his or her blood alcohol level is greater than the Legal Limit in the jurisdiction in which the Injury occurred. "Legal Limit" means the lowest measure of blood alcohol concentration at which point there are legal consequences to operating a motorized vehicle, including but not limited to suspension of driving privileges, fines, impounding of a vehicle; or
   5) is incarcerated.

II. Benefits are not payable or provided under this Policy, and no premiums will be waived, for any portion of any period of Disability, nor for any other loss covered under this Policy, that results, directly or indirectly, from:
   1) the Insured Person's intentionally self-inflicted harm, or attempted suicide, including inhaling gas or absorbing fumes, regardless of mental state;
   2) the Insured Person's committing or attempting to commit a criminal offence, under the laws in the jurisdiction where the offence took place;
   3) the use of any drug, poisonous substance, intoxicant or narcotic, other than as prescribed by and taken in accordance with the instruction of a Physician;
   4) engaging in an illegal occupation, a riot or insurrection or any form of public disturbance or an act of declared or undeclared war;
   5) normal pregnancy and childbirth;
   6) any type of opportunistic infection or sickness if the Insured Person had Acquired Immune Deficiency Syndrome (AIDS) and/or has tested positive for Human Immunodeficiency Virus (HIV or any subtypes) or had symptoms of the above which were diagnosed or Manifested themselves prior to the applicable Effective Date;
   7) Subjective Conditions: including, but not limited to, chronic fatigue syndrome, chronic pain syndrome, fibromyalgia, Epstein Barr syndrome or any other subjective syndrome or condition;
   8) Mental Disorders and Substance Use Disorders: any psychiatric, psychological or emotional disorder including but not limited to, depression, anxiety, stress, burnout, or any mental disorder or substance use disorder. Such disorders include psychotic, emotional or behavioral disorders and disorders related to substance abuse or dependency;
   9) The Insured Person's service in the armed forces, the reserves, or any other military organization.

SAMPLE

Named Exclusions

No benefits will be payable or provided under this Policy, and no premiums will be waived, for any portion of any period of Disability, nor for any other loss covered by this Policy, which result, directly or indirectly, from conditions the Company has excluded by name or specific description in an endorsement or amendment to this Policy.

Incarceration

No Elimination Period will start or continue, no benefits will be payable, and no premiums will be waived, for any portion of any period of Disability during which the Insured Person is incarcerated.

TERRITORIAL EXCLUSIONS AND LIMITATIONS

1) Injuries which are Not Covered
   No benefits will be payable, and no premiums will be waived, for any Disability or other loss under this Policy that results, directly or indirectly, from an Injury that occurs, while the Insured Person has been traveling or residing for more than 60 days outside of Canada, the United States of America, the United Kingdom or Australia.

2) Suspension of Benefits and Premium Waiver
   No benefits will be payable, and no premiums will be waived, for any portion of any period of Disability during which the Insured Person travels or resides outside of Canada, the United States of America, the United Kingdom or Australia.

BENEFIT LIMITATIONS

Back and Neck Injuries
Benefits for back and neck injuries will be considered for payment only where substantiated by diagnostic medical tests. Benefits for Soft Tissue Injuries of the back, neck and surrounding tissues will be limited as described in the Soft Tissue Injuries Limitation below.

Soft Tissue Injuries and Conditions
If any portion of any period of Disability results, directly or indirectly, from a Soft Tissue Injury or Condition, benefits will be limited as follows:

1) If the Insured Person's Occupational Class as shown on the Schedule of Benefits is Class "BB", benefits are limited to 20 days for each period of Disability.
2) If the Insured Person's Occupational Class as shown on the Schedule of Benefits is Class "B", benefits are limited to 40 days for each period of Disability.
3) If an Insured Person's Occupation Class as shown on the Schedule of Benefits is Class "A", benefits are limited to 60 days for each period of Disability.
4) If the Insured Person's Occupational Class as shown on the Schedule of Benefits is "B", Class "BB", or Class "A" when the Insured Person has received payments for a total of 180 days for all such periods of Disability, no further benefits will be payable for any other periods of Disability resulting, directly or indirectly, from Soft Tissue Injuries or Conditions.

If the Insured Person's Occupational Class as shown on the Schedule of Benefits is "Executive" or Class "AA", benefits due to Soft Tissue Injuries and Conditions are not limited for each period of Disability. However, when the Insured Person has received payments for a cumulative total of 36 months for all such periods of Disabilities, no further benefits will be payable for Soft Tissue Injuries or Conditions.

Soft Tissue Injury Extension Option
This Soft Tissue Injury Extension Option amends the Soft Tissue Injury or Soft Tissue Condition limitation applicable to the Insured Person. This option applies to the Insured Person only if the Insured Person has paid for this option and it is shown on the Schedule of Benefits. This option is not available with Non-Occupation Injury coverage. This option is only available if the occupation of the Insured Person is a truck driver.

The number of days of Business Overhead benefits that are payable for a Soft Tissue Injury or Soft Tissue Condition are extended to 120 days if the Insured Person sustains the Soft Tissue Injury or Soft Tissue Condition in an accident that occurs only while the Insured Person is driving the truck that he uses for employment or self-employment. This extension does not apply to a Soft Tissue Injury sustained in an accident in any other motor vehicle.

This option does not change any other provision of the Soft Tissue Injuries or Soft Tissue Condition limitation.

Unemployment / Minimal Work
If the Insured Person sustains an Injury during any period that the Insured Person has been Unemployed

SAMPLE

for more than 60 days, Regular Occupation shall be deemed to mean Reasonable Occupation.

Leave of Absence
If the Insured Person sustains an Injury while on a Leave of Absence, Regular
Occupation shall be deemed to mean Reasonable Occupation until the scheduled return to work date. Thereafter, Regular Occupation shall be deemed to mean the occupation that the Insured Person was actively involved in for compensation just prior to the Insured Person's Leave of Absence. However, Regular Occupation shall continue to mean Reasonable Occupation if the Leave of Absence was not established and documented before the Insured Person sustained such Injury.

SECTION 5 GENERAL, TERMINATION & PREMIUM PROVISIONS

THIRTY DAY RIGHT TO EXAMINE POLICY

Within 30 days after receipt by the PolicyOwner, this Policy may be returned to the Administrator's Head Office or to the agent from whom it was bought. We will cancel this Policy from the Effective Date and any premium paid will be returned in full, provided no claims have been incurred during that period.

GENERAL PROVISIONS

PolicyOwner The PolicyOwner is the individual named in the Schedule of Benefits. All rights and privileges under this Policy belong to the PolicyOwner, unless otherwise expressly stated in this Policy.

Changes Changes to this Policy may be requested in writing by the PolicyOwner and submitted to the Administrator for consideration. Any such change may be subject to payment of a service fee as well as the submission of other requirements, which the Company may deem necessary for the approval of such a change.

Proof of Claim To make or continue a claim for benefits under this policy, the Insured Person will have to provide proof of claim by:

1) fully completing claim forms requested by Us;
2) providing information We request which may be relevant to the claim (including the Insured Person's health, income and activities) and cooperating in the release of information from others that may be relevant to the claim, (including the Insured Person's present or past health care providers);
3) if We request it, being interviewed by a representative of the Company, by telephone or in person; and,
4) if We request it, participating in examinations, assessments or interviews by health care or other professionals of Our choosing.

During a claim, We can ask the Insured Person for further proof, in the manner described above, that the claim remains payable. If We do, the Insured Person must provide the requested information or documentation within 30 days (except that if what We request cannot be provided within 30 days of Our request, it must be provided as soon as reasonably possible). If such continuing proof is not provided within the time required, any further benefits in respect of the claim will be forfeit.

These obligations regarding proof of claim are specifically intended to continue even if there has been a breach of the terms of this Policy.

Incontestability The statements made in the application, in any subsequent application, or in any application for reinstatement, except for fraudulent misstatements and statements erroneous as to Age or Sex, shall be incontestable after this Policy has been in effect for two years from the applicable Effective Date, or the effective date of an endorsement or amendment to this Policy, or from the effective date of the latest reinstatement.

Policy Years and Anniversaries Policy Years and Policy Anniversaries shall be computed from the applicable Effective Date.

SAMPLE

Currency Amounts payable under this Policy, either to or by the Company, shall be payable in the lawful currency of Canada in Canada.

Age In this Policy when We refer to the Insured Person's age on any date, We mean the age on their last birthday.

Misstatement of Age or Sex If the Insured Person's date of birth or Sex has been misstated in the application for coverage under this Policy, all benefits payable under this Policy will be those that the premiums paid would have purchased at the correct Age or Sex but shall not exceed the Company's issue or qualifying limits in effect at that time. If, because of the misstatement, the Company accepts a premium for a period or periods beyond the date coverage would have ceased according to the correct Age or Sex, or if at the correct Age or Sex the coverage would not have become effective, the Company's liability will be limited to the refund of all premiums paid for the period during which coverage would not have been in effect. In no event will any adjustment under this provision cause the amount of any benefit to increase over the amount shown on the Schedule of Benefits.

Non-participating This Policy does not participate in the Company's profits or surplus.

Conformity with Law This Policy is subject to all applicable laws of Canada or any of its provinces or territories.

SAMPLE

TERMINATION PROVISIONS

Termination by PolicyOwner: The PolicyOwner may terminate this Policy by giving advance written notice of termination to the Administrator by registered mail to its head office or chief agency in the Province, or by delivery thereof to an authorized agent of the Company in the Province. Upon receipt of such written notice, the coverage provided by this Policy will continue until the next monthly premium due date and then terminate.

Termination of Coverage: All of the Insured Person's coverage under this Policy terminates on the earliest of the following dates:

1) the monthly premium due date next following the date the Administrator receives written notice from the PolicyOwner to terminate this Policy;
2) the date the Grace Period expires;
3) the date of the Insured Person's death; or
4) the Insured Person's 75th birthday for Injury Coverage;

PREMIUM PROVISIONS

Premiums Payable The Premium shown on the Schedule of Benefits, or on any subsequent endorsements or amendments to this Policy, is payable to the Administrator, during the life of this Policy. The first premium is due and payable on the applicable Effective Date and thereafter, as shown on the Schedule of Benefits. If any cheque or other instrument given for payment is not honored, the premium will be considered unpaid.

Premiums continue to be payable while benefits for the Insured Person are being paid under this Policy unless and until We have notified the PolicyOwner that We have approved a waiver under a Waiver of Premium Benefit.

Change in Premium The Company reserves the right to change the premium from time to time for policies, including this one, in any Class Grouping.

The Company will not change the premium during the first 12 months from the date any coverage under this Policy first became effective and thereafter, no more than once during any 12 month period.

If the Company finds it necessary to change the premium on a Class Grouping, it will give at least 31 days prior written notice to the PolicyOwner at the most recent address as shown on the Administrator's records. The written notice will state the new premium amount and the effective date of the change.

Premium Mode Premiums are payable monthly unless prior approval is obtained in writing from The Company.

Additional Fees The Administrator may charge the PolicyOwner a fee for service for any payment transaction, which is denied for reason of non-sufficient funds (NSF) in accordance with its then current fee schedule. The Administrator will notify the PolicyOwner of the fee and its due date. Failure to pay the fees as requested will be deemed to be a non-payment of premium.

Grace Period Thirty-one days of grace will be allowed for payment of each overdue premium after the first premium during which time this Policy will continue in effect. If any premium or any Additional Fees are wholly or partially unpaid at the end of the Grace Period, this Policy will then lapse. There will be no Grace Period if the PolicyOwner has already given the Administrator notice to terminate this Policy. If a period of Disability starts during the Grace Period, the overdue premium must be paid before the Company will approve any claim.

Reinstatement If this Policy lapses because the premium is not paid when due or within the Grace Period, but We receive payment in full within 60 days from the date that the premium was due, this Policy will be reinstated without evidence of the Insured Person's insurability. This does not apply if We have received notice of termination of this Policy from the PolicyOwner.

If We receive payment of the premium more than 60 days but less than 180 days after the date the premium was due, this Policy will be reinstated if:

1) evidence of the Insured Person's insurability is submitted as required; and
2) the application for reinstatement is approved

The reinstated Policy will cover Disability or loss that results from an Injury sustained after the date of reinstatement. In all other respects, the rights of the PolicyOwner, the Company and the Administrator will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

In no event will We reinstate this policy more than 180 days after the date the premium was due.

Waiver of Premium Benefit After the Insured Person has been Totally Disabled for 30 continuous days and benefits have become payable, premiums for Business Overhead Expense falling due thereafter while the Insured Person is Totally Disabled will be waived until the earliest of:

1) the date the Insured Person ceases to be Totally Disabled;
2) the end of the Maximum Benefit Period for which Total Disability Benefits are payable;
3) the last day of the benefit period as shown on the Schedule of Benefits or in any endorsement or amendment to this Policy;

Premiums must be paid when due, until The Company specifically approves a claim for waiver of premium under this Policy.

SECTION 6 STATUTORY CONDITIONS

It is a legal requirement that these conditions be reproduced in this Policy in the following form. In these statutory conditions loss means a benefit for which a claim is made under this Policy.

The Contract The application, this Policy, any document attached to this policy when issued and any amendment to the contract agreed on in writing after this Policy is issued constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Waiver The Company shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing and signed by the Company.

SAMPLE

Copy of Application The Company shall upon request furnish to the Insured Person, PolicyOwner, or to a claimant under this contract a copy of the application.

Material Facts No statement made by the insured or a person insured at the time of application for the contract may be used in defense of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

Relation of Earnings to Insurance

1) Where the benefits for loss of time payable hereunder, either alone or together with benefits for loss of time under another contract, exceed the money value of the time of the person insured, the insurer is liable only for that proportion of the benefits for loss of time stated in this policy that the money value of the time of the person insured bears to the aggregate of the benefits for loss of time payable under all such contracts and the excess premium, if any, paid by the insured shall be returned to the insured by the insurer.
2) The other contract referred to in subcondition (1) may include,
    a) a contract of group accident and sickness insurance; or
    b) a life insurance contract whereby the insurer undertakes to pay insurance money or to provide other benefits in the event that the person whose life is insured becomes disabled as a result of bodily injury or disease.

Notice and Proof of Claim

1) The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, must:
    a) give written notice of claim to the Company:
        i) by delivery of the notice, or by sending it by registered mail, to the head office or chief agency of the Company in the province, or
        ii) by delivery of the notice to an authorized agent of the Company in the province, not later than 30 days after the date a claim arises under the contract on account of an accident, or disability,
    b) within 90 days after the date a claim arises under the contract on account of an accident, or disability, furnish to the Company such proof as is reasonably possible in the circumstances of:
        i) the happening of the accident or the start of the disability,
        ii) the loss caused by the accident, or disability,
        iii) the right of the claimant to receive payment,
        iv) the claimant's age, and
        v) if relevant, the beneficiary's age; and
    c) if so required by the Company, furnish a satisfactory certificate as to the cause or nature of the accident, or disability for which claim is made under the contract and, in the case of disability, its duration.
2) Failure to give notice of claim or furnish proof of claim within the time required by this condition does not invalidate the claim if:
    a) the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year after the date of the accident or the date a claim arises under the contract on account of disability, and it is shown that it was not reasonably possible to give the notice or furnish the proof in the time required by this condition, or
    b) in the case of the death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than one year after the date a court makes the declaration.

Insurer to Furnish Forms for Proof of Claim The Company must furnish forms for proof of claim within 15 days after receiving notice of claim, but if the claimant has not received the forms within that time the claimant may submit his or her proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

Rights of Examination As a condition precedent to recovery of insurance monies under the contract:

SAMPLE

1) the claimant must give the Company an opportunity to examine the person of the Insured Person when and as often as it reasonably requires while the claim hereunder is pending; and
2) in the case of death of the Insured Person, the Company may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

When Loss of Time Benefits Payable The initial benefits for loss of time shall be paid by the Company within 30 days after receiving proof of claim. Payment shall be made thereafter in accordance with the terms of the contract but not less frequently than once in each succeeding 60 days while the Company remains liable for the payments, providing the Insured Person when required to do so, furnishes proof of continuing Disability.

When Monies Payable Other Than for Loss of Time All monies payable under this contract other than benefits for loss of time, shall be paid by the Company within 60 days after it has received proof of claim.

Limitation of Actions: Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable provincial legislation, or within the time set out below, whichever period is longer.

Any action or proceeding against Us for the recovery of insurance money under this contract shall not be commenced more than two years after the date the insurance money became payable (three years in Quebec) or would have become payable if it had been a valid claim.

– END OF POLICY –

PRIVACY STATEMENT (Co-operators Life Insurance Company)

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting Your Personal Information
We, Co-operators Life Insurance Company, may from time to time collect information about you such as:
1) information establishing your identity (for example, name, address, phone number, date of birth, etc.) and your personal background;
2) information related to or arising from your relationship with and through us;
3) information you provide through the application and claim process for any of our insurance products and services; and
4) information for the provision of products and services.

We may collect information from you, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, MIB, LLC., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using Your Personal Information
This information may be used from time to time for the following purposes:
1) to verify your identity and investigate your personal background;
2) to issue and maintain insurance products and services you may request;
3) to evaluate insurance risk and manage claims;
4) to better understand your insurance situation;
5) to determine your eligibility for insurance products and services we offer;
6) to help us better understand the current and future needs of our clients;
7) to communicate to you any benefit, feature and other information about products and services you have with us;
8) to help us better manage our business and your relationship with us; and
9) as required or permitted by law

SAMPLE

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, LLC. and financial institutions.

We may also use this information and share it with the Co-operators group of companies † ("The Co-operators Group")

1) to manage our risks and operations and those of Co-operators Life Insurance company,

2) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests, and
3) to let The Co-operators Group know your choices under "Other uses of your personal information" for the sole purpose of honouring your choices.

You may choose not to have this information shared or used for any of these "Other uses" by contacting us as set out below, and in this event, you will not be refused insurance products or services just for that reason. We will never use or share your health information for these purposes. We will respect your choices and, as mentioned above, we may share your choices with The Co-operators Group for the sole purpose of honouring your choices regarding "Other Uses of Your Personal Information".

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

Other Uses of Your Personal Information
Please note that this paragraph is not applicable if this form is submitted by an independent representative or a representative that is attached to a firm other than Co-operators Life Insurance Company.

1) We may, where not prohibited by law, use this information to promote our products and services which may be of interest to you. We may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided. Consent to the use of any information to offer you products or services is optional, and if you do not wish to receive such information, you may call or write to Co-operators Life Insurance Company at the telephone number or address shown below.
2) We may also, where not prohibited by law, share this information with The Co-operators Group for the purpose of referring you to them or promoting to you products and services which may be of interest to you. We and The Co-operators Group may communicate with you through various channels, including telephone, computer or mail, using the contact information you have provided. You acknowledge that as a result of such sharing they may advise us of those products or services provided.
3) If you also deal with The Co-operators Group, we may, where not prohibited by law, consolidate this information with information they have about you to allow us and any of them to manage our relationship with you.

Your Right to Access Your Personal Information
You may obtain access to the information we hold about you at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information, to ask questions about our privacy policies or to request that the information not be used for any or all of the purposes outlined in "Other uses of your personal information", please contact your Co-operators representative directly, or you may contact our Privacy Office at:

The Co-operators Privacy Office, 130 Macdonell Street, Guelph, ON, N1H 6P8
E: privacy@cooperators.ca **T: 1-888-887-7773**

Our Privacy Policies
You may obtain more information about our privacy policies by asking for a copy of brochure about

SAMPLE

privacy, by calling us at the toll-free number shown above or by visiting our web site at www.cooperators.ca

†The Co-operators is a group of Canadian companies which includes:
> Co-operators General Insurance Company
> Co-operators Life Insurance Company
> COSECO Insurance Company
> CUMIS General Insurance Company
> CUMIS Life Insurance Company
> Federated Agencies Limited
> HB Group Insurance Management Ltd.

HOW TO MAKE A COMPLAINT (Co-operators Life Insurance Company)

We Value Your Opinion
We all stand to gain from open communication. Whether it's used to answer a question, solve a problem or share a success, communication is the key. While we welcome all positive comments you may have, it is equally important for us to know when you have a problem so that we can resolve it and retain your confidence. At the same time, we use your feedback to continually improve the quality of products and services we provide to you and other clients.

If You Have a Complaint or Encounter a Problem
We want to handle your complaint in the most efficient and professional manner possible. Here's a quick and easy step-by-step reference to ensure your concern receives the attention it deserves.

Step 1: Start at the Source
If a problem occurs, it is generally easier to check the facts and come to a resolution at the point where the problem originated.

Start by contacting The Edge Benefits Inc. toll-free at 1-800-908-9917.

Save yourself valuable time by collecting all the relevant information before you make your initial contact:
- Assemble all supporting documents concerning your complaint, paying special attention to date(s).
- Obtain the names of any employees that were involved.
- Clarify the circumstances in your own mind and determine what you would like us to do.

Step 2: Escalate the Concern
If you are not satisfied with the outcome of Step 1, we encourage you to escalate your concern by contacting Co-operators Life Insurance Company. Depending on your product or service, you may be referred to a manager or an appeals process to ensure your concern is reviewed.

By Mail:
Co-operators Life Insurance Company
1920 College Avenue Regina, SK S4T 1C4
E: phs_individual_life@cooperators.ca T: 1-800-454-8061

Step 3: Contact the Co-operators Ombuds Office
If you are not satisfied with the outcomes of the previous steps, you may request additional consideration of your concern in writing to the Ombuds Office. Please note the Ombuds Office will only review concerns that have gone through the appropriate steps above so you will want to indicate who you have already spoken with.

By Mail:
Ombuds Office, The Co-operators Group Limited
130 Macdonell Street, Box 3608 Guelph, ON N1H 6P8
E: ombuds@cooperators.ca T: 1-877-720-6733 F: 1-519-823-9944

SAMPLE

If you are a resident of Saskatchewan, you can also escalate your concern to the Financial and Consumer Affairs Authority.
By Mail:
Financial and Consumer Affairs Authority
Superintendent of Insurance
Ste 601-1919 Saskatchewan Dr.,
Regina, SK S4P 4H2
Email: fcaa@gov.sk.ca
T: 1-306-787-5645

The Co-operators is a registered trademark of The Co-operators group of companies and is used with permission.

Business overhead expense insurance (due to disability) is underwritten by Co-operators Life Insurance Company and administered by The Edge Benefits Inc.

SAMPLE

ABOUT THE EDGE BENEFITS INC.

Our mission is to safeguard the lifestyle of our customers ~ simply.

The Edge Benefits has been incorporated since 1985, and is a proud member of
The Co-operators group of companies.

Our simplified approach to offering complex living benefit solutions to the Canadian consumer has been revolutionary in the insurance industry. By working with leading Canadian insurers, we build best-in-class lifestyle protection products to meet the ever-growing needs and challenges faced by our customers.

We are a full service company. We issue all policies, collect premiums, and provide support when our customers need us most – in the event of a claim.

Claims Procedures
Before paying any benefits, claim forms must be completed and sent to the Insurer. Please call The EDGE Claims Customer Care 1-800-908-9917, Ext. 401; Direct – 1-877-920-EDGE (3343) or email claimscustomercare@edgebenefits.com, to obtain the appropriate forms and for details on claims procedures.

Money Back Guarantee
Within 30 days after receipt by the PolicyOwner, this Policy may be returned to the Administrator's Head Office or to the agent from whom it was bought. We will cancel this Policy from the Effective Date and any premium paid will be returned in full, provided no claims have been incurred during that period.

PRIVACY STATEMENT (The Edge Benefits Inc.)

How We Collect Your Information
We collect and keep information about you, which is needed to provide the products and services you request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, MIB, LLC., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How We Use Your Information
We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for The Edge Benefits Inc., or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, MIB, LLC., financial institutions, third party administrators, and any references you provide. We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business. If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada, when necessary.

For further information on the privacy policies and procedures of any of the Insurers that partner with The Edge Benefits Inc. or to access your information or to ask us to correct information, you can contact us at:

The Edge Benefits Inc.
1255 Nicholson Road, Newmarket, ON, L3Y 9C3
1-877-902-EDGE (3343)

SAMPLE

SAMPLE

1255 Nicholson Road
Newmarket ON L3Y 9C3
Tel: 1-800-908-9917
Fax: 1-866-273-5557

The EDGE Plans are developed and administered by The Edge Benefits Inc.

TM/®1 Registered trademarks of the Edge Benefits Inc.