the EDGE®

Critical Illness

the EDGE®

POLICY BOOKLET

CRITICAL ILLNESS

IMPORTANT NOTE: You are only covered for those benefits applied for and for which premium has been received. Please see your Schedule of Benefits Issued by the Administrator for Confirmation of plan purchased.

PLEASE READ YOUR POLICY CAREFULLY
This Policy is a legal contract between you and the Company. Possession of this policy booklet alone does not entitle you to insurance under this policy. The policy must be in effect, a Schedule of Benefits must be issued by the Administrator and premiums must be paid.

POLICY INDEX

SAMPLE

Chubb Life Insurance Company of Canada (herein called "The Company") having issued Master Policy No. CO10396003 to THE EDGE BENEFITS Inc. (herein called the "Administrator") agrees to provide insurance coverage and pay benefits as described in this Policy to the extent herein provided and subject to all of the exclusions, limitations and provisions of this Policy for the Insured stated in the Schedule of Benefits from whom the appropriate premium has been received.

DEFINITIONS

"Accident" means a sudden, unforeseen, fortuitous event.

"Age" means the attained age of the Insured.

"Administrator" means The Edge Benefits Inc.

"Dependent Child or Dependent Children" means the Primary Insured's eligible unmarried natural, adopted, stepchild or common law child who is principally dependent on the Primary Insured or the Primary Insured's Spouse for financial support and is:

a) from birth to 21 years of age;
b) under age 25 and attending school on a full-time basis; or
c) over age 21 and dependent by reason of mental or physical infirmity and incapable of self-sustaining employment, and totally dependent on the Primary Insured or the Primary Insured's Spouse for financial support.

Dependent children can only be covered under either the Primary Insured or the Primary Insured's Spouse. Coverage for future dependent children will commence the latter of 10 months after the policy effective date, OR on the date of birth.

"Eligible Person" means an individual who is a permanent resident of Canada and between Age 18 and Age 64 inclusive at the time of application for the Policy.

"Hospital" means a legally constituted establishment which meets all of the following requirements:

a) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
b) provides 24 hour a day nursing service by registered or graduate nurses;
c) has a staff of one or more licensed Physicians available at all times;
d) provides organized facilities for diagnosis and surgical facilities; and
e) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

"Immediate Family Member" means spouse, parent or stepparent, child or stepchild, brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

"Injury" means bodily injury resulting directly or independently of all other causes from an Accident, which is caused by external, violent, and visible means and sustained while

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an Insured Person is covered under this policy. Injury must result within a 365 day period after the date of the Accident.

"Insured Person" means an Eligible Person who has been approved for critical illness insurance as provided under this Policy.

"Physician" means a Doctor of Medicine (M.D.) duly licensed to practice medicine in Canada and recognized by the College of Physicians and Surgeons in the Province in which the treatment is rendered, who is not the Insured and who is not the Insured's Immediate Family Member as defined.

"Policy Effective Date" means the date that coverage under the policy will commence. The Policy Effective Date is shown on the Schedule of Benefits issued by the Administrator.

"Premium Due Date" means the first premium is due and payable at time of application. The Policy will not take effect without its payment. After the first premium, premiums are payable to the Administrator in advance on a monthly basis by pre-authorized Debit (PAD). The PAD date occurs on the date of each month as determined by the Insured and is reflected on the Schedule of Benefits issued by the Administrator.

"Reinstatement Date" means the date the insurance under this Policy is put back into force if this Policy terminates as a result of unpaid premiums.

"Sickness" means any illness, disease or physical condition which causes a covered loss and for which symptoms are manifested while this policy is in force.

For Critical Illness insurance, a "Sickness" means any of the Insured Conditions or any other illness, disease, or physical condition.

"Schedule of Benefits" means that part of this Policy confirming the Principal Sum, Policy effective Date and monthly premium applicable to an Insured.

CRITICAL ILLNESS INSURANCE

30 Day Survival
If the Insured is diagnosed with or meets the definition of an Insured Condition or a Partial Payment Benefit condition, after the effective date or latest reinstatement date of coverage, and survives a period of 30 days following the date of diagnosis, or such longer period of time set out in the description of the insured condition or Partial Payment Benefit condition, the Company will pay the applicable benefit.

Principal Sum
The Principal Sum for the Insured shall be the benefit amount selected by the Insured on their Application and reflected on the Schedule of Benefits issued by the Administrator.

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Maximum Benefit for Insured Person
Tier 1: Guaranteed Issue Critical Illness available in units of $5,000 to a maximum of $75,000.
Tier 2: If qualifying questions are satisfied, an additional $25,000 or $50,000 is available for a maximum total of up to $125,000 of Critical Illness coverage in force with EDGE.

Maximum Benefit for Dependent Child or Children –$10,000

One Payment
The Company shall only be obligated to pay the Principal Sum once notwithstanding that an Insured Person may be diagnosed with, suffer, or undergo more than one of the Insured Conditions, except as outlined under the Second Event Benefit, Cancer Recurrence or Partial Payment Benefits.

Partial Payment Benefits
Partial Payment Benefits are not deemed to be Insured Conditions, nor do they fall under the category of Insured Conditions for the purposes of the Second Event Benefit. Payment of a Partial Payment Benefit does not reduce eligible payment of a principal sum payment. Each Partial Payment Benefit is payable only once.

DCIS Benefit
Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured 20% of the Principal Sum up to a maximum of $20,000 if, while insured, the Insured is diagnosed with DCIS and the Insured survives 30 days thereafter.

Early Stage Prostate Cancer (T1a or T1b) Treatment
Subject to the terms, conditions and other provisions of this policy, the Company will pay the Insured Person 20% of the Principal Sum up to a maximum of $20,000 if, while insured, the Insured Person undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and the Insured Person survives 30 days thereafter.

No Partial Payment Benefit will be payable unless the Physician has recommended at least one of the above treatments.

Second Event Benefit

Category of Insured Conditions

Cardiovascular: Heart Attack, Stroke, Coronary Artery Bypass, Aorta Surgery or Heart Valve Replacement or Repair.
Cancer: Cancer
Other: Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Dementia, including Alzheimer's Disease, Dismemberment, Loss of Independence, Loss of Speech, Major Organ Failure, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease, Severe Burns.

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"If, after the first Critical Illness Diagnosis Benefit has been paid, an Insured is diagnosed with or meets the definition of an Insured Condition, We will pay the Second Event Benefit amount stated in the Policy Schedule, subject to the following conditions:

a) The diagnosis or treatment of the second event Insured Condition cannot be the same Category of Insured Conditions as the first diagnosis.
If the first diagnosis was in the Cardiovascular or Cancer Category of Insured Conditions, the Insured must be considered (by the treating Physician) fully recovered and not actively receiving treatment (treatment does not include preventive medications and follow up visits to the doctor) for a period of at least 90 days; or

If the first diagnosis was in the Other Category of Insured Conditions, a period of 180 days must lapse between the first diagnosis and the diagnosis of the Insured Condition being claimed for under the Second Event Benefit.

b) The Insured has satisfied the 30 day survival period.

The Second Event Benefit cannot be related to or caused by the first diagnosis or treatment in any way. The Second Event Benefit is payable only once.

Payment of the Second Event Benefit will represent full and final discharge of all claims under this Policy. Following payment of the Second Event Benefit, coverage under this Policy will terminate for the Insured."

DEFINITION OF CRITICAL ILLNESS INSURED CONDITIONS

"Insured Conditions" means Aorta Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, Cancer Recurrence, Coma, Coronary Artery Bypass Surgery, Deafness, Dementia, including Alzheimer's Disease,, Dismemberment, Heart Attack, Heart Valve Replacement or Repair, Loss of Independence, Loss of Speech, Major Organ Failure, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease, Severe Burns and Stroke.

Additional "Insured Conditions" for Insured Children or for Dependent Children means Cerebral Palsy, Cystic Fibrosis, Down's Syndrome and Muscular Dystrophy.

Note that any insured condition diagnosed prior to the effective date of coverage will be excluded.

DEFINITIONS

"AIDS" means Acquired Immune Deficiency Syndrome.

"Activities of Daily Living" means the following six (6) activities:

1. Maintaining continence: controlling urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;

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3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
5. Eating: performing all major tasks of getting food into the body; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower

"Aorta Surgery" means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a Physician certified as a cardiovascular surgeon. Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

"Aplastic Anemia" means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

a) Marrow stimulating agents;
b) Immunosuppressive agents; or
c) Bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a Specialist.

"Bacterial Meningitis" means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

"Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)" means the unequivocal diagnosis of ALS by a neurologist licensed and practicing in Canada.

"Benign Brain Tumour" means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

SAMPLE

"Blindness" means the total and irrecoverable loss of sight in both eyes due to Injury or Sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A Physician certified in ophthalmology must clinically confirm the diagnosis in writing.

"Cancer" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

a) Carcinoma in situ;
b) Kaposi's Sarcoma or other AIDS related cancers and cancer in the presence of human immunodeficiency virus (HIV);
c) Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth;
d) Prostate cancer diagnosed as T1 N0 M0 or equivalent staging;
e) A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage, except as provided by Cancer Recurrence.

A Physician certified as an oncologist must confirm diagnosis in writing.

"Cancer Recurrence" means, If the insured person has already been diagnosed with Cancer and, while insured, a new diagnosis of Cancer is made, a benefit will be paid, subject to all the policy terms and provisions, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No Treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

"Cerebral Palsy" means a definite diagnosis of definite cerebral palsy, a non-progressive neurological defect characterized by spasticity and uncoordinated movements. A physician who is certified as a neurologist must confirm the diagnosis in writing.

"Cognitive Impairment" means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation, and reasoning, which is measurable and results from demonstrable organic cause as diagnosed by a Physician. The degree of Cognitive Impairment must be sufficiently severe as to require a minimum of eight continuous hours of daily supervision.

"Coma" means the Insured has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A Physician who is certified as a neurologist must confirm diagnosis in writing.

"Coronary Artery Bypass Surgery" means surgery performed by a Physician who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered critical illness.

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"Cystic Fibrosis" means a definite diagnosis of cystic fibrosis which is a hereditary disorder affecting the exocrine glands, resulting in chronic lung disease and pancreatic insufficiency. A physician who is specialized in Medical Genetics must confirm the diagnosis in writing.

"DCIS" means the diagnosis by a licensed Physician, of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A Physician certified as an oncologist must confirm the diagnosis in writing.

"Deafness" means the diagnosis of permanent loss of hearing in both of the Insured's ears, with an auditory threshold of more than 90 decibels in each ear. A Physician, who is certified as an otolaryngologist must confirm diagnosis in writing.

"Dementia, including Alzheimer's Disease" means a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

a) Aphasia (a disorder of speech);
b) Apraxia (difficulty performing familiar tasks);
c) Agnosia (difficulty recognizing objects); or
d) Disturbance in executive functioning (e.g., inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured must exhibit:

a) Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
b) Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The diagnosis of Dementia must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

"Dismemberment" means the total and permanent "loss" of any two limbs. "Loss" as used with reference to arm or leg means complete severance at or above the elbow or knee joint.

"Down Syndrome" means a definite diagnosis of Down syndrome supported by chromosomal evidence of Trisomy 21. A physician who is specialized in Medical Genetics must confirm the diagnosis in writing.

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"Early Stage Prostate Cancer (T1a or T1b) Treatment" means the diagnosis must be made by a specialist. No benefit will be payable unless the specialist has recommended one of the following treatments:

- Prostate Surgery
- Radiation Therapy
- Chemotherapy
- Hormone Therapy

"Heart Attack" means a definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) heart attack symptoms; or
b) new electrocardiogram (ECG) changes consistent with a heart attack; or
c) 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 under this condition for:

A) elevated biochemical cardiac markers with a:
   i. Troponin Level of less than 1
   ii. CK-Mb Level of less than 4, or
B) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

"Heart Valve Replacement or Repair" means undergoing surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

"Loss of Independence" means the definitive diagnosis by a licensed Physician of either:

1) Being totally and permanently unable to perform, by oneself, at least two (2) of the six (6) Activities of Daily Living or,
2) Cognitive impairment.

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of independence must persist for at least ninety (90) days from the date of the diagnosis.

"Loss of Speech" means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 continuous days. The diagnosis of Loss of Speech must be made by a specialist.

"Major Organ Failure" means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded), both lungs, both kidneys,

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or bone marrow, in which the affected organ is unresponsive to any treatment and for which the insured is medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow transplant.

"Major Organ Transplant" means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist."

"Motor Neuron Disease" means a definite diagnosis of one of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Primary lateral sclerosis
- Progressive spinal muscular atrophy
- Progressive bulbar palsy
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

"Multiple Sclerosis" means the diagnosis using the most recent McDonald criteria.

"Muscular Dystrophy" a definite diagnosis of muscular dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscular biopsy. A physician who is certified as a neurologist must confirm the diagnosis in writing.

"Occupational HIV Infection" means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Person's effective date of coverage.

Payment under this condition requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;
b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
e) The accidental injury must be reported, investigated, and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

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Exclusions: No benefit will be payable under this condition if:

- The Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
- A licensed cure for HIV infection is available prior to the accidental injury; or,
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

"Paralysis" means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to Injury or Sickness, provided such loss of function continually lasts for 90 consecutive days and such loss of function is thereafter determined on evidence satisfactory to the Company to be permanent. A Physician certified as a neurologist must confirm diagnosis in writing.

"Parkinson's Disease" means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in signs of progressive impairment.

"Severe Burns" means the Insured has third degree burns covering at least 20% of the surface area of their body. A Physician who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.

"Stroke" means that the Insured has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the Stroke, confirmed in writing by a Physician who is certified as a neurologist.

LIMITATIONS AND EXCLUSIONS

90 Day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion
The Company will not pay the Critical Illness Benefit for a diagnosis of DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment, and Cancer 90 days from the effective date, or latest reinstatement date of coverage.

In the event of a diagnosis within this 90 day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer exclusion period, coverage under this policy for the Insured will remain in force but DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer will be a Pre-Existing Condition and the Critical Illness Benefit will not be payable. This 90 day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion does not apply to a diagnosis of another Insured Condition or a subsequent diagnosis of an unrelated Cancer.

This policy does not provide benefits for any claim caused directly or indirectly by or resulting from any of the following:

1. intentionally self-inflicted Injury, suicide or any attempt thereat, while sane or insane;
2. declared or undeclared war or any act thereof;

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3. for Injury or Sickness, other than one of the Insured Conditions, even though such Injury or Sickness may have been complicated by one of the Insured Conditions;
4. a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex;
5. the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel;
6. the commission or attempted commission by the Insured of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed;
7. misuse of medication or the abuse of drugs or intoxicants;
8. any Pre-existing Medical Condition, if applicable.
9. For paralysis, blindness, deafness, major burns, stroke, coma or dismemberment, no benefit will be paid if the condition is a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle race or speed competition on land and/or water, parachuting or underwater activities, including scuba and snuba diving.

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims.

"Pre-existing Medical Condition" means a sickness suffered from or injury sustained by an Insured Person for which he or she sought or received medical advice, consultation, investigation, diagnosis, or for which treatment was required or recommended by a licensed medical practitioner during the twenty-four (24) months immediately prior to such Insured Person's effective date of insurance or prior to any increase in the amount of insurance and which directly or indirectly causes the insured condition to occur within the first twenty-four (24) months from the Insured Person's effective date of insurance or from any increase in the amount of insurance.

CHANGES TO COVERAGE

Change in Premium

The Company reserves the right to change the premium from time to time. If the Company finds it necessary to change the premium, the Administrator will give at least 31 days prior written notice to the Insured Person at the most recent email or street address, as shown in the Administrator's records.

Decreases in Insurance

Decreases in the amount of insurance on an Insured Person will take effect on the monthly anniversary date following receipt of the Insured's written request to the Administrator.

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Increases in Insurance
Increase in the amount of insurance on an Insured Person will take effect, for the increased amount when received and approved by the Administrator, and premiums have been debited from the Insured's account for any additional benefits purchased.

Reinstatement of Insurance

a) Within 60 days

An Insured whose insurance terminated due to non-payment of premium may request reinstatement of coverage within 60 days following the date of termination of insurance by submitting a written request to the Administrator. Reinstatement will take effect on the day following the latest termination date of the Policy (the "Reinstatement Date") provided payment of overdue premiums is made.

b) Within 61 – 90 days

An Insured whose Policy terminated due to non-payment of premium may request reinstatement of coverage within 61 to 90 days following the date of termination of the Policy by submitting a written application to the Administrator. Reinstatement will take effect on the Premium Due Date coincident with or next following the date of the written application for critical illness insurance is received and accepted by the Administrator (the "Reinstatement Date").

The amount of critical illness insurance reinstated will be that amount in effect immediately prior to the Policy termination. Premiums will be based on the reinstated amount of critical illness insurance, subject to any subsequent Premium Rate changes.

The reinstated Policy will only cover Critical Illness Conditions that are diagnosed after the latest Reinstatement Date, subject to the terms and conditions of the Policy.

Termination of Insurance
An Insured's coverage terminates on the earliest of the following dates:

a) the date the Critical Illness Benefit is paid;
b) the date of the Insured's death;
c) the date the coverage or Policy terminates for any reason;
d) the Premium Due Date coincident with or next following the Insured's 70th birthday

STATUTORY CONDITIONS
Applicable to All Benefits outlined in this policy booklet

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. All references to the "insurer" in these statutory conditions means the "Company."

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.

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Beneficiary Designation It is understood that all indemnities will be payable to the Insured Person. In the event of the death of the Insured Person prior to any claim being settled, all indemnities will be paid to their beneficiary, as on file with the Administrator. In the event there is no such designated beneficiary, all indemnities will be paid to the Estate of the Insured Person. An electronic beneficiary designation is valid, and the enrolment application is part of this contract of insurance.

Waiver The insurer 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 an officer of the insurer.

Copy of Application The insurer shall upon request furnish to the Insured Person 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.

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Termination of Insurance

1. The contract may be terminated
    a. by the insurer giving to the insured 15 days' notice of termination by registered mail or 5 days' written notice of termination personally delivered, or
    b. by the insured at any time on request.
2. If the contract is terminated by the insurer,
    a. the insurer must refund the excess of premium actually paid by the insured over the prorated premium for the expired time, but in no event may the prorated premium for the expired time be less than any minimum retained premium specified in the contract, and
    b. the refund must accompany the notice.
3. If the contract is terminated by the insured, the insurer must refund as soon as practicable the excess of premium actually paid by the insured over the short rate premium calculated to the date of receipt of the notice according to the table in use by the insurer at the time of termination.
4. The 15-day period referred to in subparagraph 1.a. of this condition starts to run on the day the registered letter or notification of it is delivered to the insured's postal address.

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 insurer:
        i. by delivery of the notice, or by sending it by registered mail, to the head office or chief agency of the insurer in the province, or
        ii. by delivery of the notice to an authorized agent of the insurer in the province, not later than 30 days after the date

a claim arises under the contract on account of an accident, sickness or disability,

b. within 90 days after the date a claim arises under the contract on account of an accident, sickness or disability, furnish to the insurer such proof as is reasonably possible in the circumstances of:
    i. the happening of the accident or the start of the sickness or disability,
    ii. the loss caused by the accident, sickness 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 insurer, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim is made under the contract and, in the case of sickness or 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 sickness or 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 insurer 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:

1) the claimant must give the insurer 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 insurer 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 insurer 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 insurer 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

SAMPLE

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.

Grace Period
A Grace Period of 31 days will be granted for the payment of premiums accruing after the first premium, during which Grace Period the policy shall continue in force, but the Insured shall be liable to the Company for the payment of the premium accruing for the period the policy continues in force. No Grace Period will be granted when a written notice of cancellation or termination has been received by us at our offices.

Not in Lieu Of
This policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance, or similar coverage.

Gender
Any reference to the masculine gender in this policy will also include the feminine gender.

Conformity with Provincial Statutes
Any provision of this policy or any condition of this policy which is in conflict with the statutes of the province in which the policy is delivered is hereby amended to conform to the minimum requirements of such province.

Limitation of Actions
An action or proceeding against the Company for the recovery of a claim under this contract shall not be instituted after 1 year from the date on which the cause of action arose.

Contesting the Policy
In the absence of fraud, the validity of this policy will not be contested if it has been in force for two (2) years from its issue date and all premiums due in that time have been paid.

Misrepresentation
If it is found that an Insured materially misrepresented his eligibility or medical status in order to obtain insurance under this policy, the Company has the right to void the application within the first two (2) years of the date of issue or within two (2) years of any change requested by the Insured.
A misrepresentation is a false statement on an insurance application as to a past or present fact which leads the Company to issue an insurance contract whereas the Company would not have issued the contract if the accurate facts were known.

Legal Actions
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of this policy.

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 (Alberta, British Columbia, Manitoba), or other applicable

SAMPLE

provincial legislation.

CLAIMS

Payment of Claims
Benefits payable due to a critical illness will be payable directly to the Insured Person. In the event the Insured Person dies prior to the benefit being paid, the payment will be made to the beneficiary on record.

If, at the death of the Insured Person, there is no surviving beneficiary, the benefit shall be payable in one sum to the Estate of the Insured Person.

Should a discrepancy occur, the benefit proceeds may be paid into court.

Beneficiary
An Insured has the right to name a beneficiary when he applies for insurance. An electronic beneficiary designation is valid, and the enrolment application is part of this contract of insurance.

All other indemnities of this policy will be payable to the Insured.

An Insured can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

Currency
All monies payable under this contract shall be paid in lawful Canadian currency.

SAMPLE

All Benefits outlined herein are underwritten and provided by Chubb Life Insurance Company of Canada.

ABOUT CHUBB LIFE INSURANCE COMPANY OF CANADA

This insurance coverage is underwritten by Chubb Life Insurance Company of Canada ("Chubb Life").

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.

All terms of coverage are governed by the provisions of the master contracts issued to THE EDGE BENEFITS Inc.

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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 – 1-877-902-EDGE (3343) or email claimscustomercare@edgebenefits.com to obtain the appropriate forms and for details on claims procedures.

Quality Guarantee
You have thirty days to decide if the coverage meets your needs. If the coverage does not meet your needs, simply mark "Cancel" on your Schedule of Benefits and return it with the policy booklet to The Edge Benefits Inc. who will cancel your coverage from the effective date and refund any premium paid, provided no claims have been incurred during that period.

PRIVACY STATEMENT

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, the Medical Information Bureau, 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, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, 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

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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:

Tel: (800) 908-9917 or (905) 836-7133 Fax: (866) 273-5557
The Edge Benefits Inc**.**
1255 Nicholson Road, Newmarket ON, L3Y 9C3

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