Industrial Alliance Insurance and Financial Services Inc.

(hereinafter called the Company)

Issued to:

(hereinafter called the Policyholder)

Policy Number:

Effective Date:

Expiry Date:

In consideration of the payment of the premium in the amount and in the manner set forth herein, the Company agrees to insure eligible persons of the Policyholder who are named or designated herein and for whom application is made by the Policyholder, for loss resulting from Injury or Sickness to the extent herein provided and subject to all the exclusions, limitations and provisions of this policy.

All periods of time under this policy begin and end at 12:01 a.m., Standard Time, at the address of the Policyholder.

This policy will be automatically renewed for further consecutive terms upon payment of the premium at the rate and in the amount determined by the Company at the time of renewal, subject to the part titled "Termination of Policy".

The provisions set forth on the following pages together with this page constitute the policy.

In witness whereof, the Company has caused this policy to be executed by its President and Chief Executive Officer and Corporate Secretary, but it will not be binding upon the Company until countersigned by the Company's Registrar.

PRESIDENT AND CHIEF EXECUTIVE OFFICER

CORPORATE SECRETARY

COUNTERSIGNED

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REGISTRAR

DEFINITIONS

"**Accident**" or "**Accidental**" whenever used in this policy means a sudden, unforeseen and unexpected event which arises from a source external to an Insured Person and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease or treatment for the illness or disease. This event must occur while this policy is in force and be the basis of claim.

"**Actively at Work**" whenever used in this policy means actually at work at the Participant's usual place of employment on a regular Full-Time or Part-Time basis and performing all the usual duties of the Participant's normal Occupation.

"**Chronic Medical Condition**" whenever used in this policy means a disease, Sickness or Injury resulting in the Insured Person having a medical condition which has at least one of the following characteristics: the condition continues indefinitely and has no known cure; the condition comes back or is likely to come back; the condition is permanent; the condition results in the Insured Person needing to be rehabilitated or specially trained to cope with it; the condition results in the Insured Person needing long term medical care which includes regular monitoring, consultation, check ups, examinations or tests.

"**Coverage Period**" whenever used in this policy means one calendar year from the effective date of an Insured Person's DSAI coverage.

"**DSAI**" whenever used in this policy means the Diagnostic and Specialist Access Insurance coverage described in this policy and includes the Limited Specialist Coverage Benefit.

"**Dependent Child**" whenever used in this policy means any natural child, step-child, or legally adopted child of the Participant, who receives support and maintenance from the Participant, resides in Canada, and is:

(a) under 21 years of age and unmarried; or

(b) 21 years of age but less than 25 years of age, unmarried, and is in full-time attendance at a School for Higher Learning; or

(c) mentally or physically infirm.

Notwithstanding the above limitations, this definition will also include a child of the Participant's Spouse who is in the care, custody and control of the Participant and living in a parent-child relationship with the Participant.

"**Diagnostic and Specialist Access Insurance**" whenever used in this policy means the insurance coverage described in this policy.

"**Diagnostic Procedure**" whenever used in this policy means a specific test or series of steps done to help diagnose a disease or condition.

"**Full-Time or Part-Time Employee**" whenever used in this policy means an employee of the Policyholder whose period of work is not less than 20 hours per week at full pay.

DEFINITIONS (Continued…)

"**Hospital**" whenever used in this policy means an institution contracted with Us, located in the United States or Canada, where services are available. It must maintain organized facilities for medical, diagnostic and surgical care for patients who are Hospital Confined and for which a charge is made that the Insured Person is legally obligated to pay, maintain a staff of one or more duly licensed Physicians, provide 24-hour nursing care under supervision of a registered graduate professional Nurse, have surgical facilities on its premises or have a contract with another institution with a valid license to provide surgical services, and be legally operating in the jurisdiction where it is located.

Except when provided elsewhere in the policy, this definition does not include an institution that is principally for: rest, nursing, long-term, extended, or custodial care; convalescence; care of the aged, alcoholics, drug addicts, or runaways. Also, it does not include services rendered at a military or veteran's hospital, soldier's home or any hospital that is contracted for or operated by the federal government or any of its agencies for members or former members of the armed forces, unless an Insured Person is legally required to pay for the services.

"**Hospital Confined**" whenever used in this policy means the Insured Person is admitted to the facility as an overnight bed patient for a minimum of 15 consecutive hours.

"**Injury**" whenever used in this policy means sudden, traumatic Accidental or unanticipated damage to the body not of gradual onset. The cause must be external, physically violent, and precede the damage.

"**Insurance Act**" whenever used in this policy means the applicable insurance legislation in the applicable provincial jurisdiction.

"**Insured Person**" whenever used in this policy means a Participant, Spouse and Dependent Child as designated in Section 1 of the Schedule.

"**Maximum Amount Payable**" whenever used in this policy means the fee negotiated between the Physician, Medical Clinic or Out-patient Surgical Facility and Us.

"**Medical Clinic**" whenever used in this policy means a licensed private or public health facility in Canada that is devoted to the care of out-patients.

"**Medically Necessary**" whenever used in this policy means the shortest, least expensive, or least intense level of treatment, care or service rendered or supply provided, as determined solely by Us, to the extent required to diagnose or treat an Injury or Sickness. The service or supply must be consistent with the Insured Person's medical condition, is known to be safe and effective by most Physicians who are licensed to treat the condition at the time the service is rendered, and is not provided primarily for the convenience of the Insured Person or Physician.

"**Member of the Immediate Family**" whenever used in this policy means a person at least 18 years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the above include natural, adopted or step relationships), Spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

"**Nurse**" whenever used in this policy means a graduate registered nurse (R.N.) or nurse who is licensed to practice nursing service by a governmental agency having jurisdiction over such licensing. The nurse is neither the Insured Person nor a Member of the Immediate Family and must not ordinarily reside in the Insured Person's Residence.

DEFINITIONS (Continued…)

"**Occupation**" whenever used in this policy means the occupation engaged in by the Participant for wage or profit immediately prior to the occurrence of any Injury or Sickness under this policy.

"**Occurrence**" whenever used in this policy means each treatment plan approved by Us for an Insured Person. A succeeding treatment plan is considered an occurrence if the treatment plans are separated by both the Insured Person's return to Canada or province of Residence and a period not less than 24 hours.

"**OneWorld Assist**" whenever used in this policy means the claims service provider engaged by the Company to provide claims coordination and claims payment services under this policy.

"**Out-patient Surgical Facility**" whenever used in this policy means a licensed public or private medical facility that has an organized staff of Physicians located in Canada and is contracted by the Company.

"**Participant**" whenever used in this policy means a Full-Time or Part-Time Employee who is insured under this policy.

"**Physician**" whenever used in this policy means a qualified doctor of medicine (M.D.) who is duly registered and licensed in the jurisdiction in which he practices, who prescribes drugs and/or performs surgery and who gives medical care within the scope of his licensed authority. The physician cannot be a Member of the Immediate Family of the Insured Person.

"**Pre-Authorization**" whenever used in this policy means the process We employ to ensure We have been notified of an admission or provision of service before services are provided in order to determine if the admission or provision of service is Medically Necessary and covered by the policy.

Pre-Authorization by Us means the surgery or Diagnostic Procedure has been approved by Us based on confirmation from the specialist Physician's office or from the appropriate Canadian facility that:

(a) the Insured Person has been placed on a surgical/Procedural Waiting List; and

(b) the Diagnostic Procedure(s) or specialist consultation cannot be performed earlier than 21 days from the date the Insured Person is placed on the surgical/Procedural Waiting List.

"**Pre-Existing Condition**" whenever used in this policy means:

(a) a condition for which an Insured Person is given medical care, treatment, services, medication, diagnosis, diagnostic test or consultation prior to the Insured Person's effective date of coverage; or

(b) a condition which produced symptoms prior to the Insured Person's effective date of coverage and such symptoms must be distinct and significant enough to establish onset or manifestation by one of the following tests:

(i) the symptoms would allow one learned in medicine to make a diagnosis of the disorder; or

(ii) the symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment.

This includes but is not limited to any condition for which the Insured Person is already on a Procedural Waiting List in Canada.

DEFINITIONS (Continued…)

"**Procedural Waiting List**" whenever used in this policy means a list of patients who have been recommended for Diagnostic Procedure by an appropriate specialist Physician in Canada and for whom the procedure has not been initiated or completed.

"**Related Medical Condition**" whenever used in this policy means any medical condition for which the Insured Person has experienced symptoms, received medication, advice or treatment in the 24 months prior to the effective date of an Insured Person's coverage, whether the condition has been diagnosed or not and which in the opinion of Our chief medical officer, is considered to be an underlying cause of, or directly related to the medical condition which is the subject of the claim.

"**Residence**" whenever used in this policy means the primary dwelling of which the Insured Person is an occupant and the premises on which it is situated.

"**School for Higher Learning**" whenever used in this policy includes any university, college, CEGEP {College D'Enseignement General et Professionel (community colleges in Quebec)} or trade school.

"**Sickness**" whenever used in this policy means a disorder of an Insured Person's bodily function or structure causing physical symptoms which, if not treated, would result in deterioration of the Insured Person's health.

"**Spouse**" whenever used in this policy means a person who is under the age of 75, resides in Canada, and:

(a) to whom the Participant is legally married;

(b) to whom the Participant is married by a marriage that is voidable and has not been declared null and void; or

(c) with whom the Participant has continuously cohabited and who has been publicly represented as the Participant's spouse for a minimum of 12 months immediately before a loss is incurred under the policy.

Only one individual will qualify as a spouse.

If the Participant is legally married but is also cohabiting with an individual as described under (b) or (c) above, the Participant may elect in writing which one of the individuals will qualify as a spouse under this policy. This election must be filed with the Policyholder. The Company will not be bound by an election not filed before the event insured against. If an election is not filed, the spouse will be the individual to whom the Participant is legally married.

"**We, Us, Our**" whenever used in this policy means the Company in conjunction with OneWorld Assist.

Whenever a reference to the masculine gender appears in this policy, it will also be construed to include the feminine gender.

Attached to and forming part of Policy Number

COVERED BENEFITS AND SERVICES

1. Diagnostic Procedures

   If approved by Us, Medically Necessary Diagnostic Procedures related to conditions or treatment not otherwise limited or excluded under the policy. Covered Diagnostic Procedures are limited to the following:

   Magnetic Resonance Imaging (MRI)
   Computerized Axial Tomography (CAT or CT scans)

2. Medical Referrals

   Once a procedure for an Insured Person has been approved by Us, OneWorld Assist will schedule appointments, coordinate the Diagnostic Procedure and make any travel arrangements if necessary. Requests for a specific Medical Clinic or Physician may be considered and must be approved in advance by Us.

3. Transportation

   Transportation costs incurred by an Insured Person while travelling to and from the approved diagnostic facility will be reimbursed upon completion of an authorized Diagnostic Procedure or medical referral.

   This benefit is calculated by measuring the round-trip travel distance from the Insured Person's Canadian Residence to the approved diagnostic facility according to the most recent Rand McNally geographical data available to Us. The maximum benefit per Diagnostic Procedure or medical referral is calculated at the rate of $.25 per mile up to a maximum benefit of $500.00 per Occurrence.

LIMITED SPECIALIST COVERAGE BENEFIT

If an Insured Person is referred by their general practitioner (G.P.) to a specialist Physician for assessment while insured under this benefit and the specialist Physician confirms that the assessment cannot be provided within 21 consecutive days of the referral by the G.P., the policy will pay benefits for the cost of an assessment by a specialist Physician approved by Us, subject to the following:

(a) the referral by the G.P. is to a specialist Physician in one of the following medical specialties: Cardiology, Ear, Nose and Throat, Gastroenterology, General Surgery, Neurology, Ophthalmology, Orthopedics, Rheumatology, Spine Team, and Urology;

(b) the assessment is for the purpose of determining a condition which may result in a diagnostic test.

OneWorld Assist will make the first available appointment with the appropriate specialist Physician at the geographical location closest to the Insured Person and make every effort to schedule the special Physician assessment within 21 days from the referral by the G.P. and/or approval of the request.

Travel expenses to the specialist Physician approved by Us are not included under this benefit.

For an Insured Person, the Limited Specialist Coverage Benefit provides for a maximum of two assessments per Insured Person per Coverage Period. Each assessment includes an initial and follow-up consultation.

Attached to and forming part of Policy Number

CONTINUATION OF INSURANCE DURING A LEAVE OF ABSENCE

If a Participant commences a general leave of absence, the amount of insurance in respect of such Participant may be continued, with no increases or changes during such leave, for the duration of such leave up to a maximum of six consecutive months.

If a Participant commences a maternity and/or parental leave of absence, the amount of insurance in respect of such Participant may be continued, with no increases or changes during such leave, for the duration of such leave up to the maximum permitted by applicable provincial Employment Standards Legislation.

Insurance will only be continued by the Company provided:

(a) the Policyholder has approved the leave of absence; and

(b) premium payments continue to be submitted on a regular basis.

Insurance of a Participant that is continued during a leave of absence will terminate in accordance with the part titled "Termination of Policy".

Notwithstanding the above, if a Participant does not continue their Diagnostic and Specialist Access Insurance during their leave of absence, then he will be considered a new Participant upon return to work at the end of such leave and will only again become insured for Diagnostic and Specialist Access Insurance as specified in the Schedule and subject to all the terms and conditions of this policy.

LIMITATIONS

Policy benefits are subject to limitations described below.

1. Lifetime Maximum

   Benefits under this policy are provided to an overall lifetime maximum of $1,000,000.00 U.S. per Insured Person. When the total benefits for an Insured Person reaches the lifetime maximum the coverage afforded the Insured Person under the policy terminates.

2. Pre-Existing Condition Limitation

   Benefits for Diagnostic and Specialist Access Insurance are limited for any Pre-Existing Condition that existed during the 24 months prior to the Insured Person's effective date of coverage. Diagnostic and Specialist Access Insurance coverage is not provided for any Pre-Existing Condition until after the Insured Person has been continuously insured for 24 months under this policy.

3. Benefit Maximum

   Benefits payable under this policy for medical and/or Medical Clinic expenses in respect of an Insured Person are limited to the Maximum Amount Payable.

4. Benefits not Provided in Province of Residence

   An Insured Person is not entitled to receive benefits under this policy for services and supplies that are provided in the province of Residence of the Insured Person.

Attached to and forming part of Policy Number

EFFECT ON CLAIMS OF TERMINATION OF INSURANCE

Termination of this policy and the Diagnostic and Specialist Access Insurance in respect of an Insured Person will not prejudice any claim where:

(a) the policy has been terminated in accordance with the provisions of the part titled "Termination of Policy", and

(b) the Insured Person has been placed on a Procedural Waiting List prior to the termination date of the policy.

The Limitations, Exclusions and other terms and conditions of coverage in the policy will apply.

EXCLUSIONS

This policy does not provide Diagnostic and Specialist Access Insurance benefits for the following:

1. Services and supplies that are:

   (a) not medically necessary;

   (b) not recommended or approved by a Physician;

   (c) not rendered within the scope of the Physician's license;

   (d) furnished by a government plan, Medical Clinic or institution unless the Insured Person is legally required to pay for the services;

   (e) charged in excess of the Maximum Amount Payable;

   (f) provided without prior written Pre-Authorization by Us; or

   (g) provided after the termination date of an Insured Person's Diagnostic and Specialist Access Insurance.

2. Injury or Sickness occurring during or arising from an Insured Person's course of employment for which benefits are provided or payable under Workers' Compensation or under any act or law which provides benefits for such Injury or Sickness for which an Insured Person failed to file a claim for Workers' Compensation benefits for which they were eligible.

3. Injury or Sickness caused by: an act of declared or undeclared war; service in the military forces of any country, including non-military units supporting such forces; the Insured Person committing or attempting to commit civil tort or an indictable offence or taking part in a riot (meaning the Insured Person is taking an active part in common with three or more others by using or threatening to use force or violence without authority of law).

4. Injury or Sickness, while sane or insane, resulting from or related to self-inflicted Sickness or Injury, flagrant self-abuse such as continued behaviour contrary to a Physician's recommendation, suicide, threatened suicide, alcohol abuse, or drug addiction or abuse. This includes an Accident where alcohol or drugs were involved; treatment related to any psychological, mental or emotional disorders or treatment of any sexually transmitted disease.

EXCLUSIONS (Continued…)

5. Procedures, devices, services, supplies, or drugs that We consider experimental or investigative because they are:

   (a) considered as such by protocol of the U.S. Department of Health and Human Services or any of its subsidiary agencies; or

   (b) not formally approved by the U.S. Federal Drug Administration, American Medical Association, or the National Institute of Health for that particular diagnosis or specific treatment prescribed; or

   (c) primarily used in the laboratory or research setting that has and/or have progressed to only limited human use.

6. Treatment to remove a birthmark;

7. Services and supplies rendered to treat hair loss or to promote hair growth, including but not limited to hair transplants and wigs;

8. Routine physical exams, checkups, and related x-ray and lab expenses, drugs and medicines, except those prescribed in and taken home from the Hospital where permission was Pre-Authorized by Us;

9. Blood products storage where not necessary or not in conjunction with a scheduled covered surgery;

10. Blood products when replaced by donation;

11. Organ or tissue or transplants, including transplants for burns and related services, except corneal transplants;

12. The implant of an artificial organ or any service or supply in connection therewith;

13. Items or devices primarily used for comfort or commonly installed in homes, including but not limited to air purifier, humidifier, dehumidifier, whirlpool, air conditioning, water bed, exercise equipment or ultraviolet lighting;

14. Personal or home-based artificial kidney equipment;

15. Growth hormone treatment, regardless of the reason for prescription;

16. Foot care including but not limited to: shoe inserts, foot care related to corns, calluses, bunions, hallux valgus, flat feet, weak arches or weak feet;

17. Treatment or surgery of bony protuberance of the forefoot and toes, including misalignment of the same (i.e., bunions, spurs, hammertoes);

18. Any dental treatment or services;

19. Treatment of temporomandibular joint dysfunction, craniomandibular joint dysfunction, myofacial pain syndrome and all related conditions, orthognathic reconstructive surgery;

20. Private duty services of a health care provider;

EXCLUSIONS (Continued…)

21. Eye exams for corrective lenses, including contact lenses, eyeglasses and their fitting, radial keratotomy, corneal modulation, refractive keratoplastry or any similar procedure, speech or vision therapy, including eye exercises, hearing exams, hearing aids and their fitting;

22. Emergency medical care provided through a public or private medical facility;

23. A Chronic Medical Condition;

24. A Related Medical Condition;

25. Sex change operations and complications from that surgery, artificial insemination, in-vitro or in-vivo fertilization, testing, treatment or medication for the primary purpose of achieving conception, maintaining pregnancy or preventing abortion, infertility and impotency testing and treatment, abortion, voluntary sterilization, reversal procedures or sterilization;

26. Acupuncture, chelation therapy, or laetrile used in form or any derivative or variation thereof;

27. Treatment for weight loss, or for exogenous or morbid obesity, including but not limited to: gastric bypass, gastric stapling, or balloon catheterization, liposuction or reconstructive surgery, any food supplement or augmentation, diet, health or exercise programs, health club dues, or weight reduction clinics;

28. Any treatment related to pregnancy or complications thereof;

29. Prosthesis, corrective devices and medical appliances which are not surgically required, unless necessitated by Injury, deformity or Sickness which occurs while the Insured Person is covered under the policy;

30. Chronic Fatigue Syndrome including, but not limited to diagnostic workups;

31. Sclerotherapy, for the treatment of varicose veins of the extremities;

32. Any treatment relating to birth defects or congenital illnesses;

33. Services and supplies (including but not limited to splints and braces) prescribed or rendered solely to allow for participation in any sports related activity, or solely for strengthening, conditioning or maintaining a muscle, bone or joint function;

34. Injury or Sickness occurring while engaged in any hazardous, high risk or extreme sport activities including but not limited to: sky or scuba diving, parachuting, mountain climbing, ballooning, hang gliding, bungee cord jumping, stunt flying, crop dusting or the operation of an ultra light aircraft, racing of any form (other than on foot) and all professional sports;

35. Expense for which no benefit is specifically described in the policy, in any amendment to the policy, or an expense specifically excluded in the policy.

Attached to and forming part of Policy Number

CHANGE IN COVERAGE

A Participant may elect Optional Spouse and/or Optional Dependent Children coverage at any time by making written application to the Policyholder within 60 days of a change of family status. If the Participant does not exercise this option within the 60 day period then no change may be made until the anniversary date of this policy.

TERMINATION OF POLICY

This policy may be terminated by the Company or by the Policyholder by one giving to the other 30 days notice in writing of such intention to terminate, delivered personally or sent by registered mail to the latest address of the Company or the Policyholder, as the case may be and thereupon, the policy will cease on the expiration of such 30 days.

This policy may be terminated by the Company forthwith provided such cancellation is given in writing, delivered personally or sent by registered mail to the latest address of the Policyholder in the event of failure by the Policyholder to remit premiums to the Company as and when due.

EFFECTIVE DATE OF INSURANCE OF AN INSURED PERSON

Each person who is eligible for insurance under this policy shall become an insured on the later of:

A. With respect to the Participant:

   (a) the effective date of this policy;

   (b) the date he becomes an eligible person, as specified in Section 1 of the Schedule, provided the Participant is Actively at Work on that date.

B. With respect to an insured Spouse and/or insured Dependent Child:

   (a) coincident with the effective date of the Participant's insurance when the Participant elects the Optional Spouse and/or Optional Dependent Children coverage on his completed and signed application received by the Policyholder;

   (b) on the first day of the month coincident with or next following the date the Participant elects the Optional Spouse and/or Optional Dependent Children coverage as specified in the part titled "Change In Coverage".

   Any future Dependent Children are automatically insured under the Optional Dependent Children coverage, if elected.

Attached to and forming part of Policy Number

TERMINATION OF INSURANCE OF AN INSURED PERSON

Insurance will immediately terminate on the earliest of the following dates:

A. With respect to the Participant:

(a) the date this policy is terminated;

(b) the premium due date if the Policyholder fails to pay the required premium for a Participant, except as the result of an inadvertent error;

(c) on the last day of the month in which the Participant reaches 75 years of age;

(d) the premium due date next following the date a Participant ceases to be associated with the Policyholder in a capacity making such person eligible for insurance hereunder.

B. With respect to the insured Spouse and/or insured Dependent Child:

(a) the date such person ceases to be an eligible person as specified in Section 1 of the Schedule;

(b) the date the Participant's insurance is terminated.

CHARGE FOR MISSING A SCHEDULED APPOINTMENT

An Insured Person who fails to meet Our scheduled appointment for any pre-authorized treatment will be required to indemnify Us with the following applicable charge before treatment is performed at a later date. This charge does not apply if the appointment is re-scheduled more than 24 hours prior to the appointment or if We determine that it was not reasonably possible for the appointment to be rescheduled.

The charge for a missed appointment is as follows:

Missed consultation:	$100.00
Missed Diagnostic Procedure:	$200.00

PERFORMANCE OF HEALTH SERVICES

If rendering of health services is delayed or is made impractical or impossible because of circumstances beyond Our control, or because We have not received all information required to determine eligibility, We will be held harmless. The service provided by Us is a supplementary service. It is agreed by all parties that services under the health services legislation of the applicable province should be used in emergency situations.

INADVERTENT ERROR

The insurance of an Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports or comply with any of the provisions of this policy when such failure is due to inadvertent error or clerical mistake. This clause does not apply to claims reporting. Claims must be reported within the time frame specified in "Notice and Proof of Claim" under the part titled "General Provisions".

Attached to and forming part of Policy Number

GENERAL PROVISIONS

THE CONTRACT

This policy, including the endorsements, insertions, riders or attachments, if any, and the application for the contract if attached to the policy, constitutes the entire contract and no agent has authority to change the contract or waive any of its provisions.

CONFIDENTIALITY OF INFORMATION

The Policyholder acknowledges that all information provided to the Company in connection with an application for insurance or insurance coverage of a person will be treated as confidential.

The Company and the Policyholder are obliged to comply with legislation relating to the collection, retention, use and disclosure of personal information about policyholders, certificate holders and personnel. The Policyholder acknowledges receipt of the Company's Privacy Policy ("the Privacy Policy") attached as Appendix 1, setting out the Company's standards in dealing with personal information and agrees to manage any personal information held by it on behalf of the Company in a manner consistent with the Privacy Policy. Additionally, the Policyholder agrees to abide by any privacy procedures relevant to it provided by the Company from time to time. Such procedures are intended to implement the principles set out in the Privacy Policy.

WAIVER

The Company will be deemed not to have waived any conditions of this contract, either in whole or in part, unless the waiver is clearly expressed in writing and signed by a duly authorized officer of the Company.

CLAIMS PROVISIONS

(a) How To Claim

(i) The Insured Person or the agent of the Insured Person shall provide notice of claim by phoning OneWorld Assist at 1-866-515-1627.

(ii) It is the responsibility of the claimant to produce any documentation required by OneWorld Assist to enable them to process and confirm the eligibility of the claim.

(iii) All required documentation must be provided within 12 months from the date of loss.

(iv) To qualify for reimbursement of eligible expenses, original, itemized receipts must be provided within 12 months from the date the expense is incurred.

(b) Payment To Provider

Medical Clinics and Physicians will be reimbursed directly by Us for Pre-Authorized medical expenses.

GENERAL PROVISIONS (Continued…)

CLAIMS PROVISIONS (Continued…)

(c) Notice and Proof of Claim

The Insured Person or the agent of the Insured Person shall:

(i) provide notice of claim not later than 30 days from the date a claim arises under the policy on account of Injury or Sickness;

(ii) within 90 days from the date a claim arises under the policy due to an Injury or Sickness, furnish to Us such proof as is reasonably possible in the circumstances of the happening of the Injury or the commencement of the Sickness, and the loss occasioned thereby, the right of the claimant to receive payment, and his age; and

(iii) if so required by Us, furnish a satisfactory certificate as to the cause or nature of the Injury or Sickness for which claim may be made under the policy.

FAILURE TO GIVE NOTICE OR PROOF

Failure to give notice of claim or furnish proof of claim within the time prescribed does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than 12 months from the date of the Injury or Sickness, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

RIGHTS OF EXAMINATION

As a condition precedent to recovery of insurance money under this policy, the claimant shall afford to Us an opportunity to examine the person of the Insured Person when and so often as we reasonably require while the claim thereunder is pending.

WHEN MONEY IS PAYABLE

All benefit monies payable under this policy by the Company will be paid in U.S. dollars within 60 days after We have received proof of claim satisfactory to Us.

LIMITATIONS ON ACTIONS

An action of proceeding against Us for recovery of a claim shall not be commenced more than 12 months after the date the insurance money became payable or would have become payable if it had been a valid claim.

COORDINATION OF BENEFITS

The Insured Person is not entitled to receive duplicate payment of benefits from this insurance in addition to those provided under any other insurance benefit plan. The Company has the right to proceed at its own expense in the name of the Insured Person against third parties who may be responsible for providing indemnity of benefits similar to this insurance.

GENERAL PROVISIONS (Continued…)

EXCESS COVERAGE

No benefits are payable for Injury or Sickness for which there is other insurance providing medical payments or medical expense coverage regardless of whether the coverage is primary, excess or contingent. If We make payment on behalf of the Insured Person, the Insured Person agrees to assign to Us any right the Insured Person has against the other insurer.

INSPECTION OF RECORDS

The Policyholder will, from time to time, whenever requested by the Company during the term of this policy and for 12 months after its expiration, permit the Company to inspect all records of the Policyholder relating to this policy and all persons insured hereunder.

SUBROGATION

The Insured Person agrees that We shall be subrogated to their rights to damages, to the extent of the benefits provided by the policy, for Injury or Sickness that a third party is liable for or causes.

The Insured Person agrees to assign to Us their claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. The Insured Person must promptly advise Us in writing whenever a claim against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. The Insured Person agrees to fully cooperate in protecting Our rights against a third party.

LEGAL ACTION

No action at law or in equity will 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 the requirements of this policy. No such action will be brought after the expiration of 12 months (two years in Alberta and British Columbia, and three years in Quebec) after the time written proof of loss is required to be furnished.

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 legislation.

APPENDIX 1

PRIVACY POLICY FOR iA FINANCIAL GROUP

iA Financial Group is composed of Industrial Alliance Insurance and Financial Services Inc. and its subsidiaries ("iA"). iA is committed to protecting its clients', employees' and representatives' (the "Individual's") privacy, and to ensuring the confidentiality of the personal information provided to iA in the course of its business.

iA's Privacy Policy sets out the standards for collecting, using, disclosing and storing Individual's personal information. iA's Privacy Policy also explains how iA safeguards the Individual's personal information and right to access that information.

PERSONAL INFORMATION

Personal Information is any information about an individual that identifies him, such as financial, lifestyle or health information, but not their name, or business title, address, telephone and email.

Personal information has to be protected regardless of its characteristics or its form, whether written, graphic, audio, visual, computerized or any other form.

PURPOSE OF INFORMATION COLLECTION

Collecting information about an Individual is necessary in order for iA to provide the Individual with high quality services. The nature and sensitivity of the information iA collects about an Individual varies according to the services iA provides the Individual and to legal requirements imposed on iA (such as information required for tax purposes).

The purposes for which iA collects personal information about an Individual are identified at or before the time of collection. For example, information may be collected while submitting an application, opening an account, or submitting a claim.

Purposes for collecting information generally include providing products or services requested, confirming the Individual's identity, protecting against fraud, or dealing with matters concerning the relationship between iA and the Individual.

CONSENT

When iA obtains personal information from an Individual, iA initially requires the Individual's consent to collect, use or disclose the information for the purposes specified. iA will obtain the Individual's consent for any additional use, disclosure or collection, or if the purpose is changed.

iA generally seeks the Individual's express written consent in order to collect, use or disclose personal information. Where appropriate, iA may accept the Individual's verbal consent. Occasionally, iA may imply consent where iA can infer consent from the Individual's action or inaction.

Consent must be given by the Individual or the Individual's authorized representative such as a legal guardian or a person having a power of attorney.

APPENDIX 1 (Continued…)

PRIVACY POLICY FOR iA FINANCIAL GROUP (Continued…)

CONSENT (Continued…)

The Individual may withdraw his consent at any time, subject to legal or contractual restrictions. iA will inform the Individual of the consequences of such withdrawal, including the possibility that iA may not be able to provide a product or process a request. If the Individual chooses to withdraw his consent, iA will record the decision in its file.

In limited circumstances, iA may collect, use or disclose personal information without the Individual's knowledge and consent. This occurs when legal, medical, or security reasons may make it impossible or impractical to seek consent, or when information is being collected for the investigation of a potential breach of contract, the prevention or detection of fraud, or for law enforcement purposes.

LIMITS TO COLLECTION, USE AND DISCLOSURE

iA only collects the personal information iA needs directly from the Individual or from a third party where the Individual allows iA to collect the information. iA cannot use an Individual's personal information for other purposes without his consent or disclose the Individual's personal information to anyone except with the Individual's consent.

iA may however collect, use or disclose the Individual's personal information without the Individual's consent as permitted or required by law.

iA will limit the collection, use and disclosure of the Individual's personal information to the purposes iA has identified to the Individual. The Individual's personal information is only accessible to certain authorized persons, and only to the extent necessary to perform their duties.

iA will occasionally share the Individual's personal information with service providers or agents to ensure the proper administration of products, or to provide the Individual with the services the Individual requires. In certain circumstances, iA may use service providers outside Canada, including the United States. iA is responsible for the service provider's compliance with privacy legislation, and will ensure that the level of protection of personal information is comparable to that provided by iA.

The Individual has the right to know, on request, to whom the information was disclosed. Only in rare instances is iA prevented by law from making such disclosure. iA maintains accurate records, recording to whom iA disclosed personal information and in what circumstances it was disclosed.

SHARING PERSONAL INFORMATION

iA may establish a list of clients (names, addresses and telephone numbers) and share this list with companies within iA Financial Group. The Individual may request that his name be removed from such a list by writing to the Privacy Officer at the address provided below.

With the Individual's consent, iA may also share the Individual's personal information with companies within iA Financial Group in order to know the Individual better, better meet the Individual's needs and offer the best possible service and client experience. If the Individual does not want to receive such offers for products and services, the Individual may choose not to provide consent.

iA does not sell the Individual's personal information to third parties.

APPENDIX 1 (Continued…)

PRIVACY POLICY FOR iA FINANCIAL GROUP (Continued…)

ACCURACY

iA makes every possible effort to ensure that an Individual's personal information is as accurate and complete as necessary for the purposes it is collected, used, or disclosed.

RETENTION

iA only retains the Individual's personal information for as long as needed for the purposes that it was collected. iA must destroy this information in accordance with the law and iA's file retention guidelines. When iA destroys an Individual's personal information, iA makes sure that confidentiality is secured and that no unauthorized person can access the information during the destruction process.

ACCOUNTABILITY

iA is responsible for the Individual's personal information in iA's possession or control, including information that may be transferred by iA to third parties for processing. iA requires such third parties to keep personal information under strict standards of privacy and protection.

iA adheres to legislated and self-imposed rules, aimed to safeguard the Individual's privacy. iA's Privacy Officer is responsible for the oversight of this Privacy Policy and processes and procedures that iA has, to protect the Individual's personal information. Additional rules are established in a code of conduct, market conduct standards as well as insurance industry guidelines and applicable law.

iA's staff is trained on these processes and procedures and is provided with information about privacy laws.

SAFEGUARDS

iA has implemented and continues to implement rigorous safeguards so that the Individual's personal information remains strictly confidential and is protected against loss or theft, as well as unauthorized use, disclosure, access, copying, or modification.

Protection methods include organizational measures such as requiring security clearances and limiting access to a "need-to-know" basis, physical measures (e.g. building access cards for employees, visitor registration and identification cards, off-site backups and archiving), and technological measures such as the use of passwords and encryption (e.g. the use of firewalls and routinely changing passwords).

REQUEST FOR ACCESS TO INFORMATION AND AMENDMENTS

An Individual has the right to be informed whether iA holds personal information about him and to see that information. The Individual also has the right to enquire as to how iA collected the information, how iA used it and to whom it may have been disclosed.

This information will be provided to the Individual within a reasonable time from the date iA receives the Individual's written request. iA may charge a reasonable fee for processing the Individual's request.

APPENDIX 1 (Continued…)

PRIVACY POLICY FOR iA FINANCIAL GROUP (Continued…)

REQUEST FOR ACCESS TO INFORMATION AND AMENDMENTS (Continued…)

In certain limited and specific circumstances, iA may refuse to provide to the Individual the requested information. Exceptions to the Individual's access right can include information that contains references to other individuals, information that cannot be disclosed for legal, security or commercial proprietary reasons, information that has been obtained in the course of an investigation of a potential breach of contract or fraud, information that is prohibitively costly to provide, and information that is subject to litigation or other privilege.

In cases where iA holds medical information about the Individual, iA may refuse to provide the Individual with direct access to this information and may instead request that a health care professional be designated to provide the information to the Individual.

The Individual may challenge the accuracy and completeness of his personal information. iA will respond to an amendment request within a reasonable time.

Any request for access to information or request for an amendment may be sent to the following address:

Privacy Officer
iA Financial Group
1080 Grande Allée West
PO Box 1907, Station Terminus
Québec (Québec) G1K 7M3
Email: PrivacyOfficer@ia.ca

COMPLAINTS AND CONCERNS

iA's employees and representatives are trained to respond to questions or concerns about personal information. Should an Individual be unsatisfied with an iA employee's or representative's response, the Individual may contact the Privacy Officer at the address mentioned above.

In addition, any complaint concerning the protection of personal information should be addressed to the Privacy Officer.

REVIEW OF THE POLICY

This Policy shall be reviewed every three years. It shall also be reviewed whenever there are substantive changes to legislative or regulatory requirements.

Attached to and forming part of Policy Number

SCHEDULE

Section 1 - Insured Persons - The following persons or categories of persons are Insured Persons under this policy:

Classification of Insured Persons	Name or Category of Insured Persons
Class 1	Full-Time or Part-Time Employees of the Policyholder under age 75 who reside in Canada and are covered under the provincial health insurance plan of their province of Residence.
Class 2	Spouses of Class 1 Insured Persons as elected in the application for insurance submitted by the Participant, who are covered under the provincial health insurance plan of their province of Residence, and for whom the applicable premium has been paid.
Class 3	Dependent Children of Class 1 Insured Persons as elected in the application for insurance submitted by the Participant, who are covered under the provincial health insurance plan of their province of Residence, and for whom the applicable premium has been paid.

Section 2 - Benefits

Classification of Insured Persons	Payment of Benefit
Class 1	If an Insured Person is placed on a surgical/Procedural Waiting List in Canada, We will indemnify or pay benefits for the services described for DSAI under this policy, subject to Pre-Authorization by Us, and the Limitations, Exclusions and other terms and conditions of coverage in this policy. All benefit amounts, Limitations and Exclusions within this policy are in U.S. dollars.
Class 2	If an Insured Person is placed on a surgical/Procedural Waiting List in Canada, We will indemnify or pay benefits for the services described for DSAI under this policy, subject to Pre-Authorization by Us, and the Limitations, Exclusions and other terms and conditions of coverage in this policy. All benefit amounts, Limitations and Exclusions within this policy are in U.S. dollars.

SCHEDULE (Continued…)

Section 2 - Benefits (Continued…)

Classification of Insured Persons	**Payment of Benefit**
Class 3	If an Insured Person is placed on a surgical/Procedural Waiting List in Canada, We will indemnify or pay benefits for the services described for DSAI under this policy, subject to Pre-Authorization by Us, and the Limitations, Exclusions and other terms and conditions of coverage in this policy. All benefit amounts, Limitations and Exclusions within this policy are in U.S. dollars.

Section 3 - Premium - The premium for the initial term of this policy is payable monthly in arrears on or about the 15th day of the following month calculated at the following rates:

Class 1 - $ per Participant per month
Class 2 - $ per Spouse per month
Class 3 - $ per all Dependent Children per month

All premium payments made to the Company will be in lawful Canadian currency.