



Health Insurance

For New International Students



PLEASE READ THIS POLICY CAREFULLY

CONTACT THE 24-HOUR TOLL-FREE EMERGENCY ASSISTANCE NUMBER AT 1-800-995-1662 (NORTH AMERICA) OR COLLECT (416) 340-8444 FOR HOSPITAL ADMISSIONS, OR IF INCAPACITATED, AS SOON AS POSSIBLE.

This insurance is designed to cover losses arising from sudden and unforeseeable circumstances. Coverage is subject to certain limitations and exclusions, including but not limited to a pre-existing conditions exclusion as defined under Definitions and General Exclusions section of this policy.

INSURING AGREEMENT

In consideration of the payment of the premium, the insurer (various underwriters of Lloyd's of London), agrees with the policyholder to reimburse up to the limits detailed in this policy for costs incurred during the policy term subject to all of the exceptions, limitations and provisions of this policy.

Any word explained in the Definitions section herein will have the same meaning throughout this document.

The currency of this policy is expressed in Canadian dollars (CAD).

GEOGRAPHICAL AREA OF COVERAGE

Worldwide

EFFECTIVE DATE AND POLICY TERM

This policy takes effect at 12:01 a.m., local standard time on the date stated on the enrolment form or the date coverage is approved by the insurer and from which date all insurance months shall be calculated. It continues in force for the period for which premium has been paid. Coverage may be renewed subject to approval by the insurer for further consecutive terms, not exceeding 12 months, on payment of premium at the rate and in the amount determined at the time of renewal by the insurer.

ELIGIBILITY

For the purposes of this policy, insured persons shall be considered as those persons who:

1. Are enrolled as a fulltime student, on a fellowship, faculty member, staff member, on foreign assignment at an accredited educational facility;
2. Are under age 65;
3. Are an eligible Dependent;
4. Have been enrolled **under this Policy**;
5. Have paid the required premium or had such premium paid on their behalf by the policyholder;
6. Have requested and received approval for extension of coverage upon termination of assignment and while traveling back to Home Country and have paid premium for this period or have had the premium paid on their behalf.

TERMINATION BY INSURED

The Insured may terminate this contract at any time by giving written notice of termination to the Plan Administrator acting on behalf of the Insurer, or by delivery thereof to an authorized agent (e.g. school or organization). If this Policy is cancelled prior to the Effective Date for medical reasons, the Insured will receive a full refund of premiums paid.

If this Policy is cancelled after the Effective Date, the insurer will refund the premiums paid subject to proof of existing equivalent coverage being in place. Refunds are subject to no claims having been incurred, paid, or pending. A waiting period of 90-days applies to all refunds.

OTHER INSURANCE

If, at the time of loss, the insured person has insurance from another source for benefits provided under this policy, the policy with the earliest effective date will be deemed to be first payor. Any benefits payable by the following shall not be considered as a covered cost under this policy:

- Any group or individual hospital or medical plan.
- Any government hospital or medical plan.
- Any Worker's Compensation Act.
- Any public or tax-supported agency.

DEFINITIONS

Accident: Any sudden and unforeseen event occurring during the policy term, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

Benefits: Any covered expenses/services that the insurer will pay under this policy.

Benefit Maximum: The amount stated as the maximum payable for any particular benefit per policy year, unless otherwise stated.

Claim Administrator: Norfolk International Group Inc.

Corrective Device: A device that is required by You on the advice of a Physician to correct a debilitating physical impairment and without which it would be a physical impossibility for You to continue Your studies or Your teaching responsibilities at the educational institution in which You are enrolled or are teaching. "Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids.

Coverage Period: The period of time during which You are insured for the benefits provided by this Policy, starting from 12:01 a.m. on the Effective Date until 12:00 midnight on the latest of the date (a) specified as the Termination Date on the enrollment form; or (b) of termination of any extension of this Policy. The maximum Coverage Period including extensions is 365 consecutive days from the Effective Date.

Coverage for a maximum of 90 consecutive days is available to Insureds permanently returning to their Home Country or Primary Place Of Residency provided premium has been paid for this term.

Day Patient: A patient who occupies a hospital bed or is charged for a hospital bed.

Deductible: The dollar amount for which the insured person is liable, before any remaining eligible expenses are reimbursed under this policy.

Dependent: wherever used in the Policy means:

- a) The spouse of an Insured Person (but excluding those legally separated), and under the age of 65.
- b) Unmarried children, step-children, foster children and legally adopted children, who are dependant on the Insured Person for support, provided that such children are not less than 15 days old and not more than 18 years old at the date the Policy was purchased (or 24 years old provided it can be proved that the child is continuing in full-time education).

Diagnostic Services: Laboratory tests and x-ray services, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions.

Effective Date: The date you arrive in the location of foreign study or assignment. Coverage is automatically provided to a maximum of 10 days while traveling to location of foreign study or assignment from your Home Country or Primary Place of Residency, or a later date as communicated by Plan Administrator.

Emergency: A sudden and unexpected turn of events or change of condition that requires immediate medical treatment.

Expatriate: A person who leaves his/her home country to reside in a foreign country for which he/she does not hold a valid passport.

Home Country: The country for which the insured person holds a passport. Where the insured person holds more than one passport, the home country will be taken to mean the country that the insured person has declared on the application form.

Hospital: Any medical or surgical institution which is legally licensed in the country in which it is located and whose main activities are not those of a rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident physician.

Hospital Services: Costs for accommodation, nursing, operating theatres, drugs, dressings, diagnostic procedures or any other necessary costs made by the hospital for medical treatment.

Immediate Family Member: Refers to spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandson, granddaughter, grandfather or grandmother of the insured person.

Injury: An unexpected and unforeseen harm to the body caused by an accident occurring while the policy is in force and resulting, directly and independently of all other causes, in the insured person incurring medical expenses.

Inpatient: A patient who occupies a hospital bed for more than 24 hours for medical treatment and for which admission was recommended by a physician or surgeon.

Insured Person/You/Your: An eligible person as defined in the eligibility section of this policy.

Insurer: Certain underwriters at Lloyd's of London, England who provide this insurance.

Maternity Care: Refers to the medically necessary expenses associated with pregnancy and childbirth.

Medical Appliances: Minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, orthotics and the temporary rental of a wheelchair when prescribed by a physician or surgeon.

Medical Assistance Provider: SelectCare.

Medical Expenses: Those medical and related expenses for which coverage is provided under the Major Medical Benefits section of this policy which are necessarily incurred as a result of injury or sickness while coverage is in force under this policy as to the insured person.

Medically Necessary: Those services or supplies which are provided to you that are required to identify or treat your sickness or injury and that are necessary for the relief of acute pain or suffering, or to identify or treat your sickness or injury; or with respect to Hospital services, those which cannot safely be provided to you as an outpatient. This excludes routine or follow-up treatment for any pre-existing medical condition.

Norfolk International Group Inc: The third party administrator and claims administrator appointed by the insurer.

Outpatient: An insured person who receives treatment, including diagnostic services at a hospital, or other medical institution, or at a physician's office, where the insured person is not admitted or confined to a hospital bed as an inpatient or day patient.

Overall Maximum Limit: The total aggregate benefits limit that may be claimed as the result of any injury or sickness by an insured person. Such limit is indicated in the wording of this policy.

Physician or Surgeon: A legally licensed medical practitioner recognized by the law of the country where treatment is provided and who, in rendering such treatment, is practicing within the scope of his/her licensing and training. A physician or surgeon must not be the insured person or an immediate family member of an insured person.

Pre-Existing Medical Condition: Any medical condition for which the Insured sought medical attention, excluding routine check-up, had a change in medication for, or for which symptoms manifested themselves within a period of 90-Days prior to the Effective Date of coverage.

Primary Place of Residency: The location where the Insured maintains a permanent residence that is not located in the Home Country.

Reasonable and Customary Costs: Costs incurred for approved, eligible treatment or supplies that do not exceed the standard costs of other providers of similar standing in the same region, for the same treatment of a similar sickness or injury.

Sickness: Any unexpected and unforeseen illness or disease manifesting itself while this policy is in force as to the insured person and which causes the insured person to incur medical expenses.

Termination Date: The date your coverage under this Policy ends. Coverage ends on the latest of the date and time, (a) the date you request as the end date of your application or (b) the date you permanently return to your home country or (c) for **Insureds permanently returning to their Home Country**, a maximum of 90 consecutive days from the date of return provided premium has been paid to cover this period.

MAJOR MEDICAL BENEFITS

Maximum Limit

Notwithstanding the limits stated in the separate sections of this policy, the overall maximum limit for medical expenses shall not exceed two million dollars (\$2,000,000) per lifetime of an Insured.

Reimbursement is 100% with no deductible.

Hospital Benefits

When, by reason of injury or sickness, an insured person is confined to a hospital, the insurer will pay the reasonable and customary costs for room and board charges (up to semi-private room accommodation), including the costs relating to physicians, surgeons, nursing, operating room, prescription drugs, dressings, diagnostic services, medical appliances, and any other necessary cost made by the hospital for inpatient hospital services, day patient hospital services, as well as costs incurred in an intensive care unit. Insured persons must obtain pre-authorization from Norfolk

International Group Inc. or the medical assistance provider.

Physician's Fees

All Reasonable and Customary Charges made by a Physician for professional services or Medical Treatment.

Medical, Surgical and Diagnostic Services

When by reason of injury or sickness, an insured person incurs expenses for any of the following while under the regular care and attendance of a physician or surgeon, the insurer will pay the reasonable and customary costs incurred for the following:

Corrective Devices. A device that is required by you on the advice of physician to correct a debilitating physical impairment and without which it would be a physical impossibility for you to continue your studies or your teaching responsibilities at the educational institution in which you are enrolled or are teaching. "Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids.

Diagnostic, X-Ray, and Laboratory Services. X-Ray or Laboratory examinations under the attendance or supervision of a physician or surgeon for diagnostic services. Laboratory and x-ray services must be provided by or ordered by a physician. This policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans for reasons considered non-emergency unless such services are pre authorized and arranged in advance by the insurer.

Prescription Medication. Limited to a 60-day supply of any one type per policy year unless prescribed while a Hospital in-patient.

Medical Equipment and Supplies. (Payable only if required as the result of a covered Sickness or Injury). Purchase of medical supplies, including dressings and prosthetic appliances. When required as the result of a covered Sickness or Injury only, up to \$350 for prescription glasses or contact lenses or up to \$500 for hearing aids. Rental charges for wheelchairs, crutches, Hospital-type bid or other appliances, not to exceed the purchase price.

Emergency Transport. The full cost of licensed ambulance service to the nearest Hospital when Medically Necessary. Emergency transfers between Hospitals when ordered by the attending Physician, including user fee; OR, taxi fare to or from a hospital or medical clinic for eligible medical care to a maximum of \$100.

Emergency Dental Care. Pays up to \$600 reimbursement for the immediate relief of acute dental pain caused by other than a blow to the face. All treatment must be initiated within 48 hours from the time the Emergency began and must be completed no later than 90-days after treatment began assuming coverage is in force during the treatment period Dental conditions for which the Insured has previously received treatment or advice are not covered.

Accidental Dental Care. Up to \$2500 for Emergency dental care treatment to repair or replace natural or permanently attached artificial teeth as the result of any Injury caused by an Accidental blow to the mouth. Up to \$500 for emergency repairs to artificial teeth including bridges and denture plates. Treatment must take place within 90 days of the Accident. Expenses incurred as a result of chewing Accidents or Injury due to placing an object to or in the mouth are not payable.

Eye Exams. Reasonable and Customary charges for one non-emergency eye exam performed by a licensed Optometrist per 365-day period. Note: *The costs of glasses or contact lenses are NOT covered unless required as per the Medical Equipment and Supplies Benefit, above.*

Paramedical Services. The services of a registered massage therapist, chiropractor, physiotherapist, osteopath, naturopath, speech therapist, podiatrist or

acupuncturist up to a maximum of \$1,000 per profession per policy year per Insured.

Psychiatric Care. Up to \$25,000 for the services of a Psychiatrist while hospitalized as an inpatient due to an emotional disorder.

Psychologist, psychiatrist, counselor **covered** to a combined maximum of \$2500 per policy year per Insured on outpatient basis

Private Duty Nursing Care. Up to \$5,000 for the services of a Registered Nurse, Registered Nurse Assistant or Home Care Worker when ordered by the attending Physician.

HIV/AIDS Coverage. Expenses incurred as a result of a positive HIV, AIDS, or ARC diagnosis, that was diagnosed after coverage commenced, will be covered to a lifetime maximum of \$10,000. Urgent or emergency Injuries or Sicknesses will be paid under the overall Policy maximum benefits as acute, medically necessary treatments. Expenses incurred as a result of a diagnosis of HIV, AIDS/ARC that occurred prior to becoming insured under this policy are not covered.

Annual Physician Visit. When a minimum of 6 months coverage has been purchased, Insurer will pay up to \$100 for one visit to a General Practitioner (Physician) during the policy year for a non-emergency exam and associated tests.

Your insurance also covers;

Trauma Counseling. If a Insured suffers a covered loss listed in the Schedule of losses, (other than loss of life) within 90 days from the date of an accident which occurred during the coverage period, the Insurer will pay up to six sessions of trauma counseling by a registered Psychologist when ordered by the attending physician.

Returning Insured Benefit. Coverage for a maximum 90 days is available to Insureds permanently returning to their Home Country provided premium has been paid for this period.

The following benefits are covered with the prior approval from the SelectCare. The maximum amount payable for the following Transportation benefits cannot exceed \$1,000,000 in total per Coverage Period.

- **Air Evacuation.** The cost of transporting You to the nearest hospital or to a Hospital in Your Home Country, if Medically Necessary, either:
 - a) as a stretcher fare in a regular flight, including economy return fares for qualified medical attendants (not a relative) and their associated fees and expenses; or
 - b) an appropriately equipped air ambulance, including associated fees and expenses for a qualified crew.

Land ambulance costs at each end of the flight or connecting flights are included. The attending Physician must certify that the Insured is medically fit for the type of transfer selected.

- **Family Transportation and Subsistence Allowance.** If You have no family members within 500 kilometers of Your location while You are outside Your Home Country and You are Hospitalized and Your Hospitalization is expected to last a minimum of 7 days or in the event of the death of the Insured. The Insurer will pay up to a combined maximum of \$7500 towards the cost of round-trip transportation based on the lowest available fare for the most direct route for two (2) persons nominated by You to travel to Your bedside, as well as for commercial accommodation and meals for a maximum period of 7 days for these two (2) persons. The attending Physician must certify that the situation is serious enough to warrant the visit. Submit all bills and receipts to the Claim Administrator.

- **Repatriation or Burial of Deceased.** If death occurs during the Coverage Period as a result of a covered Injury or Sickness, Insurer will pay either (a) up to \$12,500 towards the reasonable and necessary costs for the preparation and return of the Insured's remains to the Insured's Home Country in a standard transportation container or (b) up to \$10,000 for the cost of preparing the remains, cremation or burial, and a burial plot in the location where death occurs. The costs for a coffin, urn, headstone or funeral are excluded. In the event of death by suicide the maximum payable by the Insurer will be 50% of above stated maximums.
- **Return Home:** If in the event of Emergency Sickness or Injury of the Insured which necessitates the return home of the Insured for immediate medical attention, the Insurer will reimburse the actual extra cost of a one-way economy airfare by the most direct route, for the Insured to return to Insured's Home Country, to a maximum of \$5000.
- **Costs of Returning Home due to Family Emergency.** If the Insured must unexpectedly return Home due to the fact that an immediate member who is not traveling with the insured has died, or is hospitalized for a serious illness, the Insurer will pay up to a lifetime maximum of \$2,500 towards the cost of round-trip transportation based on the lowest available fare for the most direct route to the location nearest the institution where the family member is being held. Insurer will also pay up to lifetime maximum of \$1,000 for commercial accommodation and meals for the Insured. This Return Home benefit must occur within the Coverage Period.

GENERAL EXCLUSIONS

This policy does not cover expenses caused or contributed to directly or indirectly by:

1. Elective or Non-Emergency Medical Treatment, including any treatment given to maintain the stability of a chronic sickness or condition, including the refill of medication, tests or examinations forming part of a normal regime, or treatment not required for the immediate relief of pain and suffering, or that could reasonably be postponed until the Insured returns to his/her Home Country (except as provided under the Annual Physician Visit benefit).
2. Any continuing treatment of an Injury or Sickness if the Claim Administrator has requested that the Insured return to his or her Home Country following Emergency Medical Treatment;
3. Medication commonly available without a prescription; contraceptives, vaccinations or injections; vitamin preparations; or medication received on a preventive basis, except as provided under the HIV/AIDS Coverage Benefit;
4. The Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency HIV/AIDS Coverage Benefit, except as provided under the HIV/AIDS benefit;
5. Air travel, other than as a passenger in a certified commercial aircraft that provides passenger service and complies with government regulations concerning pilot licensing and current certificates of airworthiness;
6. Active participation in war or any act of war, or while participating in any armed forces training exercises or manoeuvre; radioactive contamination or committing or attempting to commit any criminal act;
7. Intentionally self-inflicted injury, suicide or self-destruction or any attempt (while sane or insane);
8. Mountaineering, scuba diving, rock or precipice climbing, hang gliding, paragliding, sport parachuting, sky diving, athletic or sports

- activities for remuneration or prize money, or while riding or driving in or on any motorized vehicle or device in any race of speed contest;
- 9. Misuse of medication, use of intoxicants or illegal drugs, or treatment thereof or accidents related thereto;
- 10. Any prescription medication classified as a Life Style drug;
- 11. Injuries received when the insured person's blood contains more than 80 milligrams of alcohol per 100 milliliters of blood or in the absence of a specific measurement the professional opinion of the attending physician;
- 12. Examinations by, or the services of, a physician if required solely for the use of a third party;
- 13. Any claim arising from a trip or assignment undertaken outside the location of foreign residency for the purpose of securing treatment or therapy unless pre-approved by the insurer;
- 14. Persons age 65 or over;
- 15. Any costs incurred during any period for which the appropriate premium has not been paid or while the policy is not in force as to the insured person;
- 16. Traveling contrary to the medical advice of a Physician or Practitioner or for the purpose of obtaining Medical Treatment or when a terminal prognosis was given to the Insured prior to the Coverage Period;
- 17. Routine treatment or follow-up of any pre-existing medical condition; and,
- 18. Pregnancy, miscarriage, childbirth or termination of pregnancy or expenses relating thereto.

This policy also includes the following clauses/endorsements:

LIMITED WAR EXCLUSION CLAUSE

Notwithstanding anything to the contrary contained herein, this insurance does not cover loss consequent on:

- war, whether declared or not, between any of the following countries, namely, China, France, the United Kingdom, the Russian Federation and the United States of America, or
- war in Europe, whether declared or not, other than:
 - civil war,
 - any enforcement action by or on behalf of the United Nations, in which any of the countries stated in above or any armed forces thereof are engaged.

NUCLEAR, CHEMICAL, BIOLOGICAL TERRORISM EXCLUSION

Notwithstanding any provision to the contrary within this insurance or any endorsement thereto it is agreed that this insurance excludes any losses, directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of nuclear, chemical, biological terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement:

"*Nuclear, chemical, biological terrorism*" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical agent and/or biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

"*Chemical*" agent shall mean any compound, which, when suitably disseminated, produces incapacitating,

damaging or lethal effects on people, animals, plants, or material property.

"Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause illness and/or death in humans, animals or plants.

PROCEDURES APPLICABLE TO MEDICAL CLAIMS

The Insurer will pay Benefits provided that:

- 1. the Insured Person has contacted and received Pre-Authorization of any costs to be incurred as either a Day-Patient or an In-Patient. In an emergency when the claims administrator cannot be contacted in advance, then the admission to Hospital must be reported as soon as reasonably possible;
- 2. written details of all claims have been sent to the claims administrator as soon as possible and in any event not later than 365 days from the beginning of the Medical Treatment;
- 3. all documentation relating to the claim including the claim form and accounts are originals and not copies; and
- 4. the required premiums have been paid relative to the Insured Person making the claim.

It is understood that:

- 1. the insurer can ask for medical information from any Physician or Surgeon as often as required and if necessary examine the Insured Person; and
- 2. the insurer shall be notified of any circumstances that may lead to a claim against a third party or any other insurance; and
- 3. in the case of a claim in the Insured Person's Home Country, proof of the Insured Person's entry date into their Home Country is provided.

All pertinent information shall be sent to:

Norfolk International Group Inc.
Suite 1100, 940 – 6 Ave. SW
Calgary, AB
T2P 3T1

IN A MEDICAL EMERGENCY CONTACT:

SelectCare Risk Management Corp.

SelectCare

24-Hour Emergency Number

IDENTIFICATION NO. GFRW1062

From all countries other than Canada and United States

Call Collect: (416) 340-8444

From Canada and United States Call: 1-800-995-1662

The following information will have to be provided at the time of the phone call:

- Caller's name, telephone number and relationship to the patient.
- Patient's name, age, sex, and location.
- SelectCare identification number (GFRW1062).
- Nature of medical problem.
- Telephone numbers of medical personnel involved.
- How and when the next communication will take place.

IMPORTANT

In order for medical evacuation expenses to be covered by the program, you must have SelectCare either authorize or arrange the trip.

All admissions to Hospital must also be handled through SelectCare. Failure to contact SelectCare in the event of hospitalization will affect settlement of your claim.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Benefits

The principal sum is \$50,000

Aggregate Limit of Liability: \$5,000,000

The insurer shall not be liable for any amount in excess of the above stated aggregate limit of liability.

If the aggregate amount of all indemnities otherwise payable by reason of coverage provided under this policy exceeds such aggregate limit of liability, the insurer shall not be liable as respects each insured for a greater proportion of the indemnity otherwise payable than the aggregate limit of liability bears to the aggregate amount of all such indemnities.

Eligibility

As outlined in this policy with the exception that dependants of the insured employee are not eligible for AD&D benefits.

Coverage

If such injuries shall result in any one of the following specific losses within one year from the date of accident, the insurer will pay the benefit specified as applicable thereto, based upon the principal sum stated in the insured person's application provided, however, that not more than one (the largest) of such benefits shall be paid with respect to all injuries resulting from one accident.

Loss of LifeThe Principal Sum
Loss of Both Hands or Both Feet.....The Principal Sum
Loss of Entire Sight of Both Eyes.....The Principal Sum
Loss of One Hand and One Foot.....The Principal Sum
Loss of One Hand and Entire
Sight of One Eye.....The Principal Sum
Loss of One Foot and Entire
Sight of One Eye.....The Principal Sum
Loss of Speech and Hearing.....The Principal Sum
Loss of Use of Both Arms
or Both Hands.....The Principal Sum
Quadriplegia.....The Principal Sum
Paraplegia.....The Principal Sum
Hemiplegia.....The Principal Sum
Loss of One Arm
or One Leg.....Three Quarters of The Principal Sum
Loss of Use of One Arm
or One Leg.....Three Quarters of The Principal Sum
Loss of One Hand
or One Foot.....Two Thirds of The Principal Sum
Loss of Entire
Sight of One Eye.....Two Thirds of the Principal Sum
Loss of Use of
One Hand.....Two Thirds of The Principal Sum
Loss of Speech
or Hearing.....Two Thirds of The Principal Sum
Loss of Thumb and Index Finger
of Same Hand.....One Third of The Principal Sum
Loss of Four Fingers
of Same Hand.....One Third of The Principal Sum
Loss of Hearing
in One Ear.....One Quarter of The Principal Sum
Loss of All Toes
of Same Foot.....One Eighth of The Principal Sum

"Loss" shall mean:

- With respect to hand or foot, the actual severance through or above the wrist or ankle joint;
- With respect to arm or leg, the actual severance through or above the elbow or knee joint;
- With respect to eye, the total and irrecoverable loss of sight;

- With respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree;
- With respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid of device;
- With respect to thumb and index finger, the actual severance through or above the first phalange;
- With respect to fingers, the actual severance through or above the first phalange of all four fingers of the same hand;
- With regard to toes, the actual severance of both phalanges of all toes of the same foot.

"Loss" as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs.

"Loss of use" shall mean the total and irrecoverable loss of function of an arm, hand or leg, provided such loss of function is continuous for twelve consecutive months and such loss of function is thereafter determined on evidence satisfactory to the Insurer to be permanent.

Exposure and Disappearance

Loss resulting from unavoidable exposure to the elements and arising out of hazards described above shall be covered to the extent of the benefits afforded an insured person.

If the body of an insured person has not been found within one year of the disappearance, stranding, sinking or wrecking of the conveyance in which the insured person was riding at the time of the accident, it shall be presumed subject to all other conditions of the policy, that the insured person suffered loss of life resulting from bodily injuries sustained in the accident and covered under this policy.

PROVISIONS

Notice of Claim: Written notice of claim must be given to the insurer within 30 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice by or on behalf of the claimant to the insurer or to any authorized agent of the insurer, with information sufficient to identify the insured person, shall be deemed notice to the insurer.

Claim Forms: The insurer, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Time of Payment of Claim: Indemnities payable under this policy will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims: Indemnity for accidental loss of life will be payable to the beneficiary of record in a lump sum. The lump sum payment will be made immediately upon receipt of the required proofs of claim.

If, at the death of the insured person, there is no surviving beneficiary, the accidental loss of life

indemnity shall be payable in one sum to the estate of the insured person.

All other indemnities will be payable to the insured person.

Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the body of any insured person whose injury is the basis of claim when and as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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 the requirements of this policy. No such action shall be brought after the expiration of three years (or the minimum time, if more than three years, permitted by law in the province where the insured person resides) after the time written proof of loss is required to be furnished.

Designation or Change of Beneficiary: Subject to any statutory restrictions, an eligible insured person may designate a beneficiary to receive death benefits payable under this policy or may change any beneficiary already appointed, by filing written notice. No designation or change of beneficiary under the policy shall be binding upon the insurer until the original letter of beneficiary designation, or a duplicate thereof, is received by the designated custodian of beneficiary records. No assignment of interest shall be binding upon the insurer until the original letter of assignment, or a copy thereof, is received by the insurer. The insurer assumes no responsibility for the validity or legal sufficiency of such designation or change of beneficiary assignment.

Conformity with Provincial Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the province where this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such province.

Workers' Compensation Laws: This policy is not in lieu of and does not affect any requirements for coverage under any Workers' Compensation Law.

GENERAL PROVISIONS AND LIMITATIONS

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

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 signed by the Insurer.

Premium Payment. The full premium is due and payable when You apply for insurance. If for any reason the premium paid for the coverage applied for is incorrect, the insurer will a) charge and collect the difference, or b) shorten the Coverage Period if an underpayment in premium cannot be collected, or c) refund any overpayment. Coverage will be null and void if for any reason the financial institution does not honor Your payment. The premium is calculated using the most current premium rates on the date You apply for coverage, and Your age and the Effective Date. We reserve the right to decline any application for insurance.

Arbitration. Any differences with respect to medical opinion will be settled between two medical experts appointed by the two parties. This dispute resolution will be in writing. Any differences of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts.

Legal Proceedings. No legal proceedings shall be commenced until 60 days after a claim had been correctly submitted and no such action shall be brought unless commenced within three years from the first date of treatment.

The Laws of Canada and the province of Alberta govern this policy and any dispute arising out of this Policy shall be settled in the courts of Alberta.

Misrepresentation and Fraud. All benefits under this policy shall be voidable if the insurer determines, whether before or after the loss, the insured Person has concealed or misrepresented any material fact or circumstance concerning this policy or his/her interest therein, or in the case of fraud or false swearing by you or if you refuse to disclose information or permit the use of such information, pertaining to any of the insured Persons under this policy. The completed and signed application form is the basis of and forms part of this policy and any erroneous responses therefore constitute material misrepresentation. Any claim to which any concealed or misrepresented material fact or circumstance pertain shall not be payable under this policy and you shall be solely responsible for all expenses relating to your claim, including emergency medical evacuation costs.

Payment of Benefits. The claims administrator will, on behalf of the insurer, make payment to the insured person or legal representative or directly to the provider of treatment or services. Payment will be made in Canadian currency.

Refunds. Refunds are calculated on a pro-rata basis from the date postmarked on Your written request or on the date such fax or e-mail request is received by the Plan Administrator and are subject to a minimum refund amount of \$10.

Pre-Authorization. All inpatient and day patient hospitalizations and special outpatient Services must be pre-authorized and arranged in advance by Norfolk International Group Inc. or the medical assistance provider.

Termination by Insurer.

- 1) The Insurer may terminate this contract at any time by giving a minimum of 30-days written notice of termination to the Insured .
- 2) The notice of termination may be mailed to the Insured, or sent by fax or email, or where another party or agent has sent the enrolment, that party or agent may be notified by mail, fax or e-mail.
- 3) Termination would be effective the end of the current term for which premium has been paid.

Policy Extensions. The maximum Coverage Period available under this Policy is 365 consecutive days from the Effective Date. Any request for policy extension must be made to the Plan Administrator prior to the Termination Date of Your existing coverage. Coverage for this Policy extension will be void from inception if Your financial institution does not honor payment.

Insureds returning to their home country permanently can continue to be covered under the policy for a period of up to 90 consecutive days, provided the required premium is paid prior to the departure of the insured person. The insurer shall have no liability for

any claim incurred where the required premium has not been paid.

Automatic Continuation of Coverage. If the Insured is unavoidably delayed for a reason in no way attributable to the Insured, beyond the end of the Coverage Period, this Policy will automatically remain in effect at no extra premium for a period not to exceed:

- a) 72 hours, if delayed while traveling as a fare paying passenger in a licensed public conveyance or by private vehicle and the delay is caused by mechanical breakdown, a traffic Accident or inclement weather; or
- b) the period of confinement as an in-patient in a Hospital OR the period during which You are unable to travel on medical grounds acceptable to the Claim Administrator. Following discharge from Hospital or following medical approval to travel, an additional 72-hour extension will be granted.

Subrogation

If an insured person suffers a loss covered under this policy, the insurer is granted the right from the insured person to take action to enforce all the rights, powers, privileges and remedies of the insured person, to the extent of benefits paid under this policy, against any person or organization which caused such loss. Additionally, if no fault benefits or other collateral sources of payment of expenses are available to the insured person, regardless of fault, the insurer is granted the right to make a demand for, and recover those benefits. If the insurer institutes an action, the insurer may do so at its' own expense, in the insured person's name, and the insured person will attend at the place of loss to assist in the action. If the insured person institutes a demand or action for a covered loss he or she shall immediately notify the insurer so that it may safeguard its' rights. The insured person shall take no action after a loss that will impair the rights of the insurer.

Statutory Conditions

The application, the policy, any document attached to the policy when issued, and any amendment to the contract agreed upon in writing after the policy is issued, constitute the entire contract. Any provision of the policy, which, on its effective date, is in conflict with the statutes of the jurisdiction in which the policy was issued, is hereby amended to conform to the minimum requirements of such statutes.

Identification of Insurer/Action Against Insurer

This insurance has been effected in accordance with the authorization granted to the undersigned by certain underwriters at Lloyd's, whose definitive members and proportions underwritten by them can be ascertained by reference to this policy which bears the seal of Lloyd's Policy Signing Officer and has been certified by the Underwriter's Attorney In Fact in Canada and may be seen at the office of the undersigned. The underwriters identified in the said contract shall be liable hereunder each for his own part and not one for another in proportion to the several sums by each of them subscribed to the said contract.

ANNEX B – LLOYD’S POLICYHOLDERS’ COMPLAINT PROCEDURE

Should a policyholder wish to file a complaint relative to a Lloyd’s policy effected through a correspondent, the policyholder must be provided with the following Lloyd’s Complaint Protocol:

HOW TO MAKE A COMPLAINT

If you have a complaint with any aspect of your Lloyd’s Insurance, please refer to the broker/agent who arranged your policy for you.

If you are not satisfied, please submit your written complaint to:

Lloyd’s Canada Inc.
Broker & Management Services
1155 rue Metcalfe, Suite 1540
Montreal, Quebec H3B 2V6

Tel: 1-877-4LLOYDS
Fax: (514) 861-0470
Email: lineage@lloyds.ca

Your written complaint will be forwarded to Lloyd’s Complaints Department in London, which ensures that Lloyd’s Underwriters and their representatives deal with claims and complaints in an acceptable manner. It acts as an impartial mediator. When undertaking a review, this Department takes account of general legal principles, good insurance practice, and whether all events surrounding a given case have been considered fairly.

RESIDENTS OF ONTARIO

You may avail yourself of the services of the Insurance Ombudsman by requesting a letter from the broker/agent who arranged your policy for you (stating their final position on your complaint) and forwarding this letter along with your written complaint to:

Insurance Ombudsman
Financial Services Commission of Ontario
Box 85, 5160 Yonge Street
North York, Ontario M2N 6L9
Fax: (416) 590-8480

PRIVACY GUIDELINES

Norfolk International Group Inc., recognize and respect every individual’s right to privacy. When you apply for coverage or submit a claim, we establish a confidential file of personal information.

We use the information to administer the individual benefit plan under which you are covered. This includes many tasks, such as:

- Determining your eligibility for coverage under the plan
- Enrolling you for coverage
- Assessing your claims and providing you with payment
- Managing your claims
- Verifying and auditing eligibility and claims
- Underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- Preparing regulatory reports, such as tax slips

We limit access to information in your file to Norfolk International staff or persons authorized by Norfolk International Group who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Norfolk International Group, your health care provider, other insurance and reinsurance companies, and your plan administrator may also exchange information when the information is needed to administer the group benefit plan.