

# TIPS VISITORS TO CANADA EMERGENCY MEDICAL INSURANCE POLICY

## IMPORTANT NOTICE

When reading through this **Policy**, bold capitalized words are defined terms whose definition appears in the definitions section of the **Policy**.

- This **Policy** is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that **You** read and understand **Your Policy** upon receipt as **Your** coverage is subject to certain limitations, conditions or exclusions.
- **Pre-existing Condition** exclusions apply to **Medical Conditions** and/or symptoms that existed prior to **Your Period of Coverage**. Check to see how these apply and how they relate to **Your Effective Date**.
- In the event of an **Injury** or **Sickness**, prior medical history will be reviewed when a claim is reported.
- This **Policy** provides travel assistance and **You** are required to notify the **Emergency Assistance Provider** prior to **Treatment**. This **Policy** limits benefits should **You** not contact the assistance provider within the specified time period.

## 10 DAY RIGHT TO EXAMINE

Please take the time to read **Your Policy** and review all of **Your** coverage. If **You** have any questions **You** may contact **Your** agent, **You** may cancel this **Policy** within **10 days** of purchase for a full refund provided it is prior to **Your Period of Coverage**.

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## WHAT DOES THIS POLICY COVER?

This **Policy** covers only the specific situations, events and losses mentioned in this document and only under the conditions **We** describe.

Make sure **You** check **Your Policy Confirmation** to confirm **Your** benefits, coverage and limits.

Coverage under this **Policy** is secondary to all other sources of recovery. Any benefits payable under this **Policy** are in excess of any other coverages **You** may have with any other insurance company or any other source of recovery.

## SCHEDULE OF MAXIMUM BENEFITS

	Sum Insured
Emergency Hospital and Medical	Plan Purchased Limit
Medical Evacuation/ Emergency Return Home	\$10,000
Cremation/Burial at Destination	\$1,500
Accommodation & Meals	Included
Travel Assistance	

## ELIGIBILITY REQUIREMENTS

### Who Is Eligible for Coverage?

All of the following restrictions apply:

- **You** must not have a **Medical Condition** for which a **Physician** has advised **You** against travel prior to **Your Effective Date**.
- **You** must not have been diagnosed with a **Terminal Sickness** prior to **Your Effective Date**.
- **You** must not be eligible for benefits under any Canadian federal, provincial or territorial government health insurance plan.
- **You** must be over **14 days old** and under **85 years** of age during the entire **Period of Coverage**.
- **You** do not reside in a nursing home, assisted living home, convalescent home, hospice or rehabilitation centre.
- **You** do not require any assistance with **Normal Daily Activities**.

If **You** do not meet these eligibility requirements, **Your** insurance is void and the **Company's** liability is limited to a refund of the premium paid.

## PERIOD OF COVERAGE

### Effective Date - When Coverage Begins

Coverage under this **Policy** begins on the earliest of the following:

- a) the date of **Your** arrival in Canada, if **You** purchased the coverage before that date; or
- b) **48 hours** after the date and time of purchase if **You** purchase this insurance after arrival in Canada.

### When Coverage Ends

**Your Coverage** ends on the earliest of the following events:

1. When **You** cancel **Your** insurance;
2. The date **You** become eligible for coverage under any Canadian federal, provincial or territorial government health insurance plan;
3. The **Expiry Date** as shown on **Your Policy Confirmation**; or
4. On the date **You** return to **Your Home Country**.

**You** must incur the **Emergency** medical expenses in Canada. However, coverage under this **Policy** includes the **Emergency** medical expenses **You** incur during any side trip outside of Canada during **Your Period of Coverage** if the side trip begins in Canada. **Your** accumulated stay in Canada during the **Period of Coverage** must be greater than the accumulated length of time **You** spend on **Your** side trips outside Canada. The maximum duration of any side trip outside of Canada cannot exceed **30 days** in duration. No coverage is allowed in **Your Home Country**.

### Automatic Extension of Coverage

**Your** insurance will automatically be extended beyond **Your Expiry Date** as shown on **Your Policy Confirmation** if:

1. **Your** scheduled **Common Carrier** is delayed, coverage will be extended for up to **72 hours**; or
2. **You**, **Your Travelling Companion**, or a **Family Member** travelling with **You** are hospitalized on or prior to **Your Expiry Date**. Coverage will be extended for the duration of the **Hospital** stay and for up to **5 days** after discharge from the **Hospital** while outside **Your** country of residence; or
3. **You**, **Your Travelling Companion**, or a **Family Member** travelling with **You** are unable to travel due to a medical reason that does not require hospitalization. Coverage will be extended for up to **3 days** and must be documented by a **Physician** at **Your** destination.

## Extending Coverage After Departure

If **You** decide to extend **Your Period of Coverage** after departure contact **Your** agent.

**We** will extend **Your Coverage** under this **Policy** beyond **Your Expiry Date**, as long as:

1. **You** have not experienced an **Injury** or **Sickness**, or have not had medical **Treatment** during **Your Period of Coverage**;
2. Coverage under this **Policy** is in force at the time **You** request an extension;
3. **You** pay any additional required premium for such extension.

In all other circumstances, coverage may be extended beyond the above time frames, but only at the **Company's** discretion. In no event shall coverage be extended for a period exceeding **12 months** from **Your** original **Departure Date**.

Failure to make medical information known will render this coverage extension null and void.

## How Do You Become Insured

**You** become insured and this brochure becomes an insurance **Policy**:

- When **You** are named on a completed insurance **Policy Confirmation**; and,
- When **You** pay the required premium on or before **Your** coverage **Effective Date**.

## TRAVEL ASSISTANCE

### When It Applies

If **You** require **Emergency** medical care during **Your Period of Coverage**.

### What We Provide - 24/7

#### A. MEDICAL ASSISTANCE

1. Worldwide multi-lingual medical and dental referrals. If **You** need care from a **Physician**, dentist or medical facility while **You** are travelling, **We** can help **You** find one.
2. Advance payment to **Hospital**. We will provide advance payment to a **Hospital** if it is required to secure **Your** admission for a covered **Sickness** or **Injury**.
3. Monitoring of **Treatment**. If **You** are hospitalized, **Our** medical staff will stay in contact with **You** and the **Physician** caring for **You**. **We** can also notify **Your** family and **Your** doctor back home of **Your Sickness** or **Injury** and update them on **Your** status.
4. Transfer of insurance information to medical providers. If **You** require medical **Treatment** for an **Injury** or **Sickness**, **We** will provide the emergency medical providers with any coverage information that they require.
5. Vaccine and blood transfers. If required, **We** will coordinate the transfer of required blood or vaccine to **You**.
6. Dispatch of doctors and specialists. If **You** need the care of a **Physician** or specialist, **We** will coordinate the appropriate dispatch.
7. Transfer of medical records. If and when required for **Emergency Treatment**, **We** will coordinate the transfer of medical records and related information to the treating **Physician**.
8. Updates to family, employer and home **Physician**. If **You** are hospitalized, **We** will provide appropriate medical condition updates to **Your** family, employer and/or personal doctor.

#### B. MEDICAL EVACUATION AND REPATRIATION SERVICES

All evacuation and repatriation services must be pre-approved and arranged by **Us**.

1. **Emergency** medical evacuations. If **Our** medical team and the local **Physician** caring for **You** agree that the local care facility cannot treat **Your Sickness** or **Injury**, **We** will provide transport and any necessary accompaniment to transfer **You** to the nearest appropriate facility.
2. Transportation of someone to join **You** if **You** are hospitalized. If **You** are hospitalized for an **Emergency Sickness** or **Injury**, **We** will arrange for the economy class round-trip ticket to bring a friend or Family Member to **You** if **You** are alone and a doctor recommends that someone travel to join **You**.

3. Transportation after stabilization. Once **You** are medically stable to return home, **We** will arrange for the cost of a one way **Fare** to get **You** home (less any refunds from **Your** unused return trip tickets).
4. Repatriation of mortal remains. **We** will reimburse the cost of reasonable and necessary services to transport **Your** remains to **Your** place of residence.

## What Happens When You Call For Assistance

- **You** will be referred to the most appropriate service provider for **Your** situation.
- **We** will confirm that a **Policy** has been issued.
- Prior to receiving all relevant medical information, **We** will handle **Your Emergency** assuming **You** are eligible for benefits under this **Policy**. If it is later determined that a **Policy** exclusion applies to **Your** claim, **You** will be required to reimburse **Us** for any payments **We** have made on **Your** behalf
- **You** will be reminded that any services rendered are subject to the terms and conditions of this **Policy**. If it is later determined that a **Policy** exclusion applies to **Your** claim, **You** will be required to reimburse **Us** for any payments **We** have made on **Your** behalf.
- Where a claim is payable **We** will arrange, to the extent possible, to have any medical expenses billed directly to the **Company**.

## What To Do When You Need Assistance

Have **Your Policy** number or confirmation of coverage with **You** at all times. Contact **Our** assistance provider at the telephone numbers listed below. Access is available **24 hours per day, 365 days per year** at the following numbers. If **You** cannot successfully place a collect call to the **Emergency Assistance Provider** as instructed below, please dial direct and submit the charges incurred to make the call along with **Your** claim documents.

USA & Canada	1-800-334-7787
Elsewhere Operator Assisted Collect	905-667-0587
Direct Dial	1-905-667-0587

Email: [assistance@oldrepublicgroup.com](mailto:assistance@oldrepublicgroup.com)

When contacting **Our** assistance provider, please provide **Your** name, **Your** policy number, **Your** location and the nature of the **Emergency**.

## Limitation on Emergency Assistance Provider Services

The **Company** and/or the **Emergency Assistance Provider** reserve the right to suspend, curtail or limit services in any area or country in the event of:

- rebellion, riot, military uprising, war; or
- labour disturbances, strikes; or
- nuclear **Accidents**, acts of God, or refusal by the authorities in the country where assistance is required, to permit the delivery of such services.

The **Emergency Assistance Provider** will use its best efforts to provide the required services during any such occurrence.

The **Emergency Assistance Provider's** obligation to provide services described in this **Policy** is subject to the terms, conditions, limitations and exclusions set out in this **Policy**. The medical professional(s) suggested or designated by the **Company** or the **Emergency Assistance Provider** to provide services according to the benefits and terms of this **Policy** are not employees of the **Company** or the **Emergency Assistance Provider**. Therefore, neither the **Company** nor the **Emergency Assistance Provider** shall be held responsible or liable for any negligence or other acts or omissions on their part, nor for the availability, quality, quantity or results of any medical **Treatment** or service **You** may receive or **Your** failure to obtain or receive any medical **Treatment** or service.

# EMERGENCY MEDICAL

## Plans Available

Age Availability	Length of Period of Coverage	Limits of Coverage By Plan
Ages 14 days to 69 years	Over 7 days up to 365 days	Plan I = \$50,000 Plan II = \$100,000 Plan III = \$150,000
Ages 70 years to 84 years	Over 7 days up to 365 days	Plan I = \$50,000 Plan II = \$100,000

## When It Applies

If **You** experience a medical **Emergency** during **Your Period of Coverage**.

## What We Cover

The eligible **Emergency** medical expenses that **We** cover are listed as follows:

1. **Emergency Medical Expenses:** as listed below and ordered or prescribed by a **Physician** as **Medically Necessary** for diagnosis or **Treatment of Your Emergency Sickness or Injury**:
  - a) the services of a **Physician**, surgeon or in-**Hospital** duty nurse;
  - b) **Hospital** accommodation for recovery of an **Injury or Sickness**;
  - c) transportation furnished by a professional ambulance company to and from a **Hospital**;
  - d) diagnostic laboratory procedures, subject to prior approval by **Us**;
  - e) medical equipment purchased or rented for therapeutic purposes subject to prior approval by **Us**;
  - f) prescription medications required to treat an **Emergency Medical Condition or Injury**, which are prescribed by a **Physician** and dispensed by a licensed pharmacist.
  - With respect to **Emergency** medical expenses described above, **You** or someone acting on **Your** behalf are required to immediately contact the **Emergency Assistance Provider** at the telephone numbers provided on page 4 of this **Policy** before admission to **Hospital** or within **24 hours** after a life or organ-threatening **Emergency**. Failure to do so will result in **You** being responsible for **30%** of any eligible expenses incurred.
2. **Emergency Return Home:** if **You** have a medical **Emergency**, the **Company**, in consultation with its medical advisors, the **Emergency Assistance Provider** and the local attending **Physician**, may determine that **You** should be transported back to **Your Home Country** for continued **Treatment**. The **Company** will then arrange transportation along with proper medical supervision, and the **Company** will pay, up to the maximum amount stated below for the **Plan You** purchased, the following expenses:
  - a) the extra cost of a one way **Fare** on a commercial airline by the most direct route back to **Your Home Country**; or
  - b) the cost to accommodate a stretcher to transport **You** on a commercial airline by the most direct route back to **Your Home Country**, if a stretcher is **Medically Necessary** plus the cost of a round-trip **Fare**, reasonable meal and overnight accommodation expenses and professional fees for the services of a qualified medical attendant (other than a **Family Member**) to accompany **You**, when an attendant is **Medically Necessary** or required by the airline; or
  - c) the cost for air ambulance transportation when **Medically Necessary**.
  - The amount payable under this benefit for **Emergency Return Home** expenses is limited to an aggregate maximum of **\$5,000** when the **Sum Insured** selected and paid for by **You** is **\$50,000 or less**; otherwise the maximum amount payable under this section shall be up to the **Sum Insured** indicated on **Your Policy Confirmation**.
  - **Emergency Return Home** services must be approved and arranged in advance by the **Company**. If no such approval is obtained **We** will not cover **30%** of the eligible expenses.

With respect to items #1 and #2 above, the **Company** reserves the right to return **You** to **Your Home Country** before any **Treatment** or following **Emergency Treatment** for **Sickness or Injury**, if the medical evidence obtained from **Our** medical advisor and **Your** local attending **Physician** confirms **You** are able to return to **Your Home Country** without

endangering **Your** life or health. If **You** elect not to return to **Your Home Country** following the **Company's** recommendation to do so, any further expenses related to the **Emergency** will not be covered by this **Policy** and all coverage will end.

3. **Emergency Dental:** treatment ordered by a licensed dentist or dental surgeon as follows:
  - a) **Treatment** or repair of natural or permanently attached artificial teeth which are damaged by an **Injury** to the head or mouth. **We** will reimburse **You** for **Reasonable and Customary** expenses up to a maximum of **\$2,000** for any one **Injury**;
  - b) up to **\$300** to relieve acute pain and suffering not related to an **Injury**.
4. **Emergency Paramedical Services:** performed by a chiropractor, chiropodist, physiotherapist, osteopath or podiatrist for **Medically Necessary Emergency Treatment** up to **\$300** per category of practitioner. Expenses for general health examinations for check-up purposes, cosmetic treatments, or services performed by a **Family Member** are not covered.
5. **Accommodation and Meals:** up to **\$150 per day** to a maximum of **\$1,500** for commercial accommodation and meals, essential telephone calls and taxi fares in the event **You** are relocated to receive **Emergency Treatment** or delayed beyond the **Expiry Date** shown on the **Policy Confirmation** due to a **Sickness or Injury** to **You**, **Your Travelling Companion** or a **Family Member** who is travelling with **You**.
  - The claim must be supported by original receipts for eligible expenses and the local attending **Physician's** written diagnosis of the **Sickness or Injury**
6. **Visit to Bedside:** if **You** are hospitalized due to a **Sickness or Injury** and the local attending **Physician** recommends in writing that a relative or close friend should visit at **Your** bedside, remain with **You** or accompany **You** back to **Your Home Country**, subject to prior approval by the **Company**, expenses will be reimbursed up to **\$1,000** for:
  - a) the cost of a round-trip **Fare** by the most direct route for the relative or close friend; plus
  - b) for commercial accommodation and meals.
7. **Repatriation:** in the event of **Your** death during **Your Period of Coverage**, the **Company** will reimburse the reasonable costs actually incurred for the preparation and repatriation of **Your** body or ashes to **Your Home Country** up to the **Sum Insured** as indicated on **Your Policy Confirmation**, or up to **\$10,000** for cremation or burial in the place where death occurs.
  - No benefit is payable for the cost of a headstone, casket, urn and/or funeral service expenses.
8. **Identification of Remains:** in the event of **Your** death during **Your Period of Coverage**, if someone is legally required to identify **Your** remains before **Your** body is released, expenses will be reimbursed for:
  - a) a round-trip economy airfare for someone to travel via the most direct route to the place where **Your** remains are located; plus
  - b) up to **\$450** for commercial accommodation and meals.
  - This benefit must be approved and arranged in advance by the **Company**.

## What We Exclude

There is no coverage and no benefits will be payable for any claim for:

1. Expenses related to a **Sickness, Injury, or Medical Condition** if, in the **6 months** prior to **Your Effective Date**, **You** had sought or received **Treatment** or taken medication for that condition;
2. Expenses related to a **Sickness, Injury, or Medical Condition** that in the opinion of **Our** Medical Director would have caused a person to seek medical advice, diagnosis, care or **Treatment**, during the **6 months** prior to the **Effective Date**;
3. Expenses related to a **Sickness, Injury, or Medical Condition** associated with any **Treatment** **You** were receiving prior to **Your Effective Date** of coverage or that medical advisors were aware would arise during the **Period of Coverage** as a result of **Your** current state of health;
4. **Recurrence** of a **Sickness, Injury or Medical Condition** for which **You** were hospitalized for more than **72 hours**, or for which hospitalization was recommended by **Your Physician**, within the **365 day** period prior to **Your Effective Date**;
5. Expenses incurred for medical care or services where travel was undertaken contrary to medical advice or after receiving a prognosis of a **Terminal Sickness**;
6. **Treatment**:
  - a) not required for the immediate relief of acute pain and suffering;
  - b) which can reasonably be delayed until expiration of **Your Policy** or **Your** return to **Your Home Country**;
  - c) for follow-up **Treatment, Recurrence** of a **Medical Condition** or subsequent **Emergency Treatment** or hospitalization for a **Medical Condition** or related **Medical Conditions** for which **You** had received **Emergency Treatment** during **Your Period of Coverage**.
7. Transplants of any kind;
8. Expenses incurred whereby this **Policy** was purchased specifically to obtain **Hospital** or medical **Treatment** outside **Your Home Country** whether or not recommended by **Your** attending **Physician**;
9. The cost of replenishing any medication that was in use on **Your Departure Date** from **Your Home Country** or for the maintenance of any course of **Treatment** that commenced prior to **Your** date of arrival in Canada;
10. Unless prior approval is obtained from the **Company, Emergency** air transportation; surgery; diagnostic testing; cardiac procedures including but not limited to cardiac catheterization, angioplasty or surgery;
11. **Your** mental, emotional or nervous disorders resulting from any cause, including but not limited to anxiety or depression;
12. Any elective medical **Treatment**;
13. Pregnancy or childbirth, complications of pregnancy or childbirth, or voluntarily induced abortion; or a child born during **Your Period of Coverage**;
14. **Your** use of drugs, alcohol, or any medication that results directly or indirectly in the condition causing a claim;
15. **Your** suicide, attempted suicide or any intentionally self-inflicted **Injury**;
16. **Your** participation in **Extreme Activities**;
17. **Your** participation in organized professional sporting activities;
18. Driving a motorcycle, moped, or scooter, whether or not **You** are driving on publicly maintained roads, driving off-road or on private property (unless **You** hold an applicable valid Canadian driver's license);
19. **Your** riding, driving or participating in races of speed or endurance;
20. Piloting an aircraft or air travel on any air supported device other than as a fare-paying passenger on a flight operated by a **Common Carrier**;
21. Fraud, concealment, or deliberate misstatement in relation to any matter affecting this insurance or in connection with the making of any claim hereunder;
22. **Your** Participation in a crime or malicious act;
23. Participation in a riot or insurrection;

24. War or act of war (whether declared or undeclared), invasion, act of foreign enemy, hostilities, civil war, rebellion, revolution, insurrection or military uprising or usurped power;
25. **Act of Terrorism** by nuclear means and terrorism by dissemination of biological, chemical and or bio-chemical agents and substances;
26. Participation in the armed forces;
27. Events related to travel warnings issued by Foreign Affairs Canada prior to **Your Effective Date** that were or continue to be in effect for any country, region or city of destination during **Your Period of Coverage** as reflected in **Your** travel itinerary; or
28. **Contamination** resulting from radioactive material or nuclear fuel or waste.

## What We Pay

**You** will be reimbursed for the **Reasonable and Customary** charges for the services incurred to treat an **Emergency Sickness or Injury**. The **Company** is responsible for up to the amount shown on **Your Policy Confirmation**.

## What To Do If You Have A Claim

For **You** to receive **Treatment**:

Contact the **Emergency Assistance Provider** at the telephone numbers provided in the Travel Assistance section on page 4. **You** or someone on **Your** behalf must do this prior to receiving **Treatment** for **Your** medical **Emergency**.

**You** or someone acting on **Your** behalf, **must** authorize **Us** to access all medical documentation from the **Treatment** provider at **Your** location and **Your** attending **Physician(s)** at home for the applicable pre-existing time period.

In order to qualify for coverage under this provision, **You must** submit to **Us** with **Your** claim:

1. The completed medical claim form;
2. Original receipts or other proofs of payment;
3. Detailed medical documentation; and
4. Any other information **We** deem necessary to properly adjudicate **Your** claim.

## GENERAL POLICY PROVISIONS

**Assignment of Benefits:** Where the **Company** has paid expenses or benefits to **You** or on **Your** behalf under this **Policy**, the **Company** has the right to recover, at its own expense, those payments from any applicable source or any insurance **Policy** or plan that provides the same benefits or recoveries. This **Policy** also allows the **Company** to receive, endorse and negotiate eligible payments from those parties on **Your** behalf. When the **Company** receives payment from any other insurer, or any other source of recovery to the **Company**, the respective payor is released from any further liability with respect to the claim.

**Autopsy:** In the event of **Your** death, the **Company** may request an examination or autopsy subject to any applicable laws relating to autopsies.

**Concealment and Misrepresentation:** The entire coverage will be void, if before, during or after a loss, any **Material Fact** or circumstance relating to this **Policy** has been concealed or misrepresented

**Conformity With Existing Laws:** Any provision of this **Policy** which is in conflict with any federal, provincial or territorial law where this **Policy** is issued is hereby amended to conform to the minimum requirements of that law. In all other respects, the terms and provisions of this **Policy** shall apply.

Despite any other provision contained in the contract, the contract is subject to the statutory conditions in the Insurance Act respecting contracts of accident and sickness insurance.

**Contract Changes:** This **Policy** is a legal contract between **You** and **Us**. It, including any endorsements and attached papers are the entire contract. No change in this **Policy** is valid unless approved in writing by one of **Our** officers. No agent has the right to change this **Policy** or to waive any of its provisions.

**Currency:** All premiums and benefits under this **Policy** are payable in Canadian currency based on a) the rate of exchange set by any chartered bank in Canada on the last date of service, or b) on the date the payment is issued to the provider of service.

**Limitation of Liability:** The **Company's** liability under this **Policy** is limited solely to the payment of eligible benefits, up to the maximum amount purchased for any loss or expense. The **Company** upon making payment under this **Policy** does not assume any responsibility for the availability, quality, results or outcome of any **Treatment** or service, or **Your** failure to obtain any **Treatment** or service covered under the terms of this **Policy**.

**Medical Examination:** The **Company** reserves the right to have **You** medically examined in the event of a claim.

**Medical Records:** In the event of a claim, **You** agree to provide access to and **We** reserve the right to review any and all medical records or documentation relating to **Your** claim(s) from any licensed **Physician**, dentist, medical practitioner, **Hospital**, clinic, insurer, individual, institution or other provider of service relating to the validity of **Your** claim.

**Refund of Premium:** For other than the "10 Day Right to Examine" on page 1, if **You** return to **Your Home Country** before **Your Expiry Date**, **You** may request a refund of the premium **You** paid for the unused days provided that:

1. **You** submit proof of **Your** date of return; and
2. **You** have not incurred a claim for benefits under the **Policy**.

- A request for a premium refund must be submitted to **Your** agent.
- If a claim is received after a request for premium refund has been processed, **You** will be financially responsible for paying the claim and the **Company** will forward the claim to **You** for settlement.

**Right of Recovery:** In the event that **You** are found to be ineligible for coverage, any benefit is paid in error, payment is made in excess of the amount allowed under the provisions of this **Policy**, a claim is found to be invalid, or benefits are reduced in accordance with any **Policy** provision, the **Company** has the right to collect from **You** any amount which it has paid on **Your** behalf to medical providers or other parties or seek reimbursement from **You**, **Your** estate, any institution, insurer, or person to whom the payment was made.

**Subrogation:** If **You** suffer a loss caused by a third party, the **Company** has the right to subrogate **Your** rights of recovery against the third party for any benefits payable to or on **Your** behalf, and will, at its own expense and in **Your** name, execute the necessary documents and take action against the third party to recover such payments. **You** must not take any action or execute any documents after the loss that will prejudice the **Company's** rights to such recovery.

**Sworn Statements:** **We** have the right to request that claims documents be sworn under oath and have **You** examined under oath in respect to any claim documents submitted.

## DEFINITIONS

**Accident** means a happening due to external, violent, sudden or fortuitous causes beyond **Your** control which occurs during the **Period of Coverage**.

**Act of Terrorism or Terrorism** means the unsanctioned and illegal use of violence (excluding general civil disturbance, rioting and act of war (declared or undeclared) or the intentional release of a biological material), which caused destruction of property, **Injury** or death for the express or implied purpose of achieving a political, ethnic or religious goal or result.

**Caregiver** means the permanent full-time person who is entrusted with the well-being of **Your dependent(s)** and who cannot reasonably be replaced.

**Children** means any insured unmarried person who is dependent upon **You** for support, is travelling with **You** and is either: i) under **21 years** of age; ii) under **26 years** of age if a full-time student; or iii) of any age who is mentally or physically handicapped.

**Common Carrier** means commercial airline carrier, cruise ship, ferry, bus, train, taxi, limousine or other similar vehicle that is licensed, intended and used primarily to transport passengers for hire not including rented, leased or privately owned vehicles.

**Company, We, Our, Us** means Reliable Life Insurance Company, Hamilton, Ontario.

**Contamination** means poisoning of people by nuclear, chemical and/or biological substances that cause **Sickness** or death.

**Departure Date** means the later of the date shown as such on the **Policy Confirmation** or the date **You** actually leave **Your Home Country**.

**Effective Date** means the date **Your** insurance coverage under this **Policy** begins. (See page 2)

**Emergency** means an unforeseen **Sickness** or **Injury** that requires immediate **Treatment** to prevent or alleviate existing danger to life or health. An **Emergency** no longer exists when medical evidence indicates that **You** are able to return to **Your Home Country** or continue with **Your** visit in Canada.

**Emergency Assistance Provider** means the service that is provided to **You** **24 hours** a day, 365 days a year, by calling the **Emergency** numbers provided in this **Policy**.

**Expiry Date** means the date coverage under this **Policy** ends as shown on **Your Policy Confirmation**;

**Extreme Activities** means participating in any of the following: Anti-gravity jumping, assault course, battle re-enactment, bungee jumping, canyoning, cascading, coastering, gliding, gorge swinging or canyon swinging, gorge walking, hang-gliding, high diving, horse jumping (not polo), hunting, hydro speeding, kite surfing, microlighting, mountainboarding, ostrich riding or racing, parachuting, paragliding, parapenting, parascending over land or snow, quad biking, repelling, rock climbing (not mountaineering) rock scrambling, sand yachting, scuba diving (unless qualified and not diving deeper than 130 feet), shark diving, skydiving, orbital and sub-orbital space flight, spelunking, tall ship crewing, via ferrata, weightless jumping, white or black water rafting (grades 5 to 6), yachting (racing or crew) outside territorial waters.

**Family Member** means **Spouse**, parent, legal guardian, step-parent, grandparent, grandchild, in-laws, natural or adopted child, stepchild, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew or an employed **Caregiver** for unmarried dependent **Children** under **16 years** of age.

**Fare** means the lowest single seat fare from any International Air Transportation Association carrier.

**Home Country** means **Your** country of permanent residence.

**Hospital** means a duly licensed facility which accommodates inpatient care, which has registered nurses on a full-time basis, a laboratory and an operating room where surgical operations are performed by qualified surgeons. Excluded are convalescent homes, rest homes, nursing homes, homes for the aged, drug and alcohol treatment centres, health spas or clinics or any facility not operated **24 hours** per day under the supervision of a **Physician**.

**Injury** means sudden bodily damage caused by an **Accident** during the **Period of Coverage**.

**Material Fact** means any fact that would cause **Us** to decline **Your** application for insurance or charge more premium than **You** have paid for the insurance **Policy**.

**Medical Condition** means an irregularity in a person's health which required or requires medical advice, consultation, investigation, **Treatment**, care, service or diagnosis by a **Physician**.

**Medically Necessary** means **Treatment** or services that are appropriate for the relief of **Sickness** or **Injury** in an **Emergency**, based on generally accepted professional medical standards.

**Minor Infection** means an infection that ends **30 days** prior to the **Effective Date** of coverage and does not require: use of medication for a period greater than **15 days**; more than one follow-up visit to a **Physician**; hospitalization; surgical intervention; or, consultation with a medical specialist. A chronic infection or the complication of a chronic infection is not a minor infection.

**Normal Daily Activities** means eating, bathing, use of a toilet, getting in and out of a bed or chair, and dressing.

**Physician** means a person, other than **You**, a **Travelling Companion** or a **Family Member**, who is qualified and legally licensed to practice medicine, perform medical **Treatment** and/or surgery within the scope of their licence in the place where the medical services are rendered.

**Policy** means this document and **Your Policy Confirmation** for insurance hereunder, which is issued in consideration of payment of the required premium.

**Policy Confirmation** confirms the insurance coverage **You** have purchased sets forth **Your Policy** purchase date, **Your Departure Date** from **Your Home Country** and the **Expiry Date** of **Your Period of Coverage**, and forms an integral part of the **Policy** contract.

## CLAIMS INFORMATION

### Contact Us

Reliable Life Insurance Company  
P.O. Box 557, Hamilton, Ontario L8N 3K9

Fax:	905-528-8338
Toll Free Fax:	1-866-551-1704
Telephone:	905-523-4731
Toll Free in Canada & USA:	1-888-831-2222

If **You** experience an emergency or require assistance while **You** are travelling at any time call the numbers listed below. If **You** cannot successfully place a collect call to the **Emergency Assistance Provider** as instructed below, please dial direct and submit the charges incurred to make the call along with **Your** claim documents.

USA & Canada	1-800-334-7787
Elsewhere Operator Assisted Collect	905-667-0587
Direct Dial	1-905-667-0587

Email: [assistance@oldrepublicgroup.com](mailto:assistance@oldrepublicgroup.com)

### How To Submit A Claim

**You** can download a claim form directly from **Our** website:  
[www.reliablelifeinsurance.com/TIPS](http://www.reliablelifeinsurance.com/TIPS)

or **You** can contact **Us** toll free at: 1-888-831-2222

To make a claim for benefits under this **Policy**:

- Submit **Your** claims forms within **30 days** after the expense or loss is incurred or as soon as is reasonably possible;
- Written proof of the claim must be submitted within **90 days**, but not later than **12 months** after the date of the event or loss.

Written Proof of a Claim shall include:

1. the completion of any claim forms furnished by the **Company**;
2. original receipts;
3. a written report, complete with the diagnosis by the attending **Physician**, if applicable, and any other form of documentation deemed necessary by the **Company** to validate **Your** claim.

Original substantiating claims documentation must be provided, however, the **Company** may accept certified copies if the original documentation cannot be provided for a reasonable cause. Failure to provide applicable substantiation for a claim shall invalidate any claim under this **Policy**. All documents required to support or validate the claim, including English or French translations of such documents, must be provided free of expense to the **Company**.

### Claim Payments

**We** will pay covered claims within **30 days** of receiving all of the necessary information required to accurately assess **Your** claim.

Benefit payments will be made to **You** or to any person or entity having a valid assignment to such benefits. In the event of **Your** death, any balance remaining or benefits payable for loss of life will be paid to **Your** estate, unless otherwise indicated.

### Limitation of Action

If **You** have a claim in dispute under this **Policy**, **You** must begin any legal action or proceeding against the **Company** within **24 months** following the date of the event which caused the claim. All legal actions or proceedings must be brought in the province of Ontario where the head office of the **Company** is located.

**Pre-Existing Condition** means a **Medical Condition** other than a **Minor Infection**, for which **Treatment** has been received or taken or which exhibited symptoms, prior to **Your Effective Date** and within the period specified for the plan **You** have chosen, and includes a medically recognized complication or **Recurrence** of a **Medical Condition**.

**Reasonable and Customary** means charges that are usually made by other providers of similar standing for residents in the locality where the charges are incurred, for comparable **Treatment**, services or supplies for a similar medical **Emergency**.

**Recurrence** means the appearance of symptoms caused by or related to a **Medical Condition** which was previously diagnosed by a **Physician** or for which **Treatment** was previously received.

**Sickness** means an acute illness, acute pain and suffering or disease that requires **Emergency** medical **Treatment** or hospitalization due to the sudden onset of symptoms during the **Period of Coverage**.

**Spouse** means the person who is legally married to **You**, or if not married to **You**, has been living in a conjugal relationship with **You** for a continuous period of at least one year.

**Stable and Controlled** means the **Medical Condition** is not worsening and there has been no alteration in any medication for the condition or its usage or dosage, nor any **Treatment**, prescribed or recommended by a **Physician** or received within the time period specified in this **Policy**, prior to **Your Effective Date**.

**Sum Insured** means the amount of insurance coverage **You** have purchased.

**Terminal Sickness** means a **Medical Condition** from which no recovery is expected and which carries a prognosis of death within **12 months** of **Your Effective Date**.

**Travelling Companion** means the person who is travelling with **You** during **Your Period of Coverage** up to a maximum of five persons, including **You**.

**Treat, Treated** or **Treatment** means any medical, therapeutic or diagnostic procedure prescribed, performed or recommended by a **Physician** including but not limited to prescribed medication, investigative testing and surgery.

**You or Your** means a person who is eligible and named on the **Policy Confirmation** for insurance under this **Policy** and for whom the required premium has been paid.

In this **Policy**, words and terms denoting the singular shall be interpreted to mean the plural and vice versa, unless the context clearly indicates otherwise.

## PRIVACY

The **Company** is committed to protecting **Your** privacy. Collecting personal information about **You** is essential to **Our** ability to offer **You** high-quality insurance products and service. The information provided by **You** will only be used for determining **Your** eligibility for coverage under the **Policy**, assessing insurance risks, managing and adjudicating claims and negotiating or settling payments to third parties. This information may also be shared with third parties, such as other insurance companies, health organizations and government health insurance plans to adjudicate and process any claim. In the event that **We** must share **Your** information with a third party who conducts business outside of Canada, there is a possibility that this information could be obtained by the government of the country in which the third party conducts business. **We** take great care to keep **Your** personal information accurate, confidential and secure.

**Our** privacy policy sets high standards for collecting, using, disclosing and storing personal information. If **You** have any questions about the **Company's** privacy policy, please contact **Our** Privacy Officer at 905-523-5587 or by email at: [privacy@oldrepublicgroup.com](mailto:privacy@oldrepublicgroup.com).

### Underwritten by:

Reliable Life Insurance Company  
Hamilton, Ontario



Paul M. Field, C. A.  
Chief Executive Officer  
July 2013

TEV0713

## 24 HOUR TRAVEL ASSISTANCE

If **You** require medical **Treatment** for a **Sickness** or **Injury** during **Your Period of Coverage**, **You** must contact the **Emergency Assistance Provider** at the telephone numbers listed below. If **You** cannot successfully place a collect call to the **Emergency Assistance Provider** as instructed below, please dial direct and submit the charges incurred to make the call along with **Your** claim documents.

USA & Canada	1-800-334-7787
Elsewhere Operator Assisted Collect	905-667-0587
Direct Dial	1-905-667-0587

Email: [assistance@oldrepublicgroup.com](mailto:assistance@oldrepublicgroup.com)

In the event of an **Emergency** that requires assistance, medical **Treatment** or hospitalization, **You** must contact the **Emergency Assistance Provider** within the time specified at the telephone numbers indicated above, prior to admission to **Hospital** or within **24 hours** after a life or organ-threatening **Emergency**, unless **You** are unconscious or physically unable. As an alternative, someone else such as a family member, **Travelling Companion**, friend, **Hospital** or medical staff person may call on **Your** behalf. If **You** do not call the **Emergency Assistance Provider** within the time specified, **You** will be responsible for paying **30%** of any eligible medical expenses incurred.

## EMERGENCY MEDICAL INFORMATION REQUIRED

When contacting the Emergency Assistance Provider concerning a medical emergency, the following information will be required:

### 1. Information concerning the Insured:

Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Telephone Number in Canada: \_\_\_\_\_

Other Travel Insurance Info: \_\_\_\_\_

### 2. Where can the Insured be reached?

Location of Insured: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

If in Hospital, Room #: \_\_\_\_\_

Hospital Telephone Number: \_\_\_\_\_

### 3. Summarize the circumstances (What happened? When?)

\_\_\_\_\_  
\_\_\_\_\_

### 4. Attending Physician at destination

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax: \_\_\_\_\_

### 5. Insured's medical history and current medications.

\_\_\_\_\_  
\_\_\_\_\_

### 6. Family physician

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax: \_\_\_\_\_

### 7. Information about the caller:

Name: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

Telephone Number where you can be reached:  
\_\_\_\_\_