GROUP INSURANCE

HALIFAX REGIONAL MUNICIPALITY

Policy No. 140831

N.S.U.P.E. Local 13

Desjardins
Financial Security

Money working for people

Life, health, retirement

Your Group Insurance

HALIFAX REGIONAL MUNICIPALITY

Policy No. 140831

N.S.U.P.E. Local 13

For information regarding Claims, Administration or Billing Inquiries, you may contact our:

Group Customer Contact Centre

Toll-Free number: 1-800-263-1810

You may also access Claim forms and other information online at:

www.desjardinsfinancialsecurity.com

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on April 1, 2010. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.

Use of masculine is intended to include both women and men.

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BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation: Mandatory

Eligibility Requirements

Number of hours worked per week:

A minimum of 20 hours per week for permanent full-time employees.

A minimum of 20 hours of the regular scheduled work week for employees that job share.

Full-Time Temporary Employees with a minimum one year contract must work a minimum of 20 hours per week.

Eligibility Period: Nil

Waiver of Premium

Benefits for which premiums are waived in the event of Total Disability:

- Basic Participant Life Insurance Benefit
- Dependent Life Insurance Benefit
- Participant Optional Life Insurance Benefit
- Spouse Optional Life Insurance Benefit
- Participant Long Term Disability Benefit

Beginning of Waiver of Premium:

The day on which Participant Long Term Disability Benefit payments commence.

BENEFIT SCHEDULE

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Amount of Insurance:	* 2 times annual Earnings, rounded to the next higher $1,000, if not already a multiple, up to a maximum of $200,000.
Non-Evidence Maximum of Insurability:	$200,000
*** Reduction of Amount:**	On the 65th birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.

Benefit Termination

Age Limit:	Age 70 of the Participant.

BENEFIT SCHEDULE

DEPENDENT LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: $5,000 Each Child: $2,000
Commencement of Newborn Children Insurance:	From birth

Benefit Termination

Age Limit:	Age 70 of the Participant.

BENEFIT SCHEDULE

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance:	Any multiple of $10,000 with a maximum of $300,000.
Non-Evidence Maximum of Insurability:	All amounts of Participant Optional Life Insurance are subject to Evidence of Insurability.

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

BENEFIT SCHEDULE

SPOUSE OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance:	Any multiple of $10,000 with a maximum of $300,000.
Non-Evidence Maximum of Insurability:	All amounts of Spouse Optional Life Insurance are subject to Evidence of Insurability.

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

BENEFIT SCHEDULE

PARTICIPANT LONG TERM DISABILITY BENEFIT

Percentage and Maximum of Benefit:	66.67% of monthly Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $4,000.
Non-Evidence Maximum of Insurability:	$4,000
Elimination Period:	The later of 119 consecutive days, the expiration of sick leave, or the last day a benefit is payable under the loss of income salary continuation plan.
Maximum Benefit Period:	To age 65
Cost-of-Living Adjustment following the Consumer Price Index:	3%. First increase after the end of the Elimination Period plus 1 year.
Taxability of Benefits:	Non-taxable

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries which are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

1) is under 22 years of Age, and over whom the Participant or the Spouse of the Participant exercises parental authority or exercised parental authority until he reached the Age of majority; or

2) has no spouse, is under 26 years of Age and is a full-time student at an accredited educational institution, and over whom the Participant or the Spouse of the Participant would exercise parental authority if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a “functional impairment” that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a “person suffering from a functional impairment,” this person must be living with the Participant or the Spouse of the Participant who would exercise parental authority over him as if he were a minor.

   It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, excluding bonuses, overtime pay, incentive pay and automobile allowances.

Employee means a person who is domiciled in Canada and who is

1) employed by the Employer on a permanent full-time basis, or on a temporary full-time basis with a minimum one year contract and working not less than the number of hours specified in the Benefit Schedule.

2) retired, having been immediately prior to such retirement, an employee as defined above.

However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any companies listed on the application of the Policyholder for the policy or specified in the Benefit Schedule.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave or Parental Leave means any official period of maternity or parental leave taken by a Participant in accordance with provincial or federal legislation, or an agreement between the Participant and the Employer, or any other period during which a Participant receives maternity benefits under the Employment Insurance program.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means a person who is domiciled in Canada and who is

1) the legal Spouse of the Participant by virtue of a religious or civil marriage ceremony; or

2) the common-law Spouse of the Participant with whom the Participant has been living in a conjugal relationship continuously for a period of at least 12 months.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days after the date of his eligibility.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

1) the date on which the insurance of a Participant first becomes effective under the policy,

2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible,

4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

WAIVER OF PREMIUM

1) For the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, premiums will be waived for a Participant who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

   a) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

   b) the date on which the Participant ceases to be Totally Disabled,

   c) for the Life Insurance Benefit, the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

   d) the date on which the Participant attains Age 65 or retires, if earlier,

   e) in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the BENEFIT SCHEDULE, the date on which each Benefit or the policy terminates except for the Basic Participant Life Insurance Benefit, the Dependent Life Insurance Benefit, the Participant Optional Life Insurance Benefit, the Spouse Optional Life Insurance Benefit and the Participant Long Term Disability Benefit.

2) Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

3) A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

4) In the case of the Life Insurance Benefit, if a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

   a) the Participant became Totally Disabled while insured under this Benefit,

   b) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

   c) the Participant dies within 12 months from the onset of his Total Disability,

   d) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

   e) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.

5) To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

   In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

1) the date on which the Participant no longer qualifies as an Employee, as defined in the policy,

2) the date on which the Participant ceases to belong to a class of Participants eligible for insurance,

3) the date on which the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

4) the end of the period for which required premiums were paid on behalf of the Participant,

5) the date on which the Participant retires, unless eligible for retirement coverage,

6) the date on which the Participant ceases to be Actively At Work,

7) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

1) the date on which the insurance of the Participant terminates,

2) the date on which the Participant no longer has any Dependents,

3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

4) the date on which Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

No action or proceedings may be initiated against the Insurer for the recovery of any claim within 60 days or after 2 years following the expiration of the time in which proof of claim is required.

BENEFICIARY

Subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, the death benefit is paid as follows:

1) in the event of the Spouse's death:

   to the Spouse's legal heirs;

2) in the event of the death of the Participant's Dependent Child:

   a) to the Spouse, if alive, or

   b) if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation

   a) for which he would earn 60% or more of his Earnings in effect immediately prior to commencement of Total Disability; and

   b) for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

   A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;

3) Prior approval must be obtained from the Policyholder before any payment may be made;

4) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary (codes B14054 or B113878 respectively).

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced for any reason other than due to policy termination, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

1) $200,000; or

2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

If the Life Insurance of a Participant aged 65 or younger terminates because of the termination of the policy and provided that the Participant was insured under this Benefit for five consecutive years immediately prior to such policy termination, the Participant will be entitled to convert to an individual policy any amount of insurance, up to the higher of $5,000 or 25% of the Participant's amount of insurance, without evidence of insurability. However, such amount of insurance will be reduced by any group life insurance for which the Participant becomes eligible during the 31 days following the termination of the policy.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 60 days of receipt of satisfactory proof of claim to the Insurer.

DEPENDENT LIFE INSURANCE BENEFIT

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

COMMENCEMENT OF NEWBORN CHILDREN INSURANCE

Insurance for a newborn Child of a Participant with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

SPOUSE CONVERSION PRIVILEGE

If the Dependent Life Insurance of a Spouse aged 65 or younger, insured for a minimum amount of $5,000, terminates for any reason other than policy termination, the Participant or the Spouse, in the event of the death of such Participant, may convert the Dependent Life Insurance on the Spouse to an individual policy, without evidence of insurability, subject to the following conditions:

1) The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Spouse under this Benefit;

2) The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

3) The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

4) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Spouse's Age at nearest birthday and the class of risk to which the Spouse belongs;

5) If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Spouse may convert;

6) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Spouse under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Spouse dies within 31 days of the termination of his insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Participant or the Spouse, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Participant Optional Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Optional Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Optional Life Insurance Benefit is payable in respect of a Participant who commits suicide, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Optional Life Insurance of a Participant aged 65 or younger terminates under any of the conditions specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit and not solely the Participant's request, the Participant will be entitled to convert that insurance to an individual policy, without evidence of insurability.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit will apply to any individual policy available under this Benefit except that the maximum amount that may be converted under this Benefit will be the maximum specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit, minus the amount of any Basic Participant Life Insurance that may be converted.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Optional Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

SPOUSE OPTIONAL LIFE INSURANCE BENEFIT

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Spouse applying for any amount of Spouse Optional Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Spouse Optional Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent Spouse died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Spouse in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Spouse Optional Life Insurance Benefit is payable in respect of a Spouse who commits suicide, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance.

BENEFIT TERMINATION

This Benefit terminates on the date the Spouse attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

CONVERSION PRIVILEGE

If the Optional Life Insurance of a Spouse aged 65 or younger terminates for any reason other than policy termination and not solely the Participant's request, the Participant or the Spouse, in the event of the death of such Participant, may convert this insurance to an individual policy, without evidence of insurability.

The amount of individual life insurance for the Spouse will be limited to the lesser of:

1) $200,000; or

2) the difference between:

   a) the sum of the amount that may be converted under the CONVERSION PRIVILEGE of the Dependent Life Insurance Benefit applicable to the Spouse and the amount of Spouse Optional Life Insurance in force on the date the insurance is terminated; and

   b) the amount of insurance for which the Spouse is eligible under another group life insurance at the time of exercising the conversion right.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Dependent Life Insurance Benefit will apply to any individual policy available under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Spouse dies within 31 days of termination of his insurance under this Benefit, the amount of Spouse Optional Life Insurance payable will be the amount that the Participant or the Spouse, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

Net Monthly Earnings means the monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled, **in respect of an Employee with less than 35 years of service**, means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation

   a) for which he would earn 66.67% or more of his Earnings in effect immediately prior to commencement of Total Disability; and

   b) for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

   A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Total Disability or Totally Disabled, **in respect of an Employee with 35 or more years of service**, means a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and

2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The amount of Long Term Disability Benefit payable under this Benefit will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to commencement of Total Disability.

Long Term Disability Benefits are payable at the end of each month following the completion of the Elimination Period.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

If a Participant continues to be insured under this Benefit while on Maternity or Parental Leave, then the Elimination Period for any Total Disability that begins during such leave will be deemed to commence on the date the Participant is scheduled to return to active full-time employment with the Employer, provided the Participant is then still so disabled and insured under this Benefit.

COST-OF-LIVING ADJUSTMENT

During a continuous period of Total Disability, the Long Term Disability Benefit payable to a Participant under this Benefit will be increased by an amount equal to the percentage, as specified in the Benefit Schedule, of that monthly Benefit payable immediately prior to such increase, subject to the following conditions:

1) the initial increase will become effective in accordance with the COST-OF-LIVING ADJUSTMENT section of the Benefit Schedule;

2) subsequent increases will become effective on each anniversary of the initial increase; and

3) for any year in which the Consumer Price Index (CPI) is less than the percentage specified in the Benefit Schedule, the increase for that specific year will be equal to that of the CPI.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Direct Offset

Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and

b) any amount the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan including early retirement benefits but excluding

i) benefits payable on behalf of his Dependents; and

ii) any increase in benefits due solely to cost-of-living, after benefit payments commence; and

c) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

2) Indirect Offset

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

a) 85% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

b) 85% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Participant from all sources, whether he receives or is eligible to receive this income, will include all of the following:

a) any Long Term Disability payments under this Benefit;

b) any monthly Earnings or payments from the Employer;

c) any disability benefits payable under the Canada Pension Plan or the Quebec Pension Plan, including early retirement benefits and benefits payable on behalf of Dependents, but excluding any increase in benefits after benefit payments commence due solely to the cost-of-living;

d) any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;

e) any disability benefits payable under any other group or association insurance plan;

f) any benefits payable from a retirement or pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;

g) any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

In the event that a lump-sum payment is made under any of the above-mentioned sources in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

3) Limitations

No benefits are payable for a period of Total Disability

a) during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;

b) during a formal Maternity or Parental Leave taken by a Participant, as provided for under provincial or federal legislation;

c) during a Maternity Leave commencing on the earlier of

i) the elected date of leave, as mutually agreed to by the Employer and the Participant; and

ii) the date of birth of the child;

and ending on the earlier of

i) the elected date of return to active full-time employment with the Employer, as mutually agreed to by the Employer and the Participant; and

ii) the actual date the Participant is again Actively At Work with the Employer;

d) during a Parental Leave as mutually agreed to by the Employer and the Participant;

e) during the imprisonment of the Participant due to conviction of an offence;

f) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of Total Disability commencing during the first 12 months of coverage of a Participant, if such Total Disability was directly or indirectly the result of a sickness or injury that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.

However, if the policy has been in force for less than 12 months, and the Participant has been covered under a comparable benefit under the Employer's previous group insurance policy, for any period of time immediately prior to the Effective Date of the policy, that period of time will apply in determination of the 12 month coverage period.

4) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

a) intentionally self-inflicted injuries while sane or insane;

b) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

c) committing, or attempting to commit a criminal offence;

d) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident which occurred while the Participant was insured under this Benefit;

e) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

f) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

1) 2 consecutive weeks of active full-time employment during the Elimination Period; or

2) 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

1) co-ordination of access to health care services;

2) support program for returning to work;

3) negotiations for a gradual return to work,

4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

1) the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;

2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

4) if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity

B = Monthly Earnings of the Participant immediately prior to the commencement of Total Disability

C = Long Term Disability Benefits otherwise payable under this Benefit

5) while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

1) the date on which the Participant ceases to be Totally Disabled;

2) the date on which the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

3) the date set by the Insurer on which the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;

4) the date on which payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;

5) the date on which the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

6) the date on which the Participant attains the Age Limit specified in the Benefit Schedule.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

If a Participant is not Totally Disabled on the date this Benefit terminates but was receiving Long Term Disability Benefits under this Benefit less than 6 months prior to such date, such Participant will be eligible to a resumption of Long Term Disability Benefits if he again becomes Totally Disabled from the same or related causes prior to

1) 90 days after the termination of this Benefit; or

2) 180 days after the last day he was Totally Disabled.

The reinstated Long Term Disability Benefits will be equal to those which the Participant was previously eligible to receive and will continue for the remainder of the Maximum Benefit Period.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

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