La Capitale
Insurance and
Financial Services

Contract 006925

Association des procureurs aux poursuites criminelles et pénales (Active members)

Plan effective as of November 1, 2016

GROUP INSURANCE PLAN

Insured by

La Capitale
Insurance and
Financial Services

Contract 006925

Association des procureurs aux poursuites criminelles et pénales (Active members)

Plan effective as of November 1, 2016

In collaboration with

The Association des procureurs aux poursuites criminelles et pénales, in cooperation with Samson Groupe Conseil and La Capitale Insurance and Financial Services, is pleased to present this booklet outlining the benefits included under the group insurance plan offered to criminal and penal prosecuting attorneys.

Please note that this document is intended for information purposes only and has no contractual value. Only the terms and conditions of the contract signed with the Insurer may be used to decide on legal matters.

We invite you to read the information contained in this booklet carefully to gain a better understanding of your benefits. Please contact the Human Resources department of the ministry or of your employer if you have any questions about this group insurance plan.

IMPORTANT

This document does not include all contractual clauses regarding definitions, eligibility, enrolment, termination of insurance and other specifications. You may access this information by consulting the contract available from your Association or your employer.

100%

This document is printed on paper made from 100% post-consumer recycled material. A simple gesture that goes a long way to help protect our environment and the resources around us.

TABLE OF CONTENTS

GENERAL INFORMATION 5
1. Eligibility 5
2. Participation in insurance and exemption 5
3. Insurance coverage 7
4. Definitions 8
5. Beneficiary 12
6. Extension of coverage for dependents of a deceased participant 13
7. Extension in the event of conversion of Life Insurance 13
8. Conversion privilege 13
9. Waiver of premiums 15
10. Maintaining insurance during a temporary interruption of work 16
11. Termination of insurance 18
12. Modifications to the contract 19
13. Claims procedure 19

LIFE INSURANCE 21
1. Participant's Basic Life Insurance (mandatory participant) 21
2. Accidental Death and Dismemberment Insurance (mandatory participation) 21
3. Spouse's and Dependent Children's Basic Life Insurance (mandatory participation) 23
4. Optional Life Insurance (optional participation) 23
5. Accelerated benefit payment in the event of terminal illness 24
6. Exclusions that apply to item 4 24

HEALTH INSURANCE (MANDATORY ENROLMENT) 25
1. Hospitalization expenses 25
2. Accommodation expenses in a residential and long term care centre 25
3. Rehabilitation centre 25
4. Travel Insurance 26
5. Trip Cancellation Insurance 26
6. Prescription drugs 26
7. Other eligible expenses reimbursed at 75% 28
8. Exclusions and reduction of coverage 31

LONG TERM DISABILITY INSURANCE (MANDATORY PARTICIPATION) 35
1. Elimination period 35
2. Benefit period 35
3. Provisions for seasonal and casual employees hired for a period equal to or greater than 12 months 36
4. Benefit amount 36
5. Rehabilitation 38
6. Indexation 39
7. Exclusions and reduction of coverage 39
8. Supplement to pregnancy-related Employment Insurance or Quebec Parental Insurance Plan benefits 40

TRAVEL INSURANCE 41

TRIP CANCELLATION INSURANCE 49

ANSWERS TO YOUR QUESTIONS 55

GENERAL INFORMATION

1. Eligibility

ATTORNEYS

The working conditions guidelines determine which attorneys are eligible for insurance, as well as with their eligibility date. The waiting period is 1 month of continuous service, or any other period specified in the working conditions guidelines. Attorneys whose normal work week is 25% or less of full time hours are not eligible for insurance. Attorneys who have taken full early retirement are no longer eligible for Long Term Disability Insurance.

DEPENDENTS

The spouse or dependent child of an attorney becomes eligible for insurance on the same date as the attorney, if that person is already the spouse or a dependent child, or on the date on which that person subsequently becomes the spouse or a dependent child.

2. Participation in insurance and exemption

Participation in the following benefits is mandatory for eligible attorneys, according to the coverage status selected:

- Participant's Basic Life Insurance (individual or family coverage if there are eligible dependents)
- Participant's Accidental Death and Dismemberment Insurance (AD&D)
- Long Term Disability Insurance
- Spouse's and Dependent Children's Basic Life Insurance
- Health Insurance (individual, family or single-parent coverage if there are eligible dependents)

  Participation in this benefit is also mandatory for eligible dependents.

Attorneys or their dependents may, however, waive or terminate coverage under the Health Insurance benefit by providing written notice to the employer, along with proof to the Insurer's satisfaction that they are covered under another group insurance plan with similar benefits. However, as soon as coverage under the other group plan ends, they must immediately apply for in the Health Insurance benefit by demonstrating to the Insurer's satisfaction that they are no longer able to remain insured under the other plan.

In addition, a participant with no dependent children and whose spouse is age 65 or over may, in the case of the Health Insurance benefit, opt to replace family coverage with individual coverage. Any participant who chooses to do so cannot subsequently modify the coverage status.

Furthermore, any attorney age 65 or over, or any attorney with a dependent age 65 or over, may opt to obtain coverage under this contract for prescription drugs that are covered under the RAMQ's Basic Prescription Drug Insurance Plan. Attorneys wishing to obtain such coverage must complete an application form for themselves and their dependents within 31 days following the earliest of the following dates:

a) The date on which the attorney reaches age 65

b) The date on which the oldest dependent to insure reaches age 65

In such a case, the participant must pay the additional premium in accordance with the number of insureds age 65 or over in the family. Any participant who reaches age 65 after the date referred to under item b) above and whose spouse has prescription drug insurance coverage under the group plan must also obtain coverage for prescription drugs under this contract if the participant wishes to maintain the spouse's coverage.

If the participant registers with the *Régie de l'assurance maladie du Québec* for prescription drug insurance coverage, the spouse must also be insured under that plan.

No applications will be accepted after the 31-day deadline specified above.

Enrolment in the following benefits is optional:

- Participant's Optional Life Insurance
- Spouse's Optional Life Insurance
- Dependent Children's Optional Life Insurance

Attorneys must complete an application form obtained from their Human Resources department and specify the optional benefits selected.

Exemption forms can also be obtained from Human Resources.

Attorneys who are exempt from coverage under the Health Insurance benefit must still apply for in Basic Life Insurance and AD&D, and for Long Term Disability Insurance.

3. Insurance coverage

The following options are available under the Health Insurance benefit, subject to the terms and conditions of participation:

a) Individual coverage (covering the participant only)

b) Family coverage (covering the participant, the participant's spouse and their dependent children)

c) Single-Parent coverage* (covering the participant and the participant's dependent children)

The following options are available under the Participant's Basic Life Insurance benefit:

a) Individual coverage if the participant has individual coverage under the Health Insurance benefit.

b) Family coverage if the participant has family or single-parent coverage under the Health Insurance benefit.

   Participants who are exempted from Basic Health Insurance are automatically granted family coverage status.

The following options are available under the Spouse's and Dependent Children's Basic Life Insurance benefit:

a) Family coverage (covering the participant's spouse and dependent children) if the participant has family coverage under the Health Insurance benefit.

   Participants who are exempted from the Health Insurance benefit are automatically granted family coverage status under this benefit.

b) Single-parent coverage (covering the participant's dependent children) if the participant has single-parent coverage under the Health Insurance benefit.

* Single-parent coverage may only be selected if the participant does not have a spouse as defined under the contract.

Any future change to coverage in order to obtain family or single-parent coverage status may require evidence of insurability stating that the individuals the participant wants to add are insurable and in good health.

However, no evidence of insurability is required in the following cases:

a) If the participant applies for family coverage within 31 days following a marriage, recognition of a "common-law spouse" or the birth or adoption of a first child.

b) If the participant applies for single-parent coverage within 31 days following the birth or adoption of a first child.

c) Upon the birth or adoption of a dependent child if the participant already has family or single-parent coverage.

Spouse's and Dependent Children's Optional Life Insurance can only be obtained if the spouse and dependent children are covered under Basic Life Insurance.

4. Definitions

COMMERCIAL ACTIVITY

An assembly, conference, convention, exhibition, show or seminar of a professional or commercial nature. The activity must be public, under the responsibility of an official organization and in compliance with the legislation, regulations and policies of the region where it will be held. The commercial activity must be the only reason for the planned trip.

PARTICIPANT

Any person defined below who is eligible for insurance and who pays the required premiums, unless the premiums are being waived:

- **Attorney:** A lawyer as defined in the legislation and the regulations respecting criminal and penal prosecuting attorneys.

BUSINESS PARTNER

A person with whom the insured is associated for business purposes as part of a company with 4 shareholders or fewer, or a profit-making corporation with 4 partners or fewer.

INSURED

A participant, the participant's spouse and their dependent children, if any.

TRAVEL COMPANION

The person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid with those of the insured.

SPOUSE

The man or the woman who, on the date of the event giving entitlement to benefits:

i) is married or civilly united to the participant, or

ii) has been cohabiting in a conjugal relationship with the participant for more than one year, or for less than one year if he or she is the father or mother of a child of the participant, or

iii) is cohabiting in a conjugal relationship with the participant and had previously cohabited with the participant for an entire period of at least one year.

Note that the status of spouse may be cancelled by any of the following events, as the case may be:

– In the case of a marriage, a judgment of divorce between the participant and the spouse.

– In the case of a common-law union, de facto separation for at least 90 days.

– In the case of a civil union, dissolution of the union by a notarized act or court decision.

If a participant has a spouse meeting the definition in i) above, and another spouse meeting the definition in ii) or iii) above, the Insurer shall recognize as the spouse the person designated by the participant as his or her spouse by written notice to the Insurer. The spouse must remain the same person for all benefits insured under the contract.

DEPENDENT CHILD

The term "dependent child" designates any of the following individuals:

i) A person under age 18 for whom the participant or spouse exercises parental authority. However, such a person will be considered a dependent child until his or her 21st birthday, provided that person has no spouse and depends to a large degree on the participant or participant's spouse for support.

ii) A person age 25 or under who has no spouse and is attending a recognized educational institution as a duly registered full-time student, and for whom the participant or spouse would exercise parental authority if a minor.

iii) A person who has reached the age of majority, who has no spouse and is domiciled at the participant's home, for whom the participant or spouse would exercise parental authority if a minor, and who is afflicted with a total disability or functional impairment, as defined in the applicable legislation, that occurred while the person met any of the conditions indicated under i) or ii) above, and has remained totally and continuously disabled since that date.

The concept of parental authority for a person other than a child of the participant or participant's spouse must be confirmed by a court judgment or by a valid will of the father or mother or by a statement on their part to such effect forwarded to the public curator or public trustee.

PREPAID TRAVEL EXPENSES

Any amount paid by and for the insured to purchase a package trip, including tickets from a public carrier and rental of motor vehicles from an accredited firm. Also includes amounts paid by the insured for land arrangements usually included in a package trip, whether the reservations are made by the insured or by a travel agency, as well as amounts paid by the insured in relation to registration fees for a commercial activity.

HOST AT DESTINATION

The person at whose principal residence the insured is planning to stay by prior agreement.

DISABILITY

During the Long Term Disability Insurance elimination period and the 78 weeks that follow:

Disability means a state of incapacity resulting from an illness, including an accident, a complication resulting from pregnancy or a surgical procedure directly related to family planning, which requires medical care and/or treatment administered by a recognized professional working in the healthcare field and which renders the insured totally unable to carry out the regular duties of his or her job or any other comparable job with similar compensation offered by the employer.

Thereafter:

Disability means a state of incapacity resulting from an illness, including an accident, a complication resulting from pregnancy or a surgical procedure directly related to family planning, which requires medical care and/or treatment administered by a

recognized professional working in the healthcare field and which renders the insured totally unable to carry out the regular duties of his or her job.

NON-SMOKER

An insured who during the last 12 months has not used tobacco in any form. In the case of any misrepresentation by the insured, the insurance under this benefit shall be null and void and the liability of the Insurer shall be limited to refunding the premiums collected. A person who changes his or her smoking patterns must provide the Insurer with a written attestation to this effect. The insured must have ceased smoking for 12 months before the change may be put into effect.

DISABILITY PERIOD

For the first 52 weeks:

Any uninterrupted period of disability, or a series of successive periods of disability separated by less than 15 days of full-time work or availability for full-time work, unless the participant can establish to the satisfaction of the employer or the employer's representative that a subsequent period is due to an illness or accident that is completely unrelated to the reason for the previous disability. However, any period in which the participant needs to be away from work for treatment prescribed by a physician and related to a previous disability shall be considered to be part of the same disability. For this purpose, such period may be calculated on an hourly basis.

Thereafter:

Successive periods of disability interrupted by less than 30 days of continuous full-time work during the period in which benefits are paid under the employer's salary insurance plan, or interrupted by less than 6 months of continuous full-time work during the period starting upon termination of benefit payments under the employer's salary insurance plan shall be deemed to be an extension of the same disability period, unless the subsequent disability is caused by an illness or injury that is completely unrelated to the reason for the previous disability and begins after the participant returns to full-time work.

SALARY

The annual salary based on the participant's regular work week, under the working conditions guidelines or rules pertaining to attorneys, and used to calculate benefits under the employer's salary insurance plan. The salary excludes any other bonuses, allowances or additional compensation.

However, for the purpose of calculating the contribution to the retirement plan of an attorney afflicted with a total disability, salary is defined as follows:

During the Long Term Disability Insurance elimination period and the 78 weeks that follow, the salary is the amount used to calculate the salary insurance benefit paid by the employer. Thereafter, the salary is the amount determined at the end of the period described above, indexed on January 1 of each calendar year that follows the end of such period by more than 6 months, based on a percentage that corresponds to the lowest of:

- The indexation policy set out on the January 1 in question for retirement annuities payable under the Quebec Pension Plan;
- 3%; and
- The percentage of variation in the salary scale for attorneys that applies to the year prior to the January 1 in question.

The salary indexation is revised when the percentage of variation in the salary scale for attorneys is applied retroactively.

TRIP

A trip for the purpose of tourism or leisure, or a trip for the purposes of business or attendance at a commercial activity entailing the insured's absence from his or her province of residence.

For the purposes of Trip Cancellation insurance, a trip represents a tourism or leisure trip or a trip for the purposes of business, or a commercial activity that includes a stay of at least one (1) night at destination, either in or outside the insured's province of residence.

5. Beneficiary

Participants may designate a life insurance beneficiary or change an existing beneficiary designation by means of a written statement filed at the head office of the Insurer, subject to provisions of the law. The Insurer shall not be liable for the legal validity of any change of beneficiary.

6. Extension of coverage for dependents of a deceased participant

Following the death of a participant, Basic Life Insurance and Health Insurance coverage for the participant's dependents will be extended without payment of premiums until the earliest of the following dates:

- The last day of a 12-month period immediately following the participant's death.
- The date on which the dependents' insurance would have ended if the participant had been alive.
- The date on which this benefit or contract is terminated.

7. Extension in the event of conversion of Life Insurance

While the contract is in force, when a participant, the participant's spouse or their dependent children cease to be eligible for insurance and they are entitled to exercise their conversion privilege, their Basic and Optional Life Insurance will be extended for a period of 31 days.

8. Conversion privilege

Participant's Basic Life Insurance, Dependents' Life Insurance and Optional Life Insurance

TERMINATION OF MEMBERSHIP IN THE GROUP

Participants whose membership in the group of insureds terminates before age 65 and who hold an amount of life insurance of at least $10,000 are entitled to convert their life insurance in whole or in part or, if applicable, the life insurance for their dependents, to an individual life insurance policy without having to provide evidence of insurability for themselves or their dependents.

The amount of insurance on the participant's life that may be converted must be at least $10,000 and may not exceed the amount of all the life insurance coverage that the participant held under the contract on the conversion date or $400,000, whichever is lower.

In addition, each dependent who has at least $5,000 of life insurance coverage under this contract may convert a minimum of $5,000, without exceeding the amount of insurance on his or her life on the conversion date or $400,000.

To exercise this conversion option, participants must apply in writing to the Insurer within 31 days following the date on which their membership in the group of insureds terminates. Coverage under this contract remains in force until the date on which it is converted to an individual life insurance policy, without however exceeding the aforementioned 31-day period. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

EXPIRY OF THE CONTRACT

Participants who have been insured for a minimum of 5 years and who have at least $10,000 of life insurance coverage are entitled to convert their life insurance coverage, in whole or in part, to an individual life insurance policy within 31 days following the expiry of this contract if it is not replaced or the replacement contract provides for a lesser amount of insurance.

The amount of insurance that may be converted must be at least $10,000 or 25% of the amount of the participant's life insurance on the expiry of the contract, whichever amount is greater.

To exercise this conversion option, participants are not required to provide evidence of insurability but must apply in writing to the Insurer within 31 days following the expiry date of this contract. Any reduction in the amount of insurance due to age or a change in category of insureds does not give entitlement to the conversion privilege.

COVERAGE AVAILABLE UPON CONVERSION

Participants who exercise their conversion privilege according to the aforementioned provisions may obtain an individual whole life or term life insurance policy, without accessory coverage, of the type issued at that time by the Insurer in such circumstances and in accordance with any insurance regulations and all applicable legislation.

The premiums applicable to the individual life insurance products when exercising the conversion privilege are determined in compliance with the terms and conditions of any insurance regulations and all applicable legislation.

Health Insurance

The conversion privilege enables any insured covered under the Health Insurance benefit to obtain health insurance coverage, through a separate contract and without evidence of insurability, in accordance with the rates and conditions stipulated by the Insurer and in effect at that time for this type of coverage, subject to sending a written request to the Insurer within 31 days following one of the following events:

– The insured participant ceases to be eligible for this insurance prior to termination of the contract. The conversion privilege may then be exercised by and for the insured participant, or for the participant's spouse and dependent children, if they were covered.

– The participant retires.

– The spouse or a dependent child ceases to be the spouse or a dependent child as defined in the contract.

– The end of the extended coverage period for dependents of a deceased participant.

9. Waiver of premiums

Life Insurance and Accidental Death and Dismemberment Insurance

If a participant is afflicted with a disability while these benefits are in force, the Insurer will waive payment of any premiums payable by the participant that fall due after the participant's accumulated sick days have been used up, for as long as the disability lasts. This coverage terminates on the participant's 65th birthday.

Long Term Disability Insurance

If a participant is afflicted with a disability while this coverage is in force, the Insurer will waive payment of any premiums payable by the participant that fall due after the participant's accumulated sick days have been used up. This coverage terminates on the participant's 62nd birthday. Retirement due to disability is not deemed to be a termination of insurance.

Note: A disabled participant who participates in a rehabilitation program or a gradual return to work, as set out in the working conditions guidelines, will continue to benefit from a waiver of premiums for the Participant's Basic Life Insurance, Accidental Death and Dismemberment Insurance and Long Term Disability Insurance.

10. Maintaining insurance during a temporary interruption of work

a) A participant who ceases to be actively at work on a full-time basis due to an unpaid leave of absence, suspension or temporary layoff must remain insured under the Health Insurance benefit by paying the total premium, including the employer's share. Such participants may also remain insured under all other benefits, provided they submit a request in writing to the Insurer within 31 days following one of these events and pay the total premium. However, insurance coverage may not be maintained in force for a period exceeding 6 months in the case of a temporary layoff, or exceeding 12 months in the case of an unpaid leave. The elimination period for a disability that begins during one of the above-mentioned periods shall begin as of the planned date of return to work.

   In certain situations, the Quebec *Act respecting labour standards*, which takes precedence over this clause, provides for an extension of the 12-month period mentioned above.

b) In the case of an unpaid leave, suspension or temporary layoff of less than 30 days, all of the participant's benefits shall be automatically maintained in force and the related premiums must continue to be paid to the Insurer. However, the participant may choose to suspend all benefits, ***excluding the Health Insurance benefit***, during the unpaid leave provided the request is submitted prior to the start of the unpaid leave. In such a case, coverage will automatically resume upon returning to work with pay.

c) When a participant is dismissed and disputes the dismissal through any appropriate recourse, the Health Insurance benefit is maintained in force and the total premium (employee and employer share) is payable by the participant. Such participants may remain insured under all other benefits, provided they submit a request in writing to the Insurer within 31 days following the dismissal or suspension and pay the total premium. If the participant's recourse is lost, the insurance shall terminate on the date the final decision is made.

d) In the case of full early retirement, all of the participant's benefits shall be automatically maintained in force, with the exception of Long Term Disability Insurance, and the premiums applicable to the maintained benefits must continue to be paid to the Insurer. In the event of a return to work, Long Term Disability Insurance coverage is automatically resumed without evidence of insurability.

e) In the case of gradual early retirement, all of the participant's benefits shall be automatically maintained in force and the related premiums must continue to be paid to the Insurer. However, such participants may be fully or partially exempted from Long Term Disability Insurance provided they submit a request to the Insurer within 30 days following the start of such gradual early retirement. Participants who are partially exempt must continue to pay 100% of the premium from their salary, and the Insurer will then refund the premium overpayment to the participant 3 times a year.

   In the case of a full-time return to work by a participant who is fully exempted from Long Term Disability Insurance, coverage shall resume on the date on which the Insurer approves the evidence of insurability.

f) In the case of gradual retirement, all of the participant's benefits shall be automatically maintained in force and the related premiums must continue to be paid to the Insurer. However, such participants may be partially exempted from Long Term Disability Insurance and have prorated coverage based on the time worked, provided they submit a request to the Insurer within 30 days following the start of such gradual retirement. Such participants shall continue to pay 100% of the premium from their salary, and the Insurer will then refund the premium overpayment to the insured 3 times a year.

g) Participants on partial leave without pay or taking part in an unpaid deferred salary leave program shall remain insured under all benefits held at the beginning of the leave, provided the premium is paid. For the purpose of calculating the premium and the coverage under the Life Insurance and Long Term Disability Insurance benefits, the participant's salary is the amount the participant would have received had such leave not been taken. Any disability that begins during an unpaid deferred salary leave shall be deemed to start on the same date as that indicated in the working conditions guidelines to determine the salary insurance period.

h) In the case of a "non-returning" paid leave that, by agreement, will lead into retirement, all of the participant's benefits shall be automatically maintained in force, with the exception of Long Term Disability Insurance, and the premiums applicable to such benefits must continue to be paid to the Insurer.

In the case of gradual retirement, the participant becomes eligible for the retirees' plan.

11. Termination of insurance

a) Participant's insurance terminates on the earliest of the following dates:

- The date on which the contract terminates, or for each of the benefits, their respective date of termination:
  - Participants' Basic Life Insurance, Participant's Basic Accidental Death and Dismemberment Insurance: Date of participant's retirement;
  - Participant's Optional Life Insurance: Age 70 or date of participant's retirement, if earlier;
  - Health Insurance: Date of participant's retirement or, for a disabled participant, date of termination of employment if earlier than retirement;
  - Long Term Disability Insurance: Date when the participant's age and elimination period totals 62, or date of participant's retirement, if earlier;
- The date on which the participant no longer meets the eligibility conditions;
- The date on which the participant terminates employment.

b) Insurance for the spouse and/or dependent children terminates on the earliest of the following dates:

- The date on which the contract terminates, or for each of the benefits, their respective date of termination:
  - Spouse's and Dependent Children's Basic Life Insurance: Date of participant's retirement;
  - Spouse's and Dependent Children's Optional Life Insurance: Date of participant's 70th birthday or the date of the participant's retirement, if earlier;
  - Health Insurance: Date of participant's retirement or, for a disabled participant, date of termination of employment, if earlier than retirement;
- The date on which the participant's insurance terminates;
- The date on which the person ceases to be considered the spouse or a dependent child;
- The date on which the Insurer receives written notice from a participant who wants Individual coverage;
- In the case of a spouse, the date on which the Insurer receives written notice from a participant who wants Single-Parent coverage.

12. Modifications to the contract

The Policyholder may at any time, upon agreement with the Insurer, make modifications to the contract with respect to the individuals eligible for insurance, the scope of coverage and the sharing of costs among classes of insureds. Any such modifications shall then apply to all insureds, whether they are active, disabled or retired.

13. Claims procedure

Health Insurance

Prescription drugs: Direct electronic claims payment

When making prescription drug purchases, insureds present their service card to the pharmacist. La Capitale will automatically issue payment for the insured portion of prescription drug expenses. There's no need to fill out a claim form, and insureds pay only the uninsured portion of prescription drug expenses including any applicable deductible.

Other expenses

Participants must submit a duly completed, signed and dated claim form to the Insurer's head office. It is important to follow the directions on the form and enclose original receipts and paid invoices for the expenses incurred. Participants should keep copies for their records as the originals will not be returned. In the event of hospitalization, participants show their service card at the time of admission, and the hospital will then file a claim directly with the Insurer. Participants must provide the group and employer identification numbers and their Social Insurance Number. All claims must be submitted to the Insurer no later than 12 months following the date expenses are incurred.

Life Insurance

The beneficiary must contact the Insurer to obtain all required claim forms and submit a claim for the insured amount.

Accelerated benefit payment in the event of terminal illness

Upon request, the Insurer will send the participant an "Application for Accelerated Payment of Participant's Life Insurance" form, which will indicate the maximum amount the participant is eligible to receive under the accelerated payment option. The participant must complete the form and return it to the Insurer, along with the beneficiary's written consent and a copy of the medical report confirming the participant's condition. The accelerated payment conditions are described in item 5 under the Life Insurance benefit.

Long Term Disability Insurance

When a participant becomes disabled as defined herein, the Insurer must be notified in writing within 90 days of the onset of disability. Written proof of the participant's illness or accident and of the participant's disability must be provided by the participant within the same time period. Benefits are payable to the participant after expiry of the elimination period. The claim form must be completed by the participant, the employer and the attending physician, then forwarded to the Insurer as soon as possible.

LIFE INSURANCE

1. Participant's Basic Life Insurance *(mandatory participant)*

Upon the death of a participant, the Insurer will pay to the beneficiary a benefit equal to:

Coverage status*	Amount of insurance
Individual	1 x participant's annual salary
Family	2 x participant's annual salary

* Please refer to page 7 to determine the coverage status.

The amount of insurance is subject to a maximum of $350,000, increased to $500,000 if evidence of insurability deemed satisfactory by the Insurer is presented. The amount payable is reduced by 50% at age 65. This coverage terminates on the date of the participant's retirement, subject to application for the retirees' plan.

2. Accidental Death and Dismemberment Insurance *(mandatory participation)*

If a participant who has not retired suffers an accident while this coverage is in force and sustains any of the losses specified in the table below within 365 days following the date of such accident, the Insurer will pay a benefit equal to a percentage of the amount of Participant's Basic Life Insurance, as specified in the table below. The maximum amount payable under this benefit for all losses related to the same accident or multiple accidents occurring within the same 365-day period may not exceed 100% of the amount of Basic Life Insurance payable in the event of the participant's death, except in the case of quadriplegia, paraplegia, and hemiplegia, where the maximum amount payable is limited to 200% of the amount of Basic Life Insurance

Loss	Percentage
- Quadriplegia	200%
- Paraplegia	200%
- Hemiplegia	200%
- Loss of life	100%
- Total loss of vision in both eyes	100%
- Loss of both hands or both feet	100%
- Loss of one hand or one foot and total loss of vision in one eye	100%

Loss	Percentage
- Loss of one hand and one foot	100%
- Loss of speech and of hearing in both ears	100%
- Loss of one leg or one arm	50%
- Total loss of vision in one eye	50%
- Loss of one hand or one foot	50%
- Loss of speech or of hearing in both ears	50%
- Loss of the thumb and index finger of the same hand	33 1/3%
- Loss of at least four fingers of one hand	33 1/3%
- Loss of hearing in one ear	33 1/3%
- Loss of all toes of one foot	16 2/3%

Exclusions and reduction of coverage

This coverage does not apply and benefits shall not be payable to the participant if the loss sustained occurs in the following cases:

- While carrying out any of the duties of an airplane crew or any duty whatsoever related to a flight.
- Due to war, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.
- Due to attempted suicide or suicide, or voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.
- During the insured's participation in a criminal act or an act deemed to be criminal, including the act of driving a motor vehicle while having a blood alcohol level in excess of the prescribed legal limit where the accident occurred.
- Any condition occurring while the participant is on active duty with the armed forces of any country.
- Due to an illness which appears at the time of an accident but that is not due to such accident.
- Following medical or dental treatment, surgery or anesthesia.
- While driving a motor vehicle, boat or aircraft while under the influence of drugs or medication not taken in compliance with the physician's prescription or manufacturer's recommended dosage.

3. Spouse's and Dependent Children's Basic Life Insurance *(mandatory participation)*

The amount of insurance payable following the death of an insured spouse or dependent child age 24 hours or older is equal to $10,000. This coverage terminates no later than the date of the participant's retirement, subject to application for the retirees' plan.

4. Optional Life Insurance *(optional participation)*

Participant

Participants may obtain from 1 to 20 units of Optional Life Insurance, each unit being equal to 1/2 of the annual salary. The amount of insurance is subject to a maximum of $1,500,000 minus the amount of Basic Life Insurance. This coverage is reduced by 50% at age 65, and terminates at the latest when the participant reaches age 70 or on the date of the participant's retirement, if earlier. This coverage is subject to evidence of insurability in accordance with the Insurer's requirements at the time of the participant applies for this benefit or each time a new unit of Optional Life Insurance is added. See "Exclusions" under item 6.

Spouse and dependent children

As well, participants who applied for Spouse's and Dependent Children's Basic Life Insurance may obtain amounts equal to the following on the life of their spouse and dependent children:

- 1 to 20 units of $10,000, maximum $200,000, for a spouse. This coverage is reduced by 50% when the participant reaches age 65.
- 1 to 5 units of $10,000, maximum $50,000, for a dependent child (age 24 hours or older).

This coverage is subject to evidence of insurability in accordance with the Insurer's requirements at the time the participant submits an application for this benefit or each time a new unit of Optional Life Insurance is added. See "Exclusions" under item 6.

5. Accelerated benefit payment in the event of terminal illness

A disabled participant under age 63 who has been granted a waiver of premiums and whose life expectancy is no more than 12 months may obtain an accelerated benefit payment by submitting an application in writing to the Insurer, accompanied by appropriate medical evidence and the beneficiary's written consent.

The amount paid is limited to 25% of the amount of Life Insurance coverage held by the participant (Basic and Optional), subject to an overall maximum of $50,000.

At the participant's death, the insured amount payable by the Insurer is reduced by the amount paid as an accelerated benefit plus interest at the annual rate of 10%.

The Insurer assumes no responsibility with regard to the tax treatment of any accelerated benefit paid. Furthermore, this privilege ceases upon termination of the contract, even for participants who have been granted a waiver of premiums.

6. Exclusions that apply to item 4

These benefits do not apply if the participant dies from suicide or the effects of any attempted suicide during the first 2 years following the effective date of this benefit, its reinstatement or any increase in the benefit amount, whether or not the insured is of sound mind at the time of suicide or attempted suicide. In such case, insurance under this benefit, or the increase in insurance, as the case may be, shall be null and void and the liability of the Insurer shall be limited to refunding the premiums collected.

HEALTH INSURANCE
(Mandatory enrolment)

If the participant or the participant's spouse or dependent children are required to incur expenses following an accident or illness, the participant shall be entitled to a reimbursement of such expenses, up to the maximum amounts specified hereafter.

The expenses specified in items 1, 2, 3, 4 and 5 are exempt from any deductible and are reimbursed at 100%.

1. Hospitalization expenses

The Insurer reimburses hospitalization expenses incurred in Canada in excess of amounts payable under any government insurance plan, up to the cost of a semi-private room, without any limit as to the number of days, provided that the hospitalization begins while insurance is in force.

2. Accommodation expenses in a residential and long term care centre

Expenses for occupying a room in a residential and long term care centre, within the meaning of the *Act respecting health services and social services*, or in a hospital centre in which the insured is receiving long term care, in excess of the expenses payable under any government insurance plan, up to the cost of a semi-private room, provided that occupancy of such room begins while insurance is in force. However, for extended care of a chronic condition in departments or hospital centres specializing in this type of care, hospitalization expenses shall be limited to 180 days per calendar year.

3. Rehabilitation centre

Expenses for occupying a room, including meals, for at least 12 consecutive hours, in a rehabilitation centre, within the meaning of the *Act respecting health services and social services*, in excess of the expenses payable under any government insurance plan, up to the cost of a semi-private room (two beds), provided the insured is admitted to such centre less than 14 days following the end of hospitalization and such hospitalization begins while insurance is in force. However, these expenses are limited to a maximum of 180 days per disability.

4. Travel Insurance

(See description of benefit on page 41.)

5. Trip Cancellation Insurance

(See description of benefit on page 49.)

ANNUAL DEDUCTIBLE:

The expenses described in items 6 and 7 are reimbursed after deduction of a $50 deductible per calendar year for participants with Individual coverage, a $100 deductible for participants and their dependents insured under Single-Parent coverage and a $150 deductible for participants and their dependents insured under Family coverage. *For new participants, the full deductible applies for the calendar year in which their coverage begins.*

The following services and supplies are eligible for reimbursement, provided they are medically required, prescribed by a physician and necessary for the treatment of the insured.

6. Prescription drugs

Expenses reimbursed at 75%, after application of the deductible. However, if eligible expenses incurred for the participant and the insured dependents, if any, exceeds $2,400 per calendar year, the excess amount is eligible for reimbursement at 100%.

a) The Insurer reimburses **pharmaceutical services and prescription drugs** that are covered under the RAMQ's Basic Prescription Drug Insurance Plan (BPDIP), as established under the *Act respecting prescription drug insurance* (R.S.Q., c. A-29.01). However, these services and prescription drugs are not covered for participants age 65 and over and their dependents, or for dependents age 65 and over, unless the participant has specifically requested otherwise.

b) Subject to the following exclusions, the Insurer reimburses prescription drug expenses, other than those mentioned in the preceding paragraph, that are included in the *Association québécoise des pharmaciens propriétaires* (AQPP) prescription drug formulary and are dispensed by a licensed pharmacist or duly authorized physician and may only be obtained on prescription from a physician or dentist for which the directions for use are specifically related to the following pathological conditions: heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma.

EXCLUSIONS

- Drugs coded "V" or "Z" in the drug formulary of the AQPP.
- Products considered to be food substitutes, cosmetic products, soaps, sunscreens and tanning oils, skin emollients, shampoos and other products for scalp treatment.
- Dietetic substances or foods.
- Homeopathic medicines.
- Drugs administered primarily for preventive purposes. For the purposes of this exclusion, a drug used to stabilize or regulate a pathological condition diagnosed by a physician is not considered to be used for preventive purposes.
- Products used to treat hair loss or wrinkles or any other treatment administered primarily for aesthetic purposes, unless required as the result of an accident.
- Smoking cessation products.
- Drugs or substances used for the treatment of impotence, subject to item c).
- Any substances used for the purpose of insemination, and contraceptive and prophylactic jellies and foams.
- Drugs provided during a period of hospitalization.

Furthermore, the Insurer may deny reimbursement of any drugs prescribed for a condition other than those listed in the manufacturer's directions for use or not prescribed in accordance with current medical practice. The Insurer may, among other things, require a medical diagnosis and limit reimbursement to a reasonable maximum.

In the event that Health Canada approves a new drug that may substantially affect the cost of coverage under this benefit, the Insurer reserves the right to exclude such drug from coverage if it does not appear on the drug formulary of the Régie de l'Assurance-maladie du Québec, or modify the applicable premium as of the drug's date of approval.

c) **Prescription drugs for the treatment of erectile dysfunction** following prostate surgery, dispensed by a pharmacist or duly authorized physician, up to a maximum of $1,000 of eligible expenses per calendar year, per insured.

7. Other eligible expenses reimbursed at 75%

The following services and supplies are eligible for reimbursement, provided they are medically required, prescribed by a physician and necessary for the treatment of the insured:

- Expenses for the purchase of an **intrauterine device (IUD).**
- Professional fees of **registered nurses or nursing assistants** who are members in good standing of a relevant professional order recognized by appropriate legislative authorities, for medical care provided outside the hospital, excluding care provided by any person who usually resides in the participant's home or is a member of the participant's family, up to a maximum of $15,000 of eligible expenses per period of 36 consecutive months, per insured.
- Expenses for **oxygen** and the rental of equipment for its administration, **blood and blood plasma**, except expenses for the preservation or freezing of blood or plasma.
- Expenses for **ultrasounds** carried out for prevention or diagnostic purposes outside a hospital centre, up to an eligible maximum of $500 per year, per insured.
- Expenses for the rental of **therapeutic devices**, up to a lifetime maximum of $12,500 of eligible expenses per insured.
- Expenses for the rental, or purchase of a basic model if this option is deemed more economical by the Insurer **of a wheelchair or hospital bed**.
- Expenses for the purchase or replacement of an **artificial limb** for a loss occurring while insurance is in force.
- Expenses for the rental, replacement or purchase of **dressings, external prostheses** (except dental prostheses), **crutches, splints, casts, supports, trusses, orthopedic corsets and other orthopedic devices**.
- Expenses for **X-rays, laboratory analyses and electrocardiograms** performed without being hospitalized, for prevention or diagnostic purposes.
- Expenses for **cosmetic surgery** following an accident occurring while insurance is in force, subject to a maximum of $6,250 of eligible expenses per accident, provided that services began within 12 months following the date of the accident.
- Expenses for the purchase of a **breast prosthesis** required following a radical mastectomy, in excess of the amount paid by the *Régie de l'assurance-maladie du Québec*.
- Professional fees of **audiologists, speech-language pathologists and occupational therapists** who are a members in good standing of a relevant professional order recognized by appropriate legislative authorities, up to a maximum of $750 of eligible expenses per calendar year, per insured. Only one treatment per day, per insured, is eligible for reimbursement.

- Expenses for the purchase of a **capillary prosthesis (wig)** required following chemotherapy treatments.
- Expenses for the purchase of **glasses or contact lenses** required following cataract surgery.
- The initial or replacement cost of **orthopedic shoes or foot orthotics** that are custom-made for the insured by a specialized orthopedic laboratory licensed under the *Public Health Protection Act*, (R.S.Q. c. P-35), up to $625 of eligible expenses per calendar year, per insured.
- Expenses for the purchase of **corrective footwear**, sold by a specialized orthopedic laboratory licensed under the *Public Health Protection Act*, (R.S.Q. c. P-35), up to $250 of eligible expenses per calendar year, per insured.
- Expenses for the substance used in **sclerosing injections** that are medically necessary and administered by a physician, up to a maximum of $25 of eligible expenses per treatment and 15 treatments per calendar year, per insured.
- Expenses for the purchase of an appliance used to manage diabetes **(glucometer, dextrometer** or any other appliance of a similar nature) as well as the travel case for transporting it, upon presentation of a complete report from the attending physician stating that the insured is insulin-dependent, up to $300 of eligible expenses per period of 60 consecutive months, per insured.
- Expenses for the purchase, replacement, rental, adjustment or repair of a **hearing aid** up to $1,500 of eligible expenses per period of 48 months, per insured.
- Expenses incurred for a **stay in a private clinic** recognized as specialized in treatment for alcoholism or drug addiction, excluding addiction to smoking, up to $80 of eligible expenses per day and a lifetime maximum of $2,500 of eligible expenses per insured.
- Expenses for the purchase of **support stockings**, up to a maximum of 4 pairs per calendar year, per insured.
- Expenses incurred for **required alterations to the insured's home or vehicle** in the event the insured is permanently required to use a wheelchair due to an accident that occurs while this insurance benefit is in force, up to a lifetime maximum of $3,000 of eligible expenses.
- Expenses for **magnetic resonance imaging (MRI)** carried out outside a hospital centre for purposes of diagnosis, up to $800 of eligible expenses per calendar year, per insured.
- Expenses for the purchase of a **transcutaneous electrical nerve stimulator** for nerves only, up to an eligible maximum of $1,000 per calendar year, per insured.

- Expenses for the purchase of an **insulin pump** used to manage diabetes, provided that the use of such an apparatus is required by the medical condition of the insured. However, the maximum reimbursement is limited to $6,000 per period of 5 consecutive years, per insured.
- **Multiservices coverage** — Home Care and Assistance

  Expenses for the services described hereafter, when recommended by a physician and deemed necessary following hospitalization or day surgery, are eligible for reimbursement, up to an overall eligible maximum of $500 per calendar year, per insured, for all of these expenses, provided the expenses are incurred within 30 days following the hospitalization, or discharge from the day surgery unit, and the services cannot be provided by a person who resides with the insured.

  a) Fees for home assistance services, invoiced by a specialized organization, for purposes of washing, feeding, dressing and looking after the insured's basic hygienic needs.

  b) Expenses incurred for a stay in a residential establishment specialized in post-hospitalization care.

  c) Basic expenses for the insured's general home maintenance services (meal preparation, housekeeping, laundry and dishwashing, lawn mowing and snow removal) performed by someone other than a close relative of the insured.

  d) Expenses for childcare services provided for minor children by a person other than a close relative of the insured.

  e) Public transportation expenses incurred to attend medical appointments at a physician's office or hospital, including expenses for accompaniment, if necessary, by someone other than a close relative of the insured.

  To access the services specified under items a) and b), we recommend contacting our referral service at the numbers below. Also, following hospitalization or day surgery, we offer a telephone service providing information about different resources available in the area where the insured resides (CLSC, pharmacies, laboratories, hospital centres, etc.)

  - **Montreal: 514 286-8330**
  - **Toll free: 1 800 206-1291**

The following services and supplies are eligible for reimbursement, provided they are medically required and necessary for the treatment of the insured. However, the insured's condition does not need to be confirmed by a physician.

- Professional fees of **physiotherapists or physical rehabilitation therapists** working under the supervision of a physiotherapist or a physiatrist, who are members in good standing of a relevant professional order recognized by

appropriate legislative authorities, up to $750 of eligible expenses per calendar year, per insured, for all of these specialists. Only one treatment per day, per insured, is eligible for reimbursement.

– Professional fees of **chiropractors** (including X-rays), who are members in good standing of a relevant professional order recognized by appropriate legislative authorities, up to $750 of eligible expenses per calendar year, per insured. Only one treatment per day, per insured, is eligible for reimbursement.

– Professional fees of **podiatrists, osteopaths, naturopaths, homeopaths, acupuncturists, dietitians, social workers and orthotherapists**, who are members in good standing of a relevant professional order recognized by appropriate legislative authorities or of a professional association recognized by the Insurer, up to $750 of eligible expenses per calendar year, per insured, per specialty. Only one treatment per day, per insured, is eligible for reimbursement.

– Professional fees of **psychoanalysts and psychologists** who are members in good standing of a relevant professional order recognized by appropriate legislative authorities, limited to one visit per day, up to $750 of eligible expenses per calendar year, per insured, per specialty.

– Professional fees of **massage therapists and kinesitherapists** who are members in good standing of a professional association recognized by the Insurer, up to $750 of eligible expenses per calendar year, per insured, for all of these specialties.

– Professional fees of a **dentist** for treatment of a fractured jaw or damage to healthy, natural and vital teeth caused by an accident occurring while insurance is in force, provided that services are rendered within 12 months following the date of the accident. However, if more than one type of treatment exists for the insured's dental condition, the Insurer reimburses expenses based on the least expensive normal and appropriate treatment.

– Expenses for transportation by **ambulance** to the nearest hospital centre able to provide the care required, including emergency air or rail transportation.

8. Exclusions and reduction of coverage

Subject to the provisions of the *Act respecting prescription drug insurance*, any expenses incurred in the following cases are excluded from coverage under this benefit and are not eligible for reimbursement by the Insurer:

– Preventive vaccines;

– Dentures, eyeglasses, contact lenses and their adjustment, except if required as the result of an accident;

– Injections provided as part of a weight reduction program;

- Surgery, treatments or prostheses provided for aesthetic purposes, except following an accident;
- Care or treatment provided primarily for aesthetic purposes, protective glasses or sunglasses and care or treatment provided free of charge;
- Any product or service that is not medically required;
- Capillary prostheses (wigs), except following chemotherapy treatments;
- Eye or hearing examinations;
- Voluntary self-inflicted injury or self-mutilation, whether or not the insured is of sound mind;
- Treatment or services provided by a member of the insured's family or by a person who resides with the insured;
- Periodic medical examinations, medical examinations for the purposes of employment, admission to an educational institution or insurance, or health trips;
- Any condition occurring while the insured is on active duty with the armed forces of any country;
- Due to war, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended;
- Due to participation in a criminal act or an act deemed to be criminal;
- Any treatment, services or products of an experimental nature;
- Any user charge, deductible or coinsurance required by any public plan for products or services eligible for reimbursement under this benefit.

For the Travel Insurance benefit, the exclusions and reductions listed under the coverage description shall apply in addition to those stipulated above.

For the Trip Cancellation Insurance benefit, the exclusions are listed under the coverage description.

Also excluded are any expenses payable under any other individual or group plan and expenses for which the insured is entitled to an indemnity under the *Act respecting industrial accidents and occupational diseases*, the *Automobile Insurance Act*, the Quebec *Hospital Insurance Act*, the Quebec *Health Insurance Act* and any other federal or foreign law with similar provisions.

Also excluded are any expenses for care, services or supplies that the insured is not required to pay, that the insured would not be required to pay if he or she had invoked the provisions of a government insurance plan, or that the insured would not have had to pay in the absence of this coverage.

LONG TERM DISABILITY INSURANCE *(Mandatory participation)*

Upon receipt and approval by the Insurer of proof establishing that a participant has become disabled as defined under the contract, and following expiry of the elimination period, the Insurer will pay monthly benefits to the participant, the amount of which is determined hereafter.

1. Elimination period

The elimination period is a waiting period during which benefits are not payable. The length of this period is 6 months or until the participant's sick leave bank has been depleted, if longer.

2. Benefit period

The first benefit payment is made as of the 31st day following expiry of the above-mentioned elimination period, and subsequent payments are made each month thereafter. Furthermore, benefits cease to be payable on the earliest of the following events:

- The last day of the week in which the participant reaches age 62.
- The date on which total disability ends.
- The date on which the participant becomes eligible for a retirement annuity without actuarial reduction and has at least 35 years of credited service for calculation purposes under the participant's retirement plan.
- The date of the participant's retirement.
- The date the participant fails to provide proof of continuing disability deemed satisfactory by the Insurer.
- The date the participant refuses to undergo a medical examination as required by the Insurer.
- The date of the participant's death.

3. Provisions for seasonal and casual employees hired for a period equal to or greater than 12 months

SEASONAL EMPLOYEES:

Monthly benefits are payable for the periods of employment only.

The elimination period and the benefit period for which disability benefits are paid shall be determined based on the longer of the following periods:

a) The current period for which the employee was called back.

b) The average length of the 3 most recent periods for which the employee was called back.

CASUAL EMPLOYEES:

The provisions describing the calculation of monthly benefits paid by the Insurer shall also apply to casual employees eligible for insurance. Monthly benefits are calculated as if the employer had paid salary insurance benefits, even if such benefits cease on the scheduled termination date of the casual employee's contract of employment.

4. Benefit amount

a) When the salary insurance benefits paid by the employer to the disabled employee are equal to either 2/3 or 50% of the employee's salary, the amount payable by the Insurer is the additional amount required to reach 75% of the employee's gross salary. The same salary is used to calculate the benefits from the employer and the Insurer. When the disabled employee is no longer receiving salary insurance benefits from the employer, the amount payable is equal to 60% of the gross salary.

b) Starting from the 4th year of disability, in addition to the benefits described in paragraph a), the Insurer shall pay into the participant's retirement plan double the monthly contribution the participant would normally be required to pay. Payment of such contribution by the Insurer shall begin on the date the participant ceases to be exempted from paying such contribution under the retirement plan. No contributions shall be paid after the date on which the participant starts receiving retirement benefits under such plan.

When a refund of accumulated contributions, with interest, or a refund of the present value of the retirement benefits is requested by a participant who meets the eligibility conditions for an employee suffering from a terminal illness, the Insurer shall cease making contributions as of the date the participant's refund request is received by the *Commission administrative des régimes de retraite et d'assurances* (CARRA). The provisions that apply in the case of a partial recovery shall be determined on an ad hoc basis.

In all cases, the maximum monthly benefits payable are initially limited to $10,000.

Furthermore, starting from the 3rd year of disability, the total of the disability insurance benefits specified above in paragraphs a) and b) and the net initial benefits from other sources may not exceed 90% of the participant's net salary at the onset of disability. However, for the calculation of the 90% maximum, the amount of the contribution to the pension plan, as provided for under paragraph b), is limited to the amount of a single contribution.

The following income is considered to be income from other sources:

- Income received under the *Act respecting industrial accidents and occupational diseases*.
- Income received under the *Quebec Automobile Insurance Act*.
- Income received under the *Act to promote good citizenship*, the *Crime Victims Compensation Act*, or the Quebec Pension Plan (initial disability benefit amount only).
- Any disability benefits paid under a retirement plan of which the participant is a member.

The participant's initial salary before the onset of disability is indexed annually in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan, up to a maximum of 3%, for coordination purposes.

At the Insurer's request, the participant must submit an application for disability benefits under the above-mentioned plans and legislation. If the participant fails to do so, the Insurer may, for the period in which the participant is in default and subject to a 60-day written notice, consider any income that would have been paid to the participant had he or she submitted such application to be income received from other sources.

Also, for the purposes of calculating income from other sources, a disabled participant who is entitled to disability income benefits under the CPP or QPP and who has applied for retirement income from the CPP or QPP shall be presumed to have received the disability income benefits he or she would have received if an application had been submitted, or that he or she would continue to receive if an application for retirement income benefits had not been submitted.

"Net salary" means the salary after deduction of Quebec Pension Plan contributions, Employment Insurance (Human Resources and Skills Development Canada) contributions, Quebec Parental Insurance Plan contributions and applicable provincial and federal government income taxes, in accordance with the declarations of exemption made to the employer.

*For the purpose of calculating **provincial income tax**, the only exemptions considered are the basic exemption, the spousal exemption, the dependent child exemption, the exemption for individuals maintaining a self-contained domestic establishment, the personal exemption for physical or mental impairment, and the family tax reduction exemption.*

*For the purpose of calculating **federal income tax**, the only exemptions considered are the basic exemption, the spousal exemption or equivalent amount, and the exemption for handicapped persons.*

5. Rehabilitation

Any participant who agrees to enter a rehabilitation program sponsored by the Insurer is entitled to the monthly rehabilitation benefits described below. The benefits end after the expiry of a 24-month period following the beginning of the rehabilitation program, an interruption of the program, or the withdrawal of the Insurer's approval of the program.

Monthly rehabilitation benefits are equal to the amount of the participant's monthly benefits prior to registration in the rehabilitation program, reduced by an amount equal to 50% of the remuneration for work carried out under the rehabilitation program.

If the participant's income from rehabilitation benefits and remuneration for work carried out under the rehabilitation program exceeds 100% of the participant's basic net monthly salary at the beginning of the elimination period, monthly rehabilitation benefits are reduced by the excess amount. For calculation purposes, the basic net salary is indexed annually in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan, up to a maximum of 3%.

If, at the end of the rehabilitation program, the participant works in an occupation where the compensation is lower than the disability benefits he or she would have been entitled to receive if still on disability, the Insurer will pay a residual benefit equal to the disability benefit reduced by 100% of the compensation received from such occupation at the end of the rehabilitation program.

Such residual benefit is indexed according to the provisions set out in the following point, and shall cease upon the death of the participant, on the participant's 62nd birthday, or on the participant's date of retirement if earlier.

In the event that the participant leaves his or her job or becomes disabled again, the benefit payable shall be the disability benefit the participant would have received had he or she not participated in the rehabilitation program, reduced by an disability income relating to such job and originating from any public or private plan for which the participant is eligible.

6. Indexation

When the insured is no longer receiving disability benefits from the employer, the benefits paid by the Insurer are indexed on January 1 each year, in accordance with the same conditions as those applicable to benefits payable under the Quebec Pension Plan. However, the indexation is limited to 3%.

7. Exclusions and reduction of coverage

Benefits shall not be payable to the participant under this insurance coverage:

a) If the participant's total disability occurs due to any of the following causes:

   - War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.
   - Voluntary self-inflicted injury or self-mutilation, whether or not the participant is of sound mind.
   - Participation in a criminal act or an act deemed to be criminal.
   - Any condition occurring while the participant is on active duty with the armed forces of any country.
   - Alcoholism, drug addiction or compulsive gambling, except for a period of disability during which the participant is receiving treatment or uninterrupted medical care as a part of a detoxification treatment or rehabilitation in an establishment, agency or institution specialized for such purposes.

- Termination of employment in order to undergo plastic surgery performed solely for aesthetic purposes, unless such surgery is required following an illness or injury.

b) For a period of total disability corresponding to one of the following periods:

   - A period of maternity leave taken in compliance with a provincial or federal statute or maternity leave granted by the employer; any such leave is deemed to begin on the planned leaving date or the delivery date, whichever is earlier.

   - A period during which the participant is receiving maternity benefits provided for under the *Employment Insurance Act* or the *Quebec Parental Insurance Act*.

c) For any period of disability during which the participant is not under the care of a physician. In the event of a disability due to a mental illness, the disabled participant must be under the care of a specialist in psychiatry.

d) For any period during which the participant engages in any gainful occupation, except within a rehabilitation program.

8. Supplement to pregnancy-related Employment Insurance or Quebec Parental Insurance Plan benefits

When a participant who is otherwise eligible for benefits is subject to the exclusion in relation to maternity leave mentioned above in item 6.b) and is receiving pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits, the Insurer will pay a supplement calculated to cover the difference between the amount of pregnancy-related Employment Insurance benefits or Quebec Parental Insurance Plan benefits payable and the amount to which the participant would have been entitled if the exclusion in relation to maternity leave was not applicable.

TRAVEL INSURANCE

IMPORTANT

In the case of departure outside your province of residence, you must contact the Assistor at the following numbers: 1 800 363-9050 or 514 985-2281 **ONLY** if you suffer from a known illness or condition and you are unsure about your health condition or you are awaiting diagnosis (please refer to the "Exclusion and reduction of coverage" section below.)

The customary and reasonable expenses described in the Travel Insurance section are eligible for reimbursement if incurred following an emergency situation resulting from an accident or illness occurring while the insured is temporarily outside the province of residence, provided the insured is covered under the government health insurance plan of the province of residence.

To be considered as temporarily outside the province of residence, the insured's stay must not exceed 6 consecutive months; the stay may however be extended beyond 6 months if the extension is due to an illness or accident that occurs during the 6-month period and a return to the province of residence is impossible due to justifiable medical reasons.

If the stay extends beyond 6 months, the participant may maintain the insurance coverage, subject to submitting a written request to the Insurer and provided the participant is eligible for the Quebec hospitalization and health insurance plans.

Benefits are granted over and above and not in replacement of any benefits provided under government programs. Expenses are subject to a maximum lifetime reimbursement of $1,000,000 per insured.

EXCLUSION AND REDUCTION OF COVERAGE

To be covered under this benefit, insured persons who have a known illness or condition must ensure before departure that their health condition is stable and under control, that they can carry out usual daily activities and that they are experiencing no symptoms that may reasonably suggest that any complications may arise or that medical care may be required during the planned stay outside the province of residence.

An illness or condition is considered to be stable in the absence of any:

- deterioration;
- relapse;

- diagnosis of terminal phase;
- chronicity likely to lead to deterioration or complications during the planned trip outside the province of residence.

Insured persons with a known illness or condition who are unsure about their health condition or who are awaiting diagnosis must contact the Assistor at least 15 days before departure to obtain confirmation of insurance coverage under this benefit.

ELIGIBLE EXPENSES

Hospitalization, medical and paramedical expenses

- Expenses for hospitalization in a semi-private or private room, in excess of the amounts reimbursed or eligible for reimbursement under the government health insurance plan of the insured's province of residence.
- Incidental expenses (telephone, television, parking, etc.) related to hospitalization, upon presentation of supporting documents, up to a maximum of $100 per hospitalization.
- Professional fees of a physician for medical, surgical or anesthetic care other than fees for dental care; expenses incurred are payable only for the portion of expenses in excess of the benefits payable under the government health insurance plan of the insured's province of residence.
- The cost of drugs obtained on prescription by a physician in an emergency treatment situation.
- Professional fees of a registered nurse for private nursing care dispensed exclusively in a hospital, when medically necessary and prescribed by the attending physician, up to a maximum reimbursement of $3,000. The nurse must not be related to the insured nor be a travel companion.
- Rental of therapeutic devices and purchase of trusses, corsets, crutches, splints, casts and other orthopedic devices, when prescribed by the attending physician.
- Professional fees of a dentist for treatment of accidental injury to natural teeth caused by an accident occurring outside the insured's province of residence, up to a maximum reimbursement of $1,000 per accident; to be covered, expenses must be incurred within 12 months following the accident.

Assignment outside the province of residence

- Hospitalization expenses and the professional fees of a physician for the portion of expenses in excess of those covered under the provincial plan and which are not eligible for reimbursement due to the sole fact of being incurred

for non-urgent treatment or pregnancy-related care, are covered under this benefit if the expenses are incurred while the participant is on assignment outside the province of residence for the purposes of his or her employment for a period of 30 consecutive days or more. To be eligible, expenses must be incurred in the nearest area to the participant's assignment where the required treatment or services are available.

Expenses for transportation

- Expenses for transportation of the insured by air or surface ambulance to the nearest medical centre where adequate medical care is available. This service also includes transfers between hospitals when the attending physician and the Assistor deem that current facilities are inadequate for treating the patient or stabilizing the patient's condition.
- Repatriation expenses for the insured to return to the place of residence by an adequate public carrier in order to receive appropriate treatment, as soon as the insured's health condition so allows and insofar as the means of transport initially planned for the return cannot be used. If required by the insured's health condition, the Assistor will send a medical escort on site to accompany the insured on the return trip. Repatriation must be approved and planned by the Assistor.
- When the insured is repatriated or transported, the Assistor organizes and pays expenses for the insured's spouse and dependent children or the insured's travel companion, as applicable, to return to the insured's province of residence, up to the cost of a regularly scheduled airline flight, train or bus ticket, if the means of transport initially planned for the return cannot be used.
- When the insured's health condition does not allow medical repatriation and hospitalization outside the province must extend beyond 7 days, the Assistor will organize and pay round-trip transportation expenses to enable a close relative of the insured, residing in the insured's province of residence, to be at the bedside of the insured. The maximum reimbursement is $1,500. However, these expenses are not eligible for reimbursement if the insured is already accompanied by a close relative age 18 or over, if the necessity of a visit is not confirmed by the attending physician, or if the visit is not approved in advance and planned by the Assistor.
- The Assistor will make the necessary arrangements to return home any children under age 18 accompanying the insured if, following the insured's accident or illness, the insured or another accompanying adult is unable to do so personally.
- If the insured is unable to drive the automobile used for a trip following an illness or accident that occurs during the trip and no other passenger is able to drive the vehicle, the Assistor will pay the expenses incurred by a commercial agency to return the insured's personal vehicle home or rental vehicle to the nearest appropriate vehicle rental agency, up to a maximum reimbursement of $1,000.

- In the event of the insured's death, when necessary, the Assistor will organize and pay expenses for a round-trip economy class ticket by the most direct route (airplane, bus, train) to allow a close relative to identify the remains prior to repatriation, provided that no close relative age 18 years or over is accompanying the insured on the trip and is able to do so. The maximum reimbursement is $1,500.
- In the event of the insured's death, the Assistor will pay for the cost of preparing and returning the remains of the insured (excluding the cost of the coffin or casket) to the place of burial in the province of residence, subject to a maximum reimbursement of $5,000, or a maximum reimbursement of $3,000 in the event of cremation or burial on site.

Living expenses

- Expenses for accommodation and meals in a commercial establishment the insured must incur when obliged to postpone the return trip home due to an illness or bodily injury suffered by the insured, a close relative accompanying the insured or a travel companion, subject to a maximum reimbursement of $150 per day for a maximum of 8 days.

TRAVEL ASSISTANCE SERVICE

On request, the Assistor will provide insureds with worldwide travel assistance service 24 hours a day, 365 days a year, excluding countries at war or known to be in a state of political instability, making any intervention by the Assistor physically impossible.

- Advances for expenses covered under the Travel Insurance benefit. The Assistor then files a claim for reimbursement of expenses covered under the government health insurance plan of the insured's province of residence and with the Insurer.
- In the event of illness or accident abroad, the Assistor will provide straightforward medical information and information as to the location of an appropriate medical centre. If necessary, the Assistor will help coordinate the insured's admission to an appropriate clinic or hospital.
- Subject to the provisions herein, once notified of an illness or accident suffered by the insured outside the province of residence, the Assistor will coordinate communication between its medical service, the attending physician, and ultimately the insured's family doctor, in order to ensure any decisions made are best adapted to the situation.
- The Assistor will take charge of transmitting any urgent messages when the insured is personally unable to do so.

- The Assistor will ensure, insofar as possible, the dispatch of any drugs that are indispensable for the ongoing treatment of the insured in the event that it is impossible to obtain such drugs or equivalent drugs on site. In all cases, drugs must be paid for by the insured and then, if eligible, reimbursed by the Insurer.
- Upon presentation of supporting documents, the Assistor will reimburse the insured for any telephone and other communication expenses incurred by an insured in distress abroad in order to gain access to covered services.
- Upon request by the insured, the Assistor will provide any information required in the event of major problems occurring during the trip following the loss of the insured's passport, visa, credit card, etc.
- The Assistor will provide insureds in distress abroad with telephone access to a multilingual interpretation service.
- In the event that an insured is involved in legal proceedings following a traffic accident, highway code violation or any other civil offence, the Assistor will provide assistance by recommending names of lawyers. This service is only applicable in Canada and the United States.

OBLIGATIONS OF INSUREDS

- Insureds must notify the Assistor of any incident, accident or illness as soon as possible.
- As soon as they are able to do so, insureds must obtain the prior approval of the Assistor before taking any initiative or incurring any expenses. If the insured fails to fulfil this obligation, the Assistor will be relieved of its obligations to the insured.
- When an insured has benefited from repatriation under the terms of this Travel Insurance benefit, the Assistor reserves the right to claim any ticket held by the insured that was not used due to services provided by the Assistor.
- For the purposes of this benefit and with regard to any funds advanced or reimbursed by the Assistor, the insured hereby assigns and subrogates the Assistor in all of his or her rights and recourses to any reimbursement from which he or she benefits or claims to benefit in accordance with any public or private plan providing insured services similar to those for which advances or expenses have been incurred by the Assistor. Insureds shall agree to sign any document and execute any deed required by the Assistor in order to give full and complete effect to this assignment and subrogation and specifically mandate the Assistor for this purpose as attorney and representative for submitting any claim and collecting any reimbursement.

EXCLUSIONS AND REDUCTION OF TRAVEL INSURANCE COVERAGE

In addition to the exclusions and reductions of coverage specified for the Health Insurance benefit, the Insurer and the Assistor will issue no reimbursement nor provide any assistance to the insured in the following cases:

- When the loss occurs in the insured's province of residence.
- When the insured refuses without any valid medical reason to comply with the Assistor's recommendations with regard to repatriation or the choice of hospital or required care; by required care is meant the treatment needed to stabilize the insured's medical condition.
- If the insured fails to contact the Assistor as soon as possible in the event of a medical consultation or hospitalization following an accident or sudden illness.
- When expenses are incurred due to pregnancy and any related complications within 8 weeks preceding the expected date of delivery.

In such case, the insured must contact the Insurer at least 7 days prior to departure to inform the Insurer of his or her medical condition.

- When the loss is related to a known condition of the insured that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.
- When the expenses incurred outside the insured's province of residence could have been incurred in the province of residence, without danger to the insured's life or health, with the exception of immediately required expenses following an emergency situation resulting from an accident or sudden illness. For the purposes of this exclusion, the fact that the treatment available in the province of residence may be of a different quality than that available outside the province does not constitute a danger for the insured's life or health.
- When expenses are incurred for insureds in hospitals for the chronically ill, services for the chronically ill in public hospitals, extended care homes or thermal spas.
- For elective or non-emergency surgery or treatment, or if the trip was taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip was taken on the recommendation of a physician.
- For an accident occurring while the insured is practising any sporting activity involving remuneration, motor vehicle competition or any speed contest,

gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity.

- If the insured has consumed toxic quantities of alcohol, drugs or medication.
- For repatriation or travel assistance services, when the loss occurs in a country that is at war, whether declared or undeclared, is known to be experiencing political instability or during a riot, uprising, repression, restriction on free circulation, strike, explosion, nuclear activity, radioactivity or other events involving an Act of God making any intervention by the Assistor physically impossible.

The Insurer may, at any time and at its sole discretion, change the Assistor for the purposes of this benefit.

NOTE

If recommended by a physician, the Insurer will reimburse hospital and medical expenses outside Quebec, over and above the amount covered under the government plan, when the services in question are not available in Quebec, i.e. when the claim is not the result of a temporary lack of availability of such services. Hospital and medical expenses outside Canada are eligible only when the services are not offered in Quebec or elsewhere in Canada. The expenses must be covered by the *Régie de l'assurance maladie du Québec* and are subject to an annual maximum of $50,000 per insured.

EMERGENCY CONTACT INFORMATION

To obtain assistance services, be sure to have the information shown on your insurance certificate handy, and contact the Assistor by telephone at one of the following numbers:

- **In Canada and the United States 1 800 363-9050**
- **Elsewhere in the world (collect call) (+1) 514 985-2281**

TRIP CANCELLATION INSURANCE

In accordance with the conditions described hereafter, the Insurer will reimburse 100% of the expenses incurred by the insured following the cancellation or interruption of a trip, insofar as the expenses incurred are related to travel expenses paid in advance by the insured while this benefit is in force and that, at the time travel arrangements were finalized, the insured was not aware of any event that could reasonably lead to the cancellation or interruption of the planned trip. The expenses covered are limited to $5,000 per insured, per trip.

ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION

The trip must be cancelled or interrupted due to one of the following causes:

a) An illness or accident preventing the insured, the insured's travel companion, a close relative of either, or a business partner of the insured from performing his or her usual activities, which is sufficiently serious to justify the cancellation or interruption of the trip.

b) Death of the insured, the insured's spouse, the insured's child or spouse's child, or the insured's travel companion or business partner.

c) Death of a close relative of the insured, other than the insured's spouse or child, or a close relative of the travel companion if the funeral is scheduled to take place during the trip or the preceding 14 days.

d) Death or emergency hospitalization of the host at destination.

e) The insured's or travel companion's summons for jury duty or subpoena to act as a witness in a case scheduled to be heard during the planned trip, provided the person involved is not a party to the litigation and has taken all necessary measures to have the hearing postponed.

f) Quarantine of the insured or travel companion, provided that quarantine ends 7 days or fewer prior to the scheduled date of departure.

g) Hijacking of the airplane on which the insured is travelling.

h) Damage rendering the principal residence of the insured, of the travel companion or of the host at destination uninhabitable, provided the residence remains uninhabitable 7 days or fewer prior to the scheduled date of departure, or the damage occurs during the time of the trip.

i) Transfer of the insured or travel companion, by the same employer, to a location more than 100 kilometres from the current place of residence, provided the transfer is required within the 30 days preceding the scheduled date of departure.

j) Terrorism or any other situation in the country to which the insured is travelling, provided the Government of Canada issues a warning that Canadians should not travel in that country during the time of the planned trip and that the warning was issued after travel expenses were incurred.

k) Missed departure due to a delay in the means of transportation used to reach the point of departure, provided that the means of transportation used provides for scheduled arrival at the point of departure at least 3 hours prior to the time of departure, or at least 2 hours prior to departure if the distance to be covered is less than 100 kilometres. The delay must be caused by atmospheric conditions, mechanical problems (except for a private automobile), a traffic accident or an emergency road closure, each of the latter two causes requiring confirmation by a police report.

l) Atmospheric conditions such that the departure of the public carrier used by the insured, at the point of departure of the planned trip, is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip, or preventing the insured after departure from making a scheduled connection with another carrier, provided the scheduled connection after departure is delayed by at least 30% (minimum 48 hours) of the planned duration of the trip.

m) Damage occurring to a commercial establishment or location where a commercial activity is scheduled to be held, preventing the activity from taking place, provided that a written cancellation notice is issued by the organization officially responsible for the activity.

n) Involuntary loss of permanent employment of the insured or the insured's spouse, provided the person in question has been working for the employer for at least one year.

EXPENSES COVERED

The following expenses are covered, provided they are incurred by the insured, and are limited to $5,000 per insured, per trip.

a) In the event of cancellation prior to departure:

   - The non-refundable portion of prepaid travel expenses.
   - Additional expenses incurred by the insured if the insured's travel companion must cancel due to one of the eligible reasons for cancellation provided hereunder and the insured decides to proceed with the trip as initially planned; expenses are eligible up to the amount of the cancellation penalty applicable at the time the travel companion has to cancel.
   - The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if departure is delayed due to atmospheric conditions and the insured decides not to proceed with the trip.

b) In the event of missed departure, at the beginning of or during the trip, due to one of the reasons provided hereunder, the additional cost charged by a scheduled public carrier for economy class travel, via the most direct route, to the initially planned trip destination.

c) If the return is earlier or later than planned:

   – The additional cost of a one-way economy class ticket, by the most direct route to the point of departure, by the means of transportation initially planned, or if the initially planned means of transportation cannot be used, the fees charged by a scheduled public carrier for economy class travel, by the most economical means of transportation, via the most direct route, for the insured to return to the initial point of departure; these expenses must be pre-approved by the Insurer.

     However, if the return is delayed by more than 7 days due to an accident or illness suffered by the insured or travel companion, expenses incurred are eligible, provided the person in question was admitted to hospital as an inpatient for more than 48 hours within the 7-day period.

   – The unused and non-refundable portion of the ground portion of prepaid travel expenses.

EXCLUSIONS APPLICABLE TO TRIP CANCELLATION INSURANCE

This benefit does not cover losses due to the following causes or to which such causes have contributed:

– Any trip taken for the purpose of obtaining or with the intention of receiving medical treatment or hospital services, whether or not the trip is taken on the recommendation of a physician.

– Any trip taken to visit a person who is ill or has suffered an accident, whereby the cancellation or interruption of the trip is due to a change in the medical condition or the death of such person.

– War, whether declared or undeclared, or active participation in an insurrection, whether real or apprehended.

– Active participation of the insured or travel companion in a criminal act or an act deemed to be criminal.

– Pregnancy, and any related complications, within 8 weeks preceding the expected date of delivery.

– Suicide or attempted suicide by the insured or travel companion, or voluntary self-inflicted injury or self-mutilation, whether or not the person is of sound mind.

– If the insured has consumed toxic quantities of alcohol, drugs or medication.

- Participation in any sporting activity involving remuneration, motor vehicle competition or speed contest, gliding or hang-gliding, mountaineering, skydiving, whether in freefall or not, bungee jumping or any other dangerous activity.
- A medical condition for which the insured or travel companion has been hospitalized, or has received or been prescribed medical treatment or consulted a physician within 90 days preceding the date on which travel expenses were incurred, except if it is proven to the satisfaction of the Insurer that the condition of the person in question is stable at the time expenses are incurred. Any change in medication, including use and dosage, is considered to be a medical treatment.
- Any loss related to a known condition of the insured or travel companion that is subject to periods of sudden deterioration and cannot be controlled by medication or otherwise.

NOTICE OF CANCELLATION

In the event that a cause for cancellation occurs prior to departure, the trip must be cancelled within a maximum period of 48 hours, or if this period ends on a statutory holiday, by the next working day, and notice must be provided to the Insurer at the same time. The Insurer's liability is limited to the cancellation costs stipulated in the travel contract that are applicable 48 hours following the date of the cause for cancellation, or if a statutory holiday, on the next working day.

COORDINATION OF BENEFITS

Any benefits payable hereunder will be reduced by any amounts payable under another individual or group insurance plan. Also excluded from coverage are any expenses incurred that an insured would not have had to pay if not covered under this benefit.

CLAIMS UNDER TRIP CANCELLATION INSURANCE

When filing a claim, insureds must provide the following supporting documents:

- Unused travel tickets.
- Official receipts for additional transportation expenses.
- Receipts for ground travel arrangements and other expenses paid. Receipts must include the contracts officially issued by a travel agent or accredited firm, specifying the non-refundable amounts in the event of cancellation. Written proof that the insured has requested a reimbursement of travel expenses from the travel agent or accredited firm must be forwarded to the Insurer, along with the reply received from the travel agent or accredited firm as to the outcome of such request.
- Official documents certifying the reason for cancellation. If the trip is cancelled for medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising where the illness or accident occurred. The medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip.
- An official police report, if the means of transportation used is delayed because of a traffic accident or emergency road closure.
- An official report issued by the appropriate authorities pertaining to atmospheric conditions.
- Written proof issued by the official organizer of a commercial activity confirming that the event is cancelled and the specific reasons why.
- Any other report required by La Capitale in support of the insured's claim.

ANSWERS TO YOUR QUESTIONS

- **When and how can you contact us?**

  Call 1 800 463-4856 or 418 644-4200 Monday to Friday, from 8:30 a.m. to 5:00 p.m.

  Be sure to have your service card handy when you call. It shows your contract number and identification number and having this information on hand helps us to provide you with the most efficient service possible.

- **Moving?**

  Please contact us and tell us your new address as soon as possible. This is the best way to avoid any mailing delays.

- **Do you have dependent children over the age of 17 or 20*?**

  Remember that every semester you must provide us with confirmation of full-time student status by completing and returning the section at the bottom of your claim form. (*According to the age specified in your contract.)

- **Need a claim form?**

  Most claim forms are available to download from our website at www.lacapitale.com. You can also obtain forms from your employer's group plan administrator or the group policyholder.

- **Help us to help you**

  In all correspondence, please indicate your name, contract number, employer number as well as the identification number shown on your service card.

- **Claiming expenses for services provided by healthcare professionals?**

  For healthcare professionals such as physiotherapists, psychologists or otherwise, if you are using a claim form, the professional must stamp or seal the form. The professional's signature and licence number must also be provided, along with the dates of treatments and the name of the patient.

  The Insurer accepts personalized and computerized receipts from healthcare professionals, provided they contain the information specified above.

- **Have any questions about your reimbursement cheque?**

  If you've received a lower reimbursement than you expected, remember that at the beginning of the year, you may have a deductible to cover or coinsurance to pay. You can see the breakdown of your reimbursement on your cheque stub or deposit confirmation.

  Please be reminded that uncashed cheques expire after 6 months.

CONTACT US

CONTACT LA CAPITALE INSURANCE AND FINANCIAL SERVICES INC.

Quebec City	Montreal
625 Jacques-Parizeau St.	Suite 820
P.O. Box 1500	425 De Maisonneuve Blvd W
Quebec QC G1K 8X9	Montreal QC H3A 3G5
418 644-4200	**514 873-6506**

Toll free: 1 800 463-4856

TRAVEL INSURANCE

You can contact the Assistor at the following numbers:

In Canada and the United States: **1 800 363-9050**

Elsewhere in the world (collect call): **(+1) 514 985-2281**

The Policyholder may at any time, upon agreement with the Insurer, make modifications to the insurance benefits with regard to the individuals eligible for insurance, the scope of coverage and the sharing of costs among classes of insureds. Any such modifications may apply to all insureds, whether they are active, disabled or retired. **THIS DOCUMENT IS PROVIDED FOR INFORMATION PURPOSES ONLY AND IN NO WAY MODIFIES THE TERMS AND CONDITIONS OF THE CONTRACT.**

QUICK REFERENCE

Group No.: **006925**

Employer No.:

Identification No.:

Person Contacted:

Telephone No.:

Fax No.:

E-mail:

NOTES

Notes

Notes

Notes

A people-driven company
whose activities are centred
around group insurance.

Advisers who are available and
motivated to build a productive
partnership with our customers.

A wide range of group insurance
products and services.

lacapitale.com

(01-2012)

100%