Manulife
Insurance

Your guide to Lifecheque®

CRITICAL ILLNESS INSURANCE

Lifecheque is a unique kind of insurance…it's about recovery. Getting sick isn't something any of us like to think about. But it can happen. Thanks to improvements in healthy living and medical science, there is a good chance you can recover and get on with life.

But getting better costs money. Treating and coping with illness can mean significant and often unexpected costs.

Lifecheque is designed to help you with the unexpected. It provides a cash benefit if you're diagnosed with one of the 24 covered conditions described in the contract and you satisfy the waiting period. This can give you the financial freedom to focus on what really matters … getting better.

The money is yours to use any way you want. For example, you can:

- Find the best health care available – anywhere
- Hire a nurse or caregiver to help you at home
- Make mortgage payments
- Replace lost income

Because recovery will be your first priority

- Recovery means a cash benefit. Lifecheque covers conditions that pose the greatest threat to your health, present significant recovery demands and financial challenges.
- Recovery means coverage for conditions that may not be life threatening, but that will alter your life. Our **Early Intervention Benefit** provides 25% of your coverage (up to a maximum of $50,000 per insured person provided you meet the requirements set out in the contract).
- Recovery means getting your money fast. If you're diagnosed with a critical illness, you'll probably spend a lot of time waiting – for appointments, for test results, for treatment. Lifecheque's unique **Recovery Benefit** helps you get some money faster, without having to fulfill the waiting period. Money in your hands faster can help your recovery begin sooner.
- Recovery means giving you features that provide peace of mind. For clients who qualify, our **LivingCare Benefit** provides a monthly Care Benefit if they become functionally dependent and satisfy the waiting period (90 days).
- **Health Service Navigator**® offers you and your eligible family members access to a service that provides reliable and current health resources and information. And Health Service Navigator allows you to access this helpful service as soon as you have your policy – you don't need to wait until you make a claim.

Health Service Navigator includes:

- Access to world-class doctors for second opinions
- Medical coordination services for care in the U.S.; arranging appointments; coordination support for specialized transportation needs; assistance with special needs such as translation services; hospital discharge and return home coordination
- Help navigating the Canadian health care system, including access to provincial health screening guides
- Help finding a health care provider, health care facility and community support group
- Health and drug library; medical conditions database; health news; health calculators and self assessment tools

This brochure provides an overview of Lifecheque critical illness insurance. Your contract will provide details of the coverage available under the plan you choose.
Note: Health Service Navigator® is not contractual and Manulife cannot guarantee its availability.

Who is an 'eligible' family member?

The insured person's family member(s) are eligible for Health Service Navigator, if they are:

Spouse – terms "spouse" and "spousal" includes a spouse or common-law partner as defined by the *Income Tax Act* (Canada).

Child – the insured person's natural or adopted child or stepchild (stepchild must be living with the insured person) who is unmarried, is not employed full-time, and is not yet 21 years old, or, if a full-time student at an accredited school, college or university, is under 25 years old.

Coverage that fits your needs*

Manulife's four Lifecheque plans provide coverage amounts ranging from a minimum of $25,000 to a maximum of $2,000,000. You choose the amount and the type of coverage* you need:

Primary (Term 65) Lifecheque

An economical solution that will help protect you during your prime income-earning years (up to age 65) with premiums that never change for the duration of your contract.

Level (Term 75) Lifecheque

Coverage that offers you protection into your retirement years (up to age 75) with premiums that never change for the duration of your contract.

Renewable (Term 10 or Term 20) Lifecheque

We have two Renewable options for you to choose from: 10-year and 20-year.

Both Renewable options offer you protection into your retirement years (up to age 75) with premiums that increase every 10 or 20 years. Renewable coverages can be changed to other Lifecheque coverages after issue without evidence of insurability (see contract for details).

10-year and 20-year Renewable coverages may be changed to:

- Primary (Term 65) coverage after issue (after one year and up to age 44)
- Level (Term 75) or Permanent Pay to age 100 coverage after issue (after one year and up to age 64)

Permanent Lifecheque

Protection for life, with premiums that never change for the duration of your contract. We have two payment options available on Permanent Lifecheque:

1. Pay to age 100
2. Limited Pay – an accelerated payment duration of 15 years

Getting your money back

And what if you don't ever need Lifecheque? There are three **Return of Premium riders** available. Our Return of Premium with Early Surrender Option rider is available on our Level (Term 75) and Permanent plans. Our Return of Premium at Expiry rider is available on our Primary (Term 65) and Level (Term 75) plans and our Return of Premium on Death rider is available on all Lifecheque plans. All riders are available for an additional charge (subject to underwriting). You'll find more information about these riders later in this brochure.

* Depending on the plan you choose, if you're diagnosed with one of the covered conditions or early intervention conditions as defined in your contract, and you satisfy a specified waiting period (30 days in most cases) you'll receive a Lifecheque benefit. Your contract will provide details of the coverage available under the plan you choose. Restrictions may apply and some waiting periods are longer than 30 days. Your advisor can provide more details.

Covered conditions

Here's a list of conditions covered under all of the Lifecheque plans, the contract wording that describes the conditions and an explanation of that wording.

Condition	What the contract says	What it means
Aortic surgery	The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist. **Waiting period** The 30 days following the date of surgery. **Exclusions** We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	The aorta is the largest artery in the body and replacement of diseased portions with a graft is covered.
Aplastic anemia	A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: ■ marrow stimulating agents, ■ immunosuppressive agents, or ■ bone marrow transplantation. The diagnosis of aplastic anemia must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed.	Aplastic anemia is a result of your body not producing enough new blood cells. When this happens, you often feel tired. Also leaves you at higher risk of developing infections and sometimes uncontrolled bleeding occurs. Aplastic anemia is a rare and serious condition that can develop at any point in your lifetime. Sometimes this condition appears suddenly or slowly over time. Treatment for this condition includes medications, blood transfusions or a stem-cell transplant.
Bacterial meningitis	A definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist. **Waiting period** Until the date the criteria outlined above have been met. **Exclusion** We will not pay a covered condition benefit for viral meningitis.	Bacterial meningitis is an infection that leads to the inflammation or swelling of the brain and spinal cord. Many types of bacteria can cause this type of inflammation. Bacterial meningitis is often treated with antibiotics and may require hospitalization.
Benign brain tumour	A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of a benign brain tumour must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions** Exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for benign brain tumours and related conditions.*	Primary brain tumours originate in the brain and can be benign or malignant. ■ Benign brain tumours that are slow growing have distinct borders and don't typically spread. ■ Malignant brain tumours that are fast growing would fall under our cancer covered condition. Secondary brain tumours (metastatic brain tumours) that are malignant are the more common type of brain tumour. These tumours result from cancer that started elsewhere in the body and spread (metastasized) to the brain. This would fall under our cancer covered condition benefit. Benign brain tumours diagnosed in the first 90 days of the contract or last reinstatement, or benign brain tumours whose symptoms first appear in that time period are not eligible for a benefit.

Condition	What the contract says	What it means
Blindness	A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by: ■ the corrected visual acuity being 20/200 or less in both eyes, or ■ the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed.	The blindness can be caused by injury, disease, or degenerative disease of the eyeball, of the optic nerve or nerve pathways connecting the eye to the brain, or the brain itself.
Cancer (life threatening)	A definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of cancer must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions*** Exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for cancers and related conditions.*	There are many types of cancers and this definition covers many of them including cancers such as carcinoma and melanoma. The main exclusions are for cancers that are not generally looked upon as life-threatening and are readily treatable. Some of these early stage cancers are covered under our Early Intervention Benefit conditions described later in this document. Cancers diagnosed in the first 90 days of the contract or last reinstatement, or cancers whose symptoms first appear in that time period are not eligible for a benefit. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of diagnosis. Your advisor can help you to understand all requirements and exclusions as related to this covered condition.
Coma	A definite diagnosis of a state of unconsciousness, with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less. The diagnosis of coma must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions** We will not pay a covered condition benefit for the following conditions: ■ a medically induced coma ■ a coma which results directly from alcohol or drug use, or ■ a diagnosis of brain death.	A state of being incapable of responding to internal or external stimuli, caused by disease or injury that continues for at least four days.
Coronary artery bypass surgery	The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The procedure must be determined to be medically necessary by a specialist. **Waiting period** The 30 days following the date of surgery. **Exclusions** We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	Only coronary artery bypass surgery is covered. The procedures that are excluded do not require open-heart surgery and have a lower recovery demand. Coronary angioplasty will be covered at a lower benefit amount to reflect this lower recovery demand. See section titled *Early Intervention conditions* later in this document.

Condition	What the contract says	What it means
Deafness	A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed.	The deafness can be caused by an accident, injury or illness which causes you to totally and permanently lose your hearing in both ears. The amount of hearing loss required to qualify under this definition can be easily measured and accurately confirmed by professional testing.
Dementia, including Alzheimer's disease	A definite diagnosis of dementia characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function: ■ aphasia (a disorder of speech) ■ apraxia (difficulty performing familiar tasks) ■ agnosia (difficulty recognizing objects), or ■ disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life. The insured person must exhibit: ■ dementia of at least moderate severity evidenced by a Mini Mental State exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function, and ■ evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period. For purposes of the policy, reference to the Mini Mental State exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res 1975;12(3):189. The diagnosis of dementia must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions** We will not pay a covered condition benefit for affective or schizophrenic disorders, or Delirium.	Dementia, including Alzheimer's disease is characterized by a progressive deterioration of memory. In order to be diagnosed, some areas of mental (cognitive) function must be affected, such as; difficulty performing multiple tasks, inability to think clearly, which affects daily life. Certain conditions must be shown in order to qualify as noted in the contract.
Heart attack	A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: ■ heart attack symptoms ■ new electrocardiogram (ECG) changes consistent with a heart attack, or ■ development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. The diagnosis of heart attack must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions** We will not pay a covered condition benefit for: ■ elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or ■ ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.	A heart attack claim is not valid if the elevated biochemical cardiac markers are as a result of coronary angioplasty and there are no associated findings of new Q waves; or, if an incidental finding of ECG changes suggests a prior heart attack without a corroborating event.

Condition	What the contract says	What it means
Heart valve replacement or repair	The undergoing of surgery to replace any heart valve with either a natural or mechanical valve, or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist. **Waiting period** The 30 days following the date of surgery. **Exclusions** We will not pay a covered condition benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	There are four valves in the heart (aortic, pulmonary, mitral, tricuspid) that control the flow of blood from one of the chambers of the heart to another. Replacement or repair of any one or more of these valves with human, animal or mechanical valves is covered under this condition.
Kidney failure	A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of kidney failure must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed.	Chronic kidney failure patients require dialysis, either peritoneal dialysis or hemodialysis, for the rest of their lives or until they can be given a kidney transplant.
Loss of limbs	A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist. **Waiting period** The 30 days following the date the second limb is severed.	The event can be the result of an accident, injury or illness.
Loss of speech	A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist. **Waiting period** Until the date the criteria outlined in loss of speech above have been met. **Exclusions** We will not pay a covered condition benefit for all psychiatric-related causes.	The total and irreversible loss of the ability to express thoughts and ideas by vocal sounds. This can be the result of an accident, injury or illness, but excludes psychiatric causes.
Major organ failure (on waiting list)	A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure (on waiting list), the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. The diagnosis of the major organ failure must be made by a specialist. **Waiting period** The 30 days following the date of the insured person's enrollment in the transplant centre specified above.	Your waiting period for this benefit will begin as soon as you are registered on a recognized transplant list in Canada or the United States.

Condition	What the contract says	What it means
Major organ transplant	A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow and limited to these entities. The diagnosis of the major organ failure must be made by a specialist. **Waiting period** The 30 days following the date of transplantation.	If you undergo any of the five listed medically necessary transplants, you may be covered.
Motor neuron disease	A definite diagnosis of one of the following: ■ amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) ■ primary lateral sclerosis ■ progressive spinal muscular atrophy ■ progressive bulbar palsy, or ■ pseudo bulbar palsy Policy coverage is limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed.	Motor neuron disease is a progressive degenerative disorder which affects the central nervous system and is characterized by muscular weakness and a wasting away of muscle without any sensory changes. As the nerves degenerate, the muscles weaken and deteriorate. The most frequently mentioned motor neuron disease is amyotrophic lateral sclerosis (ALS), which is more commonly known as Lou Gehrig's Disease.
Multiple sclerosis	A definite diagnosis of at least one of the following: ■ two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination ■ well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination, or ■ a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart. The diagnosis of multiple sclerosis must be made by a specialist. **Waiting period** Until the date the multiple sclerosis criteria outlined above has been met.	Multiple sclerosis is an extremely difficult condition to diagnose and usually takes a number of tests to exclude other possibilities before it is confirmed. Symptoms vary according to which part of the brain and spinal cord is affected; therefore, physical symptoms are very different among the different forms of multiple sclerosis. This definition has centered around the neurological abnormalities, as opposed to the degree of physical impairment. With multiple sclerosis, areas of the fatty myelin sheaths of the nerve fibers are destroyed, thus blocking nerve impulses to and from the brain. Demyelination is typical evidence of multiple sclerosis.

Condition	What the contract says	What it means
Occupational HIV infection	A definite diagnosis of infection with human immunodeficiency virus (HIV) resulting from accidental injury during the course of the insured person's normal occupation, which exposed the insured person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of: ■ the coverage issue date, and ■ the effective date of last reinstatement of that coverage. Payment under this covered condition requires satisfaction of all of the following: ■ the accidental injury must be reported to us within 14 days of the accidental injury ■ a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative ■ a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive ■ all HIV tests must be performed by a duly licensed laboratory in Canada or the United States, and ■ the accidental injury must have been reported, investigated and documented in accordance with current workplace guidelines in Canada or the United States. The diagnosis of occupational HIV infection must be made by a specialist. **Waiting period** The 30 days following the date that all of the criteria outlined in occupational HIV infection above have been met. **Exclusions** We will not pay a covered condition benefit for occupational HIV infection if: ■ the insured person has elected not to take any available licensed vaccine offering protection against HIV ■ a licensed cure for HIV infection has become available prior to the accidental injury, or ■ HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use.	This benefit would be of value to people who work in occupations where they may come in contact with blood or body fluids (physician, dentist, nurse, police officer etc.). The reporting procedures are necessary to ensure that HIV is contracted as a result of occupational exposure and not from drug use or sexually transmitted means.
Paralysis	A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist. **Waiting period** Until the date the paralysis criteria outlined above has been met.	This condition has a 90-day waiting period to eliminate cases of temporary paralysis. This waiting period is shorter than many typical accident coverage plans.

Condition	What the contract says	What it means
Parkinson's disease and specified atypical parkinsonian disorders	A definite diagnosis of primary Parkinson's disease, a permanent neurologic condition characterized by bradykinesia (slowness of movement) and at least one of: ■ muscle rigidity; or ■ rest tremor Specified atypical parkinsonian disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The insured person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease. The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist. **Waiting period** Until the later of: ■ the day all of the criteria outlined for Parkinson's disease above have been met, and ■ 30 days from the date of diagnosis. **Exclusions** We will not pay a covered condition benefit for any other types of parkinsonism. We will not pay a covered condition benefit if, within the first year of the later of: ■ the coverage issue date, and ■ the date of last reinstatement of the coverage, the insured person has any of the following: ■ signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, or a specified atypical parkinsonian disorder, regardless of when the diagnosis is made, or ■ a diagnosis of Parkinson's disease, or a specified atypical parkinsonian disorder. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for: ■ Parkinson's disease, or ■ specified atypical parkinsonian disorders,or any critical illness caused by: ■ Parkinson's disease, or ■ specified atypical parkinsonian disorder or its treatment.	Parkinson's disease and specified atypical parkinsonian disorders are a progressive, degenerative disease of the central nervous system. The disease is characterized by muscular rigidity, tremor and slow movements. Parkinson's disease and specified atypical parkinsonian disorders originating from exposure to certain drugs or toxic chemicals, etc., will not be covered. Although the disease does not have to have progressed to a point where daily supervision is required, a level of impairment must have been reached. If signs and symptoms leading to a diagnosis occurs within the first year, no benefit is payable. Please note that signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of diagnosis.

Condition	What the contract says	What it means
Severe burns	A definite diagnosis of third-degree burns over at least 20 per cent of the body surface. The diagnosis of severe burns must be made by a specialist. **Waiting period** The 30 days following the date the severe burns occurred.	There are three levels of burns. They are medically known as 'first', 'second' and 'third degree'. 'First degree' burns damage the top layer of skin (e.g. sunburn). 'Second degree' burns go deeper into the layers of skin. 'Third degree' burns are the most serious, as they destroy the full thickness of the skin. The 20 per cent requirement of third degree burns is considered to be life threatening.
Stroke (cerebrovascular accident)	A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with: ■ acute onset of new neurological symptoms, and ■ new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist. **Waiting period** Until the date the criteria outlined in stroke above have been met. **Exclusions** We will not pay a covered condition benefit for: ■ transient ischemic attacks ■ intracerebral vascular events due to trauma, or ■ lacunar infarcts which do not meet the definition of stroke as described above.	This definition covers all three causes of stroke: thrombosis, caused by a blockage by a thrombus (clot) that has built up on the wall of a brain artery; embolization, caused by an embolus (usually a clot) that is swept into a brain artery causing blockage; hemorrhage, which is caused by the rupture of a blood vessel in or near the brain's surface. Your deficit must last for more than 30 days for you to be eligible for a benefit. Any incident with symptoms lasting less than 24 hours is referred to as a TIA (transient ischemic attack) and does not qualify for coverage.

*For complete details on exclusions as noted in section 6 of the Lifecheque contract, please consult your advisor.

Early intervention conditions

Condition	What the contract says	What it means
Chronic lymphocytic leukemia (CLL) Rai stage 0	A definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL). For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Conkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975. The condition must be diagnosed by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions*** We will not pay an early intervention benefit for Monoclonal Lymphocytosis of Undetermined Significance (MLUS). Additional exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for cancers and related conditions.*	Chronic lymphocytic leukemia (CLL) Rai stage 0 is a type of cancer that affects the blood and bone marrow. This is where blood cells are made. The term chronic means that the condition progresses more slowly than other types of leukemia. The cells affected by the disease are a type of white blood cells called lymphocytes. These help the body fight infection.
Coronary angioplasty	The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist. **Waiting period** The 30 days following the date of the procedure.	Coronary angioplasty is the widening of one or more of the three coronary arteries with a balloon. A balloon-tipped catheter is inserted into an artery (usually in the groin) and threaded up the body to the blockage or narrowing, where the balloon is then inflated. Recovery is short (approximately one day) and the risks of heart attack or emergency bypass surgery as a result of the procedure are low. Nearly 50 per cent of patients with coronary artery disease are treated with this procedure. The medical term for this procedure is PTCA (percutanous transluminal coronary angioplasty).
Ductal carcinoma in situ of the breast	A definite diagnosis of ductal carcinoma in situ of the breast. The condition must be diagnosed by a specialist and confirmed by biopsy. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions*** Exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for cancers and related conditions.*	Ductal carcinoma in situ of the breast is an early, treatable stage of breast cancer. Ductal carcinoma in situ of the breast diagnosed in the first 90 days of the contract, or Ductal carcinoma in situ of the breast whose symptoms first appear in that time period are not eligible for a benefit.
Papillary or follicular thyroid cancer stage T1	A definite diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis. The condition must be diagnosed by a specialist and confirmed by a biopsy. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions*** Exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for cancers and related conditions.*	Thyroid cancer is a type of cancer in which malignant cells form in the tissues of the thyroid gland. There are different types of thyroid cancer of which papillary cell cancer is the most common. Follicular thyroid cancer forms in the follicular cells of the thyroid and grows slowly. This form of cancer is highly treatable.

Condition	What the contract says	What it means
Stage A (T1a or T1b) prostate cancer	A definite diagnosis of stage A (T1a or T1b) prostate cancer. The condition must be diagnosed by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions*** Exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for cancers and related conditions.*	If you are diagnosed with the early stage of prostate cancer (T1a or T1b) you may be covered. The early stages of prostate cancer are considered treatable. At this stage, tumours cannot be felt and must be diagnosed by biopsy. Early stage prostate cancer (T1a or T1b) diagnosed in the first 90 days of the contract, or early stage prostate cancer (T1a or T1b) whose symptoms first appear in that time period are not eligible for a benefit.
Stage 1 malignant melanoma	A definite diagnosis of Stage 1A or 1B malignant melanoma that is 1.0 mm or less in depth and non-ulcerated. The condition must be diagnosed by a specialist. **Waiting period** The 30 days following the date the condition is diagnosed. **Exclusions*** We will not pay an early intervention benefit for malignant melanoma in situ. Additional exclusions are described in section 6 of the Lifecheque contract under the subheading *Exclusions for cancers and related conditions.*	Typically, melanoma starts in the cells that are found in the outer layer of the skin. These cells grow out of control and form a tumour. Melanomas are often black or brown in colour but may be many shades. As with all types of skin cancer, there is an increased risk of malignant melanoma related to excessive sun exposure. If found early, it is treatable, curable and has a high survival rate.

*For complete details on exclusions as noted in section 6 of the Lifecheque contract, please consult your advisor.

Exclusions and limitations for critical illness benefits

What the contract says

General
No benefit will be paid if the person insured for any critical illness benefit under this policy, while sane or insane, suffers a covered condition or an early intervention condition as a result of any of the following:
a) intentional self-inflicted injuries
b) committing or attempting to commit a criminal offence
c) operating a motor vehicle while the concentration of alcohol in 100 millilitres of blood exceeds 80 milligrams.
d) The insured person's intentional use or intake of:

- any prescription drug or narcotic other than as instructed by a physician
- any drug or narcotic legally available for sale in Canada without a prescription other than as recommended by the manufacturer
- any drug or narcotic not legally available in Canada
- any poisonous substance or intoxicant, including alcohol.

What it means

Exclusions are directed at conditions, resulting from specified circumstances in the contract. These exclusions are standard provisions for policies of this nature.

These exclusions apply to all covered conditions and early intervention conditions already described. You will receive a benefit if you both meet the criteria for the conditions listed earlier and do not fall under one of these exclusions.

There are no exclusions for war or acts of war.

Waiting period
No covered condition benefit or early intervention benefit will be paid unless the insured person satisfies the waiting period. The waiting period is specified for each covered condition or early intervention condition in section 5 of the Lifecheque contract.

Exclusions for cancers and related conditions
In these exclusions, the term "any cancer" includes all cancers, even if they would not have been covered under the definitions for cancer for a covered condition benefit or an early intervention benefit.

We will not pay a covered condition or early intervention benefit if, within the first 90 days following the later of:

- the coverage issue date, and
- the date of last reinstatement of the coverage, the insured person has any of the following:
- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the coverage), regardless of when the diagnosis is made, or
- a diagnosis of cancer (covered or excluded under the coverage)

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

We will not pay a covered condition benefit for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis
- any non-melanoma skin cancer, without lymph node or distant metastasis
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis
- chronic lymphocytic leukemia classified less than Rai stage 1, or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For the purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For the purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975

What it means (continued)

Exclusions for benign brain tumours and related conditions

We will not pay a covered condition or early intervention benefit if, within the first 90 days following the later of:

- the coverage issue date, and
- the date of last reinstatement of the coverage, the insured person has any of the following:
- signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the coverage), regardless of when the diagnosis is made, or
- a diagnosis of benign brain tumour (covered or excluded under the coverage).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not provided within this period, we have the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

We will not pay a covered condition benefit for pituitary adenomas less than 10 mm.

Out of country diagnosis

If a covered condition or early intervention condition is diagnosed in a jurisdiction other than Canada and the United States, no benefit will be payable unless the insured person affected by that condition makes all medical records that we request available to us. Based on the medical records, we must be satisfied that these conditions have been met:

- the same diagnosis would have been made if the covered condition or early intervention condition had occurred in Canada or the United States;
- the physician making the diagnosis was licensed to practice in the jurisdiction in which the diagnosis was made and had credentials equal to any defined for that condition in your policy;
- the diagnosis is fully supported by all appropriate diagnostic tests and other investigation which would normally be completed in Canada or the United States (including those required by the specific definition of the covered condition or early intervention condition); and
- the same surgery or medically necessary non-surgical interventional procedure as defined in your policy for an early intervention condition or covered condition would have been advised if the diagnosis had been made in Canada or the United States.

We also have the right to request that an insured person undergo an independent medical examination by a specialist appointed by us.

Lifecheque LivingCare Benefit*

What the contract says

When the insured person is functionally dependent

The insured person is functionally dependent when we determine that, even with the use of medications, assistive devices, appliances, or other aids:

- the insured person cannot do two or more of the activities of daily living without substantial assistance from another person, or
- due to cognitive impairment, the insured person needs substantial supervision to protect themselves from threats to health or safety.

To be considered functionally dependent, the insured person must also:

- be under the regular care of a physician
- follow recommended treatments, and
- use assistive devices that are appropriate for the conditions causing them to be functionally dependent.

Activities of daily living

The activities of daily living are specific basic daily tasks that the insured person needs to be able to do to maintain their own health and safety.

The activities of daily living used to determine if the insured person is functionally dependent are:

- **Bathing** which means washing their body in a bathtub (including getting into or out of the bathtub), or in a shower (including getting into or out of the shower), or by a sponge bath. Bathing does not include the insured's ability to wash their hair or to reach their back or feet.
- **Eating** which means feeding themselves from a cup, bowl or plate, or by a feeding tube. Eating does not include preparing or serving their meals.
- **Dressing** which means putting on and taking off all necessary items of clothing and any medically necessary braces, surgical appliances or artificial limbs. A "necessary item of clothing" is any item of clothing that can be made, purchased, or purchased and altered and that is reasonable for the insured person's health, comfort and dignity in the environment in which they normally live.
- **Toileting** which means getting to and from, and on and off the toilet, and performing the associated personal hygiene.
- **Transferring** which means moving into or out of a bed, chair or wheelchair.
- **Maintaining continence** which means controlling their bowel and bladder function or, if they cannot maintain control, performing the associated personal hygiene (including the use of incontinence products and caring for a catheter or colostomy bag).

Cognitive impairment

A cognitive impairment is a loss of, or deterioration in, intellectual capacity. The insured person's loss or deterioration must meet these three conditions:

1. It must be comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia or the result of severe brain injury.
2. It must be demonstrated by impairment in:
   a) short-term or long-term memory
   b) orientation as to people, places or time
   c) deductive or abstract reasoning, or
   d) judgment as it relates to the insured person's awareness of their own safety and the safety of others.
3. It must be confirmed and measured by clinical evidence and standardized tests.

Exclusion

A cognitive impairment does not include any mental or nervous disorder, including but not limited to anxiety disorders, mood disorders, sleep disorders, pain disorders, personality disorders and psychotic disorders.

Additional peace of mind built right in

Care support services

Because you will need more than financial support if you're faced with a long term illness or injury, LivingCare lets you access care support services once a year, either during the waiting period or while receiving benefits.

Manulife will designate a care advisor who can help you navigate and connect to the long term care network in your local area. They'll help find and arrange for service providers and community programs and will provide health information if requested.

Waiver of Premium

Premiums don't have to be paid while care benefits are payable. And, we will refund any premiums that were paid during the waiting period.

* The LivingCare Benefit is subject to separate underwriting approval.

Exclusions and limitations for the LivingCare Benefit

What the contract says

General

We will not consider the insured person to be functionally dependent and we will not pay any care benefits under this policy if the insured person, while sane or insane, becomes functionally dependent because of any of the following:

a) intentionally self-inflicted injuries

b) committing an act that would be a criminal act according to the laws of Canada, no matter where the act was committed

c) operating a motor vehicle while the concentration of alcohol in 100 millilitres of blood exceeds 80 milligrams, or

d) the insured person's intentional use or intake of:

- any prescription drug or narcotic other than as instructed by a physician
- any drug or narcotic legally available for sale in Canada or the United States without a prescription, in a manner other than as recommended by the manufacturer
- any drug or narcotic not legally available in Canada or the United States, or
- any poisonous substance or intoxicant.

Residing outside Canada and the United States

The insured person will not be considered functionally dependent while he or she is residing outside Canada and the United States, and we will not pay a care benefit while the insured person resides outside Canada and the United States.

Any days when the insured person resides outside Canada and the United States will not be considered days when the person is functionally dependent for the purpose of satisfying the waiting period.

What it means

Exclusions are directed at conditions, resulting from specified circumstances in the contract. These exclusions are standard provisions for policies of this nature.

These exclusions apply to the LivingCare Benefit already described. You will receive a benefit if you both meet the criteria for the LivingCare Benefit listed earlier and do not fall under one of these exclusions.

There are no exclusions for war or acts of war.

Return of Premium riders

Our Return of Premium with Early Surrender Option rider, Return of Premium at Expiry rider and Return of Premium on Death rider are available at an additional cost. Here's a chart that outlines the differences between these three riders.

Rider	How it works*	Can be added to …
Return of Premium with Early Surrender option (ROPS)	Returns 100% of eligible premiums paid if: ■ The Lifecheque coverage and the ROPS rider have been in effect for at least 15 years ■ The insured is not eligible for a covered condition benefit, and ■ The Lifecheque coverage is cancelled.	■ Level (Term 75) – issue ages 18 to 60 ■ Permanent (pay to age 100) – issue ages 18 to 60 ■ Permanent (pay for 15-years) – issue ages 18 to 55
Return of Premium at Expiry (ROPX)	Returns 100% of eligible premiums paid if it is in effect at the expiry date of the coverage and the insured is not eligible for a covered condition benefit.	■ Primary (Term 65) – issue ages 18 to 45 ■ Level (Term 75) – issue ages 18 to 60
Return of Premium on Death (ROPD)	Returns 100% of eligible premiums paid if the insured dies before becoming eligible for a covered condition benefit.	■ Renewable Term 10 – issue ages 18 to 60 ■ Renewable Term 20 – issue ages 18 to 54 ■ Primary (Term 65) – issue ages 18 to 45 ■ Level (Term 75) – issue ages 18 to 60 ■ Permanent (pay to age 100) – issue ages 18 to 60 ■ Permanent (pay for 15-years) – issue ages 18 to 55

*If the Return of Premium benefit amount (not including the policy fee or premiums paid for any Waiver of Premium on Disability rider) equals the coverage limit, we no longer require premiums for the Return of Premium rider. The maximum ROP benefit is limited by the Lifecheque coverage amount less any Recovery Benefit and/or Care Benefits paid or payable. Any Lifecheque coverage amount decrease will result in a reduction to the Return of Premium benefit for that coverage.

What if I become disabled?

If you become disabled before the age of 60, we'll cover your Lifecheque premiums for you if you've purchased the Waiver of Premium rider.

This rider is available on both individual and multi-life policies. If it's a multi-life policy and the claim is accepted, the entire premium is waived for all people covered under the policy. It is also available on the owner of the policy even if he or she has no other coverage.

Is Lifecheque coverage available for children?

Thinking about a child getting sick is beyond anyone's imagination. But it happens. And if it does, your child's recovery will be your first priority. That may mean you'll do everything you can to be there for them and to make sure that they get the very best medical advice and treatment available. Lifecheque can help. A Lifecheque benefit can help take away any financial worries and let you focus on what really matters … helping your child get better.

The Children's Lifecheque rider provides payment of the benefit when the child is diagnosed with (and satisfies the initial waiting period for) one of the following:*

- Aplastic anemia
- Bacterial meningitis
- Blindness
- Cancer (life threatening)
- Cerebral palsy
- Congenital heart conditions
- Cystic fibrosis
- Deafness
- Down syndrome
- Kidney failure
- Loss of speech
- Major organ failure (on waiting list)
- Major organ transplantation
- Muscular dystrophy
- Paralysis

Who can be covered under a Children's Lifecheque Rider?

Children between the ages of 0 and 17 inclusive, whose parent has Lifecheque coverage. The parent must be between the ages of 18 and 55.

The Children's Lifecheque rider covers all children who are named on the application and who we've approved when the rider is issued, including adopted children and stepchildren (medical information is required). All future natural born children (born after the date the application for this rider is signed) are also covered without any further medical information. Restrictions apply for children who do not survive 30 days after birth and for children born within 10 months of the time the rider is issued or of the date of the latest effective date of reinstatement.*

How much coverage is provided?

You determine what amount of coverage is appropriate. Children's Lifecheque rider is available in increments of $5,000. You can purchase a minimum of $5,000 up to $100,000 in coverage provided your children's rider coverage is not greater than 50% of the amount of the parent's coverage.

Is it costly?

No. The rider costs $50 per year for every $5,000 of coverage and it will cover all of your children as outlined above.

How long does the coverage last?

Coverage continues until the child's age 21 or the insured parent's age 65, whichever is earlier. If the insured parent dies or receives a Lifecheque benefit prior to the termination of this rider, the premiums stop, but the coverage continues on each child until his or her 21st birthday.

* Your contract will provide details of the coverage available under the plan you choose. Restrictions may apply and some waiting periods are longer than 30 days. Your advisor can provide more details.

For more information contact your advisor or visit manulife.ca

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