



SUN CRITICAL ILLNESS INSURANCE

Guide to critical illness definitions



Life's brighter under the sun

Sun Life Guide to critical illness definitions

Sun Critical Illness Insurance policies sold after October 18, 2021

Sun Critical Illness Insurance (Sun CII) offers financial help to pay the costs associated with life-altering illnesses. If the insured person suffers one of the covered critical illnesses and meets the survival period as described by your policy, you'll* receive a lump-sum payment.

This guide will help you understand the illnesses, conditions and procedures covered by a Sun CII policy.

* For the purposes of this guide, "you" and "your" means the owner of the policy.





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Important information about the illnesses and how they're defined

Where applicable, we use standardized definitions developed by the Canadian Life and Health Insurance Association (CLHIA).

- Some illnesses have a survival period. The insured person must be alive at the end of the survival period to satisfy the requirement for these illnesses. For illnesses that do not have a survival period, the insured person must be alive at the time the diagnosis is made. You can find the survival period in the illness definition, or in the summary at the end of the guide.
- The following illnesses require symptoms to be present for a specified qualifying period: Acquired brain injury due to external trauma, coma, dementia, including Alzheimer's disease, loss of independent existence, multiple sclerosis, paralysis, Parkinson's disease and specified atypical parkinsonian disorders, stroke and type 1 diabetes mellitus (childhood illness). The length of the qualifying period is included in the definition of each illness and in the summary at the end of the guide.
- Cancer, benign brain tumour, Parkinson's disease and specified atypical parkinsonian disorders have exclusion periods. If the insured person has signs, symptoms or investigations that lead to a diagnosis within the exclusion period, we'll exclude coverage for these illnesses from your policy.

Remember: If you're replacing critical illness insurance from another company, the insured person will not have coverage for these illnesses during the exclusion period.



What you need to know about claiming for a critical illness insurance benefit

All criteria in the definition of the covered critical illness must be met in order to qualify for benefit payment

The policy must be in effect on the date a claim is submitted. We must receive the claim within 1 year of the date the insured person is diagnosed with a covered critical illness.

The diagnosis and treatment for any covered critical illness must be made by a specialist.

The written diagnosis must:

- include appropriate information to assess the covered critical illness, and
- be prepared and signed by a specialist licensed and practising in Canada or the United States or another physician acceptable to us.

If an illness develops or is diagnosed while outside of Canada or the United States

You can make a claim for a critical illness insurance benefit if a covered critical illness develops or is diagnosed while outside of Canada or the United States. You'll need to provide us with all of the information we need to assess the claim.

If the medical records of the insured person are not in French or English, you must provide the original records along with a translation of the records into either French or English.

Based on the medical records we receive, we must be satisfied that the same diagnosis or treatment would have been made if the illness developed or was diagnosed in Canada.



The policy includes other terms and conditions not covered in this guide

This guide is a general reference only and does not form part of your policy. Each policy is unique, and includes additional exclusions and limitations that define when a benefit is not payable. It's your responsibility to review the policy and ensure you're aware of the exclusions and limitations that apply.

Illnesses not specifically mentioned or not meeting the stated criteria are not covered. All illnesses must also satisfy the description in the policy.

Illnesses eligible for full benefit payout

If the insured person is diagnosed with one of these critical illnesses and meets the survival period (when applicable), you'll receive a lump sum payment of your coverage amount and the policy will end. We refer to this list of illnesses as Group 1.

Acquired brain injury due to external trauma

Acquired brain injury due to external trauma means a definite diagnosis of new damage to brain tissue caused by traumatic head injury, resulting in newly developed significant neurological deficit that:

- results from an external trauma severe enough to have prompted the insured to seek a medical consultation in less than a week after the occurrence of the trauma
- is present and verifiable on clinical examination
- is corroborated by abnormal magnetic resonance (MR) and/or computed tomography (CT) brain imaging studies, that confirm brain trauma and
- persist for more than 180 consecutive days following the date of diagnosis.

The diagnosis of acquired brain injury due to external trauma must be made by a specialist.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:

- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function

Headache or fatigue will not be considered a neurological deficit.

Exclusion

No benefit will be payable under this condition for:

- an abnormality seen on imaging studies of the brain without corresponding clinical impairment,
- neurological impairment without corresponding imaging study lesions,
- a concussion that does not have abnormal imaging studies.

Aortic surgery

Aortic surgery means 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.

Survival period

The insured person must survive for 30 days following the date of surgery.

Exclusion

No benefit will be payable under this condition for angioplasty, intra arterial procedures, percutaneous trans catheter procedures or non surgical procedures.

Aplastic anemia

Aplastic anemia means 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
- bone marrow transplantation.

The diagnosis of aplastic anemia must be made by a specialist.

Bacterial meningitis

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The bacterial meningitis must result in neurological deficits persisting for at least 90 consecutive days from the date of diagnosis.

The diagnosis of bacterial meningitis must be made by a specialist.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:

- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function

Headache or fatigue will not be considered a neurological deficit.

Exclusion

No benefit will be payable under this condition for viral meningitis.

Benign brain tumour

Benign brain tumour means 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 new objective neurological deficit(s).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The diagnosis of benign brain tumour must be made by a specialist.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:

- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function

Headache or fatigue will not be considered a neurological deficit.

Exclusion

No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

90 day exclusion period for benign brain tumour

No benefit will be payable for benign brain tumour if, within the first 90 days following the later of:

- the date the application for this policy was signed
- the policy date, shown on the Policy summary, or
- the underwriting decision date, but only if shown under the heading, Amendments to this policy
- the most recent date this policy was put back into effect (reinstatement)

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 policy), regardless of when the diagnosis is made, or
- a diagnosis of benign brain tumour (covered or excluded under the policy).

! Your responsibility to notify us about benign brain tumour

You have a responsibility to notify us about benign brain tumour, regardless of when a diagnosis is made:

- If we are notified within 6 months of the date of the diagnosis and the coverage for benign brain tumour is excluded based on the 90 day exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.
- To notify us, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Blindness

Blindness means 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.

Cancer

Explanation

Cancer (also known as carcinoma) is the abnormal or malignant growth of cells which spread throughout the body destroying healthy tissue. Critical illness insurance covers all life-threatening cancers, leukemia, lymphoma, Hodgkin's disease as well as tumours in the presence of Human Immunodeficiency Virus (HIV). Cancer is a general term used to describe a wide variety of growths, some less serious than others, including those that are not critical. The less serious and those not critical are excluded from the list of covered illnesses. An example of an excluded cancer is cancer-in-situ of the cervix, which is usually identified and treated before the malignant cells have invaded adjacent tissues. However, if one of these excluded cancers is not cured and then worsens, benefits may become payable providing the policy remains in force. Certain less serious forms of cancer may be eligible for a partial benefit payout, as described later.

Cancer means a definite diagnosis of a malignant tumour. This tumour must be 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 and must be confirmed by a histopathology report or appropriate pathological testing in the case of non solid tumours.

Exclusion

No benefit will be payable for the following:

- lesions described as benign, pre malignant, uncertain, borderline, non invasive, carcinoma in situ (Tis), or tumours 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
- gastro-intestinal stromal tumours classified as AJCC Stage 1
- grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than medication to counteract the effects from hormonal oversecretion by the tumour

For 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 Cancer Staging Manual, 7th Edition, 2010. For 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.

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Cancer continued

90-day exclusion period for Cancer

No benefit will be payable for cancer if, within the first 90 days following the later of:

- the date the application for the policy was signed
- the policy date shown on the Policy summary, or
- the underwriting decision date but only if shown under the heading, Amendments to this policy
- the most recent date the policy was put back into effect (reinstatement)

The insured person has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made, or
- a diagnosis of cancer (covered or excluded under the policy).

! Your responsibility to notify us about cancer

You have a responsibility to notify us about cancer, regardless of when a diagnosis is made:

- If we are notified within 6 months of the date of the diagnosis and the coverage for cancer is excluded based on the 90 day exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for cancer or any critical illness caused by any cancer or its treatment.

To notify us, contact us at the toll free phone number shown at the beginning of this policy. We will then send you the appropriate form to be completed.

Coma

Coma means 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 4 or less.

The diagnosis of coma must be made by a specialist.

Exclusions

No benefit will be payable under this condition for:

- a medically induced coma
- a coma which results directly from alcohol or drug use, or
- a diagnosis of brain death.

Coronary artery bypass surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a specialist.

Survival period

The insured person must survive for 30 days following the date of surgery.

Exclusion

No benefit will be payable under this condition for angioplasty, intra arterial procedures, percutaneous trans catheter procedures or non surgical procedures.

Deafness

Deafness is defined as 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.

Dementia, including Alzheimer's disease

Dementia, including Alzheimer's disease, means a definite diagnosis of dementia, which must be 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, which must be 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 6 month period.

The diagnosis of dementia must be made by a specialist.

Exclusion

No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

Heart attack

Explanation

A heart attack (also known as myocardial infarction or coronary thrombosis) may occur when the normal supply of blood to the heart is interrupted by a blocked artery or clot, causing part of the heart muscle to die. The usual symptom is acute chest pain but symptoms are not limited to chest pain. The diagnosis of a recent heart attack therefore, is confirmed by the detection of abnormal electrical activity over the surface of the heart, which is seen on an electrocardiograph (ECG) and the detection of raised levels of cardiac biochemical markers released from the damaged heart muscle tissue.

Heart attack (acute myocardial infarction) means 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 acute myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new pathological Q on ECG following coronary angiography and/or angioplasty.

The diagnosis of heart attack (acute myocardial infarction) must be made by a specialist.

Survival period

The insured person must survive for 30 days following the date of diagnosis.

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Heart attack continued

Exclusions

No benefit will be payable under this condition 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.

Heart valve replacement or repair

Heart valve replacement or repair means 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.

Survival period

The insured person must survive for 30 days following the date of surgery.

Exclusion

No benefit will be payable under this condition for angioplasty, intra arterial procedures, percutaneous trans catheter procedures or non surgical procedures.

Kidney failure

Kidney failure means 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.

Loss of independent existence

Loss of independent existence means a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

The diagnosis of loss of independent existence must be made by a specialist.

Activities of daily living are:

- Bathing: the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices
- Dressing: the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices
- Toileting: the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices
- Bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained
- Transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices, and
- Feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

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Loss of independent existence continued

If the insured person has a loss of independent existence before the policy anniversary nearest their 18th birthday, you must wait to send us a claim for this illness. The earliest you may submit a claim is the policy anniversary nearest the insured person's 18th birthday. The latest you may submit a claim is the policy anniversary nearest the insured person's 19th birthday.

Loss of limbs

Loss of limbs means 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.

Loss of speech

Loss of speech means 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.

Exclusion

No benefit will be payable under this condition for all psychiatric related causes.

Major organ failure on waiting list

Major organ failure on waiting list means 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 date of diagnosis is the date of the insured person's enrollment in the transplant centre.

The diagnosis of the major organ failure must be made by a specialist.

Major organ transplant

Major organ transplant means 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.

Motor neuron disease

Motor neuron disease means a definite diagnosis of one of the following conditions and is limited to these conditions:

- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- progressive bulbar palsy, or
- primary lateral sclerosis
- pseudo bulbar palsy.
- progressive spinal muscular atrophy

The diagnosis of motor neuron disease must be made by a specialist.

Multiple sclerosis

Multiple sclerosis means 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
- 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.
- well defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination, or

The diagnosis of multiple sclerosis must be made by a specialist.

Occupational HIV infection

Occupational HIV infection means 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 person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of:

- the most recent date the application for the policy was signed
- the policy date, or
- the most recent date the policy was put back into effect (reinstatement).

Payment under this condition requires satisfaction of all of the following:

- the accidental injury must be reported to us within 14 days of the accidental injury
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States, and
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative
- the accidental injury must have been reported, investigated and documented in accordance with current workplace guidelines for Canada or the United States.
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive

The diagnosis of occupational HIV infection must be made by a specialist.

Exclusion

No benefit is payable under this condition if:

- the insured person has elected not to take any available licensed vaccine offering protection against HIV
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.
- a licensed cure for HIV infection has become available prior to the accidental injury, or

Paralysis

Paralysis means 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.

Parkinson's disease and specified atypical parkinsonian disorders

Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

- muscular rigidity, or
- rest tremor.

The insured person must exhibit objective signs of progressive deterioration in function for at least 1 year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders means a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist.

Exclusion

No benefit is payable under this condition for all other types of parkinsonism.

1 year exclusion period for Parkinson's disease and specified atypical parkinsonian disorders

No benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders if, within 1 year following the later of:

- the date the application for the policy was signed
- the underwriting decision date if included in the policy, or
- the policy date
- the most recent date the policy was put back into effect (reinstatement)

The insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of Parkinsonism, regardless of when the diagnosis is made, or
- a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of Parkinsonism.

Your responsibility to notify us about Parkinson's disease and specified atypical parkinsonian disorders

You have a responsibility to notify us about Parkinson's disease or specified atypical parkinsonian disorders, regardless of when a diagnosis is made:

- If we are notified within 6 months of the date of the diagnosis and the coverage for Parkinson's disease or specified atypical parkinsonian disorders is excluded based on the 1 year exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for Parkinson's disease or specified atypical parkinsonian disorders or any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

Severe burns

Severe burns means a definite diagnosis of third degree burns over at least 20% of the body surface.

The diagnosis of severe burns must be made by a specialist.

Stroke

Explanation

A stroke (also known as cerebrovascular accident, or CVA) occurs when the blood supply to the brain is reduced either by a blockage (embolus) or a blood clot (thrombosis) or due to haemorrhage, resulting in permanent damage to functions controlled by the brain. Depending on which part of the brain is damaged, this can result in paralysis to one side of the body and impairment of speech or vision. Tiny mini-strokes that do not produce symptoms or persisting neurologic impairment are not covered.

Stroke (cerebrovascular accident) resulting in persistent neurological deficits means a definite diagnosis of an acute cerebrovascular event caused by intra cranial thrombosis or haemorrhage, 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 consecutive days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new persistent neurological deficits.

The diagnosis of stroke (cerebrovascular accident) must be made by a specialist.

Survival period

The insured person must survive for 30 days following the date of diagnosis.

New neurological deficits must be detectable by a physician and may include, but are not restricted to:

- measurable loss of hearing
- objective loss of sensation
- paralysis
- localized weakness
- dysarthria (difficulty with pronunciation)
- dysphasia (difficulty with speech)
- dysphagia (difficulty in swallowing)
- measurable visual impairment
- impaired gait (difficulty walking)
- difficulty with balance
- lack of coordination
- new onset seizures undergoing treatment or
- measurable changes in neuro-cognitive function

Headache or fatigue will not be considered a neurological deficit.

Exclusion

No benefit is payable under this condition for:

- transient ischaemic attacks
- intracerebral vascular events due to trauma, or
- lacunar infarcts which do not meet the definition of stroke as described above.

Illnesses eligible for partial benefit payout

If the insured person is diagnosed with and survives one of these illnesses, you'll receive a partial lump sum benefit. We refer to this list of illnesses as Group 2. The partial lump sum payment will be equal to 15% of the critical illness insurance benefit amount to a maximum of \$50,000 per condition. You can make one claim per partial payout illness, to a maximum of four partial payments. The policy will not end, and you must continue to pay premiums for coverage to continue. The full critical illness benefit amount will not be reduced and the coverage will be available for any future claims.

90 day exclusion period for cancer

No benefit will be payable for cancer if, within the first 90 days following the later of:

- the date the application for the policy was signed
- the policy date
- the underwriting decision date if included in the policy, or
- the most recent date the policy was put back into effect (reinstatement)

The insured person has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made, or
- a diagnosis of cancer (covered or excluded under the policy).

Your responsibility to notify us about cancer

You have a responsibility to notify us about cancer, regardless of when a diagnosis is made:

- If we are notified within 6 months of the date of the diagnosis and the coverage for cancer is excluded based on the 90 day exclusion, coverage for all other covered critical illnesses will continue.
- If information is not provided within 6 months of the date of diagnosis, we have the right to deny a claim for cancer or any critical illness caused by any cancer or its treatment.

Cancer – Chronic lymphocytic leukemia (CLL) Rai stage 0

Chronic lymphocytic leukemia (CLL) means a definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL).

The diagnosis of chronic lymphocytic leukemia must be made by a specialist and confirmed by pathological examination of the tissue.

Exclusion

No benefit will be payable under this condition for Monoclonal lymphocytosis of undetermined significance (MLUS).

Cancer – Ductal carcinoma in situ of the breast

Ductal carcinoma in situ of the breast is a non invasive cancer.

The diagnosis of ductal carcinoma in situ of the breast must be made by a specialist and confirmed by pathological examination of the tissue.

Cancer - Gastrointestinal stromal tumours classified as AJCC Stage 1

The diagnosis of gastrointestinal stromal tumours classified as AJCC Stage 1 must be made by a specialist and confirmed by pathological examination of the tissue.

Cancer - Grade 1 neuroendocrine tumours (carcinoid)

The diagnosis of grade 1 neuroendocrine tumours (carcinoid) must be made by a specialist and confirmed by pathological examination of the tissue. The grade 1 neuroendocrine tumours (carcinoid) must be confined to the affected organ and treated with surgery alone.

Cancer – Papillary thyroid cancer or follicular thyroid cancer stage T1

Papillary thyroid cancer or follicular thyroid cancer means 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 diagnosis of papillary thyroid cancer or follicular thyroid cancer must be made by a specialist and confirmed by pathological examination of the tissue.

Cancer – Stage A (T1a or T1b) prostate cancer

The diagnosis of stage A (T1a or T1b) prostate cancer must be made by a specialist and confirmed by pathological examination of the tissue.

Cancer – Stage 1A malignant melanoma

Stage 1A malignant melanoma is a melanoma confirmed by biopsy to be less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion.

The diagnosis of stage 1A malignant melanoma must be made by a specialist and confirmed by pathological examination of the tissue.

Coronary angioplasty

Coronary angioplasty means 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.

Survival period

The insured person must survive for 30 days following the date of the procedure.

Childhood illnesses eligible for full benefit payout

Sun CII includes coverage for five additional illnesses when the insured is between ages 0 and 17 years. If the child is diagnosed with and survives one of these critical illnesses, you'll receive a lump sum payment of your coverage amount and the policy will end. Coverage for these conditions ends on the child's 24th birthday.

Cerebral palsy

Cerebral palsy means a definite diagnosis of a non progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements.

The diagnosis of cerebral palsy must be:

- made before the insured person's 24th birthday, and
- made by a specialist.

Congenital heart disease

Congenital heart disease means a definite diagnosis of at least one of the covered heart conditions.

Covered heart conditions

- Coarctation of the aorta
- Ebstein's anomaly
- Eisenmenger syndrome
- Tetralogy of Fallot
- Transposition of the great vessels

The diagnosis of the heart condition must be:

- made before the insured person's 24th birthday
- made by a specialist, and
- supported by cardiac imaging acceptable to us.

Survival period

The insured person must survive for 30 days following the date of diagnosis.

Congenital heart disease also covers specific conditions described below for which open heart surgery is performed to correct the condition.

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Congenital heart disease continued

Covered heart conditions if open heart surgery is performed

These heart conditions are covered only if open heart surgery is performed to correct at least one of them:

- Aortic stenosis
- Atrial septal defect
- Discrete subvalvular aortic stenosis
- Pulmonary stenosis
- Ventricular septal defect.

Procedures not covered by this definition are:

- Percutaneous atrial septal defect closure
- Trans catheter procedures which include balloon valvuloplasty.

The diagnosis of the heart condition must be made and the surgery:

- recommended by a specialist
- supported by cardiac imaging acceptable to us, and
- performed by a specialist.

Survival period

The insured person must survive for 30 days following the date of surgery.

Cystic fibrosis

Cystic fibrosis means a definite diagnosis of cystic fibrosis where the insured person has chronic lung disease and pancreatic insufficiency.

The diagnosis of cystic fibrosis must be:

- made before the insured person's 24th birthday, and
- made by a specialist.

Muscular dystrophy

Muscular dystrophy means a definite diagnosis of muscular dystrophy where the insured person has well defined neurological abnormalities, confirmed by electromyography and either muscle biopsy or other testing acceptable to us that confirms the diagnosis.

The diagnosis of muscular dystrophy must be:

- made before the insured person's 24th birthday, and
- made by a specialist.

Type 1 diabetes mellitus


Type 1 diabetes mellitus means a definite diagnosis where the insured person has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least three months.

The diagnosis of Type 1 diabetes mellitus must be:

- made before the insured person's 24th birthday, and
- made by a specialist.

Summary of survival periods

Illness	Eligibility qualifying period	Survival period
Acquired brain injury	180 days	n/a
Aortic surgery	n/a	30 days following the date of surgery
Bacterial meningitis	90 days	n/a
Coma	96 hours	n/a
Congenital heart disease (childhood illness)	n/a	30 days following the date of diagnosis. If surgery is performed, 30 days following the date of the surgery.
Coronary angioplasty (illness eligible for partial benefit payout)	n/a	30 days following the date of the procedure
Coronary artery bypass surgery	n/a	30 days following the date of surgery
Dementia, including Alzheimer's disease	6 months	n/a
Heart attack	n/a	30 days following the date of diagnosis
Heart valve replacement or repair	n/a	30 days following the date of surgery
Loss of independent existence	90 days	n/a
Loss of speech	180 days	n/a
Multiple sclerosis	Refer to full definition	n/a
Occupational HIV infection	Refer to full definition	n/a
Paralysis	90 days	n/a
Parkinson's disease and specified atypical parkinsonian disorders	1 year	n/a
Stroke	30 days	30 days following the date of diagnosis
Type 1 diabetes mellitus (childhood illness)	3 months	n/a

 Conditions not listed in the table do not have an eligibility qualifying period or a survival period.

Glossary

Age

Age means a person's age on their birthday nearest to a particular date. This is known as "age nearest". For example, a person's age at the policy date means their age on their birthday nearest to the policy date.



Canadian Life and Health Insurance Association (CLHIA)

The CLHIA is a voluntary non-profit association with member companies accounting for 99 per cent of Canada's life and health insurance business.

The mission of the CLHIA is to serve its members in areas of common interest, need or concern. In carrying out this mission, the CLHIA will ensure that the views and interests of its diverse membership and of the public are equitably addressed.

Survival period

The length of time the insured must survive after being diagnosed with a critical illness before making a claim.

Specialists

When we refer to specialists, we mean a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness for which a benefit is being claimed. These specialists must be certified by a specialty examining board.

You and we

In this document, you and your mean the owner of this policy. We, us, our, and the company mean Sun Life Assurance Company of Canada.

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