SECURE TRAVEL

RIMI VISITORS TO CANADA TRAVEL INSURANCE

Danforth INSURANCE

Emergency Assistance

In the event of an emergency or if you require medical treatment you must contact MSH Assistance immediately at:

+1 (855) 471 4321
toll-free from the USA and Canada

+1 (437) 567 9642
collect where available

rimiassistance@mshassistance.com

It is your responsibility to ensure that MSH Assistance has been contacted prior to receiving treatment. Your benefits will be limited to 80% of eligible expenses to a maximum of $25,000 if you fail to do so, other than in extreme circumstances when treatment is required to resolve a life threatening medical crisis.

IMPORTANT NOTICE – Please read carefully

- Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your policy as your coverage may be subject to certain limitations or exclusions.
- Your policy may not cover medical conditions and/or symptoms that existed prior to your trip. Check to see how this applies in your policy and how it relates to your effective date.
- In the event of an accident, injury or sickness, your prior medical history may be reviewed when a claim is reported.
- Costs incurred in your country of origin are not covered.
- Your policy provides travel assistance; you are required to notify MSH Assistance prior to medical treatment. Your policy may limit benefits should you not contact MSH Assistance before seeking medical treatment.
- Please take the time to read this policy to ensure that it meets your needs and contact your agent if you have any questions. You may cancel this policy within 10 days of the purchase date for a full refund provided it is before the effective date. Other refunds available are described under Refunds in the General Provisions section of this policy.

THIS POLICY CONTAINS A CLAUSE WHICH MAY LIMIT THE AMOUNT PAYABLE.

NOTE: Italicized words are defined terms whose definition appears in the definitions section of the policy.

LLOYD'S UNDERWRITERS' POLICYHOLDERS' COMPLAINT PROTOCOL, FOR ACCIDENT AND SICKNESS INSURANCE POLICIES

Lloyd's strives to enhance your customer experience with us through superior service and innovative insurance products.

We have developed a formal complaint handling protocol in accordance with the Insurance Companies Act of Canada to ensure your concerns as our valued customer are addressed expeditiously by our representatives. This protocol will assist you in understanding the steps we will undertake to help resolve any dispute which may arise with our product or service. All complaints will be handled in a professional manner. All complaints will be investigated, acted upon, and responded to in writing or by telephone by a Lloyd's representative promptly after the receipt of the complaint. If you are not satisfied with our products or services, you can take the following steps to address the issue:

- Firstly, please contact the broker who arranged the insurance on your behalf about your concerns so that he or she may have the opportunity to help resolve the situation.
- Should you remain dissatisfied with the initial response, you may request that we refer your complaint, to "Lloyd's Complaints Office", who will review the complaint and reply to you directly.

Lloyd's Underwriters

Attention: Complaints Office:

Royal Bank Plaza South Tower

200 Bay Street, Suite 2930, P.O. Box 51 Toronto, ON

M5J 2J2

Tel: 1-877-455-6937

E-mail: info@lloyds.ca

The Financial Consumer Agency of Canada supervises all federally regulated financial institutions, which includes federally regulated insurance companies, for compliance with federal consumer protection laws, including the requirement to have a complaint-handling process in place. FCAC does not resolve individual complaints.

If you have a problem with a financial product or service, you may first file a complaint with Lloyd's Complaints Office:

If you are not satisfied with how your complaint has been handled by Lloyd's, you can escalate the complaint to the following third-party complaints body:

Ombudservice for Life and Health Insurance (OLHI). OLHI is an independent free service that helps consumers with concerns and complaints about life and health insurance products and services.

You can contact the OLHI at:

2 Bloor St. West, Suite 700 Toronto, ON M4W 3E2

Phone: 416-777-9002 or 1-888-295-8112

Website: https://olhi-oap.ca/en/

For Québec complainants you may contact:

Autorité des marchés financiers (AMF):

Toll Free: 1-877-525- 0337

Québec: (418) 525-0337

Montréal: (514) 395-0311

Website: http://www.lautorite.qc.ca

If you want to know your rights or need information about Lloyd's Underwriters complaint-handling process, you may contact FCAC by online form, mail, or telephone. FCAC uses information from consumer enquiries to support its mandate.

Website: www.canada.ca/fcac

Online form: https://www.canada.ca/en/financial-consumer-agency/corporate/contact-us.html

Phone:

For service in English: 1-866-461-FCAC (3222)

For service in French: 1-866-461-ACFC (2232)

For calls from outside Canada: 613-960-4666

Teletypewriter (TTY): 1-866-914-6097 / 613-947-7771

Video Relay Service: FCAC welcomes Video Relay Service (VRS) calls. You do not need to authorize the relay service operator to communicate with FCAC. Visit https://srvcanadavrs.ca/en/ to learn more.

Mailing address:

Financial Consumer Agency of Canada

427 Laurier Avenue West, 5th Floor

Ottawa (Ontario) K1R 7Y2

RDW1010

04 August 2026

ELIGIBILITY

To be eligible for coverage, on the effective date, you must:

1. be a visitor to Canada or a person in Canada under a valid work or student visa, a Canadian or an immigrant not eligible for benefits under a government health insurance plan; and
2. be at least 15 days of age and less than 90 years of age; and
3. not be travelling against the advice of a physician and/or not have been diagnosed with a terminal illness; and
4. not be experiencing new or undiagnosed signs or symptoms and not know of any reason to seek medical attention, other than medically necessary follow-up care, monitoring, testing, or treatment related to a sickness or injury that was first diagnosed and treated during a previous period of coverage and was eligible for coverage without end of emergency being declared. Any extension of coverage is subject to the Insurer's approval and the terms, conditions, eligibility requirements, and limitations outlined under the Extension of Coverage section of this Policy.
5. be fully independent with the activities of daily living (dressing, bathing, eating, using the toilet or getting in or out of a bed or chair).
6. have not been diagnosed or treated for kidney condition requiring dialysis within the last 24 months.
7. have not been diagnosed or receiving treatment for or requiring a bone marrow or organ transplant within the last thirty-six (36) months and are not currently awaiting a bone marrow or organ transplant. For transplants that occurs more than 36 months, maintenance treatment alone does not affect eligibility.
8. have not been diagnosed with a terminal illness, defined as an illness for which life expectancy is less than twenty-four (24) months.
9. have not taken home oxygen in the past 12 months prior to the effective date.
10. have not been diagnosed with pancreatic, liver, lung, brain, or any cancer that has metastasized, and have not been diagnosed with or treated for any other cancer within the past five (5) years and are not currently undergoing treatment, excluding basal cell carcinoma.

INSURING AGREEMENT

1. In consideration of having paid the required premium in full for the selected sum insured, the insurer agrees to pay the reasonable and customary costs up to the selected sum insured incurred by you in case of an emergency occurring while in Canada or while on a temporary visit to another country. A minimum of 51% of your coverage period must be spent in Canada and time spent outside of Canada is limited to a maximum of 30 days per visit. There is no coverage while in your country of origin.
2. The insurer will pay such eligible expenses, less any applicable deductible, up to the amount shown in the schedule of fees set by the government plan in your province or territory of residence in Canada for non-Canadian residents and only in excess of those reimbursable by any group or individual, private or public plan or contract of insurance, including any auto insurance plan.
3. Subject to all terms and conditions of the policy, the benefits are payable to a maximum of the sum insured insofar as such services are medically necessary. Benefit limits are per insured person, per trip including any extensions.
4. This policy, the application and the confirmation of insurance constitute your contract of insurance.
5. The insurer reserves the right to decline any application or any request for an extension of coverage.
6. The plan type purchased and the sum insured selected cannot be changed after the effective date indicated on your confirmation of insurance.
7. Only one policy can be issued to you and all premiums paid for any additional policy will be returned to you. When more than one policy of this form is issued by the insurer and is in force with respect to you at the time of claim, only one such policy, the earliest by effective date, will apply.

DURATION OF COVERAGE

1. The maximum coverage period under this plan is 365 days per policy.
2. Coverage will extend for a temporary visit during the coverage period. Proof of all travel dates will be required in the event of a claim.
3. **Effective Date**

Your insurance policy commences on the latest of:

a. the date and time you apply for and pay for this insurance;
b. 12:01 a.m. (local time) on the effective date as shown on your confirmation of insurance; or
c. the date and time of your arrival in Canada. Proof of your date of arrival may be required.

Exception: When this policy is purchased prior to leaving your country of origin, and provided the appropriate premium is paid, coverage will commence on the date of departure from your country of origin (date indicated on your plane ticket) for your uninterrupted travel to Canada.

4. **Waiting Period**

If you purchase this coverage after your arrival in Canada there is no coverage for any sickness that began, or for which you experienced symptoms, during:

a. the 48-hour period following the effective date of the policy if insurance is purchased within 30 days of your arrival to Canada; or
b. the 7-day period following the effective date of the policy if insurance is purchased more than 30 days after your arrival to Canada.

Exception: The Waiting Period will be waived if this policy is purchased on or prior to the expiry date of an existing Secure Travel RIMI Visitors to Canada Travel Insurance policy already issued by the insurer, to take effect on the day following such expiry date provided no increase in the sum insured option is applied for. The existing policy must be in effect on the date of purchase and there must be no gap in coverage.

5. **Expiry Date**

Coverage under this plan terminates on the earliest of:

a. 11:59 p.m. (local time) on the expiry date shown on your confirmation of insurance;
b. 365 days after the effective date of your insurance;
c. the date you become eligible for a government health insurance plan in Canada;
d. the date and time you arrive in your country of origin with no intention to return to Canada during the coverage period;
e. the date when you exceed 49% of your coverage period while visiting another country;
f. the 31st day of a temporary visit to another country, other than your country of origin;
g. 11:59 p.m. (local time) on an earlier date calculated by the insurer due to an incorrect or insufficient premium payment, including a lapsed monthly payment.

6. **Temporary Return Home**

You may return to your country of origin for a temporary visit prior to your expiry date and your coverage will resume with no additional premium once you return to Canada providing you remain eligible. The premium for the number of days of your temporary visit will not be refunded or reissued. Any medical condition for which symptoms were present or you received medical treatment during a temporary visit is not covered.

7. **Extending Your Coverage**

If you wish to remain in Canada beyond the expiry date of this policy, you must contact your broker or sales agent prior to the expiry date and have no reason to seek medical attention during the new period of coverage.

You may purchase a new policy subject to the policy terms, conditions and premium schedule in effect at the time the new policy is requested. The cost of additional days of insurance will be calculated using the age of the insured on the effective date of the new policy provided that:

a. you remain eligible for insurance;
b. you have not experienced any changes in your health since your effective date or arrival date;
c. the request for the new policy is received prior to the expiry date of your coverage;
d. the required premium is paid.

If you have submitted a claim, the insurer will review your file before granting an extension. The insurer reserves the right to decline any request for extension.

Note: The minimum premium is $20 per policy.

8. **Family Coverage**

If you have purchased family coverage at the time of application, your policy covers you and all family members named on the application (please refer to the definition of family) if:

a. coverage dates are the same for all family members; and
b. all family members live at the same address while in Canada; and
c. the premium for family coverage is paid prior to the effective date as shown on the application or confirmation of insurance.

9. **Automatic Extension of Coverage**

Upon notifying MSH Assistance your coverage will extend automatically, without additional premium, for up to 72 hours if your stay is prolonged beyond the expiry date due to any of the following reasons:

a. Delay beyond your control of the vehicle, airline, bus, train or government operated ferry system in which you are riding or are scheduled to ride as a passenger. The delay must occur prior to the expiry date and the conveyance must be due to arrive prior to the expiry date;
b. Medical evidence supports that you are medically unfit to return to your country of origin due to a covered sickness or injury on or before the expiry date.
c. You are hospitalized due to an emergency on the expiry date indicated on your confirmation of insurance as a result of a covered sickness or injury. Coverage extends for the period of hospitalization and the 72-hour extension will commence upon release from hospital.

Note: All claims incurred after the termination date of the insured person's insurance policy must be supported by documented proof of the event resulting in the delayed return. This benefit does not include costs associated with flight change.

BENEFITS

The insurer will reimburse the reasonable and customary costs for eligible expenses described in this section that are incurred as the result of a covered emergency up to the sum insured, subject to all policy limitations, exclusions and provisions. However, certain expenses, as specified below, are covered only with the prior approval of MSH Assistance.

1. **Hospital Accommodation**

a. Charges up to the ward rate (semi-private room for Enhanced plan) charged by the hospital. If medically necessary, expenses for treatment in an intensive care or coronary care unit are also covered.
b. Emergency-room fees.
c. Emergency out-patient services provided by a hospital when medically necessary.

2. **Medical Services**

Medical treatment by a legally licensed physician, surgeon, anesthetist or registered graduate nurse (other than an immediate family member of the insured person).

3. **Diagnostic Services**

Laboratory tests and x-rays that are ordered by the attending physician and that are part of the emergency medical treatment. This policy does not cover magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans, digital x-rays, sonograms or ultrasounds and biopsies unless such services are approved in advance by MSH Assistance.

4. **Prescriptions**

Drugs, including injectable drugs and sera, that can only be obtained upon medical prescription, that are prescribed by a physician and that are supplied by a licensed pharmacist when medically necessary for emergency medical treatment, except when needed to stabilize a chronic condition or a medical condition which an insured person had before the trip. This benefit is limited to a 30-day supply and up to $750 ($1,500 for Enhanced plan) per prescription, unless the insured person is hospitalized.

5. **Private Duty Nurse**

When approved in advance by MSH Assistance and prescribed by an attending physician, the professional services of a registered private duty nurse (other than by an immediate family member) as the result of a covered emergency when medically necessary and while hospitalized or in lieu of hospitalization. Coverage is limited to $5,000 when in lieu of hospitalization.

6. **Follow-up Visits**

Follow-up visits must be approved in advance by MSH Assistance. Follow-up visits may include consultation, testing, diagnostics, and treatment and are permitted on the date of the emergency or discharge and during the 14 days following. All follow-up visits must be directly related to the initial emergency and required by the treating physician. No exceptions will be granted under this benefit.

7. **Paramedical Services**

When approved in advance by MSH Assistance, the services (including x-rays) of a licensed chiropractor, physiotherapist, podiatrist, or osteopath to a maximum of $300 ($500 for Enhanced plan) per insured person, per profession listed above.

8. **Dental Emergency**

When performed by a legally qualified dentist or oral surgeon, emergency dental treatment:

a. up to $1,000 ($3,000 for Enhanced plan) to repair or replace whole or sound natural teeth or permanently attached artificial teeth damaged as a result of an accidental blow to the face; and
b. up to $300 ($500 for Enhanced plan) for relief of pain caused other than by a blow to the face and for which you have not previously received treatment or advice.

Treatment must be initiated within 72 hours from the time the emergency began and be completed no later than 90 days after treatment began and before your expiry date or you return to your country of origin.

9. **Medical Appliances**

When approved in advance by MSH Assistance and prescribed by the attending physician, up to a maximum of $5,000 for minor appliances such as crutches, casts, splints, canes, slings, trusses, braces, walkers and/or the temporary rental of a wheelchair, not exceeding the purchase price.

10. **Emergency Transportation**

a. Licensed ambulance services (includes taxi fare in lieu of ambulance) to the nearest medical facility capable of providing the required emergency medical treatment;
b. Transportation between hospitals when ordered by the attending physician for emergency medical treatment;
c. If, as the result of a covered emergency, your treating physician or the MSH Assistance Medical Team recommends that you be returned to Canada or your country of origin, the costs incurred for:
    i. one-way economy airfare on a commercial flight via the most direct route, including the cost for additional seats to accommodate a stretcher or upgrading charges if your attending physician states in writing that it is medically necessary;
    ii. return economy airfare via the most direct route for a qualified medical attendant to accompany you if required by the airline or if your attending physician states in writing that it is medically necessary;
    iii. air ambulance if medically necessary only when approved and arranged by MSH Assistance.

11. **Accidental Death & Dismemberment**

The insurer agrees to pay up to $50,000 ($100,000 for enhanced), for loss of life, limb or sight of an insured person resulting directly from accidental injury occurring during the coverage period, except while boarding, riding in, or alighting from an aircraft.

Benefits are payable according to the following schedule:

a. 100% of sum insured resulting from the same accidental injury for loss of:
    i. life; or
    ii. entire sight of both eyes; or
    iii. both hands; or
    iv. both feet; or
    v. one hand and entire sight of one eye; or
    vi. one foot and entire sight of one eye.
b. 50% of sum insured resulting from the same accidental injury for loss of:
    i. entire sight of one eye; or
    ii. one hand; or
    iii. one foot.

Loss of hand or hands, or foot or feet means severance through or above the wrist joint or ankle joint, respectively. Loss of eye or eyes means total and irrecoverable loss of the entire sight.

Only one amount is payable (the largest) if you suffer more than one of these losses.

Exposure and Disappearance

If you are exposed to the elements or disappear as a result of an accident, a loss will be covered if:

a. as a result of such exposure, you suffer one of the losses specified in the schedule of losses above; or
b. your body has not been found within 52 weeks from the date of the accident. It will be presumed, subject to evidence to the contrary, that you suffered loss of life.

12. **Flight Accident**

Up to $50,000 in case of death of an insured person as a result of an injury sustained during the coverage period while travelling as a fare-paying passenger on a commercial airline. If the total

claims for the same accident exceed $300,000, the insurer's liability for that accident is limited to $300,000 which will be shared proportionately among all claimants involved in the same accident and who are covered under all policies underwritten by the insurer.

13. Repatriation of Remains

In the event of your death as a result of covered accident or unforeseen sickness:

a. up to a maximum of $5,000 ($10,000 for Enhanced plan) toward the actual cost incurred for the preparation of remains and transportation (including a standard shipping container) to your country of origin; or

b. up to $2,500 ($5,000 for Enhanced plan) for cremation and/or burial at the place of death.

The cost of the casket, urn or funeral is not covered.

14. Recurrent Condition Coverage

This benefit provides up to $25,000 in coverage for the recurrence of a previously diagnosed condition and is available only if you have selected and paid for Plan 2 and purchased coverage on an annual policy basis. The condition must have been initially diagnosed and treated under a RIMI Secure Travel policy within the same policy year, with no gap in coverage, and must have been stable, as defined under this policy.

Eligible expenses include physician consultations, diagnostic tests, prescribed treatments, hospitalization, and follow-up care that is deemed medically necessary.

Benefit Limit

Coverage provides a maximum of $25,000 per recurrent condition. Once this limit is reached, no further benefits are payable for that condition.

All other terms and conditions of the base policy apply.

The following benefits apply only if you have selected and paid for the Enhanced plan as shown on your confirmation of insurance.

15. Transportation to Bedside

When approved in advance by MSH Assistance, single round-trip economy airfare plus up to $150 per day to a maximum of $3,000 for the cost of meals and commercial accommodation for one person of your choice to:

a. be with the insured person if the insured person is travelling alone and has been hospitalized as the result of a covered emergency. To be payable, this benefit requires that the insured person eventually be hospitalized as an in-patient for at least 3 consecutive days and that the attending physician provide written certification that the situation was serious enough to warrant the visit; or

b. identify the deceased insured person prior to the release of the body, where necessary.

16. Meals and Accommodation

When approved in advance by MSH Assistance, up to $150 per day, to an overall maximum of $3,000 for your commercial accommodation, meals, essential telephone calls, internet fees, bus or taxi fare or rental car in lieu and child care costs for your dependents up to age 18 (excluding child care provided by an immediate family member), if, upon a physician's advice:

a. you or your travel companion are hospitalized on the date you are scheduled to return to your country of origin or place of residence in Canada; or

b. you or your travel companion are transferred to a different hospital in another city for emergency medical treatment.

The fact that an insured person is unable to travel must be certified by the attending physician and claims must be supported with original receipts from commercial organizations.

17. Hospital Allowance

Up to $50 per day to a maximum $500 for incidental expenses billed by the hospital such as telephone, television or internet charges while you are hospitalized.

18. Return and Escort of Children

When approved and arranged in advance by MSH Assistance, up to economy airfare to return accompanying dependent children to the departure point in the event that you are returned to your country of origin or Canada under the Emergency Transportation benefit. The insurer will also pay for an escort to accompany the dependent children.

19. Excess Baggage Return

When approved and arranged in advance by MSH Assistance, up to $500 for the cost of returning your excess baggage to the departure point in the event that you are returned to your country of origin or Canada under the Emergency Transportation benefit.

EXCLUSIONS

This policy does not cover losses or expenses related in whole or in part, directly or indirectly, to any of the following:

1. Any sickness, injury, medical or mental health condition that existed prior to the effective date if you have selected and paid for Plan 1, as indicated on your Confirmation of Insurance.

   If you have selected and paid for Plan 2, as indicated on your Confirmation of Insurance, there is no coverage for any sickness, injury or medical condition that existed prior to the effective date, other than:

   a. Up to Age 60: Any sickness, injury or medical condition that was stable, as defined under this policy, in the 90 days prior to the effective date.

   b. Age 61–64: Any sickness, injury or medical condition that was stable, as defined under this policy, in the 120 days prior to the effective date.

   c. Age 65–69: Any sickness, injury or medical condition that was stable, as defined under this policy, in the 120 days prior to the effective date, provided you have accurately answered "No" to all questions on the medical declaration and meet the eligibility requirements. If any question is answered "Yes," there is no coverage for any sickness, injury or medical condition that existed prior to the effective date, whether or not stable.

   d. Age 70–84: Any sickness, injury or medical condition that was stable, as defined under this policy, in the 180 days prior to the effective date, provided you have accurately answered "No" to all questions on the medical declaration and meet the eligibility requirements. If any question is answered "Yes," there is no coverage for any sickness, injury or medical condition that existed prior to the effective date, whether or not stable.
   Exception – Recurrent Condition Coverage: Notwithstanding the provisions of 1(a) through (d) above, this exclusion does not apply to recurrent conditions covered under Plan 2, provided the condition:

      i. Was previously diagnosed and treated under a RIMI Secure Travel policy in the same policy year, provided there was no gap in coverage; and

      ii. Was stable, as defined under this policy, for the required period before the effective date of the current policy.

   e. Age 85 or older: Applicants age 85 or older are not eligible for Coverage for Pre-Existing Conditions under this policy. Coverage for Pre-Existing Conditions cannot be purchased, elected, issued or applied for once an insured person has reached age 85.

2. Expenses related to a sickness or injury that would have caused an ordinarily prudent person to seek medical treatment, advice, diagnosis or care during the 90 day period immediately prior to the effective date.

3. Any medical treatment that is not emergency medical treatment for the immediate relief of acute pain and suffering, including any elective or cosmetic surgery or treatment.

4. Any sickness or injury which occurred prior to the effective date of your policy when coverage has been extended after your arrival in Canada.

   Exception: This exclusion does not apply to eligible recurrent conditions under Plan 2, if the condition was previously diagnosed and treated under a RIMI Secure Travel policy in the same policy year where there was no gap in coverage and meets the stability requirements defined in this policy.

5. Any costs incurred outside of Canada after you exceed 30 consecutive days in any country other than Canada during the coverage period.

6. Any costs incurred due to your travelling against the advice of a physician or any loss resulting from your sickness or medical condition that was diagnosed by a physician as a terminal illness prior to the effective date.

7. Any medical treatment which can reasonably be delayed until you return to your country of origin by the next available means of transportation, whether you intend to or not.

8. Any medical treatment of an ongoing condition, regular care of a chronic condition, home health care, investigative testing, rehabilitation, convalescent or ongoing care or medical treatment of an acute sickness and/or injury after the initial emergency has ended. This exclusion does not apply to Plan #2 as applicable to the recurrent condition benefit.

9. Expenses incurred whereby this policy was purchased specifically to obtain medical treatment outside your country of origin, whether or not recommended by your attending physician.

10. Any medical treatment in your country of origin.

11. Any medical condition for which symptoms were present or for which you received medical treatment during a temporary visit to your country of origin during the coverage period.

12. Transplants including, but not limited to, cornea or organ transplants or bone marrow transplants, artificial joints, prosthetic devices or implants including any associated charges. Implants required to stabilize an emergency medical condition may be covered if pre-approved by MSH Assistance.

13. The replacement of an existing prescription whether by reason of loss, unless otherwise specified elsewhere in this policy, renewal or inadequate supply or the purchase of drugs and medications (including vitamins) which are commonly available without a prescription or which are not legally registered and approved in Canada or which are not required as a result of an emergency.

14. Loss or damage to hearing devices, eyeglasses, sunglasses, contact lenses, or prosthetic teeth, limbs or devices and resulting prescription thereof.

15. Any expense arising from, related to, or resulting from pregnancy, maternity, prenatal care, postnatal care, childbirth, miscarriage, abortion, fertility treatment, newborn care, or any complication thereof, whether routine, elective, emergency, or medically necessary, unless injury occurs.

16. For children under 2 years of age any sickness or medical condition resulting from or related to a congenital defect.

17. Expenses for any benefit or medical treatment that requires prior approval by MSH Assistance if such approval was not provided, except in extreme circumstances where such medical treatment is performed on an emergency basis immediately upon admission to hospital.

18. A disorder, disease, condition or symptom that is emotional, psychological or mental in nature unless the insured is hospitalized.

19. Loss, death or injury, if at the time of the loss, death or injury, evidence supports that you were affected by, or the medical condition causing the loss was in any way contributed to by, the use of alcohol, prohibited drugs or any other intoxicant.

20. Committing or attempting to commit an illegal act or a criminal act by an insured person.

21. Your suicide, attempted suicide or self-inflicted injury, whether you are sane or insane.

22. Rock or mountain climbing, hang gliding, parachuting, bungee jumping, or skydiving; participation in any motorized race or speed contest; participation in any sport as a professional athlete (for which the insured person is remunerated) or scuba diving (except if certified by an internationally recognized and accepted program such as NAUI or PADI, or if diving depth does not exceed 30 meters).

23. Death or injury sustained while operating or learning to operate any aircraft as pilot or crew.

24. Travel to, from or through any country, region or city for which, prior to your departure date, the Canadian Government, or any department thereof, has issued a warning to avoid all travel or to avoid non-essential travel during the time of your trip if the loss is the result of the reason for which the warning was issued.

25. War, invasion, act of a foreign enemy, declared or undeclared hostilities, civil war, riot, rebellion, revolution or military power or your unlawful visit in any country.

26. Contamination resulting from radioactive material or nuclear fuel or waste or the release of weapon(s) of mass destruction (nuclear, chemical or biological).

27. Service in, or training for, the armed forces, national guard or organized reserve corps of any country or international authority.

28. The worsening, recurrence, side effects or complications of a medical condition resulting from your non-compliance or failure to follow the directions of a physician or other health care provider.

    Note: Recurrent Condition Coverage does not apply to any recurrence resulting from non-compliance Or failure to follow the directions of a physician or other health care provider.

DEFINITIONS

Certain italicized terms used in this policy are defined in this section.

Accident means a sudden, unforeseen, unexpected and unintentional event exclusively attributable to an external cause resulting in bodily injury.

Chronic Kidney Disease, Kidney failure, or renal failure, occurs when the kidneys can no longer filter waste products from the blood effectively, resulting in the accumulation of toxins and imbalances in body fluids and electrolytes. It can be classified as chronic (gradual decline in kidney function) and may eventually require dialysis or kidney transplantation.

Country of Origin means the country for which the insured person holds a passport. If the insured person holds more than one passport, the country of origin will be taken to mean the country that the insured person has declared on the application. Where a family is to be covered by the policy, there will be deemed to be one country of origin for the family, which will be the country of origin declared on the application.

Deductible means the amount (if applicable), in Canadian dollars, which the insured must pay before any remaining eligible expenses are reimbursed under this policy. The deductible applies once per insured person, per covered emergency.

Dependent Children means unmarried persons residing with you and dependent on you for support if you are their parent, grandparent or legal guardian, and on the effective date they are at least 15 days of age and:

a. under 21 years of age; or

b. under 26 years of age and a full-time student; or

c. have a mental or physical impairment.

Emergency means an unexpected and unforeseen sickness or injury occurring during the coverage period for which you require immediate medical treatment for the relief of acute pain or suffering occurring while on a covered trip and that such medical treatment cannot be delayed until your return to your country of origin, whether you intend to or not. An emergency no longer exists when you are declared medically fit to travel by the MSH Assistance Medical Team and no further benefits are payable in respect of the medical condition which caused the emergency.

Family means you and/or your spouse up to age 69 and your dependent children when your names appear on the application or confirmation of insurance. Coverage dates must be the same for all family members. All family members must live at the same address while in Canada.

Follow up care: Follow-up Visit means a medically necessary consultation, examination, test, diagnostic service, or treatment prescribed or required by the treating physician following an initial Emergency, provided such service is directly related to and necessary for the continued management of the sickness or injury that was the primary reason for the initial Emergency treatment. Elective, routine, unrelated, or additional diagnostic testing or treatment that is not medically necessary to address the main Emergency complaint is not covered as part of the Follow-up Visit.

Government Health Insurance Plan means the health care coverage provided by Canadian federal, provincial and territorial governments to their residents.

Heart Disease or Condition is any Angioplasty or Stenting in or around the heart (coronary or carotid arteries or aorta), Angina, Atrial Fibrillation, Heart Failure (with reduced or preserved ejection fraction), Heart Attack/Myocardial Infarction, Irregular Heartbeat or Heart Murmur due to valvular pathology, Pacemaker/Defibrillator insertion, any Cardiovascular, Valve or Bypass surgery or any other condition or diagnosis relating to the Heart or Blood Vessels of the Heart.

Heart Failure is a condition in which the heart is unable to pump blood efficiently, leading to insufficient blood flow to meet the body's needs. This can result from various underlying issues, including coronary artery disease, high blood pressure, or previous heart attacks. Symptoms may include fatigue, shortness of breath, and fluid retention.

Hospital means an institution which is designated as a hospital by law; which is continuously staffed by one or more physicians available at all times; which continuously provides nursing services by graduate registered nurses; which is primarily engaged in providing diagnostic services and medical and surgical treatment of a sickness and/or injury in the acute phase, or active treatment of a chronic condition; which has facilities for diagnosis, major surgery and in-patient care. The term hospital does not include convalescent, nursing, rest or skilled nursing facilities, whether separate from or part of a regular general hospital, or a facility operated mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre or health spa.

Hospitalization or **Hospitalized** means an insured occupies a hospital bed for more than 24 hours for medical treatment and for whom admission was recommended by a physician when medically necessary.

Immediate Family Member means the spouse, natural or adopted child, step-child, parent, step-parent, legal guardian, legal ward, brother, sister, step-brother, step-sister, in-law, grandparent, grandchild, aunt, uncle, niece, nephew of the insured person.

Injury means an unexpected and unforeseen harm to the body that is caused by an accident, sustained by an insured person during the coverage period and that requires emergency treatment that is covered by this policy.

Insured, Insured Person means any eligible person named on the application and confirmation of insurance for whom the required premium has been paid.

Insurer means the Lloyd's Underwriters subscribing to this policy and providing the insurance coverage described herein. The insurer is responsible for the payment of eligible benefits in accordance with the terms, conditions, limitations and exclusions of this policy.

In-patient means a patient who occupies a hospital bed for more than 24 hours for medical treatment and for whom admission was recommended by a physician when medically necessary.

Liver Failure is a medical condition where the liver loses its ability to function effectively, leading to severe impairment in metabolic processes, detoxification, and production of essential proteins. This condition can be acute (sudden onset) with no long-term impact to the liver or chronic (gradual deterioration). with a diagnosis of cirrhosis or end stage liver disease.

Medical Treatment means any reasonable procedure which is medical, therapeutic or diagnostic in nature, which is medically necessary and which is prescribed by a physician. Medical treatment includes hospitalization, basic investigative testing, surgery, prescription medication (including prescribed as needed) or other treatment directly related to the sickness, injury or symptom.

Medically Necessary, in reference to a given service or supply, means such service or supply:

a. is appropriate and consistent with the diagnosis according to accepted community standards of medical practice;

b. is not experimental or investigative in nature;

c. cannot be omitted without adversely affecting the condition of the insured person or quality of medical care;

d. cannot be delayed until the insured person returns to their country of origin.

Mountain Climbing means the ascent or descent of a mountain requiring the use of specified equipment including crampons, pick axes, anchors, bolts, carabiners and lead-rope or top rope anchoring equipment.

MSH Assistance means the company designated by the insurer to provide emergency assistance services.

Physician means a medical practitioner who is registered and licensed to practice in accordance with the regulations applying in the jurisdiction where the person practices. A physician must be a person other than the insured person or an immediate family member.

Reasonable and Customary Costs means costs that are incurred for approved, covered medical services or supplies that do not exceed the standard fee of other providers of similar standing in the same geographical area, for the same treatment of a similar sickness and/or injury.

Sickness means a sudden and unforeseen disease or disorder of the body which results in loss during the coverage period. The sickness must be sufficiently serious to prompt a reasonably prudent person to consult a physician for the purpose of medical treatment.

Spouse means the person to whom the insured is legally married or with whom the insured has been living in a common-law relationship for at least the last 12 months.

Stable means any medical condition (whether or not the diagnosis has been determined) for which there has been:

a. no hospitalization; and

b. no new diagnosis, treatment or prescribed medication; and

c. no change* in treatment or medication; and

d. no new, more frequent or more severe symptoms; and

e. no new test results showing deterioration; and

f. no referral to a specialist (made or recommended) and you are not awaiting surgery or the results of further investigations performed by any medical professional.

*Change includes any new treatment or medication, stopped treatment or medication, increase or decrease in treatment or medication but does not include transition between generic and brand-name versions of drugs with the same active ingredient and dosage or the routine adjustment of dosage within prescribed parameters when you are taking insulin or oral diabetes medication.

Sum Insured means the maximum amount payable that you have selected at the time of purchase and paid for, or that applies to a given insurance coverage.

Terminal Illness means the insured person has a condition that is cause for the physician to estimate that the insured person has less than 6 months to live.

Travel Companion means someone who shares travel arrangements with you up to a maximum of 4 people.

Trip means the period between the effective and expiry date shown on your confirmation of insurance.

You, Your, Yourself means the insured person.

LIMITATIONS AND RESTRICTIONS

Notification to MSH Assistance

MSH Assistance must approve in advance any surgery, invasive procedure, diagnostic testing or treatment (including, but not limited to, cardiac catheterization), prior to the insured undergoing such surgery, procedure, testing or treatment. It remains your responsibility to inform your attending physician to call MSH Assistance for approval, except in extreme circumstances where such action would delay surgery required to resolve a life threatening medical crisis.

In the event of a medical emergency, you must notify MSH Assistance within 24 hours of admission to a hospital and before any surgery is performed.

If you fail to do so without reasonable cause, then the insurer will pay 80% of the claim payable. You will be responsible for the remaining 20% of the claim payable. You will be responsible for any expenses that are not payable by the insurer.

Limitation of Benefits

Once the insured person is deemed medically stable to return to their country of origin or by virtue of discharge from a medical facility, the emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the emergency will no longer be eligible for coverage under this policy.

Inability to Obtain Medical Records

In the event that the insurer is unable to obtain medical records from your country of origin your medical history will be based on information developed from your attending physician's report, medical examination or other sources of pertinent information.

Availability and Quality of Care

Neither the insurer nor MSH Assistance shall be responsible for the availability or quality of any medical treatment (including the results thereof) or the failure of the insured person to obtain medical treatment during the coverage period.

Medical Transfer or Repatriation

The insurer reserves the right, as reasonably required and at its expense, to transfer you to any hospital or to transport you to Canada or your country of origin during an emergency for medical treatment of your sickness or injury.

If you refuse to be transferred or transported when declared medically fit to travel by the MSH Assistance Medical Team, any continuing costs incurred for such sickness or injury after your refusal will not be covered and the payment of such costs becomes your sole responsibility. Coverage for the sickness or injury ceases upon your refusal and no coverage will be provided for that sickness or injury for the remainder of the coverage period.

Limits on Assistance Services

MSH Assistance reserves the right to suspend, curtail or limit services in any area or country in the event that war, political instability or hostility renders the area inaccessible by MSH Assistance. MSH Assistance will use its best efforts to provide services during any such occurrence.

Limitations on Renewal

Upon renewal of coverage, for a claim reported under the previous policy, the following wording will be applied in the policy: Any medically required follow-up appointment that is scheduled after the expiry date of the policy with respect to an accident or sickness (limited to $1,000 for sickness), must be pre-approved by the Assistance Centre and will only be considered for reimbursement if the initial emergency is reported to the Assistance Centre prior to the expiry date and if that initial emergency is a payable claim.

Privacy Policy

The insurer places great importance on the protection of your privacy. Your personal information will be collected, used and disclosed only for the purpose of providing you with the insurance services you requested. This information remains confidential, as is required under applicable federal and provincial laws. In the event of a claim, MSH Assistance and the insurer may collect your personal health information held by a third party. This information may be released to employees of MSH Assistance and the insurer for claims analysis and to better serve you.

In no case will the insurer release this information to any person or organization that is not clearly entitled to it without first seeking your consent.

https://www.americas.msh-intl.com/privacy-policy/

GENERAL PROVISIONS

Aggregate Limit

The total aggregate limit for all losses resulting from any one incident under all travel insurance policies underwritten by the insurer is $20,000,000 CAD.

Applicable Law

This contract of insurance is governed by the laws of the province or territory where this policy was issued. Any legal proceeding by you, your heirs or assigns shall be brought in the courts of the province or territory where this policy was issued.

Arbitration

Notwithstanding any clause in this policy, the parties hereto undertake to submit to an arbitration process, to the exclusion of the courts, any present or future dispute relating to a claim. The arbitration proceedings shall be governed by the arbitration law in force in the Canadian province or territory of residence of the insured. The parties agree that any action will be referred to arbitration.

Currency

All sums payable under this policy are in Canadian currency. If an insured person has paid a covered expense in a currency other than Canadian currency, the insured person will be reimbursed in Canadian currency at the prevailing rate of exchange on the date that the claim payment is made. This insurance will not pay interest.

Limitation of Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or any other applicable legislation.

Limitation of Benefits

Once the insured person is deemed medically stable to return to their country of origin or by virtue of discharge from a medical facility, the emergency will be deemed to have ended, whereupon any further consultation, treatment, recurrence or complication related to the emergency will no longer be eligible for coverage under this policy.

Misrepresentation and Non-Disclosure

The entire coverage under this policy shall be voidable if the insurer determines, whether before or after loss, that the insured person has concealed, misrepresented or failed to disclose any material fact or circumstance concerning this policy or their interest therein, or if the insured person refuses to disclose information or to permit the use of such information, pertaining to any of the insured persons under this policy. Consequently and following a loss, no claim shall be payable by the insurer and the insured person shall be solely responsible for all expenses relating to their claim, including medical repatriation costs.

Misstatement of Age

If your age has been misstated to the insurer, the coverage and/or premium may be adjusted in accordance with the correct age as of the date you applied for coverage to become effective. Any premium adjustment is payable upon receipt of a premium notice.

Other Insurance

This insurance is a second payor plan. For any loss or damage insured by, or for any claim payable under any other liability, group or individual basic or extended health insurance plan, or contracts including any private or provincial or territorial auto insurance plan providing hospital, medical, or therapeutic coverage, or any other insurance in force concurrently herewith, amounts payable hereunder are limited to those covered benefits incurred outside your country of origin that are in excess of the amounts for which an insured person is insured under such other coverage.

You may not claim or receive in total more than 100% of the loss caused by the insured event.

Overpayment of Benefits

Nothing in this policy will prevent the insurer from recovering from the person or organization to which such payment has been made any overpayment of benefit, irrespective of the cause of such overpayment.

Premium Payment

The required premium is due and payable at the time of application and will be determined according to the rate schedule then in effect. All payments must be made by credit card. Premium rates, policy terms and conditions are based on your age as of the effective date. If the premium paid is insufficient for the coverage selected, the insurer will charge and collect any underpayment. Coverage will be null and void if the premium is not received, if credit card charges are invalid or if no proof of your payment exists.

If you have selected the Monthly Payment Option, monthly payment amounts will be calculated as $^{1}/_{12}$ of the total premium due. An amount equal to two months' premium plus a policy issue fee will be billed on the effective date of the policy. The remaining 10 monthly payments will be billed on the same date of the subsequent 10 months.

If a payment is not received, the insurer will advise your broker of the missed payment. The expiry date will be calculated based on all premium payments received. If a replacement payment is not received prior to the expiry date all coverage will cease under this policy. The insurer will not be liable for any claims that occur after the policy has expired.

Protecting Your Privacy

The insurer places great importance on the protection of your privacy. Your personal information will be collected, used and disclosed only for the purpose of providing you with the insurance services you requested. This information remains confidential, as is required under applicable federal and provincial laws. In the event of a claim, MSH Assistance and the insurer may collect your personal health information held by a third party. This information may be released to employees of MSH Assistance and the insurer for claims analysis and to better serve you.

In no case will the insurer release this information to any person or organization that is not clearly entitled to it without first seeking your consent. For details of the insurer's privacy policy please see:

Refunds

1. If cancellation of your policy is requested prior to the effective date, the full premium paid will be refunded less any applicable administration fee. If the policy was purchased for a Super Visa application, satisfactory proof from Citizenship and Immigration Canada that your Super Visa was denied will be required prior to the refund being accepted and processed.
2. The premium paid (less any administration fees) may be partially refunded for the unused portion of the premium if termination of your policy is requested because you must return to your country of origin prior to your scheduled return date, or you become eligible and/or covered under a government health insurance plan during the coverage period.

   Note: Requests for refunds must be received in writing by your broker or sales agent no later than 60 days from the date you became eligible and/or covered under a government health insurance plan, or the date of your early return, or the expiry date of your policy. Once your broker or sales agent receives satisfactory proof (e.g. airline ticket/boarding pass, customs/immigration stamp) of your early return, or proof of the date you became eligible and/or covered under a government health insurance plan, your refund will be calculated from that date, otherwise calculation of such refunds will be based on the postmarked date of your written request.

Subrogation

If an insured person suffers a loss covered under this policy, the insurer is granted the right from the insured person to take action to enforce all the insured person's rights, powers, privileges, and remedies, to the extent of benefits paid under this policy, against any person, legal person or entity which caused such loss. Additionally, if "no fault" benefits or other collateral sources of payment of medical expenses are available to the insured person, regardless of fault, the insurer is granted the right to make demand for, and recover, those benefits. If the insurer institutes an action it may do so at its own expense, in the name of the insured person, and the insured person will attend at the place of loss to assist in the action, in addition to providing the insurer all information, cooperation and assistance as the insurer may reasonably require. If the insured person institutes a demand or action for a covered loss, the insured person shall immediately notify the insurer so that the insurer may safeguard its rights. The insured person shall take no action after a loss that will impair the rights of the insurer set forth in this paragraph and shall do all such things as are necessary to secure such rights.

STATUTORY CONDITIONS (GENERAL CONDITIONS IN QUÉBEC)

Notwithstanding any other provision herein contained, this contract is subject to the Statutory Conditions in the Insurance Act respecting contracts of accident insurance.

The Contract

The application, this policy, any document attached to this policy when issued and any amendment to the contract agreed on in writing after this policy is issued constitute the entire contract and no agent has authority to change the contract or waive any of its provisions.

Waiver

The insurer is deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the insurer.

Copy of Application

The insurer must, upon request, furnish to the insured or to a claimant under the contract a copy of the application.

Material Facts

No statement made by the insured or a person insured at the time of application for the contract shall be used in defence of a claim under or to avoid the contract unless it is contained in the application or any other written statements or answers furnished as evidence of insurability.

Notice and Proof of Claim

The insured or a person insured, or a beneficiary entitled to make a claim, or the agent of any of them, shall,

a. give written notice of claim to the insurer,
   i. by delivery thereof, or by sending it by registered mail to the head office or chief agency of the insurer in the province, or
   ii. by delivery thereof to an authorized agent of the insurer in the province,

   not later than 30 days from the date a claim arises under the contract on account of an accident, sickness or disability;

b. within 90 days after the date a claim arises under the contract on account of an accident or sickness, furnish to the insurer such proof as is reasonably possible in the circumstances of:
   i. the happening of the accident or the start of the sickness,
   ii. the loss caused by the accident or sickness,
   iii. the right of the claimant to receive payment,
   iv. the claimant's age, and
   v. if relevant, the beneficiary's age; and

c. if so required by the insurer, furnish a satisfactory certificate as to the cause or nature of the accident, sickness or disability for which claim may be made under the contract and as to the duration of such sickness or disability.

Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time required by this condition does not invalidate the claim if,

1. the notice or proof is given or furnished as soon as reasonably possible, and in no event later than 1 year after the date of the accident or the date a claim arises under the contract on account of sickness or disability, and it is shown that it was not reasonably possible to give the notice or furnish the proof in the time required by this condition, or
2. in the case of death of the person insured, if a declaration of presumption of death is necessary, the notice or proof is given or furnished no later than 1 year from the date a court makes the declaration.

Insurer to Furnish Forms for Proof of Claim

The insurer shall furnish forms for proof of claim within 15 days after receiving notice of claim, but if the claimant has not received the forms within that time the claimant may submit their proof of claim in the form of a written statement of the cause or nature of the accident, sickness or disability giving rise to the claim and of the extent of the loss.

Rights of Examination

As a condition precedent to recovery of insurance money under the contract,

a. the claimant must give the insurer an opportunity to examine the person of the person insured when and as often as it reasonably requires while the claim is pending, and
b. in the case of death of the person insured the insurer may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies.

When Moneys Payable

All money payable under this contract shall be paid by the insurer within 60 days after it has received proof of claim.

ASSISTANCE SERVICE

In the event of an emergency or if you require medical treatment you must contact MSH Assistance immediately at:

+1 (855) 471 4321
toll-free from the USA and Canada

+1 (437) 567 9642
collect where available

rimiassistance@mshassistance.com

Emergency Call Centre — No matter where you are professional assistance personnel are ready to take your call 24 hours a day, 7 days a week.

Referrals — MSH Assistance can refer or direct you to nearby medical providers (hospitals, clinics and physicians).

Benefit Information — Explanation of this policy is available to you and to the medical providers who are treating the insured person.

Medical Consultants — The MSH Assistance team of medical professionals, available 24 hours a day, will monitor the services given in the event of a serious emergency.

Direct Billing — Whenever possible, MSH Assistance will instruct the hospital or clinic to bill MSH Assistance directly.

Claims Information — MSH Assistance will answer any questions you have about the eligibility of your claim, standard verification procedures and the way that the benefits under this policy are administered.

MSH Assistance must be contacted before you seek medical treatment. If your condition renders you unable to do so, then someone else must contact MSH Assistance immediately on your behalf. It is your responsibility to ensure that MSH Assistance has been contacted prior to receiving medical treatment or as soon as reasonably possible.

CLAIMS

Claims Procedures

The insured person may designate a beneficiary for the Repatriation of Remains and Accidental Death & Dismemberment benefits to receive the amount payable for their death. In the absence of such designation, the beneficiary shall be the estate of the insured person. All other benefits are payable to the insured person.

The insured person is responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim, the insured person must submit:

a. a fully completed Claim Form (provided by MSH Assistance upon notification of claim);

b. all original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all dates and type of treatment, and the name of the medical facility and/or physician;

c. original prescription drug receipts (not cash receipts) from the pharmacist, physician or hospital showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost;

d. a copy of your airfare ticket and passport confirming travel dates and entry into Canada. For side trips, proof of both departure from and return to Canada. The type of proof depends on whether you travelled via airline or car (for example, copies of airline tickets, itinerary, boarding passes, gas receipts, hotel receipts, meal receipts, toll highway receipts, original duty-free shop receipts);

e. written proof of claim within 90 days of the date of receipt of services covered under this policy;

f. additional information pertinent to the insured person's claim, as may be required by MSH Assistance after receipt of the claim;

g. the unused portion of the insured person's air ticket to MSH Assistance, if the Emergency Transportation benefit is used.

IDENTIFICATION OF INSURER

LLOYD'S

Underwritten by:

Effected with certain Lloyd's Underwriters as scheduled herein ("the Insurers"), through Lloyd's Approved Coverholder ("the Coverholder");

MSH INTERNATIONAL (CANADA) LTD.
Suite 602, 150 King St West,
Toronto, Ontario, Canada M5H 1J9

Claims administered by:

MSH Assistance
150 King Street West, Suite 602, PO Box 75
Toronto, Ontario M5H 1J9

DANFORTH INSURANCE

www.danforthinsurance.com

+ 1-647-350-0332

info@danforthinsurance.com