ALBERTA MEDICAL ASSOCIATION | ADIUM Insurance Services Inc.

Manulife

AMA Critical Illness Insurance

Help protect your family's financial future

Critical Illness (CI) Insurance is designed to help reduce your financial stresses if you are diagnosed with a covered medical condition. **It will provide you with a lump-sum payment that you can use however you choose, allowing you to focus on recovery, rather than your bills**. Not all medical costs are covered by disability insurance, supplemental health insurance and/or government health care plans. CI can help fill the gaps in coverage so that you can maintain your lifestyle and reduce the financial stress you may experience if faced with a critical illness.

As an AMA member, you can take advantage of exclusive plans like this, which members have benefitted from for over 70 years administered by AMA's ADIUM Insurance Services. Thanks to the power of your group membership, you'll be hard-pressed to find lower rates on individual plans.

Along with **highly competitive rates**, you can enjoy:

- Third-party administration by ADIUM
- No built-in sales commissions
- An easy application and approval process

Exclusive to AMA members who are:

- In good standing with the AMA or Northwest Territories Medical Association (NWTMA)
- Canadian residents at time of application

This product is also available to your spouse by marriage or under any other formal union recognized by law; or a person of the opposite sex or of the same sex who is publicly represented as your spouse for a period of at least 12 months. You can only cover one spouse at a time.

The Manufacturers Life Insurance Company (Manulife)

Overview

30-day money-back guarantee

Once you receive your Certificate of Insurance, read it carefully. If you are not completely satisfied with your coverage you may return it within 30 days. Your coverage will be canceled and your premiums refunded in full. You may cancel your coverage at any time, but the money-back guarantee only applies to the first 30 days.

Protection at a glance

	Critical Illness Insurance
Eligibility to apply	Under age 65
Portability[1]	Worldwide
Change of occupation allowable	Yes
Spousal coverage available	Yes
Evidence of medical insurability required	Yes
Termination age	75
Insurance provider	Manulife

* AMA non-resident membership is required if residing outside of Alberta.

This brochure provides the highlights but not all the details of the AMA Critical Illness Plan. The complete terms, conditions, exclusions and limitations governing the coverage are found in the group insurance policies.

Coverage amounts

- New higher limits! You or your spouse may apply for **$50,000 to $1,000,000** in coverage, in increments of $10,000 (units).
- Evidence of insurability is required for all coverage amounts for which you apply.

25 critical conditions are covered

- Aortic surgery
- Aplastic anemia
- Bacterial meningitis
- Benign brain tumour
- Blindness
- Cancer (life threatening)
- Coma
- Coronary artery bypass surgery
- Deafness
- Dementia, including Alzheimer's disease
- Heart attack
- Heart valve replacement or repair
- Kidney failure
- Loss of independent existence
- Loss of limbs
- Loss of speech
- Major organ failure (on waiting list)
- Major organ transplant
- Motor neuron disease
- Multiple sclerosis
- Occupational HIV infection
- Paralysis
- Parkinson's disease and specified atypical Parkinsonian disorders
- Severe burns
- Stroke

Extra advantages

Freedom to spend the benefit as you wish

How you spend the benefit payment is entirely up to you. Use it to meet expenses not covered by your government health care plan or other existing insurance plan, to buy specialized equipment, to make home modifications, or even to allow a loved one to take time off work to care for you.

Unlike Disability Insurance, which provides income replacement for a period of time while you are unable to work, Critical Illness Insurance provides a lump-sum benefit whether or not you are able to work.

You benefit even if you recover

As long as you meet the conditions to receive a benefit payment, the Critical Illness benefit is paid to you even if you make a full recovery. If you're insured, you will receive a benefit for the following:

- The diagnosis of a covered condition or surgery for one of the covered conditions,
- The completion of the prescribed survival period, and
- The approval of your claim

Optional riders

Enhance your insurance coverage by purchasing one or more of the following optional riders, subject to evidence of insurability and approval by Manulife.

Waiver of Premium

Under this rider, **if you become totally disabled before age 65 and the disability lasts for at least six consecutive months, you'll no longer have to pay premiums for your CI coverage**. This benefit will apply for as long as you continue to be totally disabled and will end on the January 1st on or after your 75th birthday. You're considered "totally disabled" if you are unable to perform the duties of any occupation.

Waiver of Premium is not payable after age 65.

Child Critical Illness

If you apply, Critical Illness coverage is also available for your child(ren).

Coverage is available from a minimum of $5,000 to a maximum of $20,000, in increments of $5,000 (units). The coverage amount applies to each child regardless of how many children you have.

One premium covers (all) your eligible child(ren) for the same 25 critical conditions as the member/spouse plan, plus an additional six illnesses:

- Cerebral palsy
- Congenital heart disease
- Cystic fibrosis
- Down syndrome
- Muscular dystrophy
- Type 1 diabetes

Eligibility

- **A child that is** not married, dependent on you or your spouse for support, and is under the age of 21 (age 25 if the dependant is a full-time student), including adopted children and stepchildren, or children of any age if incapable of supporting themselves because of physical or mental disability.
  - — Once you opt for coverage, newborn infants are automatically covered.
- You must have coverage in order to obtain dependent child coverage.

Critical Illness Insurance rates

Monthly premium per $10,000 of coverage for you and your spouse.

Age	Non-Smoker		Smoker	
	Male	Female	Male	Female
Under 30	$0.96	$0.91	$1.24	$1.10
30-34	$1.34	$1.70	$1.88	$2.31
35-39	$1.62	$2.13	$2.49	$3.42
40-44	$2.37	$2.90	$4.39	$5.50
45-49	$4.06	$4.21	$8.66	$8.78
50-54	$6.59	$5.63	$16.27	$12.28
55-59	$10.43	$7.58	$26.89	$16.00
60-64	$17.16	$10.74	$43.18	$20.57
65-69	$29.69	$17.57	$66.23	$29.15
70-74*	$48.03	$25.98	$117.31	$41.79

* Renewal rates only.

Optional rider
Waiver of Premium Monthly premium of 6% of base premium.
Child Critical Illness (covers all children) Monthly premium of $2.64 per $5,000 unit.

Rates are renewable yearly and not guaranteed. Rates are calculated based on your age, gender and smoking status as of January 1st of each year and will increase as you move into the next age band.

Grace period: If you miss a premium due date, you will have a 31-day grace period to pay the premium due. Your policy will remain in force during the grace period.

When coverage ends

Child Critical Illness premiums stop after you no longer have eligible dependent children.

Your and your spouse's Critical Illness coverage ends:

- On the policy anniversary date following termination of your membership in the AMA or NWTMA;
- On the policy anniversary date following your or your spouse's 75th birthday;
- On the first of the month following AMA's receipt of your or your spouse's written request to terminate coverage;
- For failure to pay premiums, subject to the grace period of 31 days;
- For a spouse, the date the policy no longer includes spouse coverage;
- The date the Critical Illness Insurance benefit is paid;
- The first of the month following the date the spouse no longer satisfies the required definition of "spouse";
- The date of your or your spouse's death;
- The date the AMA or Manulife terminates the group policy.

Exclusions

No benefits are payable for claims resulting directly or indirectly from any of the following:

- Declared or undeclared insurrection or rebellion;
- Voluntary participation in a riot or act of civil disobedience;
- Intentionally self-inflicted injuries or attempted suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions;
- Committing or attempting to commit a criminal offence;
- Use of illegal or illicit drugs or substances, misuse of drugs or alcohol; or
- The Insured's death during the applicable survival period.

No Critical Illness benefit shall become payable for any illness, disorder or surgery excluded by or omitted from the Covered Critical Illness Conditions section.

Appendix for Critical Illnesses Covered

Covered illnesses – adults	Description
Aortic surgery	Undergoing 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 physician. The Insured 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	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: a) marrow stimulating agents; b) immunosuppressive agents; or c) bone marrow transplantation. The diagnosis of aplastic anemia must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.
Bacterial meningitis	Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days following the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist physician. The Insured must survive for 90 days following the date of diagnosis.
Benign brain tumour	Definite diagnosis of non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. **Exclusions** No benefit will be payable under this condition for pituitary adenomas less than 10 mm. No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Benign brain tumour (continued)	Moratorium period exclusions No benefit will be payable under this condition and the Insured's coverage for benign brain tumour will terminate if within the first 90 days following the later of: a) The date the application for this coverage was signed; or b) The effective date of the Insured's coverage, the Insured has any of the following: i. Signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this policy), regardless of when the diagnosis is made; or ii. A diagnosis of benign brain tumour (covered or excluded under this policy). While the Insured's insurance for benign brain tumour terminates, insurance for all other covered conditions remains in force. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for benign brain tumour or any Critical Illness caused by any benign brain tumour or its treatment.
Blindness	A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by: a) the corrected visual acuity being 20/200 or less in both eyes; or b) the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.
Cancer (life threatening)	A definite diagnosis of a tumour which 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 physician. The Insured must survive for 30 days following the date of diagnosis. **Exclusions** No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Cancer (life threatening) (continued)	No benefit will be payable under this condition for the following: a) Lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in situ (Tis), or tumours classified as Ta; b) 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; c) Any non-melanoma skin cancer, without lymph node or distant metastasis; d) Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; e) 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; f) Chronic lymphocytic leukemia classified less than Rai Stage 1; or g) Malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2. **Moratorium period exclusions** No benefit will be payable under this condition and the Insured's coverage for cancer will terminate if within the first 90 days following the later of: a) The date the application for this coverage was signed; or b) The effective date of the Insured's coverage, the Insured has any of the following: i. signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under this policy), regardless of when the diagnosis is made; or ii. a diagnosis of cancer (covered or excluded under this policy). While the Insured's insurance for cancer terminates, insurance for all other covered conditions remains in force. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for cancer or, any Critical Illness caused by any cancer or its treatment. For purposes of this policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. For purposes of this 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.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Coma	A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of coma must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. **Exclusions** No benefit will be payable under this condition for: a) a medically induced coma; b) a coma which results directly from alcohol or drug use; or c) a diagnosis of brain death.
Coronary artery bypass surgery	The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist physician. The Insured must survive for 30 days following the date of surgery. **Exclusions** No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
Deafness	A definite diagnosis of 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 physician. The insured must survive for 30 days following the date of diagnosis.
Dementia, including Alzheimer's disease	A definite diagnosis of progressive deterioration of memory and at least one of the following areas of cognitive function: a) Aphasia (a disorder of speech); b) Apraxia (difficulty performing familiar tasks); c) Agnosia (difficulty recognizing objects); or d) 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.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Dementia, including Alzheimer's disease (continued)	The Insured must exhibit: a) 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 b) 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 physician. The Insured must survive for 30 days following the date of diagnosis. **Exclusions** No benefit will be payable under this condition for affective or schizophrenic disorders or delirium. For purposes of this policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189
Heart attack	A definite diagnosis of death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: a) Heart attack symptoms; b) New electrocardiogram (ECG) changes consistent with a heart attack; or c) Development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. The diagnosis of heart attack must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. **Exclusions** No benefit will be payable under this condition for: a) 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 b) ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Heart valve replacement or repair	The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The Insured 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	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 physician. The Insured must survive for 30 days following the date of diagnosis.
Loss of independent existence	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. Activities of daily living are: 1) Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices; 2) 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; 3) Toileting – the ability to get on and off the toilet and maintain personal hygiene, with or without the aid of assistive devices; 4) 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; 5) Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and 6) Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices. The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.
Loss of limbs	A definite diagnosis of 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 physician. The Insured must survive for 30 days following the date of diagnosis.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Loss of speech	A definite diagnosis of 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 physician. No additional survival period is required once the conditions described above are satisfied. **Exclusion** No benefit will be payable under this condition for any psychiatric related causes.
Major organ failure on waiting list	A definite diagnosis of 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 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. For the purposes of the survival period, the date of diagnosis is the date of the Insured's enrolment in the transplant centre. The diagnosis of major organ failure must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.
Major organ transplant	A definite diagnosis of 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 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 major organ failure must be made by a specialist physician. The Insured must survive for 30 days following the date of the transplant.
Motor neuron disease	A definite diagnosis of one of the following: a) Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), b) Primary lateral sclerosis, c) Progressive spinal muscular atrophy, d) Progressive bulbar palsy, or e) Pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Multiple sclerosis	A definite diagnosis of at least one of the following: a) Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or b) Well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or c) A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart. The diagnosis of multiple sclerosis must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.
Occupational HIV infection	A definite diagnosis of human immunodeficiency virus (HIV) resulting from accidental injury during the course of the Insured's normal occupation, which exposed the Insured to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of: a) The date the application for this coverage was signed; or b) The effective date of the Insured's coverage. Payment under this condition requires satisfaction of all of the following: a) The accidental injury must be reported to the Company within 14 days of the accidental injury; b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines. The diagnosis of occupational HIV infection must be made by a specialist physician. The Insured must survive for 30 days following the date of the second serum HIV test described above. **Exclusions** No benefit will be payable under this condition if: a) The Insured has elected not to take any available licensed vaccine offering protection against HIV; b) A licensed cure for HIV infection has become available prior to accidental injury; or c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Paralysis	A definite diagnosis of 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 physician. The Insured must survive for 90 days following the precipitating event.
Parkinson's disease and specified atypical Parkinsonian disorders	A definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease. Specified atypical Parkinsonian disorders – 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 or a specialist physician. The Insured must satisfy the above conditions and survive for 30 days following the date all these conditions are met. **Exclusions** No benefit will be payable for Parkinson's disease or specified atypical Parkinsonian disorders if, within the first year following the later of: a) The date the application for this coverage was signed; or b) The effective date of the Insured's coverage, the Insured has any of the following: i. Signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical Parkinsonian disorder or any other type of Parkinsonism (covered or excluded under this policy), regardless of when the diagnosis is made; or ii. A diagnosis of Parkinson's disease, a specified atypical Parkinsonian disorder or any other type of Parkinsonism (covered or excluded under this policy). No benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders for any other type of Parkinsonism. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorders or, any critical illness caused by Parkinson's disease or specified atypical Parkinsonian disorders or its treatment.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – adults	Description
Severe burns	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 physician. The Insured must survive for 30 days following the date the severe burn occurred.
Stroke	A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with: a) Acute onset of new neurological symptoms; and b) New objective neurological deficits on clinical examination persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. **Exclusions** No benefit will be payable under this condition for: a) Transient ischaemic attacks; b) Intracerebral vascular events due to trauma; or c) Lacunar infarcts which do not meet the definition of stroke as described above.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – child	Description
Cerebral palsy	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 by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis.
Congenital heart disease	A definite diagnosis of at least one of the covered heart conditions described below for which open heart surgery is performed to correct the condition. Covered heart conditions: a) Coarctation of the aorta b) Ebstein's anomaly c) Eisenmenger syndrome d) Tetralogy of Fallot e) Transposition of the great vessels The diagnosis of the heart condition must be made by a specialist physician and be supported by cardiac imaging acceptable to the Company. The Insured Dependent Child must survive for 30 days following the date of diagnosis. 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): a) Aortic stenosis b) Atrial septal defect c) Discrete subvalvular aortic stenosis d) Pulmonary stenosis e) Ventricular septal defect Procedures not covered by this definition are: a) Percutaneous atrial septal defect closure b) Trans-catheter procedures which include balloon valvuloplasty The diagnosis of the heart condition must be made and the surgery must be recommended and performed by a specialist physician and be supported by cardiac imaging acceptable to the Company. The Insured Dependent Child must survive for 30 days following the date of surgery.
Cystic fibrosis	A definite diagnosis of cystic fibrosis where the Insured Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis.

Appendix for Critical Illnesses Covered (continued)

Covered illnesses – child	Description
Down syndrome	A definitive diagnosis of Down syndrome supported by chromosomal evidence of trisomy 21. The diagnosis of Down syndrome must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis.
Muscular dystrophy	A definite diagnosis of muscular dystrophy where the Insured Dependent Child has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy. The diagnosis of muscular dystrophy must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis.
Type 1 diabetes mellitus	A definite diagnosis where the Insured Dependent Child has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least 3 months. The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The Insured Dependent Child must survive for 90 days following the date of diagnosis.

Need assistance?

If you need help or advice before you apply, you can get in touch with one of ADIUM's licensed insurance advisors. Our salaried advisors will help you determine your coverage needs in a professional and objective manner. Contact ADIUM for more information.

You can also get help online by using our insurance calculators at **albertadoctors.org**.

How to Apply

Once you've decided on the products you'd like to apply for...

1. **Download** the Disability Insurance application form at **albertadoctors.org**.

2. **Return** your application to ADIUM in one of three ways:

By mail:
ADIUM Insurance Services Inc.
Alberta Medical Association
12230 106 Avenue NW
Edmonton AB T5N 3Z1

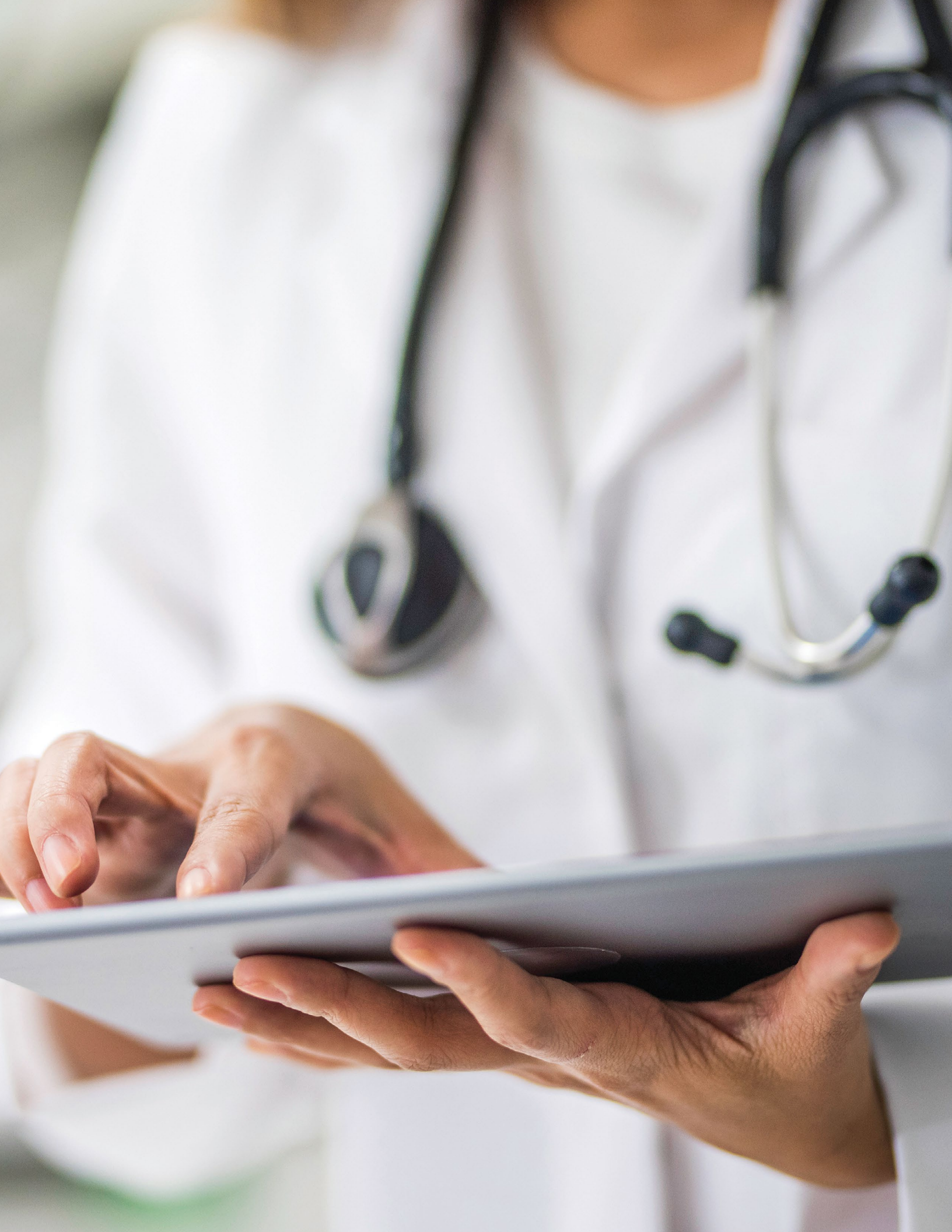
By fax:
780-488-7558
or toll-free 1-877-302-3486*

By email:
adium@albertadoctors.org*

3. **No need to send money** with your application. Upon approval of your application, you will receive your certificate of insurance and a premium notice for the balance of the insurance year (to December 31). You may pay your invoice by cheque, or you may set up monthly (interest-free) or annual pre-authorized payments (P.A.P.).

If you have any questions about completing the application please contact ADIUM at 780-482-0692, toll-free at 1-888-492-3486, or by email at **adium@albertadoctors.org.**

*Please be advised that transmitting your personal information electronically is not a secure method of electronic communication and has several risks associated with it. As such, we encourage you to use the AMA Member Dashboard (www.albertadoctors.org/dashboard) for the exchange of personal information, as it is a more secure method.



Members-only protection for you and your family

Remember to consider these other insurance products to help protect your and your family's financial future, offered at great rates by the Alberta Medical Association.

- Disability Insurance
- Professional Expense Insurance
- Term Life Insurance
- AMA Health Benefits Trust
- Accidental Death & Dismemberment Insurance

For more information:

780-482-0692

or toll-free at

1-888-492-3486

albertadoctors.org/insurance

albertadoctors.org

ALBERTA MEDICAL ASSOCIATION | ADIUM Insurance Services Inc.

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Dedicated to serving Alberta's medical profession. Our specialty is you.

Manulife

AMA's ADIUM Insurance Services Inc. administers the plans and is available to answer questions regarding coverage and provide any necessary forms. Disability, Professional Overhead Expense, Term Life and Critical Illness insurance are underwritten by The Manufacturers Life Insurance Company (Manulife). This brochure provides the highlights but not all the details of the Alberta Medical Association plans. The complete terms, conditions, exclusions and limitations governing the insurance coverage are found in the group insurance policy issued to the Alberta Medical Association by The Manufacturers Life Insurance Company.

Plans underwritten by The Manufacturers Life Insurance Company (Manulife).

21_259734 (12/2021)