General Conditions of your contract
Select – 01

To contact the Insurer
For information: 1-877-270-7721
For claims: 1-877-886-5042


ACCIRANCE, PERSONAL ACCIDENT INSURANCE

General Conditions of your contract
Select – 01

Financial services including insurance, annuities, credit and related services


ACCIRANCE, PERSONAL ACCIDENT INSURANCE

General Conditions of your contract
Select – 01

Financial services including insurance, annuities, credit and related services


CONTRACT
Your contract consists of the following documents:
1) these GENERAL CONDITIONS;
2) the most recent SPECIAL CONDITIONS;
3) the Insurance Application, where applicable;
4) any rider or appendix confirming a change to or update of the contract.

30-DAY CONTRACT EXAMINATION PERIOD – The contract holder has 30 days from the date the contract is received to read the contract and notify the Insurer if they are not satisfied. For Quebec residents, this 30-day period begins after the contract holder receives the contract and the Distribution Guide. At the request of the contract holder, the Insurer will terminate the contract, and this termination will take effect as of the date the contract came into force. This date is indicated in the SPECIAL CONDITIONS of the Accirance contract. Furthermore, the Insurer will provide a refund to the contract holder of any premiums paid, provided no claims have been submitted.

1. OBJECT AND DESCRIPTION
1) Accirance provides for the payment of a benefit in the event that the insured sustains an accident. This benefit is paid if, as a result of the accident, the insured:
   a) dies;
   b) sustains a covered dismemberment or loss of use;
   c) sustains a covered fracture;
   d) is in a coma;
   e) becomes totally disabled;
   f) incurs expenses covered under the contract.
2) Accirance also provides for the payment of a benefit if an insured over 14 days of age but under 25 years dies of causes not related to an accident.
3) The coverage and benefit amount are determined in accordance with the contractual conditions in effect at the time the event giving rise to payment of the benefit occurs.
4) If children are born while this coverage is in force, they will be insured automatically and free of charge from the day they are over 14 days of age up to the next contract renewal. As of this date, children will remain insured if:
   a) their name is indicated in the most recent SPECIAL CONDITIONS;
   and
   b) the contract holder pays the required premium for these children.

2. DEFINITIONS
For the purpose of this contract, the following terms (shown in italics in this contract) mean:
Accident: any bodily injury, certified by a physician, resulting directly from a sudden and unforeseen external cause and independent of any illness or other cause.
Age or aged: the age of the insured at the time of the event giving rise to a benefit.
Benefit: an amount paid by the Insurer. Under the conditions of the contract, the benefit can be a lump sum, a reimbursement of expenses incurred, or a monthly annuity.
Canadian resident: a person who is legally authorized to live in Canada and who resides in the country for at least 6 months per year.
Child: any person under age 25 who is the child or grandchild of the contract holder, an insured or either of their spouses.
Coma: a definite diagnosis of a state of deep 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 neurologist practising in Canada.
Contract holder: a person age 18 or older who signs a contract with the Insurer and who is a Canadian resident when the contract takes effect. This person is considered to be the owner of the contract, and may also be an insured. Their name appears in the most recent SPECIAL CONDITIONS.

Dismemberment or loss of use: the permanent severance or the complete and permanent loss of use of:
1) one finger and all of its phalanges, without loss of the hand;
2) one hand and the wrist joint, without loss of the arm;
3) one arm and the elbow joint;
4) one toe and all of its phalanges, without loss of the foot;
5) one foot and the ankle joint, without loss of the leg;
6) one leg and the knee joint;
7) sight in one eye, speech or hearing.

To be considered permanent, the loss of use must last for at least six months.

Fracture: the violent rupture of the larynx, the trachea or a bone.

Healthcare facility:
1) A facility where people are seen for the purpose of:
   a) preventive care;
   b) medical diagnoses;
   c) treatment; or
d) physical or mental rehabilitation.

2) Unless otherwise indicated, the Insurer recognizes as a healthcare facility any facility that meets the definition of the term “centre” under Quebec’s Act respecting health services and social services. This act covers, among others:
   a) hospitals;
   b) hospital centres;
   c) residential and long-term care centres;
   d) rehabilitation centres; and
   e) local community service centres.

3) However, the definition of healthcare facility does not include:
   a) private practices;
   b) infirmaries where religious or teaching institutions receive members of their staff or students;
   c) convalescent, rest, or long-term care homes, or homes for the chronically ill;
   d) homes for the aged.

Hospitalization: a stay in a healthcare facility.

Insured: any person whose name is indicated in the most recent SPECIAL CONDITIONS under the section “Insured(s)”. Moreover, they must be a Canadian resident when their Accirance contract takes effect.


Loss of hearing or “loss of use of hearing”: permanent loss of hearing diagnosed by an ear-nose-and-throat specialist practising in Canada. The insured must have an auditory threshold of more than 90 decibels within a speech-frequency range of 500 to 3,000 Hz.

Loss of sight or “loss of use of sight”: permanent loss of sight diagnosed by an ophthalmologist practising in Canada. The insured must have a corrected visual acuity of less than 20/200, or a field vision of less than 20 degrees.

Parent: the contract holder, an insured or their spouse if one of their children is insured under this contract.

Physician: any person, other than the insured, who is licensed to practise medicine and who does not live with the insured or the contract holder.

Reasonable expenses: expenses paid for services that do not exceed the normal rates for these services in the region where they are provided.

Renewal period: the period between the date the notice of renewal is sent out by the Insurer and the date on which the current period of insurance ends.

Spouse: the spouse of the contract holder or an insured is the person who:
1) is married to or living in a civil union with the contract holder or insured; or
2) can prove that he or she and the contract holder or an insured have been living in a conjugal relationship for at least 12 months; or
3) can prove that he or she and the contract holder or insured have been living in a conjugal relationship and that they had a child together.

This person must not have been separated from the contract holder or insured for 90 days or more as a result of a breakdown in the relationship. The Insurer is not responsible for the validity of the designation of spouse.

Student: a person under age 25 who is a duly registered, full-time student at an educational institution that is recognized by the appropriate government authorities.

Total disability or “totally disabled”: a student’s state of incapacity which totally prevents them from performing any gainful employment or from continuing their studies. This incapacity must be the result of an accident and require continuing medical care. If the student requires specialized medical care, they must receive it from an appropriate specialist to be considered totally disabled.

Treatment(s):
1) consultations with a physician, another healthcare professional or a paramedical professional, or care received from such persons;
2) medical examinations;
3) use of medications; or
4) hospitalization.

3. CONTRACT YEAR AND CONTRACT ANNIVERSARY
Each one-year period following the effective date of a contract corresponds to one contract year. Contract anniversaries fall on the dates marking the beginning of each new contract year. The Insurer determines these anniversaries starting on the date the contract takes effect.

4. EFFECTIVE DATE
1) When the contract holder takes out Accirance over the telephone or on-line, the contract takes effect the next day.
2) When the contract holder takes out Accirance by completing the Insurance Application, the contract takes effect on the date the Insurer receives the Insurance Application.

5. DURATION OF CONTRACT AND RENEWAL
The duration of the contract is indicated in the most recent SPECIAL CONDITIONS. Thereafter, unless otherwise notified by the contract holder, the contract is renewed automatically provided that the premiums are paid.

When taking out insurance, the contract holder authorizes the Insurer to use the information submitted to manage their file and remind them of the contract renewal. The contract holder also authorizes the Insurer to collect new particulars from a third party, should the need arise.

6. PREMIUM
1) When the contract is signed, the contract holder authorizes the Insurer to deduct the periodic premium required to maintain the contract in force. The Insurer can deduct this amount from the contract holder’s chequing account or from the latter’s credit card account.
2) The contract holder has a period of 30 days to pay any required premiums, except the initial premium. The contract remains in force during this period. The 30-day period does not apply when the contract holder has indicated that they wish to terminate the contract.

3) The premium payable is based on:
   a) the age of each insured on the effective date of the contract or its subsequent renewal date;
   b) the sex of each insured;
   c) the frequency of payment selected by the contract holder.

The required premium is indicated in the most recent SPECIAL CONDITIONS.

4) The premium can be subject to certain conditions determined by the Insurer when taking out insurance.
7. **BENEFITS**

1) Only an event that occurs while the contract is in force may give rise to a benefit.

2) The payment of any benefit is dependent upon the various conditions of the contract being met. Also, the amount of the benefit is based on the conditions in effect at the time of the event giving rise to the benefit.

8. **CLAIMS**

1) You can submit a benefit claim by visiting www.desjardins.com/accrurance, or you can call 1-877-886-5042 and the Insurer will send you the necessary forms.

2) All claims must be submitted to the Insurer in writing within 30 days of the event giving rise to a benefit. Claims must be sent to the following address:

   Desjardins Financial Security Life Assurance Company
   Case postale 520, succursale Lévis
   Lévis (Québec) G6V 7E2

3) The Insurer may request any information, proof, or any other document deemed necessary to examine a claim. This information, proof or document must be provided to the Insurer within 90 days following the date of the claim.

4) A claim will not necessarily be refused if the proof and information required are not received within the time specified. However, a valid reason for missing the deadline must be presented. In such cases, the required documents must be sent to the Insurer within 90 days following the date of the event giving rise to the claim.

5) When a claim is submitted, the Insurer reserves the right, at its expense, to have the insured examined by a health professional. This health professional will be chosen by the Insurer.

6) The Insurer does not pay any benefits when a claim includes omissions or misrepresentations, whether or not they are fraudulent. Those who receive amounts to which they are not entitled must repay them to the Insurer at a reasonable rate of interest determined by the Insurer.

**Exclusions:**

The Insurer will not pay any claims under $5. Furthermore, the Insurer will not pay any benefits unless it has first obtained the authorization required for the collection and disclosure of personal information. This authorization can be given by:

1) the contract holder; or

2) any other individual who claims to have rights to the benefits.

9. **PAYMENT OF BENEFITS**

The Insurer pays the benefits as follows:

1) in case of the reimbursement of expenses incurred, to the contract holder;

2) in case of the death of an insured:
   a) to the contract holder, if living; otherwise
   b) to the designated beneficiary, if living; otherwise
   c) to the legal heirs of the insured;

3) in case of the payment of other benefits for an insured:
   a) if the insured is under age 18 on the benefit payment date, to the contract holder if alive; otherwise, to the insured’s guardian;
   b) if the insured is age 18 or over on the benefit payment date, to the insured.

10. **COORDINATION OF BENEFITS**

If an insured is covered under more than one insurance plans (private or public), the total amount of benefits that may be paid to reimburse expenses can never exceed the expenses actually incurred.

If an insured is covered under one or more plans that do not provide for the coordination of benefits with other plans, the insured must first be reimbursed by these other plans. The Insurer’s responsibility is then limited to the portion of expenses that are not reimbursed under these other plans.

If the other plans include a provision regarding the coordination of benefits, benefits will be divided proportionally between these plans and that of the Insurer, based on the amounts that should have been paid under each plan.

11. **BENEFICIARY DESIGNATION**

The contract holder may designate a beneficiary using the appropriate form. Beneficiary designations are valid for the duration of the contract if they are sent in writing to the Insurer while the contract holder is alive. More than one person can be designated. The contract holder may also change the beneficiary by notifying the Insurer in writing. However, the Insurer is not liable for the contract holder’s choice of beneficiary.

12. **CURRENCY**

The amounts indicated in the contract are in Canadian currency. For eligible expenses incurred outside Canada, the Insurer uses the exchange rate in effect at the time the benefit is paid.

13. **EXCLUSIONS AND LIMITATIONS**

1) **Benefits are not payable under the contract** in the following cases:
   a) if the accident results directly or indirectly from an intentionally self-inflicted injury or attempted suicide, while the insured is sane or insane;
   b) if an illness, an impairment or infection contributed to the bodily injury;
   c) if the bodily injury is due to an illness or an infection contracted accidentally;
   d) if the bodily injury is due to a complication or other events resulting from a treatment;
   e) if the accident is the result of a war, whether war be declared or not, a riot, a revolution or an act of terrorism;
   f) if the accident occurs while the insured is participating in any criminal act or related offence;
   g) if the accident results from the insured’s participation in one of the following activities:
      i) gliding or hang gliding;
      ii) parachuting;
      iii) climbing or mountain climbing;
      iv) underwater diving;
      v) bungee jumping;
      vi) rodeo;
      vii) go-karting;
   h) if the accident occurs while the insured is:
      i) taking part in a sporting activity for which they are paid;
      ii) taking part in a motor vehicle competition;
      iii) training for a motor vehicle competition;
   i) if the accident occurs after the insured has abused medication or alcohol or if the insured’s blood contains traces of drugs. Abusive use of medication is that which exceeds the dosage recommended by a health specialist. Abusive use of alcohol is that which results in a blood alcohol level equal to or above 80 mg of alcohol per 100 ml of blood;
   j) with regard to clauses 20, 23 and 24, if the claim is for the reimbursement of expenses incurred and is payable by:
      i) any government agency; or
      ii) any other private insurance plan;
   k) if the expenses are incurred more than 104 weeks after the accident;
   l) if the care or services are provided by a person who is related to the insured or the contract holder;
m) if the accident is solely the result of treatment, surgery or anesthesia;

n) in the event of accidental death, dismemberment or loss of use occurring more than 52 weeks after the accident. This exclusion does not apply if the insured is in a coma at the end of this period. In this case, the Insurer will determine the benefits payable, where applicable, at the end of the coma.

2) Multiple contracts
   a) If an insured is covered under several Accirance contracts with a cost-free period, they are entitled to benefits under only one of these contracts. If there are several contracts with a cost-free period to consider when determining a benefit amount, the Insurer will select the most advantageous one.
   b) At any time, regardless of the number or type of Accirance contracts in force for one insured, this insured is entitled to benefits under only two of these contracts. The Insurer considers the two most advantageous contracts when determining the benefits payable. However, in compliance with the above, only one contract with a cost-free period will be taken into consideration for the payment of a benefit.

14. RESPONSIBILITIES OF THE CONTRACT HOLDER
The contract holder must notify the Insurer of any change regarding their address, as well as of any change regarding the financial institution where they do business for payment of the premiums. If the Insurer is not notified of these changes and is unable to collect the premiums, the Insurer will assume that the contract holder wishes to terminate the contract. Coverage will be terminated at the end of the 30-day period provided for in this contract.

15. CONTRACT HOLDER’S RIGHTS
The contract holder may not:
   1) assign this contract (transfer its ownership); or
   2) hypothecate the contract (assign it as collateral).

16. RIGHT OF SUBROGATION
By enrolling, the contract holder agrees that the Insurer automatically acquires the right to prosecute the perpetrator of the damage in the contract holder’s name and at the insurer’s own expense, up to the amount of benefits it paid out.

17. AMENDMENT AND CANCELLATION OF CONTRACT
At renewal, the Insurer may amend or terminate the contract provided that all Accirance contracts in the same category are also modified or cancelled. The contract holder must also be notified at least 30 days in advance. In the event of changes, it will be assumed that the contract holder has accepted these amendments 30 days following receipt of the notice.

The contract holder may, at any time, ask the Insurer to change or terminate the contract by contacting the Insurer by phone and the request takes effect the following day.

The effective date of the change is, however, different if the contract holder submits a request during a renewal period. If the contract holder requests a change during this period, it only takes effect on the start date of the next insurance period. Similarly, if the contract holder asks the Insurer to cancel the contract during a renewal period, the contract is only terminated on the date of the end of the current insurance period.

Moreover, when a contract is amended, the Insurer will either increase or decrease the premium:
   1) on the date the amendment takes effect; and
   2) based on the number of days remaining until the next renewal.

When an amendment leads to an increase in the premium, the contract holder must pay the amount of the increase in order for the amendment to take effect.

If the contract holder terminates the contract, the Insurer will reimburse the unused portion (in days) of the premium. An administrative fee will be deducted by the Insurer from the refund amount. Exclusion: The Insurer will not reimburse any premiums if a claim has already been approved under the contract.

The contract terminates when the Insurer sends a cancellation notice to the contract holder and, for any premiums subsequent to the initial premium, the 30-day period for premium payment has elapsed.

The contract also terminates when a claim for benefits is received containing fraudulent statements or omissions. In this case, the coverage terminates the first day of the contract month following the month in which the contract holder is notified in writing that such coverage will be terminated.

18. INSURANCE IN CASE OF DEATH, DISEMBRERMENT, FRACTURE, COMA OR LOSS OF USE
When an insured sustains, as the result of an accident, one of the losses listed in the SCHEDULE OF LOSSES below, the Insurer pays a benefit. This benefit is a lump sum equals to the amount of insurance indicated for the loss.

<table>
<thead>
<tr>
<th>SCHEDULE OF LOSSES</th>
<th>Dismemberment or loss of use of</th>
</tr>
</thead>
<tbody>
<tr>
<td>two of the following body parts:</td>
<td></td>
</tr>
<tr>
<td>hand, foot, arm or leg or sight in one eye</td>
<td>$500,000</td>
</tr>
<tr>
<td>hearing in both ears and speech</td>
<td>$500,000</td>
</tr>
<tr>
<td>one hand, one foot, one arm or one leg</td>
<td>$250,000</td>
</tr>
<tr>
<td>hearing in both ears or speech</td>
<td>$250,000</td>
</tr>
<tr>
<td>sight in one eye or hearing in one ear</td>
<td>$75,000</td>
</tr>
<tr>
<td>one finger or one toe (per finger or toe)</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Death of an insured under age 25 at the time of the accident</th>
</tr>
</thead>
<tbody>
<tr>
<td>accidental death, while on board a common carrier</td>
</tr>
<tr>
<td>accidental death, due to other circumstances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Death of an insured age 25 or older at the time of the accident</th>
</tr>
</thead>
<tbody>
<tr>
<td>accidental death while on board a common carrier</td>
</tr>
<tr>
<td>accidental death, due to other circumstances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>skull*, spine (except the coccyx), pelvis, hip</td>
</tr>
<tr>
<td>rib, sternum, coccyx, larynx, trachea, shoulder blade, humerus, patella, tibia, fibula or femur</td>
</tr>
<tr>
<td>bone not included above</td>
</tr>
</tbody>
</table>

* The skull includes the frontal, sphenoid, ethmoid, occipital, parietal and temporal bones.

<table>
<thead>
<tr>
<th>Coma</th>
</tr>
</thead>
<tbody>
<tr>
<td>for a duration of 96 consecutive hours or longer</td>
</tr>
</tbody>
</table>
Exclusions and Limitations:

1) An insured who is aged 75 or over on the date of the accident is entitled to only 50% of the benefits provided for in the SCHEDULE OF LOSSES.

2) If an insured sustains multiple losses described in the SCHEDULE OF LOSSES as a result of the same accident, the Insurer pays a single benefit. The benefit paid is the one that corresponds to the highest amount provided in the SCHEDULE OF LOSSES for the losses sustained.

3) If, as the result of an accident, the insured:
   a) sustains one or more of the losses described in the SCHEDULE OF LOSSES; and
   b) dies as the result of this accident within 365 days immediately following the accident;
      the Insurer pays only the accidental death benefit.

4) The total amount paid under the coverage is limited to $500,000 per insured per accident. This maximum is $1,000,000 per insured in the event of accidental death on board a common carrier.

5) If more than two insureds covered under a same Accrurance contract die accidentally on board a common carrier, the insurance amount payable by the Insurer is limited to $2,000,000. The benefit payable for each insured is reduced proportionately.

6) If, as the result of the same accident, more than two insureds covered under multiple Accrurance contracts die accidentally on board a common carrier, the total insurance amount payable by the Insurer is limited to $10,000,000 for all insureds combined. The benefit payable for each insured is reduced proportionately.

7) The Insurer pays a lesser benefit if an insured dies as the result of an accident while travelling in a common carrier as a:
   a) driver;
   b) pilot;
   c) crew member; or
   d) non-paying passenger.
   The benefit paid will be the amount provided for accidental death due to other circumstances.

8) For a benefit to be payable for a fracture, the fracture must be diagnosed within 30 days following the accident.

9) No benefit will be payable for medically induced comas, comas which result from alcohol or drug abuse or for diagnoses of brain death.

19. INSURANCE IN CASE OF NON-ACCIDENTAL DEATH

The Insurer pays a $20,000 benefit if an insured aged over 14 days but under 25 years dies a non-accidental death.

Exclusions:

The Insurer pays no benefit if the death occurs during the 12 months following the effective date of this coverage and is the result of:

1) suicide, or
2) a health problem for which the insured received one or more treatments during the 6 months prior to the effective date of the contract or the date the insured was added to the contract.

These conditions also apply during the 12 months following any reinstatement of this coverage following a period of interruption.

20. MEDICAL AND PARAMEDICAL COVERAGE

The Insurer pays a lump sum or reimburses reasonable expenses incurred for an insured as a result of an accident, for the following care, services or items:

1) the services of a registered nurse if prescribed by the attending physician. The Insurer pays a lump sum equal to $50 per day for a maximum of 30 days per accident;
2) the services of a:
   a) chiropractor;
   b) occupational therapist;
   c) osteopath;
   d) physiotherapist; or
   e) orthotherapist;

   The Insurer pays a lump sum equal to $25 per treatment, up to $250 per accident for all of these professionals combined. These professionals must be members in good standing of their professional association.

3) emergency transportation immediately following an accident up to a maximum of $10,000 per accident;
4) the purchase or rental of a cane, crutches, pressure garments or a walker up to a maximum of $500 per accident;
5) the purchase or rental of a wheelchair up to a maximum of $5,000 per accident;
6) the purchase of an initial hearing aid or artificial eye, up to a maximum of $700 for each prosthesis (for a hearing aid, the Insurer pays a lifetime maximum of $700 per insured);
7) the replacement of broken prescription eye glasses or contact lenses, up to $300 per accident;
8) the purchase or rental of an orthosis, up to $400 per accident. An orthosis is a rigid orthopedic appliance designed to protect, immobilize or support a limb or another part of the body. The orthosis is directly attached to the body part requiring treatment.

21. DENTAL CARE COVERAGE

When an insured receives dental care as the result of an accident, the Insurer pays the following lump sums, up to a maximum of $1,250 per accident:

1) $250 per natural and healthy tooth that must be treated or replaced; and
2) $250 for the repair or replacement of dentures.

22. TRANSPORTATION AND ACCOMODATION COVERAGE

If, as the result of an accident, the insured must incur transportation and accommodation costs to receive treatments, the Insurer pays a lump sum equal to $75 per day for a maximum of 10 days per accident, subject to the following conditions:

1) the treatments must not be available within 50 km of the insured’s home;
2) the 50-km distance is based on a one-way trip only.

This insurance also covers transportation and accommodation expenses incurred by the parents or third party, where applicable, of a hospitalized insured child to remain at that child’s bedside. The child must be hospitalized because of an accident and the healthcare facility must be located more than 50 km from their home. This benefit is subject to the maximum amounts per accident stipulated above.

23. EDUCATIONAL COSTS COVERAGE

The Insurer reimburses all of the following expenses if, solely as a result of an accident, one of the following situations applies to the insured:

1) Private tutoring – If an insured student becomes totally disabled and must incur reasonable expenses for private tutoring, the Insurer will reimburse these expenses under the following conditions:
   a) the total disability must require the insured to interrupt their studies for a continuous period of at least 30 days;
   b) the private tutoring must be part of the insured’s normal curriculum;
   c) the private tutoring must be provided by a person with an appropriate teaching diploma;
   d) reimbursed expenses are limited to a maximum of $30 per hour;
   e) the maximum reimbursement is $3,500 per accident.
2) **School transportation** – If an insured student is unable to use their usual means of transportation for going to and from school and has to incur reasonable expenses to travel back and forth to school, the **Insurer** will reimburse these expenses under the following conditions:
   a) the expenses reimbursed are limited to a maximum of $15 per day;
   b) the maximum reimbursement is $150 per accident.

3) **Re-orientation expenses** – If an insured student becomes totally disabled and must, as a result of the total disability, incur expenses to change their field of study, the **Insurer** will reimburse the reasonable expenses incurred.
   Reimbursement of these expenses is limited to a lifetime maximum of $4,000 per insured.

4) **Tuition Fees** – If an insured student becomes totally disabled during a semester for which they have incurred tuition fees, the **Insurer** will reimburse the portion of those fees not refunded by the educational institution in question.
   Reimbursement of these expenses is limited to a maximum of $2,000 per accident.

24. **MONTHLY BENEFIT PAYABLE DURING SCHOOL HOLIDAYS**

If, as a result of an accident, an insured student is totally disabled during a holiday period, the **Insurer** pays a monthly benefit for this period. Payment of this benefit is subject to the following conditions:

1) the **accident** that caused the total disability must have occurred during the school year preceding the holiday period;
2) the **insured** must be age 16 or over;
3) the **benefit** is $850 a month, less any amount payable by a government board or agency;
4) the **Insurer** will not pay any **benefits** for the first 7 days of total disability;
5) the **student** must be under the continuous care of a **physician** throughout the total disability period;
6) **benefit** payments terminate when the total disability ends or no later than the end of the vacation period;
7) the holiday period is the period determined by the **student’s** school as the summer holiday period. However, no **benefit** is payable before May 1st and after August 31st of the same year.

25. **INSURANCE IN CASE OF HOSPITALIZATION**

If an insured is hospitalized as a result of an accident, the **Insurer** pays a lump sum equal to $75 for each complete and consecutive 24-hour period of hospitalization following the first 24 hours of hospitalization for a maximum of 30 days per accident. This 24-hour waiting period applies to each new period of hospitalization.

**Exclusion:**

No **benefit** will be paid for the first 24 hours of any period of hospitalization.

---

**Dissatisfied? Let us know.**

As a responsible company that is attentive to the needs of its clients, Desjardins Financial Security wants to provide products and services that meet our clients’ expectations. However, if you are dissatisfied with any of our products or services, please let us know by visiting our website at www.dfs.ca/complaint or by contacting the Dispute Resolution Officer at 1-877-838-8185.