

2020

UNDERSTANDING THE COVERED CONDITIONS



equiliving

ABOUT EQUITABLE LIFE OF CANADA®



Equitable Life® is proud to be one of Canada's largest mutual life insurance company. We operate only in Canada and are owned by our participating policyholders, not shareholders. This allows us to focus on management strategies that foster prudent long-term growth, continuity and stability.

We are dedicated to meeting our commitments to our customers – to provide good value and meet their needs for insurance protection and wealth accumulation – now and in the future. That's why Canadians have turned to Equitable Life since 1920 to protect what matters most.

Equitable Life is a focused, stable and strong company.

Our mutual structure is a key element of our value proposition, along with our diversified product portfolio and superior service. As an organization we're progressive, competitive and firmly committed to serving the best interests of our policyholders, through longer-term strategies that foster ongoing stability, growth and profitability.

ABOUT THIS GUIDE

The following provides some background information about the EquiLiving® covered conditions. It is intended to help you understand what is and what is not covered under an EquiLiving policy. Unless otherwise specified in the policy contract, you must survive for 30 days following diagnosis of a covered condition before a benefit payment will be made. While Equitable Life has made every effort to ensure the accuracy of the information presented here, the policy contract governs in all cases.



Heart attack	1
Stroke.....	1
Cancer (life-threatening)	2
Alzheimer's disease.....	2
Aortic surgery	3
Aplastic anaemia	3
Bacterial meningitis.....	3
Benign brain tumour.....	4
Blindness	4
Coma.....	5
Coronary artery bypass surgery	5
Deafness.....	5
Heart valve replacement	5
Kidney failure	5
Loss of independent existence	6
Loss of limbs	7
Loss of speech	7
Major organ failure on waiting list	7
Major organ transplant.....	7
Motor neuron disease	7
Multiple sclerosis	8
Occupational HIV infection	8
Paralysis	9
Parkinson's disease	9
Severe burns.....	9
Additional covered conditions for children	10
Cerebral palsy	10
Congenital heart disease.....	10
Cystic fibrosis.....	11
Muscular dystrophy	11
Type 1 diabetes mellitus	11
Early detection benefit covered conditions	12
Early prostate cancer	12
Ductal breast cancer.....	12
Superficial malignant melanoma	12
Coronary angioplasty.....	12

Covered critical conditions	Contract definition	Background information
Heart attack	is defined as “a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in: Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: • heart attack symptoms • new electrocardiogram (ECG) changes consistent with a heart attack • 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. Exclusion: No benefit will be payable under this condition for: • elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or • ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.”	A heart attack (also known as myocardial infarction) results when the normal supply of blood to the heart is interrupted by a blocked artery or clot causing part of the heart muscle to die. The diagnosis of heart attack is generally confirmed by the detection of abnormal electrical activity over the surface of the heart which is seen on an electrocardiogram (ECG) and the detection of raised levels of cardiac biochemical markers released from the damaged heart muscle tissue. No benefit is paid should an ECG reveal changes suggesting a previous heart attack.
Stroke	(Cerebrovascular accident) is defined as “a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with: • acute onset of new neurological symptoms, and • new objective neurological deficits on clinical examination, persisting for more than 30 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. Exclusion: No benefit will be payable under this condition for: • Transient ischaemic attacks; or, • Intracerebral vascular events due to trauma; or, • Lacunar infarcts which do not meet the definition of stroke as described above.”	A stroke occurs when there is permanent damage to an area of the brain due to any of the following events: • There is bleeding into the brain (a hemorrhage) • An artery supplying the brain becomes blocked by a blood clot (a thrombosis), • A blood clot from another part of the body is carried to the brain and blocks an artery in the brain (an embolus) Neurological sequelae must last more than 30 days. Transient ischemic attacks (TIAs) are not covered.

Covered critical conditions	Contract definition	Background information
Cancer (life-threatening)	is defined as “a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of cancer must be made by a specialist. Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers: • Carcinoma in situ, or • Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion), or • Any non-melanoma skin cancer that has not metastasized, or • Stage A (T1a or T1b) prostate cancer. Moratorium period exclusion No benefit will be payable under this condition if: Within the first 90 days following the later of: • the effective date of the policy, or • the effective date of last reinstatement of the policy, the insured person has any of the following: • signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made, • a diagnosis of cancer (covered or excluded under the policy). This medical information as described above must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided, the company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.”	Cancer is a type of abnormal or malignant (cancerous) cell growth that spreads throughout the body destroying healthy tissue. Some cancers are not considered life threatening and are not covered under this benefit. However, if a cancer spreads to surrounding tissue or organs or progresses, the EquiLiving benefit will be paid. Note: your policy includes an early detection benefit that provides limited coverage for three non life-threatening cancers as defined under the early detection benefit covered conditions. No benefit is payable under the policy if cancer is diagnosed or if there are any signs, symptoms, tests or consultations within 90 days of the policy being issued or reinstated, that lead to the diagnosis of cancer. You can elect to have your policy continue without coverage for cancer or other covered conditions resulting from, or the treatment of, any cancer.
Alzheimer's disease	is defined as “a definite diagnosis of a progressive degenerative disease of the brain. The insured person must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The diagnosis of alzheimer's disease must be made by a specialist. Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.”	Alzheimer's is a leading cause of dementia. It is a progressive, degenerative, and irreversible disease of the brain that will eventually erode a person's memory and ability to think, reason and coordinate movement. Dementia as a result of other brain diseases, psychiatric conditions, substance abuse and other physical illnesses is not covered under the policy.

Covered critical conditions	Contract definition	Background information
Aortic surgery	is defined as "the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist."	The aorta is the large blood vessel leading from the heart and supplying branch arteries leading to various organs. If it becomes diseased, it weakens and can rupture. When this happens, it must be surgically replaced with a graft. The benefit is paid when the surgery occurs.
Aplastic anaemia	is defined as " a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: • marrow stimulating agents; • immunosuppressive agents; • bone marrow transplantation. The diagnosis of aplastic anemia must be made by a specialist."	Aplastic anaemia is a bone marrow disorder that results in a low hemoglobin level and red blood cell count, a low white blood cell count and a low platelet count. The benefit is paid if a blood transfusion is required and if one of the specified treatments is also required.
Bacterial meningitis	is defined as "a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist. Exclusion: No benefit will be payable under this condition for viral meningitis."	Bacterial meningitis is an inflammation of the covering of the brain and spinal cord, caused by a bacterial infection. The benefit is paid if the bacterial infection is confirmed by laboratory analysis and there is neurological damage which lasts for at least 90 days.

Covered critical conditions	Contract definition	Background information
Benign brain tumour	is defined as "a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumour must be made by a specialist. Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm. Moratorium period exclusion No benefit will be payable under this condition if: Within the first 90 days following the later of: • the effective date of the policy, or • the effective date of last reinstatement of the policy, the insured person has any of the following: • signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is made, • a diagnosis of benign brain tumour. This medical information as described above must be reported to the company within six months of the date of the diagnosis. If this information is not provided, 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."	A benign brain tumour is a non-cancerous growth in the brain or its protective membranes (meninges), cranial nerves or pituitary gland. No benefit is payable under the policy if a benign brain tumour is diagnosed or if there are any signs, symptoms, tests or consultations within 90 days of the policy being issued or reinstated, that lead to the diagnosis of benign brain tumour. You can elect to have your policy continue without coverage for benign brain tumour or other covered critical conditions resulting from, or the treatment of, any benign brain tumour.
Blindness	is defined as "a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by: • the corrected visual acuity being 20/200 or less in both eyes; or, • the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist."	Blindness is the total and irreversible loss of vision in both eyes.

Covered critical conditions	Contract definition	Background information
Coma	is defined as "a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less. The diagnosis of coma must be made by a specialist. Exclusions: No benefit will be payable under this condition for: • a medically induced coma; or, • a coma which results directly from alcohol or drug use; or, • a diagnosis of brain death."	A coma is an unconscious state from which a person cannot be aroused or woken even with intense external stimulation. The coma state must continue for a continuous period of 96 hours with a Glasgow score of four or less. Life support systems must be required and the coma must not be drug or alcohol induced for the benefits to be paid.
Coronary artery bypass surgery	is defined as "the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a specialist."	Coronary artery bypass surgery is open heart surgery to correct the narrowing or blockage of one or more coronary arteries. Only coronary artery bypass surgery is covered. No other procedures to improve blood flow to the heart are covered. Note: your policy includes an early detection benefit that provides limited coverage for coronary angioplasty as defined under the early detection benefit covered conditions.
Deafness	is defined as "a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist."	Deafness is the total and irreversible loss of hearing in both ears.
Heart valve replacement	is defined as "the undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a specialist. Exclusion: No benefit will be payable under this condition for heart valve repair."	When a heart valve is damaged beyond repair it must be surgically replaced by a new valve, either natural or man-made. While replacement surgery is covered under the policy, surgical repair of a heart valve is not.
Kidney failure	is defined as "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."	There is a permanent loss of function of both kidneys. The person insured must have regular dialysis treatment or a kidney transplant.

Covered critical conditions	Contract definition	Background information
Loss of independent existence	is defined as "a definite diagnosis of: a) a total inability to perform, by oneself, at least two of the following six activities of daily living, or, b) Cognitive impairment, as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of loss of independent existence must be made by a specialist. Activities of daily living are: • Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment. • Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances. • Toileting – the ability to get on and off the toilet and maintain personal hygiene. • Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained. • Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment. • Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils. Cognitive impairment is defined as "mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight hours of daily supervision. Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments." Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause."	Loss of independent existence describes a total and permanent inability to perform by oneself, at least two of the activities of daily living. It also describes a mental deterioration and loss of intellectual ability that is sufficiently severe to require a minimum of eight hours of daily supervision. The diagnosis of loss of independent existence must be confirmed for a continuous period of 90 days. A mental or nervous disorder without a demonstrable organic cause is not covered. For plans insuring children, coverage for loss of independent existence does not apply until age 18 at which time it is added automatically.

Covered critical conditions	Contract definition	Background information
Loss of limbs	is defined as "a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of loss of limbs must be made by a specialist."	Two or more limbs are cut off at or above the wrist or ankle joint, as a result of an accident, injury or illness.
Loss of speech	is defined as "a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of loss of speech must be made by a specialist. Exclusions: No benefit will be payable under this condition for all psychiatric related causes."	If you have a total, permanent and irreversible loss of speech due to a physical injury or disease which has lasted for at least 180 days, the benefit becomes payable.
Major organ failure on waiting list	is defined as "a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America 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 person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist."	In certain conditions, any of the heart, lungs, liver, kidneys or bone marrow can become injured or diseased sufficiently such that the person insured needs an organ transplant. Because finding a suitable donor may be a lengthy process, the insured person may claim for this benefit once enrolled in a recognized transplant program.
Major organ transplant	is defined as "a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the insured person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist."	In certain conditions, any of the heart, lungs, liver, kidneys or bone marrow can become injured or diseased sufficiently such that the person insured needs an organ transplant. This benefit will be paid when the person insured undergoes transplant surgery as a recipient.
Motor neuron disease	is defined as "a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist."	Motor neuron disease is a progressive disorder, which affects the central nervous system and causes muscles to weaken and deteriorate. The most common form is ALS or amyotrophic lateral sclerosis, better known as Lou Gehrig's disease.

Covered critical conditions	Contract definition	Background information
Multiple sclerosis	Is defined as “a definite diagnosis of at least one of the following: • two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or, • well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or, • a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart. The diagnosis of multiple sclerosis must be made by a specialist.”	Multiple sclerosis is a progressive brain and spinal cord disease with multiple and varied neurological symptoms and signs. For this reason, MS can be difficult to diagnose and usually takes a number of tests before it is confirmed.
Occupational HIV infection	Is defined as “a definite diagnosis of infection with human immunodeficiency virus (HIV) resulting from accidental injury during the course of the insured person’s normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy. Payment under this condition requires satisfaction of all of the following: a) The accidental injury must be reported to the insurer 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 of America; e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines. The diagnosis of occupational HIV infection must be made by a specialist. Exclusions: No benefit will be payable under this condition if: • The insured person has elected not to take any available licensed vaccine offering protection against HIV; or, • A licensed cure for HIV infection has become available prior to the accidental injury; or, • HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.”	The HIV (AIDs virus) infection must be caused by an accidental exposure to HIV-contaminated blood or bodily fluids, in the course of performing your job or occupation. In order to give reasonable assurances that the HIV infection was caused by an accidental exposure at work, certain reporting requirements and medical lab testing must be met.

Covered critical conditions	Contract definition	Background information
Paralysis	Is defined as "a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of paralysis must be made by a specialist."	Paralysis is the complete and permanent loss of voluntary movement in at least two limbs, for a continuous period of at least 90 days, whether caused by an accident, illness or disease.
Parkinson's disease	is defined as "a definite diagnosis of primary idiopathic Parkinson's disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses). The Insured Person must require substantial physical assistance from another adult to perform at least two of the following six activities of daily living. The diagnosis of parkinson's disease must be made by a specialist. Activities of daily living are: • Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment. • Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances. • Toileting – the ability to get on and off the toilet and maintain personal hygiene. • Bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained. • Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment. • Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils. Exclusion: No benefit will be payable under this condition for all other types of parkinsonism."	Parkinson's disease is a progressive degenerative disease of the central nervous system that is characterized by rigid muscles, tremor and slow movements.
Severe burns	is defined as "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."	Only third degree burns are covered under the policy. They are the most serious type of burn, involving all layers of the skin. Coverage is provided if the person insured has third degree burns covering at least 20% of the body.

ADDITIONAL COVERED CONDITIONS FOR CHILDREN

* Issue ages 30 days – 17 years

Covered critical conditions	Contract definition	Background information
Cerebral palsy	is defined as “a definitive diagnosis of definite cerebral palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements”.	Cerebral palsy results in impaired muscle co-ordination and weakness caused by damage to the brain.
Congenital heart disease	is defined as “a diagnosis of the following heart conditions: i) The following conditions are covered following a 30-day survival period from diagnosis or birth whichever comes later. The diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. • Atresia of any heart valve • Coarctation of the aorta • Double inlet ventricle • Double outlet left ventricle • Ebstein’s anomaly • Eisenmenger syndrome • Hypoplastic left heart syndrome • Hypoplastic right ventricle • Single ventricle • Tetralogy of fallot • Total anomalous pulmonary venous connection • Transposition of the great vessels • Truncus arteriosus ii) The following conditions are covered only when open heart surgery is performed for correction of the condition and following a 30-day survival period from diagnosis or birth whichever comes later. • Aortic stenosis • Atrial septal defect • Discrete subvalvular aortic stenosis • Pulmonary stenosis • Ventricular septal defect The diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada or the U.S. Exclusions: Trans-catheter procedures such as balloon valvuloplasty or percutaneous atrial septal defect closure are excluded. All other congenital cardiac conditions are excluded.”	Congenital heart disease refers to a group of cardiac malformations that are present at birth, but may not be diagnosed until later in childhood. When open heart surgery is performed, the conditions covered vary in severity from mild to those that may disappear on their own as the child grows. Only cases requiring surgery are covered by critical illness insurance.

ADDITIONAL COVERED CONDITIONS FOR CHILDREN (CONTINUED)

* Issue ages 30 days – 17 years

Covered critical conditions	Contract definition	Background information
Cystic fibrosis	is defined as “a definitive diagnosis of cystic fibrosis with evidence of chronic lung disease and pancreatic insufficiency”.	Cystic fibrosis is a genetic disorder that results in production of abnormally thick mucus. This can lead to breathing problems, lung disease, malnutrition and problems with growth and development.
Muscular dystrophy	is defined as “a definitive diagnosis of muscular dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy”.	Muscular dystrophy is a hereditary condition in which there is a progressive weakening and wasting of muscles.
Type 1 diabetes mellitus	is defined as “a diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada or the U.S. and there must be evidence of dependence on insulin for a minimum of three months.”	Type 1 diabetes mellitus is caused by a failure of the pancreas to produce insulin, which results in a daily dependence on insulin injections for survival. Insulin lets sugar (glucose) enter the body cells, where it is used for energy. Without insulin, sugar remains in the blood and the blood sugar level rises above what is safe for the body.

EARLY DETECTION BENEFIT COVERED CONDITIONS

Covered critical conditions	Contract definition	Background information
Early prostate cancer	is defined as "the presence of either stage T1A or T1B early prostate cancer, as measured under the TNM classification system."	When diagnosed early, these four early detection benefit covered conditions are very treatable and generally not life threatening.
Ductal breast cancer	is defined as "the presence of ductal carcinoma in-situ of the breast, as confirmed by biopsy."	This benefit can be paid twice during the lifetime of the policy, but only once for any condition. The benefit is limited to the lesser of 15% of the then current sum insured to a maximum of \$50,000.
Superficial malignant melanoma	is defined as "the presence of any malignant melanoma that is less than or equal to 1.0 millimetre in depth." Note: a "cancer and other related covered conditions exclusion applies. See Cancer (life-threatening).	No benefit will be payable under this condition if: Within the first 90 days following the later of: - the effective date of the policy, or - the effective date of last reinstatement of the policy, the insured person has any of the following: - signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made, - a diagnosis of cancer (covered or excluded under the policy). This medical information as described above must be reported to the company within six months of the date of the diagnosis. If this information is not provided, the company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.
Coronary angioplasty	is defined as "the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a specialist."	You can elect to have your policy continue without coverage for cancer or other covered conditions resulting from, or the treatment of, any cancer.

Only a broad overview of the Equiliving policy is given here. While Equitable Life has made every effort to ensure the accuracy of the information presented here, the policy contract governs in ALL cases. If this information differs from the policy contract, the policy contract prevails.

Works for me.®

Canadians have turned to Equitable Life since 1920 to protect what matters most. We work with your independent financial advisor to offer individual insurance and savings and retirement solutions that provide good value and meet your needs – now and in the future.

Equitable Life is not your typical financial services company. We have the knowledge, experience and ability to find solutions that work for you. We're friendly, caring and interested in helping. And we're owned by our participating policyholders, not shareholders, allowing us to focus on your needs and providing you with personalized service, financial protection and peace of mind.



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