LLOYD'S

Effected with certain Lloyd's Underwriters (hereinafter called the "Insurer") through

Burns & Wilcox

Bay Adelaide Centre, West Tower
333 Bay Street, Suite 850
Toronto, ON M5H 2R2
www.burnsandwilcox.ca

B0142BA1901167

GROUP ACCIDENT INSURANCE POLICY

For purposes of the *Insurance Companies Act* (Canada), this document was issued in the course of Lloyd's Underwriters' insurance business in Canada.

Insuring Agreement

POLICYHOLDER: **CURL BC**

POLICY NUMBER: BW190997

EFFECTIVE DATE OF POLICY: SEPTEMBER 1, 2019

PERIOD OF INSURANCE: SEPTEMBER 1, 2019 TO SEPTEMBER 1, 2020
(All periods of time begin and end at 12:01 a.m. Local Standard Time at the policyholder's address)

The Insurer agrees to provide insurance to the Policyholder in exchange for payment of the required premium. The policy contains the limits of liability, exceptions, limitations, provisions, terms and conditions under which the Insurer agrees to insure Covered Persons and pays benefits.

IDENTIFICATION OF INSURER/ACTION AGAINST INSURER

This insurance has been effected in accordance with the authorization granted to Burns & Wilcox Canada by certain Lloyd's Underwriters whose definitive numbers and proportions are stated in the Table attached to Agreement No. **B0142BA1901167**. The Underwriters will be liable hereunder each for his own part and not one for another in proportion to the several sums that each of them subscribed to the said Agreement.

In any action to enforce the obligations of the Underwriters, they can be designated or named as "Lloyd's Underwriters" and such designation will be binding on the Underwriters as if they have each been individually named as defendant. Service of such proceedings may validly be made upon Attorney in Fact in Canada for Lloyd's Underwriters, whose address for such service is 1155 rue Metcalfe, Suite 2220, Montréal, (Québec) H3B 2V6.

NOTICE: Any notice to the Underwriters may be validly given to Burns & Wilcox Canada.

In witness whereof the policy is signed, as authorized by the Underwriters, by Burns & Wilcox Canada.

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The Policyholder is required to read the policy and if incorrect, return it immediately for alteration.
In the event of an occurrence likely to result in a claim under the insurance, immediate notice should be given to Burns & Wilcox Canada at the above-noted address.

THE POLICY CONTAINS A CLAUSE WHICH MAY LIMIT THE AMOUNT PAYABLE

DEFINITIONS

For the purposes of the Policy, the definition of any word, if not defined in the text where it is used, may be found in Definitions or in the Benefits Schedule.

Accident means a sudden, unexpected event that results in bodily Injury to the Covered Person at the time the event occurs, arises from an external source to the Covered Person and occurs at an identifiable time and place during the Period of Insurance.

Active Service means a Covered Person is either 1) Actively at Work performing all regular duties on a full time basis either at his Employer's place of business or someplace the Employer requires him to be; or 2) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

Actively at Work means the Covered Person is present at his usual place of employment with the Policyholder, or at another location as assigned or directed by the Policyholder, and is mentally and physically capable of performing the regular duties of the job for which he is employed. On any day that is not a Covered Person's regularly scheduled work day (vacation, personal days, weekends or holidays) the Covered Person will be considered Actively at Work on such day provided he is not absent due to any type of leave and was Actively at Work on his last regularly scheduled work day. A Covered Person who usually performs the regular duties of his job at their home is considered Actively at Work if they meet all the above requirements and can work at the Policyholder's usual place of employment if required to do so.

Annual Earnings means the annual gross base earnings received from the Employer, not including any additional form of income such as, but not limited to bonuses, overtime, dividends, commissions and profit sharing. If an employee's income includes commission, annual earnings will include commissioned earnings averaged over the immediately preceding 24 months, or if the Employee has not been employed for at least 12 months, commissioned earnings will be averaged from the date of employment.

Conveyance means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.

Covered Accident means an Accident that occurs during the Period of Insurance for a Covered Person and results in a Covered Loss or Injury for which benefits are paid.

Covered Activity means any activity indicated in the Benefits Schedule and insured under the Policy.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

Covered Loss or Covered Losses means an Injury occurring or Illness which first manifests itself during the Period of Insurance for which a Covered Person is insured under the Policy.

Covered Person means an eligible person who is within the covered class(es) listed in the Policy and for whom the required premium is paid when due.

Dependent means a Covered Person's:

1. lawful Spouse under age 70, or a partner of the same or opposite sex under age 70, who immediately prior to the loss has been residing with the Covered Person for at least 12 months, and who has been publicly represented as the partner of the Covered Person during such period.
2. unmarried Child(ren) under age 22;
3. unmarried Child(ren) at least 22 years of age but less than age 26 who are:
    (a) not employed on a regularly full-time basis; and
    (b) dependent primarily on the Covered Person for support and maintenance; and
    (c) enrolled as a full-time student at an accredited college, university or other institution of higher learning or a vocational or licensed technical school.

The age limitations will not apply to a Covered Person's unmarried Child who is incapable of self-support due to a mental disability or physical handicap. Proof of such incapacity must be furnished to the Insurer immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

The term "Child" means the Covered Person's natural child, legally adopted child, or child placed in the Covered Person's home for purposes of adoption, foster child, stepchild, or other child for whom the Covered Person has legal guardianship (proof will be required). A child must reside with the Covered Person in a parent-child relationship and be eligible to be claimed as an exemption on the Covered Person's federal income tax return.
Important Note: In the event the Covered Person shares physical custody of the child with another parent, the requirement that the child reside with the Covered Person will be waived.

Elimination Period means the number of days at the beginning of a period of Disability for which no benefit is paid, as stated in the Benefits.

Employee means for eligibility purposes, an Employee of the Employer, who is in one of the Class(es) of Eligible Covered Persons.

Employer means the Policyholder and any affiliates, subsidiaries or divisions stated in the Policy and which are covered under the Policy on the date of issue or subsequently agreed to by the Insurer.

Hospital means an institution that:

1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons; is a duly licensed institution, operated lawfully in its area;
2) provides 24-hour nursing service by registered nurses on duty or call;
3) has a staff of one or more licensed Physicians available at all times;
4) provides organized facilities for diagnosis, treatment and surgery, either
   a) on its premises; or
   b) in facilities available to it, on a pre-arranged basis;
5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
6) is not a facility for the treatment of drug addiction, alcoholism, treatment of the aged.

The Insurer will not deny a claim for services rendered in a hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability:

1) the Joint commission of Accreditation of Hospitals; or
2) the Canadian Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

Hospital Confined or Confinement means any period for which a charge for room and board is made by a Hospital; or for any period during which a Covered Person incurs Covered Medical Expenses as a result of emergency care within 72 hours following an accidental bodily injury; or any period during which a Covered Person incurs Covered Medical Expenses as a result of surgery performed at a Hospital on an out-patient basis.

Hospital Stay means a stay of 24 or more continuous hours as a registered resident bed-patient in a Hospital.

Immediate Family Member means the Covered Person, the Covered Person's spouse, and the child(ren), (includes legally adopted or step child(ren), parents, parents-in-law, brothers, sisters, brothers-in-law, sisters-in-law, grandson, granddaughter, grandfather or grandmother of the Covered Person and of the Covered Person's spouse.

Injury means bodily Injury caused by the direct result of an Accident occurring while the Policy is in force as to the Covered Person whose Injury is the basis of the claim which results solely and independently of all other causes in a Covered Loss.

Institution of higher learning means an accredited institute, college, university, CEGEP or trade school.

Occurrence means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one occurrence without regard to the period of time or the area over which such losses occur.

Period of Insurance means the 12 continuous month period defined for the Policyholder for which the insurance is in force, from the effective date or an anniversary of the Policy.

Physician means a person who is a qualified doctor of medicine. As such, he must be acting within the scope of his license under the laws in the jurisdiction in which he practices and providing only those medical services which are within the scope of his license or certificate. It does not include a Covered Person or a Covered Person's spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the previous include natural, adopted and step relationships), grandson, granddaughter, grandfather or grandmother or other relative.

Reasonable (Usual) and Customary Charges means the amount standardly charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Residence means the primary dwelling of which the Covered Person is an occupant and the premises on which it is situated.

Trip means travel by air, land, or sea.

We, Our, Us means the Insurer providing the insurance or its authorized representative Burns and Wilcox Canada.

The male pronoun will be construed as the feminine when the person is a female.

Benefits Schedule

Policy Number:	BW190997
Policyholder:	Curl BC
Policyholder's Address:	2001A – 3713 Kensington Ave. Burnaby, British Columbia V5B 0A7
Period of Insurance:	September 1, 2019 to September 1, 2020 (both days at 12:01 a.m. Local Standard Time at the Policyholder's address)
Premium Deposit:	$2,500 (non-refundable), to be reconciled and adjusted twice annually (April and September), based on the reported monthly bordereaux and at a rate of $0.75 per Covered Person.
Currency:	All dollar values expressed in the Policy will be paid in CAD currency

Classes of Covered Eligible Persons:

Class	Description All Covered Persons who are classed below are eligible for coverage:	Hazard
1	All Registered Members (Participants, Coaches, Officials , Instructors and Volunteers) including Drop-In Players who have registered with the Policyholder, and whose names are on file with the Policyholder	Sponsored Events Accident Insurance Protection – Hazard J

Accidental Death & Dismemberment Benefit:

Class	Applicable Principal Sum
1	$15,000

Aggregate Limit of Liability:

Aggregate Limit of Liability or Accident Event Limit: $1,000,000

Benefits Schedule – Cont'd

Ancillary Accident Benefits:
Any benefits paid under the Ancillary Accident Benefits shown below are paid in addition to any other Accidental Death & Dismemberment benefits paid unless otherwise stated:

Surgical Reattachment Benefit	
Maximum Benefit	As stated in the Surgical Reattachment Benefit
Repatriation Expenses Benefit	
Maximum Amount	$5,000
Identification Expenses Benefit	
Maximum Amount	$5,000
Funeral Expenses Benefit	
Maximum Amount	$1,000
Rehabilitation Expenses Benefit	
Maximum Amount	$5,000
Fracture Schedule Benefit	
Maximum Amount	$3,000
Emergency Taxi and Ambulance Expenses Benefit	
Maximum Amount	$50
Tuition Fees Expenses Benefit	
Maximum Amount	$2,000
Accidental Medical Expenses Benefit	
Maximum Amount for any one accident	$15,000
Accidental Dental Expenses Benefit	
Maximum Amount for any one accident	$5,000

ADDITIONAL EXCLUSION(S) AND/OR LIMITATION(S)
In addition to the exclusions stated under the Exclusions section of the Policy, the following limitation(s) and/or exclusion(s) also apply to coverage provided under the Policy:

- Not Applicable

SCOPE OF COVERAGE PROVISIONS

The Insurer agrees with the Policyholder, to the extent and in the manner provided, that if at any time during the Period of Insurance a Covered Person sustains a bodily injury caused by an Accident, which shall solely and independently of any other cause within 12 calendar months from the date of the Accident causing the Injury occasions his death or disablement as defined, the Insurer will pay to the Covered Person, or to the Covered Person's Beneficiaries, Executors or Administrators, according to the Covered Losses Schedule, provided such injuries are sustained by a Covered Person under the circumstances and in the manner described in the Hazard stated in the Policy, which is applicable to such Covered Person.

Exposure and Disappearance

If, while insured under the Policy, the Covered Person is unavoidably exposed to the elements because of an Accident, and if, as a result of such exposure and within 365 days of the Accident, the Covered Person sustains a loss for which benefits are otherwise payable hereunder such loss will be covered under the Policy.

If, while insured under the Policy, the Covered Person is not found within 365 days from the date of an Accident, it will then be deemed, subject to all terms and provisions of the Policy, that the Covered Person has inevitably suffered a Loss of Life. The Insurer will pay the Principal Sum under the Insurance provided that the person or persons to whom such sum is paid shall sign an undertaking to refund such sum immediately to the Insurer if the Covered Person is subsequently found to be living.

Aggregate Limit of Liability

The maximum amount the Insurer will pay for all Covered Losses resulting from the same Accident will not exceed the Aggregate Limit of Liability as stated in the Benefits Schedule.

If the total amount payable for all Covered Losses in any one Accident exceeds the Aggregate Limit of Liability, each Covered Person’s Covered Loss will be paid at the same ratio that the Aggregate Limit of Liability has to the total amount of all Covered Losses. The Insurer shall not be liable for amounts in excess of the Aggregate Limit of Liability.

HAZARD J8 – SPONSORED EVENTS ACCIDENT PROTECTION

The Hazards described in Description of Hazard apply only to the Covered Persons who are within a class to which the Hazard applies as stated in the Benefits Schedule.

DESCRIPTION OF HAZARD

The insurance provided to a Covered Person to which Hazard J8 applies, will apply only to Injury, as defined in the Policy, sustained by the Covered Person:

- While participating in a game or practice session or activity of the Sport(s) specifically stated in the Schedule of Covered Sports and/or Activities. Such game or session or activity must be approved and under the direct supervision of proper authority of the team, club, or organization of the Policyholder of which the Covered Person is a registered participant.
- Travelling directly to or from a game or practice session or competition of the Sport(s) specifically stated in the Schedule of Covered Sports and/or Activities, along a normal or reasonable route, without delay or stop-over with other Covered Persons, under the supervision of proper authority of the team, club, or organization of the Policyholder of which the Covered Person is a participant.

SCHEDULE OF COVERED SPORT AND/OR ACTIVITY

As reported by the Policyholder, in respect of the regular programs and/or activities and/or special events of the Summer Recreation Committee, on the Policy's anniversary date and kept on file with the Policyholder

- Curling

The following explain the Accidental Death & Dismemberment Benefits available under the Policy. All benefits paid are stated in the Benefits Schedule.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

COVERED LOSSES SCHEDULE

If Injury sustained by a Covered Person results in any of the following losses within 365 days of the date of Accident, the Insurer will pay the Percentage of the Principal Sum set opposite such loss. If more than one of the following losses is sustained by a Covered Person as the result of one Accident, the total amount payable in respect of such losses shall not exceed the Principal Sum or in the case of paralysis benefits shall not exceed 200% of the Principal Sum.

The Principal Sum is the amount of Principal Sum applicable to the Covered Person as determined in accordance with the Benefits Schedule.

Loss of:	**Benefit:** (Percentage of Principal Sum)
Life	100%
Both Arms	200%
Both Legs	200%
Both Hands	200%
Both Feet	200%
Entire Sight of Both Eyes	200%
One Hand and One Foot	200%
Either Hand or Foot and Sight of One Eye	200%
Speech and Hearing in Both Ears	200%
Speech	200%
Hearing (in Both Ears)	200%
Whole of Lower Jaw	133%
One Arm	150%
One Leg	150%
One Hand	150%
One Foot	150%
Sight of One Eye	150%
Hearing (in One Ear)	40%
One Kidney	40%
One Lung	40%
Thumb and Index Finger of Either Hand	67%
Four Fingers of Any One Hand	67%
All Toes on Any One Foot	50%

Hemiplegia	200%
Paraplegia	200%
Triplegia	200%
Quadriplegia	200%
Brain Death	100%
Use of Both Arms	200%
Use of Both Legs	200%
Use of Both Hands	200%
Use of Both Feet	200%
Use of One Hand and One Foot	200%
Use of Either Hand or Foot and Entire Sight of One Eye	200%
Use of One Arm	150%
Use of One Leg	150%
Use of One Hand	150%
Use of One Foot	150%
Use of One Kidney	40%
Use of One Lung	40%
Use of Thumb and Index Finger of Either Hand	67%
Use of Four Fingers of Any One Hand	67%

"Member" means Loss of Hand or Foot, Loss of Sight, Loss of Whole or Lower Jaw, Loss of Speech and Loss of Hearing. "Loss of a Hand or Foot" means complete severance through or above the wrist or ankle joint. "Loss of Sight" means total and permanent loss of sight that is irrecoverable, including by surgical and artificial means. "Loss of Whole or Lower Jaw" means complete severance of whole or lower jaw. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of Kidney or Lung" means total and irrecoverable loss of function that cannot be corrected by natural, surgical or artificial means. "Loss of Thumb and Fingers of Any One Hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. "Loss of Toes of Any One Foot" means the complete severance through the metatarsophalangeal joint. Severance means the complete separation and dismemberment of the part from the body.

"Paralysis" means total and irreversible loss of use.

"Hemiplegia" means total and irreversible Paralysis of the upper and lower limbs on one side of the body.

"Paraplegia" means total and irreversible Paralysis of both lower limbs.

"Triplegia" means total and irreversible Paralysis of three limbs.

"Quadriplegia" means total and irreversible Paralysis of both upper and lower limbs.

"Loss of Use" means loss of functional, normal, or characteristic use or paralysis of the entire arm or leg, hand and or foot, including but not limited to Quadriplegia, Triplegia, Paraplegia or Hemiplegia, kidney or lung; which continues without interruption for a period of 12 consecutive months and at the end of such period is determined by a Physician to be continuous, permanent and irrecoverable. The final determination as to whether a "Loss of Use" is permanent and irrecoverable will be made through use of the most current edition of the "Guides to the Evaluation of Permanent Impairment" published by the Canadian Medical Association. In the event the referenced guide ceases to be published, the Insurer will select another appropriate measurement of impairment values. The determination must be made by a Physician. The Insurer has a right, at their own expense, to have the determination verified by a Physician of their choice.

The term "Loss" with reference to Brain Death means irreversible unconsciousness with total loss of brain function and a complete absence of electrical activity of the brain, even though the heart is still beating.

SURGICAL REATTACHMENT BENEFIT

If as the result of an injury, the Covered Person, suffers a complete severance of a limb or an appendage or part of a limb or appendage, and if such severed limb or appendage or part is surgically reattached to that Covered Person, the Insurer will then pay a surgical reattachment benefit to the Covered Person in accordance with the following:

1: Whether or not the Covered Person regains the use of the severed limb, appendage or part, the Insurer will pay a benefit that is equal to fifty percent (50%) of the specific accidental loss benefit that would have been paid for the severance of such limb, appendage or part under the Covered Losses Schedule, if the surgical reattachment had not been performed.

2: If, within 365 days immediately after the reattachment of the severed limb, appendage or part, the Covered Person suffers a total, irrecoverable and permanent loss of use of such reattached limb or part of a limb, the Insurer will pay a benefit that is equal to the benefit under the Covered Losses Schedule for loss of use of such limb or part of a limb minus the amount(s) paid under this surgical reattachment benefit.

3: If, within 365 days immediately after the reattachment of the severed limb, appendage or part, such reattachment fails and the limb, appendage or part must be amputated, the Insurer will pay a benefit that is equal to the benefit under the Covered Losses Schedule for the specific accidental loss of such limb, appendage or part minus the amount(s) paid under this surgical reattachment benefit.

The amount payable under this surgical reattachment benefit and the Covered Losses Schedule, for all losses sustained by the Covered Person as the result of any one accident will not exceed the Principal Sum.

REPATRIATION EXPENSES BENEFIT

If injury sustained by a Covered Person results in a claim being paid for Accidental Death and such injuries occurred more than 50 kilometres from the Covered Person's place of residence, the Insurer will pay, in addition, all customary and reasonable expenses incurred for preparation of the Covered Person for burial or cremation and transportation of the Covered Person from the place of the accident to the Covered Person's place of residence, up to the maximum stated in the Benefits Schedule.

If a Covered Person is covered by two or more Policies issued by the Insurer, the Insurer's total liability for loss sustained by such Covered Person will not be cumulative and will not exceed the largest amount available under any one of the Policies.

IDENTIFICATION EXPENSES BENEFIT

If a Covered Person dies away from home as the result of an accident, the Insurer will pay up to the maximum stated in the Benefits Schedule, for board and lodging for a member of the immediate family or authorized representative while en-route and/or during stay in the city or town where the Covered Person’s body is located for the purpose of identifying his body, including transportation by the most direct route by a licensed common carrier to and from such location.

If transportation occurs in a vehicle other than by a licensed common carrier, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Payment will be made if, as the result of an accident, the Covered Person suffers loss of life at least 50 kilometres away from his place of residence.

If a Covered Person is covered by two or more Policies issued by the Insurer, the Insurer's total liability for loss sustained by such Covered Person will not be cumulative and will not exceed the largest amount available under any one of the Policies.

FUNERAL EXPENSES BENEFIT

If a Covered Person accidentally dies away from home (more than 50 kilometres from his place of residence), the Insurer will pay up to the maximum stated in the Benefits Schedule, for the services and/or materials provided by a mortician, undertaker, crematorium or funeral home, related to the burial or cremation of the deceased Covered Person and charges for the purchase of a burial plot, gravesite or mausoleum for the interment of the remains thereof, including any markers or monuments. Payment will be made if, as a result of an accident, the expenses are actually incurred at the time of the Covered Person’s death, less any charges for preparation of the remains for travel which are reimbursed under the Repatriation Expenses Benefit.

If a Covered Person is covered by two or more Policies issued by the Insurer, the Insurer's total liability for loss sustained by such Covered Person will not be cumulative and will not exceed the largest amount available under any one of the Policies.

REHABILITATION EXPENSES BENEFIT

If injury sustained by a Covered Person results in a claim being paid other than for Accidental Death, the Insurer will pay, in addition, for the reasonable and necessary expenses actually incurred up to the maximum stated in the Benefits Schedule for special training of the Covered Person provided:

1. such training is required because of the Injury and in order for the Covered Person to be qualified to engage in an occupation in which he would not have been engaged except for such Injury;

2. expenses are incurred within 3 years from the date of the Accident; and,

3. no payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

If a Covered Person is covered by two or more Policies issued by the Insurer, the Insurer's total liability for loss sustained by such Covered Person will not be cumulative and will not exceed the largest amount available under any one of the Policies.

FRACTURE SCHEDULE BENEFIT

If Injury sustained by a Covered Person results in any of the following losses, the Insurer will pay the Percentage of the Principal Sum set opposite such loss, not to exceed the maximum stated in the Benefits Schedule. If more than one of the following losses is sustained by a Covered Person as the result of one Accident, the total amount payable in respect of such losses will not exceed the overall maximum shown in the Benefits Schedule:

	PERCENTAGE OF THE PRINCIPAL SUM
For complete fracture	
Of the skull (depressed)	100%
Of the skull (not depressed)	33%
Of the spine (one or more vertebrae)	50%
Of the jawbone (mandible or maxilla)	33%
Of the thigh (femur)	33%
Of the pelvis	33%
Of the knee cap	27%
Of the lower leg	25%
Of the shoulder blade	25%
Of the ankle (small bones)	25%
Of the wrist (small bones)	25%
Of the forearm (compound or comminuted)	23%
Of the forearm (not compound)	12%
Of the sacrum or coccyx	17%
Of the sternum	17%
Of the arm, between elbow and shoulder	17%
Of the collarbone	12%
Of the nose	12%
Of two or more ribs	10%
Of one hand (one or more metacarpals)	8%
Of one foot (one or more metacarpals)	8%
Of one rib	5%
Of any bone not specified above	3%
For complete dislocation	
Of the hip	42%
Of the knee (with open primary repair)	33%
Of the shoulder (with open reduction)	25%
Of the wrist	17%
Of the ankle	17%
Of the elbow	12%
Of the bones of foot, other than toes	8%

Severance of tendon or tendons	
Heel (achilles)	22%
Ankle	20%
Knee	18%
Foot (not toes)	17%
Elbow	17%
Wrist	12%
Hand (including fingers)	12%
Miscellaneous	
Ruptured kidney (operative)	27%
Ruptured liver (operative)	27%
Ruptured spleen (operative)	27%
Punctured lung with open surgery	23%
Burns requiring one or more skin grafts	22%
Knee injured and requiring surgery (when there is no fracture or dislocation)	22%
Bone operation, injured portion removed (when there is no fracture or dislocation)	20%

EMERGENCY TAXI AND AMBULANCE EXPENSES BENEFIT

If an Injury necessitates immediate medical attention, the Insurer will pay the reasonable expenses incurred for a licensed taxi or ambulance services to transport the Covered Person to either a Physician's office or the nearest Hospital, up to a maximum stated in the Benefits Schedule, as the result of any one accident.

TUITION FEES EXPENSES BENEFIT

If, within 30 days from the date of an Accident, an Injury totally confines the Covered Person to his Residence or Hospital for a period in excess of 40 continuous school days, the Insurer will pay the expenses incurred within 12 months, immediately following the date of the accident for the tuition services of a certified and qualified teacher other than a relative living in the same Residence, at a rate not to exceed $35 per hour. The maximum payable as the result of any-one accident will not exceed the maximum stated in the Benefits Schedule.

ACCIDENTAL MEDICAL EXPENSES BENEFIT

If as the result of an Injury the Covered Person incurs expenses beginning within 30 days after the date of the Accident for treatment by a legally qualified Physician, the Insurer will pay the expenses incurred, but not exceeding the reasonable, customary and prevailing charges in the geographic area concerned for necessary:

a) Physician, surgeon or anaesthetist fees;

b) care or services from a Hospital including x-rays and medicines (excluding any and/or all experimental medical treatments and any and/or all experimental drugs not approved by Drugs Directorate, Health Protection Branch of Health and Welfare Canada and any and/or all patent medicines);

c) services from a registered graduate nurse (R.N. or L.P.N.), (excluding any nurse who is employed or engaged by the Policyholder), not related to the Covered Person by blood or marriage, when recommended by a Physician, subject to a maximum of $5,000 per any one Accident;

d) professional ambulance service, or when recommended by a Physician, by any other conveyance licensed to transport passengers for hire to or from the nearest Hospital which is equipped to provide the required treatment, subject to a maximum of $1,000 per any one Accident;

e) services of a licensed physiotherapist or certified athletic sports therapist (excluding any licensed physiotherapist or certified athletic sports therapist employed or engaged by the Policyholder), when recommended by a Physician, subject to a maximum of $500 per any one Accident;

f) services of a licensed chiropractor (excluding any licensed chiropractor employed or engaged by the Policyholder), subject to a maximum of $500 per any one Accident;

g) rental of a wheel chair or other approved durable equipment for temporary therapeutic treatment, but not to exceed the purchase price prevailing at the time such necessary rental, subject to a maximum of $5,000 per any one Accident;

h) purchase of hearing aids, crutches, trusses, braces (excludes dental braces), casts and splints, but not including the cost of replacement, subject to a maximum of $750 per any one Policy period;

i) drugs or medicines prescribed in writing by a legally qualified Physician or legally qualified dentist, and dispensed by a registered pharmacist or Physician subject to a dispensing maximum of 30 day supply,

received by the Covered Person within the 52 week period immediately following the date of the Accident, but not to exceed, in total, the maximum amount stated in the Benefits Schedule for any one Accident.
Subject to the Conditions, Limitations and Exclusions of this Policy, it is agreed that all Covered Persons must be covered under a Provincial Government Health Insurance Plan to be eligible for this Benefit, and the Insurer's Liability in respect of benefits or expenses payable under this Benefit shall be in excess of benefits available to the Covered Person as "Insured Services" under any Legislative Act of a Canadian Province or Territory respecting insurance of residents against the cost of hospital or medical services, but only to the extent such excess costs are permitted to be paid by law.

Benefits paid under the Accidental Medical Expenses Benefit of the Policy are reduced by any amount paid or payable under any other policy providing similar reimbursement expense benefits.

ACCIDENTAL DENTAL EXPENSES BENEFIT

If as a result of an Injury:

(a) the Covered Person incurs expenses for accidental Injury to whole or sound teeth, including capped or crowned teeth; and

(b) requires treatment within 30 days and is incurred within 52 weeks of the date of the Accident, which is payable by the Covered Person, or the parent or guardian of the Covered Person, up to a maximum of the fee specified in the current Dental Fee Guide in the province in which the work is performed; except that for expenses incurred outside of Canada, the maximum will be based on the current Ontario Dental Association Fee Guide.

If, due to the age of the Covered Person, dental development is not sufficient to permit completion of treatment within 52 weeks from the date of the Accident, a report will be required from the attending dentist within 90 days of the date of the Accident, detailing pertinent facts as to the damage and the reasons precluding completion of the required treatment. Upon receipt of a satisfactory report and the completion of such treatment, the Insurer will pay the necessary dental expenses subject to the limits set out below.

(c) Provided always that if the Covered Person shall be entitled under any other contract to payment in whole or in part of such fees and charges, then this Insurer shall be liable only for the excess of such fees and charges, not exceeding in any event the maximum amount stated in the Benefits Schedule for any one Accident.

Benefits under the Accidental Dental Expenses Benefit of the Policy are reduced by any amount paid or payable under any other policy providing similar reimbursement expenses benefits.

EXCLUSIONS

The Insurer will not pay insurance benefits for any claim if the accident or loss arising out of bodily Injury is caused or resulted from:

1. intentional self-injury, suicide or any attempted suicide;

2. War, whether be declared or not or any act of war as defined below;

3. active participation in any acts of terrorism, riots of any kind (including civil commotions);

4. engaged in or taking part in any capacity in the armed forces services (air, land or sea) or its operations of any country or international authority;

5. injury sustained while a pilot or crew member of an aircraft (except as a result of being a passenger on any transport-type aircraft having a current and unrestricted airworthiness certificate and be operated by a duly licensed pilot);

6. injury sustained while on an aircraft owned or leased, by or on behalf of the Covered Person or the Policyholder, or any of the Policyholder's Affiliate or Subsidiary;

7. Acts of Terrorism which involve the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s).

Acts of Terrorism means any acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

War means civil war or commotion, insurrection, hostilities or warlike operations (whether war be declared or not), invasion, military or usurped power or martial law, rebellion or revolution.

ADDITIONAL EXCLUSION(S) AND/OR LIMITATION(S)

Any additional exclusion(s) and/or limitation(s) that apply to coverage under the Policy are shown in the Benefits Schedule under "Additional Exclusion(s) and/or Limitation(s)."

TERMINATION OF INSURANCE PROVISIONS

Date of Policy Termination
Termination takes effect at 11:59 P.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Insurer will be without prejudice to any claims originating prior to the date of termination.

The Policy automatically terminates on the earlier of:
1) The last day of the Period of Insurance shown in the Policy; or
2) The premium due date if the Policyholder fails to pay the required premium, subject to the policy grace period stated in the "Premium Provisions" of the Policy.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Insurer to terminate the Policy on the last day of the period for which premiums have been paid.

If the Policy is terminated due to non-payment of premium, it may be reinstated if mutually agreed, in writing, by the Policyholder and the Insurer. Reinstatement request must be made in writing to the Insurer within 60 days of the termination date. All required and due premiums must be paid prior to reinstatement.

The Policyholder or the Insurer may terminate the policy as of any premium due date or anniversary date of the policy by giving written notice to the other at least 60 days prior to such date, unless such longer notice period is required pursuant to applicable insurance regulations. Any premium rate guarantee will not affect the Policyholder's or the Insurer's right to terminate the Policy.

The Policyholder and the Insurer may terminate the Policy at any time by written mutual consent.

If premiums have been paid beyond the date of termination, the Insurer will compute and refund the unearned premium using the short rate table, or if premiums have been paid short of the date of termination, the Policyholder will remit the difference as advised to the Insurer.

Covered Person's Date of Termination
A Covered Person's coverage under the Policy ends on the earliest of:

1) The date the Policy terminates or insurance for a Class of Covered Eligible Persons' is terminated;
2) The date the Covered Person is on full-time active duty in the armed forces of any country or international authority;
3) The date the Covered Person ceases to be associated with the Policyholder in a capacity making such Covered Person eligible for insurance as described in the Policy, provided all required premiums are paid;
4) The last day of the last period for which premiums have been paid;
5) The date the Covered Person is no longer Actively at Work, provided all required premiums are paid, unless otherwise noted below;
6) The next premium due date after the date the Covered Employee is no longer in a Class of Covered Eligible Persons or satisfies the eligibility requirements under the Policy; or

7) The next premium due date after the Covered Employee attains the maximum Age for insurance under the Policy, as stated in the Benefits Schedule.

PREMIUM PROVISIONS

The Insurer provides insurance in return for payment of premiums. The premium stated in the Benefits Schedule is paid to the Insurer by the Policyholder in the manner stated in the Benefits Schedule and is based on rates currently in force, the plan, and the Volume of Insurance in force. Premium is due on the Effective Date of Policy and any subsequent policy anniversary date.

The Insurer requires the Policyholder to furnish an Employee Census. If at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit as of the next premium due date.

If any premium payment is not paid when due, the Policy will be terminated as of the premium due date except as stated under Policy Grace Period.

Premium Rate Changes

The Insurer may change the premium rate(s) periodically with at least 90 days advanced written or authorized electronic notice. No premium rate changes will be made until 12 months after the Effective Date of Policy. Increase in rate(s) will not be made more than once in a 12 month period. The Insurer, however, reserves the right to change rate(s) at any time, if any of the following events occur:

1) A change in the Policy terms.
2) An affiliated organization, division, subsidiary, or eligible class is added to or deleted from the Policy.
3) A change in any provincial or federal or local law, or regulation affecting the Policy and the Insurer's benefit obligation.
4) The number of Covered Persons eligible for coverage increases or decreases since the later of the Effective Date of Policy and the date of the last renewal of the Policy.
5) A change in the factors bearing on the risk assumed.
6) Coverage is reinstated following failure to pay premium during the Policy Grace Period.
7) A misrepresentation in the information relied on in establishing the rate for the Policy.
8) The Policyholder fails to provide sufficient information, as required by the Insurer, to confirm adequacy and accuracy of premiums and rates being paid.

If an increase or decrease in rates takes effect on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next premium due date.

Policy Grace Period
After payment of the first premium, the Policy will have a 31 day policy grace period. This means that if premium is not paid on or before the date it is due, the Policyholder has a 31 day policy grace period to pay. During this time, the Policy will stay in force provided the Policyholder pays all the premiums due by the last day of the policy grace period unless the Policyholder gives the Insurer written notice of the discontinuation of the coverage in advance of the date of discontinuation and in accordance with the terms of the Policy. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the policy grace period.

Policy Reinstatement
The Policy may be reinstated within 60 days of lapse if it has lapsed for non-payment of premium, if the Policyholder submits written application to the Insurer, the Insurer accepts the application and the Policyholder makes payment of all overdue premiums.

CLAIMS PROVISIONS

Notice of Claim: Written notice of claim, death or Injury must be given to the Insurer within 31 days after a Covered Loss begins. Failure to give notice within such time shall not invalidate nor reduce a claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably practicable. Notice can be given to the Insurer at the address stated in the Policy or such other place as the Insurer may designate for this purpose. Notice should include the Covered Person's name, address, Policyholder's name and Policy Number.

Claim Forms: When the Insurer receives a notice of claim, the Insurer will send forms for filing proof of loss. If claim forms are not sent within 30 days, the claimant will satisfy the requirements of written proof of loss by sending the written proof as shown below. Proof of loss must describe the occurrence, extent and nature of the loss.

Proof of Loss: Written proof of loss must be given to the Insurer within 90 days after the date of loss. If the proof of loss is not submitted within 90 day, it should be sent as soon as reasonably possible otherwise the claim may be reduced or invalidated. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

Such proof of loss includes but is not limited to the circumstances of the happening of the Accident or the commencement of the disability, and the loss occasioned thereby, the right of the claimant to receive payment, his age, and the age of the Beneficiary if relevant and may be required by the Insurer to furnish a satisfactory certificate as to the cause or nature of the Accident or disability for which claim may be made under the Policy and as to the duration of such disability.

Beneficiary: The beneficiary(ies) of a Covered Person shall be the person(s) designated in writing by the Covered Person on file with the Policyholder. Any Covered Person who has not made an irrevocable designation of beneficiary may designate a new beneficiary at any time by filing with the Policyholder a written request for such change, but such change shall become effective only on receipt of request. The change of beneficiary shall relate back and take effect on the date of execution of the written request, but without prejudice to the Insurer on account of any payment made by it.

Payment of Claims: The Insurer will pay a claim after receipt of acceptable proof of loss. Any payment made in good faith will discharge the Insurer's liability to the extent of the claim.

Benefits for Loss of Life are payable to the Covered Person's beneficiary. The designation will be as follows:

1) Beneficiaries designated in writing by the Covered Person for the Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any Group Life Insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) The Covered Person's estate.

All other claims will be paid to the Covered Person. If the Covered Person is a minor, incompetent or otherwise unable to give a valid release for the claim, the Insurer may make arrangement to pay claims to the Covered Person's legal guardian, committee or other qualified representative.

Recovery of overpayment: If benefits are overpaid, the Insurer will have the right to recover the amount overpaid by the following.

1) A request for lump sum payment of the amount overpaid; or
2) Offset or reduction of any proceeds payable under the Policy by the amount overpaid.

Time of Payment of Claims: Benefits for loss covered by the Policy, other than benefits that require periodic payment, will be paid not more than 60 days after the Insurer receive proper written proof of such loss. Benefits for loss covered by the Policy that require periodic payment shall be paid on a timely basis provided that the Insurer receives proper written proof of such loss.

Physical Examinations and Autopsy: The Insurer has the right to have a Physician of their choice examine the Covered Person as often as is reasonably necessary. This section is applicable when a claim is pending or while benefits are being paid. The Insurer has the right to also request an autopsy in the case of death, unless forbidden by law. The Insurer will pay for the cost of the examination or autopsy.

Subrogation: To the extent the Insurer pays for a loss suffered by a Covered Person, the Insurer will take over the rights and remedies the Covered Person had relating to the loss. This is known as subrogation. The Covered Person must help the Insurer to preserve the Insurer's rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Insurer may reasonably require. If the Insurer takes over the Covered Person's rights, the Covered Person must sign an appropriate subrogation form supplied by the Insurer. The Insurer has the right to offset future benefits payable to the Covered Person under the Policy against any such Recovery.

GENERAL POLICY PROVISIONS

Assignment:
The Policy is not assignable, whether by operation of law or otherwise. Benefits may be assigned. No assignment of interest in Loss of Life Benefit shall be binding on the Insurer until the original or duplicate thereof is received by the Insurer. The Insurer assumes no responsibility for the validity of this assignment.

Certificates of Insurance:
Where it is required by law, or on request of the Policyholder, the Insurer will make available to all Covered Persons booklets outlining the benefits, conditions, exclusions and limitations of the Policy.

Clerical Error:
Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Insurer, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Insurer and is rectified promptly upon discovery. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms. After an error is found, the Insurer will take appropriate action, which may include adjusting, collecting or refunding premium.

Conformity with Provincial or Territorial Laws:
Notwithstanding any other provision of the Policy, the Policy is subject to the statutory conditions of the provincial or territorial *Insurance Act* applicable to contracts of accident and sickness insurance for the Covered Person's province or territory of residence in Canada.

Currency:
Payments, reimbursements and amounts stated throughout the Policy are in the currency stated in the Benefits Schedule, unless otherwise stated.

Contract/Changes:
The Policy, including any amendments, endorsements and attached papers, the signed application of the Policyholder, the questionnaire of the Policyholder and any individual applications of Covered Persons is the entire contract between the Policyholder and the Insurer. A copy of the application, if any, of the Policyholder shall be attached to the Policy when issued. All statements made by the Policyholder or by a Covered Person are deemed representations and not warranties. No such statement will cause the Insurer to void the insurance under the Policy or be used as defense of a claim, unless it is contained in a written application.

Changes valid to the Policy may be made at any time by an amendment or endorsement signed by the Insurer, provided that any such amendment which reduces or eliminates coverage was either requested in writing by the Policyholder or signed by the Policyholder. The Insurer may also, on 60 days written notice to the Policyholder, change or modify the provisions of the Policy to comply with any applicable requirements of any provincial and/or territorial or federal law or regulation. No agent may change the Policy or waive any of its provisions.

Insolvency:
The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose on the Insurer any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make the Insurer liable to the creditors of the Policyholder, including Covered Persons under the Policy.

Incontestability:
Except for nonpayment of premiums, the Insurer will not contest the validity of a Covered Person's coverage after it has been in force for 2 years from its date of issue. No statement made by a Covered Person relating to his insurability shall be used to contest the validity of his insurance after the insurance has been in force for 2 years during his lifetime, exclusive of any period of disability; nor unless it is contained in a written application signed by him.

Legal Action:
No legal action may be brought to recover on the Policy until there has been full compliance with all the terms of the Policy. All Policy terms will be interpreted under the laws of the province or territory of Canada in which the Policy was issued. No legal action may be brought to recover on the Policy before 60 days following the date written Proof of Loss was given to the Insurer. No legal action may be brought against the Insurer more than 2 years after the time required for written Proof of Loss.

Misrepresentation and Fraud:
The entire Policy will be void, whether before or after a loss, if the Insurer determines that the Policyholder, Covered Person, or its agent has concealed or misrepresented any material fact or circumstance concerning the Policy, including any claim or any case of fraud by the Policyholder, Covered Person, Third Party Administrator, or other agent relating to the Policy.

Misstated Data:
The Insurer has relied on the underwriting information provided by the Policyholder, its Third Party Administrator, or other Agent in the issuance of the Policy. Should subsequent information become known which, if known prior to issuance of the Policy, would have affected the rates, terms, or conditions for coverage, the Insurer will have the right to revise the rates, terms, or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

Waiver:
Failure of the Insurer to strictly enforce its rights under the Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Insurer at any time under the same or different circumstances.

Workers' Compensation:
The Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits and does not satisfy any requirements for coverage by any Workers' Compensation Act or similar law.

CODE OF CONSUMER RIGHTS AND RESPONSIBILITIES

Insurers (including Lloyd's Underwriters), along with the brokers and agents who sell home, auto and business insurance are committed to safeguarding your rights both when you shop for insurance and when you submit a claim following a loss. Your rights include the right to be informed fully, to be treated fairly, to timely complaint resolution, and to privacy. These rights are grounded in the contract between you and your insurer and the insurance laws of your province. With rights, however, come responsibilities including, for example, the expectation that you will provide complete and accurate information to your insurer. Your policy outlines other important responsibilities. Insurers and their distribution networks, and governments also have important roles to play in ensuring that your rights are protected.

Right to Be Informed

You can expect to access clear information about your policy, your coverage, and the claims settlement process. You have the right to an easy-to-understand explanation of how insurance works and how it will meet your needs. You also have a right to know how insurers calculate price based on relevant facts. Under normal circumstances, insurers will advise an insurance customer or the customer's intermediary of changes to, or the cancellation of a policy within a reasonable prescribed period prior to the expiration of the policy, if the customer provides information required for determining renewal terms of the policy within the time prescribed, which could vary by province, but is usually 45 days prior to expiry of the policy.

You have the right to ask who is providing compensation to your broker or agent for the sale of your insurance. Your broker or agent will provide information detailing for you how he or she is paid, by whom, and in what ways.

You have a right to be told about insurers' compensation arrangements with their distribution networks. You have a right to ask the broker or agent with whom you deal for details of how and by whom it is being paid. Brokers and agents are committed to providing information relating to ownership, financing, and other relevant facts.

Responsibility to Ask Questions and Share Information

To safeguard your right to purchase appropriate coverage at a competitive price, you should ask questions about your policy so that you understand what it covers and what your obligations are under it. You can access information through one-on-one meetings with your broker or agent. You have the option to shop the marketplace for the combination of coverages and service levels that best suits your insurance needs. To maintain your protection against loss, you must promptly inform your broker or agent of any change in your circumstances.

Right to Complaint Resolution

Insurers, their brokers and agents are committed to high standards of customer service. If you have a complaint about the service you have received, you have a right to access Lloyd's Underwriters' complaint resolution process for Canada. Your agent or broker can provide you with information about how you can ensure that your complaint is heard and promptly handled. Consumers may also contact their respective provincial insurance regulator for information. Lloyd's is a member of an independent complaint resolution office, the General Insurance OmbudService.

Responsibility to Resolve Disputes

You should always enter into the dispute resolution process in good faith, provide required information in a timely manner, and remain open to recommendations made by independent observers as part of that process.

Right to Professional Service

You have the right to deal with insurance professionals who exhibit a high ethical standard, which includes acting with honesty, integrity, fairness and skill. Brokers and agents must exhibit extensive knowledge of the product, its coverages and its limitations in order to best serve you.

Right to Privacy

Because it is important for you to disclose any and all information required by an insurer to provide the insurance coverage that best suits you, you have the right to know that your information will be used for the purpose set out in the privacy statement made available to you by your broker, agent or insurance representative. This information will not be disclosed to anyone except as permitted by law. You should know that Lloyd's Underwriters are subject to Canada's privacy laws - with respect to their business in Canada.

LLOYD'S UNDERWRITERS' POLICYHOLDERS' COMPLAINT PROTOCOL

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

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

- Firstly, please contact the broker who arranged the insurance on your behalf about your concerns so that he or she may have the opportunity to help resolve the situation.
- If your broker is unable to help resolve your concerns, we ask that you provide us in writing an outline of your complaint along with the name of your broker and your policy number.

Please forward your complaint to:
Lloyd's Underwriters
Attention: Complaints Officer
1155 rue Metcalfe, Suite 2220, Montréal (Québec) H3B 2V6
Tel: 1.877.455.6937 Fax: 514.861.0470
E-mail: info@lloyds.ca

Your complaint will be directed to the appropriate business contact for handling. They will write to you within two business days to acknowledge receipt of your complaint and to let you know when you can expect a full response. If need be, we will also engage internal staff in Lloyd's Policyholder and Market Assistance Department in London, England, who will respond directly to you, and in the last stages, they will issue a final letter of position on your complaint.

In the event that your concerns are still not addressed to your satisfaction, you have the right to continue your pursuit to have your complaint reviewed by the following organizations:
General Insurance OmbudService (GIO) assists in the resolution of conflicts between insurance customers and their insurance companies. The GIO can be reached at:
Toll free number: 1.877.225.0446
www.giocanada.org

For Quebec clients:
Autorité des marchés financiers (AMF). The regulation of insurance companies in Québec is administered by the AMF. If you remain dissatisfied with the manner in which your complaint has been handled, or with the results of the complaint protocol, you may send your complaint to the AMF who will study your file

and who may recommend mediation, if it deems this action appropriate and if both parties agree to it. The AMF can be reached at :
Québec: 418.525.0337
Montréal 514.395-0311
Toll-free: 1-877.525.0337
www.lautorite.qc.ca

If you have a complaint specifically about Lloyd's Underwriters' complaints handling procedures, you may contact the Financial Consumer Agency of Canada (FCAC).
Financial Consumer Agency of Canada (FCAC) provides consumers with accurate and objective information about financial products and services, and informs Canadians of their rights and responsibilities when dealing with financial institutions. FCAC also ensures compliance with the federal consumer protection laws that apply to banks and federally incorporated trust, loan and insurance companies. The FCAC does not get involved in individual disputes. The FCAC can be reached at :

427 Laurier Avenue West, 6th Floor, Ottawa, ON K1R 1B9
Services in English : 1.866.461.FCAC (3222)
Services in French : 1.866.461.ACFC (2232)
www.fcac-acfc.gc.ca

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PRIVACY: NOTICE CONCERNING PERSONAL INFORMATION

Who we are

We are the Lloyd's underwriter(s) identified in the insurance contract and/or the certificate of insurance. Your privacy is important to us. This privacy notice explains what personal information we collect, use and disclose about policyholders, beneficiaries, claimants and witnesses and for what purposes, in compliance with applicable Canadian privacy laws.

What personal information we collect

Personal information is any information about an identified and or identifiable individual. The personal information that is collected for a clear and legitimate use and disclosure generally includes the following:

- Identification and contact information (name, address including postal code, country, telephone number, email address, month and date of birth, drivers licence, employer, job title, employment history, family details)
- Policy information (policy number, policy amounts, policy terms)
- Claim information (claim number, information relating to a potential or existing claim)
- Payment information (credit card details, bank account details, credit score)
- Other information related to your insurance cover or a claim only for legitimate business purposes

We also collect information about you when you visit www.lloyds.com. Further details can be found on our online Privacy & Cookies policy at http://www.lloyds.com/common/privacy-and-cookies-statement.

We will not use your personal information for marketing purposes and we will not sell your personal information to other parties.

How we use your information

By purchasing insurance from certain Lloyd's Underwriters ("Lloyd's"), a customer provides Lloyd's with his or her explicit consent to the collection, use and disclosure of personal information. Meaningful consent is subject to the customer's understanding of the nature, purpose and consequences of the collection, use or disclosure of their personal information.

Information is generally collected, used, disclosed and stored in order to provide you with the insurance products that you have requested, including to:

- Identify you and provide you with insurance cover
- Communicate with Lloyd's policyholders
- Calculate, collect or refund premiums
- Underwrite policies and facilitate policy administration
- Evaluate and process claims
- Detect and prevent fraud, carry out anti-money laundering and sanction checks
- Investigate and prosecute fraud
- Meet our regulatory and other legal obligations

- Enforce terms or exercise rights under the insurance contract
- Analyze insurance risk and business results
- Improve our services and offerings
- Provide general client care
- Defend or prosecute legal claims
- Renew your insurance policy
- Transfer of books of business, company sales and reorganisations

Or as may be otherwise required or authorized by law.

Your information may be shared and disclosed

In order to fulfil the purposes described in this Privacy notice, we may share your personal information with other third parties that we have engaged to provide services on our behalf, or who otherwise assist us in providing you with services, such as affiliated organizations, sub-contractors, agents/coverholders, legal counsel, insurers, brokers, reinsurers, loss adjusters and other service providers.

We will limit this disclosure to only the Personal Information that is reasonably necessary for the purpose or service for which the third party or affiliate will provide. We will use contractual and other means to provide a comparable level of protection while the information is being processed by these service providers, including limiting such service providers to using your Personal Information solely to provide Lloyd's with the specific service for which they were engaged, and for no other purpose. You can obtain more information about our policies and practices with respect to the use of Personal Information by Third Party Service Providers by contacting us as described below, under the section "How to Contact Us" at the end of this document.

Some of these entities may be located outside of Canada, therefore your information may be processed in a foreign jurisdiction, where it will be subject to the laws of that jurisdiction, which may be different than the laws in your province. Personal information that is stores or processed outside of Canada may also be accessible to the law enforcement and national security authorities of that jurisdiction.

We may also share or transfer your Personal Information where reasonably required in the context of a sale, merger or amalgamation of all or part of our business or the insurance or securitization of our assets. In any such case, the recipient parties will be contractually required to keep the information confidential and use it only for the purposes of the transaction, or proposed transaction, in question. In the event a business transaction is affected, assignees or successors of Lloyd's or our business or assets, or those of our affiliated entities, may use and disclose Personal Information only for the purposes as set out in this Privacy notice, unless further consent is obtained.

We may also share your Personal Information with law enforcement, national security agencies or other governmental officials as required or permitted by law, such as in response to a court order or a verified request relating to a criminal investigation or alleged illegal activity, where we are legally obligated to contribute information to compulsory insurance databases, or where required to detect, prevent or prosecute fraud.

Authority to collect, use and disclose personal information

When you share information with us for particular purposes, such as providing you with insurance, you give us explicit consent to collect, use and disclose your information for those purposes. Canadian law also authorizes us to collect, use and disclose personal information without consent in certain circumstances prescribed by law, which may include the following:

- Detecting or suppressing fraud
- Investigating or preventing financial abuse
- For communication with the next to kin or authorized representative of an injured, ill or deceased individual
- Investigating a breach of an agreement or a contravention of the laws of Canada or a foreign jurisdiction where obtaining consent would compromise the availability or accuracy of the information
- Witness statement necessary to assess, process or settle insurance claims
- Information that is produced in the course of an individual's employment, business or profession

There may be situations where we need your additional consent to collect, use, and disclose information about you. In those situations, we will ask you for consent separately. You do not have to give your consent and, subject to legal and contractual restrictions, you can withdraw your consent to us collecting, using and disclosing your information at any time. However, withdrawing your consent may affect our ability to provide you with insurance cover or other services.

Retention and security

We retain personal information for as long as necessary to provide you with insurance cover and meet the other purposes for collection, use and disclosure described in this Privacy notice, or as otherwise required or permitted by law, When your Personal information is no longer required, we will make all reasonable efforts to ensure all electronic and hard copies of such information are securely destroyed and irreversibly deleted from our systems.

We use various physical, technical and administrative security measures, appropriate to the sensitivity of the personal information, that are designed to protect against loss, theft, unauthorized access, disclosure, copying, use or modification by. Although we will take reasonable measures to protect personal information, the transmission of information through the internet or other electronic means is not guaranteed to be secure and may create risks for the privacy and security of your information.

How to access your personal information

Subject to certain exceptions provided by applicable law, you have the right to access your personal information, request corrections about your personal information if you identify any inaccuracies, and request that we delete your information. If you would like to exercise any of these rights, please contact the Ombudsperson at info@lloyds.ca.

The Ombudsperson can also provide additional information about Lloyd's policies and practices, answer questions about the collection, use, disclosure or storage of personal information by Lloyd's and its service providers located outside of Canada, as well as discuss any complaints you may have regarding collection, use and disclosure of your personal information.

Changes

We may amend this Privacy notice from time to time as our business evolves, in response to legal developments, as new technologies become available, or as we introduce new features, products or services.

When we make changes to wording of this Privacy notice we will revise the "last updated" date at the bottom of this Privacy notice. You should check back here periodically to find out if any changes have been made to this Privacy notice. If we make substantial changes we will, as appropriate prominently post these changes to our Site or notify registered Users directly.

How to contact us

Further information about Lloyd's personal information protection policy may be obtained by visiting https://www.lloyds.com/lloyds-around-the-world/americas/canada/market-conduct from your broker, or by contacting Lloyd's by phone: 514 861 8361, 1 877 455 6937, or email info@lloyds.ca.

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SEVERAL LIABILITY NOTICE

The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.

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SANCTION LIMITATION AND EXCLUSION CLAUSE

No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

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15 September 2010