Helping protect you, your family and your finances

For more than 65 years, Alberta Medical Association members have benefited from our highly competitive group insurance plans, administered by AMA's ADIUM Insurance Services Inc. By purchasing insurance through ADIUM you can obtain coverage at a lower rate than you probably would if you applied as an individual.

With AMA group insurance plans you benefit from:

- the power of volume purchasing which results in highly competitive group insurance rates
- AMA Premium Credit™
- third-party administration by ADIUM
- no built-in sales commissions
- well-designed medical underwriting processes that ensure good risk selection and a favourable claims experience from a physicians only risk

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AMA Premium Credit™

For the 15th consecutive year we are offering premium credits to AMA members on our Disability, Professional Overhead Expense and Term Life Insurance plans. Under a financial model called “refund accounting” the insurance company returns excess premiums to AMA members.

Disability Insurance – 5% off our published rates
Professional Overhead Expense – 5% off our published rates
Term Life Insurance – 25% off our published rates

Please note that the insurance rate schedules in this brochure are before the 2019 credits. Rates and premium credits are not guaranteed.

30-day money back guarantee:
You may cancel your coverage at any time. If you decide to cancel your coverage within 30 days, your premiums will be refunded.

Exclusive to AMA members who are:
- in good standing with the AMA or Northwest Territories Medical Association (NWTMA);
- Canadian residents at time of application.
Protection for yourself and your family at a glance

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Disability insurance</th>
<th>Professional overhead expense insurance</th>
<th>Term life insurance</th>
<th>Critical illness insurance</th>
<th>Accidental death &amp; dismemberment insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 65</td>
<td>Under age 65</td>
<td>Under age 75</td>
<td>Under age 65</td>
<td>Under age 65</td>
<td>Under age 75</td>
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<td>Practice requirements to apply</td>
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<td>Actively practicing full-time¹</td>
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<td>N/A</td>
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<td>Portability²</td>
<td>Worldwide</td>
<td>Worldwide</td>
<td>Worldwide</td>
<td>Worldwide, prior approval for outside Canada and the United States</td>
<td>Worldwide</td>
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<td>Yes</td>
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<td>Spousal coverage available</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>via Member/Family plan</td>
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<tr>
<td>Proof of good health required</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td>Termination age</td>
<td>70, or retirement if earlier</td>
<td>80, or retirement if earlier</td>
<td>75</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

¹ Average of 25 hours per week, 42 weeks per year.
²AMA non-resident membership is required if residing outside of Alberta.

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

Disability, Professional Overhead Expense, Term Life and Critical Illness insurance are underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial Group of Companies. Accidental Death and Dismemberment is underwritten by Industrial Alliance Insurance and Financial Services.
Disability Insurance

Disability Insurance (DI) is a smart way to protect your lifestyle today and your plans for tomorrow. If an accident or illness prevents you from working, the plan provides a monthly income benefit that helps you pay for everyday expenses and avoid using your retirement savings.

Coverage:
- Monthly benefit at a minimum of $500 and a maximum of $25,000 per $100 unit.
- Your maximum coverage depends on your income (see Income/benefit guide on next page).
- Proof of earned income is required at time of application. However, if you’re in your first two years of medical practice, you may purchase up to $7,000/month (family physician) or $10,000/month (specialist), including coverage from all other sources, without providing proof of earned income.

Elimination Period
- Number of days you are disabled before payments begin.
- You may choose a 30, 60, 90 or 120-day elimination period, or a combination of the periods.
- The elimination period may be satisfied with intermittent periods of disability from the same cause accumulated:
  - within six months for the 30, 60 and 90-day elimination periods; and
  - within nine months for the 120-day elimination period.

Benefit Period
- The maximum benefit period for continuing total and residual disabilities commencing before age 63 is 65 years of age.
- The maximum benefit period for continuing total and residual disabilities commencing at or after age 63 and prior to age 70 is 24 months.

Total disability
- means you are unable, due to sickness or injury, to perform the essential duties of your regular occupation, under the regular care of a physician, and not engaged in any other gainful occupation.

Residual disability
- means you are not totally disabled, but as a result of sickness or injury you are under the regular care of a Physician, you have a loss of income of at least 20% and are either able to perform one or more duties of your regular occupation or engaged in another occupation. For your first six months of residual disability you will receive a minimum monthly benefit of 50% of your monthly disability insurance benefit. Thereafter, your residual disability benefit will be based on your actual loss of income.
# Income / benefit guide

Based on your net income\(^3\), the maximum monthly benefit for combined coverage under this plan and any other disability insurance plans is as follows:

<table>
<thead>
<tr>
<th>Annual Earned Income</th>
<th>Benefit Amount</th>
<th>Annual Earned Income</th>
<th>Benefit Amount</th>
<th>Annual Earned Income</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$60,000 to 62,499</td>
<td>$3,500</td>
<td>$240,000 to 249,999</td>
<td>$9,700</td>
<td>$570,000 to 579,999</td>
<td>$17,800</td>
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<td>62,500 to 64,999</td>
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<td>10,000</td>
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<td>18,100</td>
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<tr>
<td>65,000 to 68,332</td>
<td>3,800</td>
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<td>590,000 to 599,999</td>
<td>18,300</td>
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<tr>
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<td>18,600</td>
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<tr>
<td>70,000 to 72,499</td>
<td>4,000</td>
<td>280,000 to 289,999</td>
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<td>610,000 to 619,999</td>
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<td>72,500 to 74,999</td>
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<td>290,000 to 299,999</td>
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<tr>
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<tr>
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<td>540,000 to 553,332</td>
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<td>24,600</td>
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<tr>
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<td>880,000 to 889,999</td>
<td>24,800</td>
</tr>
<tr>
<td>231,250 to 239,999</td>
<td>9,500</td>
<td>560,000 to 569,999</td>
<td>17,600</td>
<td>890,000 +</td>
<td>25,000</td>
</tr>
</tbody>
</table>

\(^3\)Gross income less business expenses, but before income taxes.
Extra advantages

✔ Guaranteed acceptance

The first $1,500 of monthly disability coverage will be issued without medical evidence of insurability (and with a 90-day elimination period), if you are within your first six months of full-time practice in Alberta and are under age 65. A pre-existing condition limitation applies during the first 24 months that coverage is in effect. This means that no claims as a result of a pre-existing condition will be paid. If applying for coverage above this monthly benefit amount, you must provide medical evidence of insurability.

✔ Waiver of premium

If you are disabled for a continuous period of at least 90 consecutive days and are in receipt of disability benefits, the insurer will waive your premiums from the first day of the month following the date you became disabled.

✔ Survivor benefit

If you die during a period of total or residual disability (following the elimination period), your estate will receive a payment equal to three times your last month’s disability benefit.

✔ Transplant Donor or Cosmetic Surgery

If you become totally disabled as a result of cosmetic surgery or the transplant of a part of your body to the body of another, you may be entitled to benefits under the plan, if:

- your coverage has been in-force for at least six months;
- you have completed the elimination period; and
- for cosmetic or transplant surgery, you have been continuously totally disabled for at least 30 days.

✔ HIV/Hepatitis B/C Positive benefit

If you test positive for HIV or are determined to be a carrier of the Hepatitis B or C virus and are in an asymptomatic infectious state, you may be eligible for residual disability benefits, even if you are not disabled as defined in the plan. Residual disability benefits will be payable if you are under age 65 and you incur a loss of monthly earned income of at least 20% for the period before the date the condition was diagnosed as a consequence of:

- being required to disclose your condition to your patients by regulations approved by an appropriate government authority, hospital board, applicable medical regulatory body or licensing authority; or
- limiting of your practice of medicine by regulations approved by an appropriate government authority, hospital board, applicable medical regulatory body or licensing authority.
Guaranteed Insurability Benefit (GIB)

GIB protects your ability to obtain additional coverage in the future regardless of changes in your health. Allowing you to purchase additional DI without having to provide medical evidence of insurability (based on income qualification levels – see the Income/benefit guide). If you are age 55 or under on January 1st immediately preceding the Option Period, and have sufficient income to warrant the increase, you may purchase a monthly benefit of up to $2,500 of additional coverage at each option period, in multiples of $100, subject to our maximum issue limit.

Cost of Living Adjustment (COLA)

COLA helps you keep up with the pace of inflation by increasing your monthly benefit according to the Alberta Consumer Price Index once you have been totally or residually disabled for 12 consecutive months. The increase is subject to an annual maximum of six per cent and continues each year you remain disabled until you reach age 65.

Own Occupation

Since a return to work might not necessarily mean a return to your former level of income, Own Occupation protects your earning power. With this benefit, you are considered to be totally disabled from your regular occupation and entitled to disability benefits – even if you return to work performing different duties or find work in another field. This benefit ends once you reach age 65, at which time the condition that you must not be “engaged in any other gainful occupation” is once again applied to the definition of total disability.
Retirement Protection

During a period of total disability, it might be difficult to continue contributing to your RRSP or other investments while trying to manage the expenses of day-to-day living. Retirement Protection helps keep your retirement plan on track by providing a monthly contribution to an investment account beginning after 90 consecutive days of total disability and continuing for each month you remain totally disabled, up to age 65. If your annual earned income net of expenses is:

- less than $100,000 your monthly benefit amount is $500; or
- greater than $100,000 you may choose a monthly benefit of either $500 or $1,000.

You must be under the age of 55 to apply for this rider.
## Disability Rates

Monthly premium per $100 of monthly benefits before the AMA Premium Credit™ is applied.

<table>
<thead>
<tr>
<th>Male</th>
<th>Non-smoker - Elimination period</th>
<th>Smoker - Elimination period</th>
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</thead>
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<tr>
<td>Age</td>
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<tr>
<td>40 - 44</td>
<td>1.99</td>
<td>1.59</td>
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<tr>
<td>45 - 49</td>
<td>2.34</td>
<td>1.87</td>
</tr>
<tr>
<td>50 - 54</td>
<td>2.92</td>
<td>2.33</td>
</tr>
<tr>
<td>55 - 59</td>
<td>3.33</td>
<td>2.67</td>
</tr>
<tr>
<td>60 - 64</td>
<td>3.86</td>
<td>3.09</td>
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<tr>
<td>65 - 69**</td>
<td>2.29</td>
<td>1.95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female</th>
<th>Non-smoker - Elimination period</th>
<th>Smoker - Elimination period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>30 Days</td>
<td>60 Days</td>
</tr>
<tr>
<td>Under 35</td>
<td>$2.04</td>
<td>$1.63</td>
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<tr>
<td>35 - 39</td>
<td>3.24</td>
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<tr>
<td>40 - 44</td>
<td>3.85</td>
<td>3.08</td>
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<td>45 - 49</td>
<td>4.53</td>
<td>3.62</td>
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<tr>
<td>50 - 54</td>
<td>4.96</td>
<td>3.97</td>
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<tr>
<td>55 - 59</td>
<td>5.21</td>
<td>4.17</td>
</tr>
<tr>
<td>60 - 64</td>
<td>5.75</td>
<td>4.60</td>
</tr>
<tr>
<td>65 - 69**</td>
<td>3.41</td>
<td>2.90</td>
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</table>

### Optional Riders

<table>
<thead>
<tr>
<th>Optional Riders Attained age</th>
<th>Cost of Living Adjustment (COLA) as a percentage of basic DI annual premium</th>
<th>Own Occupation premium as a percentage of basic DI annual premium</th>
<th>Guaranteed Insurability Benefit (GIB) Monthly premium</th>
<th>Retirement Protection Monthly premium per $500 of monthly benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 35</td>
<td>15%</td>
<td>15%</td>
<td>$6.67</td>
<td>$5.42</td>
</tr>
<tr>
<td>35 - 39</td>
<td>20%</td>
<td>15%</td>
<td>$6.67</td>
<td>7.92</td>
</tr>
<tr>
<td>40 - 44</td>
<td>20%</td>
<td>15%</td>
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<td>45 - 49</td>
<td>20%</td>
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<td>50 - 54</td>
<td>20%</td>
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<td>55 - 59</td>
<td>15%</td>
<td>15%</td>
<td>–</td>
<td>12.92</td>
</tr>
<tr>
<td>60 - 64</td>
<td>15%</td>
<td>15%</td>
<td>–</td>
<td>12.92</td>
</tr>
<tr>
<td>65 - 69**</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

**Renewal rates only.

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

The complete terms and conditions governing the insurance coverage are found in the group insurance policy issued to the Alberta Medical Association by Sun Life Assurance Company of Canada (a member of the Sun Life Financial group of companies).
Exclusions and limitations
No benefits are payable for any disability:

- resulting from an act of war;
- resulting from voluntary participation in a riot or act of civil disobedience;
- resulting from injuries sustained or sickness contracted while in the military service of any country at war, whether such war be declared or undeclared;
- resulting from normal pregnancy and/or childbirth; or
- during any period of imprisonment or confinement in a similar institution.
- Your monthly disability benefit may be reduced by any other disability benefits that you may receive or be entitled to receive from any individual insurance issued after the effective date of your insurance under this policy. Please contact ADIUM for further information on this provision.

When Coverage ends
Your Disability Insurance coverage ends:

- on the policy anniversary date following termination of your membership in the AMA (or NWTMA);
- on the policy anniversary date following your 70th birthday;
- on the first of the month following receipt by the AMA of your written request to terminate coverage;
- on the date of your retirement;
- on the date of your death;
- for failure to pay your premiums, subject to the grace period of 31 days;
- when you are 65 years old if your benefits were received until age 65 or the date you have received 24 months of benefits, if such date is beyond your 65th birthday; or
- the date the group policy is terminated by the AMA;
Professional Overhead Expense Insurance

It’s taken countless hours, tireless dedication and true commitment to build a thriving practice. Your patients and your family have come to rely on you to maintain its successful operation. If a serious illness or injury prevents you from being there, Professional Overhead Expense (POE) Insurance helps keep things running by providing a vital monthly reimbursement benefit to help cover your expenses and protect your business assets.

Coverage:
- Monthly benefit at a minimum of $500 and a maximum of $20,000 per $100 unit.
- Evidence of insurability and income is required for all coverage amounts for which you apply.

Elimination Period
- Number of days you need to be totally disabled before payments begin
- You may choose a 14-day or 30-day elimination period, or a combination of these periods. (Monthly benefits in excess of $7,000 must have a 30-day elimination period.)

Benefit Period
- If you become partially or totally disabled prior to age 70, benefits are payable until the earlier of:
  - 36 months following completion of the elimination period; or
  - 12 times the monthly benefit is paid.
- If you become partially or totally disabled after age 70, benefits are payable for up to 12 months following completion of the elimination period.

Total disability
- means you are unable, due to sickness or injury, to perform the essential duties of your regular occupation, under the regular care of a physician, and not engaged in any other gainful occupation.

Partial Disability:
- means that the insured member is not totally disabled but that as a result of sickness or injury he is under the regular care of a physician and has a loss of Earned income of at least 20% of his average monthly earned income and is either:
  a) able to perform one or more duties of his regular occupation; or
  b) engaged in another occupation.

### Eligible expenses
- rent or mortgage interest
- heat, water and electricity
- interest on business loans made for office equipment or automobile
- telephone and postage
- business laundry
- employee salaries
- accounting services
- property taxes/business taxes
- lease payments (equipment and automobile)
- depreciation of scheduled principal payments on office equipment for business use of automobile
- premiums for insurance and benefit coverage for employees
- professional association membership dues
- student loan interest

### Ineligible expenses
- salaries and other remuneration paid to yourself or to members of your profession
- salaries and other remuneration paid to persons hired to perform your duties
- salaries paid to family members other than salaries paid prior to your disability
- meals, entertainment and promotional expenses
- travelling expenses
- the cost of goods, wares or merchandise including medical supplies
- the cost of implements used in your profession
- any other expenses that would not normally be incurred when you are disabled
- income taxes for you or your employees
Extra advantages

✔ Parental benefit

No matter how dedicated you are to your practice, you’ll want to be there to welcome a new addition to your family and enjoy those first moments of discovery. The POE plan may provide up to 15 consecutive weeks of benefit reimbursement for parental leave (following a waiting period of two weeks), subject to the following conditions:

- You must be enrolled in the POE plan for at least 12 months prior to the date of birth of your child or the date of placement of your child in the case of an adoption.
- You must be the biological or adoptive parent of the child.
- Benefits are payable under this feature no earlier than eight weeks before the expected date of delivery or date of placement, ending no later than 17 weeks after delivery or date of placement.
- Benefits will be the lesser of:
  - 50% of the monthly benefit; and
  - the current employment insurance (EI) monthly benefit.
- The benefit will not exceed the amount of covered monthly overhead expenses actually incurred by you.
- The benefit is designed only for adoptions and non-complicated pregnancies – if you have a disability during or after pregnancy, be it pregnancy related or not, benefits will be paid as provided under the partial or total disability benefit provisions.
- Benefits will be paid only if you are on full-time leave from your practice during the period for which benefits are claimed (no partial disability benefits will be paid).
- The rate and duration of the benefit does not change in the event of multiple births or adoptions of more than one child.

✔ Recovery benefit

If, after six months of receiving disability benefits, you return to your regular occupation, you may receive up to 50% of your previous month’s benefit during your first month of full-time practice.

✔ Recurrent disability benefit

If you suffer a total or partial disability from the same cause, within six months following the termination of a previous period of benefit payments, benefits will resume without having to re-satisfy the elimination period.

✔ Cosmetic and transplant benefit

If you become totally disabled as a result of cosmetic surgery or the transplant of a part of your body to the body of another, you may be entitled to benefits under the plan, if:

- your coverage has been in-force for at least six months;
- you have completed the elimination period; and
- for cosmetic surgery, you have been continuously totally disabled for at least 30 days.
Waiver of premium

If you are disabled for a continuous period of at least 90 consecutive days and are in receipt of disability benefits, the insurer will waive the premiums from the first day of the month following the date you became disabled.

You can purchase an optional rider for your POE coverage

Guaranteed Insurability Benefit (GIB)

This rider allows you to purchase additional POE coverage in the future without having to provide medical evidence of insurability, provided your expenses qualify you for the additional coverage.

You have the opportunity to exercise this option from April 1st to April 30th each year or 60 days following the successful completion of a medical residency program. Each year you may increase your professional overhead coverage in increments of $100 to a maximum monthly benefit of $1,000. If you are under age 40, and have sufficient expenses to warrant the increase, you may purchase up to $2,000 of additional coverage at each option period. Increases are subject to the maximum issue limit. This rider terminates at age 60.

Professional Overhead Expense Rates

Monthly premium per $100 of monthly benefits before the AMA Premium Credit™ is applied.

<table>
<thead>
<tr>
<th>Age</th>
<th>14-day waiting period</th>
<th>30-day waiting period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Non-smoker</td>
<td>Smoker</td>
</tr>
<tr>
<td>Under 39</td>
<td>$1.00</td>
<td>$1.16</td>
</tr>
<tr>
<td>40-44</td>
<td>1.24</td>
<td>1.40</td>
</tr>
<tr>
<td>45-49</td>
<td>1.72</td>
<td>1.88</td>
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<tr>
<td>50-54</td>
<td>2.15</td>
<td>2.39</td>
</tr>
<tr>
<td>55-59</td>
<td>2.15</td>
<td>2.39</td>
</tr>
<tr>
<td>60-64</td>
<td>2.51</td>
<td>2.85</td>
</tr>
<tr>
<td>65-69</td>
<td>2.79</td>
<td>3.19</td>
</tr>
<tr>
<td>70-74</td>
<td>4.00</td>
<td>4.57</td>
</tr>
<tr>
<td>75-79**</td>
<td>5.90</td>
<td>6.75</td>
</tr>
</tbody>
</table>

Guaranteed Insurability Benefit (GIB) rider

Monthly premium $3.33

**Renewal rates only.
GIB premium is $40 each year until you have reached age 60.

These figures represent the monthly rates of the Professional Overhead Expense insurance plan. Rates are yearly renewable and not guaranteed. Rates are calculated based on your age, gender and smoking status as of January 1st of each year and will increase as you move into the next age band.

The complete terms and conditions governing the insurance coverage are found in the group insurance policy issued to the Alberta Medical Association by Sun Life Assurance Company of Canada (a member of the Sun Life Financial group of companies).
Exclusions and limitations
No benefits are payable for any disability:
- resulting from an act of war;
- resulting from injuries sustained or sickness contracted while in the military service of any country at war, whether such war be declared or undeclared;
- resulting from normal pregnancy and/or childbirth, except as permitted under the parental benefit; or
- during any period of imprisonment or confinement in a similar institution.
- In no event will the benefits paid exceed the average monthly amount of covered monthly overhead expenses incurred during the six months preceding your disability.

When Coverage ends
Your Professional Office Overhead insurance coverage ends:
- on the policy anniversary date following termination of your membership in the AMA or NWTMA;
- on the policy anniversary date following your 80th birthday;
- on the first of the month following receipt by the AMA of your written request to terminate coverage;
- on the date of your retirement;
- on the date of your death;
- for failure to pay your premiums, subject to the grace period of 31 days, or
- the date the group policy is terminated by the AMA;
Life insurance is important to help protect the financial security of your loved ones. Consider how your family would be affected if you passed away and you could no longer care for them. Would they be able to pay the mortgage or would they have to sell the family home? Could they cover childcare expenses? Would they need to withdraw from their savings or take out a loan to pay expenses? Planning ahead will allow your family to continue to enjoy their current lifestyle and move forward with their life goals.

**Term Life can help you cover:**
- mortgage and other personal debt;
- funeral and other expenses;
- children’s education needs;
- replacing your income for surviving family;
- income taxes that may be payable at your death; and
- business debt or partnership insurance.

**Coverage:**
- You or your spouse may apply for up to $5,000,000 in coverage, in $50,000 units.
- Evidence of insurability is required for all coverage amounts for which you apply.

**Extra advantages**

- **Conversion privilege**
  You are entitled to convert your AMA term life insurance to an individual policy through Sun Life Financial, provided you do so before reaching age 70. To find out more about your conversion options, please speak with an ADIUM advisor.

- **Living benefit**
  The living benefit permits an insured, with a terminal illness that is expected to lead to death within one year, to access up to $200,000 of his/her death benefit to use at his/her discretion.

- **Preferred underwriting**
  If you and your spouse are healthier, low risk individuals who apply for at least $250,000 of coverage, you are automatically considered for preferred or elite rates when you apply. Through the medical underwriting process, Sun Life Financial will examine key factors such as: tobacco use, cholesterol level, blood pressure, personal and family medical history, driving record, physical build, recreational activities to assess which underwriting class you’ll qualify for.
You can purchase these optional riders for your Term Life coverage

**Future Insurance Option (FIO)**

For an additional cost you may add this rider to you or your spouse’s base term life insurance coverage if you are under age 56. It allows you to obtain additional insurance at a later date even if you become uninsurable for medical reasons. You may increase coverage without medical evidence if you apply within 60 days of one of the following events:

- marriage or eligible common-law relationship;
- birth or legal adoption of a child; or
- attainment of age 25, 30, 35, 40, 45, 50 or 55.

At each option date you are eligible to apply for $50,000 of coverage, subject to the overall plan maximum. To apply for additional coverage under this rider, you must be actively at work at time of application. If you are not actively at work when an option date occurs you cannot exercise your option unless you are on parental leave or approved leave of absence and submit written application for insurance coverage under this rider within 60 days of such option date. This rider requires medical underwriting.

**Waiver of Premium**

For an additional cost you may add this rider to your term life insurance coverage. You will not have to pay any premium for your life coverage should you become totally disabled for 3 consecutive months before age 65. This benefit will apply for as long as you continue to be totally disabled and will end on the premium due date that coincides with, or immediately follows, your 75th birthday. You are considered to be totally disabled if you are unable to perform the substantial material duties of your regular occupation as a result of sickness or injury while under the regular care of a physician and are not engaged in any other gainful occupation. This rider requires medical underwriting. Waiver of Premium can also be applied to spouse coverage.

**Term Life Insurance Rates**

Monthly premium per $50,000 benefit before the AMA Premium Credit™ is applied.

<table>
<thead>
<tr>
<th>Age</th>
<th>Standard rate</th>
<th>Preferred rate</th>
<th>Elite rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male Non-smoker</td>
<td>Male Smoker</td>
<td>Male Non-smoker</td>
</tr>
<tr>
<td>Under 25</td>
<td>$1.27</td>
<td>$2.21</td>
<td>$0.67</td>
</tr>
<tr>
<td>25 - 29</td>
<td>1.39</td>
<td>2.49</td>
<td>0.79</td>
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<tr>
<td>30 - 34</td>
<td>1.64</td>
<td>3.71</td>
<td>1.33</td>
</tr>
<tr>
<td>35 - 39</td>
<td>2.12</td>
<td>6.09</td>
<td>1.58</td>
</tr>
<tr>
<td>40 - 44</td>
<td>2.80</td>
<td>8.48</td>
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<td>45 - 49</td>
<td>4.00</td>
<td>10.55</td>
<td>2.60</td>
</tr>
<tr>
<td>50 - 54</td>
<td>6.03</td>
<td>22.80</td>
<td>4.46</td>
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<tr>
<td>55 - 59</td>
<td>10.97</td>
<td>32.49</td>
<td>7.52</td>
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<tr>
<td>60 - 64</td>
<td>20.23</td>
<td>42.82</td>
<td>13.75</td>
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<tr>
<td>65 - 69</td>
<td>30.83</td>
<td>54.22</td>
<td>14.60</td>
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<td>70 - 74</td>
<td>64.62</td>
<td>113.86</td>
<td>32.28</td>
</tr>
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</table>
Optional riders

<table>
<thead>
<tr>
<th>Future Insurance Option</th>
<th>Monthly premium</th>
<th>$2.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver of Premium</td>
<td>Monthly premium</td>
<td>16% of base plan premium</td>
</tr>
</tbody>
</table>

**Standard rates**

It is anticipated that 50% of applicants who do not smoke and are healthy will qualify for the standard non-smoker underwriting class.

**Preferred rates**

Preferred rates are available for coverage starting at $250,000. You must be in very good health and lead a low risk lifestyle to qualify for these rates. It is estimated that 40% of non-smoker applicants will qualify for the preferred underwriting class.

**Elite rates**

Elite rates are available for coverage starting at $250,000. You must be in exceptionally good health and lead a low risk lifestyle to qualify for these rates. It is expected that 20% of non-smoker applicants will qualify for the elite underwriting class.

**Exclusions and limitations**

No benefits will be paid for a death benefit, if the insured person takes their own life, regardless of whether the insured person has a mental illness or intends or understands the consequences of their actions, within two years from the effective date of the insurance coverage under this policy.

**When Coverage ends**

You and your spouse’s Term Life coverage ends:

- on the policy anniversary date following termination of your membership in the AMA or NWTMA;
- on the policy anniversary date following your or your spouse’s 75th birthday;
- on the first of the month following receipt by the AMA of your or your spouse’s written request to terminate coverage;
- for failure to pay premiums, subject to the grace period of 31 days, or
- for a spouse, upon divorce from the member (conversion option is available).
- the date the group policy is terminated by the AMA;
Critical Illness Insurance

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

**Coverage:**
- You or your spouse may apply for $50,000 to $250,000 in coverage, in $10,000 units.
- Evidence of insurability is required for all coverage amounts for which you apply.

**25 Critical conditions are covered**

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

**Extra advantages**

✔️ **Freedom to spend the benefit as you wish**

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

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

✔️ **Living benefit**

As long as you meet the conditions to receive a benefit payment, the CI benefit is paid to you even if you make a full recovery.

A critical illness insurance benefit will be paid to the insured following:

- the diagnosis of a covered condition or surgery for one of the covered conditions;
- the completion of the prescribed survival period; and
- the approval of the critical illness insurance claim.
You can purchase optional riders for your Critical Illness coverage

Waiver of Premium

Under this rider, if you become totally disabled before age 65 and the disability lasts for at least six consecutive months, premiums for the insured’s CI coverage will be waived. This benefit will apply for as long as the insured continues to be totally disabled and will end on January 1st coincident with or next following the insured’s 75th birthday. Totally disabled means the insured is unable to perform the duties of any occupation.

Child Critical Illness

If you apply, CI coverage is also available for your child*. Coverage is available from a minimum of $5,000 to a maximum of $20,000, in units of $5,000. The coverage amount applies to each child regardless of how many children you have.

The plan covers your child(ren) for the same 25 critical conditions as member/spouse plus an additional six illnesses:

- Cerebral Palsy;
- Congenital Heart Disease;
- Cystic Fibrosis;
- Down Syndrome;
- Muscular Dystrophy; and
- Type 1 Diabetes.

Critical Illness Insurance Rates

Monthly premium per $10,000 benefit

<table>
<thead>
<tr>
<th>Age</th>
<th>Male Non-smoker</th>
<th>Male Smoker</th>
<th>Female Non-smoker</th>
<th>Female Smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$1.09</td>
<td>$1.41</td>
<td>$1.03</td>
<td>$1.25</td>
</tr>
<tr>
<td>30-34</td>
<td>1.52</td>
<td>2.13</td>
<td>1.93</td>
<td>2.63</td>
</tr>
<tr>
<td>35-39</td>
<td>1.84</td>
<td>2.83</td>
<td>2.42</td>
<td>3.88</td>
</tr>
<tr>
<td>40-44</td>
<td>2.69</td>
<td>4.99</td>
<td>3.30</td>
<td>6.25</td>
</tr>
<tr>
<td>45-49</td>
<td>4.61</td>
<td>9.84</td>
<td>4.79</td>
<td>9.98</td>
</tr>
<tr>
<td>50-54</td>
<td>7.49</td>
<td>18.49</td>
<td>6.39</td>
<td>13.95</td>
</tr>
<tr>
<td>55-59</td>
<td>11.85</td>
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<td>60-64</td>
<td>19.50</td>
<td>49.07</td>
<td>12.20</td>
<td>23.38</td>
</tr>
<tr>
<td>65-69</td>
<td>33.74</td>
<td>75.26</td>
<td>19.97</td>
<td>33.13</td>
</tr>
<tr>
<td>70-74**</td>
<td>54.58</td>
<td>133.31</td>
<td>29.52</td>
<td>47.49</td>
</tr>
</tbody>
</table>

Optional rider

- **Waiver of Premium**
  Monthly premium 6% of base premium

- **Child Critical Illness (covers all children)**
  Monthly premium of $3.00 per $5,000 unit
When Coverage ends

Your and your spouse’s Critical Illness coverage ends:

- on the policy anniversary date following termination of your membership in the AMA or NWTMA;
- on the policy anniversary date following your or your spouse’s 75th birthday;
- on the policy anniversary date following the date you’re no longer a resident of Canada or the United States, or prior approval if residing elsewhere;
- on the first of the month following receipt by the AMA of your or your spouse’s written request to terminate coverage;
- for failure to pay premiums, subject to the grace period of 31 days;
- for a spouse, the date the policy no longer includes Spouse coverage
- the date the critical illness insurance benefit is paid;
- the first of the month following the date the spouse no longer satisfies the required definition;
- the date of your or your spouse’s death;
- the date the group policy is terminated by the AMA or Sun Life;

Exclusions

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

- declared or undeclared war, insurrection or rebellion;
- voluntary participation in a riot or act of civil disobedience;
- intentionally self-inflicted injuries or attempted suicide, regardless of whether the person has a mental illness or intends or understands the consequences of their actions;
- committing or attempting to commit a criminal offense;
- use of illegal or illicit drugs or substances, misuse of drugs or alcohol; or
- the Insured’s death during the required Survival Period.

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

* Please see Glossary on page 35 for the full definition of “dependent child”.

** Renewal rates only.

Waiver of Premium is not payable after age 65.

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

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

The complete terms and conditions governing the insurance coverage are found in the group insurance policy issued to the Alberta Medical Association by Sun Life Assurance Company of Canada (a member of the Sun Life Financial group of companies).
## Appendix for Critical Illnesses Covered

### Covered illnesses

<table>
<thead>
<tr>
<th>Covered illnesses – adults</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Aortic surgery** | Undergoing surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist physician. The Insured must survive for 30 days following the date of surgery.  
**Exclusion**  
No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures. |
| **Aplastic anemia** | Definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:  
a) marrow stimulating agents;  
b) immunosuppressive agents; or  
c) bone marrow transplantation.  
The diagnosis of aplastic anemia must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. |
| **Bacterial meningitis** | Definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days following the date of diagnosis. The diagnosis of bacterial meningitis must be made by a specialist physician. The Insured must survive for 90 days following the date of diagnosis.  
**Exclusion**  
No benefit will be payable under this condition for viral meningitis. |
| **Benign brain tumour** | Definite diagnosis of non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).  
The diagnosis of benign brain tumour must be made by a specialist physician.  
The Insured must survive for 30 days following the date of diagnosis.  
**Exclusions**  
No benefit will be payable under this condition for pituitary adenomas less than 10 mm.  
No benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage. |
<table>
<thead>
<tr>
<th>Covered illnesses – adults</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign brain tumour (continued)</td>
<td><strong>Moratorium period exclusions</strong>&lt;br&gt;No benefit will be payable under this condition and the Insured's coverage for benign brain tumour will terminate if within the first 90 days following the later of:&lt;br&gt;a) the date the application for this coverage was signed; or&lt;br&gt;b) the effective date of the Insured’s coverage, the Insured has any of the following:&lt;br&gt;  i) signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this policy), regardless of when the diagnosis is made; or&lt;br&gt;  ii) a diagnosis of benign brain tumour (covered or excluded under this policy).&lt;br&gt;While the Insured’s insurance for benign brain tumour terminates, insurance for all other covered conditions remains in force. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for benign brain tumour or any Critical Illness caused by any benign brain tumour or its treatment.</td>
</tr>
<tr>
<td>Blindness</td>
<td>A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:&lt;br&gt;a) the corrected visual acuity being 20/200 or less in both eyes; or&lt;br&gt;b) the field of vision being less than 20 degrees in both eyes.&lt;br&gt;The diagnosis of blindness must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.</td>
</tr>
<tr>
<td>Cancer (Life Threatening)</td>
<td>A definite diagnosis of a tumour which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma.&lt;br&gt;The diagnosis of cancer must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. <strong>Exclusions</strong>&lt;br&gt;No benefit will be payable for a recurrence or metastasis of an original cancer which was diagnosed prior to the effective date of coverage.&lt;br&gt;No benefit will be payable under this condition for the following:&lt;br&gt;a) lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in situ (Tis), or tumours classified as Ta;&lt;br&gt;b) malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;&lt;br&gt;c) any non-melanoma skin cancer, without lymph node or distant metastasis;&lt;br&gt;d) prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;&lt;br&gt;e) papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;&lt;br&gt;f) chronic lymphocytic leukemia classified less than Rai Stage 1; or&lt;br&gt;g) malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.</td>
</tr>
<tr>
<td>Covered illnesses – adults</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Cancer (continued)        | **Moratorium period exclusions**
No benefit will be payable under this condition and the Insured’s coverage for cancer will terminate if within the first 90 days following the later of:
  a) the date the application for this coverage was signed; or
  b) the effective date of the Insured’s coverage, the Insured has any of the following:
  i) signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under this policy), regardless of when the diagnosis is made; or
  ii) a diagnosis of cancer (covered or excluded under this policy).
While the Insured’s insurance for cancer terminates, insurance for all other covered conditions remains in force.
Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for cancer or, any Critical Illness caused by any cancer or its treatment.
For purposes of this policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.
| Coma                      | A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less.
The diagnosis of coma must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.
**Exclusions**
No benefit will be payable under this condition for:
  a) a medically induced coma;
  b) a coma which results directly from alcohol or drug use; or
  c) a diagnosis of brain death.
| Coronary artery bypass surgery | The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).
The surgery must be determined to be medically necessary by a specialist physician.
The Insured must survive for 30 days following the date of surgery.
**Exclusions**
No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.
<table>
<thead>
<tr>
<th>Covered illnesses – adults</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deafness</strong></td>
<td>A definite diagnosis of total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of deafness must be made by a specialist physician. The insured must survive for 30 days following the date of diagnosis.</td>
</tr>
</tbody>
</table>
| **Dementia, including Alzheimer’s disease** | A definite diagnosis of progressive deterioration of memory and at least one of the following areas of cognitive function:  
a) aphasia (a disorder of speech);  
b) apraxia (difficulty performing familiar tasks);  
c) agnosia (difficulty recognizing objects); or  
d) disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour), which is affecting daily life.  
The Insured must exhibit:  
a) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and  
b) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.  
The diagnosis of dementia must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.  
**Exclusions**  
No benefit will be payable under this condition for affective or schizophrenic disorders or delirium. For purposes of this policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189 |
| **Heart attack** | A definite diagnosis of death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:  
a) heart attack symptoms;  
b) new electrocardiogram (ECG) changes consistent with a heart attack; or  
c) development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.  
The diagnosis of heart attack must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.  
**Exclusions**  
No benefit will be payable under this condition for:  
a) elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or  
b) ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above. |
<table>
<thead>
<tr>
<th>Covered illnesses – adults</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heart valve replacement or repair</strong></td>
<td>The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist physician. The Insured must survive for 30 days following the date of surgery.</td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td>No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.</td>
</tr>
<tr>
<td><strong>Kidney failure</strong></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>The diagnosis of kidney failure must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.</td>
</tr>
<tr>
<td><strong>Loss of independent existence</strong></td>
<td>A definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery. Activities of daily living are:</td>
</tr>
<tr>
<td></td>
<td>a) bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;</td>
</tr>
<tr>
<td></td>
<td>b) dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;</td>
</tr>
<tr>
<td></td>
<td>c) toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;</td>
</tr>
<tr>
<td></td>
<td>d) 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;</td>
</tr>
<tr>
<td></td>
<td>e) transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and f) feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.</td>
</tr>
<tr>
<td></td>
<td>f) feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.</td>
</tr>
<tr>
<td></td>
<td>The diagnosis of loss of independent existence must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.</td>
</tr>
<tr>
<td><strong>Loss of limbs</strong></td>
<td>A definite diagnosis of complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.</td>
</tr>
<tr>
<td></td>
<td>The diagnosis of loss of limbs must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.</td>
</tr>
<tr>
<td><strong>Loss of speech</strong></td>
<td>A definite diagnosis of total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.</td>
</tr>
<tr>
<td></td>
<td>The diagnosis of loss of speech must be made by a specialist physician. No additional survival period is required once the conditions described above are satisfied.</td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td>No benefit will be payable under this condition for any psychiatric related causes.</td>
</tr>
<tr>
<td>Covered illnesses – adults</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Major organ failure on waiting list | A definite diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the Insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.  
For the purposes of the survival period, the date of diagnosis is the date of the Insured's enrolment in the transplant centre.  
The diagnosis of major organ failure must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. |
| Major organ transplant | A definite diagnosis of irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the Insured must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.  
The diagnosis of major organ failure must be made by a specialist physician. The Insured must survive for 30 days following the date of the transplant. |
| Motor neuron disease | A definite diagnosis of one of the following:  
a) amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease), 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 physician. The Insured must survive for 30 days following the date of diagnosis. |
| Multiple sclerosis | A definite diagnosis of at least one of the following:  
a) two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or  
b) well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or  
c) a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.  
The diagnosis of multiple sclerosis must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis. |
| Occupational HIV infection | A definite diagnosis of human immunodeficiency virus (HIV) resulting from accidental injury during the course of the Insured’s normal occupation, which exposed the Insured to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of:  
a) the date the application for this coverage was signed; or  
b) the effective date of the Insured’s coverage. |
<table>
<thead>
<tr>
<th>Covered illnesses – adults</th>
<th>Description</th>
</tr>
</thead>
</table>
| Occupational HIV infection (continued) | Payment under this condition requires satisfaction of all of the following:  
   a) the accidental injury must be reported to the Company within 14 days of the accidental injury;  
   b) a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;  
   c) a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;  
   d) all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and  
   e) the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.  

   The diagnosis of occupational HIV infection must be made by a specialist physician. The Insured must survive for 30 days following the date of the second serum HIV test described above.  

Exclusions  
No benefit will be payable under this condition if:  
   a) the Insured has elected not to take any available licensed vaccine offering protection against HIV;  
   b) a licensed cure for HIV infection has become available prior to accidental injury; or  
   c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use. |
| Paralysis | A definite diagnosis of total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.  

   The diagnosis of paralysis must be made by a specialist physician. The Insured must survive for 90 days following the precipitating event. |
| Parkinson’s disease and specified atypical Parkinsonian disorders | A definite diagnosis of primary Parkinson’s disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson’s disease.  

   **Specified atypical Parkinsonian disorders** – A definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.  

   The diagnosis of Parkinson’s disease or a specified atypical Parkinsonian disorder must be made by a neurologist or a specialist physician. The Insured must satisfy the above conditions and survive for 30 days following the date all these conditions are met. |
<table>
<thead>
<tr>
<th>Covered illnesses – adults</th>
<th>Description</th>
</tr>
</thead>
</table>
| Parkinson’s disease and specified atypical Parkinsonian disorders (continued) | **Exclusions**
No benefit will be payable for Parkinson’s disease or specified atypical Parkinsonian disorders if, within the first year following the later of:

a) the date the application for this coverage was signed; or
b) the effective date of the Insured’s coverage, the Insured has any of the following:
  i) signs, symptoms or investigations that lead to a diagnosis of Parkinson’s disease, a specified atypical Parkinsonian disorder or any other type of Parkinsonism (covered or excluded under this policy), regardless of when the diagnosis is made; or
  ii) a diagnosis of Parkinson’s disease, a specified atypical Parkinsonian disorder or any other type of Parkinsonism (covered or excluded under this policy).

No benefit will be payable under Parkinson’s disease or specified atypical Parkinsonian disorders for any other type of Parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson’s disease or specified atypical Parkinsonian disorders or any Critical Illness caused by Parkinson’s disease or specified atypical Parkinsonian disorders or its treatment.

| Severe burns | A definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist physician. The Insured must survive for 30 days following the date the severe burn occurred. |
| Stroke | A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:
  a) acute onset of new neurological symptoms; and
  b) new objective neurological deficits on clinical examination persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of stroke must be made by a specialist physician. The Insured must survive for 30 days following the date of diagnosis.

**Exclusions**
No benefit will be payable under this condition for:
  a) transient ischaemic attacks;
  b) intracerebral vascular events due to trauma; or
  c) lacunar infarcts which do not meet the definition of stroke as described above.
<table>
<thead>
<tr>
<th>Covered illnesses – child</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral palsy</td>
<td>A definite diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements. The diagnosis of cerebral palsy must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis.</td>
</tr>
</tbody>
</table>
| Congenital heart disease | A definite diagnosis of at least one of the covered heart conditions described below for which open heart surgery is performed to correct the condition. Covered heart conditions:  
  a) coarctation of the aorta;  
  b) Ebstein’s anomaly;  
  c) Eisenmenger syndrome;  
  d) Tetralogy of Fallot;  
  e) transposition of the great vessels.  
  The diagnosis of the heart condition must be made by a specialist physician and be supported by cardiac imaging acceptable to the Company. The Insured Dependent Child must survive for 30 days following the date of diagnosis.  
  Covered heart conditions if open heart surgery is performed (these heart conditions are covered only if open heart surgery is performed to correct at least one of them):  
  a) aortic stenosis;  
  b) atrial septal defect;  
  c) discrete subvalvular aortic stenosis;  
  d) pulmonary stenosis;  
  e) ventricular septal defect.  
  Procedures not covered by this definition are:  
  a) percutaneous atrial septal defect closure;  
  b) trans-catheter procedures which include balloon valvuloplasty.  
  The diagnosis of the heart condition must be made and the surgery must be recommended and performed by a specialist physician and be supported by cardiac imaging acceptable to the Company. The Insured Dependent Child must survive for 30 days following the date of surgery. |
<p>| Cystic fibrosis          | A definite diagnosis of cystic fibrosis where the Insured Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis. |</p>
<table>
<thead>
<tr>
<th>Covered illnesses – child</th>
<th>Description</th>
</tr>
</thead>
</table>
| Down syndrome             | A definitive diagnosis of Down syndrome supported by chromosomal evidence of trisomy 21.  
The diagnosis of Down syndrome must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis. |
| Muscular dystrophy        | A definite diagnosis of muscular dystrophy where the Insured Dependent Child has well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.  
The diagnosis of muscular dystrophy must be made by a specialist physician. The Insured Dependent Child must survive for 30 days following the date of diagnosis. |
| Type 1 diabetes mellitus  | A definite diagnosis where the Insured Dependent Child has total insulin deficiency and continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least 3 months.  
The diagnosis of type 1 diabetes mellitus must be made by a specialist physician. The Insured Dependent Child must survive for 90 days following the date of diagnosis. |
Accidental Death & Dismemberment Insurance

Accidental Death and Dismemberment (AD&D) Insurance provides a lump-sum benefit that is paid in addition to any benefit received from your life or disability insurance coverage. You are insured 24 hours-a-day, anywhere in the world and there’s no medical evidence of insurability required to enroll in the plan. AD&D insurance is intended to supplement, not replace, life or disability insurance coverage.

Coverage:

- Apply for up to $1,000,000 in coverage, in $50,000 units.

Two plans to choose from:

- **Member only plan** – covers you alone for the principal sum of insurance you have selected.
- **Member & Family plan** – covers you and your family members as follows:
  - if you have a spouse\(^1\) but no dependent children\(^2\), your spouse will be covered for an amount equal to 50% of your principal sum;
  - if you have a spouse and dependent children, your spouse will be covered for 40% of your principal sum and each child will be covered for 15% of your principal sum to a maximum of $100,000; or
  - if you have children but no spouse, each child will be covered for 20% of your principal sum to a maximum of $100,000.

\(^1\) Please see Glossary on page 35 for the full definition of “spouse”.

\(^2\) Please see Glossary on page 35 for the full definition of “dependent child”.

Loss benefit schedule

If you incur an injury from an accident that, within 12 months, results in the loss or permanent and total loss of use of a body part, benefits will be provided as follows:

<table>
<thead>
<tr>
<th>Table of losses</th>
<th>Amount payable (% of Principal Sum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>Principal sum</td>
</tr>
<tr>
<td>Both hands</td>
<td>Principal sum</td>
</tr>
<tr>
<td>Both feet</td>
<td>Principal sum</td>
</tr>
<tr>
<td>Entire sight in both eyes</td>
<td>Principal sum</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>Principal sum</td>
</tr>
<tr>
<td>One hand and entire sight of one eye</td>
<td>Principal sum</td>
</tr>
<tr>
<td>One foot and entire sight of one eye</td>
<td>Principal sum</td>
</tr>
<tr>
<td>Speech and hearing</td>
<td>Principal sum</td>
</tr>
<tr>
<td>One arm or one leg</td>
<td>Three-quarters of Principal sum</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>Two-thirds of Principal sum</td>
</tr>
<tr>
<td>Entire sight of one eye</td>
<td>Two-thirds of Principal sum</td>
</tr>
<tr>
<td>Either speech or hearing</td>
<td>Two-thirds of Principal sum</td>
</tr>
<tr>
<td>Four fingers of either hand</td>
<td>One-third of Principal sum</td>
</tr>
<tr>
<td>Thumb and index finger of either hand</td>
<td>One-third of Principal sum</td>
</tr>
<tr>
<td>Hearing in one ear</td>
<td>One-third of Principal sum</td>
</tr>
<tr>
<td>All toes of one foot</td>
<td>One-quarter of Principal sum</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>Two times the Principal sum</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>Two times the Principal sum</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>Two times the Principal sum</td>
</tr>
</tbody>
</table>

Extra advantages

The following benefits are also contained in the plan:

- Bereavement Benefit up to $1,000;
- Common Disaster Benefit;
- Conversion Option;
- Critical Disease Benefit up to $25,000;
- Day Care Benefit up to $5,000;
- Education Benefit up to $5,000;
- Extended Family Benefit;
- Eyeglasses, Contact Lenses and Hearing Aids Benefit up to $1,000;
- Family Transportation Benefit up to $15,000;
- Funeral Expense Benefit up to $5,000;
- Home Alteration and Vehicle Modification Benefit up to $15,000;
- Identification Benefit up to $5,000;
- Rehabilitation Benefit up to $15,000;
- Repatriation Benefit up to $15,000; and
- Spousal Retraining Benefit up to $15,000.

For more details on each of these benefits, please contact ADIUM.

**Accidental death and dismemberment insurance:**
Monthly premium per $50,000 benefit

<table>
<thead>
<tr>
<th></th>
<th>Member Only</th>
<th>Member and Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 75</td>
<td>$1.25</td>
<td>Under age 75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1.75</td>
</tr>
</tbody>
</table>

These figures represent the monthly rates of the Accidental Death and Dismemberment Plan and are not guaranteed. The complete terms and conditions governing the insurance coverage are found in the group insurance policy issued to the Alberta Medical Association by Industrial Alliance Insurance and Financial Services Inc.

**Exclusions and limitations**
Benefits are not payable in the event of:
- self-inflicted injuries or suicide, while sane or insane;
- declared or undeclared war;
- active full-time service in the armed forces of any country;
- piloting or acting as a crew member on any aircraft; or
- riding as a passenger, operator, or member of the crew on an aircraft owned, operated or leased by the policyholder (AMA).

**When Coverage ends**
Your insurance ends on the earliest of the following:
- the date the policy is terminated;
- the premium due date for which premiums have not been paid;
- on the policy anniversary date coinciding with or immediately following your 75th birthday;
- on the policy anniversary date coinciding with or immediately following termination of your membership in the AMA or NWTMA;
- on the first of the month coinciding with or immediately following receipt by the AMA of your written request to terminate coverage; or
- on death;

Your insured spouse’s and/or insured dependent children’s insurance ends on the earliest of the following:
- the date the spouse or child ceases to be eligible; or
- the date your insurance is terminated, except as provided under Extended Family Benefit.
ADIUM employs two licensed insurance advisors, who can help you determine your coverage needs in a professional and objective manner. Please contact the appropriate advisor to discuss your needs or to schedule an appointment:

**Northern Alberta (Red Deer North)**
Ms. Kelly Guest, EPC, CHS  
kelly.guest@albertadoctors.org  
1-780-482-0306

**Southern Alberta**
Ms. Mona Yam, CFP, CLU, CHS, B.Comm, BA  
mona.yam@albertadoctors.org  
1-403-205-2088

1. Be sure to read the product disclosure, exclusions and restrictions then complete the appropriate product application form found online at albertadoctors.org

2. Return your application to ADIUM
   - **By mail:**  
     ADIUM Insurance Services Inc.  
     CMA Alberta House  
     12230 106 Avenue NW  
     Edmonton AB T5N 3Z1
   - **By fax:** 780-488-7558 or toll-free 1-877-302-3486*
   - **By email:** adium@albertadoctors.org*

3. DO NOT SEND MONEY with your application. Upon approval of your application, you will receive your certificate of insurance and a premium notice for the balance of the insurance year (to December 31). You may pay your invoice by cheque, or you may set-up monthly (interest free) or annual pre-authorized payments (P.A.P.).

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

Visit www.albertadoctors.org to download applications and take advantage of the easy-to-use online tools and premium calculators.

* Be advised that email and fax are not considered secure methods of communication.
**Glossary**

**General**

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

**Plan year:** January 1 to December 31.

**Disability Insurance**

**Average monthly earned income:** is the greater of a) your average monthly earned income during any consecutive 12 month period in the 24 months immediately preceding the onset of total or residual disability, or b) your average monthly earned income for any consecutive 24 month period in the 36 months immediately preceding the onset of total or residual disability.

**Earned/Net income:** Salary, fees, commissions and bonuses and any other income earned for services performed, less any business expenses. Income from deferred compensation plans, disability policies, retirement plans or any payments, such as interest or dividends, which are not related to the performances of services, is not considered income.

**Regular Occupation:** The occupation(s) you were engaged in as of the date of the disability.

**Professional Overhead Expenses**

**Average monthly earned income:** is the greater of a) your average monthly earned income during any consecutive 12 month period in the 24 months immediately preceding the onset of total or residual disability, or b) your average monthly earned income for any consecutive 24 month period in the 36 months immediately preceding the onset of total or residual disability.

**Waiting period:** The length of time after purchasing your policy that you must wait before you can use your full coverage.

**Term Life**

**Spouse:** Your spouse by marriage or under any other formal union recognized by law; or a person of the opposite sex or of the same sex who is publicly represented as your spouse for a period of at least 12 months. You can only cover one spouse at a time. Discontinuance of cohabitation terminates the eligibility of a common-law spouse.

**Dependent Child:** Your child who is not married or in any other formal union recognized by law, dependent on you or your spouse for support, and is under the age of 21 (age 25 if the dependent is a full-time student), including adopted children and stepchildren, or children of any age if incapable of supporting themselves because of physical or mental disability. Once you opt for family coverage, newborn infants are automatically covered. You must also have coverage in order to obtain dependent child coverage.

**Accidental Death & Dismemberment**

**Spouse:** a person to whom the Participant is legally married; to whom the Participant is married by a marriage that is voidable and has not been declared null and void; or with whom the Participant has continuously cohabited and who has been publicly represented as Participant’s spouse for a minimum of 12 months immediately before a Loss is incurred under the policy.

**Dependent Child:** any natural child, step-child, or legally adopted child of the Participant, who receives support and maintains from the Participant and is:
- under 23 years of age and unmarried; or
- 23 years of age but less than 25 years of age, unmarried, and is a full-time attendance at a School for Higher Learning; or
- mentally or physically infirm.

Notwithstanding the above limitations, this definition will also include a child of the Participant’s Spouse who is in the care, custody and control of the Participant and living in a parent-child relationship with the Participant.

**Family:** You, your spouse and all dependent child(ren).
To help protect your financial future and your assets, Alberta Medical Association offers a comprehensive array of group insurance products that include:

- Disability
- Professional Overhead Expense
- Term Life
- Accidental Death and Dismemberment
- Critical Illness
- AMA Health Benefits Trust Fund (plan information provided separately)

For more information please visit albertadoctors.org/insurance or call us at 780-482-0692 or toll-free at 1-888-492-3486.

AMA's ADIUM Insurance Services Inc. administers the plans, and is available to answer questions regarding coverage and provide any necessary forms. Disability, Professional Overhead Expense, Term Life and Critical Illness insurance are underwritten by Sun Life Assurance Company of Canada, a member of the Sun Life Financial Group of Companies. Accidental Death and Dismemberment is underwritten by Industrial Alliance Insurance and Financial Services. This brochure provides the highlights but not all the details of the Alberta Medical Association plans. The complete terms, conditions, exclusions and limitations governing the insurance coverage are found in the group insurance policy issued to the Alberta Medical Association by Sun Life Assurance Company of Canada or Industrial Alliance.