Old Republic Insurance Company of Canada

insuremykids® STUDENT ACCIDENT INSURANCE

This document and the **confirmation of coverage** make up the **policy**. Take the time to read this document as it contains important information about the coverage. Bold words have a specific meaning which **we** define in Section I on page 6. If you have questions, please call **us** at 1-800-463-5437. **We** are happy to help.

A. 10 DAY FREE LOOK

The **policy** may be cancelled within 10 days of purchase for a full refund if there is no claim in process.

B. WHO IS ELIGIBLE FOR COVERAGE?

To be eligible for this coverage, the student must be:

a) more than 6 months old; and

b) less than 27 years old; and

c) live in Canada, except in the province of Quebec.

If the student is 14 years old or more at any time during the Coverage Period, they must be a full-time student in the 12 months prior to a claim. Full-time student is defined as being enrolled in a minimum of 3 courses at the same time during any 4-month period.

C. COVERAGE PERIOD

Coverage under the **policy** begins on the date and time when **we** or **our** authorized representative receive the completed application and the premium.

Coverage ends on the earlier of:

a) the expiration date shown on the **confirmation of coverage**; or

b) the date the **insured** is no longer eligible based on Section B.

The **policy** is in effect 24 hours a day, 7 days a week during the Coverage Period.

D. WHAT WE COVER

We provide the benefits described in the **policy** if the **insured** is **injured** due to an **accident** during the Coverage Period. The Critical Illness Benefit (see Benefit G5) applies whether or not an **accident** happens. The Travel Benefit (see Benefit G7) only applies if the **insured** is covered under the Platinum Plan and is 20 years old or less at the time of a claim. All the benefits are subject to the Exclusions in Section E, the Conditions and Limitations in Section F and the Exclusions Applicable to the Travel Benefit in Section H.

E. EXCLUSIONS

The **policy** does not cover:

1. Intentionally self-inflicted injuries;
2. **Sickness**, except under the Counselling Benefit (see Benefit G3), the Critical Illness Benefit (see Benefit G5) and Travel Benefit (see Benefit G7);
3. The purchase, repair or replacement of eyeglasses, contact lenses, orthotic devices, trusses, braces or prescription medication except as we describe in Section G;
4. Losses caused directly or indirectly, in whole or in part if the **insured**:
   a) commits a crime or malicious act;
   b) uses drugs, alcohol or medication.

In addition, exclusions that apply to the Travel Benefit (Benefit G7) under the Platinum Plan are in Section H.

F. CONDITIONS & LIMITATIONS

1. The **insured** can only be covered under one plan with **us.** Benefits will only be paid under one **policy.**
2. The benefits **we** pay under the **policy** are in excess of the **insured's** coverage from any other source.
3. Except for the "10 Day Free Look" under Section A, there are no premium refunds.
4. The **policy** only covers the **insured** if they attend school in Canada.
5. If the **insured** files a claim with **us, we** have the right to have a **physician** approved in **our** sole discretion examine them.
6. If the **insured** files a claim with **us**, **we** are automatically subrogated to their right to collect from third parties and can act on their behalf to enforce this right.
7. If the **insured** files a claim for similar benefits with **us** and another excess insurer, **we** coordinate the payment of benefits with the other insurer to settle the actual eligible loss**.**
8. If any material fact or circumstance relating to this policy has been concealed or misrepresented, the entire coverage will be void.
9. The **policy** is subject to the statutory conditions of the Insurance Act of the province or territory where the **insured** lives. If the **policy** and the Insurance Act disagree, the Insurance Act prevails.

G. BENEFITS

SCHEDULE OF MAXIMUM BENEFITS

BENEFIT SECTIONS | **PLAN BENEFIT MAXIMUM**

		PLATINUM	GOLD	SILVER
1.	**DEATH, DISABILITY, LOSS OF LIMB OR USE**			
	Total and Permanent Disability	$350,000	$150,000	$75,000
	Loss of Limb or Loss of Use	$150,000	$150,000	$75,000
	Accidental Death	$30,000	$20,000	$15,000
	Double Benefit for Accidental Death	$60,000	$40,000	$30,000
2.	**DENTAL TREATMENT**			
	Treatment within 10 years of Accident	Dental Association Fee Guide	Dental Association Fee Guide	Dental Association Fee Guide
	Treatment after 10 years of Accident (per tooth)	$1,650	$1,400	$1,250
	Implants (up to 2 implants per accident)	$2,000	$1,800	$1,500
	Orthodontics	$2,500	$2,500	$1,500
	Dentures and removable teeth	$500	$500	$500
3.	**MEDICAL TREATMENT AND TRANSPORTATION**			
	Hospital room expense	Full Cost	Full Cost	Full Cost
	Ambulance	Full Cost	Full Cost	Full Cost
	Emergency taxi to nearest medical facility	$350	$350	$350
	Paramedical	$800	$500	$500
	Medical Devices	$1,500	$1,500	$1,500
	Counselling	$1,000	$750	$750
	Special Training	$10,000	$6,000	$6,000
	Confinement	$30,000	$20,000	$20,000
	Travel for Specialized Treatment	$3,000	$3,000	$3,000
	Travel for Parent/Guardian	$1,000	$1,000	$1,000
	Tutoring	$6,000	$6,000	$6,000
4.	**FRACTURE OR DISLOCATION**			
	Skull (depressed), Spine (3 or more vertebrae)	$1,000	$750	$750
	Skull (not depressed), Pelvis, Spine (1 or 2 vertebrae)	$500	$250	$250
	Hip, Femur, Shoulder, Humerus, Scapula	$300	$200	$200
	Collar bone (clavicle), Elbow, Knee Cap, Leg, Forearm, Hand, Wrist or Foot	$250	$150	$150
	Jaw (except the alveolar process), Sacrum, Coccyx, Sternum, Two or more toes, fingers or ribs	$200	$150	$150
	One toe, finger, rib or any bone not specified above	$150	$150	$150
5.	**CRITICAL ILLNESS**			
	Nursing expenses	$12,500	$9,000	$9,000
	Accommodations, meals, laundry, parking	$3,000	$3,000	$3,000
6.	**MEDICAL EQUIPMENT**			
	Damage to eyeglasses and contact lenses	$350	$300	$300
	Eyeglasses and contact lenses needed due to injury	Full Cost	Full Cost	Full Cost
	Purchase of Prosthetic Device or Hearing Aids	$5,500	$5,500	$5,500
	Fix or Replace Prosthetic Device or Hearing Aids	$500	$300	$300
	Special Clothing	$400	$400	$400
7.	**TRAVEL**			
	Out of Province Emergency Medical Expenses	$200,000	N/A	N/A
	Trip Cancellation	$1,000	N/A	N/A
	Airflight Accidental Death	$5,000	N/A	N/A
	Emergency Return Flight	$1,000	N/A	N/A
	Repatriation or Burial	$5,500	N/A	N/A

1. DEATH, DISABILITY, LOSS OF LIMB OR USE

a) Total and Permanent Disability

If the **insured** is **injured** due to an **accident** and is deemed **totally and permanently disabled** as a result of that **accident,** we will pay the benefit for the plan chosen one (1) year after the date of the **accident** and after a **physician** approved in the **company's** sole discretion confirms that the **insured** is **totally and permanently disabled** due to the **accident.** If other benefits have been paid under the **policy, we** will subtract the amount paid for other benefits from the Total and Permanent Disability Benefit. If the Total and Permanent Disability Benefit is paid, no further benefits are payable under the **policy.** If the **insured** dies within one (1) year after the **accident,** the Total and Permanent Disability Benefit is not payable. If the **insured** is 21 years old or more at the time of the **accident,** the Total and Permanent Disability Benefit payable is $100,000 or the maximum benefit under the plan chosen, whichever is less.

b) Loss of Limb or Loss of Use

If the **insured** is **injured** due to an **accident** resulting in the loss of a limb, or loss of sight, hearing or speech within one (1) year, **we** pay the benefit described in the **TABLE OF INJURIES** subject to Conditions i) to v) below.

Conditions:

i) If the **insured** has more than one **injury** from the same **accident**, **we** cover the one that pays the highest benefit only.

ii) If the **insured** dies within 90 days of the **accident**, there is no coverage under this benefit.

iii) If **we** pay other benefits under the **policy**, **we** subtract them from this benefit, except for prosthetic devices.

iv) A **physician** approved in the **company's** sole discretion must confirm that the loss of sight, hearing or speech is permanent and continuous for at least one (1) year after the **accident.**

v) If the **insured** is 21 years old or more at the time of the **accident, we** pay the maximum benefit under the plan chosen or $100,000, whichever is less.

TABLE OF INJURIES

LOSS	PLATINUM	GOLD	SILVER
Both hands or both feet at or above the wrist or ankle	$150,000	$150,000	$75,000
One hand and one foot at or above the wrist or ankle	$150,000	$150,000	$75,000
One hand or one foot at or above the wrist or ankle and the sight of one eye	$150,000	$150,000	$75,000
Sight in both eyes	$150,000	$150,000	$75,000
One arm or one leg at or above the elbow or knee or the hearing in both ears or speech	$45,000	$45,000	$22,500
One hand or one foot at or above the wrist or ankle, or the sight in one eye	$30,000	$30,000	$15,000
Thumb and index finger at or above the knuckle (metacarpal-phalangeal joint)	$15,000	$15,000	$ 7,500
Part or all of one or more fingers or toes	$1,500	$ 1,500	$ 750

c) Accidental Death

If the **insured** is **injured** and dies due to an **accident, we** pay the death benefit for the plan chosen. Benefits are payable if death occurs within one (1) year of the **accident.** If the **insured** is 21 years old or more at the time of the **accident**, the maximum benefit is $10,000.

d) Double Benefit for Accidental Death

If the **insured** is **injured** and dies due to an **accident** while riding in or getting in or out of a bus, streetcar, subway train or a vehicle owned or leased by a school, **we** pay double the Accidental Death Benefit listed above. Benefits are payable when death occurs within one (1) year of the **accident.** If the **insured** is 21 years old or more at the time of the **accident,** the maximum benefit is $20,000.

2. DENTAL TREATMENT

If the **insured's** whole or sound teeth are **injured** due to an **accident** and the **insured** needs dental treatment within 60 days of the **accident**, **we** cover the cost**.** Also, if those whole or sound teeth need follow-up dental treatment, **we** cover the cost for 10 years following the **accident**.

If this is not enough time because the **insured's** teeth are still developing, then the attending **dentist** must contact **us** within 90 days after the **accident** and report why the treatment will take longer to complete. After 10 years, **we** cover up to the amount stated in the Schedule of Maximum Benefits.

If the **insured** needs orthodontic treatment due to the dental **injury**, **we** cover it up to the amount stated in the Schedule of Maximum Benefits. The same time periods as above apply.

If the **insured's** dentures or removable teeth are broken due to an **accident** and the **insured** needs treatment from a **physician** or **dentist** within 30 days of the **accident**, **we** cover the cost to fix or replace them up to the amount stated in the Schedule of Maximum Benefits.

Conditions:

i) To evaluate a claim, **we** use the Dental Association's Fee Guide for General Practitioners that is in effect at the time and place where the **insured's dentist** provides treatment;
ii) If the **insured** has capped or crowned teeth, **we** consider them to be whole and sound teeth;
iii) If there is more than one treatment that is professionally acceptable, **we** cover the least expensive one only;
iv) If the **insured** needs dental implants due to an **accident**, **we** cover up to 2 implants per **accident** and pay up to the maximum amount as stated in the Schedule of Maximum Benefits per implant.
v) If the **insured** is 21 years old or more at the time of the **accident**, **we** cover up to one (1) year of dental work;
vi) There is no coverage for routine dental visits or dental maintenance including but not limited to cleanings and fillings;
vii) There is no coverage for artificial teeth or dentures except as specifically provided;
viii) There is no coverage for cosmetic or aesthetic treatment.

3. MEDICAL TREATMENT AND TRANSPORTATION

a) Hospital Room Expense

If the **insured** is **injured** due to an **accident** and is admitted to a **hospital** in Canada for more than 24 continuous hours within 30 days of that **accident**, **we** cover the cost of a private or semi-private room for up to one (1) year. **We** also cover up to $25 a day for television and Wi-Fi service. The **insured** must have Canadian government health insurance coverage to receive this benefit.

b) Emergency Transportation

If the **insured** is **injured** due to an **accident** and travels by ambulance to the nearest medical facility for help, **we** cover the cost. If the **insured** takes a taxi or another means of transport, **we** pay up to the amount stated in the Schedule of Maximum Benefits.

c) Paramedical

If the **insured** is **injured** due to an **accident**, and a legally qualified chiropractor, osteopath, physiotherapist, athletic therapist or registered nurse begins treating the **insured's injury** within 30 days**, we** pay up to a maximum of $100 per visit up to the amount stated in the Schedule of Maximum Benefits for all providers. **We** do not cover massage therapy.

d) Medical Devices

If the **insured** is **injured** due to an **accident** and requires crutches, splints, an orthotic truss, a brace, prescription drugs, any type of cast or the rental of a wheelchair or hospital-type bed due to the **accident**, **we** cover up to the amount stated in the Schedule of Maximum Benefits. A splint, brace or orthotic device used for sports or non-therapeutic purposes is not covered.

e) Counselling

If the **insured** dies, loses a limb or the use of a limb, loses their sight, hearing or speech or are diagnosed with a Critical Illness and the **insured's physician** recommends counselling for the **insured**, the **insured's** parents, legal guardian and/or siblings, **we** cover up to the amount stated in the Schedule of Maximum Benefits for the services of a licensed psychologist.

f) Special Training

If the **insured** is **injured** due to an **accident** and needs special training to be employed, **we** provide coverage for up to 3 years after the **accident**. **We** cover up to the amount stated in the Schedule of Maximum Benefits, including $150 a day hotel and meals if the training is located more than 160 km from where the **insured** lives.

g) Confinement

If the **insured** is **injured** due to an **accident** and is continuously confined to **hospital** or to the **insured's** home except for attending medical appointments, **we** pay $750 per month under the Platinum Plan and $500 per month under the Gold or Silver Plan. This benefit starts on the 31st day of continuous confinement under a **physician's** care and ends when the **insured's** continuous confinement ends or after 40 months, whichever comes first. **We** cover only one period of continuous confinement per **accident.**

h) Travel Expenses for Specialized Treatment

If the **insured** is **injured** due to an **accident** and within one (1) year needs specialized treatment that is located more than 160 km from where the **insured** lives, **we** cover their travel expenses up to the amount stated in the Schedule of Maximum Benefits. This benefit is limited to $60 a day.

i) Travel Expenses for Parent/Legal Guardian

If the **insured** is a patient in a **hospital** due to an **accident** and the attending **physician** recommends that the **insured's** parent or legal guardian be with the **insured**, **we** cover the expense for them to travel on a common carrier up to the amount stated in the Schedule of Maximum Benefits.

j) Tutoring

If the **insured** is **injured** due to an **accident** and is continuously confined to **hospital** or to the **insured's** home under a **physician's** care for more than 30 days**, we** cover the cost of tutoring and equipment that the **insured** needs during the period of confinement up to the amount stated in the Schedule of Maximum Benefits. **We** pay up to $30 an hour for up to 6 months for a teacher to tutor the **insured** and the cost to rent necessary equipment and software that the school board recommends.

4. FRACTURE OR DISLOCATION

If the **insured** is **injured** due to an **accident** and fractures or dislocates a body part, **we** pay the benefit that corresponds to the **injury** as shown in the Schedule of Maximum Benefits. If they have more than one **injury** from the same **accident**, **we** cover the one that pays the highest benefit only.

5. CRITICAL ILLNESS

If the **insured** is diagnosed for the first time with one of the following Critical Illnesses during the Coverage Period, **we** cover the cost of treatment and services listed below for up to 3 years from the **physician**'s first diagnosis.

Critical Illnesses:

AIDS (Acquired Immune Deficiency Syndrome)	Leukaemia	Poliomyelitis
Cancer	Meningitis	Rabies
Cardiomyopathy	Multiple Sclerosis	Scarlet Fever
Diphtheria	Muscular Dystrophy	Tetanus
Encephalitis	Myocarditis	Tularaemia
Haemolytic Uremic Syndrome (Renal failure caused solely by E-coli bacterial infection)	Necrotizing Fasciitis	Typhoid

The following treatment and services are provided up to the amount stated in the Schedule of Maximum Benefits:

- a registered nurse;
- $125 a day for hotel, meal, laundry and parking expenses related to the Critical Illness if the **physician** recommends that the **insured's** parent or legal guardian be with the **insured** while they are hospitalized.

6. MEDICAL EQUIPMENT

a) Eyeglasses and Contact Lenses

If the **insured** is **injured** due to an **accident** and needs treatment from a **physician** within 30 days because they:

i) damage or break their eyeglasses or contact lenses; or

ii) need eyeglasses or contact lenses for the first time

we pay up to the amount stated in the Schedule of Maximum Benefits to fix or replace them or to buy new ones. **We** do not cover the normal replacement of eyeglasses or contact lenses if a prescription changes or if they are lost.

b) Prosthetic Device and Hearing Aids

If the **insured** is **injured** due to an **accident** and a **physician** prescribes an artificial limb, artificial eye and/or hearing aid, **we** cover the purchase of the device within 3 years after the **accident**, up to the amount stated in the Schedule of Maximum Benefits**.** If the **insured** damages or breaks their artificial limb, artificial eye and/or hearing aid due to an **accident**, **we** cover up to the amount stated in the Schedule of Maximum Benefits to fix or replace it.

c) Special Clothing

If the **insured** is **injured** due to an **accident** and a **physician** recommends special protective clothing, **we** cover the cost up to the amount stated in the Schedule of Maximum Benefits.

7. TRAVEL (PLATINUM PLAN ONLY IF THE INSURED IS 20 YEARS OLD OR LESS AT THE TIME OF A CLAIM)

a) Out-of-Province Emergency Medical Expenses

If the **insured** travels during the Coverage Period and is **sick** or **injured** outside the province or territory where they live and need **emergency treatment, we** cover it**.** If they are **sick**, it must not be due to a **pre-existing medical condition**. **We** cover **emergency treatment** from a **physician,** registered nurse, **hospital**, x-ray clinic, ground ambulance or up to $1,000 for reasonable alternative ambulance transport if needed. **We** cover the cost of crutches, braces, splints, trusses or other prosthetic devices, emergency medicine, blood and/or plasma and the rental of a wheelchair and/or a hospital-type bed. **We** do not cover the services of a family member.

With respect to emergency treatment, the insured or someone with the insured must notify the emergency assistance provider right away. Our emergency assistance provider must approve all emergency treatment.

24-HOUR EMERGENCY ASSISTANCE
1-800-334-7787 (Canada/USA) or elsewhere
collect 1-905-667-0587

Once the **emergency treatment** is over, **we** have the right to return the **insured** to the place where the trip began. Based on medical evidence, if the attending **physician** says the **insured** is healthy enough to travel without danger to their life and health, **we** will proceed to make travel arrangements. If the **insured** refuses to be returned to the place where the trip began, all benefits stop immediately.

If **we** return the **insured** to the place where the trip began and the **insured** decides to go back to the trip destination or rejoin the trip or tour itinerary, the **policy** will not cover the **insured**.

The overall maximum under this benefit is $200,000 if the **insured** has government health insurance coverage and $5,000 if they do not.

The **company** and the emergency assistance provider **we** appoint are at your service according to the conditions, limitations and exclusions of the **policy**. The medical providers **we** suggest when contacted for help are not **our** employees. Neither **we** nor the emergency assistance provider are responsible for their negligence or other acts or omissions. Neither **we** nor the emergency assistance provider are responsible for the **emergency treatment** or service you receive or do not receive, or for its availability, quality, quantity or results.

b) Trip Cancellation

If the **insured** cancels their trip before it begins due to their **sickness, injury** or death, **we** pay $1,000 or the penalty to cancel within 72 hours of the **physician's** order, whichever is less. **We** do not cover any other reason for cancellation. A **physician** must report in writing on the **sickness** or **injury** and the need to cancel the trip because of it. **We** do not cover cancellation due to emotional or mental disorders unless **hospitalized.**

c) Airflight Accidental Death

If the **insured** dies due to an airflight **accident,** within 90 days of that **accident**, **we** pay the Accidental Death benefit plus $5,000. The **insured** must be a fare-paying passenger on the flight of a **scheduled airline. We** do not cover pilots, operators or crew members.

d) Emergency Return Flight

If the **insured** needs to fly home while on their trip due to their **sickness** or **injury**, **we** pay for the unexpected flight to the place where the trip began. **We** do not cover any other reason for interrupting the trip. The attending **physician** must report in writing on the **insured's sickness** or **injury**. **We** pay the lesser of: i) a one-way economy airfare; ii), the fee to change the existing ticket; or iii) $1,000. If the **insured** receives a refund on the existing ticket, **we** subtract the refund from the benefit **we** pay.

e) Repatriation or Burial

If the **insured** dies outside the province or territory where they live due to a reason that is covered under the **policy**, **we** pay to bring their remains back to the place where their trip began or to bury or cremate their remains at the place where they died. **We** do not cover the cost of a headstone, casket and/or funeral service.

H. EXCLUSIONS APPLICABLE TO THE TRAVEL BENEFIT (G7)

The Travel Benefit (G7) does not cover:

1. **Pre-existing medical conditions** (see definition in Section I);
2. Medical conditions that would make a normally prudent person decide not to travel;
3. Declared or undeclared war, hostile acts, civil war, riot, insurrection, invasion or terrorism;
4. Taking part in military forces training, exercises or manoeuvres, professional sporting events or motorized races;
5. Taking part in mountaineering, parachuting, skydiving, parasailing, bungee jumping, gliding or piloting an aircraft or professional underwater activities;
6. Any claim that is against the law of a government plan or political subdivision in Canada;
7. Pregnancy, miscarriage, childbirth or complications within 2 months of the expected delivery date;
8. Trips taken to arrange or receive medical, **hospital**, or dental services;
9. Expenses inside the province or territory where the **insured** lives;
10. Any claim that happens more than 30 days after the **insured** leaves the province or territory where they live;
11. Therapy for a medical condition the **insured** has;
12. **Hospital** or medical services when there is no emergency; or
13. Expenses where the **insured** is 21 years old or more at the time of a claim.

I. DEFINITIONS

Accident: an unexpected event that is beyond the **insured's** control.

Company, our, us, we: Old Republic Insurance Company of Canada, Hamilton, Ontario.

Confirmation of coverage: the document that identifies the named **insured**.

Dentist: a person, other than a family member, who is legally qualified to practice dentistry in the place where services are provided.

Emergency treatment: any immediate medical care provided by a **physician** that is necessary to prevent or reduce existing danger to life or health.

Hospital, hospitalized: a licensed institution that is staffed and operated for the care and treatment of in-patients. Treatment must be supervised by **physicians** and registered nurses must be on duty 24 hours a day. A laboratory and an operating room must also exist on the premises or in facilities controlled by the establishment. A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa.

Injury, injured: sudden bodily damage due to an **accident** causing the **insured** to seek **emergency treatment.**

Insured: the person whose name is on the **confirmation of coverage,** who is eligible for coverage and for whom the required premium has been paid.

Physician: a person, other than a family member, who is legally qualified to practice medicine in the place where medical services are provided.

Policy: this document and the **confirmation of coverage** which **we** issue when the required premium is paid.

Pre-existing medical condition: a medical or related condition for which treatment or prescribed medication was needed at any time in the 90 days before the **insured's** trip began.

Scheduled airline: an airline with a license to transport fare–paying passengers. It has a regular published schedule and includes chartered flights or licensed tour companies.

Sick, sickness: an illness or disease that needs **emergency treatment** or **hospital** care. Sickness does not include emotional or mental disorders unless **hospitalized**.

Totally and permanently disabled: the **insured** cannot ever be employed.

J. HOW TO SUBMIT A CLAIM

1. Please find the policy number on the **confirmation of coverage** and write it on all correspondence with **us**.
2. To obtain a claim form, download it directly from **our** website www.insuremykids.com or call **us** toll free at 1-800-463-5437.
3. To file a claim under the **policy** with **us**:
   a) **We** must be notified of the event that caused it within 60 days.
   b) You must complete a claim form, attach a dental or medical report and submit them to **us** within 90 days of the event that caused it.
4. Submit the claim form and reports to:

   Old Republic Insurance Company of Canada
   insuremykids Claims Department
   P.O. Box 557
   Hamilton, Ontario, L8N 3K9

   Or by email to IMKClaims@insuremykids.com
5. **We** pay benefits to:
   a) the **insured;** or
   b) the **insured's** estate; or
   c) the **insured's** parent or legal guardian if the **insured** is less than 18 years old.
6. **We** evaluate claims based on the terms and conditions of the **policy**. If you do not agree with how **we** evaluated the claim, you have 2 years from the date the claim is payable or would have been payable to begin legal proceedings.

K. PRIVACY POLICY

The **company** is committed to protecting your privacy. Collecting personal information about you is essential to **our** ability to offer you high quality insurance products and service. The information provided by you will only be used for determining your eligibility for coverage under the **policy**, assessing insurance risks, managing and adjudicating claims and negotiating or settling payments to third parties. This information may also be shared with third parties such as other insurance companies, health organizations and government health insurance plans to adjudicate and process any claim. In the event that **we** must share your information with a third party who conducts business outside of Canada, there is a possibility that this information could be obtained by the government of the country in which the third party conducts business. **We** take great care to keep your personal information accurate, confidential and secure.

Our privacy policy sets high standards for collecting, using, disclosing and storing personal information. If you have any questions about the **company's** privacy policy, please contact **our** Privacy Officer by phone at 905-523-5587 or by email at: **privacy@oldrepublicgroup.com**. To review **our** complete Privacy Policy please visit **www.insuremykids.com/en/privacy.aspx.**

Underwritten by
Old Republic Insurance Company of Canada

Jason Smith, CPA, CA
President and Chief Executive Officer

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