### Definitions

When ever used in this Policy or any amendment, the following terms shall be capitalized and have the meaning specified below.

**Accident/Accidental** means a sudden, unexpected, unforeseeable, unavoidable event, leading directly and independently of all other causes, to bodily injury to an Insured during the Coverage Period.

**Application** means Our form You complete and submit to request insurance under this Policy. The Application forms part of the contract of insurance and some terms are defined in the Application, and some are defined in the Definitions section of this Policy.

**Benefit Maximum** means the amount stated as the limit payable for any particular benefit and applies to services received during the Coverage Period. Regardless of the number of policies issued in a 365 day period, Benefit Maximums do not renew for subsequent Coverage Periods until:

a) 365 days have elapsed from the Effective Date of the original policy purchased and on the anniversary date every year thereafter; or

b) The Effective Date of a new Coverage Period providing it is more than 365 days after the Effective Date of the original Coverage Period on the first policy.

**Claim Administrator** means Travel Healthcare Insurance Solutions Inc. (T.H.I.S.)

**Corrective Device** means a device that is required by You on the advice of a Physician, to correct a debilitating physical impairment and without which it would be a physical impossibility for You to continue Your studies or Your teaching responsibilities at the educational institution in which You are enrolled or are teaching. "Corrective Devices" include prosthetic limbs, wheelchairs, seeing-eye dogs, and hearing aids, but do NOT include eyeglasses.

**Coverage** means the emergency benefits described herein. Coverage is effective throughout the world however Coverage in Home Country is limited; please refer to Excursion or Coverage in Home Country - Canadians (see Benefits), and Exclusion #6.

**Coverage Period** means the period of time during which You are insured for the benefits provided by this Policy, starting from 12:01 a.m. on the Effective Date until 12:00 midnight on either the date (a) specified as the Termination Date on the Application; or (b) of termination of any extension of this Policy. If You return to Your Home Country for any reason other than Excursion or Coverage in Home Country - Canadians (see Benefits), coverage terminates effective the date of Your Return to Your Home Country. The maximum Coverage Period including extensions is 365 consecutive days from the Effective Date.

**Dentist** means a qualified doctor of dentistry lawfully licensed to practice dentistry in the place where dental services are performed, but does not include the Insured or a relative of the Insured.

**Effective Date** means the date Your coverage under this Policy begins. Coverage begins on the latest of the date and time, (a) the required premium is paid, or (b) the date You request as the Start Date on Your Application or (c) the date You leave your Home Country or (d) for returning Canadians, the date you return to Canada.

**Eligible** means a person under 65 years of age travelling outside his/her Home Country (or a Canadian returning to Canada) as a student, faculty, teacher, chaperone, participant in educational/business/cultural exchanges, along with the Insured’s spouse, parents and dependents over the age of 15 days and under 19 years.

**Emergency** means any unexpected Sickness or Injury first occurring during the Coverage Period, which requires immediate Medical Treatment to relieve acute pain and suffering.

**Home Country** means the country where the Insured permanently resides.

**Hospital** means a facility which primarily treats patients on an in-patient basis, is licensed as a Hospital by the jurisdiction where treatment is provided, provides 24 hour a day nursing services by registered or graduate nurses, has a staff of one or more Physicians available 24 hours a day, provides organized facilities for diagnosis and surgical procedures, maintains X-ray equipment and operating room facilities, is not primarily a clinic, nursing, rest or convalescent home or similar establishment and is not, other than incidentally, a location for the treatment of alcoholism or substance abuse.

**Inbound** means an Eligible Insured whose Home Country is not Canada and who is temporarily residing in Canada. Inter-provincial travel is covered.

**Injury** means bodily harm to an Insured due to an Accident that first occurs during the Coverage Period.

**Insured, You or Your** means any Eligible person who submits an application and corresponding payment for coverage under this Policy, and receives acceptance of coverage from Our Plan Administrator in the form of a confirmation or a valid policy ID card.

**Insurer, We, Us, Our** means Old Republic Insurance Company of Canada.

**Medical Treatment** means medical advice, consultation, care, service or diagnosis provided by a Physician, or eligible paramedical provider.

**Medically Necessary** means those services or supplies which are provided to You that are required to identify or treat Your Emergency Sickness or Injury and that are necessary for the relief of acute pain or suffering, or to identify or treat Your Emergency Sickness or Injury; or with respect to Hospital services, those which cannot safely be provided to You as an out-patient.

**Medication** means a drug which is considered Medically Necessary for the treatment or relief of an Emergency Injury or Sickness and which is available only with a prescription provided by a Physician or Dentist.

**Paramedical Provider** means a person who has met the professional and legal requirements necessary to provide the services of a chiropractor, osteopath, naturopath, acupuncturist, chiroprapist, or podiatrist but does not include the insured or a relative of the insured. A referral from a medical doctor is NOT required.

**Plan Administrator** means Travel Healthcare Insurance Solutions Inc. (T.H.I.S.)

**Physician** means a qualified doctor of medicine lawfully licensed to practice medicine in the place where medical services are performed, but does not include the Insured or a relative of the Insured.

**Psychiatrist** means a qualified doctor of psychiatry lawfully licensed to practice psychiatric medicine in the place where psychiatric services are performed, but does not include the Insured or a relative of the Insured.

**Psychologist** means a qualified doctor of psychology lawfully licensed to practice psychology in the place where psychological services are performed, but does not include the Insured or a relative of the Insured.

**Reasonable and Customary** means the amounts usually charged for treatment, services or supplies to provide the appropriate level of care for the severity of the Emergency condition being treated, in the geographical location where the treatment, services or supplies are being provided.

**Sickness** means the sudden onset of a disease or illness that first occurs while this insurance is in effect, and is serious enough for You to seek Emergency Medical Treatment.

**Termination Date** means the date Your coverage under this Policy ends. Coverage ends on the later of the date (a) specified as the Termination Date on the Application; or (b) of termination of any extension of this Policy. If You return to Your Home Country for any reason other than as defined in Excursion or Coverage in Home Country - Canadians (see Benefits), coverage terminates effective the date of your Return to Home Country.
When provided on an in-patient basis following an Emergency, fees are paid based on Reasonable and Customary charges for services provided during the Covered Period up to the Benefit Maximum otherwise specified. Your insurance covers up to $5,000,000 in total benefits for the following Medically Necessary services required to treat an eligible, new emergent medical condition that first begins after the Effective Date of Coverage. These Medically Necessary services include reasonable follow-up visits, tests and surgeries until the initial emergency is resolved, and the condition is stabilized.

Hospital Services • Charges made by a Hospital for semi-private room and board and other necessary services and supplies, including drugs administered, while confined to a Hospital for medical reasons; no limitation on number of days; private room where medically required as determined and approved by the Claim Administrator. For Exceptional Hospitalization Benefit, see below; Charges for Medical Treatment provided on an Emergency in patient or out-patient basis; Charges for anaesthesia or blood products and the administration of such products. Any surgical procedure requires prior written approval from the Claim Administrator, unless a delay will be life threatening or significantly affect the outcome.

Physician’s Fees • All charges made by a Physician for professional services or Medical Treatment.

Psychiatric Fees • When provided on an in-patient basis following an Emergency, fees billed separately for the services of a Psychiatrist will be paid to a lifetime maximum of $10,000. For Outpatient Psychiatric care, see Psychotherapy below.

Exceptional Hospitalization Benefit • If you are admitted to Hospital for suicide, attempted suicide, self-inflicted injuries, mental or emotional disorders (including but not limited to stress, anxiety, panic attacks, depression, eating disorders/weight problems), or psychiatric treatment, we will pay up to a lifetime aggregate limit of $50,000 for medical and/or psychiatric treatment received while you are in Hospital resulting from one or more of these causes.

Psychotherapy • Up to $1,000 Benefit Maximum for charges for out-patient care, including psychiatric and psychologic counselling.

X-rays, Laboratory and Diagnostic Tests • Charges for technical and interpretive services. Prior written approval is required from the Claim Administrator for all major diagnostic testing, including but not limited to magnetic resonance imaging (MRI) and computer axial tomography (CAT) scans.

Prescription Medication • Limited to a 30-day supply of any one type unless prescribed while a Hospital in-patient.

Immunization • Charges for immunization up to $100, provided it is a requirement of your course of studies.

Private Duty Nursing Care • Up to $15,000 Benefit Maximum for the services of a Registered Nurse, Licensed Practical Nurse or Home Care Worker, but does not include the Insured, a relative of the Insured, or someone who normally resides with the Insured, when ordered by the attending Physician.

Physiotherapy and Speech Therapy • Up to $1,000 Benefit Maximum for charges made by a physiotherapist or a speech therapist unless provided while a Hospital in-patient.

Medical Equipment and Supplies • Payable only if required as the result of a covered Sickness or Injury. Purchase of medical supplies, including dressings and prosthetic appliances; Rental charges for wheelchairs, crutches, Hospital-type bed or other apparatus, not to exceed purchase price. Up to $200 Benefit Maximum for prescription glasses or contact lenses, or up to $300 Benefit Maximum for hearing aids. Up to $300 Benefit Maximum for custom orthotics, or up to $800 Benefit Maximum for custom knee braces.

Emergency Transport • The full cost of licensed ambulance service to the nearest Hospital when medically necessary; Emergency transfers between Hospitals when ordered by the attending Physician, including user fee; OR, taxi fare to or from a Hospital or medical clinic for eligible medical care to a maximum $100.

Paramedical Services • Up to $500 Benefit Maximum per Paramedical Provider (chiropractor, osteopath, naturopath, acupuncturist, chiropodist, or podiatrist) for all services, including x-rays.

Accidental Dental Care • Up to $4,000 Benefit Maximum for Emergency dental treatment to repair or replace natural or permanently attached artificial teeth as the result of an Injury caused by an Accidental blow to the mouth. Up to $500 Benefit Maximum for emergency repairs to artificial teeth including bridges and denture plates. Treatment must take place within 90 days of the Accident. Charges incurred as a result of chewing Accidents or Injury due to placing an object to or in the mouth are not payable.

Emergency Dental Care • Up to $600 Benefit Maximum for Emergency dental treatment for the immediate relief of pain and suffering, including root canals and wisdom teeth.

Wart Treatment • Charges for treatment of any type of warts up to $500 Benefit Maximum.

Pregnancy Coverage • Where pregnancy commences after the Effective Date of this Policy, or within the 30 days prior to the Effective Date, when this Policy is purchased at the time of enrollment in a college or university, pre-natal care, childbirth and newborn care (up to age 15 days) are covered up to a combined Benefit Maximum of $25,000. The insurance must be in effect for the entire term of the pregnancy. Serious complications due to pregnancy are covered up to an additional maximum of $25,000. Serious complications do not include complications of pregnancy including but not limited to morning sickness, spotting, ultrasounds, blood and urine testing, including testing for gestational diabetes.

Annual Physician Visit • We will pay up to a total of $150 Benefit Maximum for one visit to a Physician in Canada for a non-emergency exam and associated tests, and for one consultation session and prescription of the ‘morning-after-pill’.

Eye Exams • Up to $100 Benefit Maximum for one non-emergency eye exam performed in Canada by a licenced Optometrist. Note: the cost of glasses or contact lenses is NOT covered.

Excursion • Travel outside Canada (other than to Your Home Country) is covered subject to the following conditions (a) more than 50% of the total Coverage Period must be spent in Canada and (b) travel to the United States is limited to 30 days per trip. Expenses will not be paid when incurred in Your Home Country, except where the trip to the United Country is expressly undertaken in order to participate in a school-organized sporting or extra-curricular event, or when claimed under the Coverage in Home Country – Canadians benefit (see below).

Coverage in Home Country - Canadians • For Canadians returning to Canada, coverage for a maximum 90 days is available during the Coverage Period until provincial healthcare becomes available.

Tutorial Expense • When, by reason of Sickness or bodily Injury, and within 100 days of the date of the first occurrence of said Sickness or Accident, You become disabled and confined to home or hospital and confinement continues for 30 consecutive school days, we will pay, from the first day, the actual expense incurred for the private tutorial service of a qualified teacher, subject to a maximum of $15 per hour, up to $500 Benefit Maximum.

AccessAbility - Corrective Device Defect, Malfunction and Theft Protection • If, while the device is under warranty and/or within a warranty period, the device is proven to be defective, a Corrective Device required by You for which You have not recovered, or a malfunction or defect which becomes apparent while You are covered under this Policy and which renders Your required Corrective Device unusable, we will pay up to $1,000 Benefit Maximum to replace or repair Your Corrective Device. We do not pay for defects or malfunctions which are covered by the manufacturer’s warranty.

Trauma Counselling • If an Insured suffers a covered loss listed in the Schedule of Losses, (other than loss of life – see below) within 90 days from the date of an Accident which occurred during the Coverage Period, we will pay up to 6 sessions of trauma counselling.

Accidental Death and Dismemberment • If an Insured dies or suffers a permanent loss of one member of the body as a result of a covered Accident, Injury, Sickness or malformation which occurs within 90 days from the date of an Accident which occurred during the Coverage Period, we will pay according to the following Schedule of Losses up to $50,000 Benefit Maximum. If the total claims against Us for the same Accident exceed $1,250,000, Our liability for that Accident will be limited to $1,250,000. Claims and benefits will be prorated among all claimants who are persons insured under guard.me. Benefits are payable to the Insured. In the event of the Insured’s death, benefits are payable to the beneficiary noted by the Insured. If a beneficiary is not otherwise designated by the Insured, benefits will be paid to the first of the following surviving preference beneficiaries: 1. the Insured’s spouse; 2. the Insured’s child or children jointly; 3. the Insured’s parents jointly if both are living, or the surviving parent if only one survives; 4. the Insured’s brothers and sisters jointly; or 5. the Insured’s estate.

Schedule of Losses

<table>
<thead>
<tr>
<th>Loss Type</th>
<th>Benefit Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>$50,000</td>
</tr>
<tr>
<td>Loss of Two or more Members</td>
<td>$50,000</td>
</tr>
<tr>
<td>Loss of Sight of Both Eyes</td>
<td>$50,000</td>
</tr>
<tr>
<td>Loss of One Member and Sight of one Eye</td>
<td>$50,000</td>
</tr>
<tr>
<td>Loss of One Member</td>
<td>$25,000</td>
</tr>
<tr>
<td>Loss of Sight of one Eye</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

“Loss of Member” means severance of hand or foot at or above the wrist or ankle joint respectively or complete irreversible paralysis. “Loss of Sight” must be complete and irreversible.

DISAPPEARANCE - If an Insured disappears and after a suitable period of time it is reasonable to believe that such Insured has died as a result of Bodily Injury, the Death Benefit shall become payable subject to a signed undertaking that if the belief is subsequently found to be wrong such Death Benefit shall be refunded to Us.

EXPOSURE - Injury of an Insured as a direct result of unavoidable exposure to the elements shall be deemed to have been caused by Bodily Injury, and benefits will be paid as per the Schedule of Losses, above.

COMMON CARRIER – In the event of the Insured’s death as a result of an Injury caused while traveling as a fare-paying passenger on (a) any form of public transportation (or b) on a scheduled flight on an airplane or helicopter, the benefit increases to $100,000.

The following benefits are covered with the prior approval from the Claim Administrator. The maximum amount payable for the following transportation benefits cannot exceed $300,000 in total per Coverage Period.

Air Evacuation • The cost of transporting You to the nearest Hospital or to a Hospital in Your Home Country, if Medically Necessary, either: a) as a stretcher fare on a regular scheduled flight, including economy return fares for unqualified medical attendants (not a relative) and their associated fees and expenses; or b) by appropriately equipped air ambulance, including associated fees and expenses for a qualified crew.
Benefits (cont’d)

Land ambulance costs at each end of the flight or connecting flights are included. The attending Physician must certify that the Insured is medically fit for the type of transfer selected.

Family Transportation and Subsistence Allowance • If you have no family members within 60 kilometers of your location while you are outside your Home Country and you are hospitalized and your hospitalization is expected to last a minimum of 7 days, or in the event of the death of the Insured, we will pay up to $5,000 towards the cost of round-trip transportation based on the lowest available fare for the most direct route for two persons, unless your credit card benefit insurance, and other travel insurance. Any payment made under this Policy for the purposes of obtaining Medical Treatment or when a terminal prognosis was given to the Insured prior to the Coverage Period.

Repatriation or Burial of Deceased • If death occurs during the Coverage Period as a result of a covered Injury or Sickness, we will pay either (a) up to $15,000 towards the reasonable and necessary cost of preparing and transporting the remains, cremation or burial, and a burial plot in the location where death occurs. The costs for a coffin, urn, headstone or funeral are excluded.

Exclusions

1. a pre-existing condition which means a sickness, injury or other condition that was causing signs or symptoms, and/or required medical advice or investigation, whether a diagnosis was established or not, and/or any form of medical treatment provided by a Physician or other Practitioner during the 3 month period immediately preceding the Effective Date, or if upon the commencement of the coverage, a condition was known or present which reasonably could have been expected to result in disability or death, then we will not pay for any continuing treatment of an Injury or Sickness if the Claim Administrator has determined that it is no longer necessary.

2. Elective or non-Emergency Medical Treatment, including any treatment given to maintain the stability of a chronic sickness or condition, including visits for the refill of medication, tests or examinations forming part of a normal regime, or for treatment of congenital or genetic disorders or conditions, or for treatment not required for the immediate relief of pain and suffering, or which could reasonably be postponed until the Insured returns to his/her Home Country (except as provided under the Annual Physician Visit, Immunization, Pregnancy and Eye Exam Benefits).

3. any continuing treatment of an Injury or Sickness if the Claim Administrator has requested that the Insured return to his or her Home Country following Emergency Medical Treatment; if an Insured who has been evacuated or asked to return Home later returns to Canada to resume studies/teaching in the same or subsequent policy years, the benefits payable will be limited to a maximum of $10,000 for that Sickness or Injury for which they returned Home;

4. medication commonly available without a prescription (including but not limited to ‘over-the-counter’ medications such as acetaminophen or cold/allergy remedies); fertility drugs; contraceptives; erectile dysfunction drugs; anti-baldness drugs; smoking cessation drugs; vaccinations, immunizations or injections (except as provided under the Exceptional Hospitalization Benefit); medication preparations or supplements; or medication received on a preventive or maintenance basis

5. plastic or cosmetic surgery except as a result of a covered Injury; substitution or extraction of, or repairs to an existing prosthesis, (except as payable under the Corrective Devices Benefit)

6. any expenses incurred outside the Coverage Period or while you are in Your Home Country (except as provided under the Recourse or Coverage in Home Country - Canadians Benefits); medical services for any injury that occurred or was treated, or sickness that started or was diagnosed or treated in Your Home Country during the Coverage Period;

7. the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC);

8. suicide, attempted suicide, self-inflicted injuries, mental or emotional disorders (including but not limited to stress, anxiety, panic attacks, depression, eating disorders/weight problems), or psychiatric treatment, (except as described in the Exceptional Hospitalization Benefit, Psychiatrist’s Fees benefit, or Psychotherapy benefit);

9. Your actions while they are impaired or adversely influenced by medication, drugs, alcohol or intoxicants; any medical claims related to the use or misuse of drugs or alcohol;

10. participation in professional sports or hazardous activities such as motorized contests of speed, parachuting, skydiving, hang gliding, bungee jumping, cave exploring, mountaineering, rock or cliff climbing, or scuba diving;

11. operating any type of aircraft or travelling as a passenger on any non-commercial flight; operating any form of motorized transport on land or water without a licence valid for the area where the operating in corked, or on or in any kites or gliders, or any kite’s vehicle while racing or off-road, unless no roads exist in the area in question;

12. injury or sickness caused while you are traveling or serving in any capacity as a member of any armed forces or while actively participating in any conflict of war, or sustained in criminal activity. However, if you sustain an injury as a direct result of war-like actions in which you were not an active participant and within 48 hours of the commencement of such hostilities, any expenses incurred arising from such incident will be covered.

13. any interest, finance or late payment charge.

General Policy Limitations

We reserve the right to arrange transportation to return you to your Home Country following an Emergency, either before or after you receive Medical Treatment, or Hospital or Medical Services. If you decline to return when declared medically fit to travel by the Claim Administrator, we will not pay for any continuing expenses, recurrence or complications arising from or directly or indirectly related thereto.

Limitation on Liability

The Insurer, the Plan Administrator and/or the Claim Administrator are not responsible for the availability, quality or results of any Medical Treatment, or Your failure to obtain Medical Treatment or transportation and shall not be held liable for any negligence, wrongful acts or omissions of any service provider.

General Conditions

The Contract. The Application, this Policy, any document attached to this Policy when issued, and any amendment to the contract agreed upon in writing after the Policy is issued, constitute the entire contract, and no agent has authority to change the contract or waive any of its provisions.

Waiver. The Insurer shall be deemed not to have waived any condition of this contract, either in whole or in part, unless the waiver is clearly expressed in writing signed by the Insurer.

Copy of Application. The Insurer shall, upon request, furnish to the Insurer under the contract a copy of the Application.

Premium Payment. The full premium is due and payable when you apply for insurance. If for any reason the premium paid for the coverage applied for is incorrect, we will a) charge and collect the difference, or b) shorten the Coverage Period if an underpayment in premium cannot be collected, or c) refund any overpayment. Coverage will be null and void if you do not pay your premium when due or if payment is not honoured by the financial institution designated by the Insurer.

The premium is calculated using the most current premium rates on the date you apply for coverage, for your age on the Effective Date. We reserve the right to decline any application for insurance.

Duplicate Contracts or Policies. In the event that more than one contract is issued to one Insured, benefits shall be limited to the maximum payable under one contract at any time, and a refund for duplicate premiums will be issued.

Misrepresentation or Nondisclosure. All coverage under this Policy shall be void, if, knowingly, misrepresented any material fact or circumstance concerning this coverage or subject thereof, or the interest of the Insured therein, or in the case of any fraud or false swearing of the Insured.

Material Facts. No statement made by an Insured at the time of Application for this contract shall be used in defence of a claim under or to avoid this contract unless it is contained in the Application or any other written statements or answers furnished as evidence of insurability.

Governing Law. This Policy is governed by the laws of the Canadian province of Ontario where this Policy was issued. Any action or proceeding against the Insurer for recovery of claims under this Policy must be brought in the Canadian province of Ontario and Court commences a cause of action within 2 years from the date of the cause of action, any action or proceeding against the Insurer for recovery of claims under this Policy must be brought in the Canadian province of Ontario and Court commences a cause of action within 2 years from the date of the cause of action.

Duplicate Contracts or Policies. In the event that more than one contract is issued to one Insured, benefits shall be limited to the maximum payable under one contract at any time, and a refund for duplicate premiums will be issued.

Benefit Payments. All benefits are payable to you unless you assign your right to payment directly to the service provider or another named assignee. In the event of your death all benefits are payable to the beneficiary noted by the Insured. If a beneficiary is not otherwise designated by the Insured, benefits will be paid to the first of the following surviving preference beneficiaries: 1. The Insured’s spouse; 2. The Insured’s children (whether or not they are blood relatives); 3. The Insured’s parents (jointly if both are living, or the surviving parent if only one survives); 4. The Insured’s brothers and sisters (jointly or separately); 5. The Insured’s estate.

Benefit payments do not provide for the payment of any interest. This Policy contains a clause which may limit the amount payable.

Currency. All premium amounts, Benefit Maximums and benefit payments are stated in Canadian Dollar currency. At Our option We may pay a claim in Canadian Dollar currency. For reimbursement purposes, the exchange rate on foreign currency shall be the rate determined at the date the expense was paid and quoted by the financial institution selected by the Insured. At Our option We may pay a claim in foreign currency where the loss occurred.

Co-ordination of Benefits. The benefits in this Policy are payable in excess of those available under any other valid and collectible insurance Policy or plan under which you are insured. Each claim under this Policy is subject to the terms of any other insurance Policy, and the exchange rate on foreign currency shall be the rate determined at the date the expense was paid and quoted by the financial institution selected by the Insured. At Our option We may pay a claim in foreign currency where the loss occurred.

Any amount recovery of claims under this Policy must be brought in the Canadian province of Ontario and Court commences a cause of action within 2 years from the date of the cause of action, any action or proceeding against the Insurer for recovery of claims under this Policy must be brought in the Canadian province of Ontario and Court commences a cause of action within 2 years from the date of the cause of action.

Any action or proceeding against the Insurer for recovery of claims under this Policy must be brought in the Canadian province of Ontario and Court commences a cause of action within 2 years from the date of the cause of action.

Insurance Act respecting contracts of accident and sickness insurance.
Failure to give Notice or Proof. Failure to give notice of claim or furnish proof of claim within the time prescribed above does not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible, and in no event later than one year from the date of the incident or Accident or the date a claim arises under the contract on account of Injury, Sickness or disability if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Plan Administrator to Furnish Forms for Proof of Claim. Claim Forms are provided with each ID Card issued, and are also provided to all schools and organizations. Where a Claim Form is required, the Plan Administrator will provide one to the Insured by fax, email or mail. Claim Forms are also available at our website www.guard.me

Rights of Examination. As a condition precedent to recovery of insurance money under this contract, the Company and/or its designated representative shall have, without incurring any obligation to do so, the right to examine the insured when and so often as it reasonably requires while the claim hereunder is pending. The physician and the location of such examination shall be at the Insurer’s discretion. The Insured agrees to cooperate and to provide full details to the physician. This physician may, in conjunction with input from the treating physician, make additional recommendations to assist in recovery or cure, and (b) in the case of death of the person insured, the Insurer may require an autopsy subject to any law of the applicable jurisdiction relating to autopsies.

Non compliance With Obligations. We may choose to limit or refuse payments when (a) the insured or the party concerned with the payment is negligent in the fulfilment of any obligation resting upon him/her and has thus harmed the interests of the insurer; (b) facts have been incorrectly or insufficiently provided, or have been misrepresented, or if false data has been provided, (c) where an Insured suffers an Injury or Sickness, the Insured is required to seek immediate medical treatment and to follow all doctors advice, prescriptions and orders. Failure to comply may result in reduction or refusal of payments.

When Money Payable. All money payable under this contract shall be paid by the Insurer within 90 days after it has received acceptable proof of claim.

Limitation of Actions. An action or proceeding against the Insurer for the recovery of a claim under this contract shall not be commenced more than two years after the date the insurance money became payable or would have become payable if it had been a valid claim.

CLAIM PROCEDURE

1. You must call the Emergency Assistance Number shown below BEFORE admission to Hospital as an in-patient and for prior written approval BEFORE any expenses are incurred for the following:
   - Major Diagnostic tests
   - Dental
   - Surgery
   - Air Evacuation
   - Family Transportation
   - Repatriation / Burial

2. Present Your guard.me I.D. Card to Your medical service providers.

3. Complete a claim form for EACH new Sickness or Injury when FIRST treated. Take it with You on Your first appointment if possible. You may photocopy a blank claim form for future use or obtain forms from Your organization or from our website at www.guard.me

4. Within 30 days of the first medical expense, log on to www.guard.me to file your claim electronically or MAIL:
   - Completed claim form
   - Original itemized bills / receipts
   - Include medical reports, emergency room report, history & physical, surgical, lab, x-rays and discharge reports to:
     guard.me Claims
     80 Allstate PKY
     Markham, Ontario L3R 6H3
     Remember to keep a copy for Your files.

5. For a death claim, the beneficiary or other person entitled to claim must call Travel Healthcare Insurance Solutions Inc. to report the claim. Details of claim must be submitted with an original death certificate or other proof of death, acceptable to Us. We will not accept liability for any claim submitted to Us more than 1 year after the date the loss was incurred.

Claims cannot be considered unless the claim form is fully completed and signed by the claimant and submitted with all the ORIGINAL required documentation which must be provided free of expense to Us.

Payment will not be released until all original invoices and receipts are received by the Claim Administrator.

Underwritten by:
Old Republic Insurance Company of Canada
100 King Street West, 11th Floor
Hamilton, Ontario CANADA
L8N 3K9

The Company and Our Plan Administrator (collectively “We” “Our” in this privacy section) are committed to protecting Your privacy. When You bought Your Policy You gave consent for Your personal data to be collected and processed by Us in accordance with Our Privacy/Data Protection Notice. The information contained herein will be used only 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. We collect and process Your personal data in line with applicable Privacy and Data Protection legislation. We take great care to keep Your personal information accurate, confidential and secure. If You have any questions about the Company’s Privacy Policy, please contact our Privacy Officer at (905) 923-5587 or by email to: privacy@oldrepublic-group.com.

EMERGENCY PROCEDURES

Failure to notify the Claim Administrator as required will limit Our liability to 90% of the eligible expenses incurred.

Contact the 24 Hour Toll-Free Emergency Assistance Number at 1-888-756-8428 (North America) or collect (905) 731-8291

1. within 24 hours of admission to Hospital, or if incapacitated, as soon as reasonably possible;
2. for any benefit where prior approval is required;
3. for any Excursions, prior to incurring ANY medical expenses.