# INJURY AT WORK (IAW)

FOR ONTARIO EMPLOYEES WITH CASUAL, SEASONAL, PART-TIME (less than 24 hours) OR TEMPORARY CONTRACTS

***Please complete this package if your injury at work resulted in medical attention, time off work or modified duties/hours.***

***NOTE:*** *Karis Disability Services has an internal insurance plan that provides specific support for an employee who has been injured at work. Karis Disability Services* ***does not and is not required to subscribe to WSIB insurance****. For a workplace injury please complete the forms attached and submit to AIG Insurance Company of Canada.*

## Employees Responsibilities:

- Notify your Supervisor and seek immediate medical attention within 24 hours of the incident, if required (e.g. family doctor, urgent care or emergency dept.).
- Complete the Accident/Incident/Occupational Illness/Near Miss Report Form P-5:1 within 24 hours from the incident and submit the completed form to your supervisor.
- Have your health care provider complete and sign the Attending Physician's Statement at your first visit.
- Complete and sign the employee portion (Claimant's Statement) of the Weekly Accident Indemnity form.
- Send the complete package to the Abilities Specialist so the Employer's Statement portion can be completed, and the entire package sent to AIG.
- Send all expense reimbursement claims to AIG directly.
- Familiarize yourself with the benefits available through AIG Insurance Company of Canada (AIG brochure attached)
- Actively participate in the Injury at Work process including the return to work process, follow the recommended treatment plan, work within the limitations/restrictions of a return to work plan, participate in the accident investigation.
- Review Karis Disability Services Policy for Injury at Work, including the Role of the Employee with the Disability.

## Supervisor Responsibilities:

- Provide the employee with access to immediate medical attention (ambulance, taxi if necessary).
- Ensure the employee understands Karis Disability Services Injury at Work Policy E. 6.2.2, the required timelines to seek treatment, and takes this package to their Health Care Provider for the initial visit.
- Immediately offer the employee modified hours and/or duties if appropriate. Please consult with your Supervisor, the Abilities Specialist or the HRBP (as needed).
- Inform the next level Supervisor of the injury at work and complete the P-5:2 Accident Investigation Report.
- Upload both the P-5:1 Employee Accident/Occupational/Illness Report and the P-5:2 Accident Investigation Report to UKG (The employee's UKG profile) and send to your District office within 24 hours of completion.
- P-5:1 Employee Accident/Occupational/Illness Report must be completed within 24 hours of the incident and P-5:2 Accident Investigation Report must be completed immediately after the incident.
- Inform HR Admin and Abilities Specialist if employee misses any shifts following the accident/incident.
- Send all medical documentation received to the Abilities Specialist.
- Inform HR Admin and Abilities Specialist when the employee's status changes.
- Work with the employee, their Health Care Providers, Area Manager and the Abilities Specialist to facilitate a safe and timely return to work as soon as appropriate; create the Return to Work Plan in participation with employee.

**AIG Insurance Company Of Canada**
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

# WEEKLY ACCIDENT INDEMNITY
## Claimant's Statement

**PLEASE PRINT** **Policy #**

Please ensure that original claim documents and invoices are submitted

Surname: Given Name

Address:
(Street & No.) E-Mail:

Apt./Unit No.: Telephone No.: ( )

City/Town Province Postal Code:

Date of
Birth (M/D/Y): Height: Weight: Sex: Male☐ Female

1. Date of Accident (M/D/Y):_____

2. Full details of accident and injury sustained:_____

_____

3. Have you had a similar injury previously? Yes_____No_____

Provide dates and details:_____

4. Name and Address of Physician:_____

5. Where and when did your Physician first attend you?_____

6. Names and Addresses of any other physicians who may have treated you as the result of this accident.

_____

7. What other accident or health insurance do you have?

Company:_____Indemnity:_____

8. Are you receiving a disability pension, W.S.I.B. or unemployment benefits? Yes ( ) No ( )

If "yes", for what?_____Amount: $_____Date of First Payment:_____

9. (a) Are you/were you totally disabled? Yes ( ) No ( ) From _____To _____

(b) Are you/were you house confined? Yes ( ) No ( ) From _____To _____

(c) Are you/were you hospitalized? Yes ( ) No ( ) From _____To _____

If "yes", name and address of Hospital_____

10. (a) When did you or will you resume work - PART TIME? Date:_____Time:_____AM/PM

(b) When did you or will you resume work - FULL TIME? Date:_____Time:_____AM/PM

PERSONAL INFORMATION NOTICE: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by AIG Insurance Company of Canada, its reinsurers and authorized administrators (the "Insurer") to assess my entitlement to benefits, including but not limited to determining if coverage is in effect, investigating the applicability of exclusions and co-coordinating coverage with other insurers. For these purposes, the Insurer will also consult its existing insurance files about me, collect additional information about and from me, and where required, collect information from and exchange information with, third parties. CERTIFICATION: The statements I provide in completing this claim form and otherwise in respect of my claims are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement in the making of this claim, coverage can be cancelled, payment of benefits denied and past claims payments recovered. I agree to refund to the Insurer, the amount of any payments made in the event that such amounts should not have been paid in respect of my claim.

AUTHORIZATION: I authorize, for a period of not less than twelve and not more than twenty-four months from the date hereof, any physician, practitioner, health care provider, hospital, health care institution, medical organization, clinic and any other medical or medically related facility, any insurance company or reinsurance company, workers compensation board or similar plan or organization, benefit plan administrator, federal, territorial or provincial government department, or any other corporation or organization, institution or association (including obtaining information from the group policyholder or my employer) to release and exchange with AIG Insurance Company of Canada, or representatives thereof, all personal health information, benefit payment, employment or financial information about me or any other information or records about me in its possession that is requested while administering my claim. I agree that a reproduction of this authorization shall be as valid as the original.

Dated_____Insured/Insured's Parent/Guardian Signature_____

**AIG Insurance Company Of Canada**
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
416-596-4005 | 1-877-317-8060
ahclaimscan@aig.com | www.aig.com

# ATTENDING PHYSICIAN'S STATEMENT

**The patient is financially responsible for the completion of the form**

Physician's Name (Print)
Name:_____

Address: _____

_____

Phone # _____

Patient's Name (Print)
Name:_____

Address: _____

_____

Phone # _____

Diagnosis including complications (if fracture, specify bone and type of fracture) and Nature of Injury:

_____

_____

_____

DATE OF

First Attendance M D Y

Actual Loss

Is condition the result of an accident? Y ( ) N ( )

Please outline the treatment plan recommended and prescribed:_____

Date of next scheduled follow up appointment:_____

Is your patient totally disabled and unable to perform their occupational responsibilities? ☐ Yes ☐ No

Please provide the term of total disability: From:_____To:_____

Please provide the expected return to work date: _____

Was claimant hospitalized? ( ) No, and if ( ) Yes - Give hospital name, address and date admitted.

_____

Names and addresses of other physicians or surgeons, if any, who attended claimant

_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____ SIGNATURE: _____ M.D.

ADDRESS:_____

# EMPLOYER'S STATEMENT

Name of Employee:_____Date of Employment:_____

Name of Employer:_____

Address of Employer: _____

Did the injury occur while claimant was performing the regular and assigned duties of their occupation? Yes ☐ No ☐

Did the injury occur while claimant was travelling directly to or from their regular place of employment? Yes ☐ No ☐

Description of Injury: _____

Employee was: ☐ Full-time ☐ Part-time ☐ Contract ☐ Seasonal ☐ Other _____

Employee was: ☐ Salary, weekly salary $_____ ☐ Hourly $_____/ Hr x # _____ Hrs/week ☐ Commissioned

**Note: if employee works on shift schedule, then please attach a list of the dates of shifts missed and the hours scheduled**

**If insured's scheduled hours vary from week to week, then please provide an average of hours worked in the 4 weeks prior to the date of incident.**

Occupation/Job Title:_____ Date Last Worked:_____Class No. (if applicable) _____

Will or is this employee receiving any source of income replacement during his/her term of disability (i.e. W.S.I.B, short/long term disability benefits). If yes; please advise source and amount being paid:_____

Date :_____Signature:_____

Telephone No.:_____Title:_____

**Special Risk**
**Policyholder: Karis Disability Services**
**Policy No.: SRG 9020558**

## Why You Need Accident Insurance

A serious accidental injury or death can have tremendous consequences. A serious injury may prevent you from meeting your financial obligations and your loss of life may leave your spouse with insufficient financial resources to pay for the care that your loved ones may require.

Your employer Karis Disability Services has provided for you Accident Insurance coverage underwritten by AIG Insurance Company of Canada. The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

## How It Works

You are automatically covered for a Principal Sum amount of $50,000 as long as you belong to one of the following eligible classes:

**Class I:** All active relief Employees and permanent or temporary part-time Employees of the Policyholder working less than 24 hours per week, under the age of 70 with no minimum hours per week.

**Class II:** All active temporary staff of the Policyholder working over 24 hours per week, under the age of 70.

## Here's What You Get

**Broad Accident Insurance Coverage** - Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents.

**Guaranteed Acceptance** - Coverage is provided regardless of your health history.

**Occupational Coverage** - Your coverage is in force while you are performing the duties of your occupation for your Employer.

## Definitions

**"Insured Employee"** means you, if you belong to one of the previously described classes of eligible Employees of the Policyholder who is under the age of 70.

**Eligible Dependents:**
**"Spouse"** means a person who is under the age of 70 and who is either legally married to you, or if there is no such person, is a person who, although not legally married to you, is cohabitating with you for a period of at least one year and is publicly represented as your domestic partner in the community in which you reside.

**"Dependent Child"** means a person who is either your natural child, adopted child or step-child or a child to whom you are *in loco parentis* and who is (i) under 23 years of age, unmarried and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (ii) under 26 years of age, unmarried and enrolled in post-secondary education and dependent upon you for maintenance and support and not employed for more than 25 hours per week; or (iii) by reason of mental or physical infirmity is incapable of self-sustaining employment and who is considered your Dependent Child within the terms of the Income Tax Act (Canada).

## Beneficiary Designation

**If you are an Insured Employee** and you suffer loss of life, benefits will be paid to the person or persons who are on file with your Employer as having been most recently designated by you. In the absence of any such designation, the beneficiary shall be your estate.

All other benefits will be payable to you.

## Benefits and Coverages

### Accidental Death, Dismemberment, Paralysis and Loss of Use

If a covered loss occurs within 365 days after the date of the covered accident causing the loss, the Plan will pay in one sum the indicated percentage of the Principal Sum as set out in the following Table of Losses:

### Table of Losses

| | |
|---|---|
| Loss of life | The Principal Sum |
| Loss of both hands or both feet | The Principal Sum |
| Loss of entire sight of both eyes | The Principal Sum |
| Loss of one hand and one foot | The Principal Sum |
| Loss of one hand and the entire sight of one eye | The Principal Sum |
| Loss of one foot and the entire sight of one eye | The Principal Sum |
| Loss of one arm or one leg | Four-fifths of the Principal Sum |
| Loss of one hand or one foot | Three-quarters of the Principal Sum |
| Loss of the entire sight of one eye | Three-quarters of the Principal Sum |
| Loss of thumb and index finger of the same hand | One-third of the Principal Sum |
| Loss of speech and hearing | The Principal Sum |
| Loss of speech or hearing | Three-quarters of the Principal Sum |
| Loss of hearing in one ear | Two-thirds of the Principal Sum |
| Loss of four fingers of one hand | One-third of the Principal Sum |
| Loss of all toes of one foot | One-quarter of the Principal Sum |

**Loss of Use**

| | |
|---|---|
| Loss of use of both arms or both hands | The Principal Sum |
| Loss of use of one hand or one foot | Three-quarters of the Principal Sum |
| Loss of use of one arm or one leg | Four-fifths of the Principal Sum |

**Paralysis**

| | |
|---|---|
| Quadriplegia (total paralysis of both upper and lower limbs) | Two times The Principal Sum up to a maximum of one million dollars |
| Paraplegia (total paralysis of both lower limbs) | Two times The Principal Sum up to a maximum of one million dollars |
| Hemiplegia (total paralysis of upper and lower limbs of one side of the body) | Two times The Principal Sum up to a maximum of one million dollars |

If you sustain more than one loss as a result of the same accident, only one amount, the largest, will be paid.

"Loss" when used with reference to “Quadriplegia”, “Paraplegia”, and “Hemiplegia” means the complete and irreversible paralysis of such limbs; “Hand” or “Foot” means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; “Arm” or “Leg” means the complete severance through or above the elbow or knee joint; “Thumb and Index Finger” means the complete severance through or above the first phalange; “Fingers” means the complete severance through or above the first phalange of all Four Fingers of One Hand; “Toes” means the complete severance of both phalanges of all the Toes of One Foot; “The Entire Sight of One Eye” means the total and irrecoverable Loss of Sight such that corrected visual acuity must be 20/200 or less in such eye; “The Entire Sight of Both Eyes” means the total and irrecoverable Loss of Sight in Both Eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing; “Hearing in One Ear” means the diagnosis of permanent Loss of Hearing in One Ear, with an auditory threshold of more than 90 decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Hearing” means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than 90 decibels in each ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing; “Speech” means complete and irrecoverable Loss of the ability to utter intelligible sounds; and "Loss of Use" means the total and irrecoverable Loss of Use provided the Loss is continuous for 12 consecutive months and such Loss of Use is determined to be permanent. “Loss” when used herein may also include “Loss of Life”.

## Weekly Accident Indemnity Benefit

If you suffer Injury, within thirty days after the date of the accident Total Disability, the Company shall pay a Weekly Accident Indemnity Benefit during a period of continuous Total Disability subject to the following conditions:

**Total Disability Weekly Accident Indemnity Benefit for Insured Employees:**

(a) **Benefit Amount:** 75% of your Regular Gross Weekly Income up to a maximum of $1,000 per week for a maximum of:
**Class I –** 26 weeks for any one period of continuous Total Disability and Partial Disability.
**Class II** – 13 weeks for any one period of continuous Total Disability and Partial Disability.

(b) **Waiting Period:**
**Class I** – zero (0) days from the date you have been determined by a Physician to be impaired from performing the regular duties of your occupation with your Employer.
**Class II** – four (4) days from the date you have been determined by a Physician to be impaired from performing the regular duties of your occupation with your Employer.

(c) **Partial Return to Work or Partial Disability Weekly Accident Indemnity Benefit:** Your weekly accident indemnity benefit reduced by 50% of your remuneration earned in the partial return to work program or if a return to work program is not available; 50% of your Benefit Amount as shown above up to 50% of the Maximum Number of Weeks Payable as shown above.

## Accidental Para-Medical Expense Reimbursement Benefit

If as a result of Injury, and within 30 days from the date of the accident causing such Injury, you obtain medical treatment in Canada from a legally qualified Physician and as a consequence of such Injury incurs expenses for any of the following services when recommended by a legally qualified Physician, the Company shall reimburse you the reasonable and necessary expenses for the following para-medical services:

(a) fees for private duty nursing by a licensed graduate nurse (R.N.), who does not ordinarily reside in the Insured Person's home and who is not a member of the Insured Person's Immediate Family. This benefit is payable up to $50 per hour to a maximum of $5,000 per Insured Person for all Injuries resulting from any one accident;
(b) transportation costs, when such service is provided by a professional ambulance service, to the nearest approved Hospital which is equipped to provide the required and recommended necessary treatment. This benefit is payable up to a maximum of $5,000 per Insured Person for all Injuries resulting from any one accident;
(c) Hospital charges for the difference between the public ward allowance under the Insured Person's provincial or territorial government health insurance plan and the accommodation charge for a semi-private Hospital room. This benefit is payable up to a maximum of $5,000 per Insured Person for all Injuries resulting from any one accident;
(d) fees for rental of a wheelchair, iron lung or other durable equipment, not to exceed the purchase price prevailing at the time rental became necessary;
(e) fees for services of a licensed physiotherapist. This benefit is payable up to a maximum of $300 per Insured Person for all Injuries resulting from any one accident;
(f) cost of prescription drugs and medicines (except in the Province of Quebec);
(g) expenses for hearing aids, crutches, splints, casts, trusses and braces, but excluding replacement thereof; and
(h) fees for services of a licensed chiropractor. This benefit is payable up to a maximum reimbursement of $300 per Insured Person for all Injuries resulting from any one accident.

Reimbursement shall only be made provided that expenses are:

(a) incurred in Canada;
(b) incurred within 52 weeks of the date of the accident causing Injury;
(c) incurred only for therapeutic and not elective treatment; and
(d) supported by an original receipts submitted to the Company as proof of claim.

This benefit is in excess of any similar benefit provided under any other insurance, policy or plan, including but not limited to a policy of automobile insurance and any federal or provincial hospital, medical or drug plan.

The maximum amount payable for this benefit is $10,000 for all Injuries resulting from any one accident.

### Accidental Dental Expense Reimbursement

If you suffer Injury to whole and sound teeth, and within 30 days from the date of the accident causing such Injury obtain treatment in Canada for such Injury from a legally qualified dentist or dental surgeon and incur related dental expenses, the Company shall reimburse you the amount for such dental expenses up to the amount allowed for such service in the General Practitioner Schedule of Fees and Treatment Services of the Provincial Dental Association in the province or territory in which you receive such treatment.

Reimbursement shall only be made provided that expenses are:

(a) incurred in Canada;
(b) incurred within 52 weeks of the date of the accident causing Injury;
(c) incurred only for therapeutic and not elective or aesthetic treatment; and
(d) supported by an original standard dental claim form submitted to the Company as proof of claim.

This benefit is in excess of any similar benefit provided under any other insurance, policy or plan, including but not limited to a policy of automobile insurance and any federal or provincial hospital, medical or drug plan.

The maximum amount payable for this benefit is $500 dollars for all Injuries resulting from any one accident.

### Rehabilitation Benefit

Reimburses your expenses for occupational training to a maximum of $15,000 if such expenses are incurred within two years of and as a result of an injury for which you receive a benefit under the Plan.

### Home Alteration and Vehicle Modification Benefit

Pays a benefit of up to $15,000 for modification to your home or vehicle if you suffer an injury for which you receive a benefit under the Plan and require a wheelchair to be ambulatory.

### Workplace Modification and Accommodation Benefit (for employees only)

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require special adaptive equipment or workplace modification in order to return to full-time work with your employer.

### Psychological Therapy

Pays a benefit of up to $5,000 if you suffer an injury for which you receive a benefit under the Plan and require psychological therapy within 2 years of the injury.

### In-Hospital Benefit

Pays a benefit of (i) 1% of the Principal Sum to a maximum of $2,500 per month for hospital confinements of more than 30 nights, or (ii) $1/30^{th}$ of the amount determined under (i) for hospital confinements of more than 5 but less than 30 nights, if you suffer an injury for which you receive a benefit under the Plan and are confined to hospital as a result of such injury, for a maximum of twelve months.

### Family Transportation

Pays a benefit of up to $15,000 for the expenses incurred for the transportation of an immediate family member to your hospital if you suffer an injury for which you receive a benefit under the Plan and as a result are confined to a hospital more than 100 kilometres from home.

### Repatriation Benefit

Pays a benefit of up to $15,000 to cover the expenses to return your body to your city of residence if you suffer a covered accidental death while at least 50 kilometres from home.

### Identification Benefit

Pays a benefit of up to $5,000 for the transportation of an immediate family member to identify your body if you suffer a covered accidental death at least 150 kilometres from home and a law enforcement agency requests such identification.

### Seat Belt Benefit

Pays an additional benefit of 10% of the Principal Sum to a maximum of $50,000 if you suffer a covered accidental death while operating or riding as a passenger in a private passenger automobile in which your seat belt was properly fastened.

### Day Care Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per year for the day care costs of each Dependent Child under age 13 who is enrolled, or who enrolls within 90 days, in a day care facility if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

### Dependent Child Educational Benefit
Pays an annual benefit of up to 5% of the Principal Sum to a maximum of $5,000 per school year for the tuition costs of each Dependent Child who is enrolled in post-secondary education if you suffer a covered accidental death. The benefit is payable for up to four consecutive years.

### Spousal Educational Benefit
Pays a benefit of up to $15,000 for your Spouse's expenses in enrolling in a professional or trades training program for the purpose of obtaining an independent source of income if you suffer a covered accidental death and such expenses are incurred within 30 months of your death.

### Funeral Expense
Pays a benefit of up to $5,000 to reimburse funeral expenses if you suffer a covered accidental death.

### Bereavement Benefit
Pays a benefit of up to $1,000 if you suffer loss of life in a covered accident and your eligible dependents require counseling within one year of the accident.

### Policy Exclusions
The Plan will not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

(a) suicide or any attempt thereat by you while sane;
(b) self inflicted injury or any attempt thereat by you while sane or insane;
(c) declared or undeclared war or any act thereof;
(d) sickness, disease, or bodily infirmity whether the loss or claim results directly or indirectly from any of these;
(e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;
(f) sustained while you are undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;
(g) stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm;
(h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
    (i) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
    (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
    (iii) riding as a passenger in an aircraft owned or leased by the Policyholder;
(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;
(j) injury or Loss sustained if you are on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);
(k) injury or Loss sustained while you are under the influence of alcohol and operating any vehicle or means of transportation or conveyance while your blood alcohol is over 80 milligrams in 100 millilitres of blood;
(l) injury or Loss sustained while you are under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licensed physician;
(m) the commission or attempted commission by you or injury incurred while you are in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and
(n) an act, attempted act or omission taken or made by you, or an act, attempted act or omission taken or made with your consent, for the purposes of interrupting the blood flow to your brain or to cause asphyxiation to you whether with intent to cause harm or not; and
(o) natural causes; and
(p) an accident occurring (i) while the Insured Employee is not engaged in an Occupational Activity, or (ii) while the Insured Member is not engaged in a Sanctioned Activity.

### Aggregate Limit Per Accident
The maximum amount the Company will pay for two or more Insured Persons injured in one accident is the amount of the Aggregate Limit Per Accident set out in the Policy, if any. If the total of the benefits which would be paid by the Company would exceed the Aggregate Limit Per Accident, each Insured Person shall receive their proportionate share of the amount of the Aggregate Limit Per Accident paid by the Company.

### Effective Date
Your coverage begins on the date you satisfy the definition of “Insured Employee”.

### Termination Date
Coverage ends on the earliest of:

1. the date the policy is terminated;
2. the premium due date if premiums are not paid when due;
3. the date you no longer satisfy the definition of an Insured Employee; or
4. the first day of the month following the date you no longer belong to an Eligible Class of Employees or Insured Member as set out in the Policy.