



Aviva Insurance Company of Canada

**Policy Declarations**

<b>EXCESS TRAVEL MEDICAL POLICY</b>	<b>MASTER POLICY NUMBER: T.R.A.V. 1001</b> <b>CERTIFICATE NUMBER: TR1001-00420-001</b> <b>STATUS: NEW</b>
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<b>NAMED INSURED:</b> Roller Sports Canada	<b>BROKER:</b> Pearson Dunn Insurance Inc.
<b>MAILING ADDRESS:</b> 96-400 Bloor St Mississauga, ON, L5A 3M8	<b>BROKER ADDRESS:</b> 435 McNeilly Road, Suite 103 Stoney Creek, ON, L8E 5E3

<b>POLICY PERIOD:</b>	<b>From: January 1, 2012 To: January 1, 2013</b>
	12:01 a.m. Standard time at the Mailing Address of the Named Insured as stated herein.

**WARNING - THIS POLICY MAY CONTAIN A WARRANTY THAT MAY VOID COVERAGE**

The only insurance afforded by this Policy is that which is provided by the forms indicated below. Reference should be made to the applicable forms for details.

**Description of Operations:** Sanctioned activities of the Named Insured with respect to Roller Figure Skating, Roller Speed Skating, Roller Derby, Flat Track Derby

**Forms and Endorsements Applicable to the Excess Travel Medical Policy**

Form Number	Coverage and/or Form Name	Deductible	Limits of Insurance (\$)	Premium
<b>EXCESS TRAVEL MEDICAL POLICY</b>				
<b>3100000</b>	Excess Travel Medical Insurance Coverage Form			
	Accidental / Sickness Medical Expense	N/A	\$2,000,000	
	Dental Accident		\$5,000	
	Out of Pocket Expenses		\$300	
	Trip Interruption		One Way Economy	
	Repatriation Expense		\$3,000	
	Location: Worldwide			
	Aggregate Expenses Payable for any one Accident		\$2,000,000	

**Excess Travel Medical Rating Schedule**

Rating Basis	Rate Amount	Rating (\$)
Per person / travel day		

**Minimum Retained Premium:**

**Total or Advanced Premium:**

**Deposit**

*SM Carter*  
**Authorized Signature**

Date Issued  
December 30,  
2011

Certificate Number  
TR1001-00420-001

Claims Assist  
1-866-661-7507

EXCESS SPORTS TRAVEL MEDICAL INSURANCE

Policy Number T.R.A.V. 1001

AVIVA Insurance Company of Canada  
Toronto, Ontario  
(hereinafter called the Insurer)

**SCHEDULE OF BENEFITS**

<b><u>Type of Coverage</u></b>	<b><u>Maximum Sum Insured</u></b>
Accident /Sickness Medical Expense	\$2,000,000
Dental Accident	\$5,000
Out-of-pocket Expenses	\$300
Trip Interruption	One Way Economy
Repatriation Expense	\$3,000
Aggregate Expense Payable for one Incident	\$2,000,000

**Notification within 2 business days of admission to hospital must be provided to:**

Your Broker

or

GameDay Insurance Inc.  
1-866-661-7507

**SECTION 1: GENERAL INSURING AGREEMENT**

The Insurer agrees with the policyholder to provide such coverages as are described in the following sections of this policy to all eligible persons who apply for and pay in advance the appropriate premiums thereof.

**PART I - DEFINITIONS**

"Economy flight fare" means the lowest one-way single seat fare of any ATC or DATA Air Carrier, on any flight departing from the return point of departure to the return destination.

"Eligible Person" wherever used in this policy means a member of the policyholder who is a permanent resident of Canada. Benefits upon return to place of residence shall be for a maximum of 90 days.

"Family member" wherever used herein means the legal or common-law spouse, parents, stepparents, grandparents, natural or adopted children, stepchildren, grandchildren, brothers, sisters, stepbrothers or stepsisters, brother-in-law, sister-in-law, father-in-law, mother-in-law, son-in-law, daughter-in-law, uncle, aunt, cousin.

"Hospital" means an institution operated pursuant to law for the care and treatment of injured or ill persons, which has organized facilities for diagnosis and surgery providing 24 hour service by legally qualified Physicians and Registered or Graduate Nurses, other than an institution which makes no charge that an insured person is required to pay.

"Injury" wherever used in this policy means bodily injury caused by an accident occurring while the individual certificate is in force, resulting directly and independently from all other causes in loss covered in this policy.

"Insured" wherever used in this policy means a person who is eligible for the Insurance applied for and who has paid the full premium required in advance. Premiums paid for Insurance for which a person is not eligible shall be refunded.

"Physician" means any person other than the Insured or any member of his or her immediate family who is practitioner of the healing arts whose legal and professional standing within his jurisdiction is equivalent to a doctor of medicine (M.D.) duly licensed to practice in any province of Canada.

"Pre-existing medical condition" means an injury or sickness existing prior to the effective date of the applicable insurance coverage.

"Sickness" wherever used in this policy means sickness or disease contracted and commencing while the individual certificate is in force. The term "sickness" shall include pre-existing medical conditions which were stabilized at the time of booking and in the opinion of the Insured's physician are not expected to interfere with normal activities including travel in the foreseeable future.

"Terrorism" means an ideologically motivated unlawful act or acts, including but not limited to the use of violence or force or threat of violence or force, committed by or on behalf of any group(s), organization(s), or government(s) for the purpose of influencing any government and/or instilling fear in the public or a section of the public.

## **SECTION II: ACCIDENT-SICKNESS INSURANCE**

### **PART I – EXCESS MEDICAL-HOSPITAL EXPENSE – ACCIDENT & SICKNESS**

When as a result of an injury or sickness the Insured requires necessary services of a physician, registered nurse, physiotherapist, hospital, x-ray clinic, laboratory, ambulance, or emergency medical return to the outbound point of departure, the Insurer will pay the actual expenses incurred not to exceed the maximum sum stated on the individual certificate.

Hospital services shall include all necessary services provided normally by a duly registered and licensed hospital excluding services of a nursing home, rest home, or by other non-hospital institutions.

Coverage is provided only for expenses incurred by Canadian residents which are in excess of the benefits available under any Canadian Federal or Provincial Hospital and/or Medical Plan regardless of whether or not the Insured is enrolled in such a plan.

### **PART II – ACCIDENT AND SICKNESS LIMITATIONS**

Expenses incurred for necessary medical/hospital services outside Canada as provided in Part II are covered only if the Insured returns to his permanent place of residence as soon as medically possible.

Necessary medical/hospital expenses incurred after return to permanent residence for continuation of treatment commenced abroad for which benefits are payable under Part II shall be covered for a period not to exceed 90 days for Canadian residents, immediately following the Insured's return.

### **PART III – BLANKET DENTAL ACCIDENT REIMBURSEMENT**

When an injury to whole or sound teeth including filled or restored teeth requires and receives dental treatment commencing within 30 days of the date of the accident the Insurer shall pay for the necessary expenses for such treatment rendered within 52 weeks of the accident. Payments for all treatment rendered shall be limited to an aggregate of \$5,000.00. The following provisions also apply:

- (a) Any Payments made under this section shall not exceed the amount specified in the Schedule of Fees in effect at the time of the accident as published by the Dental Association of the Province in which this policy is issued.
- (b) Capped or crowned teeth shall be deemed as whole or sound teeth.
- (c) No benefits will be payable for expenses of dental treatment incurred for the cost of replacement, adjustment or repair of artificial teeth or dentures (except as otherwise provided herein), any orthodontic treatment, any dental treatment provided solely for cosmetic or aesthetic reasons.

### **PART IV – ACCIDENT AND SICKNESS EXCLUSIONS**

This Insurance does not provide expenses incurred directly or indirectly as a result of:

- (a) Injury or sickness for which medical/hospital benefits are provided under any other insurance policy or plan except for the excess not covered under such other Insurance;
- (b) Maintenance therapy for pre-existing medical conditions;
- (c) Dental, chiropractic or any other health services not mentioned specifically in Part II – Excess Medical/Hospital Expenses;
- (d) Suicide or self destruction, intentionally self-inflicted injuries or any attempt thereof;
- (e) Declared or undeclared war, civil war, riot, insurrection, invasion, or any act thereof;
- (f) An illegal act by the Insured or beneficiary;
- (g) Participation in armed forces training exercises or maneuvers

(h) A payment which contravenes any plan of any government or political subdivision or law in Canada

#### PART V – CLAIM PROCEDURE PROVISIONS

**Notice of Claim:** Notice of claim must be given to the administrator within 30 days after the occurrence or commencement of any loss covered under this policy, or as soon afterwards as is reasonably possible.

Written notice given by or on behalf of the Insured or his beneficiary to the administrator at its home office or any branch office, with information sufficient to identify the Insured will satisfy the requirements for notice of claim.

**Proof of Loss:** Written proof of loss must be given to the administrator at its home office or any branch office within 90 days after the date of loss with respect to a claim for any loss covered under this policy. Failure to furnish proof of loss within the time required shall not invalidate or reduce any claim. If it was not reasonably possible to give proof within the required time provided proof of loss is furnished as soon afterwards as is reasonably possible. All necessary forms for filing proof of loss will be furnished by the administrator after it receives notice of claim. However, if the administrator fails to furnish the forms within 15 days after the notice is given, the time requirements for proof of loss will be satisfied if written proof describing the occurrence, the character and the extent of the loss is furnished to the administrator at its home office or any branch office within the required time.

**Payment of Claim:** All benefits payable under this policy will be paid immediately upon receipt of proof of loss satisfactory to the Insurer. Benefits payable for loss of life will be paid in accordance with the beneficiary designation provisions. All other benefits will be paid to the Insured.

However, all or any part of the benefits payable an account of hospital, nursing or medical or surgical services may, at the Insurer's option unless the Insured requests otherwise in writing not later than when filing proof of loss, be paid directly to the hospital or individuals rendering the services. Any benefit unpaid at the Insured's death will be paid to the estate.

**Physical Examination and Autopsy:** The Insurer may require the Insured to be examined by medical examiners of its choice when and as often as is reasonable during the pendency of a claim under this policy. The cost of such an examination shall be paid by the Insurer. The Insurer may, at its own expense and where not forbidden by law, have an autopsy performed also in the case of the Insured's death.

**Beneficiary Designation, Assignment:** The Insured has the right on forms furnished by the administrator to designate a beneficiary or beneficiaries: in the absence of a specific designation the beneficiary shall be Insured's legal heirs. The Insured has the right to change the beneficiary designation, and consent of the beneficiary is not required for surrender or assignment of benefits under this policy or for any change of beneficiary designation or for any changes in the coverage of this policy. No change of beneficiary or assignment of interest under this policy will be binding on the Insurer unless and until the original or duplicate of it is received at the home office of the administrator. The Insurer does not assume any responsibility for the validity of any assignment or beneficiary designation.

### SECTION III: INTERRUPTION INSURANCE

#### PART I – BENEFITS

**Out-of-Pocket Expenses:** In the event covered injury or sickness causes an Insured's delay in returning to the point of departure beyond the return date, the Insurer will pay for reasonable out-of-pocket expenses incurred by the Insured up to the per diem amount specified in the individual certificate, not to exceed the maximum applicable benefit for all such expenses.

**Trip Interruption:** If, after the outbound departure, the Insured is obliged to leave the tour upon a physician's advice due to covered illness or injury, the Insurer will pay for the cost of one-way economy class transportation to rejoin the ongoing tour or to original point of departure.

**Repatriation Expense:** In the event of covered death of the Insured, occurring after the originating flight date, the Insurer will pay the cost of the actual expenses incurred for conveyance of the body and ashes of the insured person, to the outbound point of departure, not to exceed the applicable maximum benefit.

#### PART II – EXCLUSIONS

The Insurance under Section III of the master policy does not cover any loss caused by or resulting from:

(a) Suicide or any attempt thereat, or intentionally self-inflicted injuries, while sane or insane;

- (b) Injury, sickness, death quarantine, or jury duty of the immediate family members of any insured person's travelling companion;
- (c) The suicide of a family member shall not preclude payment of benefits for trip interruption (return flight) to an Insured who is forced to cancel or interrupt a trip because of such suicide provided such benefits are otherwise payable;
- (d) Bodily injuries arising directly or indirectly, in whole or in part, out of "terrorism" or out of any activity or decision of a government agency or other entity to prevent, respond to or terminate "terrorism". This exclusion applies regardless of any other contributing or aggravating cause or event that contributes concurrently or in any sequence to the bodily injuries.
- (e) Bodily injuries arising directly or indirectly, in whole or in part, out of war, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military power. This exclusion applies regardless of any other contributing or aggravating cause or event that contributes concurrently or in any sequence to the bodily injuries.

#### PART III - LIMITATIONS

- (a) In the presence of any injury or sickness the attending physician must be informed promptly of the Insured's travel plans and any booking or cancellation of a trip must take place immediately after the physician's advice based upon his medical opinion as to whether or not the injury or sickness was likely to interfere with the trip.
- (b) Pre-existing medical conditions are covered provided they have been stabilized at the time of booking and in the opinion of the Insured's physician are not expected to interfere with normal activities including travel for the foreseeable future.
- (c) The provisions of (a) or (b) apply to the Insured whose injury, sickness or death give rise to a claim for any other benefit provided in Section III, Interruption Insurance.
- (d) No benefit will be payable for any loss resulting from covered "injury" or "sickness" suffered by the Insured while outside Canada unless the Insured receives in-patient or out-patient treatment at a hospital for the injury or sickness. In addition, no benefit will be payable if the Insured receives substitute transportation to the scheduled return destination or to rejoin the trip or tour.

#### PART IV - CLAIM PROCEDURE PROVISIONS

**Notice of Claim:** Notice of claim must be given to the administrator within 30 days after the occurrence or commencement of any loss covered under this policy, or a soon afterwards as is reasonably possible. Written notice given by or on behalf of the Insured or his beneficiary, to the administrator at its home office or any branch office, with information sufficient to identify the Insured will satisfy the requirement for notice of claim.

**Proof of Loss:** Written proof of loss must be given to the administrator at its home office or any branch office within 90 days after the date of loss with respect to a claim for any loss covered under this section of the policy. Failure to furnish proof of loss within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof of loss is furnished as soon afterwards as is reasonably possible. All necessary forms for filing proof of loss will be furnished by the administrator after it receives notice of claim. However, if the administrator fails to furnish the forms within 15 days after the notice is given, the time requirements for proof of loss will be satisfied if written proof describing the occurrence, the character and the extent of the loss is furnished to the administrator at its home office or any branch office within the required time.

**Payment of Claims:** All benefits payable under this policy will be paid immediately upon receipt of proof of loss satisfactory to the Insurer. In the event of the Insured's death all benefits otherwise payable are payable to this estate.

**Physical Examination and Autopsy:** The Insurer may require the Insured to be examined by medical examiners of its choice when and as often as is reasonable during the pendency of a claim under this policy. The cost of such an examination shall be paid by the Insurer. The Insurer may, at its own expense and where not forbidden by law, have an autopsy performed in the case of the Insured's death.

#### **SECTION IV: GENERAL POLICY CONDITIONS**

**Entire Contract-Changes in Policy:** This policy includes the endorsements and attached papers, if any, and contains the entire contract of Insurance.

No statements made by the applicant for Insurance not included herein shall void the policy or be used in any legal proceeding hereunder. No agent, except the administrator has authority to change this policy or to waive any of its provision. No change in this policy shall be valid unless approved by the administrator or an executive office of the Insurer.

**Records and Reports:** The administrator must maintain records and furnish periodically to the Insurer any information pertaining to individuals becoming insured and terminations of Insurance as the Insurer may require. The insurer may, at any reasonable time, inspect any records of the administrator which affect the Insurance under this policy.