PRODUCT GUIDE

Wawanesa Life's

QUICK ISSUE CRITICAL ILLNESS

Wawanesa Life

QUICK ISSUE CI

What is Wawanesa Life's Quick Issue Critical Illness plan?

The Quick Issue Critical Illness plan provides a lump sum living benefit to the owner of the plan on the occurrence of the first of one of the following specific critical illnesses of the insured provided the insured survives the waiting period following the onset of the critical illness. The waiting period is 30 days from diagnosis unless a longer period is specified in the Definitions of Insured Conditions as outlined in this guide. No living benefit is payable if cancer is diagnosed within 90 days of issue. If death occurs prior to, or within 30 days of, onset of the specified critical illness, a return of basic premium will be paid to the beneficiary.

The Quick Issue Critical Illness plan has three premium payment options:

10 Year Term Renewable to Age 75 provides a level amount of critical illness insurance which can be renewed every 10 years until age 75 of the insured at which time the insurance terminates. Premiums increase at each renewal.

Level Term to Age 75 provides a level amount of critical illness insurance until age 75 of the insured at which time the insurance terminates. Premiums are level and guaranteed at issue.

Level Term to Age 75 with Flexible ROP provides a level amount of critical illness insurance until age 75 of the insured at which time the insurance terminates. Premiums are level and guaranteed at issue. If the insured reaches the later of age 65 or 10 policy years before a critical illness benefit is paid and the policy is in force, the Company will refund to the policyowner 50 percent of annual premiums paid on the in force volume at the time of surrender, proportionately increasing to 100 percent return of premium at age 75.

The Quick Issue Critical Illness plan is issued upon answering 'No' to just 8 qualifying questions, provided there are no unfavourable reports from the Medical Insurance Bureau.

The 14 Covered Illnesses use industry benchmark definitions and include:
Heart Attack, Stroke (Cerebrovascular Accident), Cancer (Life-Threatening), Coronary Artery Bypass Surgery, Failure of Both Kidneys, Major Organ Transplant, Major Organ Failure on Waiting List, Paralysis, Occupational HIV Infection, Blindness, Deafness, Loss of Speech, Loss of Limbs, and Severe Burns.

Issue ages: 18- 60 years for all plan types

Issue Amounts: $10,000 - $100,000 volumes available

Policy Fee: $60 per year

QUICK ISSUE CI *Qualifying Questions*

1. Within the last two years, have you had an application for individual life insurance or critical illness insurance rated, declined, postponed or had exclusions added by Wawanesa Life or any other company?

2. Have you ever been treated for, diagnosed, consulted a doctor, received abnormal test results or experienced symptoms of the following:
   a) Heart attack, congenital cardiac defects, angina, angioplasty, coronary artery bypass, congestive heart failure, stroke, transient ischemic attack (TIA), arteriosclerosis or any other cerebrovascular disease or disease of the heart or the blood vessels, or an abnormal electrocardiogram (EKG)?
   b) Type 1 (insulin-dependent) diabetes or type 2 diabetes?
   c) Cancer or other malignant disease, growth, tumour or colon polyp?
   d) Multiple sclerosis or motor neuron disease?
   e) Any breast disorders (mass, cyst, unusual discharge, physical change, abnormal mammogram or biopsy) or prostate disorders (nodule or abnormal PSA)?
   f) Any eye or ear problems or diseases other than corrected by glasses, contact lenses or hearing aids?

3. a) Have you consulted a physician for an illness or condition which has not yet been diagnosed or for which testing is still in progress?
   b) Have you noticed any symptoms or health problems for which you have not yet consulted a physician, such as: lump or mass of the breasts, shortness of breath, chest pain, dizziness, loss of balance, numbness, rectal bleeding, prostate or other problems?

4. Have you ever tested positive for HIV or been diagnosed, treated for or had any indication of AIDS, AIDS related complex, liver or kidney failure, cirrhosis, chronic kidney disease, hepatitis B or C, or carrier of hepatitis B?

5. Within the last five years, have you received treatment or been advised to seek treatment or medical advice because of your alcohol usage?

6. Within the last five years, have you used: heroin, cocaine, hallucinogens or any other hard drugs other than as prescribed by a doctor, or methadone whether prescribed by a doctor or not, or have you received treatment or been advised to seek treatment or medical advice because of your drug usage?

7. To the best of your knowledge, has one of your natural parents or siblings ever suffered from, or are suffering from heart disease, cancer, stroke or transient ischemic attack (TIA) prior to the age of 55?

8. Does your weight exceed the weight indicated in the maximum weight table to the right?

HEIGHT		WEIGHT	
FEET/INCHES	CENTIMETERS	POUNDS	KILOGRAMS
5'0" - 5'3"	150 - 162 cm	200 lbs	91 kg
5'4" - 5'6"	163 - 169 cm	230 lbs	104 kg
5'7" - 5'9"	170 - 177 cm	250 lbs	113 kg
5'10" - 6'0"	178 - 183 cm	275 lbs	125 kg
Over 6'0"	Over 183 cm	290 lbs	132 kg

Preliminary question on application: Are you a Canadian citizen or landed immigrant? (If No, coverage is not available)

DEFINITIONS
of Insured Conditions

HEART ATTACK

Heart Attack shall mean a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, resulting in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

1. heart attack symptoms;
2. new electrocardiogram (EKG) changes consistent with a heart attack; or
3. development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
- EKG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

STROKE
Cerebrovascular Accident

Stroke is defined as a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source, with acute onset of new neurological symptoms, and new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of Diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- Transient Ischaemic Attacks; or
- Intracerebral vascular events due to trauma; or
- Lacunar infarcts which do not meet the definition of stroke as described above.

CANCER
Life Threatening

Cancer shall mean a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

1. carcinoma in situ, or
2. Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion), or
3. any non-melanoma skin cancer that has not metastasized, or
4. Stage A (T1a or T1b) prostate cancer.

Cancer Exclusion and Policy Termination

There shall be no coverage under the Insured Condition definition of Cancer, if any signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under the policy), regardless of when the Diagnosis is made, commenced within the 90 days following the later of the Issue Date and the date of last Reinstatement of the policy. In the event of any Diagnosis based on such a sign, symptom or medical problem, the policy is terminated, and the Company's sole liability in respect of the policy shall be limited to a refund, to the Policy Owner, of the premiums due and paid since the later of the Issue Date and the date of the last Reinstatement of the policy.

This medical information as described above must be reported to the Company within 6 months of the date of the Diagnosis. If this information is not provided, the Company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

CORONARY ARTERY BYPASS SURGERY

Coronary Artery Bypass Surgery shall mean the undergoing of heart Surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The Surgery must be determined to be medically necessary by a Specialist.

FAILURE OF BOTH KIDNEYS

Failure of Both Kidneys shall mean a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of Failure of Both Kidneys must be made by a Specialist.

MAJOR ORGAN TRANSPLANT

Major Organ Transplant shall mean a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Diagnosis of the major organ failure must be made by a Specialist.

MAJOR ORGAN FAILURE ON WAITING LIST

Major Organ Failure on Waiting List shall mean a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant Surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist. The Insured must survive at least 30 days following the date of enrollment into the transplant program.

PARALYSIS

Paralysis shall mean a definite Diagnosis of the total irreversible loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a continuous period of at least 90 days following the precipitating event. The Diagnosis of Paralysis must be made by a Specialist.

OCCUPATIONAL HIV INFECTION

Occupational HIV Infection shall mean a definite Diagnosis of infection with the Human Immunodeficiency Virus (HIV) resulting from an accidental injury during the course of the Insured's normal occupation, which exposed the Insured to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the Issue Date of the policy or the effective date of last Reinstatement of the policy.

Payment under this condition requires satisfaction of ALL of the following:

1. The accidental injury must be reported to the Company within 14 days of the accidental injury;
2. A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative,
3. A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
4. All HIV tests must be performed by a duly licensed laboratory in Canada, the United States of America or in any other jurisdiction as approved by the Company;
5. The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

OCCUPATIONAL HIV INFECTION (continued)

The Diagnosis of Occupational HIV Infection must be made by a Specialist

No payment will be payable under this condition if:

1. The Insured has elected not to take any available licensed vaccine offering protection against the HIV, or
2. A licensed cure for HIV infection has become available prior to the accidental injury, or
3. HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

BLINDNESS

Blindness shall mean a definite Diagnosis of the total and irreversible loss of vision in both eyes. The corrected visual acuity must be 20/200 or less in both eyes or the field of vision must be less than 20 degrees in both eyes. The Diagnosis of Blindness must be made by a Specialist.

DEAFNESS

Deafness shall mean a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The Diagnosis of Deafness must be made by a Specialist.

LOSS OF SPEECH

Loss of Speech shall mean a definite Diagnosis of the total and irreversible loss of the ability to speak for a continuous period of at least 180 days due to physical injury or physical disease. The Diagnosis of Loss of Speech must be made by a Specialist. No benefit will be payable under this condition for any psychiatric related causes.

LOSS OF LIMBS

Loss of Limbs shall mean a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as a result of an accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

SEVERE BURNS

Severe Burns shall mean a definite Diagnosis of third-degree burns covering at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

SAMPLE
Contract Provisions

BENEFITS & CONDITIONS

Critical Illness Benefit

The Critical Illness Benefit shall be payable to the Policy Owner on the first completion of a Waiting Period while this policy is in force for one of the Critical Illness Insured Conditions, subject to the other provisions of the policy. The Critical Illness Benefit amount is the then current Sum Insured, as shown in the policy face page or in the latest amendment to the contract agreed upon in writing. The Critical Illness Benefit is only payable once, and the policy then terminates, regardless of the number of Critical Illnesses that may be diagnosed. Payment of the Critical Illness Benefit will represent full and final discharge of all claims under the policy respecting the Insured.

Return of Premium on Death Benefit

The Return of Premium on Death Benefit shall be payable if the Insured does not survive the Waiting Period, or if the Insured's death results from any cause other than a Critical Illness Insured Condition, subject to the other provisions of the policy. The Return of Premium on Death Benefit amount is the sum of the annual premiums due for the policy that were paid prior to the Insured's death, adjusted for any partial surrenders (the total payout would be calculated assuming the reduced Critical Illness benefit had been in force from the Issue Date of the policy), and will be payable in accordance with the beneficiary designation then in effect. Due proof of the Insured's death and proof of claim, which are satisfactory to the Company, must be submitted to the Company's Head Office. No Return of Premium on Death Benefit is payable if the Critical Illness Benefit is payable. The Return of Premium on Death Benefit is only payable once, and the policy then terminates. Payment of the Return of Premium on Death Benefit will represent full and final discharge of all claims under the policy respecting the Insured.

Flexible Return of Premium Benefit

The Flexible Return of Premium Benefit shall be payable on surrender at the later of age 65 or 10 years from the Issue Date, or at the Expiry Date if the policy is in force and the Insured is alive at that time. No Flexible Return of Premium Benefit is payable if the Critical Illness Benefit is payable. When the Flexible Return of Premium benefit has been paid, the coverage terminates.

The Flexible Return of Premium Benefit amount is equal to a percentage of annual premiums paid, without interest, depending on the attained age and number of years the policy has been in force, according to the values shown in the Flexible Return of Premium Benefit Table included in the policy.

Any reduction in the Critical Illness Benefit will be treated as a lapse of coverage and any future Flexible Return of Premium Benefit will be calculated assuming the reduced Critical Illness Benefit had been in force from the Issue Date of the policy.

Exclusions

No Critical Illness Benefit shall be due or payable if the Insured Condition results, directly or indirectly, from any one or more of the following causes:

1. the Insured attempts to take his/her own life, or inflicts injuries on his/her own person, whether or not in possession of his/her mental faculties;
2. any violation by the Insured of the criminal law;
3. the Insured's use of illegal or illicit drugs or substances, or the Insured's misuse of medication obtained with or without prescription, or the Insured's misuse of alcohol;
4. war, whether such war is declared or undeclared, or hostile action of the armed forces of any country, or insurrection or civil commotion, irrespective of whether the Insured were actually a participant or not;
5. any sign, symptom or medical problem of the Insured, which initiated any investigation leading to the Diagnosis of a Critical Illness (other than Cancer), and which commenced prior to the later of the Issue Date and the date of the last Reinstatement of the policy.

Claims

Any claim for payment of benefit must be submitted in writing to the Company's Head Office. The Company will furnish forms for proof of claim within 15 days after receiving notice of claim. Before the Company makes any settlement under this policy, the claimant must provide evidence, satisfactory to the Company, of the occurrence of the claim. The Company shall have the right to require examination of the Insured, and confirmation of the Diagnosis of any Critical Illness Insured Condition, by any Doctor appointed by the Company. The Company is also entitled to receive proof of the Insured's date of birth and, if applicable for the claim, proof of the Insured's death.

Any Critical Illness Benefit amount due during the Insured's lifetime is payable to the Policy Owner, if living, otherwise to the Policy Owner's estate.

Extension of Benefit

If the Final Expiry Date of the policy occurs during a Waiting Period immediately following the date of the Insured's Diagnosis or Surgery, the policy shall continue in force until the earlier of the Insured's death and the end of the Waiting Period.

PREMIUMS

Payment of Premiums

The Issue Date and the Premium Period are shown in the policy face page. The first premium is payable on the Issue Date. If the Company consents, the premium payment frequency can be changed to other than annually. The amount of the premium on a frequency other than annually will be determined by the

Company. Each premium after the first is payable in advance on the first day of each premium frequency as measured from the Issue Date. Premiums are payable during the Insured's lifetime until the earlier of the Final Expiry Date and the date a Critical Illness Benefit becomes payable. Premiums are payable at the Company's Head Office, or elsewhere in accordance with the Company's then current rules.

If any cheque, or other such instrument used to pay premiums is not paid when presented for payment by the Company in the normal course of business, the premium will be considered unpaid.

Grace Period

A grace period of 30 days is allowed for payment in full of any premium due, except the first. The policy remains in force during the Grace Period. If a premium due is not paid by the end of the Grace Period, the policy will then lapse.

Reinstatement

If this policy has lapsed, an application to reinstate it can be made within 1 year after the first unpaid premium was due.

To reinstate this policy, the Company requires proof, satisfactory to the Company, that the Insured is insurable, together with the payment of all overdue premiums, and interest at an appropriate rate then set by the Company.

The reinstated policy will come into force on the earliest date on which the Company has approved the application for reinstatement and the preceding terms of this provision have been satisfied.

GENERAL PROVISIONS

Policy Owner

The first Policy Owner of this policy is the person who makes the contract with the Company, and is named in the application. The Policy Owner has the rights and privileges granted by this policy, including but not limited to the right to receive any payments due during the Insured's lifetime. If the policy is assigned, these rights will be subject to the terms of that assignment.

Beneficiary

The first beneficiary or beneficiaries, for any amounts due as a result of the Insured's death, will be as stated in the application. During the Insured's lifetime the Policy Owner may designate in writing to the Company one or more beneficiaries to receive any such amounts, and may revoke or change a designation as permitted by law.

The Company will pay any amounts due as a result of the Insured's death under the beneficiary designation in effect at the date of the Insured's death. If more than one beneficiary has been designated and one or more of them dies, such amounts will be paid to the beneficiary surviving at the date of the Insured's death or, if there

is more than one, to each of them equally. If no beneficiary is living when the Insured dies and no other designation is then in effect, any such amounts will be paid to the Policy Owner or the Policy Owner's estate.

Assignment

The Policy Owner can assign this policy as permitted by law. An assignment of this policy or of an interest in it will not be binding on the Company until the assignment or a certified copy of it is filed with the Company's Head Office. The Company is not responsible for the validity or effect of any assignment.

Incontestability

The Insured, and the Policy Owner if other than the Insured, is required to disclose to the Company in any applications, on any medical examination and in any written statements or answers furnished as evidence of insurability for this policy, every fact that is material to the insurance and is known to either of the Insured or the Policy Owner. A failure to disclose, or a misrepresentation of such a fact, will render the contract voidable by the Company.

However, the Company will not contest this policy after it has been in force continuously, during the Insured's lifetime, for 2 years from the later of the Issue Date and the date of the last Reinstatement of the policy, except in the case of fraud, or a claim for a Critical Illness Insured Condition of the Insured where the Insured's symptoms or medical problems which initiated any investigation leading to the Diagnosis commenced before the end of this 2 year period.

The Company reserves the right to contest any amendment to the contract which increases the insurance money payable or improves the Policy Class, but not after the amendment has been in force continuously, during the Insured's lifetime, for 2 years from the later of the date the amendment first takes effect and the date of the last Reinstatement of the policy, except in the case of fraud, or a claim for a Critical Illness Insured Condition of the Insured where the Insured's symptoms or medical problems which initiated any investigation leading to the Diagnosis commenced before the end of this 2 year period.

This provision does not apply to any misstatement of the Insured's age or sex.

Misstatement of Age & Sex

If the Insured's date of birth or sex has been misstated, any amounts payable will be the amounts which the premiums paid would have bought for the correct date of birth and sex. However, where the Insured's Age affects the commencement or termination of any insurance under this policy, the Insured's true Age governs.

Consideration

This policy is issued on the basis of the statements in the application, and in return for payment, on or before delivery of the policy, of the premium for the initial premium period.

Currency & Place of Payment

All amounts payable to or by the Company under this policy are payable in Canada in Canadian currency.

Non Participating

This policy is not eligible for dividends and will not participate in our divisible surplus.

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. Any change in this contract may be made only with the written consent of the Policy Owner and the Company. Only the Company's President, Vice President or Actuary have the authority to waive or agree to change any of the conditions or provisions of this policy.

Waiver

The Company will 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 Company.

Copy of Application

The Company will upon request, furnish to the Policy Owner or to a claimant under the contract a copy of the application.

Notice and Proof of Claim

The Insured or the Policy Owner, or a beneficiary entitled to make a claim, or the agent of any of them, must

1. give written notice of claim to us, within 30 days from the date a claim arises under the contract,
    a) by delivery of the notice of claim or by sending it by registered mail, to the Company's Head Office or an agency office of the Company in the province, or
    b) by delivery of the notice of claim to one of the Company's authorized agents in the province,
2. within 90 days from the date a claim arises under the contract, furnish to the Company such proof of claim as is reasonably possible in the circumstances of the happening of the claim, the right of the claimant to receive payment, and his or her age, and the age of the beneficiary, if relevant; and
3. if so required by the Company, furnish a satisfactory certificate as to the cause or nature of the injury, sickness, or disability for which the claim may be made under the contract and, if applicable, the duration of such disability.

Failure to give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed by the statutory provision 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 1 year from the date of the injury or the date a claim arises under the contract, if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed.

Company to furnish forms for Proof of Claim

The Company will furnish forms for proof of claim within 15 days after receiving notice of claim, but where the claimant has not received the forms within that time, he or she may submit his or her proof of claim in the form of a written statement of the cause or nature of the injury, sickness or disability giving rise to the claim.

Rights of Examination

As a condition precedent to recovery of insurance money under this contract, the Insured will be required to allow the Company an opportunity to examine the Insured when and so often as the Company reasonably requires while the claim under this policy is pending.

When Money Payable

All money payable under this contract will be paid by the Company within sixty days after the Company has received proof of claim.

Limitation of Actions

An action or proceeding against the Company for the recovery of a claim under this contract may not be commenced more than 1 year after the date the insurance money became payable or would have become payable if it had been a valid claim.

RATE TABLE *per $1,000 of coverage*

Age Nearest Birthday	TERM 10 to AGE 75				TERM to AGE 75				TERM to AGE 75 ROP			
	MALE		FEMALE		MALE		FEMALE		MALE		FEMALE	
	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
18	2.13	2.52	2.13	2.15	4.05	6.55	3.60	6.10	5.35	7.60	5.09	7.17
19	2.14	2.56	2.14	2.25	4.15	6.70	3.75	6.25	5.50	7.80	5.24	7.42
20	2.15	2.60	2.15	2.35	4.25	6.85	3.90	6.40	5.65	8.00	5.39	7.67
21	2.18	2.68	2.17	2.52	4.44	7.12	4.11	6.64	5.87	8.39	5.62	8.12
22	2.20	2.75	2.19	2.69	4.64	7.40	4.34	6.89	6.10	8.81	5.87	8.60
23	2.23	2.83	2.21	2.88	4.85	7.69	4.58	7.15	6.34	9.24	6.13	9.10
24	2.25	2.92	2.23	3.08	5.07	7.99	4.83	7.42	6.59	9.69	6.39	9.63
25	2.28	3.00	2.25	3.30	5.30	8.30	5.10	7.70	6.85	10.17	6.67	10.20
26	2.38	3.21	2.37	3.56	5.60	8.81	5.30	8.19	7.24	10.86	6.96	10.85
27	2.49	3.43	2.49	3.83	5.92	9.36	5.51	8.72	7.65	11.59	7.27	11.55
28	2.61	3.67	2.62	4.13	6.26	9.93	5.73	9.27	8.09	12.37	7.58	12.29
29	2.73	3.93	2.76	4.45	6.62	10.55	5.96	9.87	8.54	13.21	7.91	13.08
30	2.85	4.20	2.90	4.80	7.00	11.20	6.20	10.50	9.03	14.10	8.26	13.92
31	2.97	4.51	3.03	5.15	7.28	12.03	6.49	11.25	9.52	15.12	8.77	14.82
32	3.09	4.84	3.16	5.52	7.57	12.92	6.80	12.05	10.03	16.22	9.32	15.78
33	3.22	5.20	3.30	5.92	7.86	13.87	7.12	12.90	10.57	17.40	9.89	16.80
34	3.36	5.59	3.44	6.34	8.18	14.90	7.45	13.82	11.14	18.66	10.51	17.88
35	3.50	6.00	3.59	6.80	8.50	16.00	7.80	14.80	11.74	20.01	11.16	19.04
36	3.76	6.63	3.83	7.51	8.95	17.20	8.16	15.72	12.48	21.25	11.94	19.99
37	4.04	7.32	4.10	8.30	9.42	18.50	8.55	16.69	13.26	22.56	12.77	20.98
38	4.34	8.08	4.37	9.17	9.92	19.89	8.94	17.73	14.09	23.95	13.65	22.02
39	4.66	8.92	4.67	10.14	10.45	21.39	9.36	18.83	14.98	25.43	14.60	23.12
40	5.00	9.85	4.99	11.20	11.00	23.00	9.80	20.00	15.92	27.00	15.62	24.27
41	5.47	10.98	5.43	12.07	11.46	24.57	10.24	20.91	17.13	29.63	16.63	26.14
42	5.97	12.24	5.90	13.01	11.94	26.25	10.70	21.87	18.43	32.52	17.71	28.16
43	6.53	13.64	6.42	14.03	12.44	28.04	11.18	22.87	19.83	35.70	18.86	30.34
44	7.14	15.20	6.99	15.12	12.96	29.95	11.68	23.91	21.34	39.18	20.08	32.68
45	7.80	16.94	7.60	16.30	13.50	32.00	12.20	25.00	22.96	43.00	21.38	35.20
46	8.32	18.73	8.06	17.61	14.44	34.26	12.71	26.43	24.71	46.56	22.47	37.68
47	8.87	20.71	8.55	19.03	15.44	36.68	13.25	27.94	26.60	50.41	23.61	40.34
48	9.46	22.90	9.07	20.56	16.52	39.26	13.81	29.53	28.64	54.59	24.81	43.19
49	10.08	25.32	9.62	22.21	17.67	42.03	14.39	31.22	30.82	59.11	26.07	46.24
50	10.75	28.00	10.20	24.00	18.90	45.00	15.00	33.00	33.18	64.00	27.39	49.50
51	11.92	31.04	10.93	25.70	19.99	48.13	15.69	35.11	36.27	68.84	29.86	53.32
52	13.21	34.40	11.71	27.52	21.14	51.48	16.42	37.36	39.65	74.05	32.55	57.44
53	14.65	38.13	12.54	29.47	22.35	55.07	17.18	39.75	43.34	79.65	35.49	61.88
54	16.24	42.27	13.44	31.56	23.64	58.90	17.97	42.29	47.37	85.67	38.69	66.65
55	18.00	46.85	14.40	33.80	25.00	63.00	18.80	45.00	51.78	92.15	42.18	71.80
56	19.52	50.02	15.22	35.79	26.27	66.57	19.66	45.77	57.19	100.73	46.54	78.06
57	21.17	53.41	16.09	37.90	27.59	70.35	20.56	46.56	63.16	110.11	51.36	84.87
58	22.96	57.02	17.01	40.13	28.99	74.33	21.49	47.36	69.75	120.36	56.67	92.27
59	24.90	60.88	17.98	42.50	30.46	78.55	22.47	48.17	77.04	131.57	62.53	100.31
60	27.00	65.00	19.00	45.00	32.00	83.00	23.50	49.00	85.08	143.82	69.00	109.06

Policy fee is $60 per year | Volumes available from $10,000 - $100,000 | Issue Ages: 18 - 60 for all plans

Multiply the annual premium by 0.09 to obtain the monthly premium or by 0.52 for semi-annual premium.

Smoker rates apply if, within the last 12 months, you have used any tobacco or nicotine products including cigarettes, cigars, chewing tobacco, nicotine gum or patches or any form of nicotine substitute, or marijuana.

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