TD Insurance
Travel Medical Insurance
Per Trip Plan
Distribution Guide

Name of Insurance Product
Travel Medical Insurance Per Trip Coverage

Type of Insurance Product
Group Travel Insurance

Name and Address of Insurer:
TD Life Insurance Company
P.O. Box 1
Toronto Dominion Centre
Toronto, Ontario M5K 1A2
Phone: 1-888-788-0839

Name and Address of the Administrator:
Allianz Global Assistance
P.O. Box 277
Waterloo, Ontario N2J 4A4
Phone: 1-800-293-4941
416-977-2039
Fax: 519-742-9471

Name and Address of the Distributor:
The Toronto-Dominion Bank
P.O. Box 1
Toronto Dominion Centre
Toronto, Ontario M5K 1A2

Responsibility of the Autorité des marchés financiers.

The Autorité des marchés financiers does not express an opinion on the quality of the product offered in this guide.

The Insurer alone is responsible for any discrepancies between the wording of the guide and the policy.

Table of Contents

Introduction

This Distribution Guide describes Travel Medical Insurance underwritten by TD Life Insurance Company ("*We*", "*Us*", "*Our*", "*Ours*") under the Group Policy TI002 issued to The Toronto-Dominion Bank (the "Policyholder" or "TD Canada Trust"). Allianz Global Assistance provides administrative and adjudication services under the Group Policy. It will help *You* make a knowledgeable decision about the type of coverage that best suits *Your* needs without the presence of an insurance advisor.

All benefits under the *Certificate* are subject in every respect to the Group Policy which alone constitutes the agreement under which benefits will be provided. The principal provisions of the Group Policy affecting *Insured Persons* are summarized in the *Certificate*. The Group Policy is on file at the office of the Policyholder and upon request, *You* are entitled to examine and receive a copy of the Group Policy.

Terms in italic throughout this Distribution Guide are defined in the "Definitions" section.

Nature of the Coverage

Medical Emergency
We will pay a benefit if an *Insured Person* suffers a *Medical Emergency* during a *Covered Trip*.

Section 1: Summary of Per Trip Plan Benefits

For complete details of coverage, please refer to the applicable sections within this Distribution Guide.

Coverage	**Maximum Benefit Payable (per *Insured Person* per *Covered Trip*)**
Medical Emergency Coverage and other benefits including: • *Hospital* benefit • *Physician's* bills • Diagnostic services • Ambulance • Medical appliances • Emergency return home	Up to $5,000,000
Private duty nursing	Up to $5,000
Accidental dental	Up to $2,000
Bedside Companion benefit	Round trip economy air fare and up to $1,500 for meals and accommodation for a *Bedside Companion*.
Vehicle return	Up to $1,000
Return of deceased	Up to $5,000

Section 2: Eligibility - Who Can Apply for Coverage?

You can apply for insurance by completing an *Application* online at tdinsurance.com, or over the telephone with *Our Administrator*, from 8 a.m. to 9 p.m. ET, Monday to Saturday, toll-free at **1-800-293-4941** or **416-977-2039.**

You can also apply for top-up coverage by calling *Our Administrator* at the 24-Hour Assistance line and completing an *Application* by telephone. The telephone number is **1-800-359-6704** from Canada or the United States, or from any other countries, *You* can call collect at **416-977-5040**.

Eligibility Requirements

You may apply for coverage if *You* are:
- at least 18 years old on the *Effective Date* of *Your* Per Trip Plan;
- a *Resident of Canada*; and
- covered under a *GHIP*; and
- a TD Bank Group customer, or the *Spouse* or *Dependent Child* of a TD Bank Group customer; and

- in Canada when *You* buy the coverage; and
- have answered medical questions to determine whether *You* are eligible for this coverage (when required as part of the application process); and
- not purchasing this coverage more than 240 days before *Your Effective Date.*

What Coverage Options are Available?

There are three coverage options available under the Per Trip Plan: Single Coverage, Couple Coverage and Family Coverage.

1. **Single Coverage**

   You may apply for Single Coverage for yourself, or on behalf of *Your Dependent Child(ren)* who are travelling without either *You* or *Your Spouse* if:

   - *You* specify in *Your Application* that the *Certificate* is to cover the *Dependent Child(ren)* instead of *You*; and
   - *Your Dependent Child(ren)* meet(s) the Eligibility Requirements above, except that:
     - they do not have to be TD Bank Group customers; and
     - they may be under 18 years old.

2. **Couple Coverage**

   You may apply for coverage under the Per Trip Plan on behalf of *Your Spouse* or a *Travelling Companion* under Couple Coverage if:

   - *You* name *Your Spouse* or *Travelling Companion* in *Your Application*; and
   - *You* and *Your Spouse* or *Travelling Companion* meet the Eligibility Requirements above, except that:
     - they do not have to be a TD Bank Group customer; and
     - if *Your Travelling Companion* is *Your Dependent Child*, then he or she may be under 18 years of age.

3. **Family Coverage**

   You may apply for coverage under the Per Trip Plan for *Your Spouse* and *Your Dependent Child(ren)* under Family Coverage if:

   - *You* name *Your Spouse* and/or *Dependent Child(ren)* in *Your Application*; and
   - they meet the Eligibility Requirements above, except that:
     - they do not have to be TD Bank Group customers; and
     - *Your Dependent Child(ren)* is/are travelling with *You* or *Your Spouse*; and
     - *Your Dependent Child(ren)* may be under 18 years of age.

NOTE: Couple Coverage and Family Coverage are not available when a medical questionnaire is required as part of *Your* application process. To find out if a medical questionnaire is required, refer to "When is a Medical Questionnaire Required" below.

When is a Medical Questionnaire Required?

A medical questionnaire will be required to be completed if applying for the Per Trip Plan or a top-up of the Per Trip Plan if *You* are:

- 60 to 64 years of age for a *Covered Trip* of 30 days or longer; or
- 65 years of age and older.

If a medical questionnaire is required, the premium for the coverage or top-up of coverage will be based on the answers to the medical questions. Some applicants may not qualify for coverage or for a top-up of coverage based on their responses to the medical questions.

How to Apply for a Top-up of *Our* Coverage?

If *You* already have TD Travel Medical Insurance coverage, *You* can apply to top-up the period of coverage, by contacting *Our Administrator* by telephone, if each *Insured Person* qualifies for coverage as described under Eligibility Requirements, except that:

- *You* do not have to be in Canada when *You* buy this top-up of coverage; and
- *You* can apply either before or after *You* depart on *Your* trip as long as:
  - no *Insured Person* has suffered a *Medical Emergency* before *You* apply for this top-up of coverage; and
  - *You* apply before 11:59 p.m. ET on the date on which the original coverage terminates; and
  - the duration of *Your Covered Trip* is from one (1) day, up to 212 days but not longer than the maximum number of days allowed under *Your GHIP* for travel outside of Canada; and

- *You* pay the required premium for the top-up coverage.

Any top-up is subject to approval by *Our Administrator*.

How to Apply for *Our* Top-up Coverage When *You* Have Another Insurer's Coverage?

If *You* have another insurer's travel insurance, and wish to apply for *Our* top-up coverage, *You* can apply for *Our* Per Trip Plan **before** *Your* departure from *Your* province or territory of residence, if:

- *You* meet the eligibility criteria under *Single Coverage;* and
- the duration of *Your Covered Trip* is from one (1) day, up to 212 days but not longer than the maximum number of days allowed under *Your GHIP* for travel outside of Canada; and
- *You* pay the required premium for the top-up coverage before *Your* departure.

The terms, conditions and exclusions of *Our Certificate* issued as top-up coverage apply to *You*.

Section 3: *Medical Emergency* Coverage

What to Do in a *Medical Emergency*?

In a *Medical Emergency*, *You* must call *Our Administrator* immediately, or as soon as reasonably possible. If not, benefits will be limited as described below under "*Medical Emergency* Insurance Limitations". Some expenses will only be covered if *Our Administrator* approves them in advance.

You can get help 24 hours a day, seven days a week by calling:

- from Canada or the U.S., toll-free, **1-800-359-6704**; or
- from other countries, **416-977-5040**, collect.

Our Administrator will verify whether coverage is in effect and, if so, will direct the *Insured Person* to the nearest appropriate medical facility. *Our Administrator* will arrange for direct payment to the medical services provider wherever possible and manage the *Medical Emergency* from the initial report through to its conclusion. If a direct payment cannot be arranged, the *Insured Person* may be asked to pay for services and then submit a claim for reimbursement of eligible expenses.

NOTE: All payments and payment guarantees are subject to the terms, conditions, limitations and exclusions of the *Certificate*.

Medical Emergency Insurance Limitations

1. ***Medical Emergency Treatment* requires pre-approval**
   You must notify *Our Administrator* before obtaining *Medical Emergency Treatment* so that *We* may:
   - confirm coverage
   - provide pre-approval of *Treatment*

   If it is medically impossible for *You* to call prior to obtaining *Medical Emergency Treatment*, *We* ask *You* to call within 48 hours, or as soon as possible, or have someone call on *Your* behalf. Otherwise, if *You* do not call *Our Administrator* before *You* obtain *Medical Emergency Treatment*, *Your* Maximum Benefit Payable will be reduced to 80% of *Your* medical expenses covered under this insurance, to a maximum of $30,000.

2. **Failure to meet the requirement to be covered by a *GHIP***
   You must be covered under the *GHIP* of *Your* province or territory of residence prior to and for the entire duration of the *Covered Trip*. It is *Your* responsibility to check that *You* do have this coverage. There is no coverage under the *Certificate* if *You* do not have a valid *GHIP*.

Medical Emergency Benefits

We will pay a *Medical Emergency* benefit for eligible *Medical Emergency* expenses if an *Insured Person* suffers a *Medical Emergency* during the *Medical Emergency Coverage Period* for a *Covered Trip*.

Eligible *Medical Emergency* expenses include:

Medical Emergency coverage up to $5,000,000 per *Covered Trip*.

***Hospital* benefit**	Attendance at a *Hospital* or appropriate medical facility for *Treatment* as an inpatient, outpatient, and emergency basis, when approved in advance by *Our Administrator*.
***Physicians'* bills**	Fees charged by a *Physician*, when required as part of *Treatment* for a *Medical Emergency,* and approved in advance by *Our Administrator*.
Private duty nursing	Up to $5,000 for services performed and supplies deemed necessary by a registered nurse; including medically necessary nursing supplies.
Diagnostic services	Charges for diagnostic tests, laboratory tests and X-rays which are prescribed by the treating *Physician*, and approved in advance by *Our Administrator* if the tests involve: • magnetic resonance imaging (MRI); or • computerized axial tomography (CAT) scans; or • sonograms; or • ultrasounds; or • any invasive diagnostic procedures, including angioplasty.
Ambulance	Charges for emergency ambulance service to the nearest approved *Hospital*.
Air ambulance	Charges for emergency air ambulance only if *Our Administrator* determines that the *Insured Person's* physical condition precludes the use of any other means of transportation; and: • makes the determination before the service is provided; and • pre-approves the service; and • arranges for the service.
Prescriptions	Reimbursement of prescription drugs required as part of emergency *Treatment* while in *Hospital*. NOTE: Vitamins and patent, proprietary and experimental drugs are excluded.
Professional Fees	Up to a maximum of $300 per profession for expenses incurred as a result of a covered *Medical Emergency* which requires *Treatment* by a licensed physiotherapist, chiropractor, chiropodist, podiatrist or osteopath, if: • *Treatment* is required for the immediate relief of an acute symptom, and that, according to a *Physician*, cannot be delayed until *You* return to *Your* province or territory of residence; and • *Treatment* is ordered by a *Physician* during a *Covered Trip* and received by a licensed professional as described under this benefit.
Accidental dental	Up to $2,000 for dental *Treatment* that is: • required during a *Medical Emergency Coverage Period*; and • necessary because of a blow to natural or permanently installed teeth which results from an accident causing a *Medical Emergency*.
Emergency relief of dental pain	*Treatment* for emergency relief of dental pain is covered up to a maximum of $200.
Medical appliances	The cost of casts, crutches, trusses, braces, slings, splints, medical walking boots, and/or the rental cost of a wheelchair or walker, if: • prescribed by a *Physician*; and • required because of a *Medical Emergency*.

Emergency return home	The cost of a one-way economy fare and, if required to accommodate a stretcher, a second one-way economy fare, if: • as a result of a *Medical Emergency*, *Our Administrator* determines that an *Insured Person* should return to Canada; and • *Our Administrator* approves the transportation in advance. NOTE: *We* will also pay the expenses for a qualified medical attendant to accompany *You* to *Your* province or territory of residence if recommended by the attending *Physician* during *Your Medical Emergency* and approval is granted by *Our Administrator* in advance.
***Bedside Companion* benefit**	The cost of one round-trip economy airfare from *Your Bedside Companion's* province or territory of residence, and up to $150 per day, to a maximum of $1,500 for food and accommodation, if: • *You* are *Hospitalized* because of a covered *Medical Emergency* and are expected to remain *Hospitalized* for at least three (3) consecutive days; and • *Our Administrator* approves this benefit in advance.
***Travelling Companion* benefit**	The cost of a single one-way economy airfare for a *Travelling Companion* to return to his or her place of departure, if: • an *Insured Person* has a covered *Medical Emergency* that makes it necessary for the *Travelling Companion* to stay beyond their scheduled return date; and • *Our Administrator* approves the travel in advance.
Meals and accommodation	• up to $350 per day to a maximum of $3,500, for *Your*: - commercial accommodations and meals; and - essential telephone calls and internet usage fees; and - taxi fares (or rental car in lieu of taxi fares); • if, upon a *Physician's* discretion *You*, or *Your Travelling Companion*, are relocated to receive medical attention, for a *Medical Emergency Condition* covered under this insurance; or • *You* are delayed beyond *Your* return date in order to receive *Medical Emergency Treatment;* or • *Your Travelling Companion* requires *Medical Emergency Treatment* for any *Medical Condition* covered under this insurance. NOTE: Subject to pre-authorization from *Our Administrator.*
Incidental *Hospital* expenses	Up to $50 per day to a maximum of $500, for *Your* incidental *Hospital* expenses (telephone calls, television rental, parking), while *You* are *Hospitalized* for at least 48 hours.
Return and escort of *Dependent Children*	If *Dependent Children* are travelling with *You* or join *You* during *Your Covered Trip* and *You* are *Hospitalized* for more than 24 hours or *You* must return to *Your* province or territory of residence because of *Your Medical Emergency* covered under this insurance, this insurance covers: • the lesser of the cost of a one-way economy air fare on a commercial flight via the most cost-effective route for the return of those *Dependent Children* to their province or territory of residence or the cost incurred to change the return date of existing air fare on a commercial flight; and • the cost of a return economy air fare via the most cost-effective route on a commercial flight for an escort, if the airline requires that the *Dependent Children* be escorted.

Vehicle return	Up to $1,000 toward the cost of returning an *Insured Person's* vehicle to his or her home or the nearest vehicle rental agency, if: • the *Insured Person* is unable to return the vehicle because of a *Medical Emergency*; and • *Our Administrator* arranges for the return of the vehicle.
Return of deceased	• up to $5,000 toward the cost of preparation and transportation home of a deceased *Insured Person* if death results from a covered *Medical Emergency*; or • the burial or the cremation of an *Insured Person's* remains where their death occurred; and • one round-trip economy airfare, if: - an *Immediate Family Member* is required to identify or obtain release of the deceased; and - *Our Administrator* approves the transportation in advance. NOTE: The cost of a burial casket or urn is not covered.

Section 4: Exclusions That Apply to All Benefits

Pre-Existing Condition Exclusion

Your Pre-Existing Condition exclusion is determined by the answers provided by *You* when *You* completed *Your Application* for insurance, and where applicable, the medical questionnaire (depending on *Your* age and trip duration). To be eligible for benefits under the *Certificate*, a *Pre-Existing Condition* must be *Stable* for a specified period of time before *Your Effective Date*. The following table explains which *Pre-Existing Condition* exclusion and stability period applies to *You*. Where applicable, refer to *Your Declaration of Coverage* to find *Your* rate category.

***Your* Age**	**Rate Category**	***Pre-Existing Condition* exclusion that applies to *You*:**
• Age 59 and under; • Age 60 to 64 for a *Covered Trip* of 29 days or less	No Rate Category	*We* will not pay for any *Medical Emergency* expenses or benefits incurred directly or indirectly as a result of *Your Medical Condition* or related condition (whether or not the diagnosis has been determined), if at any time in the **90 days** before *You* depart on *Your Covered Trip, Your Medical Condition* or related condition has not been *Stable*, other than a *Minor Ailment.*
• Age 60 to 64 for a *Covered Trip* of 30 days or longer; • Age 65 and older for all *Covered Trip* durations	Rate Category A and B	*We* will not pay for any *Medical Emergency* expenses or benefits incurred directly or indirectly as a result of *Your Medical Condition* or related condition (whether or not the diagnosis has been determined), if at any time in the **90 days** before *You* depart on *Your Covered Trip, Your Medical Condition* or related condition has not been *Stable*, other than a *Minor Ailment.*
	Rate Category C, D and E	*We* will not pay for any *Medical Emergency* expenses or benefits incurred directly or indirectly as a result of *Your Medical Condition* or related condition (whether or not the diagnosis has been determined), if at any time in the **180 days** before *You* depart on *Your Covered Trip, Your Medical Condition* or related condition has not been *Stable*, other than a *Minor Ailment.*

Medical Emergency Insurance Exclusions

In addition to the exclusion outlined above, under *"Pre-Existing Condition* Exclusion," the *Certificate* does not cover any *Treatment*, services, or expenses of any kind caused directly or indirectly as a result of the following:

1. **A child born during the *Covered Trip***
   We will not pay any expenses or benefits with respect to *Your* child born during the *Covered Trip*.

2. **Abuse of alcohol, drug, or intoxicants**
   We will not pay any expenses or benefits with respect to:
   - any *Medical Condition*, including symptoms of withdrawal, arising from, or in any way related to, *Your* chronic use of alcohol, drugs or other intoxicants whether prior to or during *Your Covered Trip*; or
   - any *Medical Condition* arising during *Your Covered Trip* from, or in any way related to, the abuse of alcohol, drugs or other intoxicants.

3. **Claims related to expectant mother's complications of pregnancy, or delivery**
   We will not pay any expenses or benefits with respect to:
   - routine pre-natal or post-natal care; or
   - pregnancy, delivery or complications of either arising nine (9) weeks before the expected date of delivery or any time after delivery.

4. **Failure to transfer to an appropriate facility for *Treatment***
   We reserve the right to transfer an *Insured Person* to an appropriate medical facility, or to his or her province or territory of residence, for further *Treatment* in consultation with the *Insured Person's* treating *Physician*. Refusal to comply with an arranged transfer will release *Us* from any liability to pay any expenses incurred after the scheduled transfer date.

5. **Hazardous activities**
   We will not pay any expenses or benefits with respect to an accident that occurs while *You* are participating in:
   - any non-standard sport or activity involving a high level of risk, such as those indicated below, but not limited to:
     - parasailing, hang-gliding and paragliding; or
     - parachuting and sky diving; or
     - bungee jumping; or
     - mountaineering; or
     - cave exploration; or
     - amateur scuba diving, unless *You* hold at least a basic scuba diving license from a certified school; or
     - any airborne activity in any aircraft other than a passenger aircraft that holds a valid certificate of airworthiness.

6. **Illegal act**
   We will not pay any expenses or benefits related to *Your* commission or attempted commission of a criminal offence or illegal act, including driving while impaired or over the legal limit.

7. **Inaccurate evidence of insurability**
   We will not pay any expenses or benefits with respect to *Your* failure to provide accurate and complete evidence of insurability as described under "*Your* Obligations as an *Insured Person*," in Section 5.

8. **Intentional self-inflicted injury**
   We will not pay any expenses or benefits with respect to intentional self-inflicted injury, suicide or attempted suicide (whether or not the *Insured Person* is aware of the result of their actions), regardless of the *Insured Person's* state of mind.

9. ***Medical Emergency* occurring outside the *Coverage Period***
   We will not pay a benefit with respect to a *Medical Emergency* that occurs outside the *Coverage Period.* For example, no benefit will be paid with respect to a *Medical Emergency* that occurs after 11:59 p.m. ET on the last day of the *Coverage Period*, if *You* have not purchased top-up coverage.
   NOTE: The day of departure counts as a full day for this purpose.

10. **Mental disorders**
    We will not pay any expenses or benefits with respect to any mental, nervous or emotional disorders, including any *Medical Emergency* arising from these disorders.

11. Misrepresentation

This policy is issued on the basis of information in *Your* application (including answers to the medical questionnaire, if required). When completing the application and answering the medical questions, *Your* answers must be complete and accurate. In the event of a claim, *We* will review *Your* medical history. If any of *Your* answers are found to be incomplete or inaccurate:

- *Your* coverage will be null and void
- *Your* claim will not be paid
- *We* will refund *Your* premium

12. Non-compliance with prescribed medical *Treatment*

We will not pay any expenses or benefits with respect to any *Medical Condition* that is the result of *You* not following medical *Treatment* as prescribed to *You*, including prescribed medication..

13. Non-emergency services

We will not pay expenses or benefits with respect to non-emergency, experimental or elective *Treatment* (e.g. cosmetic surgery, chronic care, rehabilitation including any expenses for directly or indirectly related complications).

14. Ongoing *Medical Emergency Treatment* (investigations, *Treatment* and surgery) requires pre-approval

After *Your Medical Emergency Treatment* has started, *Our Administrator* must assess and approve additional medical *Treatment*. If *You* undergo a medical investigation, obtain *Treatment* or surgery that is not pre-approved, expenses and benefits will not be paid under the *Certificate*. This includes invasive testing or surgery (e.g. cardiac catheterization, other cardiac procedures, transplant and MRI).

15. Payment of benefit prohibited by Canadian law

We will not pay a benefit where the payment of the benefit is prohibited by Canadian law or where Canada has signed a treaty or agreed to a sanction prohibiting such payment.

16. Professional sports or racing

We will not pay any expenses or benefits with respect to *Your* participation in professional sports or any organized racing or speed contests.

17. Recurrence or ongoing *Treatment* once *Medical Emergency* has ended

We will not pay any expenses or benefits relating to the continued *Treatment*, recurrence or complication of a *Medical Condition* or related condition, following *Medical Emergency Treatment* during *Your* trip, if *Our Administrator* determines that *Your Medical Emergency* has ended.

18. Travel advisories

We will not pay any expenses or benefits for *Your Medical Emergency* or related *Medical Condition*, if the reason for *Your Medical Emergency* or related *Medical Condition* is associated in any way with a written formal travel warning of 'Avoid all non-essential travel' or of 'Avoid all travel' issued before *Your Effective Date* by the Canadian Government, advising Canadians not to travel to the country, region or city of *Your* trip.

19. Travel against medical advice

We will not pay any expenses or benefits relating to a *Medical Condition* incurred after *Your Physician* advised *You* not to travel.

20. Travelling when *Treatment* could be expected

We will not pay any expenses or benefits relating to:

- any *Medical Condition* or related condition if any purpose of *Your* trip is to obtain or receive a diagnosis, medical *Treatment*, surgery, investigation, palliative care, alternative therapy, as well as any directly or indirectly-related complication; or
- any *Medical Condition* for which it was reasonable, prior to departure, to expect *Treatment* or *Hospitalization* during *Your* trip; or
- any symptoms evident that it would be reasonable to expect *You* to investigate in the three (3) months prior to *Your* departure on a *Covered Trip*.

21. War

We will not pay any expenses or benefits relating to a *Medical Condition* incurred as a result of:

- an act of war, whether declared or undeclared; or
- hostile or warlike action in time of peace or war; or
- insurrection; or
- a riot, civil disorder or civil war; or
- rebellion; or
- revolution; or
- hijacking.

Section 5: General Information about this Coverage

Your Obligations as an *Insured Person*

1. Failure to disclose impacts *Your* benefits

The *Certificate* is voidable by *Us* and no benefits will be paid if a person who applies to be insured and completes a medical questionnaire as part of the *Application*:

- fails to disclose all *Medical Conditions*, current medications, prescribed medications and periods of *Hospitalization* in response to the medical questions; or
- fails to fully, completely and accurately answer the medical questions.

The *Certificate* and all coverage hereunder is voidable by *Us* even if:

- the failure to disclose or misrepresentation relates only to the amount of premium that should have been paid; or
- any failure to disclose or misrepresentation does not relate to the cause of any claim.

NOTE: *We* may investigate the answers provided to the health questions in the *Application* at any time, including at the time of claim.

2. *You* must inform *Us* of any changes to *Your* health

If an *Insured Person* is required to complete a medical questionnaire, they must contact *Our Administrator* if their *Medical Condition* changes, and/or is not *Stable,* after enrollment and before the date of departure. If *You* are unsure if *You* should inform *Us* of *Your* change in health status, please contact *Our Administrator* for assistance. The *Certificate* is **voidable** by *Us* and no benefits will be payable under it, if the *Insured Person* fails to contact *Our Administrator* as required.

3. Amending or cancelling coverage based on a change in *Medical Condition*

Where medical evidence is required, *Our* decision as to whether, and on what basis, to insure a person depends on his or her condition on the date he or she leaves on the *Covered Trip*. Therefore, if the *Insured Person's Medical Condition* changes, and/or is not *Stable*, as described above under "*You* must inform *Us* of any changes to *Your* health", before the *Covered Trip* begins, *We* may:

- cancel the *Insured Person's* insurance for that *Covered Trip*; or
- request a higher premium for that *Insured Person* for that *Covered Trip*.

If *You* do not pay the additional premium by the date the *Insured Person* departs, *We* will cancel the *Insured Person's* insurance for that *Covered Trip*. If *We* cancel insurance under this provision, *We* will refund any premiums that were paid for the cancelled coverage.

Medical Emergency Coverage Period

The *Medical Emergency Coverage Period* begins on the later of:

- the *Insured Person's Effective Date*, shown in the *Application* or most recent *Declaration of Coverage*; or
- when the *Insured Person* actually departs on the *Covered Trip*; and

ends on the earlier of:

- the *Insured Person's* scheduled return date, shown in the *Application* or most recent *Declaration of Coverage*; or
- the date the *Insured Person* actually returns to his or her province or territory of residence; or
- the date the *Certificate* terminates.

The *Medical Emergency Coverage Period* will not end if an *Insured Person* temporarily returns to his or her province or territory of residence before the termination date of *Your Certificate* as described below, under "When *Your Certificate* Terminates," provided that:

- the *Insured Person* has not incurred or submitted a claim under the *Certificate* or suffered a *Medical Emergency* during the *Covered Trip* or during his or her temporary return to his or her province or territory of residence; and
- there has been no change in any *Pre-Existing Condition* (as defined in Section 9: Definitions) during the *Covered Trip* or during the temporary return to the *Insured Person's* province or territory of residence; and
- the *Insured Person's Medical Condition* has remained *Stable* during his or her temporary return to his or her province or territory of residence; and
- the *Insured Person* was fit to resume travel on his or her *Covered Trip*.

Covered Risk

We will pay a *Medical Emergency* benefit if an *Insured Person* suffers a *Medical Emergency* during the *Medical Emergency Coverage Period* for a *Covered Trip*.
We will pay for the *Reasonable and Customary Charges* for eligible *Medical Emergency* expenses up to the Maximum Benefit Payable as described in the section "Summary of Per Trip Plan Benefits", less any amounts payable or reimbursable under:

- *a GHIP*;
- any group or individual health plans; **OR**
- any insurance policies.

Automatic Extension of *Certificate* in the Event of a *Medical Emergency*

If an *Insured Person* is suffering from a *Medical Emergency* on the date the *Medical Emergency Coverage Period* would end for any reason except cancellation of the *Certificate*, the *Medical Emergency Coverage Period* is automatically extended to 72 hours immediately following the end of the *Medical Emergency*:

- for that *Insured Person*; and
- for any other *Insured Person* if:
  - that other *Insured Person* has extended his or her trip past his or her scheduled return date because of the first *Insured Person's Medical Emergency*; and
  - *Our Administrator* has approved a *Travelling Companion* benefit for that other *Insured Person*.

When *Your Certificate* Terminates

Your Per Trip Plan *Certificate* will terminate on the earliest of:

- the scheduled return date shown in *Your Application* or, *Your* most recent *Declaration of Coverage*; or
- the date the last *Insured Person* returns to his or her province or territory of residence from the *Covered Trip*; or
- the date the last *Insured Person* is no longer eligible for coverage; or
- the date the last *Insured Person's* insurance is cancelled because of a change in *Medical Condition* before departing on the *Covered Trip*; or
- the date *Your* request to cancel *Your Certificate* is effective.

How to Contact *Our Administrator*?

1. **24-hour Emergency Assistance Number**
   To report a *Medical Emergency*, or apply for a top-up of the Per Trip Plan for a *Covered Trip*, call *Our Administrator* 24 hours a day, seven days a week:
   - from the U.S. or Canada, **1-800-359-6704**;
   - from elsewhere, call collect, **416-977-5040**.

2. **Customer Service**
   To get a claim form, cancel *Your* insurance or for general inquiries, call *Our Administrator* from 8 a.m. to 9 p.m. ET, Monday to Saturday, toll-free at **1-800-293-4941** or **416-977-2039** or mail *Your* request to:

   Re: TD Insurance Travel Medical Insurance
   Allianz Global Assistance
   P.O. Box 277
   Waterloo, Ontario N2J 4A4

   Fax: 519-742-9471

Proof of Insurance

Your proof of insurance is in the form of the *Declaration of Coverage* document that is provided to *You* when *You* complete *Your Application* for coverage. If *You* do not receive *Your* proof of insurance before *You* depart on *Your Covered Trip*, *You* must contact *Our Administrator* immediately.

You will have coverage once *You* complete all the following steps:

- applicants meet the Eligibility Requirements for insurance under Section 2: Eligibility – Who Can Apply for Coverage; and
- apply for insurance; and
- if required, *You* provide *Us* with accurate and complete evidence of insurance. See "When Is a Medical Questionnaire Required," in Section 2, and "*Your Obligations* as an *Insured Person*" above; and
- pay the required premium.

Once this is complete, *You* will receive Proof of Insurance.

Renewal and Expiry of Insurance

Your Per Trip coverage will not renew and will expire after *Your* trip is complete and coverage ceases.

Section 6: How to Make a Claim

IMPORTANT NOTE: *You* must report *Your* claim and provide supporting documentation to *Our Administrator* as soon as possible, but no later than one (1) year after the date it occurred.

Medical Emergency Claim

A *Medical Emergency* should always be reported immediately, as described in Section 3 under "What to Do in a *Medical Emergency*," or benefits will be limited.

To make an *Emergency Medical* claim, as part of the requirements under Section 8: General Conditions, under "Proof of loss and timely reporting," *We* will need documentation to substantiate the claim, including but not limited to the following:

- proof of payment by *You* and by any other benefit plan; and
- the original itemized receipts for all bills and invoices; and
- proof of travel (including departure and return dates); and
- medical records including complete diagnosis by the attending *Physician* or documentation by the *Hospital*, which must support that the *Treatment* was medically necessary; and
- proof of the accident if *You* are submitting a claim for dental expenses resulting from a *Medical Emergency*; and
- *Your* historical medical records (if *We* determine applicable).

If *You* Report the Claim Immediately

If *Our Administrator* guarantees or pays eligible expenses on behalf of an *Insured Person*, then *You* and, if applicable, the *Insured Person* must sign an authorization form allowing *Our Administrator* to recover those expenses:

- from the *Insured Person's GHIP*; and
- from any health plan or other insurance; and
- through rights *You* may have against other insurers or other parties (see Section 8: General Conditions, under "Subrogation").

If *Our Administrator* pays eligible expenses that are covered under other insurance or another plan, *You* and the *Insured Person* (if applicable) must help *Our Administrator* to seek reimbursement as required.

The *Insured Person* must also provide evidence of the actual departure date from his or her province or territory of residence. If requested, an *Insured Person* must confirm any return dates to his or her province or territory of residence, including any return dates related to an interruption in a *Covered Trip*.

NOTE: If *Our Administrator* makes an advance payment for expenses that are later discovered to be ineligible under the *Certificate*, the *Insured Person* must reimburse *Us*.

If *You* Do Not Report the Claim Immediately

In a *Medical Emergency*, *You* must call *Our Administrator* immediately, or as soon as is reasonably possible. If not, benefits will be limited as described under "*Medical Emergency* Insurance Limitations" in Section 3. If an *Insured Person* incurs eligible *Medical Emergency* expenses without first contacting *Our Administrator* for assistance and claim management, he or she must first submit receipts and other proof to:

- *GHIP*; and
- then to any group or individual health plan(s) and/or insurer(s).

Eligible *Medical Emergency* expenses not covered by a *GHIP* or other plan or insurance must be submitted to *Our Administrator* with proof of:

- claim, receipts and payment statements
- the actual departure date from *Your* province or territory of residence (Proof includes, but not limited to, a flight itinerary, gas receipts or toll-road receipts)

See Section 5 under "How to Contact *Our Administrator*," for information on how to get a claim form.

Section 7: Premiums, Cancellation and Right to Examine/Rescind Coverage

Premiums and Premium Refunds

Premiums will be based on:

- the age of the oldest person to be insured under *Your Certificate* as of the *Effective Date* of *Your Certificate*;
- *Our* pricing that is in effect at the time of *Your Application*; and
- the duration of *Your Covered Trip*; and
- *Your* coverage type (Single, Couple or Family).

If *You* are required to complete the medical questionnaire as part of *Your Application*, *Your* premiums will be based on the above and *Your* answers to the questions

The minimum premium for a top-up of coverage to the Per Trip Plan is $15.

If *You* cancel *Your* insurance, some or all of *Your* premiums may be refunded, as described below.

NOTE: Please note that premium rates can be changed without notice.

Cancelling and Right to Examine/Rescind *Your* Per Trip Plan

All requests for cancellation of the Per Trip Plan must be made to *Our Administrator*, in writing or by phone (see "How to Contact *Our Administrator,*" in Section 5). The following table explains how and when cancellations may take place.

- **by phone** – cancellation will be effective on the date of *Your* call; or
- **by written, mailed request** – cancellation will be effective on the post-marked date of *Your* request.

When Can *You* Cancel	Premium Refund/Fees
Before the departure date on *Your Application* or *Declaration of Coverage.*	Full refund
After the departure date on *Your Application* or *Declaration of Coverage* and no claim has been opened.	Pro-rated refund less a $15 administrative fee.

Section 8: General Conditions

Unless the *Certificate* or the *Group Policy* states otherwise, the following conditions apply to *Your* coverage.

Access to Medical Care

TD Life, TD Bank Group, *Our Administrator* and their affiliates are not responsible for the availability, quality or results of any medical *Treatment* or transport, or for the failure of any *Insured Person* to obtain medical *Treatment*.

Benefit Payments

This policy contains provisions removing or restricting the right of the *Insured Person* to designate persons to whom or for whose benefit money is to be payable. This means that under the *Group Policy*, neither *You* nor any *Insured Person* has the right to choose a beneficiary who will receive any benefits payable under the *Certificate*. Benefits are payable to *You* or, on *Your* behalf, to *Your* medical service provider.

Coordination of Benefits with Other insurance

- All of *Our* policies are excess insurance, meaning that any other sources of recovery *You* have will pay first, and this insurance policy will be the last to pay. The total benefits payable under all *Your* insurance, including the *Certificate*, cannot be more than the actual expenses for a claim. If an *Insured Person* is also insured under any other insurance certificate or policy, *We* will coordinate payment of benefits with the other insurer.
- In no case will *We* seek to recover against employment related plans if the lifetime maximum for all in-country and out-of-country benefits is $50,000 or less. If the lifetime maximum for all in-country and out-of-country benefits is over $50,000, *We* will coordinate benefits only above this amount.

Currency

All amounts shown are in Canadian currency.

Group Policy

All benefits under the *Certificate* are subject in every respect to the *Group Policy*, which alone constitutes the agreement under which benefits will be provided. The principal provisions of the *Group Policy* affecting *Insured Persons* are summarized in the *Certificate*. The *Group Policy* is on file at the office of the Policyholder and upon request, *You* are entitled to receive and examine a copy of the *Group Policy*.

Legal Action Limitation Period

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act*, 2002 (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the *Civil Code of Quebec*.

Misrepresentation of Facts Other than *Your* Health/Medical information

We will not pay any expenses or benefits if *You*, any person insured under the *Certificate* or anyone acting on *Your* behalf attempt to deceive *Us* or makes a fraudulent, false or exaggerated claim.

Proof of loss and Timely Reporting

If *You* are making a claim, *You* must complete and send *Our Administrator* the appropriate claim forms, together with written proof of loss (e.g., original invoices and tickets, medical and/or death certificates as described in Section 6: How to Make a Claim) as soon as possible. In every case, *You* must report *Your* claim within one (1) year from the date of the accident or the date the claim arises.

Relationship Between *Us* and the Group Policyholder

TD Life Insurance Company is affiliated with The Toronto-Dominion Bank (“TD Bank”).

Review and Medical Examination

When a claim is being processed, *We* will have the right and the opportunity, at *Our* own expense, to review all medical records related to the claim and to examine the *Insured Person* medically when and as often as may be reasonably required.

Subrogation

There may be circumstances where another person or entity should have paid *You* for a loss but instead *We* paid *You* for the loss. If this occurs, *You* agree to co-operate with *Us* so *We* may demand payment from the person or entity who should have paid *You* for the loss. This may include:

- transferring to *Us* the debt or obligation owing to *You* from the other person or entity; or
- permitting *Us* to bring a lawsuit in *Your* name; or
- if *You* receive funds from the other person or entity, *You* will hold it in trust for *Us*; or
- acting so as not to prejudice any of *Our* rights to collect payment from the other person or entity.

We will pay the costs for the actions *We* take.

Insurer’s Reply

Once *We* have approved the claim, *We* will notify *You* and payment will be made within 60 days after receipt of the required claim forms and written proof of loss.
Once the required proof has been received and the claim has been approved, payment will be made by the Insurer within 30 days.
If the claim has been denied, *We* will inform *You* of the claim denial reasons within 60 days after receipt of the required claim forms and written proof of loss.

Appeal of an Insurer’s Decision and Recourse

If *Your* claim is refused, *You* can appeal this decision by submitting new information to the Insurer. *You* may also consult the Autorité des marchés financiers or *Your* own legal advisor.

Similar Products

Other travel insurance products may be offered by other insurance companies.

Referral to the Autorité des marchés financiers

For more information about the Insurer’s obligation and the distributor’s obligation to *You*, the customer, *You* can contact the Autorité des marchés financiers at:
Autorité des marchés financiers
Place de la Cité, Tour Cominar
2640 Laurier Blvd., 4th Floor
Quebec, Quebec G1V 5C1

Telephone Numbers
Toll free: **1-877-525-0337**
Quebec: **418-525-0337**
Montreal: **514-395-0337**
Fax: **418-525-9512**
Internet: http://www.lautorite.qc.ca

Section 9: Definitions

In this Distribution Guide, the following words and phrases shown in italics have the meanings shown below. As *You* read through the Distribution Guide, *You* may need to refer to this section to ensure *You* have a full understanding of *Your* coverage, limitations and exclusions.

Administrator	Means the company *We* select to provide medical and claims assistance, claims payment, administrative and adjudication services under the *Group Policy*.
Application	Means the series of questions that form *Your* application and are submitted: • on *Your* behalf when *You* apply by telephone; or • when *You* apply online; and • if applicable, the series of medical questions that form part of *Your Application* if *You* apply online or by telephone and *Your* answers to those questions. The *Application* which is used to determine *Your* eligibility for insurance, also includes the questions asked and answers given in connection with requests to top-up a *Coverage Period*. The *Application* forms part of *Your* insurance contract and is used to process *Your* request for insurance.
Bedside Companion	Means a person of *Your* choice who is required at *Your* bedside while *You* are *Hospitalized* during *Your* trip.
Certificate	Means the Certificate of Insurance.
Certificate Holder	Means the TD Bank Group customer who has applied, and has been accepted for coverage under the Per Trip Plan.
Coverage Period	Means the time between the *Effective Date* of *Your Certificate* and the return date indicated in *Your Application* or most recent *Declaration of Coverage*. In the event of a *Medical Emergency*, *Your Coverage Period* will be extended up to 72 hours immediately following the end of the *Medical Emergency.*
Covered Trip	Means a trip: • made by an *Insured Person* outside the *Insured Person's* province or territory of residence; and • that begins on the *Effective Date* of *Your Certificate* and ends on the return date shown in the *Application* or, *Your* most recent *Declaration of Coverage*; and • is not longer than the maximum number of days allowed under *Your GHIP* for travel outside of Canada.
Declaration of Coverage	Means the document *You* receive when *You* apply for new or additional coverage under the *Group Policy*, which includes *Your Certificate* number and confirms the coverage *You* have purchased.

Dependent Child(ren)	Means *Your* natural, adopted, or step-children who are: • unmarried; and • dependent on *You* for financial maintenance and support; and - under 22 years of age, or - under 26 years of age and attending an institution of higher learning, full-time, in Canada; or - mentally or physically handicapped. NOTE: A *Dependent Child* does not include a child born while the child's mother is outside her province or territory of residence during the *Covered Trip,* and as such*,* the child will not be insured with respect to that trip.
Effective Date	Means the date *Your Certificate* takes effect and is the scheduled departure date shown in *Your Application* or *Your* most recent *Declaration of Coverage*.
GHIP ("Government Health Insurance Plan")	Means a Canadian provincial or territorial government health insurance plan.
Group Policy	Means the Group Policy No. TI002 issued by *Us* to The Toronto-Dominion Bank.
Hospital	Means: • An institution that is licensed as an accredited hospital, and is staffed and operated for the care and treatment of in-patients and out-patients. *Treatment* must be supervised by *Physicians* and there must be registered nurses on duty 24 hours a day. A laboratory and an operating room must also exist on the premises or in facilities controlled by the establishment. • A hospital is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa.
Hospitalized, or **Hospitalization**	Means to be an inpatient in a *Hospital*.
Immediate Family Member	Means an *Insured Person's*: • *Spouse*, parents, step-parent, grandparents, natural or adopted children, step-children or legal ward, grandchildren, brothers, sisters, step-brothers, step-sisters, aunts, uncles, nieces, nephews; and • mother-in-law, father-in-law, brothers-in-law, sisters-in-law, sons-in-law, daughters-in-law; and • the *Insured Person's Spouse's* grandparents, brothers-in-law and sisters-in-law.
Insured Person	Means a person: • who is eligible to be insured under the *Certificate*; and • who was named in the *Application*; and • for whom the required premium has been paid; and • on whom insurance has been issued under the *Certificate*.
Medical Condition	Means any injury, illness, or disease; complication of pregnancy within the first thirty-one (31) weeks of pregnancy; a mental or emotional disorder, including acute psychosis that requires admission to a *Hospital.*
Medical Emergency	Means a sudden and unforeseen sickness or injury that requires immediate *Treatment*. A *Medical Emergency* no longer exists when the evidence reviewed by *Our Administrator* indicates that no further *Treatment* is required at destination or *You* are able to return to *Your* province/territory of residence for further *Treatment*.

Minor Ailment	Means any sickness or injury which does not require: • the use of medication for a period greater than fifteen (15) days; or • more than one (1) follow up visit to a *Physician*, *Hospitalization*, surgical intervention, or referral to a specialist; or • which ends at least fourteen (14) consecutive days prior to the departure date of the trip. NOTE: A chronic condition or complications of a chronic condition are not considered a *Minor Ailment*.
Physician	Means a medical doctor licensed to prescribe and administer medical *Treatment* where the medical services are provided and who is not *You* or *Your Immediate Family Member* or *Your Travelling Companion*.
Pre-Existing Condition	Means any *Medical Condition*, that exists prior to *Your Effective Date*.
Reasonable and Customary Charges	Means charges incurred for goods and services that are comparable to what other providers charge for similar goods and services in the same geographical area.
Resident of Canada and/or **Canadian Resident**	Is any person who: • has lived in Canada for a total of 183 days within the last year (the 183 days do not have to be consecutive); or • is a member of the Canadian Forces.
Spouse	Means: • the person who the *Insured Person* is legally married to; or • the person the *Insured Person* has lived with for at least one (1) year and publicly refers to as his or her domestic partner.
Stable	Means that for any *Medical Condition* or related condition, other than a *Minor Ailment*, for which there have been: • No new symptoms, or more frequent or severe symptoms; or • No new test results showing a deterioration; or • No *Hospitalizations;* or • No new *Treatment*, no new medical management, no new prescribed medication; or • No change in *Treatment*, no change in medical management, no change in prescribed medication; or • No pending surgery, referrals to a specialist, or other *Treatment.* NOTE: The following exceptions are considered *Stable*: - the routine adjustment of Coumadin, warfarin or insulin (as long as they are not newly prescribed or stopped) and there has been no change in *Your Medical Condition*; or - a change from a brand name medication to a generic brand medication of the same dosage.
Travelling Companion	Means any person who travels with *You* during the *Covered Trip* and who is sharing transportation and/or accommodation with *You* (to a maximum of three people including *You*).
Treatment, or **Treated**	Means a procedure prescribed, performed or recommended by a *Physician* or other authorized healthcare professional for a *Medical Condition*. Treatment includes but is not limited to prescribed medication, investigative testing and surgery.
You, Your and **Yours**	Means the person(s) named as the *Insured Person(s)* on *Your* most recent *Declaration of Coverage*, for which insurance coverage was applied and the appropriate premium has been received by *Us*.

We, Us, Our and **Ours**	Means TD Life Insurance Company.

This is the end of the Distribution Guide.

NOTICE OF RESCISSION OF AN INSURANCE CONTRACT

NOTICE GIVEN BY A DISTRIBUTOR
Section 440 of the Act respecting the distribution of financial products and services

THE ACT RESPECTING THE DISTRIBUTION OF FINANCIAL PRODUCTS AND SERVICES GIVES YOU IMPORTANT RIGHTS.

- The Act allows you to rescind the insurance contract you have just signed when signing another contract, without penalty, within 10 days of its signature and before your effective date. To do so, you must give the insurer notice by registered mail within that time frame. You may use the model below for this purpose.
- Despite the rescission of the insurance contract, the first contract entered into will remain in force. Caution, it is possible that you may lose advantageous conditions as a result of the rescission of this insurance contract; contact your distributor or consult your contract.
- After the expiry of the 10-day delay, you may rescind the insurance at any time; however, penalties may apply.

For further information, contact the Autorité des marchés financiers at (418) 525-0337 or 1-877-525-0337.

NOTICE OF RESCISSION OF AN INSURANCE CONTRACT

To: TD Life Insurance Company
P.O. Box 1 TD Centre
Toronto, Ontario
M5K 1A2

Date: _____ _____
(date of sending of notice) Certificate #

Pursuant to section 441 of the Act respecting the distribution of financial products and services, I hereby rescind the insurance certificate issued under group master policy no.:TI002.

Entered into on: _____ In: _____
(date of signature of contract) (place of signature of contract)

_____ _____
(name of client) (signature of client)

The distributor must first complete this section.

This document must be sent by registered mail.

Sections 439, 440, 441, 442 and 443 of the Act are printed on the back of this notice.

439. A distributor may not subordinate the making of a contract to the making of an insurance contract with the insurer specified by the distributor.
The distributor may not exercise undue pressure on the client or use fraudulent tactics to induce the client to purchase a financial product or service.

440. A distributor that, at the time a contract is made, causes the client to make an insurance contract must give the client a notice, drafted in the manner prescribed by regulation, stating that the client may cancel the insurance contract within 10 days of signing it.

441. A client may cancel an insurance contract made at the same time as another contract, within 10 days of signing it, by sending notice by registered or certified mail.
Where such an insurance contract is cancelled, the first contract retains all its effects.

442. No contract may contain provisions allowing its amendment in the event of cancellation or termination by the client of an insurance contract made at the same time.
However, a contract may provide that the cancellation or termination of the insurance contract will entail, for the remainder of the term, the loss of the favourable conditions extended because more than one contract was made at the same time.

443. A distributor that offers financing for the purchase of goods or services and that requires the debtor to subscribe for insurance to guarantee the reimbursement of the loan must give the debtor a notice, drawn up in the manner prescribed by regulation, stating that the debtor may subscribe for insurance with the insurer and representative of the debtor's choice provided that the insurance is considered satisfactory by the creditor, who may not refuse it without reasonable grounds. The distributor may not subordinate the making of the contract of credit to the making of an insurance contract with the insurer specified by the distributor.
No contract of credit may stipulate that it is made subject to the condition that the insurance contract subscribed with such an insurer remain in force until the expiry of the term, or subject to the condition that the expiry of such an insurance contract will entail forfeiture of term or the reduction of the debtor's rights.
The rights of the debtor under the contract of credit shall not be forfeited when the debtor cancels, terminates or withdraws from the insurance contract, provided that the debtor has subscribed for insurance with another insurer that is considered satisfactory by the creditor, who may not refuse it without reasonable grounds.

Notes: