OmbudService for Life & Health Insurance

Ombudsman des assurances de personnes

OLHI • OAP

2013-2014 **Annual Report**

OmbudService for Life & Health Insurance

Ombudsman des assurances de personnes

OLHI • OAP

Table of Contents

About OLHI

The OmbudService for Life & Health Insurance (OLHI) is a national independent complaint resolution and information service for consumers of Canadian life and health insurance products and services, including life, disability, employee health benefits, travel, and insurance investment products such as annuities and segregated funds.

We were established in 2002 as a not-for-profit corporation and operated under the name "Canadian Life and Health Insurance OmbudService" until August 17, 2009. Our Board of Directors approved a name change to the OmbudService for Life & Health Insurance (OLHI) to emphasize our role as an independent information and dispute resolution service.

OLHI is a member of the Financial Services OmbudsNetwork (FSON), a Canada-wide dispute resolution service supported by Canada's financial services regulators and financial services firms. Our information and complaints handling staff have extensive knowledge of life and health insurance products, services and practices, and are available to promptly respond to consumer concerns, questions or complaints in both official languages, free of charge, during normal business hours and through our website at **www.olhi.ca**.

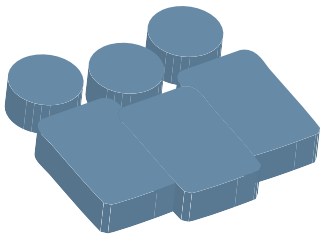
Front cover illustration: 'Early One Morning'
Acrylic and Oil on Canvas by Doug Forsythe
(www.dougforsythegallery.com) © Doug Forsythe

Highlights + Total Activity

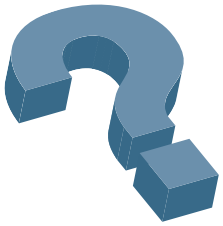
Highlights:

- Positive Ratings from OLHI's first Consumer Satisfaction Survey
- Growth in contacts with public
  - 12% over prior year
- Internet: highest referral source for complaints
  - 32.5% increase over prior year
- Increased complaint volumes
  - 24.7% over 4 years
- Governance
  - Updated OLHI By Laws
- Fiscal Prudence
  - Driving principle

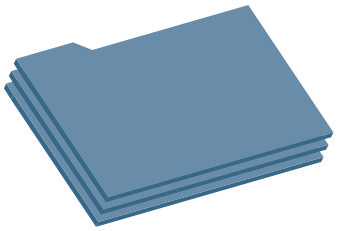
Analysis of Total Activity



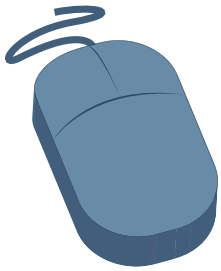
Total Contacts 74,027



Enquiries 13,126



Complaints 2,480



Web Visitors 58,421

Message from the Chair

Dr. Janice MacKinnon

Chair, OmbudService for Life & Health Insurance

"Growth is never by mere chance; it is the result of forces working together."
J.C. Penney

Reflecting on this past year, an emerging theme has been one of progress: new opportunities to enhance OLHI's services and profile were identified; internal processes continued to be improved; and relationships with stakeholders continued to be strengthened while maintaining a balance among the interests of all parties.

STAKEHOLDER RELATIONS

Our goal continues to be providing fair and timely service to consumers, which means working effectively with Member Companies and other stakeholders. Our dispute resolution process is an excellent way for consumers to have their issues resolved in a cost-free, timely and impartial way.

Through collaboration with the Canadian Life and Health Insurance Association (CLHIA) and our Member Companies, we have successfully completed the significant administrative work associated with transitioning our organization to the new Canada Not-for-profit Corporations Act.

Relations with regulators remain positive. They have expressed satisfaction with OLHI's rigorous and balanced complaint resolution process. They are also satisfied with OLHI's willingness to evolve to meet public interest requirements. We continue to have regular, collaborative interactions with our oversight body, the OmbudServices Oversight Standing Committee of the Canadian Council of Insurance Regulators (CCIR).

CONSUMER FEEDBACK

OLHI's first Consumer Satisfaction Survey, completed in October 2013, was a national survey conducted by an independent research firm. The survey:

- Gauged satisfaction among Canadian consumers who have used OLHI's services;
- Yielded a high response rate; and
- Generated overall positive ratings from the majority of consumers.

We have developed an action plan to integrate survey recommendations into our processes as we strive for continuous improvement.

OLHI remains committed to enhancing its profile and public awareness of its services. We are looking at developing new opportunities to tell our positive story.

FISCAL RESPONSIBILITY

Prudent fiscal management continues to be a driving principle. This year, OLHI's Board approved a modest budget increase to carry out the recommendations from our 2nd Independent Review and other project-related initiatives. Where we do make expenditures, we diligently ensure these are aligned with our mandate.

2ND INDEPENDENT REVIEW

This has been a year of collecting feedback on our 2nd Independent Review from stakeholders and planning for the future. During the course of the year, management developed a two-year implementation plan which was approved by OLHI Directors in March 2014.

LOOKING AHEAD

OLHI continues to further strengthen by improving our complaints resolution process and our overall communications strategy. At the same time, we commit to remaining an effective and efficient ombudservice for consumers and life and health insurers.

The next year will bring many opportunities:

- Implementing recommendations from the Consumer Satisfaction Survey;
- Fulfilling recommendations made in the 2nd Independent Review;
- Adopting a state-of-the-art case management and reporting system; and
- Growing OLHI's profile, both with the public and in the media.

In closing, I am pleased with OLHI's ongoing progress and development. I'd like to thank the Board, management and employees for their hard work and dedication, as well as our Member Companies and other stakeholders for their collaboration and transparency.

Dr. Janice MacKinnon
Chair, OLHI

Message from the Executive Director

Holly Nicholson

Executive Director & General Counsel,
OmbudService for Life & Health Insurance

"Without continual growth and progress, such words as improvement, achievement, and success have no meaning."
Benjamin Franklin

This year has been one of identifying opportunities to grow, develop and enhance OLHI's services, processes and profile.

AWARENESS

Building awareness of our services and our company profile continues to be a priority. Contacts with the public are up 12% over last year and 28.5% over the last two years. At the same time, we continue to meet our benchmark of completing 80% of complaint cases within 120 days.

Growth this past year has been primarily driven by higher complaint volumes and by a significant increase in the number of Web visits to our information services business, signifying high demand for impartial information about life and health insurance products.

STAKEHOLDER RELATIONS

While impartiality and independence are critical to OLHI – and are at the core of our mandate – it is ultimately the cooperation and efforts of all stakeholders that contribute greatly to our success.

This year, we reached out to consumers who had used our complaints services to ask them what we were doing well and what we could do better. One of the findings of our Consumer Satisfaction Survey is that consumers want to hear from us more frequently and, in particular, during the period where we review their complaint case and assess its merit. We heard them and acted promptly: our Dispute Resolution Officers now contact consumers during this time frame to better understand and clarify their concerns.

We continue working with Member Companies and industry on important issues such as improvements to the complaints process, information services, and new Articles and By-laws required by the Canada Not-for-profit Corporations Act. Significant stakeholder interaction was also required to develop the implementation plan stemming from the 2nd Independent Review. Feedback from consumers, industry and regulators was key to preparing a workable plan.

CASE MANAGEMENT PROJECT

This past year, the OLHI Board agreed that a new case management and reporting system is required. The new system will be more efficient and will provide a higher level of detail, allowing us to proactively identify and analyze trends. In the coming year, we will explore our options, select a suitable product and lay the groundwork necessary to have the replacement operational by Q1 2016.

2ND INDEPENDENT REVIEW

Last year, the key recommendations from this Review were to escalate more cases to the second and third stages of the complaint review, secure additional funding for specialized professional advice and publish more case studies. We have started implementation, beginning with an increase in staff to address higher complaint volumes. The balance of these recommendations will be implemented in the coming two years.

SUMMARY

OLHI's success stems from people, and our work this year provides resounding evidence that we would not have achieved this success without the collaboration and mutual effort from all stakeholders, Board and staff. Together, we made progress in such areas as increasing contact with the public, completing a Consumer Satisfaction Survey, and taking next steps toward a new case management and reporting system.

It is an honour to work with a Board and staff who are very committed to providing independent, impartial dispute resolution services. I am equally privileged to enjoy a collaborative working relationship with our regulators and industry. I look forward to building on our achievements over the next year.

Holly Nicholson, LL.B.
Executive Director & General Counsel, OLHI

OLHI Complaint Handling Process

1 Consumer Contact

- Provide general guidance to consumer on industry & OLHI complaints processes
- Refer consumer to Member Company to complete internal process, if applicable

2 Review by Dispute Resolution Officer

- Determine if complaint is within OLHI mandate[1]
- Consumer submits final position letter and related information
- Dispute Resolution Officer determines if there are grounds for conciliation with insurer
- If no grounds, review letter issued and possible options identified

3 Review by OmbudService Officer

- If grounds to conciliate are present, OmbudService Officer discusses complaint with parties and obtains any additional information
- Officer seeks voluntary resolution of complaint through conciliation

4 Review by Senior Adjudicative Officer

- If grounds to pursue complaint are present, Senior Adjudicative Officer ("SAO") considers and reviews complaint
- Parties speak with SAO, if desired
- SAO prepares written report with non-binding recommendations

[1] OLHI cannot accept complaints that:
- do not pertain to life and health insurance issues or are not against a Member Company;
- have been previously considered by OLHI or have been - or are currently before - a court, tribunal or other dispute resolution process;
- are made by third party service providers or relate to an uninsured plan that is administered by a Member Company.

Consumer Satisfaction Survey

OLHI's first Consumer Satisfaction Survey was completed by an independent research firm in October 2013, encompassing feedback from consumers across Canada that have used OLHI's services. The phone survey gauged English and French speaking consumers' satisfaction with three stages of our complaint handling process. The majority of consumers gave positive ratings of overall satisfaction, rating their experiences at 8.5 and 7.6 out of 10 in stages one and three, respectively. Satisfaction dipped in the second stage, where consumers rated their experience at 5.1.

In the first stage, consumers explore options and seek information. In most cases, they have not lodged a formal complaint with their insurer and OLHI provides them with guidance around how to do so. Consumers award OLHI's Dispute Resolution Officers ("DRO") high ratings for "going the extra mile", "knowledge and competency", as well as for empathy and clear communications.

"HE WALKED ME THROUGH THE PROCESS, HE REALLY EDUCATED ME. HE MADE ME FEEL LIKE SOMEBODY WOULD FINALLY LISTEN TO ME."
- Consumer feedback; stage one

"SHE WAS VERY CLEAR AND DIDN'T TALK DOWN TO ME. SHE SPOKE SIMPLY IN LAYMAN'S TERMS SO THAT I UNDERSTOOD EVERYTHING."
- Consumer feedback; stage one

In the second stage, consumers have completed their insurance company's complaint review process and have asked OLHI to review their complaint to determine if there are grounds to conciliate with the insurer. Consumers at this stage are hoping that OLHI will be able to obtain a better result with the insurer. All consumers who were surveyed at this stage did not have their case escalated to OLHI's third level (investigation) due to a lack of merit. Understandably, this stage saw a dip in consumer satisfaction: 33% were either very dissatisfied or dissatisfied with their experience with OLHI. A majority continued to believe that their complaint had merit despite OLHI's impartial and thorough review of their case. Of those dissatisfied consumers, approximately one third stated their intent to seek redress through other means.

Consumers in the second stage of our complaints process also relied on the expertise of OLHI staff and the ease of understanding the complaints process. Those who perceived their Officer as competent and who found the complaints process easy to understand provided a satisfaction rating of 9.8, compared to the average rating of 5.1 from all consumers at this stage. Another major finding at stage two is consumers' desire to be informed and updated throughout their service experience. Although they had been advised not to expect any communication during the period where we analyze their complaint and prepare a reply letter, the study found 70% of respondents wanted OLHI to seek their input. Failure to do so contributed to levels of consumer dissatisfaction. This key finding has prompted important changes to our complaints review process. Our DROs now touch base with consumers during the initial assessment phase to learn more from them.

"I WOULD HAVE APPRECIATED A LITTLE MORE PERSONAL CONTACT, SUCH AS A PHONE DISCUSSION BEFORE THE FINAL DECISION."
- Consumer feedback; stage two

"I FEEL THAT THEY SHOULD MAKE THEIR DECISION LETTER MORE BASIC AND CLEAR. I HAD TO READ OVER THE LETTER A FEW TIMES TO REALLY UNDERSTAND."
- Consumer feedback; stage two

At the third stage, OLHI has determined that a complaint contains grounds to conciliate with the insurer and, as a result, there is further investigation by an OmbudService Officer. This group provided satisfaction rates of 7.6. An important finding at this stage is that the majority of consumers were satisfied with OLHI's services, even if OLHI was unable to negotiate a more favorable outcome with the insurer.

At our fourth – and final – complaints stage, a Senior Adjudicative Officer ("SAO") reviews the complaint, interviews the parties, and issues a written report with non-binding recommendations. During the Survey period, there were no consumers at this stage.

Stemming from consumer feedback, the survey results identified three key drivers and associated actions that impact satisfaction:

- Communication: Increase contact and use "plain language" in all communications with consumers.
- Staff performance: Continue to demonstrate knowledge and expertise by going the extra mile.
- Manageability: Maintain our easy-to-use complaints process, which includes efficient handling of information and timely recommendations.

As OLHI strives for continuous improvement, we have developed an action plan to identify ways to enhance overall service quality – particularly among those in the second stage of our complaints process.

"I APPRECIATED THAT THEY WERE TAKING MY CLAIM SERIOUSLY AND WERE IMPARTIAL."
- Consumer feedback; stage three

"SHE WAS VERY CONSIDERATE AND DEFINITELY TOOK ALL MY THOUGHTS SERIOUSLY. I FELT THAT SHE WAS COMPASSIONATE TOWARDS ME RIGHT TO THE END."
- Consumer feedback; stage three

Complaint Statistics

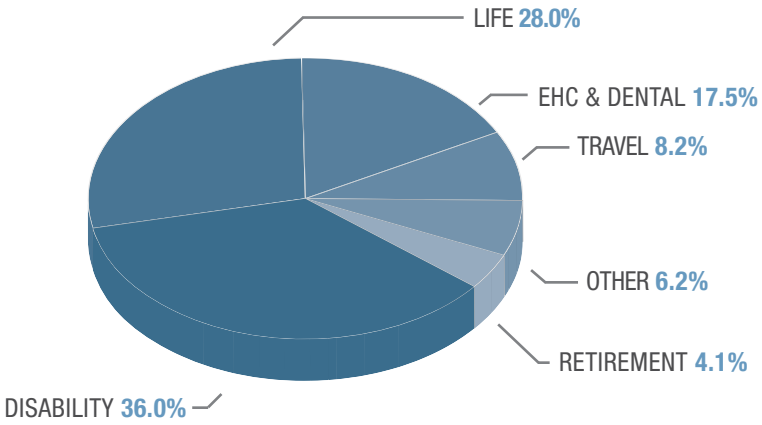
Overview

This fiscal year, OLHI received a total of 2,480 complaints – an increase of 5.5% over last year and 24.7% over the last four years. This year-over-year growth is indicative of an increase in consumer awareness as Canadians become better apprised of their options for third party review of their life and health insurance complaints.

Our top three product complaint categories remain Disability, Life and EHC & Dental. Together, these account for 81.5% of all complaints. For the third year in a row, disability complaints are below historic levels although they continue to represent the highest proportion of complaints. Life and EHC & Dental complaints remain similar to last year.

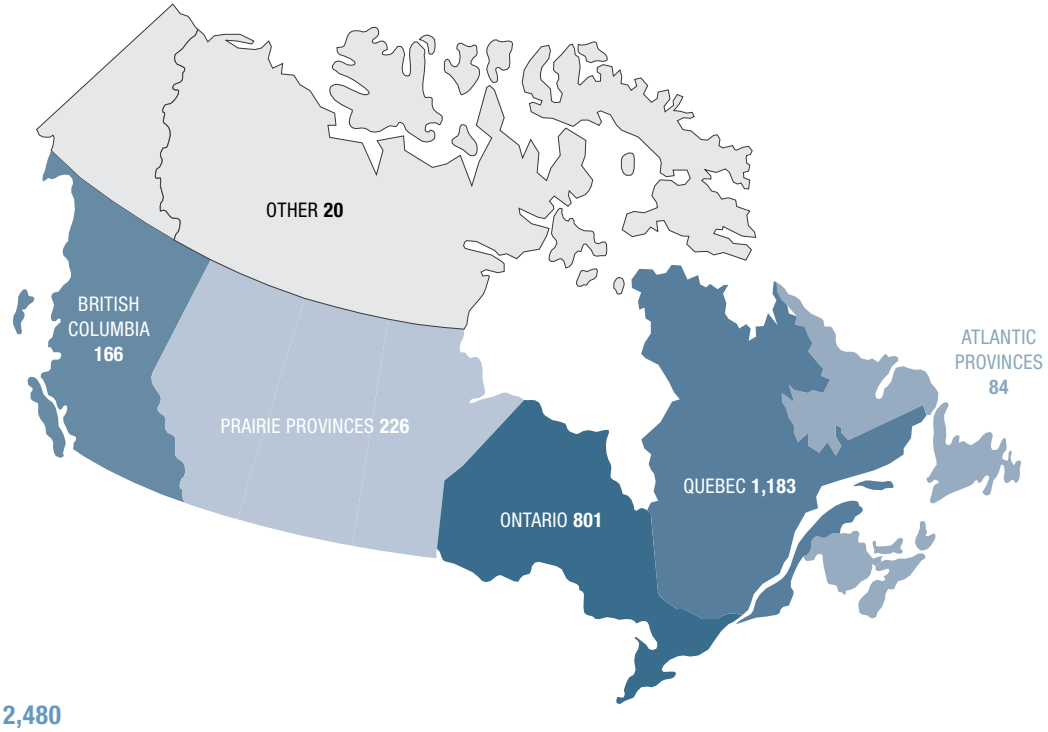
By region, we note a significant increase in complaints originating from Ontario (up 22.1%) and the Atlantic (up 23.5%) over last year. Although numbers are down slightly in Quebec, the majority of our complaints continue to originate there. Volumes in northern Canada remain low but it is noteworthy that there was an increase over last year. Volumes remain virtually unchanged in the rest of Canada.

Complaints By Product



TOTAL 2,480

Complaints By Region



TOTAL 2,480

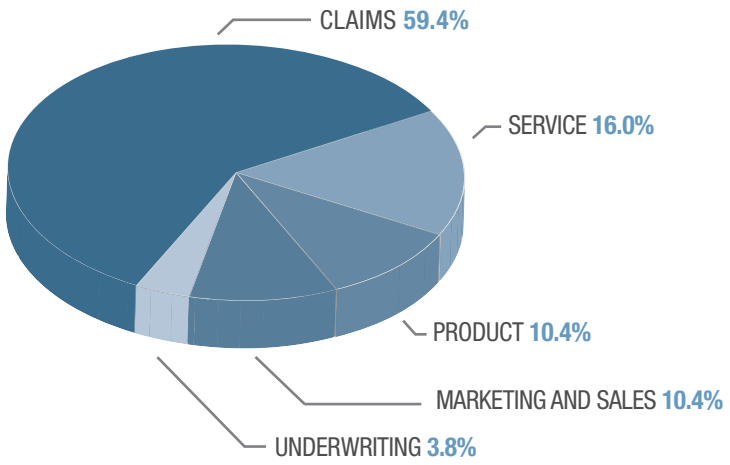
Overview

By Company Function, the Claims category continues to generate the highest proportion of complaints by far, at 59.4%. Service complaint volumes remained relatively steady over last year whereas Product complaints dropped by 4.4%. In the Marketing and Sales category, we saw an increase of 3.1% while Underwriting complaints decreased by nearly half, to 3.8%.

For the third year in a row, the Internet/Web site was the primary referral source (32.5%) for consumers searching for OLHI's services, up from 26.9% last year. This category has grown steadily each year. The government is this year's secondary source, with 18.0%, edging out Member Companies, at 17.5%. The friend/family category is steadily increasing, up by 5.3% over last year.

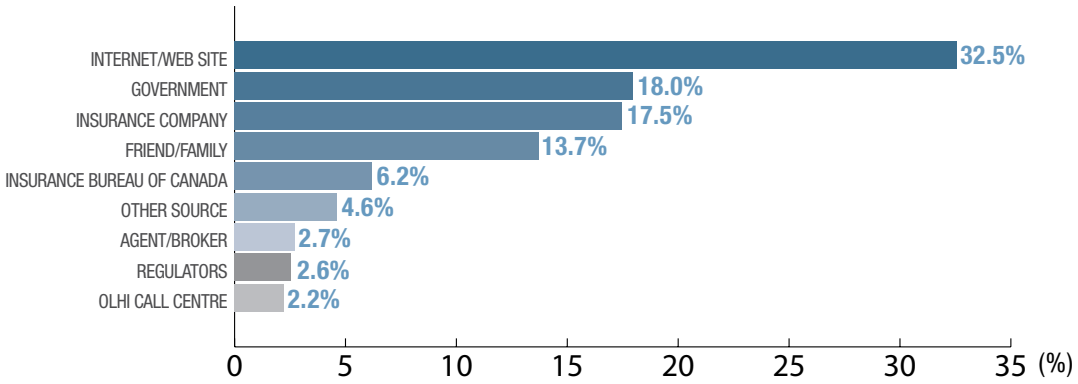
The distribution of complaints among Group, Individual and Creditor categories remains unchanged. Each of Individual and Group represent approximately 45% of complaints by line of coverage, with Creditor complaints making up the remaining 10%.

Complaints By Company Function



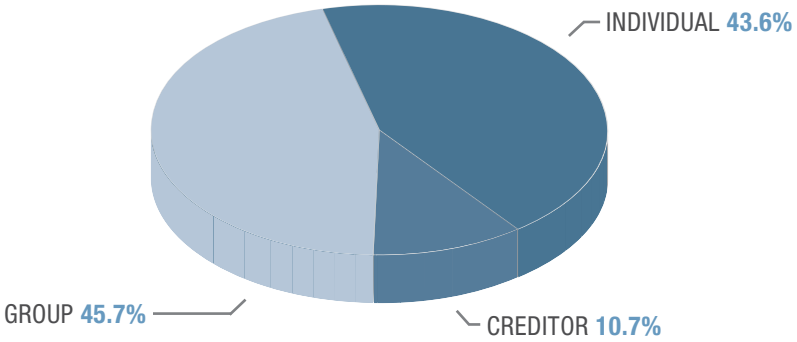
TOTAL 2,480

Complaints By Source



TOTAL 2,480

Complaints By Line of Coverage



TOTAL 2,480

Case Study 1

What is a "pre-existing" condition?

Mr. Z. purchased out-of-Canada emergency medical expense insurance in connection with a trip to the U.S. While there, he needed medical treatment for a kidney stone and, afterward, submitted a claim to the insurer for the expenses he incurred.

The claim was denied because his U.S. hospital records noted that he had experienced flank/back pain a week before his departure and he had not disclosed this to his insurer before traveling.

The exclusions section of his policy denied coverage for any sickness, injury or medical condition, occurring before the date he left on his trip, which was expected to lead to treatment or hospitalization. In sum, the insurer believed that Mr. Z. had a "pre-existing medical condition" that he was required to tell them about before traveling. All travel insurance contracts contain a clause of this nature; however, the exact disclosure requirements vary from contract to contract.

Mr. Z. appealed the denial and followed the insurer's complaint process, where the decision was upheld by the insurer. He then submitted his complaint to OLHI for review.

With both the details provided by the consumer and the insurer's file in hand, OLHI's Dispute Resolution Officer ("DRO") reviewed the case and concluded that the denial was entirely based on statements contained in the U.S. hospital records regarding prior back/flank pain. The DRO found that there had been no contact initiated by the insurer with either the U.S. hospital or the consumer. He also observed that the U.S. hospital notes stated that the consumer had experienced pain one week prior, that went away, and, in direct contradiction, that Mr. Z. had experienced "unremitting flank/back pain" for the entire week prior to his departure.

Although the insurer's Ombudsman had suggested that the claim be paid, the business unit declined the claim.

OLHI's DRO expressed doubt about the accuracy of the U.S. hospital records and suggested that this could be the basis for OLHI to approach the insurer. It was recommended that the complaint be escalated to an OLHI OmbudService Officer ("OSO") for further investigation.

The OSO spoke with the consumer directly and learned that he had made no mention whatsoever of any "flank pain" but that the back pain he had experienced one week prior to departure went away on its own with over-the-counter pain relief and a warm bath. Our OSO also reviewed the documents provided by the insurer, including the insurer's claims review process documents. His findings echoed those of the insurer's Ombudsman.

In his submission to the insurer, the OSO highlighted the incongruities in the U.S. hospital records. He suggested that the policy exclusion could not be fairly invoked given the fact that Mr. Z.'s prior back pain had gone away with a warm bath and an over-the-counter pain reliever.

"U.S. hospital records indicated pain prior to travel, which the consumer did not disclose to the insurer."

The OSO suggested that it was improbable that anyone with constant, severe pain leading up to this trip could travel anywhere and hence the unreliability of the U.S. hospital admission record. The OSO recommended that the insurer reconsider its' decision.

The insurer thanked the OSO for his comprehensive review and supported OLHI's recommendation to pay this claim. The consumer's claim was paid shortly thereafter.

Disclaimer: *Names, places and facts have been modified in the above example in order to protect the privacy of all those involved.*

Investigation Statistics

Overview

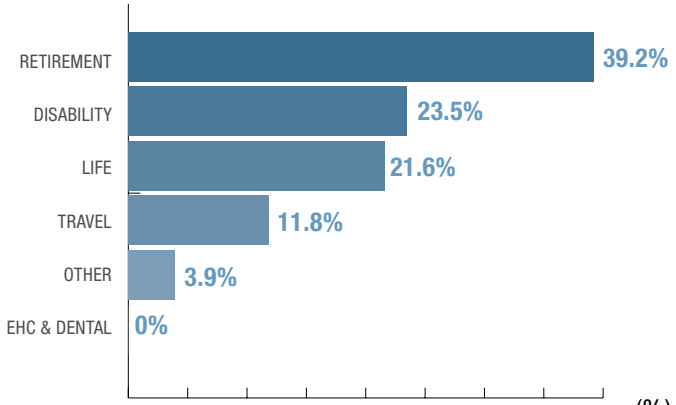
The number of investigation cases totaled 51 for this fiscal year, which is an increase of 41.7% over 2012/2013 and more than triple the number of cases in 2011/2012. This year-over-year growth reflects OLHI's commitment to ensure that all complaints with merit are escalated to the investigation stage.

By Product, Retirement cases represent the highest category of cases referred to OLHI's investigation stage – at 39.2%. This is nearly triple last year. Disability and Life complaints are down by nearly 10% each while EHC & Dental complaints declined from 11.1% to zero this year. Travel and "Other" categories remain similar.

By Company Function, we also witnessed an increase in Marketing & Sales investigations. This category ranked at the top of the list with the highest proportion of investigations this year.

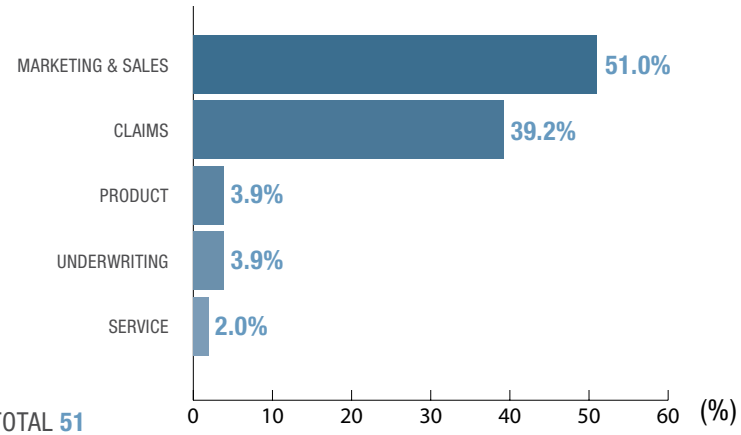
A total of 29 investigation cases were completed and closed this year. Of these, nine were settled in favour of the consumer, representing a settlement ratio of 31.1%.

Investigations By Product



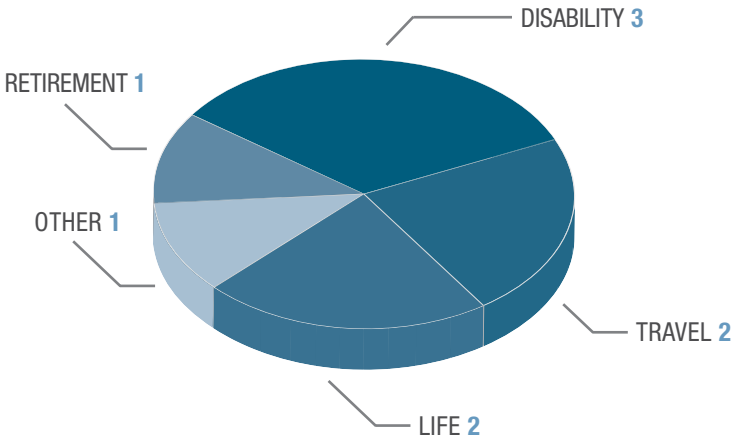
TOTAL 51

Investigations By Company Function



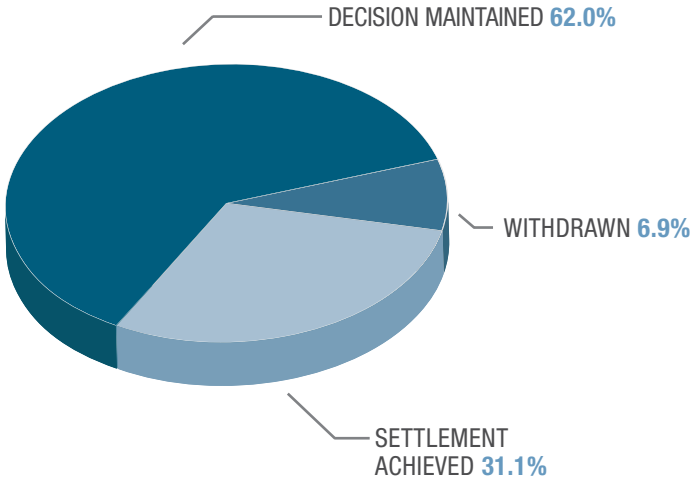
TOTAL 51

Settled Cases



TOTAL 9

Outcome By Cases Completed



TOTAL 29

Case Study 2

A critical date

Mr. F., diagnosed with cancer, made a claim on a Critical Illness insurance policy. If his claim was accepted, the insurance would have paid off a $10,000 loan he had taken out with his bank. His claim was denied on the basis that he did not have Critical Illness insurance coverage on the loan.

Mr. F. received his insurer's final position letter and contacted an OLHI Dispute Resolution Officer ("DRO"), seeking an independent review of his complaint.

During several conversations and exchanges of emails, our DRO learned that Mr. F., who had a prior line of credit that covered him for Critical Illness, converted this into a new loan a short time before making the claim. The bank denied his claim because this new loan was not insured for Critical Illness and he was diagnosed with cancer after the new loan was made.

Mr. F. claimed that he was diagnosed in early April and that the new loan was not taken out until later that month. Therefore, the coverage from the previous line of credit should be applied to pay out his claim. Meanwhile, the insurer stated that its denial was based on medical reports indicating that the cancer was not diagnosed until June, long after the line had been closed and replaced with a loan that did not provide Critical Illness coverage.

During his review, the DRO assessed that there were conflicting dates in the medical reports relating to the diagnosis date. He also questioned why Mr. F. would have taken out a new loan when he was ill, since that would result in him becoming ineligible for Critical Illness coverage under the new loan. As a result of this, the DRO recommended that the complaint be escalated for further investigation by an OLHI OmbudService Officer ("OSO").

The OSO poured over medical records, as well as the insurer's file and the consumer's documents, and had several conversations with all parties. The focus of his review was to determine whether a diagnosis had been made before the cancellation of the Critical Illness insurance coverage on the prior line of credit. Medical records showed that the confirmed date of diagnosis was in fact in June, two months after the old line of credit was closed and the new loan opened.

While written communications in early April between Mr. F.'s doctors showed mention of cancer, it was referred to as a suspected illness requiring further investigation and formal confirmation. Because insurers pay Critical Illness benefits based on clear diagnoses, not suspected conditions, his insurer would not have paid out the claim in April.

The OSO, through his investigation, also learned why Mr. F. took on a loan that wouldn't provide Critical Illness coverage at a time when he needed this coverage most: Mr. F. admitted that, when speaking with the bank to set up the new loan, he did not advise that he might have cancer.

"The main issue was whether a diagnosis had been made before the cancellation of critical illness coverage on the prior line of credit."

Because the bank did not have this information, they could not advise him to keep his current lines of credit, which provided Critical Illness, rather than taking on a loan that did not provide this coverage.

As a result, the OSO recommended to Mr. F. and the insurer that the original claim denial should be upheld.

Disclaimer: *Names, places and facts have been modified in the above example in order to protect the privacy of all those involved.*

Enquiry Statistics

Overview

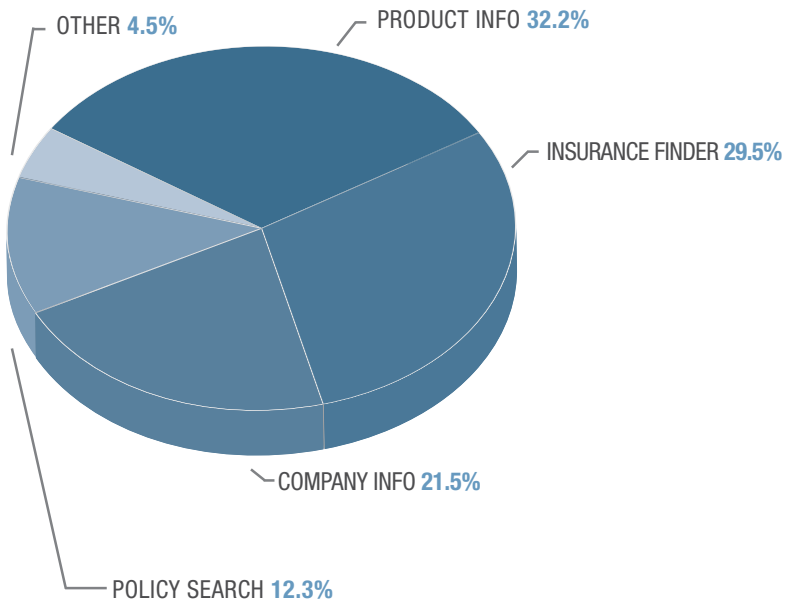
OLHI received 13,126 consumer telephone enquiries – both live or through our automated system. This number continues to decline while visits to the Web sites grow. Canadian consumers continue to place emphasis on using the Internet to search for general information about life and health insurance.

The bulk of our information enquiries continue to centre on general product information and specific life and health insurance products, represented by our Insurance Finder category. Together, these two categories make up 61.7% of all product enquiry calls.

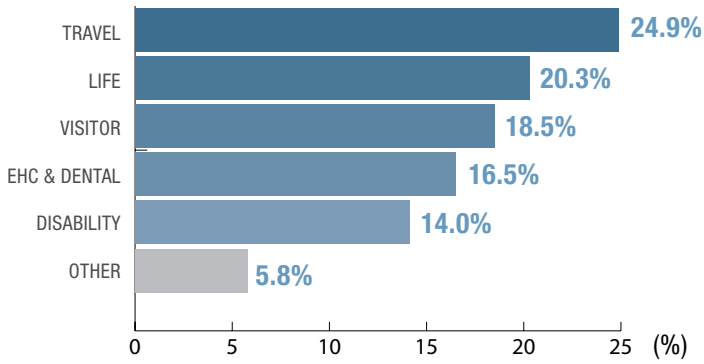
Product enquiries remain focused on Travel (24.9%), Life (20.3%) and Visitor (18.5%) insurance. This year, Life insurance information requests doubled and Visitor insurance enquiries decreased. Regarding Company enquiries, the number of consumers seeking contact information arising from merger & acquisition activity is up 50%.

Quebec continues to drive more than half of the information requests, at 56.8%, with Ontario second at 27.6%. The distribution of enquiries among other regions is virtually unchanged from last year.

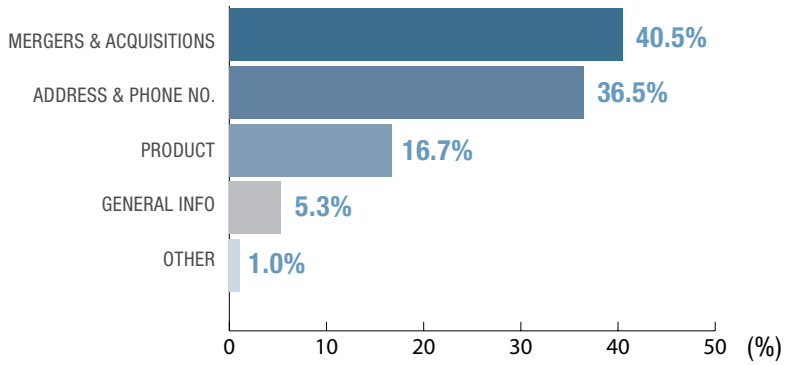
Reason for Enquiry



Analysis of Product Enquiries



Analysis of Company Enquiries



Enquiries by Region

Quebec	56.8%
Ontario	27.6%
Prairie Provinces	5.9%
British Columbia	3.3%
Atlantic Provinces	3.7%
Other	2.7%
Total	100%

Case Study 3

A key disclosure form

Mr. M. had a $25,000 term Life insurance policy. As the premium rates were about to increase dramatically and affordability was an issue, his insurance agent, who had originally sold him the policy, offered to research more affordable options.

This search proved a challenge. Mr. M. had health issues and, given the risks, few insurers would offer alternative coverage on a single life basis – at least, none that the consumer found affordable. At the end of the exercise, the agent proposed a joint last-to-die policy and wrote up an application for Mr. M. and his common-law partner, Ms. L.

The new policy was delivered and Mr. M. cancelled the previous one. He paid the premiums for just over two years before passing away. Ms. L. made a claim in order to pay final expenses and was surprised to have the claim denied because it was a joint-last-to-die policy. In such a policy, no proceeds are paid out until the death of the second spouse.

Ms. L. followed the insurer's complaint process, where the insurer upheld its decision to deny the claim. She then brought her complaint to OLHI.

The Dispute Resolution Officer ("DRO") reviewed the consumers' documents and found anomalies in the application. The consumers' statements in the application clearly indicated their intent to use the coverage for final expenses upon Mr. M.'s death and they designated Ms. L. and their daughter as beneficiaries – requirements that could not be met under a joint-last-to-die policy. The DRO recommended that the complaint be escalated to an OmbudService Officer ("OSO") for further investigation.

The OSO reviewed both the file documents and the analysis from the DRO, and concurred that there were discrepancies in the sales process. He noted a lengthy delay in issuing of the policy and that there was no copy of a Life Insurance Replacement Disclosure form in the file. This disclosure form is required to be provided whenever a consumer replaces one Life insurance policy with another. It provides a side-by-side comparison between the old and the new policies and serves to demonstrate that consumers understand the differences between the two policies.

Since recollections from the consumers and the agent differed, this missing form proved to be the crux of the issue.

In his detailed submission to the insurer, the OSO suggested that the lack of a properly completed replacement declaration form deprived Ms. L. and Mr. M. of the full and plain disclosure they were entitled to, and that their decision to purchase the new policy and cancel the previous one was not a fully informed one.

The OSO recommended that the insurer compensate the consumer for the loss of the $25,000 coverage provided by the original policy.

> ***"The consumers' decision to purchase a new policy and cancel the previous one was not fully informed."***

The insurer agreed to do so and the proposed payment was issued to the consumer.

Disclaimer: *Names, places and facts have been modified in the above example in order to protect the privacy of all those involved.*

Web Statistics

Overview

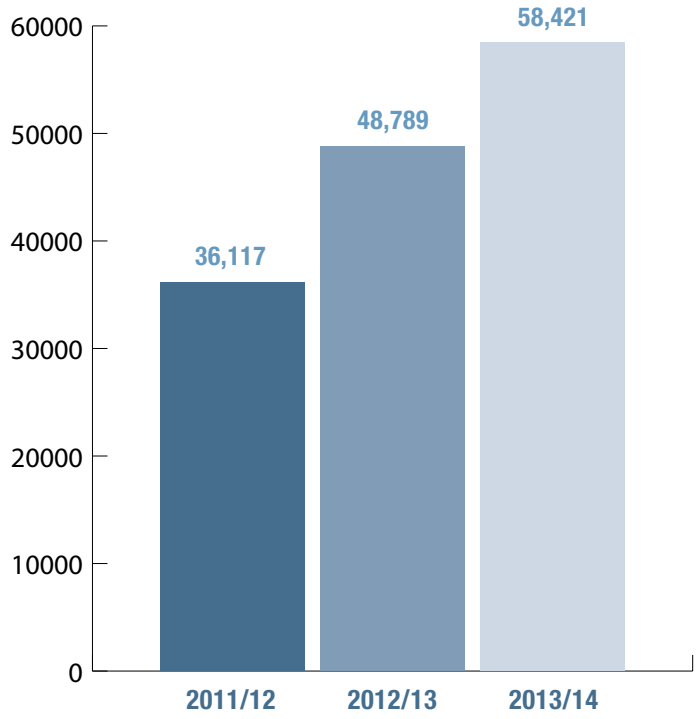
Web visits continue to dominate and grow as consumers' preferred choice for seeking information from OLHI. Visits numbered over 58,000 – an increase of nearly 20% over last year and 61.8% over the prior year. Since fiscal year 2010/2011, we have seen an increase of 106% in Web visits. For this reason, we continue to focus on providing a Web site that is consumer-friendly, professional and easy to navigate.

Nearly three in every four (71.7%) visitors to OLHI's Web sites are new visitors, evidence of our commitment to enhance public awareness of OLHI's services. Growth in new visitors has been more rapid on the French site, although the English site garners almost twice as many overall visitors.

Information Services (39.3%) remains the top viewed Web page, followed by the Insurance Finder page. Visits to the Complaints Process page have grown annually, showing a 46.5% increase over the last three years. Visits to the other pages of OLHI's Web sites remain steady.

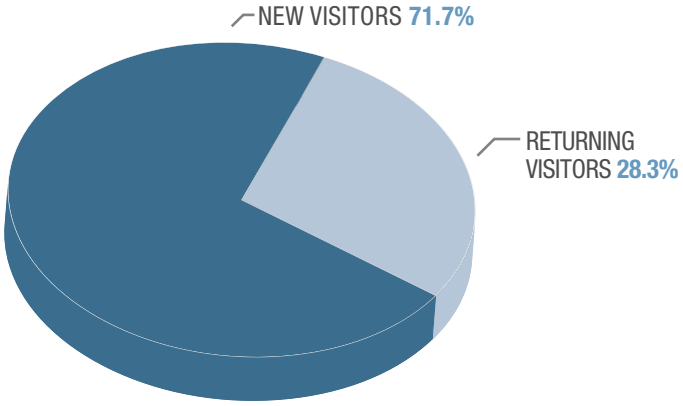
The proportion of referring sites, direct traffic and search engines as Web Traffic Sources remain virtually unchanged.

Web Visits 2011-2014



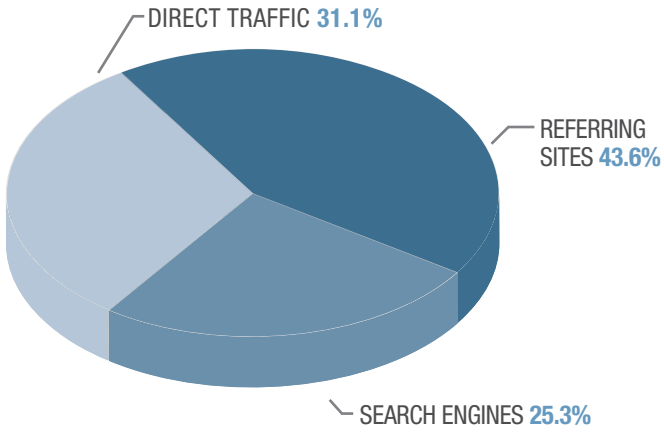
TOTAL **143,327**

New/Returning Web Visitors



TOTAL **58,421**

Web Traffic Sources



TOTAL **58,421**

Top Five Web Pages Viewed

Information Services	34,261	39.3%
Insurance Finder	27,169	31.2%
Complaints Process	13,396	15.4%
Participating Companies	6,365	7.3%
Policy Search	5,895	6.8%
Total	87,086*	100%

*Some visitors access multiple Web pages

OLHI Standards

OLHI has committed to abide by a voluntary code of service standards that guide the work and activities of its qualified professional staff. OLHI's promise to consumers includes service in accordance with the following standards:

Accessibility

OLHI provides convenient ease of contact for consumers through our national toll-free telephone number (1-888-295-8112), mail, facsimile (416-777-9750) and website (www.olhi.ca). Our services are offered in both English and French and are provided at no cost whatsoever to consumers.

Timeliness

OLHI will respond promptly to consumer enquiries and complaints. Most telephone enquiries are answered immediately by an attendant and any telephone, fax, or email messages will be returned promptly.

Courtesy

Consumers contacting OLHI will be treated courteously, professionally and with respect.

Clarity

OLHI provides consumers with clear and succinct information by telephone or in writing. Our aim is to ensure the consumer has a full and complete understanding of the issues and the positions of each party.

Accuracy

All information collected by OLHI relevant to a complaint or enquiry will be accurate and as complete and up-to-date as necessary for the purpose of assisting with the resolution of the enquiry or complaint.

Fairness & Impartiality

OLHI provides unbiased and impartial assistance with consumer complaints and enquiries. OLHI is not an advocate for either the consumer or the life and health insurance company.

Consistency

OLHI processes complaints in accordance with its mandate and terms of reference and strives to treat similar cases in a similar fashion.

Knowledge

The information provided to consumers contacting OLHI will reflect a thorough knowledge and understanding of the subject. OLHI's staff have the skills and specialized knowledge of life and health insurance products, services, and practices necessary to address consumer enquiries and complaints.

Privacy/Confidentiality

Any information collected by OLHI will remain confidential and proprietary to the OLHI in accordance with OLHI's Privacy Statement.

Independence & Objectivity

OLHI is a non-profit corporation independent of government and industry. It is governed by a Board of Directors, the majority of whom are Independent Directors with no ties to the life and health insurance industry.

Member Companies

All life and health insurance companies regulated by the Canadian federal or provincial governments are eligible to become OLHI members. Life and health insurance companies that are members of OLHI are called "Member Companies". Clients of Member Companies have access to OLHI's national independent dispute resolution service.

We are pleased to provide you with the following list of Member Companies as of July 31, 2014:

Acadia Life
ACE INA Life Insurance
Actra Fraternal Benefit Society
Aetna Life Insurance Company
Allianz Life Insurance Company of North America
American Bankers Insurance Company of Florida
American Bankers Life Assurance Company of Florida
American Health and Life Insurance Company
Assumption Mutual Life Insurance Company
Assurant Life of Canada
Assurant Solutions
Blue Cross Life Insurance Company of Canada
BMO Life Assurance Company
BMO Life Insurance Company
British Columbia Life & Casualty Company (BC Life)
Canadian Premier Life Insurance Company
Canassurance Hospital Service Association
Canassurance Insurance Company
CIBC Life Insurance Company Ltd.
CIGNA Life Insurance Company of Canada
Co-operators General Insurance Company
Co-operators Life Insurance Company
Combined Insurance Company of America
Connecticut General Life Insurance Company
CT Financial Assurance Company
CUMIS Life Insurance Company
Desjardins Financial Security Life Assurance Company
FaithLife Financial
First Canadian Insurance Corporation
First North American Insurance Company
Foresters
Foresters Life Insurance Company
Gerber Life Insurance Company
GMS Insurance Inc.
Green Shield Canada
Group Medical Services
Hartford Life Insurance Company
Humania Assurance Inc.
Industrial Alliance Insurance and Financial Services Inc.
Knights of Columbus
La Capitale Civil Service Insurer Inc.
La Capitale FSI
La Capitale Insurance and Financial Services Inc.
Legacy General Insurance Company
Liberty Life Insurance Company of Boston
Life Insurance Company of North America
London Life Insurance Company
Manitoba Blue Cross
Manulife Canada Ltd.
Manulife Financial
MD Life Insurance Company
Medavie Blue Cross
National Bank Life Insurance Company
New York Life Insurance Company
Optimum Reassurance Inc.
Pacific Blue Cross
PartnerRE Europe SE
Pavonia Life Insurance Company of Michigan
Primerica Life Insurance Company of Canada
Principal Life Insurance Company
RBC General Insurance Company
RBC Insurance Company of Canada
RBC Life Insurance Company
Reliable Life Insurance Company
Saskatchewan Blue Cross
SCOR Global Life
Scotia Life Insurance Company
SSQ Financial Group
SSQ Insurance Company Inc.
SSQ, Life Insurance Company Inc.
Standard Life Assurance Limited
Standard Life Trust Company
State Farm International Life Insurance Company Ltd.
Sun Life Financial
Sun Life Assurance Company of Canada
Sun Life Insurance (Canada) Limited
TD Life Insurance Company
Teachers Life Insurance Society (Fraternal)
The Canada Life Assurance Company
The Canada Life Insurance Company of Canada
The Empire Life Insurance Company
The Equitable Life Insurance Company of Canada
The Excellence Life Insurance Company
The Great-West Life Assurance Company
The Independent Order of Foresters
The Manufacturers Life Insurance Company
The Standard Life Assurance Company (2006)
The Standard Life Assurance Company of Canada
The Union Life, A Mutual Assurance Company / UL Mutual
The Wawanesa Life Insurance Company
TIC Travel Insurance Coordinators Ltd.
Transamerica Life Canada
Triton Insurance Company
Western Life Assurance Company

OLHI Locations + Board Members

LOCATIONS

OmbudService for Life & Health Insurance
401 Bay Street, PO Box 7
Toronto, Ontario
M5H 2Y4

Ombudsman des assurances de personnes
2001 University Street, 17th Floor
Montreal, Quebec
H3A 2A6

MEMBERS OF THE 2013-2014 BOARD OF DIRECTORS

Chair
Dr. Janice MacKinnon [1,3]
Professor, University of Saskatchewan and former Minister of Finance for Saskatchewan

Independent Directors
Lea Algar [2]
Chair, General Insurance OmbudService and former Ontario Insurance Ombudsman

Bruce Cran [1]
President, Consumers Association of Canada

Yves Rabeau [1]
Professor of Economics, Université du Québec à Montréal (UQAM)

Reginald Richard [2,3]
Former Superintendent of Insurance for New Brunswick

Industry Directors
Claude Garcia [2]
Corporate Director and former President, Standard Life Assurance Company

Dr. Dieter Kays [1]
Former Chief Executive Officer of FaithLife Financial

Dan Thornton [3]
Former Chief Operating Officer, The Co-operators Life Insurance Company

[1] Member of Governance Committee
[2] Member of Standards Committee
[3] Member of Human Resources Committee

Financial Statements of

CANADIAN LIFE AND HEALTH INSURANCE OMBUDSERVICE

(OPERATING AS OMBUDSERVICE FOR LIFE & HEALTH INSURANCE)

Year ended March 31, 2014

KPMG LLP
Bay Adelaide Centre
333 Bay Street Suite 4600
Toronto ON M5H 2S5
Canada

Telephone (416) 777-8500
Fax (416) 777-8818
Internet www.kpmg.ca

INDEPENDENT AUDITORS' REPORT

To the Member Companies of the Canadian Life and Health
Insurance OmbudService

We have audited the accompanying financial statements of Canadian Life and Health Insurance OmbudService (operating as OmbudService for Life & Health Insurance), which comprise the balance sheet as at March 31, 2014, the statements of operations and changes in operating fund balance, changes in net assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Canadian Life and Health Insurance OmbudService as at March 31, 2014, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants

June 26, 2014
Toronto, Canada

Balance Sheet

March 31, 2014, with comparative information for 2013

	2014	2013
Assets		
Current assets:		
Cash and cash equivalents (note 2)	$ 499,205	$ 570,202
Recoverable expenditures and deposits	13,513	14,198
	512,718	584,400
Capital assets (note 3)	100,808	116,694
	$ 613,526	$ 701,094
Liabilities and Fund Balance		
Current liabilities:		
Accounts payable and accrued liabilities	$ 93,033	$ 127,600
Current portion of deferred lease inducement	8,498	8,498
	101,531	136,098
Deferred lease inducement	41,781	50,277
Fund balance:		
Operating fund:		
Invested in capital assets	100,808	116,694
Unrestricted	369,406	398,025
	470,214	514,719
Commitments (note 5)		
	$ 613,526	$ 701,094

See accompanying notes to financial statements.

On behalf of the Board:

_____ Director

_____ Director

Statement of Operations and Changes in Operating Fund Balance

Year ended March 31, 2014, with comparative information for 2013

	2014	2013
Revenue:		
General assessment fees	$ 1,774,250	$ 1,695,229
Investment	6,640	8,237
	1,780,890	1,703,466
Expenses:		
Staff and adjudicative services	1,092,321	994,637
Board of Directors' fees	128,784	147,492
Rent	111,113	123,796
Professional fees	173,350	252,753
Board meetings and travel	49,417	56,418
Information technology	75,889	78,348
Management fees	47,460	44,070
Staff meetings and travel	35,025	50,419
Supplies and services	37,413	38,620
Telecommunications	24,997	26,886
Insurance	11,620	10,433
Training and development	6,531	5,662
Amortization of capital assets	23,560	18,380
Facilities fees - Toronto	5,602	7,019
Translation	1,853	4,529
FSON-related costs	460	179
Loss on disposal of capital assets	–	1,835
	1,825,395	1,861,476
Deficiency of revenue over expenses	(44,505)	(158,010)
Operating fund balance, beginning of year	514,719	672,729
Operating fund balance, end of year	$ 470,214	$ 514,719

See accompanying notes to financial statements.

Statement of Changes in Net Assets

Year ended March 31, 2014, with comparative information for 2013

	2014			2013		
	Invested in capital assets	Unrestricted operating fund	Total	Invested in capital assets	Unrestricted operating fund	Total
Net assets, beginning of year	$ 116,694	$ 398,025	$ 514,719	$ 64,289	$ 608,440	$ 672,729
Deficiency of revenue over expenses	(23,560)	(20,945)	(44,505)	(20,215)	(137,795)	(158,010)
Net change in investment in capital assets	7,674	(7,674)	–	72,620	(72,620)	–
Net assets, end of year	$ 100,808	$ 369,406	$ 470,214	$ 116,694	$ 398,025	$ 514,719

Statement of Cash Flows

Year ended March 31, 2014, with comparative information for 2013

	2014	2013
Cash provided by (used in):		
Operating activities:		
Deficiency of revenue over expenses	$ (44,505)	$ (158,010)
Items not affecting cash:		
Amortization of capital assets	23,560	18,380
Amortization of lease inducement	(4,491)	(4,493)
Loss on disposal of capital assets	–	1,835
Change in non-cash operating working capital:		
Recoverable expenditures and deposits	685	(8,012)
Accounts payable and accrued liabilities	(34,567)	43,322
	(59,318)	(106,978)
Investing activities:		
Additions to capital assets	(11,679)	(76,625)
Decrease in cash and cash equivalents	(70,997)	(183,603)
Cash and cash equivalents, beginning of year	570,202	753,805
Cash and cash equivalents, end of year	$ 499,205	$ 570,202

See accompanying notes to financial statements.

Notes to Financial Statements

Year ended March 31, 2014

The Canadian Life and Health Insurance OmbudService ("CLHIO") is a not-for-profit organization incorporated under Part II of the Canada Corporations Act, established to assist consumers with concerns and complaints about life and health insurance products and services in Canada. CLHIO is exempt from income taxes under the Income Tax Act (Canada) (the "Act"), provided certain requirements of the Act are met. CLHIO commenced operating as OmbudService for Life & Health Insurance on August 17, 2009.

1. Significant accounting policies:

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

(a) Financial instruments:

CLHIO has classified its short-term investments as held-for-trading and, therefore, these investments are measured at fair value.

The carrying amounts of financial assets and liabilities approximate their fair values due to the short-term maturity of these financial instruments.

(b) Fund accounting:

These financial statements follow the restricted fund method of accounting, whereby the activities of the general fund and restricted fund are disclosed separately. The operating fund reports unrestricted resources.

(c) Revenue recognition:

CHLIO derives its revenue primarily through assessments fees. The fees are recognized as revenue in the membership year to which they relate.

Investment income is recognized as revenue when earned.

1. Significant accounting policies (continued):

(d) Capital assets:

Capital assets are stated at cost less accumulated amortization. Amortization is provided over the estimated useful lives of the assets using the following bases and annual rates:

Asset	Basis	Rate
Office furniture	Declining balance	20%
Office equipment	Declining balance	20%
Computer equipment	Straight line	4 years
Leasehold improvements	Straight line	Over term of lease

(e) Lease inducement:

Inducements received from the landlord with respect to the leased premises are deferred and amortized over the lease term on a straight-line basis. Lease inducements are accounted for as a reduction of the lease expense over the term of the lease.

(f) Measurement uncertainty:

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from those estimates.

2. Cash and cash equivalents:

Cash and cash equivalents consist of the cash balance and high-interest savings accounts. Cash and cash equivalents comprise the following amounts:

2014	Fair value	Carrying value
Cash	$ 80,292	$ 80,292
Short-term investments	418,913	418,913
	$ 499,205	$ 499,205

2. Cash and cash equivalents (continued):

2013	Fair value	Carrying value
Cash	$ 157,929	$ 157,929
Short-term investments	412,273	412,273
	$ 570,202	$ 570,202

The short-term investments are held in high-interest savings accounts an aggregate amount of $418,913 (2013 - $412,273) with effective interest rates of 1.25% to 1.30% (2013 - 1.25% to 1.30%). Interest is receivable monthly.

3. Capital assets:

2014	Cost	Accumulated amortization	Net book value
Office furniture	$ 29,189	$ 21,143	$ 8,046
Office equipment	8,918	1,817	7,101
Computer equipment	75,894	27,302	48,592
Leasehold improvements	64,186	27,117	37,069
	$ 178,187	$ 77,379	$ 100,808

2013	Cost	Accumulated amortization	Net book value
Office furniture	$ 29,189	$ 19,132	$ 10,057
Office equipment	5,138	514	4,624
Computer equipment	67,995	9,315	58,680
Leasehold improvements	64,185	20,852	43,333
	$ 166,507	$ 49,813	$ 116,694

4. Transactions with Canadian Life and Health Insurance Association Inc. ("CLHIA"):

During the year, CLHIA provided management services to CLHIO, consisting mainly of administrative services, which amounted to $51,038 (2013 - $87,010), including the applicable taxes.

5. Commitments:

CLHIO rents office premises in Toronto and Montreal. Future minimum payments under existing leases are as follows:

2015	$ 62,000
2016	64,000
2017	35,000
2018	35,000
2019	35,000
Thereafter	35,000

6. Financial instrument risk management:

CLHIO has policies related to the identification, monitoring and mitigation of risks associated with financial instruments. The key risks related to financial instruments are credit risk and interest rate risk. How CLHIO manages each of these risks is described below:

(a) Credit risk:

Credit risk is the risk that the counterparty will fail to discharge its obligation to CLHIO. CLHIO's exposure to credit risk is limited as a large portion of assets are held in cash and high-interest savings accounts with Canadian-issued instruments with ratings of AAA. The maximum credit risk exposure as at March 31, 2014 comprises cash and cash equivalents totalling $499,205 (2013 - $570,202).

(b) Interest rate risk:

Interest rate risk is the risk that the market value of CLHIO's investments will fluctuate due to changes in the market interest rates. The risk is considered insignificant given that CLHIO holds a significant portion of its assets in cash and high-interest savings accounts.