OmbudService for Life & Health Insurance

Ombudsman des assurances de personnes

OLHI • OAP

2012-2013 **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 **www.olhi.ca**.

Congratulations to Dr. Janice MacKinnon on her appointment as a Member of the Order of Canada for her contributions to the advancement of public policy at the provincial and national levels, as an author, politician and scholar.

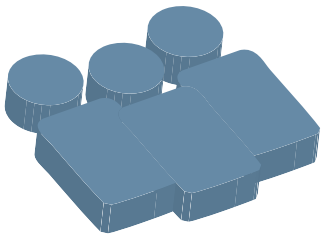
Front cover illustration: 'Fundy Shores no. 1'
Acrylic and Oil on Canvas by Doug Forsythe
(www.dougforsythegallery.com) © Doug Forsythe

Highlights + Total Activity

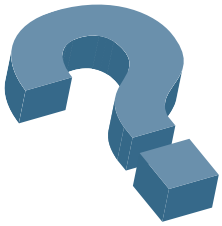
Highlights:

- 2nd Independent Review – OLHI fulfilling mandate
- Increased Web visits – 72% over 3 years
- Increased referrals from Member Companies
- Enhanced profile in Western Canada
- Initiated 1st Consumer Satisfaction Survey
- New Montreal office, IT & phone systems

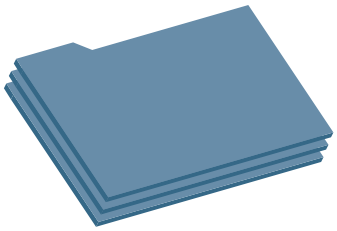
Analysis of Total Activity



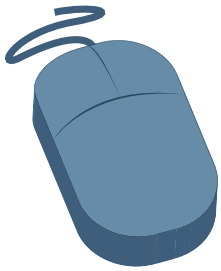
Total Contacts 66,004



Enquiries 14,865



Complaints 2,350



Web Visitors 48,789

Message from the Chair

Dr. Janice MacKinnon

Chair, OmbudService for Life & Health Insurance

"Success is neither magical nor mysterious. Success is the natural consequence of consistently applying the basic fundamentals."
Jim Rohn (Entrepreneur, author)

The past year has been particularly exciting and rewarding as we brought to fruition a number of major initiatives. Chief among them was the delivery of OLHI's 2nd Independent Review.

2ND INDEPENDENT REVIEW

In accordance with the Framework for Collaboration, Canadian financial OmbudServices -including OLHI- are required to undertake an independent review of their operations every few years to ensure that they are meeting their mandate. During this fiscal year, OLHI underwent the second of such reviews since it commenced its operations in 2002.

OLHI was most fortunate to be able to obtain the services of a consultant with the pedigree of the Honorable Justice Robert Wells to carry out this Review. His extensive work in dispute resolution in addition to his many years of service as a judge, ensured an impeccable study with insightful, discerning and practical recommendations. The OLHI Board was very happy with the way the Review was conducted and most pleased with the findings. The Final Report was shared with CLHIA, our Member companies, our Regulators and the public and is posted in both languages on OLHI's websites. Feedback from all sectors has been favourable.

The Final Report concluded that OLHI is fulfilling its mandate as prescribed by its founding documents, including the seven guidelines contained in the Framework. It reaffirmed that OLHI has worked very hard, both internally and externally with its stakeholders, to organize its work effectively and independently by implementing the 60 recommendations of the 1st Independent Review. The Report put forward 13 new recommendations that are designed to strengthen and improve OLHI's core processes and help it attain its full potential as a provider of independent, fair and impartial dispute resolution services between consumers and insurers.

One recommendation, in particular, resonated strongly with the Board: that the present method of selecting directors should not be changed. Given some of the ongoing discussions regarding the governance structures of ombudservices in general, it was reassuring to have confirmed independently that OLHI's governing mechanisms meet the standard of independence in all aspects.

OLHI has already moved forward on several recommendations. For the key ones that demand more planning, staff is using the current year to gather the necessary information to develop an implementation plan which will be adopted the following year. Stakeholders have been and will continue to be consulted throughout this process.

CONSUMER SATISFACTION SURVEY

As well, we are awaiting the results of OLHI's first Consumer Satisfaction Survey in order to incorporate its findings into the Review's implementation plan. The focus of the Survey is on determining levels of consumer satisfaction with the different stages and aspects of OLHI's Complaint Review Process. The groundwork for this Survey was undertaken in the 2012/13 fiscal year and the Final Report is due in the fall of 2013.

REGULATOR RELATIONS

OLHI's relations with its Regulators continue to be healthy and in good form notwithstanding the ongoing changes in the surrounding landscape. In that regard, the Joint Forum of Financial Market Regulators was dissolved last fall and replaced by the CCIR OmbudServices Oversight Committee, a new sub-committee of the Canadian Council of Insurance Regulators (CCIR). The transition has been smooth, with many of the same players on board, and we look forward to continue working collaboratively on issues of mutual interest and concern.

LOOKING AHEAD

The next year promises to be as exciting and challenging. Our major initiatives include:

- delivering the Final Report on OLHI's first Consumer Satisfaction Survey;
- developing an implementation plan for the 2nd Independent Review;
- enhancing awareness through Web partnering with like-minded organizations; and
- transitioning to the new Canada Not-For-Profit Corporations Act.

In closing, I wish to acknowledge all the parties and players – OLHI Board, management and staff, Member Companies and other stakeholders - whose hard work, dedication and cooperation help to further OLHI's mission and make possible an independent forum for consumer protection.

Janice MacKinnon

Dr. Janice MacKinnon
Chair, OLHI

Message from the Executive Director

Holly Nicholson

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

"Alone we can do so little; together we can do so much."
Helen Keller

This has been another successful year for OLHI as we received positive results from our 2nd Independent Review and took steps to enhance operational efficiency and independence.

NEW MONTREAL OFFICE & OPERATIONAL SYSTEMS

On the operations side, the new fiscal year opened with the Board's decision to replace OLHI's existing phone and IT network systems.

Since inception, OLHI operated with separate phone and IT networks at each office location. It was felt that it was time for OLHI to secure fully independent systems, under its direct control, which would be harmonized across the company.

Much of the spring and summer was spent assessing proposals from potential suppliers and concluding contract negotiations. The fall was dedicated to implementing the new systems and staff training. Having our key systems designed to fit our requirements and standardized across the company ensures that we will efficiently meet our present and future business needs.

The fiscal year closed with the relocation of our Montreal office. This move was carried out upon expiry of our lease with CLHIA but had been on the agenda for several years, since the recommendation that we find separate premises was made in the 1st Independent Review. We remain located in Montreal's downtown core.

2ND INDEPENDENT REVIEW

The principle focus of Justice Wells' review was the effectiveness of OLHI's complaints handling process. After extensive updates to our complaint procedures these last 4 years, we were pleased with the Review's findings that they meet applicable standards.

Naturally, the Review made several recommendations. Key among them are:

- escalation of a larger number of cases to the 2nd and 3rd stages of complaint review;
- additional funding to provide OLHI with access to specialized professional advice; and
- publication of a greater number of OLHI case studies.

Our Board has accepted these recommendations in principle as important steps to improve the transparency of OLHI's complaints processes and to enhance its credibility among stakeholders, particularly consumers. During the current year we will be collecting the necessary information required to develop a plan to implement these recommendations. Stakeholders have been, and will continue to be, consulted on these issues.

CONSUMER FEEDBACK & AWARENESS

OLHI had over 66,000 contacts with the public last year. Not surprisingly, Web visits are the largest source of these contacts as Canadians turn increasingly to the Internet to locate information. OLHI received 48,789 Web visits to its English and French sites, a 72% increase over the last three years.

This year OLHI took steps to enhance public awareness in Western Canada. In February we exhibited at the Vancouver "Zoomer" trade show where our services were promoted to over 15,000 attendees. These efforts appear to have been successful as we have seen an increase in the use of our services by Western Canadians this past year.

Another important trend is that an increasing number of consumers are hearing about OLHI's complaint review services from their insurer. This is a direct result of an agreement implemented with our Member Companies last year to notify consumers about OLHI during their internal complaints process.

SUMMARY

The cornerstones of OLHI's success to date have been collaboration with stakeholders, strategic planning, and precise execution of select projects. Dedication and hard work by the OLHI Board and staff has been critical.

The positive outcome of this year's 2nd Independent Review and growing awareness of our services among the public demonstrate the soundness of this approach. We will continue to emphasize collaboration, consensus building, and hard work as we strive to realize our full potential as an independent dispute resolution organization serving Canadian consumers and life and health insurers.

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 Complaints Counsellor

- Determine if complaint within OLHI mandate[1]
- Consumer submits final position letter and related information
- Complaints Counsellor 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 & health insurance issues or which are not against a Member Company;
- have been previously considered by it or which have been - or are currently before - a court, tribunal or other dispute resolution process;
- are made by third party service providers or which relate to an uninsured plan that is administered by a Member Company.

Step One

A consumer contacts OLHI about a complaint. An OLHI Complaints Counsellor determines whether the consumer has received a final position letter from the insurer, indicating the completion of the insurer's own internal complaint resolution process. If no final position letter has been received, the Complaints Counsellor refers the consumer to his or her insurer's internal complaint resolution process, offering general guidance on the nature and type of information required to process the complaint through the company.

Step Two

A consumer who has received a final position letter from a life and health insurance company that is an OLHI Member Company and who is not satisfied with the result, may access OLHI's independent cost free complaints resolution process.

At this stage an experienced Complaints Counsellor reviews the complaint from an independent perspective, collects all relevant facts and information, and advises the consumer how the complaint might be resolved. With OLHI's assistance, this may involve providing additional information to the consumer's life and health insurer or communicating with the insurer.

Step Three

If the complaint is not resolved at Step Two, at the discretion of OLHI it may be referred to an OmbudService Officer ("Officer") for investigation and conciliation. The Officer works with the consumer and the Member Company to attempt a voluntary resolution of the complaint. The Officer contacts both parties to collect any necessary additional information and then assesses the complaint to try to find some common ground between the parties.

Step Four

Where warranted, a complaint may be referred for a further review. This review results in a non-binding settlement recommendation to the consumer and the Member Company.

Complaint Statistics

Overview

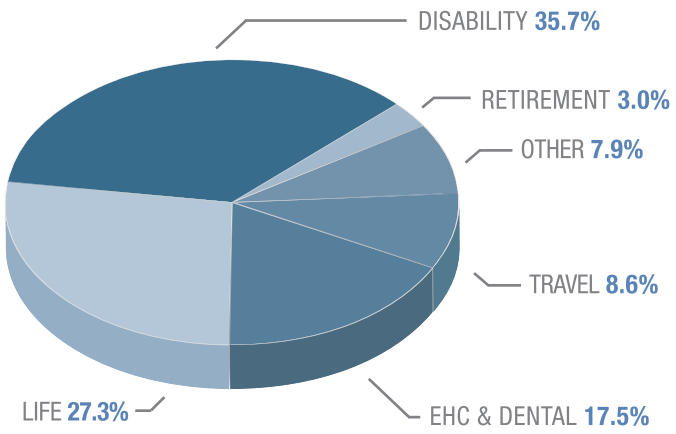
This year OLHI received a total of 2,350 complaints. While this figure is slightly less than last year's 2,444 complaints, it represents an 18% increase over case volumes experienced two years ago. This general upward trend in complaints is directly related to various initiatives undertaken since 2011 to improve awareness of OLHI's services. These include additional notifications by Member Companies to consumers during the course of their internal complaint handling processes.

As in past years, the top three product complaint categories are those related to Disability, Life, and EHC & Dental.Together, they account for 80.5% of all complaints.

For the second year in a row, Disability complaints are below historic levels, representing 35.7% of total complaints this year compared to 41.6% two years ago. In contrast, EHC & Dental claims have been trending upward during the same period. Life complaints continue to remain relatively steady at 27.3% this year.

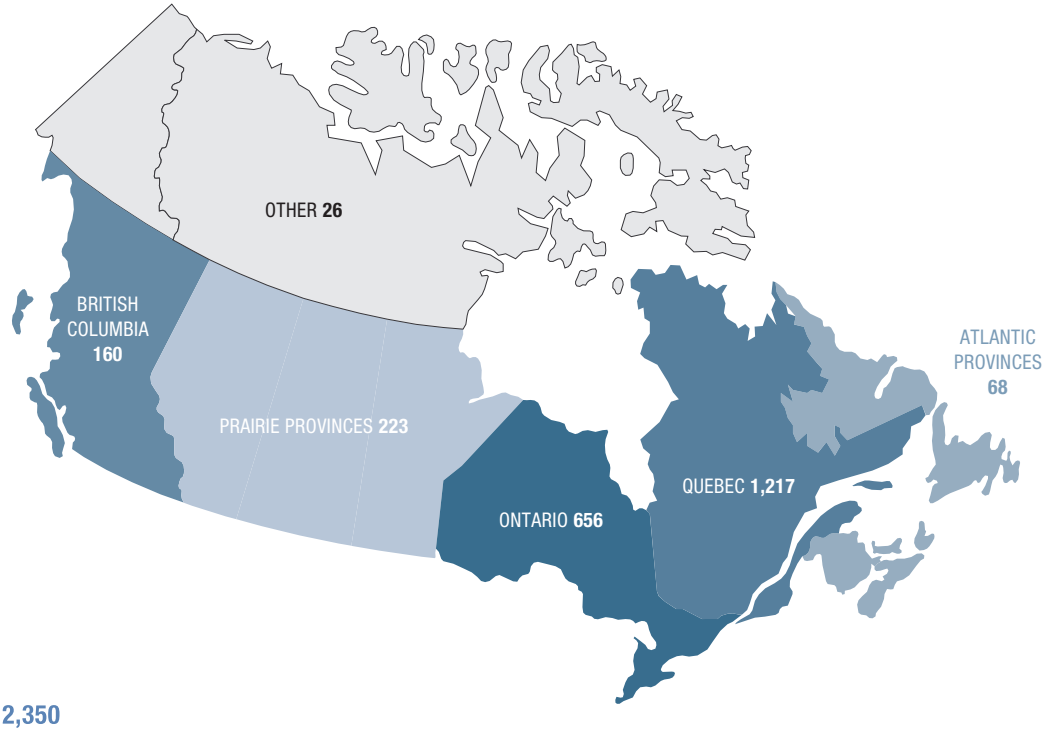
There has been an increase in complaints originating from BC and the Prairie Provinces, coupled with a decline in volumes in Quebec and Ontario. Complaints originating from other regions remained relatively steady.

Complaints By Product



TOTAL **2,350**

Complaints By Region



TOTAL **2,350**

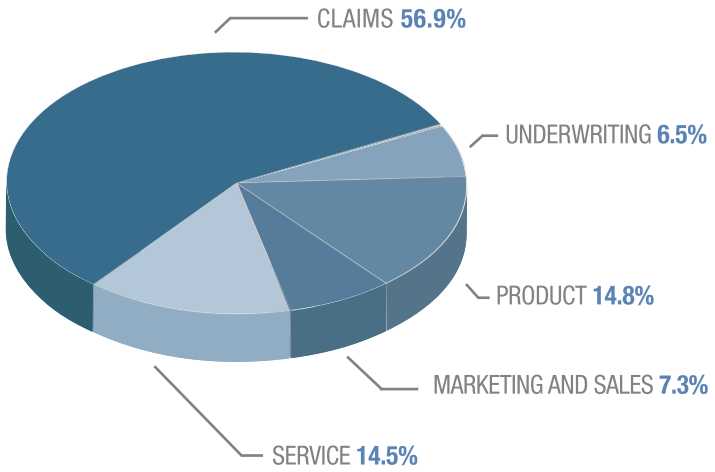
Overview

By Company Function, the Claims category continues to generate the highest proportion of complaints by far at 56.9% this fiscal year. Product design and Service categories are relatively equal at 14.8% and 14.5%, respectively. Marketing & Sales (7.3%) and Underwriting (6.5%) represent the lowest categories. The percentages for these latter four categories are similar to those of last year.

Complaints by Source show some interesting changes. Not surprisingly, the Internet/Web site was the primary method through which consumers with complaints located OLHI's services. This year, the second largest referral source for complaints was through Member Companies. This category showed a fairly large increase, climbing from 12.8% in fiscal 2011/12 to 18.5% this current fiscal year. In contrast, Government (non-regulatory) referrals declined sharply from 27% to 16.1%.

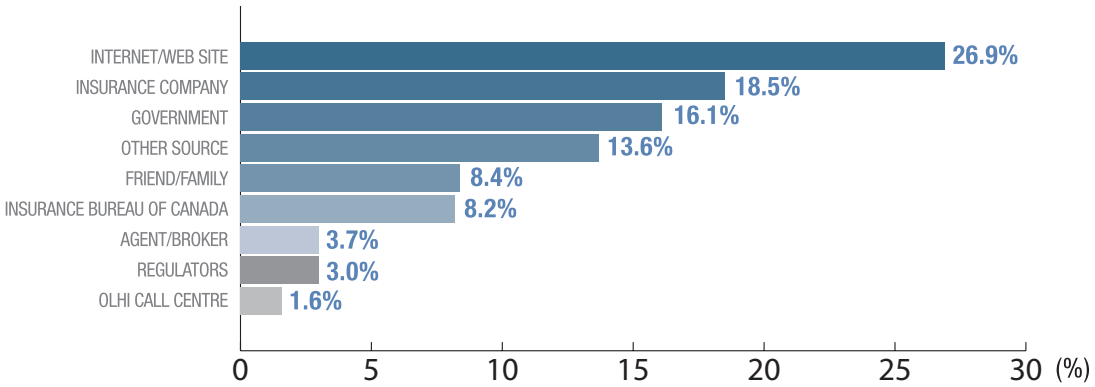
The distribution of complaints among Group, Individual, and Creditor categories has also remained stable and similar to past years.

Complaints By Company Function



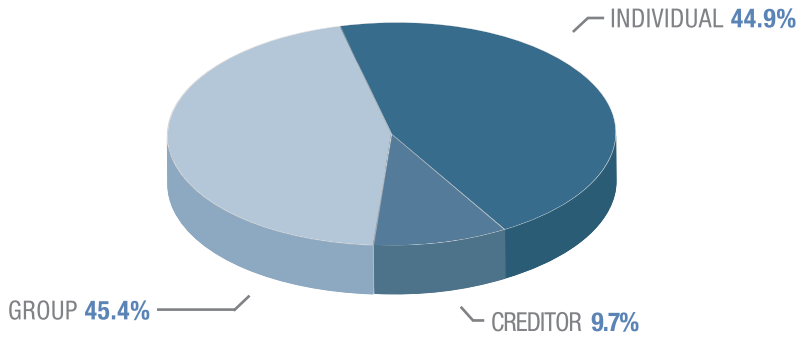
TOTAL **2,350**

Complaints By Source



TOTAL **2,350**

Complaints By Line of Coverage



TOTAL **2,350**

Case Study 1

Full Disclosure

Mr M called OLHI after he received a letter from his wife's insurer turning down her travel insurance claim. He and his wife had purchased out- of- country emergency medical and hospital insurance to cover them for an upcoming trip to the US. The insurance was bought over the phone and medical questions answered orally by both Mr M and his wife.

Unfortunately, Mrs M was admitted to hospital and underwent emergency heart surgery while on vacation. When she returned home, she submitted a claim to the insurer for her US medical and hospital expenses. These expenses were significant as Mrs M had spent over 2 weeks in hospital. The insurer denied payment for the claim on the basis that Mrs M had failed to fully disclose her medical history. Mr M contended that his wife had disclosed all necessary medical issues.

Since the insurer had issued its final position letter, our Complaints Counsellor advised Mr M that OLHI could open a complaint file to determine if there were grounds to review the insurer's decision. To start the process, Mrs M was asked to sign and submit OLHI's standard Authorization form and all relevant documents, including a copy of the insurer's final position letter.

During the initial call to OLHI Mr M asked if his wife's claim was subject to a "limitation period", that is whether there was a time limit to start a legal action against the insurer to recover his wife's expenses. He was told that the running of the limitation period was suspended while his complaint was under review by OLHI. He was advised to consult a lawyer if he had any concerns about what limitation period applied to his wife's claim since OLHI could not provide legal advice.

In accordance with industry standard practice, once Mrs M filed a claim her insurer obtained copies of her medical records. These records were provided to the insurer pursuant to a written consent signed by Mrs M at the time she filed her claim. The insurer forwarded copies of these medical records to OLHI once Mrs M's complaint file was opened.

Upon reviewing Mrs M's medical records, our Complaint Counsellor learned that Mrs M had seen her family doctor on 3 occasions just before she bought her travel insurance. These visits were made to address complaints of chest pain. A follow up test booked by her physician to investigate the symptoms was cancelled by Mrs M until she returned from her vacation. However, when she bought her travel insurance Mrs M had told the insurer that she had not seen a doctor for "any reason that was not routine within the last 12 months". In sum, the insurer had turned down Mrs M's claim for reimbursement of expenses because she was under investigation for a pre-existing medical condition within that period.

Mrs M's position was that the 3 visits she made to her doctor were in connection with a "minor ailment", which was permitted under the policy. She argued that she had no "pre-existing medical condition" nor were her visits to the doctor made in connection with such a condition. The policy defined "minor ailment" as one that did not require more than 1 follow up visit with her physician.

"Mrs M did not disclose her full medical history when applying for travel insurance"

OLHI's Complaint's Counsellor concluded that Mrs M's did not have a minor aliment because her condition required 2 follow up visits. As a result, the "pre-existing conditions" clause of the policy applied. This meant that she was required to disclose her full medical history to her insurer, including any and all consultations with doctors for "non routine reasons" within 12 months.

In the final analysis, Mrs M did not disclose her full medical/health history when applying for travel insurance and the insurer had legitimately turned down her claim for payment. Mrs M was advised that there were no grounds for OLHI to review her complaint with the insurer and her OLHI complaint was closed.

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

Investigation Statistics

Overview

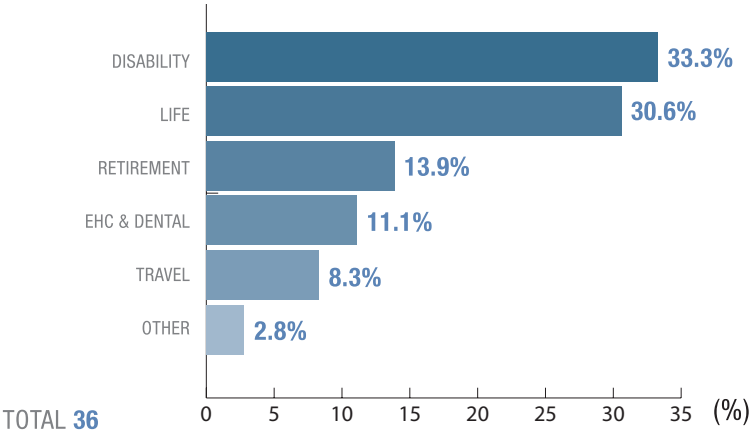
The number of Investigation cases has more than doubled compared to last fiscal year, increasing from 14 to 36. It is not clear whether this increase reflects a permanent trend or is an anomaly based on the nature and complexity of the complaints received last year. Investigation volumes for the coming year will provide insight on this fact.

By Product, Disability complaints continue to represent the highest category of cases referred to OLHI's investigation stage. This year, however, they have declined in volume by close to 10% over last year. On the other hand, there has been a sharp increase in Life investigations which have climbed to 30.6%, compared to 14.3% last fiscal year. The EHC & Dental category shows a slight increase over last year's numbers.

By Company Function, investigations pertaining to Claims continue to represent the highest category, followed by Marketing & Sales and Product design investigations, both of which represent 16.7% of the total.

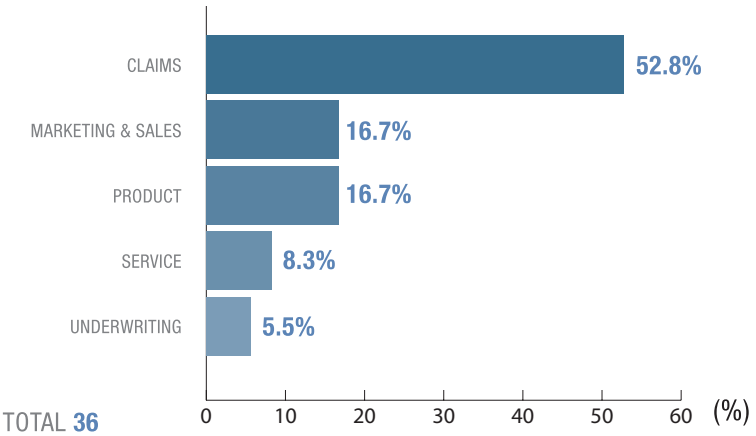
A total of 37 investigations were completed and closed this fiscal year. Of these, 11 were resolved in favour of the consumer, representing a settlement ratio of close to 30%. This figure is comparable to the settlement ratio for other international financial OmbudServices.

Investigations By Product



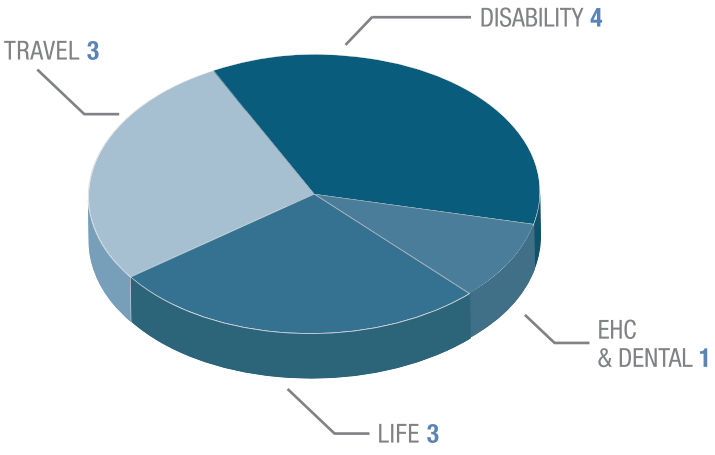
TOTAL **36**

Investigations By Company Function



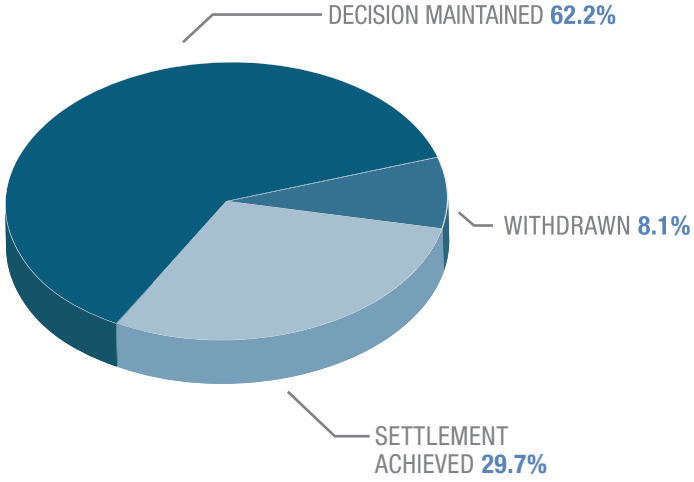
TOTAL **36**

Settled Cases



TOTAL **11**

Outcome By Cases Completed



TOTAL **37**

Case Study 2

Resolving Conflicting Messages

Mrs A called OLHI seeking assistance with her group health benefits. Her insurer had denied payment for treatments recommended for her son's cerebral palsy and issued her a letter referring her to OLHI if she wished to further pursue her complaint. All Canadian life and health insurers who are members of OLHI issue such a letter, known as a "final position letter", once their internal company complaint process is completed.

Based on their conversation, the Complaints Counsellor concluded that OLHI could proceed with an independent review of Mrs A's complaint once she had signed and submitted OLHI's Authorization form. A letter was then sent to Mrs A confirming that the complaint had been opened and she could expect to hear from OLHI within 60 to 90 days. Copies of all documents relevant to the complaint were requested from both Mrs A and her insurer, including her employee benefits brochure and all relevant correspondence.

The documents submitted by both parties were reviewed by the Complaints Counsellor. He noted that the definition of "eligible expense" in the insurance policy and in the benefits brochure contained several conditions. Nevertheless, he was not convinced that the terms of the insurer's policy clearly explained why and how the claim was not eligible. He noted that conflicting messages may have been given by the insurer. Accordingly, he recommended that the complaint be escalated to an OLHI OmbudService Officer (OSO) for further review.

Upon receipt of the complaint file, the OmbudService Officer reviewed the proceedings to date, including the documents from both parties. He then spoke at length with Mrs A, who had been left confused by the insurer's communications.

He learned that initially Mrs A was told the treatments would be covered. She was then advised, in writing, that the proposed treatments were not eligible because they were not considered "reasonable", although the insurer offered to reconsider its position if she could demonstrate that the treatments were medically supported. Based on this information, Mrs A obtained a letter from her son's doctor justifying the treatments, but the insurer denied the claim once again.

In the meantime, a representative of the insurer had mentioned to Mrs A that treatments of this nature had been previously allowed on an individual basis.

The OSO contacted the insurer to gain a better understanding of its position. In particular, he wanted to understand why Mrs A's claim had been turned down after she had submitted medical evidence that, on its face, seemed to prove that the treatments were medically reasonable. He was told that the proposed treatments were not eligible for payment because the relevant section of the policy was intended only to cover the cost of medical equipment, not the treatments themselves.

"The policy wording did not clearly explain why the claim was not eligible"

A further review of the insurer's claim file by the OSO disclosed that the position that only medical equipment was covered had surfaced after the insurer had advised Mrs A in writing that "medically reasonable" treatments would be paid.

The OmbudService Officer then made a detailed submission to the insurer. He recommended that, in the light of the lack of clarity in the policy wording and the insurer's conflicting and confusing messages to the consumer, it might consider allowing the claim without recourse to the experience-rating of the policy.

The insurer agreed to do so, and the course of treatments was allowed.

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

Enquiry Statistics

Overview

This fiscal year, OLHI answered close to 15,000 consumer enquiries on life and heath products and services, including both 'live' and automated calls*. This number has been declining year-over-year for the last 3 years. At the same time, visits to OLHI's Web sites have been growing exponentially, reaffirming that Canadians are increasingly turning to the Internet to locate information.

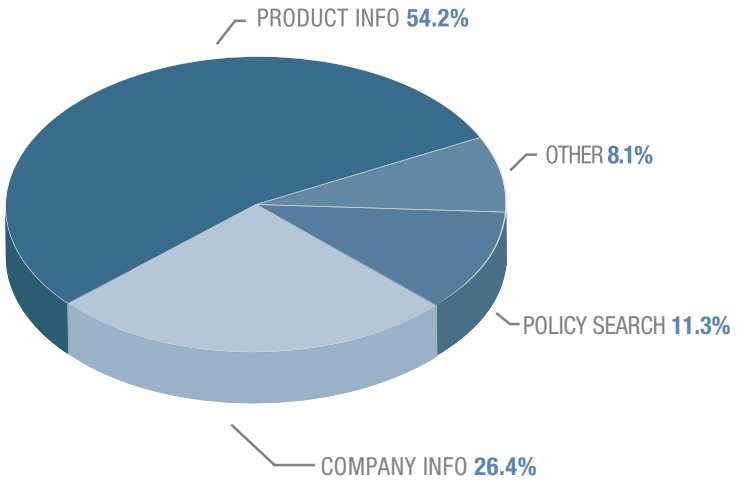
Product and Company Information continue to account for the majority of the topics for which enquiries are received. However, the Policy Search category has been growing from year to year, increasing from 5.8% in 2010/11 to 11.3% this fiscal year.

The majority of Product enquiries continue to be for travel and visitor information, as in prior years. Regarding Company enquiries, requests for Member Company coordinates continue to lead the list but the volume has decreased this fiscal year with the introduction of a new 'Member Company Mergers & Acquisitions' category.

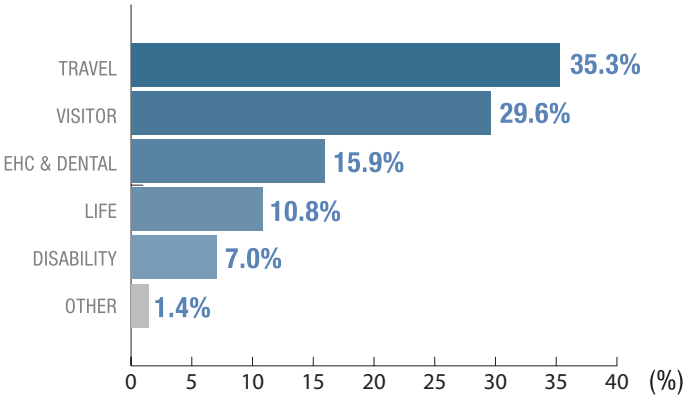
As in previous years, the majority of enquiries come from Quebec, followed by Ontario, the Prairie Provinces, BC and the Atlantic Provinces.

**Note: The installation of OLHI's new telephone system in 2012 revealed that volumes of automated inquiries were overstated in prior years and their numbers have been declining since OLHI's websites were launched in 2009.*

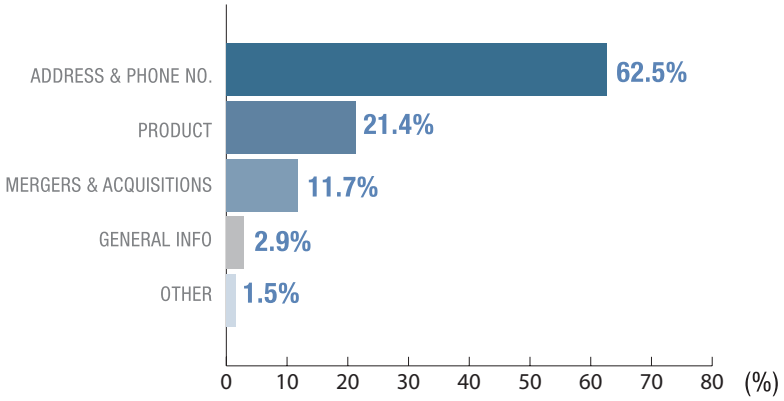
Reason for Enquiry



Analysis of Product Enquiries



Analysis of Company Enquiries



Enquiries by Region

Quebec	58.2%
Ontario	27.8%
Prairie Provinces	5.4%
British Columbia	3.0%
Atlantic Provinces	2.1%
Other	3.5%
Total	100%

Case Study 3

Arriving at a Compromise

Mr S contacted OLHI seeking help with the approval of his disability benefits. The OLHI Complaints Officer who took his call learned that he had purchased a vehicle some years before and financed the purchase with a loan. At that time, he signed up for group creditor insurance that would pay his monthly car loan payments in the event he became totally disabled. Thereafter, Mr S was diagnosed with a terminal condition. He applied for the disability benefits but his claim was denied on the basis that it was out of time.

Our Complaints Counsellor was able to determine during the call that Mr S had not received the insurer's final position letter. He advised Mr S that he would need to complete his insurer's internal complaints process before OLHI could review the complaint. Mr S was provided with the contact information for the insurer's Ombudsman.

About a month later Mr S called back upon receipt of his insurer's final position letter. The Counsellor explained that OLHI would open a complaint file once Mr S signed and submitted OLHI's Authorization form and other relevant documents. Thereafter, OLHI would request documents from the insurer and both he and the insurer would be notified in writing that the complaint was under OLHI's review.

Upon receipt of the documents from both parties, it appeared to our Complaints Counsellor that Mr S might have a reasonable case. She recommended that the complaint be transferred to an OmbudService Officer (OSO) for further investigation.

The OSO reviewed the sequence of events. Mr S last worked in October, 2010. In 2009 he had bought a new car and, through the dealership, purchased creditor life and disability insurance with a single premium that was spread over his monthly car payments. Following his disability diagnosis in the fall of 2010, he applied and was approved for CPP disability in June 2011. Mr S was under the mistaken impression that he had to apply for the CPP disability benefit before applying for any other benefits. His anxiety over his disability diagnosis and the consequent need for him to focus on daily living activities had caused him to lose track of the fact that he had creditor disability coverage.

Mr S filed his claim in August 2011. The insurance policy required him to provide his insurer with notice of the events giving rise to the disability within 30 days and to provide medical evidence establishing his claim within 90 days of onset of disability. As a result, the insurer's final position letter denied his claim on the basis that it was filed too late.

The OSO spoke to Mr S and explained the reasons why the insurer was within its rights to rely on the time limitations set out in the policy. However, he suggested that it might be possible to obtain a settlement whereby the loan payments would be covered from the date the insurer was provided with notice of the claim. Mr S readily agreed that this would be an acceptable resolution of his complaint.

"He applied for disability benefits but his claim was denied on the basis that it was out of time"

The OSO subsequently made a detailed written submission to the insurer suggesting it pay the benefits from August 2011 onwards. The basis for this suggestion was that the disability was clearly established and the insurer was not prejudiced if the claim was admitted on a "go forward" basis.

The insurer responded in short order agreeing to allow the claim from the date it received notice. This resulted in Mr S receiving a reimbursement for the payments made by him while he disputed the claim with his insurer and during OLHI's complaint process. The insurer also paid the loan instalment payments from that point forward.

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

Web Statistics

Overview

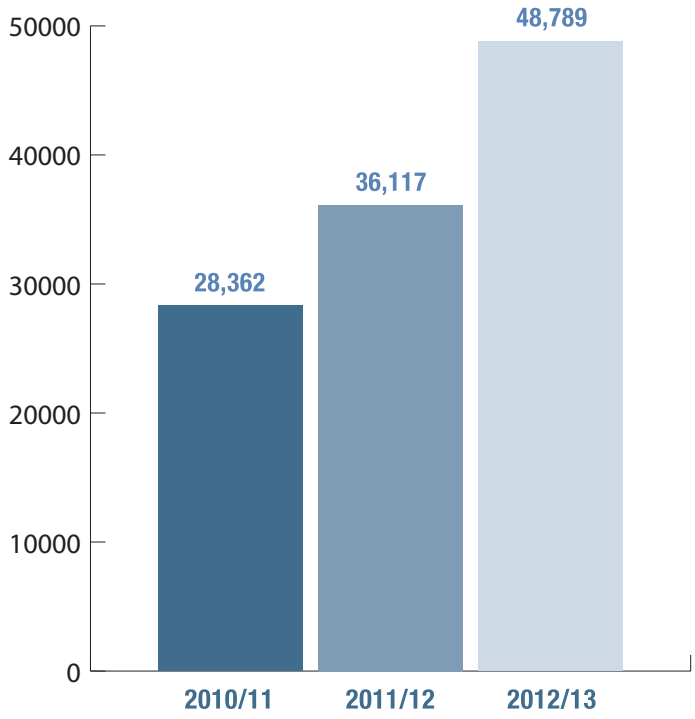
Web visits have increased by 72% over the last 3 years, growing from 28,362 in 2010/11 to 48,789 in 2012/13.

As in prior years, OLHI received a high proportion of New Visitors (over two-thirds of all visitors) to our sites, compared to Returning Visitors. This attests to the ongoing growth of public awareness of OLHI services.

The distribution of Traffic Sources has also remained relatively stable. Most Web traffic came from Referring Sites (41.6%), followed by Direct Traffic (32.3%) and Search Engines (26.1%). Google continued to be the most popular search engine used to forward traffic to OLHI's websites.

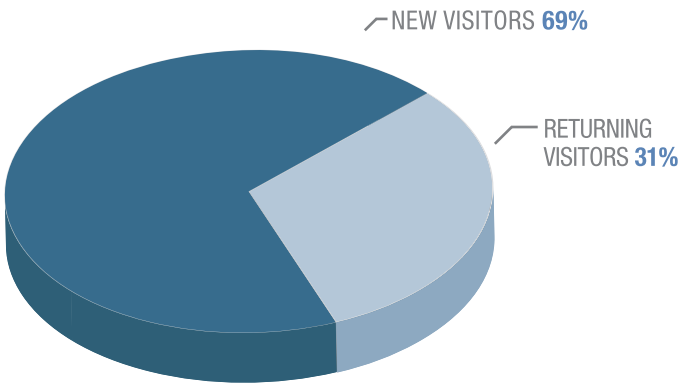
The Information Services page remains the most common page viewed for both our English and French websites. Visits to that page have almost doubled in the last year, growing from 19,648 views in 2011/12 to 38,601 this fiscal year. Views of the Complaints Process pages continue to grow steadily each year, showing an increase of 19.8% this year compared to fiscal 2011/12.

Web Visits 2010-2013



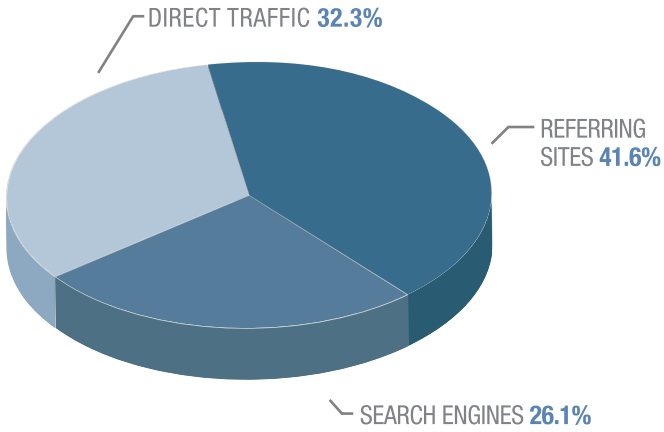
TOTAL **113,268**

New/Returning Web Visitors



TOTAL **48,789**

Web Traffic Sources



TOTAL **48,789**

Top Five Web Pages Viewed

Information Services	38,601	47.7%
Insurance Finder	17,824	22.0%
Complaint Process	10,956	13.6%
Participating Companies	7,569	9.4%
Policy Search	5,895	7.3%
Total	80,845*	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 September 6, 2013:

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
Household Life Insurance Company
Humania Assurance Inc.
Industrial Alliance Insurance and Financial Services Inc.
Knights of Columbus
La Capitale Civil Service Insurer Inc.
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
Munich Reinsurance Company
National Bank Life Insurance Company
New York Life Insurance Company
Optimum Reassurance Inc.
Pacific Blue Cross
Partner Reinsurance Company Ltd.
Penncorp Life Insurance Company
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 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 2012-2013 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

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

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

INDEPENDENT AUDITORS' REPORT

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

Report on the Financial Statements

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, 2013, 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 in our audit 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, 2013, 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.

Comparative information

Without modifying our opinion, we draw attention to the notes to the financial statements, which describes that Canadian Life and Health Insurance OmbudService adopting Canadian accounting standards for not-for-profit organizations on April 1, 2012 with a transition date of April 1, 2011. These standards were applied retrospectively by management to the comparative information in these financial statements, including the balance sheets at March 31, 2012 and April 1, 2011, and the statements of operations and changes in operating fund balances, changes in net assets and cash flows for the year ended March 31, 2012, and related disclosure. We were not engaged to report on the restated comparative information, and as such, it is unaudited.

KPMG LLP

Chartered Accountants, Licensed Public Accountants

June 26, 2013
Toronto, Canada

Balance Sheet

March 31, 2013, with comparative information for March 31, 2012 and April 1, 2011

	March 31, 2013	March 31, 2012 (Unaudited)	April 1, 2011 (Unaudited)
Assets			
Current assets:			
Cash and cash equivalents (note 2)	$ 570,202	$ 753,805	$ 744,522
Recoverable expenditures and deposits	14,198	6,186	7,420
	584,400	759,991	751,942
Capital assets (note 3)	116,694	64,289	77,168
	$ 701,094	$ 824,280	$ 829,110
Liabilities and Fund Balance			
Current liabilities:			
Accounts payable and accrued liabilities	$ 127,600	$ 84,278	$ 89,869
Current portion of deferred lease inducement	8,498	8,498	8,498
	136,098	92,776	98,367
Deferred lease inducement	50,277	58,775	67,273
Fund balance:			
Operating fund:			
Invested in capital assets	116,694	64,289	77,168
Unrestricted	398,025	608,440	586,302
	514,719	672,729	663,470
Commitments (note 5)			
	$ 701,094	$ 824,280	$ 829,110

See accompanying notes to financial statements.

Statement of Operations and Changes in Operating Fund Balance

Year ended March 31, 2013, with comparative information for 2012

	2013	2012 (Unaudited)
Revenue:		
General assessment fees	$ 1,695,229	$ 1,614,732
Investment	8,237	6,264
	1,703,466	1,620,996
Expenses:		
Staff and adjudicative services	994,637	902,964
Board of Directors' fees	147,492	172,444
Rent	123,796	121,930
Professional fees	252,753	96,320
Board meetings and travel	56,418	69,172
Information technology	78,348	59,860
Management fees	44,070	44,070
Staff meetings and travel	50,419	42,629
Supplies and services	38,620	36,887
Telecommunications	26,886	22,150
Insurance	10,433	11,210
Training and development	5,662	10,479
Amortization of capital assets	18,380	10,126
Facilities fees - Toronto	7,019	7,135
Translation	4,529	4,165
FSON-related	179	196
Loss on disposal of capital assets	1,835	–
	1,861,476	1,611,737
Excess (deficiency) of revenue over expenses	(158,010)	9,259
Operating fund balance, beginning of year	672,729	663,470
Operating fund balance, end of year	$ 514,719	$ 672,729

See accompanying notes to financial statements.

Statement of Changes in Net Assets

Year ended March 31, 2013, with comparative information for 2012

	2013			2012 (unaudited)		
	Invested in capital assets	Unrestricted operating fund	Total	Invested in capital assets	Unrestricted operating fund	Total
Net assets, beginning of year	$ 64,289	$ 608,440	$ 672,729	$ 77,168	$ 586,302	$ 663,470
Excess (deficiency) of revenue over expenses	(20,215)	(137,795)	(158,010)	(10,126)	19,385	9,259
Net change in investment in capital assets	72,620	(72,620)	-	(2,753)	2,753	-
Net assets, end of year	$ 116,694	$ 398,025	$514,719	$ 64,289	$ 608,440	$ 672,729

Statement of Cash Flows

Year ended March 31, 2013, with comparative information for 2012

	2013	2012 (Unaudited)
Cash provided by (used in):		
Operating activities:		
Excess (deficiency) of revenue over expenses	$ (158,010)	$ 9,259
Items not affecting cash:		
Amortization of capital assets	18,380	10,126
Amortization of lease inducement	(4,493)	(4,493)
Loss on disposal of capital assets	1,835	–
Change in non-cash operating working capital:		
Recoverable expenditures and deposits	(8,012)	1,234
Accounts payable and accrued liabilities	43,322	(5,591)
	(106,978)	10,535
Investing activities:		
Additions to capital assets	(76,625)	(1,252)
Increase (decrease) in cash and cash equivalents	(183,603)	9,283
Cash and cash equivalents, beginning of year	753,805	744,522
Cash and cash equivalents, end of year	$ 570,202	$ 753,805

See accompanying notes to financial statements.

Notes to Financial Statements

Year ended March 31, 2013

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.

On April 1, 2012, CLHIO adopted Canadian Accounting Standards for Not-For-Profit Organizations ("ASNPO") under Part III of The Canadian Institute of Chartered Accountants' Handbook. These are the first financial statements prepared in accordance with ASNPO.

In accordance with the transitional provisions in not-for-profit standards, CLHIO has adopted changes retrospectively, subject to certain exemptions allowed under these standards. The transition date is April 1, 2011 and all comparative information has been presented by applying ASNPO.

There were no adjustments to the fund balance as at April 1, 2011 or adjustments to excess of revenue over expenses for the year ended March 31, 2012, as a result of the transition to ASNPO.

1. Significant accounting policies:

These financial statements have been prepared by management in accordance with ASNPO.

(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:

General assessments are recognized as revenue of the operating fund in the year received or receivable.

Investment income is recognized as revenue when earned.

(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 dates of the financial statements and the reported amounts of revenue and expenses during the years. 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:

March 31, 2013	Fair value	Carrying value
Cash	$ 157,929	$ 157,929
Short-term investments	412,273	412,273
	$ 570,202	$ 570,202

March 31, 2012 (Unaudited)	Fair value	Carrying value
Cash	$ 49,769	$ 49,769
Short-term investments	704,036	704,036
	$ 753,805	$ 753,805

2. Cash and cash equivalents (continued):

April 1, 2011 (Unaudited)	Fair value	Carrying value
Cash	$ 394,809	$ 394,809
Short-term investments	349,713	349,713
	$ 744,522	$ 744,522

The short-term investments have an aggregate principal amount of $412,273 (March 31, 2012 - $704,036; April 1, 2011 - $349,713) with effective interest rates of 1.25% to 1.30% (2012 - 1.20% to 1.30%). Interest is receivable monthly.

3. Capital assets:

March 31, 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

March 31, 2012 (Unaudited)	Cost	Accumulated amortization	Net book value
Office furniture	$ 27,139	$ 16,874	$ 10,265
Office equipment	3,186	892	2,294
Computer equipment	19,867	13,741	6,126
Leasehold improvements	60,485	14,881	45,604
	$ 110,677	$ 46,388	$ 64,289

April 1, 2011 (Unaudited)	Cost	Accumulated amortization	Net book value
Office furniture	$ 27,139	$ 14,308	$ 12,831
Office equipment	3,185	319	2,866
Computer equipment	22,058	11,951	10,107
Leasehold improvements	60,485	9,121	51,364
	$ 112,867	$ 35,699	$ 77,168

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

During the year, CLHIA provided management services to CLHIO, consisting mainly of administrative and information technology services, which amounted to $87,010 (2012 - $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:

2014	$ 64,000
2015	62,000
2016	64,000
2017	35,000
2018	35,000
Thereafter	71,000

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, 2013 comprises cash and cash equivalents totalling $570,202 (March 31, 2012 - $753,805; April 1, 2011 - $744,522).

(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.