

APRIL 1, 2024  
TO MARCH 31, 2025



# ANNUAL REPORT 2025

A Renewed Impact



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# Our Commitment to Canadians



## Accessibility:

Our free services are available to consumers of life and health insurance products, notably by telephone or online.



## Timeliness:

We respond within 48 hours.



## Courtesy:

Courtesy, professionalism and respect define every interaction.



## Clarity:

We ensure that consumers understand the applicable provisions of their insurance policies and help them resolve their complaints.



## Accuracy:

Our goals are to accurately document complaints and to effectively resolve disputes.



## Fairness & Impartiality:

We are unbiased and impartial.



## Consistency:

We consistently follow a rigorous process to help resolve consumer complaints.



## Knowledge:

We are knowledgeable in the areas of insurance and dispute resolution.



## Privacy:

All our communications and cases are 100% confidential.



## Independence & Objectivity:

We are governed by a Board of Directors with a majority of independent directors.

# OLHI Services

## OLHI: Supporting Consumers Every Day

### Providing Information, Complaint Resolution and Life Insurance Policy Searches

The OmbudService for Life and Health Insurance (OLHI) is a free, fast and independent public service that helps Canadian consumers resolve disputes with their life and health insurance providers.

We offer timely and impartial assistance when consumers encounter issues with their insurer.

We guide consumers through the complaints process, answer their questions and help them locate lost policies or policies of deceased loved ones.



OLHI provides clear and accessible information about life and health insurance.

## Our services are:

### Free

Our services are **free to consumers**.

### Fast

OLHI is faster than going to court. We make every effort to complete the complaint review process within **120 days**.

### Impartial

We take an impartial look at the facts. **We don't pick a side.**

### Independent

We are governed by a Board of Directors comprised mainly of independent directors. OLHI operates in accordance with a framework of ongoing collaboration among insurance sector OmbudServices and the **Canadian Council of Insurance Regulators**.

Visit [olhi.ca](https://olhi.ca) to learn more



# Message from the Chair: Dan Levert



This year marked a period of significant transition for both the Board of Directors and the OLHI management team. In March 2025, Dr. Janice MacKinnon announced her retirement as Chair from OLHI's Board after 14 years of distinguished service. I assumed the role of Chair in April 2025. Claude Garcia, one of three Industry Directors on our Board, also announced his retirement as of September 2025.

Dr. MacKinnon has had a distinguished career in academics, public policy and in government serving as a cabinet minister in Saskatchewan for a decade. She currently serves on several boards including the University of Alberta Board of Governors and is a professor of fiscal policy at the University of Saskatchewan. She helped steer OLHI through a period of significant change and introduced important governance changes including a new process to recruit independent directors.

As the former President of Canadian Operations for Standard Life, Claude Garcia brought deep industry knowledge and leadership from his tenure in the industry and across numerous public and private sector boards. His expertise in life and health insurance, governance, and public policy helped OLHI navigate complex challenges and maintain its commitment to impartial service.

The many consumers who have benefited from our services have been well served by Janice and Claude who dedicated their time and expertise to the organization. On behalf of the current Board and team, I would like to express our sincere gratitude for their years of dedicated service and stewardship of the organization. We wish them well in their future endeavours.

## Charting the way forward

During this transition year, OLHI's new management team, ably led by Stéphanie Robillard as Executive Director and Ombudsman, and Dorothee Beaupré Bernier as Senior Deputy Ombudsman, made every effort to ensure that OLHI not only maintained its high quality of service but also enhanced it, such as more timely closure of files. OLHI is benefiting from Stéphanie's fresh perspective and expertise. In her first year as Executive Director, she led the organization through a series of structural, strategic, and operational changes that have laid a solid foundation for the future.

## Advancing our mandate

This year, OLHI enhanced its public service mandate, as we started to implement the recommendations of the fourth independent review in the areas of accessibility, consumer satisfaction, and governance improvement. Our priority for 2025-26 will be to continue implementing the recommendations of the independent review.

A key milestone this year was OLHI's active participation in the Canadian Council of Insurance Regulators (CCIR) Cooperation and Oversight Framework Review. OLHI's Industry Director, Frank Swedlove and our Executive Director are involved in this process, ensuring that our voice is heard and that our practices are aligned with evolving regulatory expectations.

## Looking ahead

As Chair, I look forward to working with our Board of five Independent and three Industry Directors to benefit all stakeholders. During uncertain times, people rely on their insurance to protect them. Our members strive to offer quality services to Canadians. It is OLHI's role to act as a bridge - informing, assisting, supporting, and promoting fairness for all by offering free, accessible, independent, and impartial dispute resolution services. We are thankful to our members and the CLHIA for their confidence in us and for their ongoing support.

# Message From the Executive Director and Ombudsman: Stéphanie Robillard



It has been a remarkable year, one filled with achievements, transformation, and growth. As this was my first year serving as Executive Director and Ombudsman, I am especially proud of the progress we have made as a team. Our organization faced substantial operational and structural changes that positioned us strongly for the years ahead. I am grateful for the dedication and resilience of the entire team in navigating these challenges, as well as for their professionalism and commitment.

We proceeded with significant developments on the human resources front. We welcomed new staff members, introduced updated human resources policies, and strengthened our internal practices. We were pleased to hire a new Corporate Secretary and Executive Assistant, Sonia Tavares, whose experience will be invaluable.

We also began working with a new communications firm. This partnership is already yielding results, notably through the development of a digital positioning plan, aimed at raising awareness of our services with all Canadians. We know people need us and we want to make sure they can find us!

Additionally, we are undertaking a complete redesign of our website, a project that is underway, and that will provide a renewed, modern platform to connect with those we serve. As part of this initiative, we are committed to enhancing website accessibility and implementing a consumer satisfaction survey. Both actions arise directly from the recommendations of our fourth independent review. In the same spirit, this very Annual Report has also been fully reimagined – with a new format and refreshing content that reflect both the changes within our organization and our forward-looking vision, as a national organization providing free and impartial services to all Canadian life and health insurance consumers.

Collaboration has remained at the heart of our work. We have been actively engaged with stakeholders and the Canadian Council of Insurance Regulators (CCIR), in the review of an important sector document, the Insurance OmbudServices Cooperation and Oversight Framework. Furthermore, and as a key priority, we are moving forward with the implementation of recommendations stemming from our fourth independent review - a process that will further strengthen our impact and accountability, including through the finalization of our terms of reference review. Ensuring alignment across these initiatives enables us to reinforce our governance and operations.

We introduced a new format for our statistical reports and data collection processes. These changes were designed to enhance the clarity, consistency, transparency and relevance of our reporting practices. Moreover, we will continue to focus on cybersecurity. We recognize that data privacy is top of mind for our members and for consumers, and we stand firm in making sure our systems and processes are as secure as possible.

Reflecting the trust Canadians place in our services and our team's dedication to resolving disputes efficiently and fairly, we saw an increase in demand for several of our services in the last year. In 2024–2025, OLHI handled:

- **5,375 inquiries, including 1,470 complaints and 3,239 policy searches.**
- **338 complaints were reviewed by our Complaints Manager.**
- **284 cases were reviewed by a Complaints Analyst.**
- **16 investigations were conducted by an OmbudService Officer.**

As we move forward, we do so with a revitalized sense of purpose and a clear vision: to be increasingly recognized as a trusted, impartial and accessible resource for all Canadian life and health insurance consumers.

I extend my heartfelt thanks to our partners, stakeholders, and supporters, who play such a vital role in advancing our mission. I want to recognize and sincerely thank the Canadian Life and Health Insurance Association (CLHIA), the CCIR, the General Insurance OmbudService (GIO) and other partners for their ongoing collaboration and support. When we establish relationships and work together, it benefits all Canadian consumers. OLHI prides itself on being an organization that cultivates partnerships and delivers impact.

I want to take a moment to acknowledge change within our Board. Two long-standing Directors, whose dedication and leadership have greatly contributed to our mission, are stepping down this year. I wish to express my sincere gratitude to Dr. Janice MacKinnon, who led the Board with distinction as its Chair for many years; she provided steady leadership and vision. I am also deeply appreciative of Claude Garcia's unwavering commitment and expertise, which have been invaluable. Their dedication, insight and wisdom have left a lasting mark. Their contributions will be deeply missed. At the same time, we are excited to welcome two new Directors who will bring fresh perspectives and energy to the Board.

Finally, to all the members of our Board, thank you for your confidence, engagement and guidance. Together, we are advancing our mission and building a stronger future for the organization and the sector we serve.

## OLHI Outreach

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# In 2024-2025, OLHI continued to engage with stakeholders from the insurance industry by attending key industry events.

*These efforts reflect our commitment to building bridges—with consumers, regulators, insurers, and partners alike.*

### Compliance and Consumer Complaints Annual Conference (CLHIA)

OLHI participated in CLHIA's annual conferences in 2024 and 2025. Stéphanie Robillard, Executive Director and Ombudsman, represented the organization on a panel of experts about complaints handling and industry update. Dorothee Beaupré Bernier, Senior Deputy Ombudsman, facilitated a workshop featuring case studies. This event is one of Canada's leading forums dedicated to compliance and complaint management in the life and health insurance sector.

### International Network of Financial Services Ombudsman Schemes

OLHI attended the INFO Network Conference organized by the global association for financial services ombudsmen. OLHI is committed to international collaboration and to strengthening its expertise in dispute resolution through the exchange of knowledge and experience with peer organizations.

### National Media Recognition

OLHI was featured on the Ici Radio-Canada program [La Facture](#), which highlighted its free policy search service for Canadians settling the estate of a deceased loved one. The segment explained how OLHI helps locate lost life insurance policies by forwarding validated requests to its member companies, which represent 99% of the Canadian life and health insurers. This national media coverage helped raise awareness of OLHI's services and reinforced its role as a trusted, impartial resource for consumers navigating complex insurance matters often during difficult times.

# How we help consumers

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*OLHI's intake process reflects our commitment to accessible and fair resolution of consumer insurance issues. These numbers show how we prioritize cases and allocate resources to help consumers effectively.*

## Inquiries

Consumers contact OLHI for assistance with their insurance concerns. Only direct contacts with our staff are classified as inquiries.

## Consumer Assistance, Complaints, Policy Searches

**OLHI responds to three types of inquiries:**

- Consumer assistance—help with insurance questions and guidance.
- Complaints—formal disputes with insurance companies.
- Policy searches—finding policies of deceased loved ones.

**OLHI can review a complaint if:**

- The complaint involves one of our member companies and falls within OLHI's mandate.
- The consumer has received a final position letter from the insurer.

## Complaints Manager Evaluations

OLHI's Complaints Manager ensures the consumer complaint meets the above conditions and falls within the scope of our mandate.

## Complaints Analyst Reviews

When a complaint is accepted for review, a Complaints Analyst conducts an independent and impartial review to determine if it has merit. The analyst speaks with both the insurer and the consumer to gather information. OLHI's complaints team works to resolve

cases as quickly as possible. This may involve informal negotiation at the complaint level.

## OmbudService Officer (OSO) Investigations

When the Complaints Analyst finds the complaint has merit, an OmbudService Officer (OSO) investigates further. If the OSO also finds merit, OLHI helps facilitate discussions between the insurer and consumer to find an acceptable solution.

## Senior Adjudicative Officer (SAO) Investigations

When no settlement is reached at the OSO level, a Senior Adjudicative Officer (SAO) may investigate the complaint. If the SAO finds merit, OLHI makes a non-binding settlement recommendation. OLHI publishes the names of insurers that do not accept our recommendations. Insurers have always accepted SAO recommendations.

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**Web Session:** An interaction between a consumer and OLHI's English or French portals.

**Inquiry:** Direct contact with OLHI's staff.

**Complaint:** OLHI received consumer complaint documents and authorization form.

**Investigation:** a complaint was escalated to OSO or SAO levels.

# How Consumers Consulted Us

2024-2025  
overview



Total 156,554

Web Sessions



151,313

Web Forms



3,629

Calls



1,538

Emails, Letters (Mail) and Faxes

74



A Web Session refers to an interaction between a consumer and OLHI's English or French portals.

A Web Form refers to a consumer who submits an inquiry directly on one of OLHI's English or French web portals.



Web Sessions

**151,313**

Inquiries

**5,375**

Consumer assistance 666

Complaints 1,470

Policy Searches 3,239

Complaints Manager Evaluations

**338**

Complaints Analyst Reviews

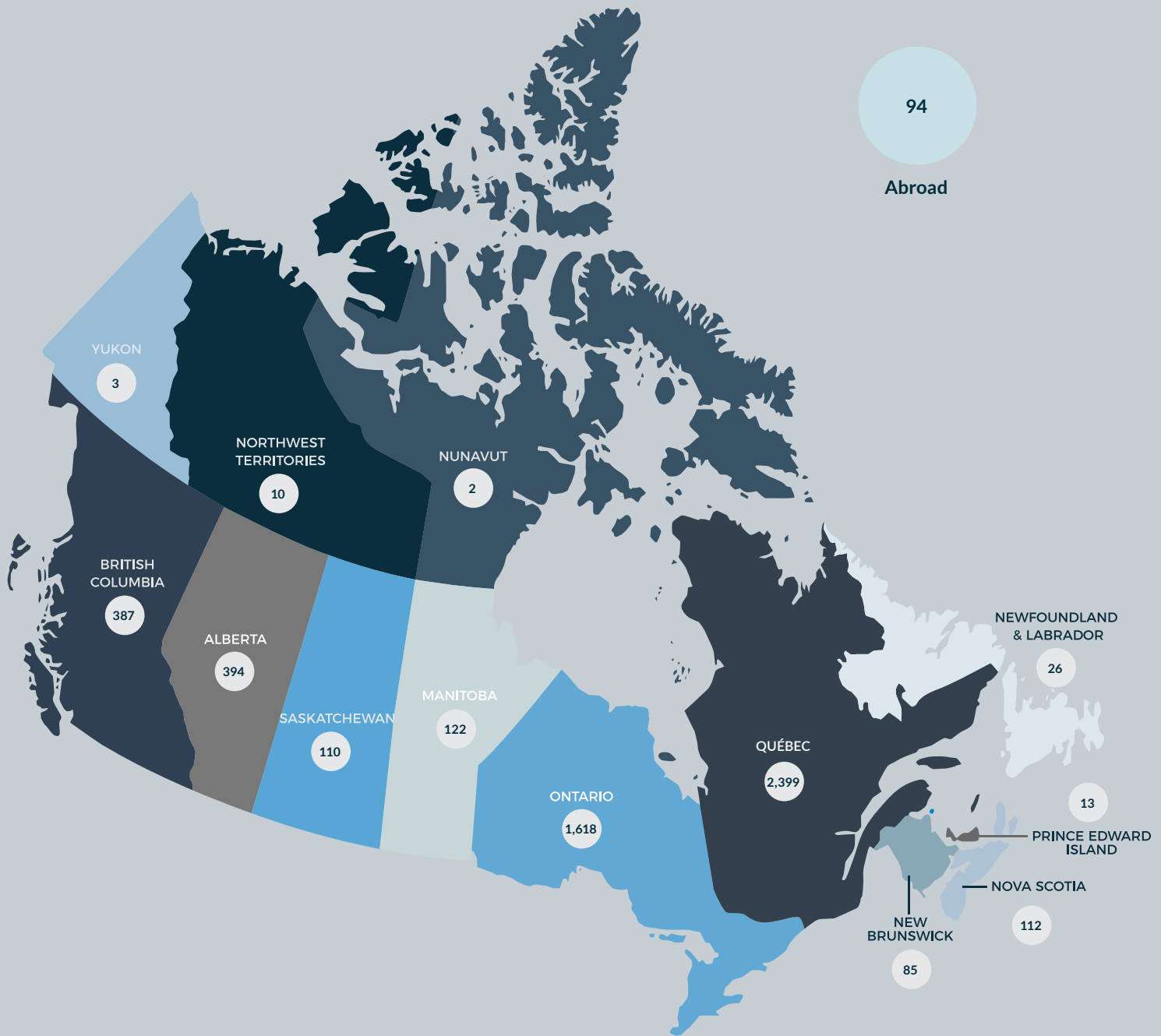
**284**

OmbudService Officer Investigations

**16**Senior Adjudicative Officer Investigations **0**

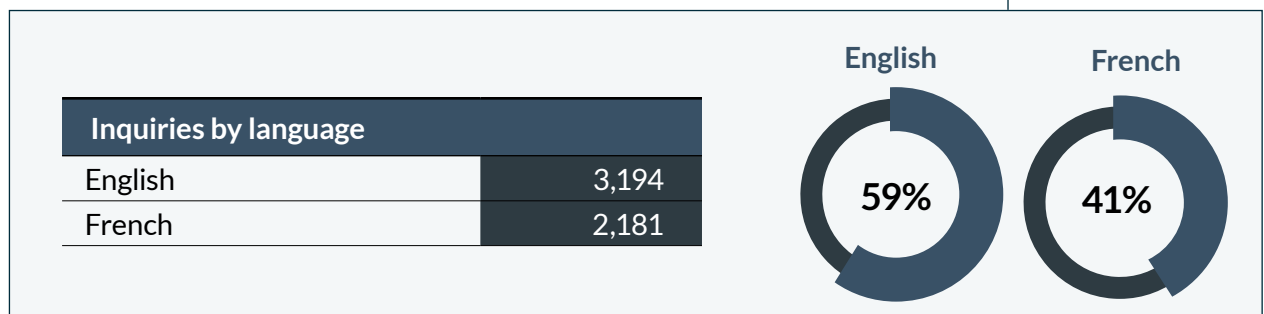


# Consumer Engagement Overview



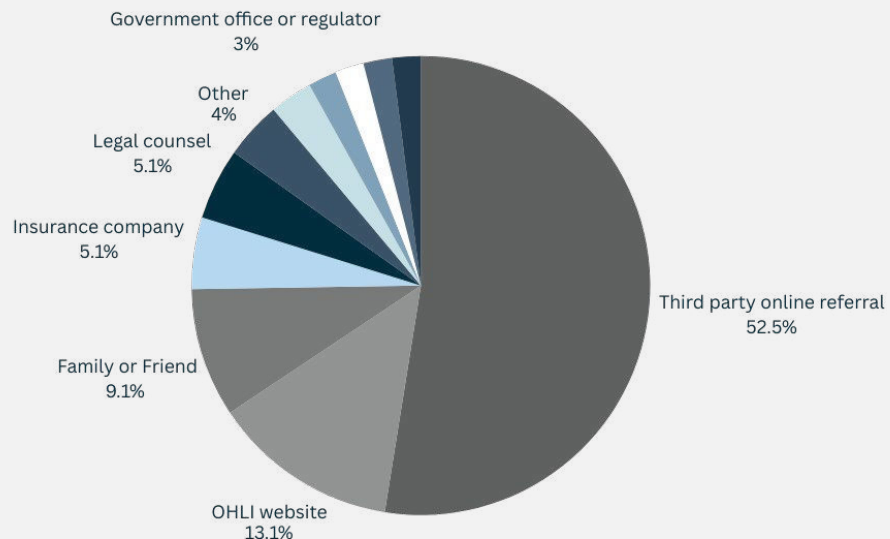
## Inquiries by provinces and territories

Inquiries by provinces and territories	
Abroad	94
Québec	2,399
Ontario	1,618
Manitoba	122
Saskatchewan	110
Alberta	394
British Columbia	387
Yukon	3
Northwest Territories	10
Nunavut	2
Newfoundland and Labrador	26
New Brunswick	85
Nova Scotia	112
Prince Edward Island	13
<b>Total</b>	<b>5,375</b>



## Inquiries by referral source

Inquiries by referral source	
Third-party online referral	2,801
OLHI website	710
Family or Friend	489
Insurance company	278
Legal counsel	275
Other	216
Canadian Life and Health Insurance Association	130
Government office or regulator	135
Service Provider	113
Media	110
Insurance Agent/Broker/Financial Advisor	118
<b>Total</b>	<b>5,375</b>



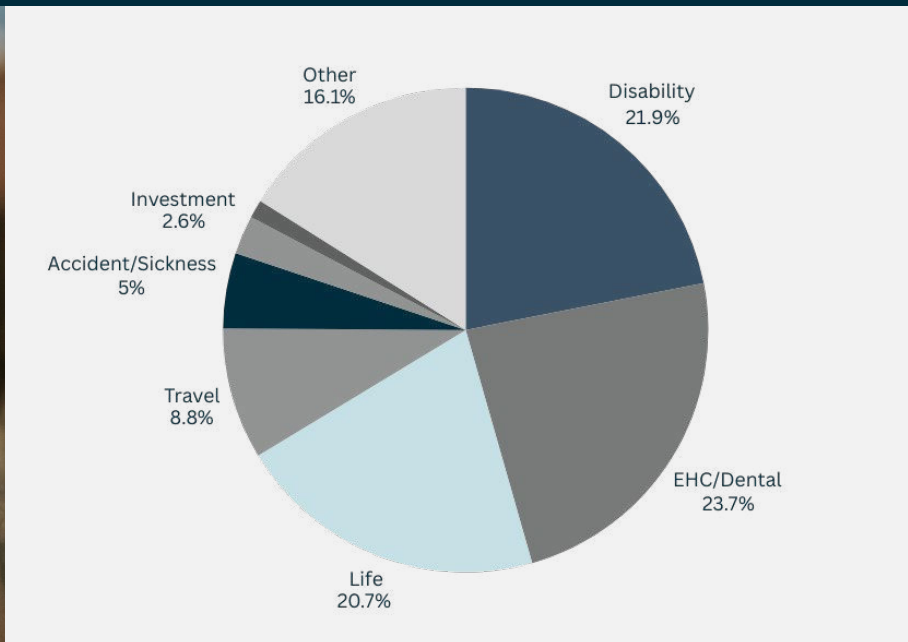
# Complaint trends and breakdown

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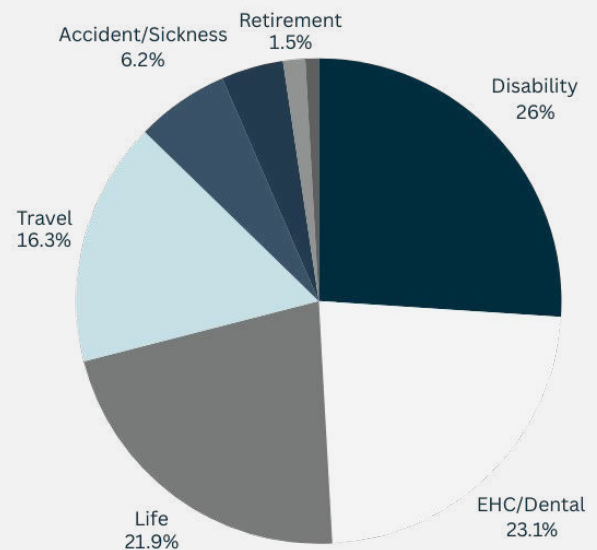
# Complaint inquiries by product

Complaint inquiries by product	
Disability	322
EHC/Dental	348
Life	305
Travel	129
Accident/Sickness	74
Investment	38
Retirement	18
Other	236
<b>Total</b>	<b>1,470</b>



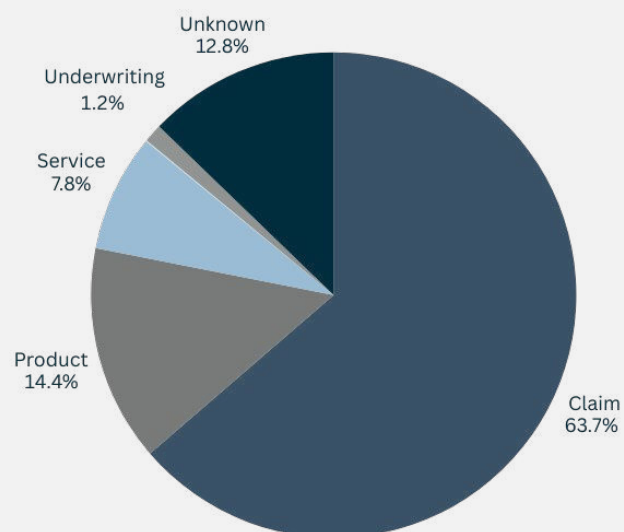
# Complaints by product

Complaints by product	
Disability	88
EHC/Dental	78
Life	74
Travel	55
Accident/Sickness	21
Investment	14
Retirement	5
Other	3
<b>Total</b>	<b>338</b>



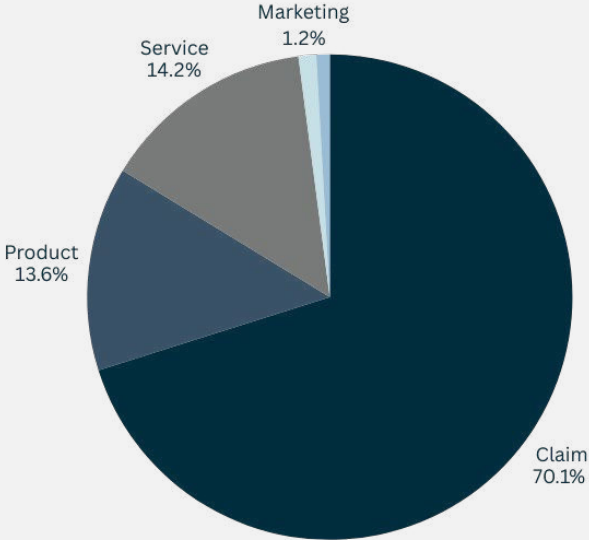
## Complaint inquiries by company function

Complaint inquiries by company function	
Claim	936
Product	212
Service	115
Marketing	1
Underwriting	18
Unknown	188
<b>Total</b>	<b>1,470</b>



# Complaints by company function

Complaints by company function	
Claim	237
Product	46
Service	48
Marketing	4
Underwriting	3
<b>Total</b>	<b>338</b>



# Case Studies

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## Case Studies

**Cases are unique but have one thing in common: they could have a major impact on the lives of the consumers who turn to us for help.**

*Disagreements and complaints also impact our members' operations. In a highly charged situation, when emotions are running high, our team is there as a sounding board. Guided by fairness and empathy, they leverage their expertise and work to find the best resolution for all involved.*

***Here are some cases that exemplify what we do and how we do it.***



## Case Study 1—Getting Fair Compensation after an Emergency

*A couple had to urgently return home mid-trip due to an emergency. They contacted the insurer's emergency assistance provider, who agreed that returning by car was the fastest and most appropriate option.*



Feeling misled and confused, the couple turned to OLHI.



They were told that expenses for gas, hotels, and mileage would be refunded “as much as possible.” However, when the claim was processed, only 70% of the costs incurred were reimbursed. The amount was capped based on the cost of a round-trip economy airfare from a city that was different from where the couple departed. Although the location was further, because it was a larger city, more travel options existed from the destination used to process the claim. This potentially led the insurer to underestimate the applicable reimbursement cap. Mileage was excluded entirely, and no information was provided regarding how the calculation was made.

Feeling misled and confused, the couple turned to OLHI. Our Complaints Analyst raised concerns about the vague guidance they had received, and the unclear method used to calculate the reimbursement cap. After informal negotiations, the insurer agreed to reimburse an additional 15% of the total expenses—covering half of what had initially been denied. This decision was based on the guidance provided by the assistance provider, who failed to mention the contractual limit, as well as the questions raised regarding how the maximum reimbursement amount had originally been determined. This resolution proved satisfactory, as the couple felt it reflected the shortcomings in the communication process.

# 15%

After informal negotiations, the insurer agreed to reimburse an additional 15% of the total expenses—covering half of what had initially been denied.



## Case Study 2—Feeling Supported Through a Critical Illness

*A consumer had undergone surgery for a brain tumour and believed they were entitled to coverage under their policy.*

However, the insurer concluded that the tumour, initially classified as benign, did not meet the policy's definition of a life-threatening cancer. Based on the initial medical assessment and policy wording, the insurer concluded that the condition did not meet the definition of a covered critical illness, and the claim was denied.

The consumer turned to OLHI for help. Our Complaints Analyst reviewed the case and highlighted concerns about the medical information used by the insurer when rendering its original decision. Given the complexity of the situation, the case was escalated to an OmbudService Officer (OSO) for further review.

Through discussions with the insurer and a reassessment by its medical consultant, it became clear that the medical condition had progressed since the original claim was assessed. With updated information, the tumour was now recognized as aggressive and life-threatening. The insurer reversed its decision and approved the claim.



The consumer  
reached out to  
OLHI for help.



## Case Study 3—Navigating Complex Policy Language

*A consumer submitted a Tax-Free Savings Account (TFSA) transfer request under their segregated funds policy. Due to administrative issues—including missing documentation—the request wasn't processed in a timely manner.*



**This resolution reflects OLHI's role in helping consumers.**



By the time the transaction was completed, the value of the investment had dropped by approximately \$1,000. The consumer believed this loss was the result of the insurer's handling of the transfer and requested that a reimbursement be issued. The insurer acknowledged the delay but maintained that the transaction was completed within the 60-day time frame allowed under the contract. Nevertheless, the consumer found the process unclear and unfair.

OLHI's Complaints Analyst reviewed the case and identified ambiguities in the contract language — particularly around what constitutes a valid request and when the processing timeline should begin. These uncertainties raised legitimate questions about how the insurer had interpreted its obligations.

Following informal negotiations and further clarifications, the insurer stood by its position that it had acted within the timeframe stipulated in the contract. However, considering the consumer's concerns and the lack of clarity in the policy wording, the insurer offered to reimburse the approximate \$1,000 loss.

This resolution reflects OLHI's role in helping consumers navigate complex policy language and ensuring that fairness, and not just technical compliance, guides outcomes.



## Case Study 4— Upholding Fairness in Emergency Medical Disputes

*A consumer contacted OLHI after they were denied reimbursement for nearly \$10,000 in medical expenses under their mother’s visitor travel insurance policy.*

She had travelled to Canada under a Super Visa (a visa that allows parents and grandparents to stay in Canada for an extended period of time) and experienced a medical emergency during her stay. She was taken to the emergency room and hospitalized. She underwent several procedures, including an Endoscopic retrograde cholangiopancreatography (ERCP)—a treatment used to diagnose and relieve blockages in the bile or pancreatic ducts.

The insurer denied a significant portion of the claim. They argued that the ERCP was investigative, not urgent, and could have been postponed until the insured returned to her home country. The consumer strongly disagreed, believing the treatment was part of a continuum of emergency care. OLHI’s Complaints Analyst reviewed the case and identified several issues. The ERCP had led to the removal of sludge and stones, suggesting it was not merely investigative but medically necessary.

The Analyst also noted that the insurer had failed to consult a specialist and had not properly applied the policy’s definitions of “emergency”, “medical emergency,” and “medically necessary.” There was also no evidence that the emergency had ended at the time of the transfer for the procedure.

Following informal negotiations and further clarifications, the insurer agreed to make a partial payment (approximately half of what had not been covered initially) on an extra-contractual basis in exchange for a release. The consumer agreed with the proposed settlement, and the complaint was resolved.

This case illustrates how OLHI’s process can lead to meaningful outcomes—not just by challenging decisions, but by ensuring that the evolving understanding of some medical conditions is considered when it matters.



This case illustrates how OLHI’s process can lead to meaningful outcomes.



## Case Study 5—Bringing Clarity at a Vulnerable Time

*A consumer contacted OLHI after their claim for short-term disability benefits was denied.*



**OLHI ensured that the consumer received a clear explanation and that the procedural concerns were addressed.**



The consumer had been placed on medical leave for two months. The insurer rejected the claim, stating that the medical documentation provided—though it included a diagnosis, functional limitations, a treatment plan, and two consultation notes—was not sufficient to prove the consumer was unable to perform the essential duties of their job.

The insurer also suggested the consumer might be able to work in a different context. OLHI's Complaints Analyst noted that the insurance company appeared to be mandating an unusually high evidentiary burden, given that the leave was short and that the documentation submitted was consistent with what is typically expected for such a claim.

Due to concerns that relevant medical information may not have been properly considered, the case was escalated to an OmbudService Officer (OSO). During discussions with the insurer, OLHI raised specific concerns about the lack of commentary on the functional limitations checked by the treating physician in the initial claim form—details that seemed to have been overlooked.

The insurer agreed to conduct an internal review. After a second round of discussions and further examination, the insurer confirmed that all medical information, including the noted limitations, had been considered. Although the insurer maintained its original decision, OLHI ensured that the consumer received a clear explanation and that the procedural concerns were addressed. The file was closed with the insurer's final position clarified to the consumer.

The OSO found the insurer's decision to deny the claim reasonable, but noted that the company could improve its file documentation practices.



# Our Members

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Acadia Life

Actra Fraternal Benefit  
SocietyAetna Life Insurance  
Company

Alan CA Inc.

Alberta Blue Cross

Allianz Care

American Bankers Life  
Assurance Company  
of Florida/Assurant

Assurant

Association  
d'Hospitalisation  
Canassurance

Aviva Canada

Beneva

BMO Life Assurance  
CompanyBlumont Annuity  
CompanyCanada Life Assurance  
CompanyCanadian Premier Life  
Insurance Company  
(Securian)Chubb Life Insurance  
Company of CanadaCIBC Life Insurance  
Company LimitedCIGNA Life Insurance  
Company of Canada  
(Connecticut General  
Life Insurance Company)Co-operators Life  
Insurance CompanyCombined Insurance  
Company of AmericaCompCorp Life  
Insurance Company  
of AmericaDesjardins Financial  
Security Life Assurance  
Company

Desjardins - State Farm

Europ Assistance S.A.  
Canada BranchEmpire Life Insurance  
Company, TheEquitable Life Insurance  
Company of Canada,  
TheFaithLife Financial  
(Serena Life)First Canadian Insurance  
Corporation

Foresters Life

Green Shield Canada

Group Medical Services  
(GMS Insurance Inc.)

Humania Assurance Inc

Industrial Alliance  
Insurance and Financial  
Services Inc.

ivari

Knights of Columbus

Life Insurance Company  
of North America

Manitoba Blue Cross

Manulife

Medavie Blue Cross

Munich Reinsurance  
America, Inc.

National Bank Life  
Insurance Company

Old Republic Insurance  
Company of Canada

Pacific Blue Cross

Pavonia Life Insurance  
Company of Michigan

Primerica Life Insurance  
Company of Canada

Quebec Blue Cross

RBC Life Insurance  
Company

Reliable Life Insurance  
Company

Saskatchewan Blue  
Cross

Sun Life Insurance

Starr Insurance

TD Life Insurance  
Company

Teachers Life Insurance  
Society (Fraternal)

Trans Global Insurance  
Company

TruStage Life of Canada

UV Insurance

Wawanesa Life  
Insurance Company, The

Zurich Canada

# Our Board

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## Our Board: Independent Directors



Dan Levert



Dr. Janice MacKinnon



Leah Myers



Geoff Plant, OBC KC



Louise Shiller

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## Our Board: Industry Directors



Claude Garcia



Dr. Dieter Kays



Frank Swedlove

## Financial Statements

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# CANADIAN LIFE AND HEALTH INSURANCE OMBUDSERVICE (OPERATING AS OMBUDSERVICE FOR LIFE & HEALTH INSURANCE)

*And Independent Auditor's Report thereon Year ended March 31, 2025*

### INDEPENDENT AUDITOR'S REPORT

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

#### Opinion

We have audited the financial statements of the Canadian Life and Health Insurance OmbudService (operating as OmbudService for Life & Health Insurance) (the "Entity"), which comprise:

- the statement of financial position as of March 31, 2025
- the statement of operations for the year then ended
- the statement of changes in operating fund balance for the year then ended
- the statement of cash flows for the year then ended
- and notes to the financial statements, including a summary of significant accounting policies

(Hereinafter referred to as the "financial statements").

In our opinion, the accompanying financial statements, present fairly, in all material respects, the financial position of the Entity as of March 31, 2025, 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.

#### Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the "**Auditor's Responsibilities for the Audit of the Financial Statements**" section of our auditor's report.

We are independent of the Entity in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

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

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**KPMG LLP**  
Bay Adelaide Centre  
333 Bay Street, Suite 4600  
Toronto, ON M5H 2S5  
Canada  
Telephone 416 777 8500  
Fax 416 777 8818

### **Responsibilities of Management and Those Charged with Governance for the Financial Statements**

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the Entity's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Entity or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Entity's financial reporting process.

### **Auditor's Responsibilities for the Audit of the Financial Statements**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.



We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.

The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit 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.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- Communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.



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Chartered Professional Accountants, Licensed  
Public Accountants

Toronto, Canada

June 17, 2025



## Statement of Financial Position

March 31, 2025, with comparative information for 2024

	2025	2024
<b>Assets</b>		
Current Assets		
Cash and cash equivalents (note 2)	\$2,017,099	\$1,941,924
Prepaid expenses and deposits	33,219	55,718
Accounts receivable	32,658	250
	<b>\$2,082,976</b>	<b>\$1,997,892</b>
<b>Liabilities and Fund Balance</b>		
Current liabilities:		
Accounts payable and accrued liabilities	\$222,271	\$675,623
Fund balance:		
Operating fund:		
Invested in capital assets	-	-
Unrestricted	1,860,705	1,322,269
	<b>1,860,705</b>	<b>1,322,269</b>
Commitments (note 4)		
	<b>\$2,082,976</b>	<b>\$1,997,892</b>

Full audited financial statements are available upon request.

## Statement of Operations

Year ended March 31, 2025, with comparative information for 2024

	2025	2024
<b>Revenue:</b>		
General assessment fees	\$2,592,760	\$2,519,115
Investment	54,819	50,594
	<b>2,647,579</b>	<b>2,569,709</b>
<b>Expenses:</b>		
Staff and adjudicative services	1,370,864	1,839,974
Professional fees	186,590	271,646
Board of Directors' fees	180,077	187,278
Board meetings and travel	101,852	96,368
Management fees (note 3)	101,632	90,661
Information technology	50,552	44,461
Rent and occupancy	35,620	39,049
Staff meetings and travel	22,525	29,458
Communications	2,055	24,426
Telecommunications	17,062	17,733
Insurance	23,970	15,868
Supplies and services	9,667	10,549
Training and development	5,682	10,011
Amortization of capital assets and intangible assets	-	9,193
Translation	995	4,095
	<b>2,109,143</b>	<b>2,690,770</b>
Excess (deficiency) of revenue over expenses	<b>\$538,436</b>	<b>\$(121,061)</b>

Full audited financial statements are available upon request.

## Statement of Changes in Operating Fund Balance

Year ended March 31, 2025, with comparative information for 2024

	2025			2024		
	Invested in capital assets	Unrestricted operating fund	Total	Invested in capital assets	Unrestricted operating  fund	Total
Net assets, beginning of year	-	\$ 1,322,269	\$ 1,322,269	\$ 9,193	\$ 1,434,137	\$ 1,443,330
Excess (deficiency) of revenue over expenses	-	538,436	538,436	(9,193)	(111,868)	(121,061)
Net assets, end of year	-	\$ 1,860,705	\$ 1,860,705	\$ -	\$ 1,322,269	\$ 1,322,269

Full audited financial statements are available upon request.

## Statement of Cash Flows

Year ended March 31, 2025, with comparative information for 2024

	2025	2024
Cash provided by (used in):		
<b>Operating activities:</b>		
Excess (deficiency) of revenue over expenses	\$538,436	\$(121,061)
<b>Items not affecting cash:</b>		
Amortization of capital assets and intangible assets	-	9,193
<b>Change in non-cash operating working capital:</b>		
Prepaid expenses and deposits	22,499	(11,070)
Accounts receivable	(32,408)	2,536
Accounts payable and accrued liabilities	(453,352)	384,522
Increase in cash and cash equivalents	75,175	264,120
Cash and cash equivalents beginning of year	1,941,924	1,677,804
<b>Cash and cash equivalents end of year</b>	<b>\$2,017,099</b>	<b>\$1,941,924</b>

Full audited financial statements are available upon request.





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## Contact OLHI

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