BACKGROUND ON CPP AND PRIVATE DISABILITY INSURANCE

Submitted to: Office of the Commissioner of Review Tribunals

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Date: April 30, 2002

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Introduction

Private disability insurance is the most likely additional source of disability income received by CPP disability recipients. According to a 1995, Statistics Canada survey conducted for Human Resources Development Canada ("HRDC"), approximately 25 percent of CPP disability beneficiaries received benefits from private insurers, 17 percent from workers compensation plans, and 13 percent from social assistance benefits. Together, more than 60 percent of CPP disability beneficiaries receive disability income from another income security program.[1]

Given the prominence of private disability insurance as an income support for CPP disability recipients, it is appropriate to explore private disability insurance, the insurance industry, and how the public and private systems interact in order to better understand the relationship between the two forms of disability benefits.

The link between CPP and private disability insurance

CPP disability benefits alone are not sufficient to provide the sole source of income support or earnings replacement for beneficiaries. There are statutory limits on the level of CPP benefits. The Canada Pension Plan is designed to replace approximately 25 percent of one's yearly maximum pensionable earnings ("YMPE"). YMPE is an amount equal to the average industrial wage; in 2001, the maximum level of disability benefit allowed was $11,221. The assumption is that CPP benefits will be supported by other forms of earnings replacement.

CPP as "first payer"

The CPP disability benefit is viewed as the "first payer" by most private insurance plans and by an increasing number of provincial workers' compensation programs. This means that other program benefits are not taken into account when calculating the amount of CPP disability benefit and conversely,

[1] *1996 Report of the Auditor General of Canada* (Ottawa: Queen's Printer, 1996) at 17.116.

that other insurance plans may take CPP disability benefits into account when calculating a claimant's entitlement to benefits. It is important to note that there is no express statutory basis for this view, merely a presumption resulting from how CPP is calculated. The Auditor General assessed eligibility for the CPP disability benefit in 1996 and reaffirmed this presumption in his analysis:

> The Canada Pension Plan contains no provision concerning the treatment of disability benefits from other sources, other than provisions allowing for reimbursement of advances paid by other plans. As other programs' benefits are not taken into account, this makes the Plan a first payer.[2]

Others assert that this concept of "first payer" is also consistent with the original intent of the Canada Pension Plan, which was to take into account CPP's relationship with other payers, including private insurers, and to be just one component of a multi-tiered pension system.[3]

Most private long-term disability replacement plans are integrated with CPP benefits by providing that private benefits, in addition to any other benefits received, must not exceed a stated percentage of a beneficiary's normal earnings.[4] This integration occurs regardless of whether the total income that the beneficiary would receive from private disability insurance derives entirely from the insurance company or a combination of CPP and private insurance top-up. Private insurance companies have also stated that premiums are actuarially adjusted to take into account the fact that it acts as second payer and that premiums would be higher in the absence of CPP.[5]

Most private insurance companies require insureds wishing to make a claim for CPP disability benefits to apply for CPP disability and to appeal a denial. Many agreements also indicate that noncompliance with these terms will result in withholding or reduction of long term disability benefits by the estimated amount of the CPP disability benefit. This appears to be a standard practice and part of standard form agreements of most private insurance policies. (See Appendix "A")

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[2] *Ibid.* at 17.132.

[3] S. Torjman, "Read the Fine Print" (April 2001) Caledon Commentary at 4

[4] *Canadian Life and Health Insurance Facts, 2001* (Toronto: CLHIA, 2001) at 13.

[5] *Supra*, note 3.

CPP legislation permits integration of benefits

The *Canada Pension Plan*[6] expressly permits integration of benefits between public and private insurance. Section 65. (3) of the Act and section 76.1 of the Regulations provide for the assignment of retroactive lump sum disability benefits to government agencies and insurance companies under agreements in which a person is found to be eligible for both CPP benefits and private insurance and the plans are integrated. Under these "agreements," the CPP disability 'amount' of the benefit is paid in advance by the insurance company, who is deemed an "Administrator of a Disability Income Program," then 'reimbursed' once the CPP disability claim is payable.[7] This amendment to the Act and to the Regulations was enacted June 1,1993 and has resulted in a number of agreements with private insurance plans pursuant to this provision.

The uniform legislation[1] permits integration of benefits

The uniform legislation upon which provincial/territorial private insurance is based, sets out statutory conditions which must form part of every contract of insurance. The uniform legislation contains provisions which allow for/assume coordination of benefits between various income replacement programs.

Condition 4 under section 300 of the *Insurance Act*[9] of Ontario provides for the partial coordination of benefits where an insured is entitled to benefits under more than one contract of disability insurance. This condition applies to disability insurance only when it forms part of an accident and sickness policy and to policies which pay benefits calculated as a proportion of the insured's pre-disability income. It states that where the cumulative benefits exceed the insured's pre-disability income, the insurer is liable to pay only a proportionate share of the total benefits to which the insured is actually entitled and that any excess premium is to be refunded.

This provision ensures that a disabled insured will *never* receive benefits that will be greater than

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[6]*Canada Pension Plan*, R.S. 1985, c. C-8.

[7]Note that the only significant condition of the agreement is that the Administrator of the disability income program does not offset the benefit paid by the CPP disabled contributors' Children's Benefit.

[8]"Uniform legislation" refers to the model insurance legislation that has been adopted in all of the common law provinces and territories governing life insurance and accident and sickness insurance.

[9]*Insurance Act*, R.S.O. 1990, c. I.8.

a predetermined proportion of his/her income, despite that insured's potentially legitimate qualification for benefits under a number of disability programs.

Section 299 of the Ontario *Insurance Act* states that, subject to section 300, the insurer must set forth in the policy every exception or reduction affecting the amount of benefits payable. An insurance agent's failure to properly explain the effect of an integration of benefits provision may constitute negligence for which the insurance company is liable.[10]

There are no legislative criteria governing how income should be defined under private insurance policies. In addition to workers' compensation and CPP disability, some plans deduct spousal earnings as household income. Some private insurance companies deduct the CPP Child's Benefit as household income. This treatment of the CPP children's benefit has been identified as contrary to the purpose of the benefit. The legislative purpose behind this provision, which provides an indexed, flat-rate benefit, was to provide additional income support to assist families where the contributor has become disabled and unable to work. It was a recognition by government that basic household needs may not be met when a contributor becomes disabled and unable to work. By deducting this benefit, the insurance companies are treating it as earnings replacement, not income support.[11]

Harmonization of CPP and workers' compensation

There is limited, but increasing harmonization of CPP disability with other public income security programs, such as workers' compensation. It is possible to receive both CPP disability and workers' compensation because eligibility for CPP is not dependant upon a work-related cause, as it is for workers' compensation. Workers' compensation also may provide partial benefits for partial loss of capacity, unlike CPP.

Most workers' compensation programs initially regarded themselves as first payers. Some provinces now harmonize their programs with CPP. Ontario's workers' compensation legislation, the *Workplace Safety and Insurance Act, 1997*[12] takes CPP disability payments into account in calculating payments for loss of earnings, i.e., it treats CPP as the "first payer."

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[10]See *Theophanous* v. *Mutual of Omaha Insurance Company*, [1991] I.L.R. 1-2718 (Ont. Gen. Div.).

[11]Torjman, *supra* note 3 at 5.

[12]S.O. 1997, c. 16, Sched. A, s. 43(5).

There is no consistency of approach across the country with respect to harmonization of workers' compensation with CPP disability. Some provinces' workers' compensation boards remain as first payer (Alberta), while others deduct percentages of CPP ranging from 50 percent (Saskatchewan) to 100 percent (Ontario and Manitoba) from workers' compensation benefits.

Between June 1998 and March 1999, HRDC entered into exchange-of-information agreements with five provincial workers' compensation boards. The agreements provide for the payment to the boards of retroactive benefits due to beneficiaries, where such amounts are to be recovered by the boards, under the assignment of benefits clause in the *Canada Pension Plan*.[13]

The significance of CPP as "first payer"

There are broader issues raised by CPP's role as "first payer" and the resulting integration and harmonization of other forms of disability income, both practical and philosophical:

1) What is the effect of integration or harmonization of benefits on the total level of benefits available to the disabled?

2) What is the effect of increasing integration of benefits on the nature of the disability insurance contract itself?

3) Is there a philosophical distinction between harmonization of two public programs versus harmonization of a public program and a private program?

Effect of integration/harmonization on level of benefits

Clearly, integration has the effect of limiting the overall level of disability benefits available to claimants. It has been justified by the argument that, without integration, it would be possible for a disabled individual to receive benefits which would equal or exceed his or her pre-disability employment income. This is an issue beyond the scope of this analysis, but it is one that should be debated. What amount of benefits should a recipient who qualifies, receive, and who should determine this?

Understanding how integration affects the level of benefits requires understanding the tax treatment of various forms of income support. Where the employer has paid all or a part of the cost of coverage of a wage loss replacement plan, a periodic benefit for disability will be taxable as income. Where the entire cost is borne by the employee, the benefit is not considered income and therefore, not taxed.[14] CPP disability benefits are fully taxed because both the employee and the employer contribute.

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[13] *Report of the Auditor General of Canada* (Ottawa: Queen's Printer, 1999) at 32.79.

[14] *Income Tax Act*, R.S.C. 1985, c. 1 (5th Supp.), s. 6(1)(f); IT-428, "Wage loss replacement

(Self-employed contributors are deemed to contribute as employer and employee and are fully taxed.) Workers' compensation benefits must be included as income but are fully deducted from tax.[15]

It is important to note that CPP benefits which are assigned to an "administrator" under the integration provisions of the CPP Act and regulations, discussed above, are still fully taxed to the beneficiary even though they are directly assigned to the insurance program and never received by that beneficiary.

From the perspective of the claimant, the greater the amount of the benefit derived from CPP in combination with private insurance (where the employer has contributed to the plan), the lower the overall level of benefit and the greater the tax consequences to the claimant. In those jurisdictions where workers'compensation acts as the first payer and does not deduct CPP, a claimant who qualifies for workers'compensation will receive higher benefits that will not be taxed.

Many disabled may not be sufficiently disabled to meet the CPP definition of disability and/or cannot meet the contribution requirement for CPP, but private insurers will still take the CPP benefit *into account* in setting the level of benefits available, even in situations where CPP entitlement is not established and therefore not directly deducted. (See example, Appendix "B")

Effect of integration/harmonization on the contract itself

Hayles[16] suggests that the proliferation of 'coordination of benefits' clauses in disability policies which list the specific income replacement payments that are to be deducted from the benefit payable and the common practice of calculating benefits as a portion of earnings, have moved these policies from non-indemnity contracts to indemnity contracts.

Benefits under life and disability policies have traditionally been viewed as non-indemnity contracts. Benefits are paid upon proof that the event insured against had occurred, with no requirement of proof of actual financial loss. Indemnity contracts are understood as contracts in which the insurer agrees to compensate the insured for financial losses arising out of the insurance risk. They require proof of actual financial loss, such as property or automobile insurance. Given the nature of the physical object

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plans" (April 30, 1979).

[15]*Ibid*, ss. 56(1)(v); 110(1)(f)(ii).

[16]R. Hayles, *Disability Insurance: Canadian Law and Business Practice*, (Toronto: Carswell, 1998) at 268 and 277.

being insured, the focus of attention on financial loss is more self-evident under these types of contracts, than under life and disability insurance.

This transformation in treatment of disability insurance from a non-indemnity contract to an indemnity contract results in a shift in emphasis of the policy which has important consequences for the insured. The result to beneficiaries is a lowering of benefit levels overall under private disability policies. There is also an onus placed on disabled beneficiaries to participate in this integration of benefits by being obliged to apply for and/or appeal CPP disability and to understand how this complex interaction of benefits and their tax treatment will affect the beneficiary's overall level of replacement income.

This significant change in treatment by insurance companies of disability insurance contracts raises a critical question: Is this how we should be envisioning disability insurance?

Impact of harmonization on the concept of disability insurance

It could be argued that it is appropriate that publicly-based income security programs harmonize the benefits payable for similar causes. Where a disability arises from a work-related injury, there would appear to be an inherent logic for workers' compensation to act as the first payer. But are there philosophical consequences if CPP became the second payer in relation to other public income support programs such as workers' compensation? Some have suggested that there is a risk that CPP's status as a universal program will be eroded: "Turning CPP into a second payer could make it a residual program rather than an insurance that provides guaranteed coverage for all who have made the required contributions."[17]

Québec has its own pension plan legislation and a very different regime in terms of treatment of disability. In Québec, workers' compensation and the QPP disability are considered mutually exclusive programs. The Québec workers' compensation program, le Commission de santé et de sécurité au travail, is the first payer in relation to QPP disability and is, in fact, the only payer. Persons with employment-based disabilities may receive financial assistance from workers' compensation or QPP disability, but not both. Québec appears to have historically directed more of its disability caseloads to social assistance than to QPP, although this might be changing as a result of financial pressures on a program such as social assistance, which is fully funded by government.[18]

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[17]S. Torjman, "The Canada Pension Plan Disability Benefit" (February 2002) Caledon Institute of Social Policy at 52.

[18]*Ibid.* at 41.

The private insurance industry

Insurance companies have the same legal status as other corporations in Canada. They have the capacity, rights, powers and privileges of a natural person (section 15 of the *Insurance Companies Act*[19]). A federally incorporated insurance company can carry on business anywhere in Canada and can do business in any foreign jurisdiction, subject only to the laws of that jurisdiction. The corporate governance of insurance companies is also similar to that of private corporations. They may implement plans of internal organization similar to that available to other federally incorporated companies.

The life and health insurance industry in Canada has become a broadly-based, highly competitive, financially powerful and influential industry. At the end of the year 2000, the Canadian Life and Health Insurance Association Inc. ("CLHIA"), the nonprofit organization of member life and health insurance companies in Canada which administers the self-regulation by the industry, reported that the Canadian private life and health insurance industry had more than $267 billion in assets.[20]

The industry plays a significant role in sustaining the finances of three levels of government through its security holdings ($25.1 billion in federal securities, $29.4 billion in provincial securities, $2.7 billion in municipal securities). It has substantial investments in foreign markets: $49.1 billion or 55 percent of premiums are generated from foreign markets.[21]

After ten years of consultation with the insurance industry, a new legislative scheme was enacted in the early 1990s, the *Insurance Companies Act*.[22] This Act allowed the industry to diversify and expand both its investments and business activities. The insurance industry may invest assets in real estate, mortgages (residential and commercial), mutual funds, stocks and bonds (corporate and government). It can engage in business activities which include: investment counseling services, portfolio management, issuing and operating credit card plans in cooperation with banks or trust companies, operating real estate brokerages and dealing in real property.

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[19]*Insurance Companies Act*, S.C. 1991, c. 47.

[20]Canadian Life and Health Insurance Association Inc., *Canadian Life and Health Insurance Facts, 2001* (Toronto: CLHIA, 2001) at 2.

[21]*Ibid*. at 2-3.

[22]*Insurance Companies Act*, S.C. 1991, c. 47, ss. 440-441; 490-514.

The purpose of the few restrictions which are placed on insurance company activities is to preserve the (thinning) distinction between insurance companies and banks or trust companies. As a result, an insurance company cannot act as executor or administrator of an estate or as trustee of a trust, or accept deposits.

Paralleling this growing incursion of the insurance industry onto the terrain of financial institutions, has been increased demands placed on government. The CLHIA has lobbied the federal government for public policy changes to allow the industry to compete with deposit-taking institutions. In a 1997 submission to a federal task force on the Canadian financial services sector, the CLHIA stated:

> The public policy framework continues to be characterized by a number of policy induced competitive inequities that disadvantage life and health insurers relative to deposit-taking institutions. A prime example is the access to the Consolidated Revenue Fund and the Crown guarantees enjoyed by CDIC in contrast to the industry's CompCorp,[23] which has neither. Moreover, the industry's exclusion from the national payments system is an example of a level playing field anomaly that detracts from the quality of competition.[24]

Although beyond the scope of this analysis, this raises an interesting question as to whether an industry which is essentially self-regulated, should have access, as a publicly funded and regulated government program would, to the Consolidated Revenue fund (the general pool of all income of the federal government).

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[23]CompCorp is an insurance company organized and financed by the industry to compensate beneficiaries of life and disability policies of member companies, who are unable to collect as a result of the insolvency of a member company.

[24]Canadian Life and Health Insurance Association Inc., "Canada's Life and Health Insurance Industry: Structural and Business Powers Framework. Submission to the Task Force on the Future of the Canadian Financial Services Sector" (October 1997) .

The private disability insurance contract

The private insurance contract is a standard form contract. This means that the issuance, delivery and often the terms of disability insurance policies are governed by uniform legislation. This legislation was developed by the Superintendents of Insurance of the provinces, in a series of federal-provincial conferences held in 1914, in response to a consensus that the growing insurance market needed to be regulated.

Two kinds of uniform legislation were developed in relation to 'insurance of the person': life insurance legislation and accident and sickness uniform legislation. With minor variations, this uniform legislation is in place in all the common law provinces and territories today.

The model life insurance legislation is found in Part V of the Ontario *Insurance Act*. It applies to disability insurance provided in a life policy. The model accident and sickness insurance legislation is found in Part VII of the Ontario *Insurance Act* and it applies to disability insurance when it forms a part of an accident and sickness policy. One needs to know how an insurance policy is classified in order to know what part of the Act it falls under and the classification depends on extent of death benefit provided in the policy.

This distinction is important. For example, section 184 of the Ontario *Insurance Act* states that the incontestability rule does *not* apply to disability insurance in Part V of the Act. The incontestability rule is stated in subsection 184(2):

> Subject to subsection (3), where a contract has been in effect for two years during the lifetime of the person whose life is insured, a failure to disclose or a misrepresentation of a fact required to be disclosed by section 183 does not, in the absence of fraud, render the contract voidable.

This means is that where disability insurance is part of a life insurance policy (not an accident and sickness policy), the insured is *not* protected by the incontestability rule and the insurer may void the contract at any time due to the insured's failure to disclose or due to misrepresentation by the insured. This is a distinction that could have a significant impact on a beneficiary.

Insurance contracts are "Utmost Good Faith" contracts

Insurance contracts are generally considered to be contracts of "Utmost Faith," requiring both parties to do more than merely perform the obligations written into the contract itself. "Utmost Faith" connotes a mutual obligation of absolute honesty or trust. It recognizes that both the insurer and the

insured are dependent on the integrity and goodwill of the other. At the outset the person being insured holds the power, as the insurer is accepting a risk about which it knows very little. Once the contract is in place the power shifts to the insurer, particularly when a claim arises and the insured is injured or ill and cannot work, and is therefore dependent upon the insurer for income.

Disability insurance contracts have also been described as "Peace of Mind" contracts. *Warrington* v. *Great-West Life Assurance Co.*[1] concerned a dispute over payment of benefits under a disability insurance policy. The B.C. Court of Appeal considered whether a disability insurance contract was a "Peace of Mind" contract which it defined as:

> Thus the door was opened for recovery in at least a category of cases often called "peace of mind" cases - i.e., situations in which freedom from mental distress or even actual enjoyment was the very thing contracted for and not provided.[2]

The Court affirmed that a contract of this kind was a "Peace of Mind" contract, by considering the effect of the insurance company's refusal to pay the benefits owed to Warrington under the terms of the contract:

> His illness was one that is likely exacerbated by stress. It seems to me that this is exactly the type of mental distress and inconvenience one buys disability insurance to avoid - in other words, that the *object* of this contract was Mr. Warrington's comfort or peace of mind.[3]

The Court also stated that the nature of disability contracts may give rise to aggravated damages. It held that a disability insurance policy is one of the few contracts in which damages for mental distress are recoverable when they result from the breach of the contract itself.

The importance of the concept of the duty of good faith and "peace of mind" in insurance contracts was reaffirmed recently by the Supreme Court in the case of *Whiten* v. *Pilot Insurance Co.*[4] The case involved a dispute over payment of a claim under a property insurance contract, but it also

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[1] *Warrington* v. *Great West Life Assurance Co.*, [1996] 39 C.C.L.I. (2d) 116n (B.C.C.A..).

[2] *Ibid.* at 127.

[3] *Ibid.* at 131.

[4] *Whiten* v. *Pilot Insurance Co.*, [2002] S.C.C. 18.

concerned the concept of good faith and fair dealing implied in contracts of insurance. The Court reaffirmed these principles in upholding a jury's high award of punitive damages for breach of contract by the insurance company:

> Insurance contracts, as Pilot's self-description shows, are sold by the insurance industry and purchased by members of the public for peace of mind. The more devastating the loss, the more the insured may be at the financial mercy of the insurer, and the more difficult it may be to challenge a wrongful refusal to pay the claim. Deterrence is required. The obligation of good faith dealing means that the appellant's peace of mind should have been Pilot's objective, and her vulnerability ought not to have been aggravated as a negotiating tactic. It is this relationship of reliance and vulnerability that was outrageously exploited by Pilot in this case. The jury, it appears, decided a powerful message of retribution, deterrence and denunciation had to be sent to the respondent and they sent it.[5]

Group insurance and the group policy

Group insurance arises where a policy is issued to an insured who is not an individual (unlike individual insurance) and who may or may not, be responsible for payment of premiums. Group insurance may take many forms. The insured is often a company, entering in on behalf of its employees, or a union, professional association, or an alumni organization. Banks and trust companies may offer group coverage to their mortgagees. Finance companies may enter into arrangements with insurers to provide disability and life coverage upon the financing of major consumer purchases, such as automobiles. Retailers and credit card issuing financial institutions may also offer group coverage to cardholders. Any organization which has the legal capacity to contract and which is in sufficiently close association with an identifiable group of individuals may qualify, as long as the group was formed originally for a purpose other than insurance coverage.[6]

The issuance of a group policy or master policy creates a plan under which insurance is offered members of the group. The policy defines the group so that the insurer and the insured (the policyholder) may later determine whether or not an individual who applies for coverage is qualified to receive it. The master policy describes the coverage, sets out terms and conditions which will apply and may contain a formula for calculation of premiums paid by group members. The individual group insured is usually given a certificate without a copy of the master policy. The certificate is usually just a summary of terms

[5] *Ibid*. at para. 129.

[6] Hayles, *supra* note 16 at 93.

of coverage rather than the complete certificate itself.[7]

Group insurance has a number of advantages over individual insurance. It may be more cost-effective for the insurer because it reduces marketing costs and reduces administration costs for the insurer (if the policyholder does some of the administration work). There are also advantages for the insured. There is less scrutiny of individual applicants under group insurance and therefore, a greater opportunity for more high risk applicants to be covered.[8] The insurer also provides coverage to many individual insureds at once, so the high cost of insuring poor risks is offset by the lower costs of covering healthy, low-risk members of the group.

Legal issues surrounding group insurance

There are a number of legal issues raised by the concept of group insurance because group insurance introduces an additional party to the contract, the contracting organization or company who 'holds' the policy on behalf of the individuals ensured under the policy. Many of these issues have been settled by the jurisprudence. The issue of contract formation arises under the law of contracts. What is the legal status of the group person insured? Are they a party to the contract? It has now been established that the group person is a party to the group contract.[9]

There is also the issue of agency. Is the policyholder an agent for the insurer? If so, is the insurer accountable for statements made by the policyholder to the individual insured? Judicial opinion in Canada holds that the policyholder does represent the insurer and the insurer is responsible for policyholder's dealings with the group person insured on the basis of agency.[10] There has also been limited support for the view that the existence of agency depends on whether insurer or policyholder administers the plan.

The jurisprudence has also held that the law of torts is applicable to insurance contracts, given, as described above, the special nature of insurance contracts. It has been held that an insurer may be vicariously liable for a policyholder's tortious acts or omissions. There is also the question whether the

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[7]Hayles, *supra* note 16 at 93.

[8]This may not be true in practice. See below, p. 23 for evidence that many consumer complaints arise from denial or discontinuation of disability benefits under group insurance policies.

[9]*London Drugs* v. *Kuehne & Nagel International Ltd.*, [1992] 3 S.C.R. 299

[10]*Tarailo* v. *Allied Chemical Canada Ltd.* (1989), 68 O.R. (2d) 288 (H.C.).

policyholder has a duty of care toward the group person insured, for example, with respect to negligent statements regarding the extent of coverage. There does not appear to be a consensus as to whether a duty of care also exists on the part of the policyholder and whether such a duty includes a duty to provide a complete explanation of the insurance.[11]

Oversight Mechanisms

Government oversight

Oversight of the private insurance industry and the private insurance contract is found at the provincial and federal levels of government. It is important to understand the differing jurisdictions of the federal and provincial governments over insurance companies and the insurance contract in order to know where mechanisms of change are located.

Federal oversight and federal legislation deal primarily with licensing of insurance companies, corporate governance of federally incorporated companies and insurance company investments and finances. The federal government does not deal with the insurance contract or marketing of insurance products to the public.

Provincial legislation also deals with licensing of insurance companies (those that are provincially incorporated), but primarily it has authority over the contractual relationship between the insurer and the insured. Provincial oversight includes: the enforceability and content of insurance contracts, disclosure and misrepresentation, the application of common law insurance doctrines such as insurable interest, and statutory conditions of sickness and accident policies.

[11] *Ibid.* and see *Twardy* v. *Humboldt Credit Union Ltd.* (1985), 34 C.C.L.T. 140 (Sask. Q.B.).

Legislative/Regulatory oversight

Federal oversight

Federal statutes and regulations deal with the financial soundness, corporate organization and solvency of federally incorporated and non-Canadian companies. The primary piece of federal legislation is the *Insurance Companies Act* which deals with all aspects of incorporation, corporate finance and organization, and the financial stability of insurance companies. This legislation and its accompanying regulations contain consumer protection provisions, but it is important to note that they deal only with issues of disclosure pertaining to credit card charges or the cost of borrowing against the cash surrender value of a policy and the establishment of complaint procedures related to this type of disclosure.[1]

The Act also sets out the powers held by the Superintendent of Financial Institutions over the supervision of the financial affairs of insurance companies. The Superintendent has the power to make orders to compel a company to cease an unsafe or unsound business or financial practice or to take control of a company's assets, where it is unable to meet its liabilities or its assets are inadequate to protect policyholders or creditors.[2]

The *Office of the Superintendent of Financial Institutions Act*[3] creates the position of Superintendent of Financial Institutions and sets up the government department responsible for ensuring compliance with the federal laws applicable to insurance companies and other financial institutions. It is important to note that the objects of the Office of the Superintendent with respect to financial institutions are solely directed to monitoring and ensuring the sound financial condition of financial institutions is upheld.

The Superintendent has the powers, functions and duties which are assigned to the Superintendent under a number of Acts, including the *Insurance Companies Act*, as described above. Funding for the operations of the Office comes directly from the industries it supervises, by way of pro-rated assessments levied on the financial institutions for costs incurred in regulating the various sectors of the financial industry.

A recent legislative development has been the creation of the Financial Consumer Agency of Canada. The agency was established to strengthen the oversight of consumer issues and expand

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[1] *Insurance Companies Act*, *supra* note 22, ss. 165(2)(f),(g); ss. 479-489.2; ss 598-607.1.

[2] *Ibid.* ss. 676-692.

[3] S.C. 1987, c. 23.

consumer education in the financial sector. Similar to the Office of the Superintendent of Financial Institutions, this agency is funded entirely by the assessments on the financial institutions it regulates. The agency is headed by a Commissioner who is responsible for supervising financial institutions to determine compliance with the consumer provisions applicable to them and "promoting the adoption" of policies and procedures designed to implement these provisions.[4]

It is important to reiterate that the consumer provisions with respect to insurance companies over which the Commissioner exercises supervision, are those provisions of the *Insurance Companies Act*, mentioned above, which deal only with consumer issues surrounding disclosure of charges applicable to credit cards or the cost of borrowing.

The Commissioner also has power to monitor any voluntary code of conduct adopted by financial institutions designed to protect the interests of consumers and "that are publicly available."[5]

Provincial oversight

As discussed above, provincial authority over insurance is much broader than the federal authority. Their powers include:

- incorporating companies with "provincial objects"
- licensing insurers and overseeing the finances of provincially incorporated companies
- licensing and regulation of insurance agents and brokers
- authority over the contractual relationship between the insurer and the insured which includes matters of disclosure and misrepresentation and matters affecting the enforceability and content of insurance contracts[6]

Each province has a regulatory office or department to oversee the activities of insurance companies, which is established by legislation. In Ontario, the regulatory authority is the Superintendent of Financial Services, whose authority is established under the *Financial Services Commission of Ontario Act*.[7] This Act also establishes the Financial Services Commission of Ontario. Its purpose is to regulate

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[4]*Financial Consumer Agency of Canada Act*, S.C. 2001, c. 9.

[5]*Ibid.* s. 3.(2)(c). Presumably, this would mean that it has no supervisory power over the Guidelines under which member insurance companies operate, see *infra* note 42.

[6]Hayles, *supra* note 16 at 72.

[7]*Financial Services Commission of Ontario Act*, S.O. 1997, c. 28.

the financial institutions sector in Ontario, which includes those engaged in the insurance business and governed by the Ontario *Insurance Act.* The Superintendent's powers also include enforcing every Act that confers powers on the Superintendent, which, with respect to insurance, is the Ontario *Insurance Act.*

The provincial legislation contains provisions which give the Superintendent broad powers to regulate the contract of insurance and the relationship between the insurer and the insured.

Under section 51 (1) of the Ontario *Insurance Act*, the Superintendent is empowered to make a report if he or she "is of the opinion that there exists a state of affairs that is or may be prejudicial to the interests of persons who have contracts of insurance with an insurer licensed in Ontario." Following this report, the Superintendent is empowered to suspend or cancel an insurer's license.

There are also provisions dealing specifically with unfair or deceptive business practices. Such practices are defined in the regulations and include:

> 4. Any illustration, circular, memorandum or statement that misrepresents, or by omission is so incomplete that it misrepresents, terms, benefits or advantages of any policy or contract of insurance issued or to be issued.
>
> 5. Any false or misleading statement as to the terms, benefits or advantages or any contract or policy of insurance issued or to be issued.[8]

Under sections 438 and 441 of the Act, the Superintendent is empowered to investigate and report on such unfair or deceptive acts or practices and to make an order:

> (a) to cease or refrain from doing any act or pursuing any course of conduct identified by the Superintendent;
> (b) to cease engaging in the business of insurance or any aspect of the business of insurance specified by the Superintendent; or
> (c) to perform the acts that, in the opinion of the Superintendent, are necessary to remedy the situation.[9]

[8]O. Reg. 7/00.

[9]*Insurance Act, supra* note 9.

Complaint reporting mechanisms

Federal

As indicated above, the Commissioner of the Financial Consumer Agency of Canada monitors financial institutions, including the insurance industry and can enforce the industry's compliance with the consumer provisions of federal legislation. However, the consumer complaint provisions of the applicable federal legislation governing insurance, the *Insurance Companies Act*, only deal with issues of complaints regarding disclosure of credit card charges and the cost of borrowing. The insurance contract itself or the relationship between the parties to the contract are elements outside federal jurisdiction.

Provincial

Provincial legislation varies with respect to procedures dealing with complaints. Ontario is one of the few provinces that has an insurance ombudsman. Under the Ontario *Insurance Act*, the Superintendent has the power to appoint the Insurance Ombudsman as an employee of the Financial Services Commission.

The Ontario Insurance Ombudsman is empowered to make enquiries into complaints about the business practices of insurers, to attempt to resolve such complaints and/or to make recommendations to the Superintendent to inquire into a complaint. The Ombudsman is self-described, however, as an "informal, last-step forum."[10] A person may submit a written complaint about an insurer's business practices to the Ombudsman if the person has already submitted a complaint to the insurer and the complaint has not been resolved within a reasonable period of time. The Ombudsman then gives the insurer the opportunity to respond to any complaint. After considering the complaint and the response, the Ombudsman may attempt to resolve the complaint or recommend that the Superintendent inquire into the complaint.[11]

The Insurance Ombudsman also offers this further qualification of its powers: "Our findings are non-binding on either party. You may want to consult a lawyer if you wish to pursue the matter further."[12]

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[10]Financial Services Commission of Ontario, "The Insurance Ombudsman: Working For You", (Ontario: Queen's Printer, 2000).

[11]*Insurance Act*, *supra* note 9, s. 5.1(3).

[12]Financial Services Commission of Ontario, *supra* note 43.

Recently the Financial Services Commission of Ontario established new standards for Ontario's consumer complaint handling system.[13] They include requirements to collect and submit consumer complaint data to the Office of the Insurance Ombudsman ("OIO") on a quarterly basis, commencing January 1, 2001, and the development of mechanisms to ensure that a complainant is informed of their right to have a complaint reviewed by the OIO.

The specific provisions of the guidelines suggest some major weaknesses with the new reporting standards related to how complaints are defined and how they are reported. The guidelines indicate that a "Reportable Complaint" is a complaint that has been "reviewed and dealt with at least one level "higher" than the level that routinely handles and makes operational decisions about the subject matter of the complaint."[14] Surprisingly, a reportable complaint *does not include* a customer complaint that is referred back to the front line operational level, following a customer's attempt to "escalate" the complaint to a "higher" level.[15]

It is difficult to understand the logical difference between a complaint that would be successfully "escalated" to a "higher" level and one that would be referred back to the front line operational level, since this is not explained. It also suggests two disturbing scenarios: 1) that customers attempting to complain about insurance practices may be sent into a complaint 'revolving door', where complaints may never reach a higher, or supervisory level within the insurance company and 2) that many complaints might never reach the OIO because they have not met this arbitrary definition of a "reportable complaint".

The complaint data reporting form (see Appendix "C") accompanying the guidelines is also deficient in not giving substantive information about the content of the complaints being dealt with by insurance companies. The form indicates nothing about the nature of the complaint received by the company (the functional categories include "claim" and "miscellaneous"). It is simply a numerical summary of complaints broken down by type of policy. It is unclear how this will meet one of the objectives of the guidelines which is to understand the nature of the complaints being dealt with by companies.

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[13]Financial Services Commission of Ontario, "Bulletin No. G-10/00 General" (November 7, 2000).

[14]Office of the Insurance Ombudsman, "Guidelines - Collection of Insurance Company Consumer Complaint Data", (November, 2000).

[15]*Ibid.*

Finally, companies will be *asked* to work with the OIO to develop mechanisms to ensure that a complainant is informed of his/her right to have complaint reviewed by the Ontario Insurance Ombudsman if it has not been resolved within a reasonable period of time. Presumably these protocols are being developed.

Insurance Industry Oversight

Despite the regulatory presence of the federal and provincial governments, the insurance industry is subject to self-regulation. The relationship between the insurance industry and the public and the business practices of the insurance industry are regulated by the industry itself. The CLHIA administers Guidelines[1] drawn up by CLHIA which govern its own activities and practices. The Guidelines govern:

- advertising of insurance products
- disclosure at the point of sale
- activities of insurance agents
- business practices of insurance companies

The CLHIA has also adopted a code of ethics which embody the principles behind the Guidelines.

It is important to observe initially, that the Guidelines are merely guidelines and not legally enforceable. They were originally developed by the provincial Superintendents of Insurance but were eventually superceded by Guidelines written by the CLHIA, in consultation with the insurance industry. It has been argued, however, that there is a strong incentive upon the insurance industry to comply with the Guidelines, in order to evade mandatory regulation imposed by government. Under self-regulation, however, there is limited ability for the public to evaluate this assertion, in the absence of any impartial third party to assess the industry's compliance with the Guidelines.

Examination of the Guidelines suggests that they do not impose very rigorous standards upon insurance companies. There are separate guidelines for life and for accident and sickness insurance and

[1]On March 20, 2002, I attempted, anonymously, to obtain a copy of the Guidelines by phoning the Consumer Assistance Centre of the CLHIA and the branch office of CLHIA in Ottawa. I was unsuccessful. The Consumer Assistance Centre agent told me that I would not be interested in reading the Guidelines because they are too long and was insistent upon knowing what specifically it was that I was concerned about. The Ottawa branch office told me that the Guidelines were for the member companies only, not the consumer. As a result, the substantive analysis of the Guidelines is based solely upon a secondary source, *Disability Insurance: Canadian Law and Practice, supra* note 16.

they apply only to individual insurance policies. The disclosure requirements for group insurance are set out in a separate guideline.

Guideline 39 governs practices around disclosure at the point of sale under accident and sickness policies. It states that a disclosure statement is to be delivered to the insured along with the policy. The Guideline also mandates a 10-day "free look"" period in which the insured is guaranteed an opportunity to review a summary of the policy terms and may rescind the contract before accepting the coverage unconditionally. The disclosure statement is to include a list of any third party payments, such as employment insurance, workers' compensation or Canada or Quebec Pension Plan which may result in a reduction of benefits under an integration of benefits clause in the policy.[2]

The Guidelines around disclosure under life insurance policies are much less demanding than under accident and sickness policies because they prescribe very limited disclosure. The Guidelines state that a company is required to give each applicant a written notice indicating that, at the applicant's *request*, he or she may receive a copy of the Association's "guide to buying life insurance" as well as a Policy Summary. The content of the disclosure is also very limited. The Guidelines focus on the financial aspects of the policy. There is no requirement for disclosure or explanation of the policy terms and exclusions.[3]

Industry complaint-reporting mechanisms

Analysis of consumer complaint-reporting mechanisms provided by the insurance industry and the nature of the complaints received, suggests that the complaint process is not transparent and that disability insurance complaints are a prominent feature.

The CLHIA operates a Consumer Assistance Centre, which receives consumer complaints about the insurance industry. Its complaint resolution process is not clearly set out in its literature, but seems to involve an initial step of referring a number of complaints directly back to the Presidents of the companies in question, for review and a response sent directly to the consumer.[4] The Centre's Annual Report for the year 2000 also reveals that disability insurance complaints were a predominant feature of complaints.(See Appendix "D")

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[2]Hayles, *supra* note 16 at 122.

[3]*Ibid.* at 121.

[4]Canadian Life and Health Insurance Inc., "Consumer Assistance Centre 2000 Annual Report", (CLHIA Inc.: Toronto, 2000) at 8.

A consumer complaint which comes to the Centre and is not resolved at the first level, either on the phone or in writing, (or which presumably comes back to the Centre despite being referred back to the company in question), has its final step in the complaints resolution process at the senior level of the Centre. A consumer who wishes to pursue a complaint which is not resolved at the senior level of the Consumer Assistance Centre, may ask the Ombudservice to pursue the matter on their behalf. The Ombudservice officer provides an informal conciliation process, mediating between the consumer and the company. In the year 2000, 17 of 138 complaints were referred to the Ombudservice. The majority of these complaints (65%) involved disability insurance products.[5]

The majority of complaints to the Centre in the year 2000 involved claims (48.9%), followed by complaints about insurance products (24.6%). Complaints about disability policies constituted the majority (50.9%) of complaints about the line of coverage.[6]

The Annual Report further analyzed the predominant reasons for complaints about disability insurance. Claims-related issues dominated the complaints about disability insurance (62.6%) and more than 53% of these involved the denial or discontinuation of benefits under a group disability policy. Product-related complaints about disability insurance constituted 30.1% of disability insurance complaints and centred on the definition of disability in the consumer's policy.[7]

A complaint-reporting mechanism about an industry and operated by that same industry, raises the inevitable concern about the capability of any organization to effectively police itself. A complaints procedure which includes referring complaints back to the industry, does not suggest an impartial method of dealing with complaints.

Conclusion

This cursory overview of public and private insurance as it relates to disability, raises a number of important questions about how these systems interact to affect the overall welfare of disabled insureds.

The analysis points to specific legislative provisions and industry practices which encourage and allow for integration of public and private disability benefits and the offsetting of those benefits. These

[5] *Ibid.* at 11.

[6] *Ibid.* at 9.

[7] *Ibid.* at 10.

factors have also fundamentally altered the conception of the disability insurance contract to the detriment of the disabled insured. They have strictly limited the level of benefits available to the disabled and have burdened claimants with procedural obligations and financial burdens.

This analysis also suggests that legislative oversight mechanisms do exist, mostly at the provincial level, but do not appear to be well-utilized. At the same time, the mechanisms of self-regulation applied by the industry are not legally binding nor are they transparent to the public.

At the same time, the common law has affirmed that the nature of the insurance contract and particularly a disability insurance contract, takes it out of the realm of ordinary contract law principles. It imports higher standards of utmost good faith and honesty on both of the parties. It also affirms that "peace of mind" or relief from mental stress is specifically contracted for when an insured enters into an insurance contract. The current practices around disability insurance do not suggest that either of these principles is being upheld.

APPENDIX “A”

GIDIP BOOKLET

This Plan is administered by
CANADIAN BENEFITS CONSULTING GROUP LTD.

with Short Term Disability claims paid by
CANADIAN BENEFITS at

2300 Yonge Street, Suite 3000
Toronto, Ontario
M4P IE4

Telephone: (416) 488-7755
Toll Free: 1-800-268-0285
Fax: (416) 488-7774

and is underwritten by
THE GREAT-WEST LIFE ASSURANCE COMPANY
(formerly The London Life Insurance Company)

Long Term Disability Claims are paid by Great-West Life

IMPORTANT

This booklet has been prepared to help you better understand your Group Insurance Disability Income Plan (GIDIP). However, it does not take the place of any contractual or other rights. In the event of discrepancy between any information contained in this booklet and the Group Policy, the terms of the Group Policy will apply.

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CAW TCA CANADA LOCAL 2213

HIGHLIGHTS

Eligibility:

You must meet the criteria of *Total Disability* and be unable to work for *14 consecutive calendar days*. Benefits become eligible on the 15th consecutive day you are certified Totally disabled with Medical Support satisfactory to Great-West Life.

Under The Short Tern Disability Contract:

Total Disability means that because of accidental bodily injury or sickness you are not able to perform *any and every duty* pertaining to your own job; AND you are not working at any job for wage or profit.

Eligible Short Term Disability Benefits are paid every 2 weeks, in arrears.

Under Employment Insurance (EI):

Employment Insurance (EI) is a government-sponsored program. If it appears that your Total Disability may continue into the Employment Insurance period of the disability claim, Canadian Benefits will provide the necessary forms for you to apply to EI for benefits.

Under The Long Term Disability Contract:

In the *FIRST 24 MONTHS* you receive Long Term Disability (LTD) benefits, *Total Disability* means that because of accidental bodily injury or sickness you are not able to perform *any and every duty* pertaining to your own job; *AND* you are not working at any job for wage or profit; *AND*, you are not confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offence.

The definition of *TOTAL DISABILITY* changes after you have received LTD benefits for a period of ***twenty-four consecutive months***: thereafter you must be TOTALLY DISABLED from performing *any and every gainful occupation* for which you are reasonably fitted by education, training or experience: *AND* not working at any job for wage or profit (other then Rehabilitative employment approved by Great-West Life); *AND* you are not confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offence.

Eligible Long Term Disability Benefits are paid monthly, in arrears.

Canada Pension Plan / Quebec Pension Plan:

You *must* apply for Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) Sick benefits if so requested by Great-West Life. If you became disabled prior to June 1, 1996, 100% of any amounts awarded to you (*excluding* CPP/QPP monies received for your dependent children) *reduce* your GIDIP benefits in that amount.

For Members who became disabled after June 1, 1996 a 90% CPP/QPP offset has been negotiated with the insurance carrier to allow for the fact that while GIDIP payments are non-taxable, CPP/QPP benefits are

taxable.

Application Forms for the Canada Pension Plan or Quebec Pension Plan (**CPP/QPP**) sick benefits are retained in our Plan Administrators office and mailed to Members, when applicable.

If such benefits are denied to you, you must, at the request of Great-West Life, appeal this decision. ***Please note that receiving CPP/QPP benefits if you become totally and permanently disabled has a positive affect on your CPP/QPP retirement benefits.***

Receiving Benefits:

In order to meet the requirements of the *Total Disability* definition you must be under the regular, active, supervised care of a Physician who is qualified to treat your Disability. As well, *you* must be following the course of treatment prescribed by the physician and which reflects recognized, standard medicine practice relative to the cause and nature of the Totally Disabling condition. If these conditions are not met and objective **medical** information is not submitted to support your claim, GIDIP benefits will not be paid.

At all times -- it is the responsibility of the Member to fulfill the terms of his/her GIDIP claim.

Medical Support:

In order to meet the needs of our Members, our Plan Administrator has retained the Services of an in-house Medical Consultant. Canadian Benefits' Medical Consultant provides various assistance to their staff in order to better service you, the Member. For example, in some instances, the Plan Administrator's Consultant can simply pick up the phone and contact your Physician directly to clarify a concern that has arisen in your claim. This limits, at times, the need for lengthy correspondence back and forth and can shorten the claim decision period on your new or ongoing GIDIP claim.

Substance Usage:

Your Plan specifically states where alcohol, drug or other substance use disorder is involved, benefits will not be eligible unless a Member is either:

1. confined in a hospital or other institution qualified to provide care and treatment for alcoholism or drug addiction and is under the continuous care of a Physician, or
2. is undergoing regular rehabilitative treatment supervised by a Physician and approved in writing by Great-West Life.

Modified Return To Work Program:

Both your Short Term and Long Term Disability Plans provide a Modified Return To Work Program for Members who are unable to return to their previous job on a full-time basis immediately after receiving GIDIP benefits under these Plans. A Modified Return To Work Program may be available to assist you in returning to your job on a fulltime basis up to the level of your pre-disability employment with the company.

If you feel you would he a candidate for such a Program while receiving GIDIP benefits, please discuss this with your disability adjudicator and contact your local Chairperson/Trustee to confirm the availability of Modified Return To Work. at your location. Alternatively, Canadian Benefits, Great-West Life, or its Representative may contact you to discuss the restrictions and or modifications pertaining to your job and schedule; the "whys", "hows" and "wheres" of a Modified Return To Work Program as well as answer any and all questions you may have relating to this Program. Physician awareness includes writing or calling your Doctor. To receive partial benefits during a return to work on a Rehabilitation schedule under your

Plan, the Insurance Company must approve the Program. Once a Modified Return To Work Program is approved by Great-West Life, you will receive benefits for the time period you are unable to work by submitting the hours you worked to the Plan Administrator. GIDIP benefits will be calculated based on the percent of the schedule you are working; for example, if you are working 60% of your regular schedule, GIDIP will pay 40% of your regular benefit.

Contributions (premiums) are waived when you are on an Insurance approved Modified Return To Work Program, however, if contributions are deducted from your wages, please refer to page 17 or 25 in reference to reimbursement.

Taxability:

Because you pay the premiums for your Disability Plan, any benefits you receive from the Plan are *non-taxable* and you will *not* receive a T4A statement.

Your CPP/QPP benefits however, are *taxable* income for you and are your responsibility. **CPP/QPP benefits (*exclusive* of any dependent benefits) are used to offset your GIDIP benefits. If you became totally disabled after June 1, 1996 only 90% of your CPP/QPP benefit is used to offset your GIDIP benefits.**

Workers Compensation (WC) Claims:

Where Disabilities are the result of work **accidents or illnesses,** GIDIP requires that you file a Workers' Compensation (WC) claim. You must also file a WC claim where it is identified that work related stress has resulted in Total Disability. Your Union Health & Safety Representative can help you do this. If WC declines your claim, you will usually be expected to file an appeal of that decision.

Under the GIDIP, disabilities arising out of a work related illness or injury cannot be considered for benefit without confirmation that a WC claim has been filed, because WC is the first payer. GIDIP provides BRIDGE-FINANCING, if your WC claim is pending, as long as you promise to repay the plan if you recover any WC Benefits in the future, for the same time period, and to Appeal the WC decision when directed to do so by the Insurance Company.

Bridge-Financing If you have filed a WC claim and need financial help while you wait for WC Board's decision, GIDIP can provide you with financial assistance when your medical information supports Total Disability.. Essentially this means that GIDIP will advance you eligible benefit money while you are awaiting and/or appealing the WC decision. To be eligible for bridge-financing you must:

- have submitted a GIDIP claim form to Canadian Benefits within 90 days of the original date of your disability, and
- provide medical proof that you are Totally Disabled, and
- complete and sign: **a)** an assignment form which allows GIDIP to recover the money you were advanced if WC accepts your claim, **b)** a form allowing WC to release information on your file to the Plan Administrator or the Insurance Company and **c)** a Reimbursement Agreement, promising to repay GIDIP any money you were advanced if your WC Claim is accepted.

If WC declines your claim, you will be required to provide a copy of their letter along with a copy of the appeal request (where applicable) to the GIDIP. If you have been on WC and your claim has been terminated, but you are unable to return to work, a release form allowing WC to release medical information to GIDIP must be on file. Without this signed release GIDIP will be unable to consider your claim.

Third Party claim (Subrogation):

If you are in a motor vehicle accident or other accident/incident where you have the right to recover compensation for loss of income which caused or contributed to your Total Disability and for which benefits were paid under GIDIP, Great-West Life will have the right to recover the amount of benefits paid to you during this period. These monies will be put back into your Plan.

This means that you are awarded compensation from a Third Party, the monies paid to you in benefits under GIDIP must be returned to the Plan with payment being made to the insuring company, Great-West Life. Your repayment to the Plan is not dependent upon specific settlement made for wage replacement. This means that if you have accepted any type of settlement, it is recognized as an all-inclusive settlement, including wage replacement, and monies advanced to you must be repaid to the Plan.

Always communicate directly with our Plan Administrator if you have any claims related concerns or questions. Canadian Benefits' address and telephone directory is located on the opening page of this GIDIP booklet. Their staff will always take the time to listen to you and offer assistance, based on your needs, in a professional and caring manner. Alternately, claim appeals or member concerns may be directed to your regional Trustee.

Board of Trustees
CAW Local 2213
Health and Welfare Trust Fund
Group Policy No. 328802

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THE
Great-West Life
ASSURANCE COMPANY

January 2001

Dear

RE:
Group Plan Number
Employee ID Number

We have received a copy of the declination letter from Canada Pension Plan.

Since medical information received supports your inability to work, it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in their letter. Please advise us by telephone or letter if you would like Great-West Life to send the medical information on file directly to Canada Pension Plan to assist with your appeal.

If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions, please call me at or toll free at

Sincerely,

Disability Claims Specialist

Sun Life
Group Disability Management

April 2000

Dear Mr.

RE: Name of Claimant:
Contract Number:
Control Number:

Your letter has been referred to me for reply and I have reviewed Mr. claim file as well as the policy provisions.

It is our position that Mr. has a duty to mitigate his losses by making all reasonable efforts to apply for and obtain CPP disability benefits. In this regard, we assert that any expenses incurred to establish eligibility for CPP benefits are his responsibility.

Furthermore, we disagree with your assertion that the benefit of a favorable decision from the Review Tribunal would accrue only to and not to Mr. . Under the provision of the policy, Sun Life will only deduct the amount of the initial award from its monthly benefit cheques. As such, Sun Life does not adjust its benefit to deduct the annual increases in the CPP disability benefit. M. would therefore be entitled to the entire increase in benefit.

The amount of Mr. CPP retirement pension is calculated based on his contributions to the plan while working. Should Mr. not pursue his application for disability benefits with CPP the amount of his pension will be adversely affected by the fact that he will not have contributed to the fund for several years. It is our understanding that this penalty is greatly reduced if he is in receipt of CPP disability benefits.

This being said, although Dr. report was not included with your letter, we recognize that Mr. health may make it difficult for him to attend the hearing. As such, we are willing to consider funding a portion of his legal fees. Although you have provided Sun Life with confirmation of your rating schedule, we would appreciate receiving an estimate of the hours and costs expected on this case.

I will provide you with a final decision as soon as we have received the above information.

Yours truly,

CLARICA

Canada Pension Plan ("CPP") Agreement

Name: **Policy:** **Certificate:**

You are responsible under your plan to apply for CPP benefits and to keep Clarica Life Insurance Company ("Clarica") informed of your application as well as any appeals. Please read this Agreement carefully, sign it, and return it to us at the following address:

I understand the Plan requires me to apply for disability benefits payable under CPP and that any CPP benefits that I am entitled to receive, reduce directly any long term disability ("LTD") payable to me under the Plan. I also understand that this reduction applies both to LTD benefits I received before my CPP entitlement was determined, as well as to LTD benefits payable after.

Therefore, in consideration of paying unreduced LTD benefits for any period during which I may be entitled to CPP benefits I agree to the following terms:

1. I will apply for CPP benefits and will immediately notify of the CPP decision.
2. I will provide **Clarica** with any CPP correspondence received from the CPP office.
3. If my application is denied, I will appeal the denial within 30 days of being requested by **Clarica** to do so.
4. I will sign the enclosed assignment form from the CPP Office, "Deduction and Payment of Canada Pension Plan Disability Benefits to an Administrator of a Disability Income Program", and return it to **Clarica** along with this Agreement form.
5. I agree that within 10 days, from the date I receive payment from CPP, I will reimburse **Clarica** in a lump sum, for all payments it has advanced to me related to CPP which have not been reimbursed directly to **Clarica** by CPP.
6. If I do not comply with any of the terms in this Agreement, I agree that **Clarica** has the right to withhold or reduce my LTD benefits, until the amount of CPP disability benefits to which I may be entitled has been exhausted.

This agreement shall bind my heirs, executors, administrators and assigns.

☐ I confirm that I applied for CPP disability benefits on

_____, _____ at _____

OR

☐ I confirm that I appealed the decline decision on

_____, _____ at _____

_____ _____

Signature Date

_____ _____

Witness Date

NOTE: If this agreement is not returned to Clarica within 2 months of being requested, your LTD benefit payments may be reduced by an estimate of the amount of benefits to which you may be entitled under the Canada Pension Plan.

DISABILITY BENEFITS STATEMENT

NOV 1999

POLICY # -
SECTION -
CERT. -

---

(30) Although your original claim for Canada Pension Plan (CPP) benefits was declined, please appeal the CPP decision as soon as possible so that adequate time is given to CPP to reassess your claim. Please sign the enclosed (CPP) Agreement forms and return one copy within two months from the date of this notice. The Agreement should reflect the date of your appeal. The second copy of the Agreement is for you. Failure to do so will result in your future benefits being reduced by our estimate of the amount deemed payable by CPP. Any expenses incurred as a result of your appeal are your responsibility.

You should write "I wish to appeal this decision" on your letter of denial from CPP and include the date, your social insurance number and signature. Please return the form to Human Resources Development Canada, Disability and Reconsideration Division. The address is on the letter of denial. Please send a copy of your appeal request to your Clarica Disability Claims Analyst. QPP applicants should contact the local branch of La Régie des Rentes du Québec for an appeal form. Please complete the form and return it to the local office, and send a copy of your appeal request to your Clarica Disability Claims Analyst.

Once approved for CPP disability benefits, please send a copy of your "Notice of Entitlement" to us. We will calculate any overpayment you have received. You must repay this amount by the due date, which will be specified by letter, or your disability benefits will be suspended until full repayment has been made. For Quebec residents, Clarica will calculate any overpayment you have received and notify you. Repayment guidelines are the same as for CPP disability benefits.

THE
Great-West Life
ASSURANCE COMPANY

November 1999

Dear Mr.

RE: LOCAL

Group Plan Number
Employee ID Number

Thank you for notifying us of your declination from Canada Pension Plan for disability benefits.

Since medical information received supports your inability to work, we believe that it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in their letter. Please advise us by telephone or letter if you would like Great-West Life to send the medical information on file directly to Canada Pension Plan to assist with your appeal.

If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions, please call

Sincerely,

Disability Claims Specialist

Sun Life

August , 2000

This letter is in reference to your Disability Insurance claim with this company.

Under the terms of the Disability Insurance Group Contract, it is the claimant's obligation to pursue CPP benefits and our obligation to follow up with this process and if CPP benefits are not actively pursued, we are then obliged to deduct an estimate from the monthly Long Term Disability benefits. Therefore, since CPP is considered first payors, please file an appeal as soon as possible. Please forward any correspondence that you may have from CPP in regards to your Disability benefit application to our offices by September 30th. Yours sincerely,

Disability Claims Adjudicator

cc: Payroll & Benefits
O.H.S. & E.

September 23,1999.

Director,
Appeals and Reconsideration,
Disability Benefits,
Canada Pension Plan,
Human Resources Development Canada
P.O. Box 2710 Main Station,
Edmonton, Alta. T5J 4C2

Dear Sir or Madam;

Re: CPP Disability Benefits

My application for Canada Pension Plan disability benefits dated January/99 was reviewed and denied.I talked this decision over with my physician who deals with CPP disability benefits on a daily basis as a consultant with the W.C.B. and he advised my not to appeal your decision. I informed the company carrying my LTD-Sun Life- of your decision and my reason not to appeal. Please note the attached letter from Sun Life suggesting I file an appeal -that is the reason I am requesting an appeal.

Thank you for your consideration of the above and I am sorry to have to waste your valuable time on such.

Yours Truly,

Sun Life

September /1999

Re: **Contract No.:** **Sub. No.:**
Employee I.D.: **Control No.:**

We have received your recent letter with regard to your Long Term Disability claim and CPP appeal status.

Under the terms of the Disability Insurance Group Contract, it is the claimant's obligation to pursue CPP benefits and our obligation to follow up with this process and if CPP benefits are not actively pursued, we are then obliged to deduct an estimate from the monthly Long Term Disability benefits. Therefore, since CPP is considered first payors, we strongly suggest that you file an appeal as soon as possible.

If we can be of any assistance or if you have any questions, please feel free to contact our office.

Yours truly,

LTD Adjudicator

Ontario Teachers Insurance Plan
Long Term Disability Insurance
Claims Services Unit

January , 2001

Subject: Long Term Disability

Dear

Thank you for sending us a copy of the declination letter from the Canada Pension Plan.

Since medical information received supports your inability to work, we believe that it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in the CPP denial letter. Please call me if you require any assistance in appealing the Canada Pension Plan decision. At your request, OTIP/RAEO will send the medical information on file directly to Canada Pension Plan to assist with your appeal.

Please keep us informed of any progress with your appeal. If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions or concerns, please do not hesitate to contact me at (519) 888-9683 or 1-800-2676-6847, ext. 145.

Sincerely,

Disability Benefits Assistant

The Mutual Group

October 1998

CANADA PENSION PLAN ("CPP") AGREEMENT

Name: P. C.

You are responsible under your plan to apply for CPP benefits and to keep The Mutual Life Assurance Company of Canada ("Mutual") informed of your application as well as any appeals. Please read this Agreement carefully, sign it, and return it to us at the following address.

I understand the Plan requires me to apply for disability benefits payable under CPP and that any CPP benefits that I am entitled to receive, reduce directly any long term disability ("LTD") payable to me under the Plan. I also understand that this reduction applies both to LTD benefits I received before my CPP entitlement was determined, as well as to LTD benefits payable after.

Therefore, in consideration of paying unreduced LTD benefits for any period during which I may be entitled to CPP benefits I agree to the following terms:

1. I will apply for CPP benefits and will immediately notify Mutual of the CPP decision.
2. I will provide Mutual with any CPP correspondence received from the CPP office.
3. If my application is denied, I will appeal the denial within 30 days of being requested by Mutual to do so.
4. I will sign the enclosed assignment form from the CPP Office, "Deduction and Payment of Canada Pension Plan Disability Benefits to an Administrator of a Disability Income Program", and return it to Mutual along with this Agreement form.
5. I agree that within 10 days, from the date I receive payment from CPP, I will reimburse Mutual in a lump sum, for all payments it has advanced to me related to CPP which have not been reimbursed directly to Mutual by CPP.
6. If I do not comply with any of the terms in this Agreement, I agree that Mutual has the right to withhold or reduce my LTD benefits, until the amount of CPP disability benefits to which I may be entitled has been exhausted.

This agreement shall bind my heirs, executors, administrators and assigns.

☐ I confirm that I applied for CPP disability benefits on

_____, XX_____ at _____

OR

☐ I confirm that I appealed the decline decision on

_____, XX_____ at_____

_____ _____

Signature Date

_____ _____

Witness Date

NOTE: If this agreement is not returned to Mutual Life of Canada within 2 months of being requested, your LTD benefit payments may be reduced by an estimate of the amount of benefits to which you may be entitled under the Canada Pension Plan.

THE
Great-West Life
ASSURANCE COMPANY

November 4, 1999

Dear

RE:
Group Plan Number
Employee ID Number
London District Catholic School Board

This is in reference to your Long Term Disability benefits.

We have received partial reimbursement from the Workplace Safety & Insurance Board for the acceptance of your claim for the period Great-West Life paid benefits to you.

Therefore, we have recalculated your monthly benefit effective which was the date you first received payment from Great-West Life for your Long Term Disability benefits.

Under the provisions of your group plan, your monthly maximum benefit amount is $1,500.00. Since you are in receipt of WSIB benefits in the amount of $1,555.49, all monies paid to you from Great-West Life while you were in receipt of WSIB benefits must be recovered.

For the period we have paid you $13,086.56. We have deducted $3,581.44 (estimating your Canada Pension Plan disability benefits which you are currently not in receipt of), which leaves an overpayment balance in the amount of $9,505.12. WSIB has reimbursed us in the amount of $4,451.04. Unfortunately, an outstanding balance of $5,054.08 remains outstanding.

Please send a cheque payable to Great-West Life Assurance Company in the amount of $5,054.08 as soon as possible.

Your current monthly Long Term Disability benefit is as follows:

LTD	$1,500.00
Less WSIB	$1,555.49
Net Benefit Payable	0.00

Your immediate attention in this matter will be appreciated. Thank you for your anticipated cooperation.

Should you have any questions regarding this matter, please contact me at 1-800-330-2270.

Sincerely,

Disability Claims Specialist

APPENDIX “B”

THE
Great-West Life
ASSURANCE COMPANY

Alberta Disability Office
800 Canada Trust Tower
10104 103 Avenue
Edmonton, Alberta
T5J 4R5

Edmonton: Ph: (403) 421-1345
Fax: (403) 425-0744

Calgary: Ph: (403) 264-7931

August 4, 1992

Dear

RE: Group Policy Number

This is in reference to your Long Term Disability claim.

Under the provisions of this group plan, Long Term Disability benefits commence following a waiting period of 24 weeks. During this waiting period and the next 24 months, you are considered disabled if disease or injury prevents you from performing the duties you regularly performed for the employer before disability started. After this initial assessment period of 24 months, you are considered disabled if disease or injury prevents you from performing the regular duties of any occupation for which you have at least the minimum qualifications.

At the present time, based on the medical information on file, you are considered unable to perform the duties of your regular job. We would like to point out, however, that your claim remains under review, and we will require updated medical documentation throughout the duration of your claim for our ongoing assessment of your continued entitlement to benefits. You will be notified should there be any change regarding the status of your claim.

The waiting period commenced on July 3, 1991 and was satisfied July 2, 1992. Your Long Term Disability benefit cheque will cover the monthly period from the 3rd of the previous month to the 2nd of the month of issue. Your first cheque covering the period July 3, 1992 to August 2, 1992 inclusive has now been released. This cheque is in the amount of $0.00 as you are still in receipt of sick leave benefits. Subsequent cheques will be issued on approximately the 22nd day of each month.

The gross benefit for which you are insured is 60% of your pre-disability monthly earnings. Your gross monthly benefit is $1107.00. Benefits will continue at this amount provided there is no other reportable income, as outlined in the transcript of the interview mailed to you for signature. Other income is either directly reduced from the gross Long Term Disability benefit or it is co-ordinated with your Long Term Disability benefit.

APPENDIX “C”

Company Complaint Data Reporting Form

Company Name: _____

Contact Name: _____ **Phone number:** _____

Ombudsman Liason Officer: _____

Fax Number: _____ **E-mail Address:** _____

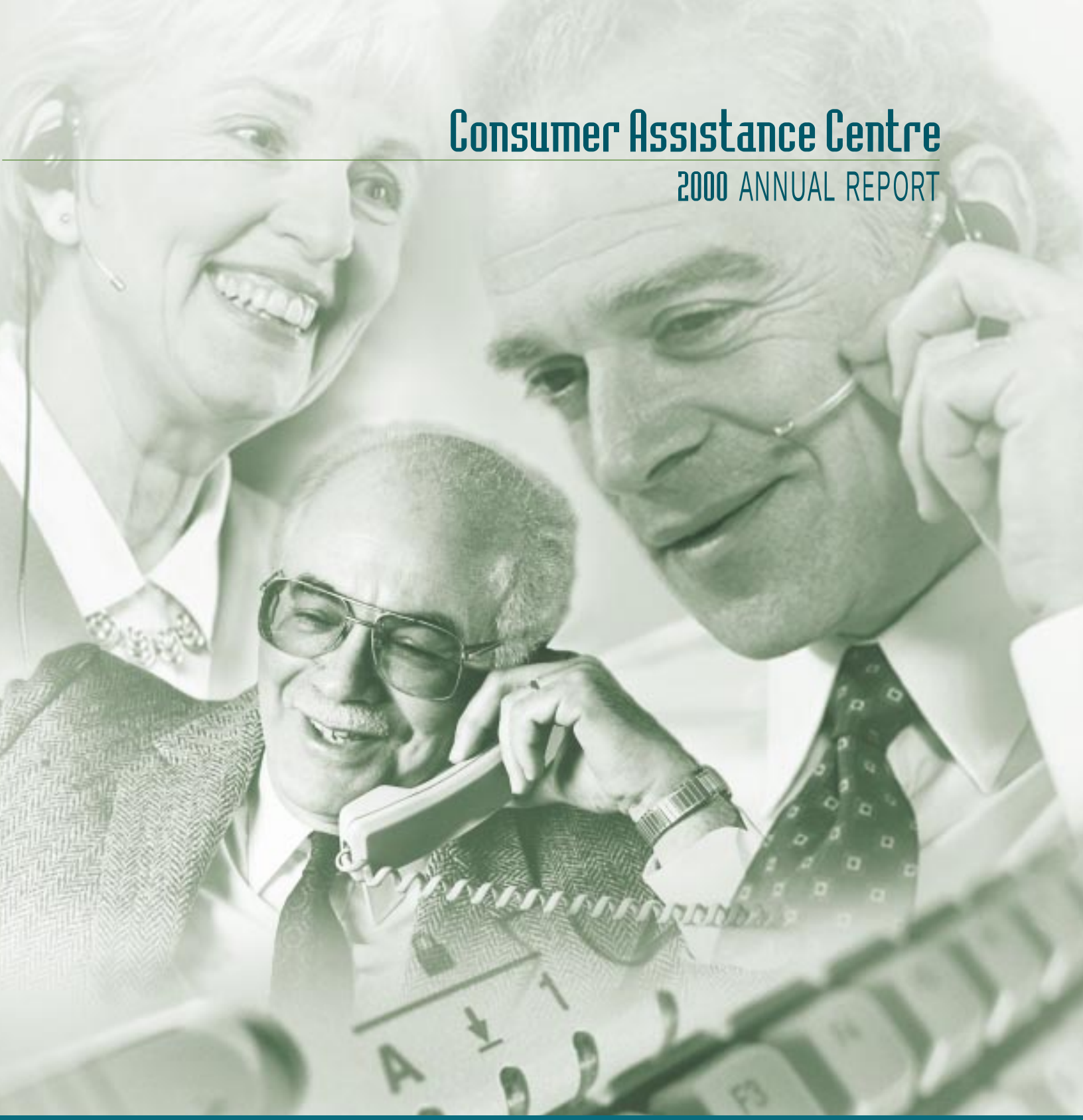
Reporting Period: 1st Quarter / 2nd Quarter / 3rd Quarter/ 4th Quarter Year _____
(circle Quarter)

Please complete the following breakdown of complaints received during the period -

	Function							
	Under-writing &Rating	Marketing & Sales	Sales Intermed-iaries	Claims	Policy - Owners Services	Product	Micell-aneous	Total
Line of Business								
Automobile								
Property & Liability								
Accident & Sickness/ Disability/Health								
Individual								
Group								
Creditor								
Total A&S								
Travel								
Individual								
Group								
Creditor								
Total Travel								
Life								
Individual								
Group								
Creditor								
Total Life								
Investments Annuities/Variable								
Insurance Contracts								
Total Complaints								

Information submitted in confidence to the Financial Services Commission of Ontario's Office of the Insurance Ombusman

APPENDIX “D”



Consumer Assistance Centre

2000 ANNUAL REPORT

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

TORONTO / MONTRÉAL / OTTAWA

1 Queen Street East
Suite 1700
Toronto, Ontario
M5C 2X9

Tel: [416] 777-2221
Fax: [416] 777-1895
www.clhia.ca

1, Rue Queen Est
Bureau 1700
Toronto (Ontario)
M5C 2X9

Tél. : [416] 777-2221
Fax : [416] 777-1895
www.accap.ca

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

Consumer Assistance Centre
2000 ANNUAL REPORT

Table of Contents

What is the Consumer Assistance Centre (CAC)?

The life and health insurance industry's Consumer Assistance Centre is a national consumer help service available in both English and French. It operates out of the Canadian Life and Health Insurance Association Inc. (CLHIA) offices in Toronto and Montreal, and is accessed by consumers through toll-free telephone lines which account for most contacts; electronic mail, now the source of most written requests for information and assistance; traditional mail; faxes; and in person.

Since its inception in 1973, the CAC has handled more than 900,000 calls, providing assistance to Canadians of all ages, from all walks of life, from all across the country.

Consumers are by far the predominant source of calls (more than 90 per cent). But agents, brokers and insurance companies also use the CAC as a central source of timely and accurate industry information.

What services are provided?

The CAC handles an average of nearly 62,000 calls per year, most of them from policyholders and other consumers.

Callers request:

- **information** about life and health insurance products and services, company addresses and phone numbers;
- copies of **publications** on life and health insurance products and services and financial/retirement planning;
- **policy search assistance**, or help locating life insurance policies that may have been misplaced;
- **information about CompCorp**, the organization that runs the industry's consumer protection plan;
- information about how **Holocaust victims and heirs** can search for lost insurance proceeds (special service); and
- in a very small number of cases, **assistance in pursuing complaints**.

Who responds to the calls?

The CAC is staffed by counsellors with extensive industry backgrounds. Most are retired insurance company executives with in-depth expertise in many aspects of the industry, including claims, law and marketing.

These counsellors bring knowledge, patience and empathy to the task and draw upon the collective industry experience of the group to provide accurate, objective information to callers. When required, they can also call on the expertise of the numerous industry specialists at the CLHIA.

Consumer concerns or complaints

In a very small number of cases a caller raises a concern or complaint about some aspect of his or her relationship with a life and health insurance company. Such problems are often resolved during the first telephone contact, when counsellors provide background information on industry practices and guidelines and common operational procedures.

If the consumer wishes to pursue a complaint further, the CAC will bring the matter to the attention of the company President, in writing.

OmbudService

In keeping with the industry's commitment to meeting the needs of life and health insurance customers, an OmbudService was introduced in 1998 to enable consumers to pursue further outstanding concerns and complaints. This service provides consumers with access to an additional conciliation process and significantly strengthens the industry's ability to respond effectively to their problems, adding value to the CAC's complaint resolution capacity.

Holocaust support service

This dedicated toll-free telephone service, also established in 1998, helps locate unclaimed insurance proceeds that may be owed to victims and survivors of the Holocaust and their heirs.

Activity Highlights

Number of enquiries

In 2000, more than 56,000 people called the CAC, seeking information and assistance on almost 72,000 different topics. More than 90 per cent of the calls came from individual consumers.

Reasons for calls

More than half the calls involved requests for product information. Another 30 per cent were from consumers seeking information about life and health insurance companies. Together, these two categories accounted for more than 80 per cent of calls received by the CAC.

Almost 70 per cent of the product information enquiries concerned health insurance, whether travel/visitors to Canada or extended health and dental insurance.

Consumer publications

In 2000, the CAC distributed almost 20,000 consumer publications from the list of a dozen titles produced and kept up to date by the CLHIA and CompCorp. The most popular publications have to do with life, disability and travel insurance.

Policy searches

More than 1,800 people called during the year for help locating possible life insurance policies on deceased persons, or for advice on how to locate possible misplaced policies of their own. Policy searches were carried out in 117 cases, with a positive "find" ratio of 14 per cent.

Concerns or complaints

Of the 72,000 enquiries, a little more than 1000, or less than 1.5 per cent, involved concerns or complaints. CAC counsellors resolved or dealt with 572 at the initial point of contact.

A further 432 complaints moved forward to written status. By year end, the CAC had made an initial response to 258 of these. The remaining 174 had been referred to the Presidents of the companies in question for response.

OmbudService

In 2000, 17 consumers expressed interest in pursuing their complaints through the OmbudService, after completing the initial complaint resolution process. This brings to 44 the number of consumers who have sought the service's help since it was established in the fall of 1998. Of the 28 cases processed by the service (five are awaiting consumer authorization before proceeding and 11 policyholders eventually elected not to use the service), 26 files have been closed. Of these, the insurer's position was revised in favour of the consumer in six cases, or 23 per cent.

Advisory Board

In April 2000, the CLHIA enhanced the industry's CAC through the establishment of a seven-person Advisory Board with a view to maximizing the CAC's usefulness to consumers.

Volume of enquiries

In 2000, the CAC responded to 56,090 calls, down slightly from the previous year, as shown in Chart i. These calls involved almost 72,000 enquiries on individual topics.

Who called us?

The CAC's clientele consists first and foremost of consumers, who consistently make up more than 90 per cent of all callers, and in 2000 accounted for fully 93 per cent. Calls from agents, involving product enquiries, policy searches and company information, have averaged almost 6 per cent of total calls during the last three years. Enquiries from insurance companies, concerning industry guidelines and regulations and company information, typically represent a little more than 2 per cent of all calls.

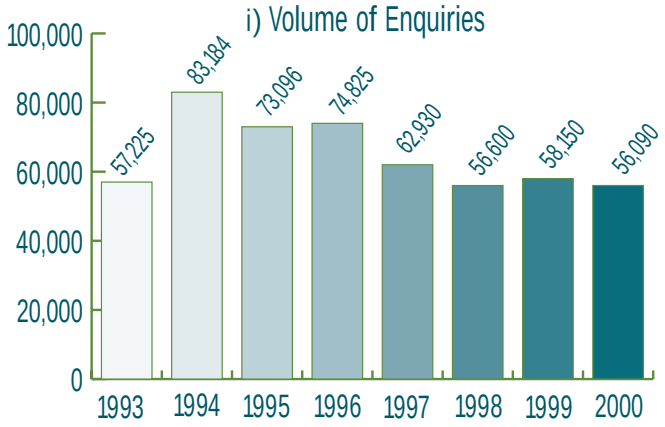
How did they hear of us?

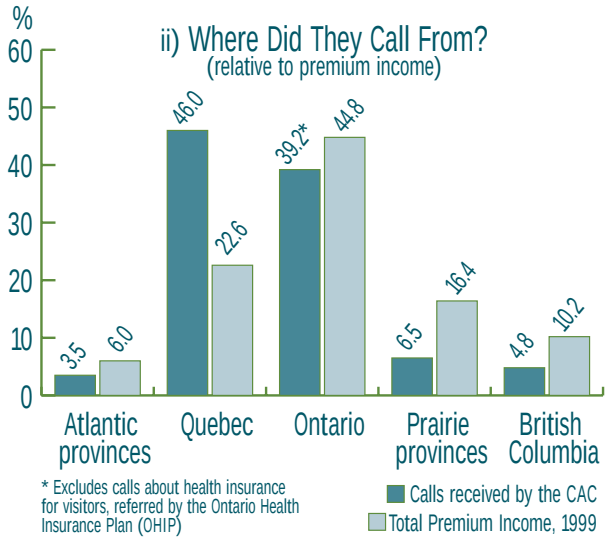
Callers learn of the CAC through a variety of sources, including agents, newspaper articles, government and constituency offices, insurance companies and other related trade and industry associations. Approximately one third of callers learn of the service through advertising in the regular white and yellow pages, and the electronic yellow pages of phone books, in 196 communities across Canada.

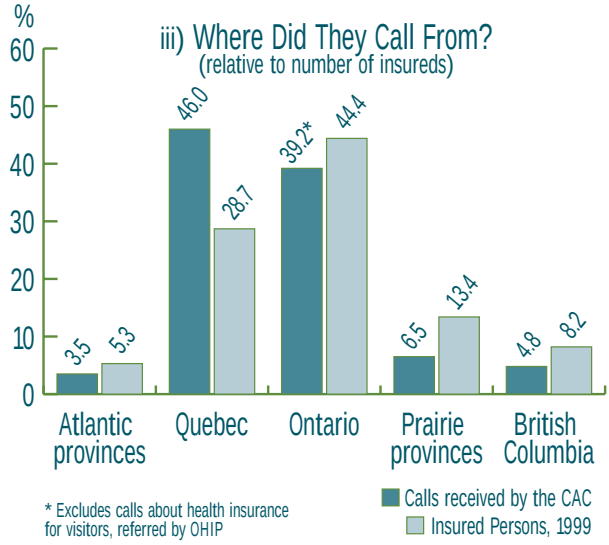
Where did they call from?

In general, the volume of calls tends to follow both the distribution of premium income and percentage of insureds across Canada. That more calls come from Quebec than any other province or region is mainly due to the fact that many Quebec government agencies routinely refer callers to the CAC. Chart ii shows the percentage of contacts from each region alongside the percentage of total premium income from the same region, based on 1999 statistics.

When the regional distribution of calls is compared to the percentage of persons insured under life and health insurance policies, as in Chart iii, the gap tends to narrow somewhat in all regions.





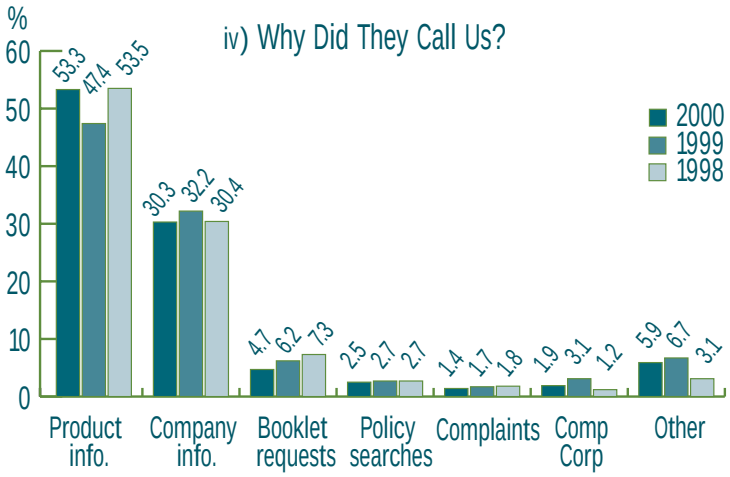


Why did they call us?

In the course of 56,090 calls to the CAC last year, 71,889 individual topics were addressed, which is to say that callers often raised more than one topic.

Chart iv shows that more than 53 per cent of the topics raised related to requests for generic information about life and health insurance products, including policy provisions and exclusions, along with questions about distribution.

The following analysis, which provides additional detail about callers' reasons for contacting the CAC, is also based on the number of topics raised.



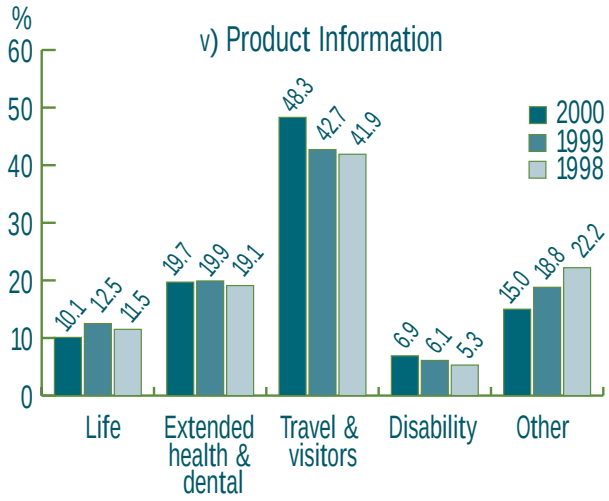
Product information

Almost 70 per cent of the product information enquiries concerned health insurance, whether related to travel and/or visitor to Canada or extended health care and dental insurance.

The year-over-year increase in the volume of travel health enquiries, as shown in Chart v, is due to changes in policy provisions and increased rates in a number of individual travel plans in 2000, primarily as the result of rising health care costs in the U.S.

The gradual increase in enquiries involving disability insurance parallels a similar rise in the volume of claims for these products, as noted in *Canadian Life and Health Insurance Facts*, the industry statistical publication.

Although travel and extended health insurance are sold on both an individual and group basis, it is estimated that 95 per cent of enquiries to the CAC are from consumers who are interested in purchasing such coverage on an individual basis, and require general information about providers, underwriting and policy provisions.



Company information

Chart vi shows that nearly 88 per cent of company information enquiries involved requests for telephone numbers and addresses and other queries of a general nature. Many of these requests were due to consumers' need for clarification as a result of industry merger and acquisition activity. Product information requests, at almost 9 per cent, involved queries about various products offered by specific companies, as opposed to generic product enquiries, which are dealt with above under "Product information."

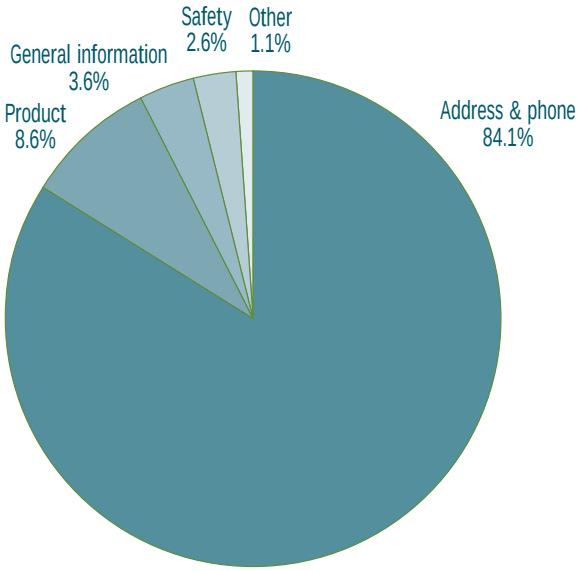
Booklet requests

The CLHIA produces a variety of consumer publications providing information, guidance and tips on the range of insurance company products and services available. The cost of production is borne by the industry. Single orders are free; a small fee is charged for bulk orders, to cover shipping charges.

The CAC distributed some 20,000 booklets in 2000, down about 8 per cent from the previous year. Requests for CompCorp booklets were for the most part bulk orders received from insurance companies and brokerages, while requests for CLHIA publications usually involved single copy orders from consumers.

The CompCorp booklet accounted for more than 50 per cent of the publications distributed in 2000. Booklets on life and disability insurance accounted for about 21 per cent; travel health insurance, about 8 per cent; retirement planning, 2 per cent; and other publications, about 18 per cent.

vi) Company Information



Consumer publications include:

Life	A Guide to Buying Life Insurance
Health	A Guide To Health Insurance (new in the summer of 2001) Disability Insurance: Where Will the Money Come from if You're Disabled? Health Insurance for Travellers: What you should know before leaving Canada
Retirement Planning	Retirement: As You'd Like It Consumer Tips: RRSPs with Life Insurance Companies
Financial Planning	Consumer Tips: Segregated Funds The Shoe Box Guide – Personal and Family Documents: What and Where are They?
Other	Canadian Life and Health Insurance Facts The Life and Health Insurance Consumer Assistance Centre
CompCorp	Consumer Protection Plan for Canadian Life and Health Insurance Policyholders

Policy searches

In 2000, the CAC received 1,821 requests from individuals either pursuing possible life insurance coverage of recently deceased persons or looking for possible misplaced policies of their own. In 117 of these cases, sufficient evidence existed to carry out formal policy searches. Sixteen policies were discovered, resulting in a positive "find" ratio of almost 14 per cent, which compares favorably with previous years.

Policy searches are conducted by both CLHIA member companies, and former member companies which contribute financially to the operations of the CAC. Requests come from heirs, beneficiaries, executors and law enforcement agencies. In 2000, 22 of the 117 requests resulted from police investigations.

CompCorp

Questions related to CompCorp came mainly from consumers who wished to confirm insurers' membership in the consumer protection plan and to clarify CompCorp guarantees for various products. More than 58 per cent of the product enquiries related to retirement products.

The number of enquiries concerning CompCorp declined from 2,301 in 1999 to 1,367 in 2000, no doubt reflective of consumer confidence in the safety of the industry.

Other

The "Other" category includes requests for general industry information and for assistance locating government services or departments.

Complaint resolution

In 2000, as shown in Chart vii, the CAC received a total of 1,004 consumer concerns or complaints, representing 1.4 per cent of the almost 72,000 enquiries. These were submitted either in writing (258 letters) or over the phone (746 calls).

Of the 746 complaints discussed over the phone, 572 or almost 77 per cent, were either resolved by the counsellor during the initial telephone contact or the consumer elected not to pursue the matter further by writing to the CAC. In the remaining 174 telephone complaints, about 23 per cent, the consumers proceeded to submit their concerns in writing.

In total, the CAC received 432 written requests for assistance and as of year end, 26 of these were still pending and 232 had been responded to by the CAC, which provided explanatory information or requested further information in order to formulate the best possible response.

The remaining 174 written requests for assistance were referred to the Presidents of the companies in question for review and a response sent directly to the consumer. Of these, 36 were still under review at time of writing. Of the 138 completed cases, the companies involved either provided additional information or modified their positions in favour of the consumer in 109 cases or 79 per cent, and maintained their positions in 29 cases or 21 per cent.

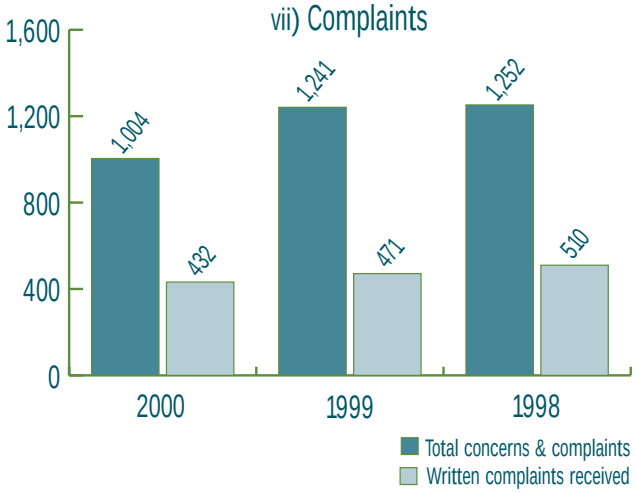
Analysis of written complaints

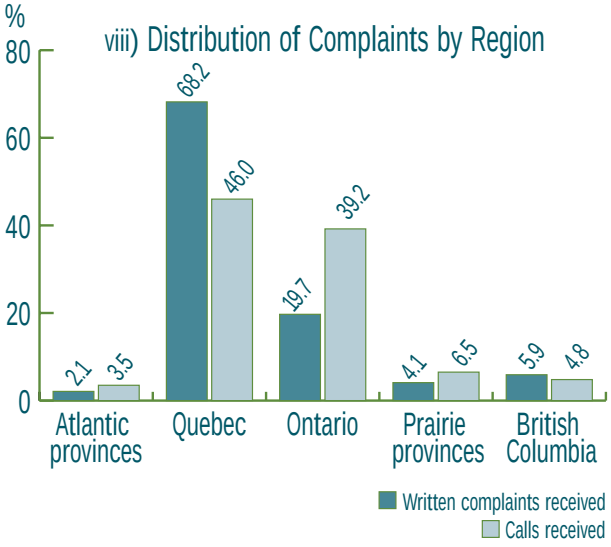
Distribution of complaints by region

In 2000, as a new service, the CAC began analyzing the distribution of written complaints by the region in which they originated.

As Chart viii shows, in the Atlantic and Prairie provinces and in British Columbia, the percentage of complaints was roughly commensurate with the percentage of total calls. In Ontario, the percentage of complaints was about half the percentage of total calls.

In Quebec, the high number of complaints relative to calls is likely due to the fact that the Superintendent of Insurance and Financial Services Bureau routinely refer consumers with complaints involving life and health insurance to the CAC as a matter of government policy.





Complaints by company function

Complaints are classified according to the five main company functions detailed in Chart ix (one complaint can involve more than one function).

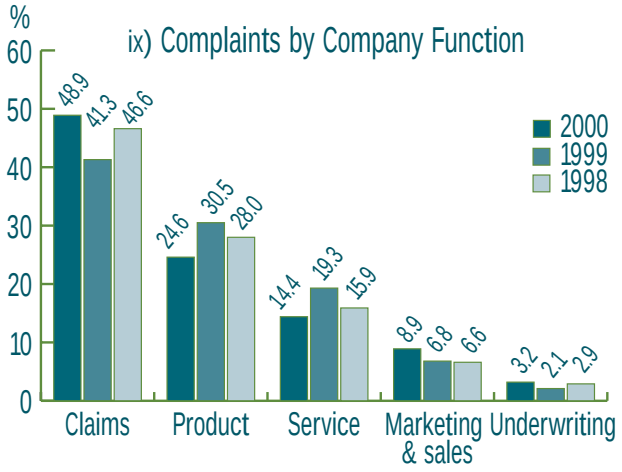
Historically, complaints involving claims-related issues have dominated. In 2000, they increased to almost 50 per cent of all complaints, while product- and service-related complaints declined.

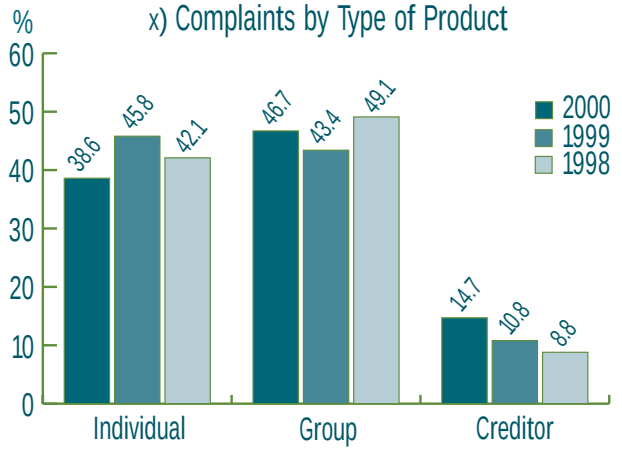
Complaints by type of product

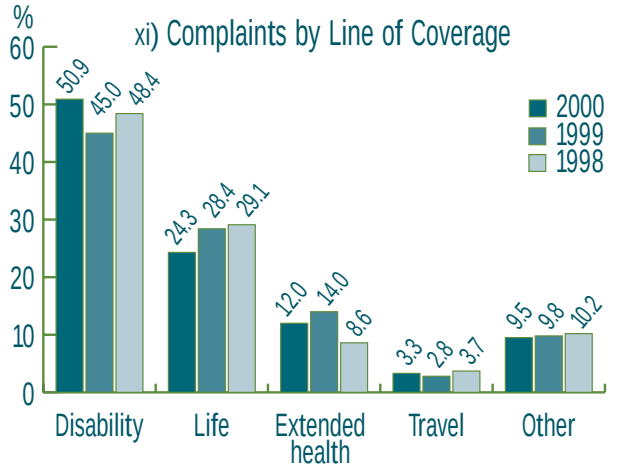
Most complaints involve either group or individual products. The decline in individual complaints shown in Chart x parallels the decline in life insurance product complaints noted in Chart xi, which most often involve individual insurance. The increase in group insurance complaints can be attributed to the rise in disability product complaints, which most often involve group insurance.

Complaints by line of coverage

Complaints involving disability products increased in 2000 after a gradual decline over the past two years, as shown in Chart xi. The decrease in complaints involving life insurance is in keeping with a similar decline in life insurance product enquiries (see page 5).







Life and disability

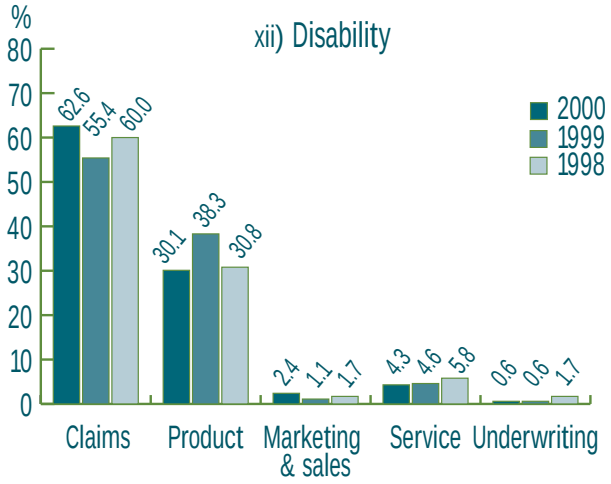
Further analysis of the predominant reasons for written complaints–disability and life insurance–follows.

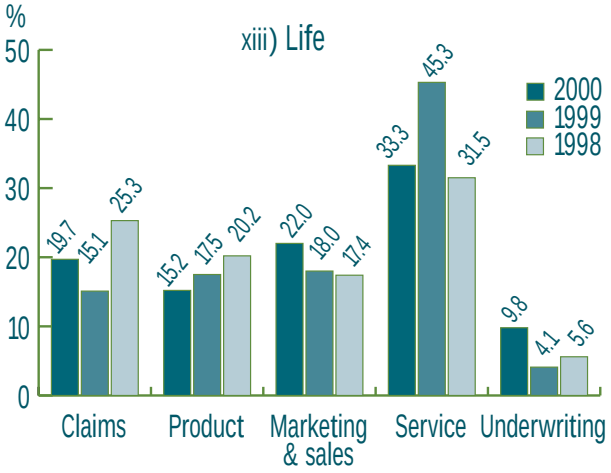
As in past years, claims-related issues dominated complaints involving disability insurance, as Chart xii shows. In 2000 the majority of these claims-related complaints–more than 53 per cent–involved the denial or discontinuation of benefits under a group disability policy. Product-related complaints about disability insurance tended to centre on the definition of disability in the consumer's policy.

Turning to life, with the exception of service and underwriting, complaints tended to be evenly distributed over all aspects of the business. As is evident from Chart xiii, complaints about service-related issues declined markedly in 2000, paralleling a similar decline in service-related complaints related to all products (page 9).

Other lines of coverage

In the remaining line of coverage categories, most complaints about extended health coverage and travel health insurance involved claims, while complaints about "other" products, which include accident and sickness insurance and retirement products, tended to involve claims and service issues respectively.





What is the OmbudService?

The OmbudService is an informal conciliation service for consumers who, having gone through the CAC's basic complaint resolution service, elect to pursue their concern or complaint further. The service is provided by trained and skilled OmbudService officers.

How does it work?

If on completion of the basic CAC complaint resolution process, a consumer wishes to pursue a matter further, they are provided with a letter and kit which, inter alia, ask for written details of the complaint and formal authorization of the OmbudService to discuss the case with the company.

An OmbudService Officer is assigned to review the information provided by the consumer. Through a series of discussions with the consumer and the company, the officer endeavours to find some "dry ground" between the two. This informal conciliation process offers the consumer an alternative to going to court to resolve a complaint.

OmbudService statistics

Of the 138 consumers whose complaints were reviewed at a senior level as the final step in the CAC's complaint resolution process last year, 17 or 12.3 per cent expressed an interest in pursuing the matter through the OmbudService and were sent information and authorization kits for review.

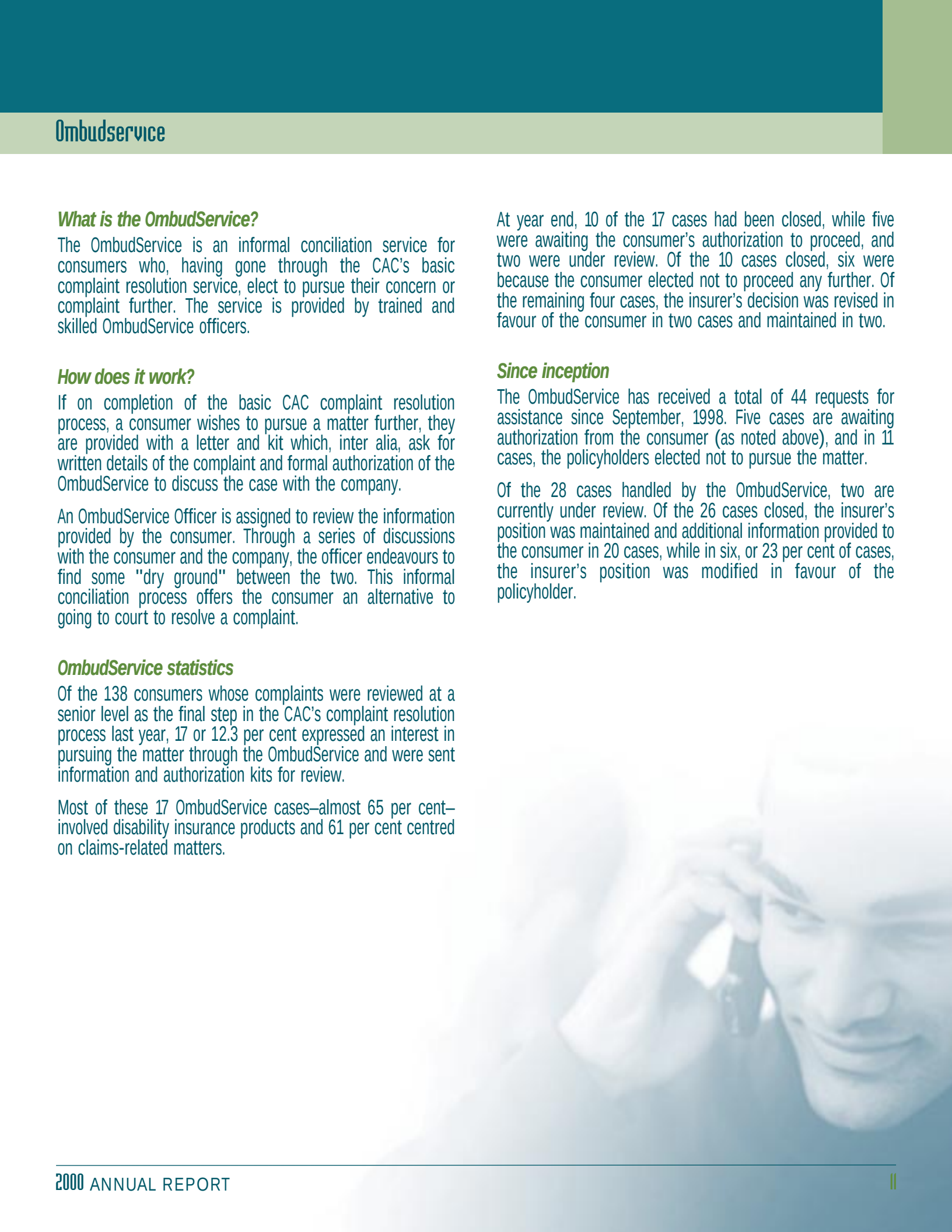
Most of these 17 OmbudService cases–almost 65 per cent–involved disability insurance products and 61 per cent centred on claims-related matters.

At year end, 10 of the 17 cases had been closed, while five were awaiting the consumer's authorization to proceed, and two were under review. Of the 10 cases closed, six were because the consumer elected not to proceed any further. Of the remaining four cases, the insurer's decision was revised in favour of the consumer in two cases and maintained in two.

Since inception

The OmbudService has received a total of 44 requests for assistance since September, 1998. Five cases are awaiting authorization from the consumer (as noted above), and in 11 cases, the policyholders elected not to pursue the matter.

Of the 28 cases handled by the OmbudService, two are currently under review. Of the 26 cases closed, the insurer's position was maintained and additional information provided to the consumer in 20 cases, while in six, or 23 per cent of cases, the insurer's position was modified in favour of the policyholder.



Holocaust Support Service

The CAC operates a dedicated, toll-free telephone service for anyone seeking information on insurance proceeds possibly owing to survivors of the Holocaust and Holocaust victims' heirs. The service was established in November, 1998, after a request for assistance from the Canadian Jewish Congress.

Although Canadian life insurance companies did not operate in continental Europe during the years 1930 to 1945, it is nonetheless possible that Canadian insurers operating in other countries, such as the United Kingdom, sold policies to people who subsequently became victims of the Holocaust.

The objective of the service is to put individuals in touch with such Canadian insurers, or with other organizations in other countries that help Holocaust survivors and the heirs of Holocaust victims locate unclaimed insurance policies on a worldwide basis.

One such organization, the International Commission on Holocaust Era Insurance Claims (ICHEIC), launched a toll-free North American call centre in February, 2000, dedicated to providing information and assistance resolving claims. As a result, the number of calls handled by the CAC's Holocaust support service has dropped from 160 in 1999 to 13 in 2000.

The CAC service has responded to 266 enquiries since inception. Of these, more than 50 per cent were from people who simply wanted to explore the possibilities, and 21 per cent were from individuals who wanted to enquire about possible unclaimed benefits from a specific carrier. The remaining calls were from people enquiring about the service itself (9 per cent); about compensation for other wartime losses, such as the wrongful death of a family member, imprisonment or forced labour (14 per cent); and about unclaimed bank accounts (4 per cent).

Advisory Board

In April, 2000, the CLHIA enhanced and strengthened the industry's Consumer Assistance Centre by establishing a seven-person Advisory Board under the Chairmanship of the Honourable Gilles Loiselle, former federal Minister of Finance. Other members of the Advisory Board are:

- Lea Algar, former Ontario Insurance Ombudsman;
- Bernard Bonin, former Senior Deputy Governor of the Bank of Canada;
- Sally Hall, former President of the Consumers' Association of Canada;
- Madeleine Plamandon, President and Director, Service d'aide aux consommateurs de Shawinigan;
- Yves Rabeau, Professor of Economics, Université du Québec à Montréal (UQAM);
- Reginald Richard, former Superintendent of Insurance for New Brunswick

The CAC Advisory Board and its two sub-committees convened on a total of three occasions in 2000 to provide guidance on the CAC's overall priorities, directions, service mix and performance with a view to maximizing its usefulness to consumers.

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Canadian Life and Health Insurance Association Inc.

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