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CAFII Executive Operations Committee Teleconference Meeting

Date:	Tuesday, July 19, 2016	**Dial-in:**	416-764-8662 or 1.888-884-4534
Chair:	G. Grant		Participant code: 4532491#
Time:	2:00 – 3:00 p.m.		Moderator code: 5829171#

Agenda

Item	Presenter	Action	Document
1. Call to Order	G. Grant		
2. Approval of Agenda and Previous Minutes			
a. Board Minutes of June 7, 2016	All	Approval	✔
b. EOC Minutes of June 21, 2016	All	Approval	✔
c. Summary of Board and EOC Action Items	B. Wycks	Update	✔
3. Regulatory			
a. Current Regulatory Issues			
i. CAFII Next Steps Re Alberta Decision on CI Sold Under a Restricted Certificate of Authority	G. Grant/B. Wycks	Discussion	✔ (2)
ii. CCIR Travel Health Insurance Issues Paper	G. Grant	Discussion	✔ (3)
iii. CCIR Annual Statement on Market Conduct	R. Beckford	Update	✔ (2)
b. Consultations/Submissions Timetable	B. Wycks	Update	✔

Next EOC Meeting [tentative]: Tuesday, August 23/16; location: TBD

Next Board Meeting (and AMF liaison lunch and meeting): Tuesday, October 4/16 hosted by RBC Insurance at 1 Place Ville Marie, 41st Floor, Montreal, QC

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CAFII Board Meeting Minutes
Tuesday, June 7, 2016
Location: St. Andrew's Club & Conference Centre
150 King Street West, 27th Floor, L1 Room, Toronto

Present:	Nicole Benson	Canadian Premier Life Insurance Co.
	Joane Bourdeau	National Bank Insurance Co.
	Linda Fiset	Desjardins Financial Security
	Chris Knight	TD Insurance *(for part)*
	Chris Lobbezoo	RBC Insurance
	Peter McCarthy	BMO Insurance *Chair*
	Kelly Tryon	The CUMIS Group *(by teleconference)*
	Robert Zanussi	Assurant Solutions
EOC Present:	Rose Beckford	ScotiaLife Financial
	Charles Blaquiere	Canadian Premier Life Insurance Co.
	Greg Grant	CIBC Insurance *Secretary*
	John Lewsen	BMO Insurance
	Sue Manson	CIBC Insurance
	Raja Rajaram	CIBC Insurance *Treasurer (by teleconference, for part)*
Also Present:	Emily Cloutier	T•O Corporate Services *Recording Secretary*
	Zack Fuerstenberg	ScotiaLife Financial *(observer for Bob Grant)*
	David Moorcroft	Stretegy2Communications *(for part)*
	Brendan Wycks	CAFII *Executive Director*
Regrets:	Nick Bilodeau	AMEX
	Bob Grant	ScotiaLife Financial
	Todd Lawrence	CIBC Insurance
	Carol Allen	Assurant Solutions
	Jason Beauchamp	BMO Insurance
	Isabelle Choquette	Desjardins Financial Security
	Eleanore Fang	TD Insurance
	Katherine Geisler	CIBC Insurance
	Moira Gill	TD Insurance
	Charles MacLean	RBC Insurance
	Diane Quigley	The CUMIS Group
	Jérôme Savard	Desjardins Financial Security
	Andrea Stuska	TD Insurance
	Ana Vu	BMO Insurance

1. **Call to Order**
   The meeting was called to order at 2:42 p.m. P. McCarthy acted as Chair; G. Grant acted as Secretary; and E. Cloutier acted as Recording Secretary.

1.1 CAFII Competition Guidelines

P. McCarthy reminded members that the Competition Guidelines provided in the package were first adopted on April 3, 2008 and last updated October 7, 2014. The practice of reviewing the guidelines annually, at the beginning of the first Board meeting after the Annual Meeting of Members, was adopted to ensure that the Board's deliberations adhere to the guidelines, which were briefly summarized.

1.2. Approval of Agenda

On a motion duly made, seconded and unanimously carried

IT WAS RESOLVED that:

The Meeting Agenda be and is approved with the following amendment: *Deletion of 3.2 Quarterly Financial Reporting – June 2016.*

1.3. Election of 2016-2017 CAFII Officers

Prior to announcing the proposed slate of Officers for 2016-17, P. McCarthy advised Directors that TD Insurance had recently informed him that it would be in a position to nominate a new Secretary & EOC Chair for appointment at the Board's October 2016 meeting. On behalf of all members of the Association, he thanked Greg Grant and CIBC Insurance for his service as EOC Chair over the last two years and on his willingness to stay on in the role of Secretary & EOC Chair until October.

On motion duly made, seconded and unanimously carried

IT WAS RESOLVED that:

The following slate of Officers be and is hereby appointed by the Board for a one year period or, in the case of the Secretary & EOC Chair, until the October 2016 Board meeting:

Chair:	Peter McCarthy, Bank of Montreal, BMO Insurance
Vice-Chair:	Joane Bourdeau, National Bank Life Insurance Company
Secretary & EOC Chair:	Greg Grant, CIBC Insurance
Treasurer:	Raja Rajaram, CIBC Insurance

2. Consent Items

2.1 Draft Board Meeting Minutes, April 12 2016

On a motion duly made, seconded and unanimously carried

IT WAS RESOLVED that:

The following Consent Items be and are approved or received for the record, as indicated in the Action column beside each agenda item:

- Summary of Board & EOC Action Items
- Balanced Scorecard
- Regulatory Update
- Regulator and Policy-Maker Visit Plan

IT WAS FURTHER RESOLVED that:

The Minutes of the meeting of the Board held on April 12, 2016 be and are adopted in the form presented, and that a copy of these minutes be signed and placed in the Minute Book of the Corporation.

3. Financial Statements as at May 31, 2016

Treasurer R. Rajaram reported on the financial statements as at May 31, 2016. He noted that the Statement of Operations is showing a year-to-date surplus of just under $33,000 at this time. However, it is expected that significant spending over the remainder of the year, in particular in the line item area of Media Outreach, will move the Association towards our budgeted deficit of $71,000 for 2016.

With respect to the Balance Sheet, there is a healthy bank balance of approximately $363,000; and we currently have unrestricted net assets of just under $392,000 which amounts to 77% of the Association's annual operating expenses. However, with the healthy spending on projects expected over the balance of the year, we anticipate that the reserves will move closer to the 58% of annual operating expenses that has been forecasted to the end of this fiscal year.

With respect to membership dues payments, the CAFII office is following up with one member, National Bank Insurance, which remains outstanding on the first instalment of its 2016 dues; and with three Associates that have not yet paid their 2016 dues.

On a motion duly made, seconded and unanimously carried

IT WAS RESOLVED that:

The CAFII financial statements as at May 31, 2016 be and are approved in the form presented.

4.1 Regulatory Consultations/Submissions Timetable:

4.1.1 BC 10-Year Review of Financial Institutions Act

B. Wycks reported that in a liaison meeting with CAFII on May 4/16, C. Rogers, CEO of BC's FICOM and Superintendent of Insurance, Ms. Rogers said that she doesn't expect the Ministry of Finance's Policy Paper arising from the province's 10-Year Review of its Financial Institutions Act and Credit Unions Incorporation Act to be published until after the next provincial election on May 9, 2017. As well, she doesn't believe that any policy positions with respect to FIA review have yet been formed in the minds of Ministry staff or Government officials.

4.1.2 BC "Effecting" of CGI Issue

B. Wycks reported that in mid-April, CAFII held a conference call with FICOM officials to discuss the Association's March 15/16 follow-up letter requesting clarification on certain points in the Commission's Information Bulletin of September 2015 on the Effecting of Creditor's Group Insurance in BC. FICOM provided clarification and comfort to CAFII on points raised related to existing certificates of insurance; and there was a discussion on the issue of auto dealers being the creditor for "a moment-in-time" meaning, therefore, that the creditor *is* involved in effecting the contract. However, FICOM expressed skepticism about this argument and asked CAFII to provide FICOM with some proof that this concept is valid.

After deliberation on this matter, the Board agreed that because the creditor for a moment-in-time issue affects more than one member of the Association, CAFII will remain engaged in this matter and will engage J. McCutcheon to provide CAFII with legal advice regarding next steps on this issue.

> **Action:** Engage J. McCutcheon of Borden Ladner Gervais to provide legal advice to CAFII on the Association's next steps in dealing with BC FICOM on the auto dealers are creditors for a moment-in-time issue [Greg; June 30/16].

With respect to the mortgage broker market, it appears that there will be no further progress with FICOM on this issue.

At a May 4 lunch meeting with CAFII in Halifax, C. Rogers advised that FICOM views its CGI Information Bulletin as having now moved fully from the realm of "Policy" into the realm of "Enforcement." Her message underlying this statement seemed to be that FICOM is not sympathetic toward nor interested in the industry's arguments about the impact of the Bulletin on auto dealers and mortgage brokers who distribute CGI; and that it will now be forging ahead to enforce the Bulletin's provisions, as they currently stand, by the March 31, 2017 implementation deadline.

4.1.3 Quebec Review of Distribution Act

B. Wycks reported that the industry is in a holding pattern on the matter of Quebec's review of its Distribution Act, waiting on the Ministry of Finance to introduce legislation. In an April 28/16 appearance before the legislature's Committee on Public Finance, Minister of Finance Carlos Leitão said his Ministry may introduce a financial omnibus bill this Fall but his comments were couched in words that appeared to suggest this timing is more hopeful than real.

4.1.4. CCIR Review of Travel Health Insurance

B. Wycks reported that on May 4/16, C. Rogers, CCIR Vice-Chair, advised CAFII that because the industry had demonstrated significant movement in terms of proposed reforms to travel health insurance, the Council then decided at its April 7-8/16 meeting that the Paper (which was slated for release in the spring) would be revised to reflect the latest industry input and released in the summer instead.

4.1.5 Saskatchewan Bill 177 Regulations

B. Wycks reported that in mid-April, Jan Seibel, Legal Counsel with Saskatchewan's Financial Consumer Affairs Authority and lead on the province's Insurance Act rewrite file, advised CAFII that the FCAA now planned to conduct its consultation with the industry on the Regulations in two parts. First, they will ask for comments on "some of the more complex issues that arose in the new Act, in particular viatical regulation, TPAs, and employee benefit plans." The FCAA hopes to have something out on this to the industry by late June. Thereafter, the FCAA is targeting having actual draft Regulations ready for dissemination to the industry, as Part II of the consultation, by late summer or early fall.

4.2 Alberta Decision on CI sold Under a Restricted Certificate of Authority

G. Grant advised that subsequent to the May 16/16 email communication from J. McCutcheon to W. Martinson, internal legal counsel at the Alberta Insurance Council, which was included in the Board meeting materials, they had connected by phone and had a cordial and positive conversation.

In that conversation, W. Martinson seemed unaware that the critical illness insurance products being sold incidentally in Alberta by deposit-taking institutions are generally simple products covering three or four major illnesses and are part of a bundle with other forms of creditor's group insurance. He also seemed unaware of the relevant definitions in both federal and provincial legislation regarding disability insurance. Mr. Martinson suggested that a written submission to the Insurance Council should be prepared and he promised to speak to J. Abram, CEO of the Council; find out when would be a good time for that submission to be brought forward and presented to the Council; and communicate the answer back to J. McCutcheon.

In concluding discussion on this matter, G. Grant advised that by the time of the next EOC meeting on June 21, CAFII should have a clearer sense of the timing for making a submission to the Alberta Insurance Council. A teleconference meeting or in-person meeting with W. Martinson, possibly with J. Abram in attendance also, would likely be arranged in conjunction with the Association's written submission.

5. Committee Reports Addressing CAFII Priorities

5.1 Media Advocacy Committee

5.1.1 Media Strategy Proposal

P. McCarthy welcomed D. Moorcroft as a visitor to the Board meeting, and invited him to highlight the "Media Strategy & Implementation Plan for CAFII" that was before the Board for consideration.

D. Moorcroft provided an overview of the proposed plan, focusing on its four key deliverables:

- Key Deliverable #1: Make CAFII's website more appealing to consumers and the media, and increase traffic to it.
- Key Deliverable #2: Enhance the external communications capability of CAFII.
- Key Deliverable #3: Develop and deliver the necessary protocols and training to help designated CAFII excel in the communication aspects of their mandates.
- Key Deliverable #4: Implement an outreach program to financial institution member public relations teams to increase their awareness of CAFII and its new website capabilities.

Mr. Moorcroft also outlined how his company, Strategy2Communications, would deliver on the plan; and the costs associated with doing so. He noted that $11,730 of the overall $51,730 cost for one year was related to redesigning the CAFII website to make it more consumer education-focused and thereby more attractive to consumers and the media; and that the other $40,000 was the cost of implementing the media relations and consumer education strategy, with himself serving as the Association's media spokesperson for the first year.

In Board discussion of the Media Strategy & Implementation Plan with D. Moorcroft, questions were posed and addressed related to using CAFII-commissioned research as content for the website and with media; overhauling the Association's website and using search engine optimization to drive traffic to it; and the process and timelines by which having a more consumer-friendly website and driving traffic to it will translate into a position of readiness for CAFII to interact with the media.

Discussion of the Media Strategy & Implementation Plan concluded with the Board's unanimous approval of the plan, as presented.

5.2 Market Conduct Committee

R. Beckford, Chair of the Market Conduct Committee, advised that her committee had recently overseen the preparation of a CAFII submission of FSCO's Draft 2016 Statement of Priorities. In addition, CAFII was currently awaiting CCIR's release of a revised version of its Harmonized Annual Statement on Market Conduct, which it had committed to release for an industry consultation period of about 45 days.

5.3 Licensing Efficiency Issues Committee

On behalf of M. Gill, Chair of the Licensing Committee, B. Wycks reported that CAFII was currently in a holding pattern with respect to New Brunswick's final position paper on reforming the licensing framework for other-than-life agents and brokers. Even though the last round of consultation with the industry was completed in January, due to resource constraints within the FCNB, the Commission's final positions on the licensing framework modernizations were not yet ready for submission to the government.

5.4 Research and Education Committee

S. Manson reported that the Research and Education Committee's travel insurance experts group was continuing to work on "terms and conditions" and "policy layout." The travel insurance experts were meeting regularly, with a view to completing as much of its mandate as possible by the end of June. When complete, the recommendations will be handed off the CLHIA travel insurance committee.

6. Other Business

6.1 CAFII Meeting and Events Calendar

B. Wycks noted the following details with respect to the two remaining CAFII Board meetings in 2016:

- a Board Meeting will be hosted by RBC Insurance at 1 Place Ville Marie, 41st Floor, Montreal, October 4/16. Immediately prior to this meeting, Board and EOC members will have a liaison lunch and industry issues dialogue session with Louis Morisset, CEO, and other staff executives from the AMF at the same location; and

- a Board meeting and CAFII Year-End Reception will take place on Tuesday, November 29/16, hosted by BMO Insurance at First Canadian Place.

6.2 Presentation and Regulator Attendees at June 7 CAFII Reception

B. Wycks advised that the following Regulator and Policy-Maker guests would be in attendance at that evening's CAFII Speaker Reception Event:

- Sean Jacobs, CCIR Secretariat
- Anatol Monid, FSCO
- Allan Amos, FSCO
- Michael Weisman, Ontario Ministry of Finance
- Stuart Wilkinson, Ontario Ministry of Finance
- David McLean, Ontario Ministry of Finance
- Amanda Lloyd, Ontario Ministry of Finance
- Terence Yim, Ontario Ministry of Finance

7. In Camera Discussion

The Board of Directors met *in camera* from 4:10 to 4:55 p.m. Following this, the meeting was ended and EOC and Board Members continued to the CAFII Presentation and Reception.

8. Termination

There being no further business to discuss, the meeting was terminated at 4:55 pm. The next CAFII Board of Directors meeting will be held on October 4, 2016, hosted by RBC Insurance at 1 Place Ville Marie, 41st Floor, Montreal.

_____ _____

Date Chair

_____

Recording Secretary

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CAFII Executive Operations Committee Meeting Minutes
Tuesday, June 21, 2016
Location: CIBC Insurance, Room #11
4th Floor, 199 Bay St., Toronto

DRAFT

EOC Present:	Carol Allen	Assurant Solutions *(by teleconference)*
	Rose Beckford	ScotiaLife Financial *(by teleconference)*
	Charles Blaquiere	Canadian Premier Life Insurance (*by teleconference)*
	Jason Beauchamp	BMO Insurance
	Eleanore Fang	TD Insurance *(by teleconference)*
	Katherine Geisler	CIBC Insurance
	Greg Grant	CIBC Insurance *Chair*
	John Lewsen	BMO Insurance
	Charles Maclean	RBC Insurance *(by teleconference)*
	Diane Quigley	The CUMIS Group *(by teleconference)*
	Raja Rajaram	CIBC Insurance *(by teleconference, for part)*
Also Present:	Emily Cloutier	T•O Corporate Services *Recording Secretary*
	Brendan Wycks	CAFII *Executive Director*
Regrets:	Isabelle Choquette	Desjardins Financial Security
	Moira Gill	TD Insurance
	Sue Manson	CIBC Insurance
	Jerome Savard	Desjardins
	Andrea Stuska	TD Insurance
	Ana Vu	BMO Insurance

1. Call to Order

G. Grant called the meeting to order at 2:08 p.m. and welcomed all in attendance.

2. Approval of Agenda and Previous minutes

a. Board Minutes of June 7, 2016

There was support for R. Beckford's suggestion to edit item *4.2 BC "Effecting" of CGI Issue* in the draft minutes of the June 7/16 Board meeting, so that only the outcome of the Board's discussion of the matter is included and that the draft minutes be brought back to the next EOC meeting for final review.

b. EOC Minutes of May 24, 2016

It was noted that in the first bullet under item 2(c), the first initial "S." was missing from "Sykes." The minutes of the EOC meeting held May 24, 2016 were approved, subject to that edit.

c. Summary of Board and EOC Action Items

B. Wycks highlighted Action Items that had been updated since the previous Summary, as follows:

- #2: with D. Quigley succeeding S. Manson as Chair of the Research and Education Committee, D. Quigley will now take on responsibility for updating CAFII's presentation on "Seven Point Guide to the Creditor Insurance Regulatory Regime."
- #4: as per the Board's discussion on June 7/16, providing further information to BC FICOM in support of the auto dealers are creditors for a moment-in-time argument will remain a CAFII issue.
- #5: B. Wycks has contacted Elizabeth Cole of BC's Ministry of Finance for an update on its expected Policy Paper, but she has been away from the office in recent weeks.
- #9: the process of registering *cafii.insurance* as an internet domain is underway and should be completed shortly.

R. Beckford reported that with respect to Action Item #6, she and I. Choquette were consulting on the proposal that CAFII engage specialized legal counsel to advise the Association on the expected overhaul of Quebec's Insurance and Distribution Acts. A recommendation on choice of counsel will likely be ready for the next EOC meeting.

3. CAFII Financial Management

a. Quarterly Financial Reporting – June 2016

G. Grant reported that some issues remained to be ironed out in the Quarterly Financial Reporting document and it would not be presented at this meeting. However, it will be finalized and circulated by the end of June.

Referring to the CAFII financial statements as at May 31, 2016, which had been presented at the June 7/16 Board meeting, G. Grant observed that with the Board's approval to engage D. Moorcroft as media strategy consultant and with the recent engagement of J. McCutcheon as legal advisor on Alberta and BC regulatory issues, the Association's level of financial reserves would gradually be drawn down over the second half of 2016.

G. Grant advised that as a further investment which would reduce the Association's level of financial reserves, it had been suggested by a member of the Media Advocacy Committee that CAFII should refresh the travel medical insurance data obtained in August 2015, by re-doing this consumer research in the Fall of 2016.

4. Strategy and Governance

a. Balanced Scorecard

G. Grant noted that while the Balanced Scorecard had been presented at the June 7/16 Board Meeting, it had been treated as a "Consent Item" at that meeting. Therefore, it was placed on the agenda for this EOC meeting to allow for discussion.

B. Wycks highlighted the updates that had been made to the Balanced Scorecard since its previous March 2016 version, noting in particular changes in the status of BC Effecting of CGI Issue; CCIR Annual Statement on Market Conduct; and Regulations in support of Bill 177, The Insurance Act (Saskatchewan).

b. Research & Education Committee Chair Succession

G. Grant advised that D. Quigley would be succeeding S. Manson as Chair of the Research & Education Committee, effective immediately. S. Manson would remain a member of that committee and would also continue to chair the Travel Medical Insurance Subcommittee.

c. Meeting Room Locations for Future EOC Meetings

E. Cloutier thanked CIBC Insurance for hosting many EOC meetings over the past several years. However, due to a recent policy change, CIBC meeting rooms were no longer accessible by non-CIBC groups. Therefore, she would be reaching out to other EOC Members to secure rooms for EOC meetings over the balance of 2016.

> **Action:** Canvas EOC Members by email to secure locations for EOC meetings for the balance of 2016. [Emily: July 15, 2016]

5. Regulatory

a. Consultations/Submissions Timetable

B. Wycks highlighted recent changes to the Regulatory Consultations/Submissions Timetable, noting in particular updates to deliverables or deadlines associated with BC FICOM 10-Year Review of FIA; BC "Effecting" of CGI Issue; Quebec Ministry of Finance Review of Distribution Act; and CCIR Annual Statement on Market Conduct.

b. Regulatory update

i. BC "Effecting" of CGI Issue: CAFII Next Steps in Support of Auto Dealers Are Creditors for a Moment-in-Time

G. Grant reported that J. McCutcheon of Borden Ladner Gervais had been engaged to provide CAFII with a legal opinion in support of the auto dealers are creditors for a moment-in-time argument.

ii. CAFII Next Steps Re Alberta Decision on CI Sold Under a Restricted Certificate of Authority

G. Grant reported that J. McCutcheon of Borden Ladner Gervais, whom CAFII has engaged as a legal advisor on this issue, recently had a telephone conversation with W. Martinson, the Alberta Insurance Council's internal legal counsel. That conversation arose from her e-mail communication to Mr. Martinson on CAFII's behalf, which sought clarification on the Life Insurance Council's recent decision that critical illness insurance cannot be sold under an RIA licence. Mr. Martinson indicated that the Life Insurance Council would be open to receiving and considering industry submissions on its decision and promised to get back to Ms. McCutcheon regarding the optimal timeline for making such a submission.

CAFII will make a written submission to the AIC in the summer, likely followed by a face-to-face meeting in the late summer or early fall with AIC staff executives and Council representatives.

5. EOC Committee Updates

a. Research and Education

On behalf of outgoing Research and Education Committee Chair S. Manson, G. Grant reported that feedback on her June 7/16 presentation had been provided to Lesli Martin of Pollara Strategic Insights, to strengthen the impact of her upcoming webinar for the CCIR Travel Insurance Working Group and other interested CCIR members. B. Wycks reported that the webinar had been confirmed for June 7/16 at 1:00 p.m. EST.

b. Media Advocacy

i. Implementation of Board-approved Media Strategy

C. Blaquiere, Chair of the Media Advocacy Committee, reported that with the recent CAFII Board approval, the Association had just signed a contract with media strategy consultant D. Moorcroft. Mr. Moorcroft will be retaining a company called RankHigher.ca to work with him and CAFII representatives on an overhaul of the Association's web site and related search engine optimization.

c. Market Conduct

R. Beckford, Chair of the Market Conduct Committee, reported that three new members had recently been appointed to her committee: C. Maclean, RBC Insurance; J. Beauchamp, BMO Insurance; and L. Ripandelli, The CUMIS Group.

ACTION: Update CAFII EOC Subcommittee Directory, and send it to the subcommittee chairs [Emily, July 5, 2016]

d. Licensing Efficiency Issues

No update at this time.

6. Other Business

a. CAFII Registration as a Lobbyist with Provincial/Federal Registries

B. Wycks noted that effective July 1, 2016, Ontario had changed its lobbyist registration law such that any organization that lobbies government officials, including regulators, for 50 hours or more per year collectively as an organization is required to register. Previously, the higher threshold required registration if 20% of any one individual's time was spent on lobbying.

That said, responding to public domain consultations does not qualify as lobbying; only meetings initiated by organizations themselves constitute lobbying. Therefore, over the past three years, CAFII has not come close to the 50 hour threshold as we have only interacted with public office holders around public consultations and have not initiated many meetings with regulators.

G. Grant observed that, due to the fact that virtually all of his lobbying is in response to consultation requests, he has been discouraged from registering as a lobbyist by most jurisdictions. Alberta is an exception to this and, in fact, Alberta has encouraged him to register so that he would not have to keep track of the time he spends on lobbying to ensure that he doesn't surpass that threshold for registration.

It was agreed that given the nature of CAFII's regulator and policy-maker relations activity, there did not appear to be a need to register as a lobbyist in Ontario or any other jurisdiction at this time. However, it was agreed that Brendan would update and circulate CAFII's existing Lobbyist Registration Regime Matrix.

> **Action:** Update and circulate CAFII's Lobbyist Registration Regime Matrix to EOC members [Brendan: July 30, 2016]
>
> **Action:** Clearly flag in the Regulator and Policy-Maker Visit Plan any CAFII regulator/policy-maker relations activity that constitutes lobbying [Brendan: Ongoing]

b. CAFII Registration of a .Insurance Internet Domain

No discussion on this issue. CAFII will proceed with registering *cafii.insurance* as an internet domain.

c. Possible LIMRA Membership for CAFII

G. Grant reported that S. Manson responded to B. Lemanski to communicate that CAFII would not consider a membership at the $20,000 U.S. level that he quoted. However, if the dues were in the range of $5,000 to $7,500 U.S. per annum, CAFII might find it more attractive to join.

d. CAFII 20th Anniversary Celebration In 2017

B. Wycks advised that 2017 would mark the 20th anniversary of CAFII's founding, and requested EOC input on how to recognize this milestone in CAFII's history. There was general EOC support for recognizing CAFII's 20th anniversary in 2017 and that Brendan would propose options for doing so. It was discussed that this may serve as an effective way to highlight CAFII's consumer education initiatives.

> **Action:** Bring forward a proposal for recognition of CAFII's 20th Anniversary [Brendan: October 4, 2016]

7. Meeting Termination

There being no further business to discuss, the meeting was terminated at 3:24 p.m.

It was noted that while the EOC does not customarily meet during the summer months, there is a tentative EOC meeting scheduled for Tuesday, July 19, 2016. The next CAFII Board meeting is scheduled for Tuesday, October 4, 2016 hosted by RBC Insurance at 1 Place Ville Marie, 41st Floor, Montreal, QC and will include our annual AMF Liaison Lunch and Industry Issues Dialogue.

_____ _____

Date Chair

_____

Recording Secretary

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Summary of CAFII Board and EOC Action Items					
	Source	Action Item	Responsible	Deadline	Status 13-Jul-16
		Atlantic Regulatory Issues			
1	EOC May 24, 2016	• Update CAFII presentation on "Seven Point Guide to the Creditor Insurance Regulatory Regime," for possible use as an educational communication to New Brunswick and/or other insurance regulators	Diane	30-Jun-16	In progress
		BC Ministry of Finance & FICOM			
2	Board June 7, 2016	• Engage J. McCutcheon to provide legal advice to CAFII on the Association's next steps in dealing with BC FICOM on the auto dealers are creditors for-a-moment-in-time issue	Greg	30-Jun-16	In progress
3	EOC Apr 26, 2016	• Conduct further research and provide additional information on auto dealers are creditors for a moment-in-time argument, to enable further CAFII discussion with FICOM.	Diane	31-May-16	In progress
4	EOC Feb 16, 2016	• Investigate opportunities to engage with BC Ministry of Finance to provide information and find out more about what will be included in the Policy Paper to be released in late 2016.	Brendan	30-Apr-16	In progress
		Quebec Regulatory Issues			
5	EOC Apr 26, 2016	• Consult on the possiblity of engaging specialized legal counsel with respect to expected overhaul of Quebec's Insurance Act and/or Distribution Act, before bringing a proposal back to EOC.	Rose, Isabelle	15-Jun-16	In progress
		Regulator and Policy-Maker Visit Plan			
6	EOC June 21, 2016	• Update and circulate CAFII's Lobbyist Registration Regime Matrix to EOC members	Brendan	30-Jul-16	Complete
7		• Clearly flag in the Regulator and Policy-Maker Visit Plan any CAFII regulator/policy-maker relations activity that constitutes lobbying	Brendan	21-Jun-16	Ongoing
8	EOC Feb 16, 2016	• Discussion notes from regulator meetings held in Halifax to be circulated to those who aren't able to attend.	Brendan	13-May-16	Complete
		Association Admin			
9	EOC June 21, 2016	• Bring forward a proposal for recognition of CAFII's 20th Anniversary	Brendan	04-Oct-16	In progress
10		• Update CAFII EOC Subcommittee Directory, and send it to the subcommittee chairs	Emily	05-Jul-16	Complete
11		• Canvas EOC Members by email to secure locations for EOC meetings for the balance of 2016.	Emily	15-Jul-16	In progress
12	EOC May 24, 2016	• Register cafii.insurance as a CAFII-controlled domain name with a registrar approved by fTLD Registry Services, LLC	Brendan, Emily	15-Jun-16	Complete
13		• Follow-up with Members and Associates who haven't yet paid the 2016 CAFII fees now due	Emily	07-Jun-16	In progress
14	EOC Jan 12, 2016	• All relevant stakeholder submissions and supporting documents to be posted to the CAFII website, e.g. Insurance Council of BC, Advocis, Independent Financial Brokers.	Emily	15-Apr-16	In progress

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July 19/16 CAFII EOC Meeting
Agenda Item 3(a)(i)

From: Grant, Greg [mailto:Greg.Grant@cibc.com]
Sent: Tuesday, July 12, 2016 12:13 PM
To: 'Gill, Moira'; 'Blaquiere, Charles'; 'Beckford, Rose'; 'charles.maclean@rbc.com'; 'diane.quigley@cumis.com'; 'isabelle.choquette@dsf.ca'; 'eleanore.fang@td.com'; 'Beauchamp, Jason'; 'Carol.Allen@assurant.com'; 'Lewsen, John'
Cc: 'Brendan Wycks'; Manson, Sue; 'Bourdeau, Joane'
Subject: RE: Letter to Joanne Abram re: Critical Illness benefits sold as Creditors' Group Insurance and under a RIA license

EOC colleagues,

Brendan and I chatted with Joanne Abram & Anthonet Maramieri from the AIC today and were told that, in fact, no decision had been made by the council. Rather, they are gathering information regarding the types of products that can be sold under a Restricted Certificate of Authority. The information collected will be put in front of the council in September or October. Whether we would have a chance to make a formal in-person presentation to the council was unclear but we can certainly ask to do so.

Joanne did not dispute the arguments I put forward (from our letter) but rather focused on what products are appropriate to be sold under a Restricted Certificate of Authority. To that end, it was suggested that we include information on how our products are sold and how we train our sellers. They also requested that we include a copy of an application. We also briefly discussed the simplicity of our products so perhaps a copy of a certificate would be a useful addition. I have included a transcript of Joanne's May email to Brendan on this subject and what she said then is actually not inconsistent with what we learned today.

Monday, May 09, 2016 2:34 PM
To: Brendan Wycks (brendan.wycks@cafii.com)
Subject: Life Insurance Council Review of Restricted Certificate Holders

Good afternoon, Brendan.

I just wanted to follow up with you as agreed after the Life Insurance Council (LIC) met in April and had the opportunity to consider the information gathered from the AIC review of the types of products offered by holders of Restricted Certificates of Authority (RCHs).

As we previously discussed, the purpose of the AIC review was to ensure that the products being sold were consistent with the products approved for sale by RCHs. During the course of the review, we found numerous instances where Critical Illness Insurance was being sold under a Certificate authorizing "Credit Related Insurance."

Credit Related Insurance, as approved by the LIC, includes creditors' group life insurance, creditors' group disability insurance, and creditors' loss of employment insurance. Critical illness insurance was not approved to be sold under a Restricted Certificate of Authority.

If your member companies wish to distribute this product through RCHs, a request would need to be made to the Life Insurance Council. Any request should include full product details, copies of application forms, copies of all information and disclosures provided to consumers on purchase, as well as information on the claims processes in place.

Further information on this issue will be provided as it becomes available.

In any case, we will be revising our submission to reflect todays discussion and will send out a new draft for review later this week. Much of the new content is contained in previous submissions, most recently regarding FICOM's 10-year review of the FIA and the "effecting issue", so we have a lot of good content to work from.

Greg

July 5, 2016

By Email

Joanne Abram
Chief Executive Officer
Alberta Insurance Council
10104 - 103 Avenue
Edmonton, Alberta
T5J2Z1
Canada

Ms. Abram:

Re: Critical Illness Insurance Benefits sold as Creditors' Group Insurance under an RIA Licence

This is a follow up to my letter dated the 10th of February 2016 and our conversation on the 12th of July.

We seek to address Council's concerns with respect to the distribution of creditors' group insurance which includes a critical illness insurance benefit and which is distributed in Alberta under a restricted insurance agent's certificate of authority. Our hope is to address Council's concerns while at the same time ensuring that our members continue to be comfortable that they can offer creditors' group insurance products to residents of Alberta which may, among other benefits, include a critical illness insurance benefit.

Can a critical illness benefit be offered under Alberta Law?

The following provisions are found in the *Insurance Act* (Alberta) (the "*Act*") and the *Insurance Agents and Adjusters Regulation*, Alta Reg 122/2001 (the "*Regulation*"):

There is the definition[1] of credit related insurance:

> *1(5) "credit-related insurance" means*
>
> *(a) creditor's group insurance, or*
> *(b) insurance effected by a creditor against the risk of default by a debtor due to involuntary loss of employment.*

The following is the definition of "creditor's group insurance[2]":

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[1] Section 1(5) of the *Regulation*

1(2) In subsections (3) and (5),

(a) "creditor's group insurance" means insurance effected by a creditor whereby the lives or well-being or the lives and well-being of a number of its debtors are insured severally under a single contract;

A group insurance policy issued to a bank which will pay all or part of the amount of a debt to the bank, in the event of an illness, insures the "well-being" of the group person insured. Such a group policy is therefore creditor's group insurance within the definition set out in the Alberta *Regulation*. Such a group policy does insure the well-being of a number of debtors severally under a single contract, as anticipated by the definition of creditor's group insurance under Alberta law.

The following are prescribed contracts of group insurance for the purposes of the definition of "insurance agent" under section 1(bb)(v) of the Act:

(a) creditor's group insurance;

There is also the Order of The Life Insurance Council and the General Insurance Council made in October of 2012 (the "Order") which specifies the classes or types of insurance for the purposes of Section 454[3] of the Act. Under the Order as currently drafted, a deposit taking institution may offer "credit related insurance". As "credit related insurance" is not further defined within the Order, it must be taken to mean what is set out in the *Regulation*. The definition set out in the *Regulation* includes creditors' group insurance which refers to "well-being". (There is no reference to disability.)

Can Banks offer a critical illness benefit under The Bank Act and Regulations?

As you are aware, there are provisions of the *Bank Act* and the *Insurance Business (Banks and Banks Holding Company) Regulations* (the "*IBBR*") which are relevant to the powers of banks to promote and administer insurance. In our view, the provisions of Alberta law summarized above align with these provisions of the *Bank Act* and the *IBBR*.

In particular, the *IBBR* grants to banks broad powers to promote authorized types of insurance.

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[2] Section 1(2) of the *Regulation*

[3] This is the section that states that a restricted insurance agency certificate may be issued to a deposit taking institution and such certificate of authority authorizes the holder and the holder's employees to act or offer to act, subject to prescribed conditions and restrictions, as an insurance agent in respect of classes or types of insurance specified by the Minister (or in this case by the Minister's delegate which is Council).

Creditors' disability insurance is one such authorized type of insurance. It is specifically defined in the *IBBR* as follows:

> *Creditors' disability insurance**,** in respect of a bank, means a group insurance policy that will pay all or part of the amount of a debt of a debtor to the bank, or to a loan company that is an affiliate of the bank, in the event of bodily injury to, **or an illness** or disability of,*
>
> > ***(a)** where the debtor is a natural person, the debtor or the spouse or common-law partner of the debtor,*
> > ***(b)** a natural person who is a guarantor of all or part of the debt,*
> > ***(c)** where the debtor is a body corporate, any director or officer of the body corporate, or*
> >
> > ***(d)** where the debtor is an entity, any natural person who is essential to the ability of the debtor to meet the debtor's financial obligations to the bank or to the loan company;*
> > *(assurance-invalidité de crédit)*

This definition is such that banks are specifically empowered under the *IBBR* to offer, as an authorized type of insurance, creditors' group insurance that covers illness (including a critical one) regardless of whether the effect of such illness is to render the insured disabled from his or her employment.

As such, there is no apparent inconsistency as between the *IBBR* and the *Act* and the *Regulation* and all of those allow a deposit taking institution to offers creditors' group insurance that includes illness benefits, including critical illness benefits.

Policy reasons to support the offering of Creditors' Group Insurance with a Critical Illness Benefit

Even if Council does not accept what seems to us clear on the face of the *Alberta Act* and the *Regulation*, the matter can be resolved if Council accepts that a bank should be able to offer creditors' group insurance which covers loss of life, disability and critical illness.

While Disability Insurance provides a benefit for those Albertans who are working and become disabled, Critical Illness provides benefits regardless of the individual's employment status. This could be a person on voluntary unpaid leave, a stay-at-home mom or dad, or a person who is retired. The inclusion of the critical illness benefit was motivated by the reality that a debtor or the debtor's spouse may be in one circumstance at the time of enrolment and another over time and in the period preceding the time of claim. In short, creditors' coverage which includes a critical illness benefit is broader and better for the consumer than a product that does not include critical illness benefits.

In addition, the typical critical illness benefit within creditors' group insurance will cover a limited number of illnesses, e.g. life threatening cancer, heart attack, stroke, coronary artery by-pass surgery, major organ failure requiring transplant, and paralysis. This is very different from individual critical illness insurance which typically covers upward of 30 different and complex

conditions. As a result, what is covered, and hence what is not covered, can be easily understood by the consumer at the time of enrolment. It is worth noting that should this situation change, i.e., Creditors' Group Insurance Critical Illness benefits become more complex, Section 507 of the Act would allow the Minister (and Council as his or her delegate) to prohibit the use of such a policy form.

Training of sales staff and consumer protection

CAFII member client representatives are required to undergo comprehensive and recurring product training and instruction on the enrolment, claims and complaints process to ensure that they provide consumers with accurate and reliable information. They are trained to point out features and limitations of the insurance and answer consumer questions. Their training ensures that representatives offering insurance have the knowledge and skills to do their jobs and serve clients well. The activities of our CAFII member client representatives – the majority of whom are salaried staff – are also well-supervised whether they work in branch or in client contact centres.

In the case of most CAFII members, the selling of creditor insurance products is federally regulated and consumers are well-protected through the financial institutions' compliance with the CBA Code of Conduct for Authorized Insurance Activities. This Code – part of the CBA's suite of Voluntary Commitments and Codes of Conduct – applies to all authorized insurance products promoted in Canada. The CBA's Voluntary Commitments and Codes of Conduct are non-legislated commitments that banks have made to their consumers in a number of areas. The banks' federal consumer regulator, the Financial Consumer Agency of Canada, oversees the banks' compliance with them and has enforcement powers through a variety of redress mechanisms.

All CAFII members also follow relevant CLHIA Guidelines, including Guideline G7 Creditor's Group Insurance, G9 Direct Marketing, and G5 Travel Insurance. These guidelines are in the public domain and CLHIA members are accountable to the public and regulators. In addition, CAFII members have been focused on consumer financial literacy for many years through the use of plain language and clear communication in their insurance products. Our members adhere to the FCAC's *Commissioner's Guidance on Clear Language (CG-3)* and the CLHIA's reference document *A Model Demonstrating Clear Communication Principles and Techniques Using Examples From Insurance Policies*. CAFII members provide marketing materials and insurance policies and certificates, detailing coverages and exclusions in a manner that is easy to understand; and they are always working to improve clarity. Consumers can take their time to do a full review of all materials during the "free look" period - typically 30 days - during which time they can cancel and receive a full premium refund.

As requested in our conversation of July 12, 2016, a sample of an application and certificate is included with this letter. For this purpose, I have included the TD Application for Mortgage Critical Illness and Life Insurance along with the Product Guide and Certificate of Insurance and could provide the same for our other member companies if you would find that helpful.

If Council feels that further clarity is required it could consider a revision to the Order. We have provided as Appendix "A" a mark-up of how Council could achieve additional clarity within an amended Order.

We hope you will find this information in this submission informative. Our hope is that after having reviewed our interpretation of the *Act* and *Regulation* you will conclude, as we have, that further clarity is not required based on the provisions of the *Act* and *Regulation*. If, however, you are of the view that further clarity is required, we hope you will be amenable to achieving that clarity through the simple amendments to the Order we have proposed in Appendix "A".

We look forward to having a chance to discuss this this in further detail when this comes forward to Council. In the meantime, should you have any questions on anything contained in this letter, or have any additional questions, please do not hesitate to get in touch with me through our Executive Director, Brendan Wycks at ...

Sincerely,

Greg Grant
Board Secretary and Chair, Executive Operations Committee
Canadian Association of Financial Institutions in Insurance

Appendix "A"
[date]

GENERAL INSURANCE COUNCIL
LIFE INSURANCE COUNCIL

Acting under delegation from the Minister the General Insurance Council and Life Insurance Council herein specify the following classes or types of insurance for purposes of section 454 of the Insurance Act.

Equipment Warranty Insurance
Cargo Type
(Insurance covering goods in transit excluding carrier liability insurance)
Travel Insurance
Group Travel Insurance
Credit Related Insurance
(Covering loss of life, disability, injury or illness, or involuntary loss of employment)
Personal Accident Type
(Group Insurance covering injury due to accident and hospitalization)
Funeral Services Insurance Type

The following businesses or prescribed enterprises may apply for certificates to act as restricted insurance agents with respect to the classes/type identified.

Automobile Dealership: Equipment Warranty Insurance and Credit Related Insurance

Equipment Dealer: Equipment Warranty Insurance and Credit Related Insurance

Travel Agency: Travel Insurance

Transportation Company: Travel Insurance and Cargo Type

Deposit Taking Institution: Credit Related Insurance, Group Travel Insurance and Personal Accident Type

Sales Finance Company: Credit Related Insurance

Customs Broker: Cargo Type

Freight Forwarders: Cargo Type

Funeral Services Business: Funeral Services Insurance Type

This specification was made at properly conducted meetings of the General Insurance Council and Life Insurance Council and takes effect on [ ]

NEWS RELEASE

For Immediate Release | Canadian Council of Insurance Regulators

CCIR releases documents for consultation

4 July 2016

TORONTO – As announced after the Canadian Council of Insurance Regulators' (CCIR) Spring meeting in April 2016, CCIR is publishing its Travel Health Insurance Products Issues Paper and its Natural Catastrophes and Personal Property Insurance Issues Paper for public consultation.

Travel Health Insurance Products Issues Paper
Canadians rely upon travel health insurance to protect them from financial hardship when travelling outside the geographical boundary of coverage of other insurance they hold (e.g. provincial health insurance plans).

Growing concerns, however, have been raised over public confidence in Canada's travel insurance market, which led the CCIR to believe that there is a potential for misalignment between consumer expectations and industry practices for travel insurance. Therefore, the CCIR has begun to assess issues related to travel health insurance in Canada in order to identify knowledge and expectation gaps that would need to be filled to enhance consumers' protection and confidence.

The CCIR's Travel Health Insurance Products Issues Paper documents the preliminary understanding that CCIR has regarding issues throughout the entire lifecycle of the travel health insurance product from product design, marketing and sales practices, involvement of third party service providers, claims management, complaint handling, consumer and seller education and data collection.

CCIR is seeking public comment on the issues raised in the paper which will inform what work needs to be done to enhance consumers' protection and confidence.

The consultation period for this issues paper will be 90 days. The deadline to provide written submissions is **September 30, 2016**.

Natural Catastrophes and Personal Property Insurance Issues Paper
Over the past few years there has been considerable media attention on natural catastrophes in Canada and changes in coverage for personal property insurance products as a result thereof. The increase in severity and frequency of natural catastrophes, not just in Canada but also globally, has brought to light potential concerns regarding the product, policy coverage options and exclusions. In addition, the CCIR is concerned that consumers may not be aware of the risks posed by natural catastrophe-related events and the consequences of limited insurance coverage for some of those events.

This Natural Catastrophes and Personal Property Insurance Issues Paper documents the preliminary understanding that CCIR has regarding the impact of natural catastrophes (from water-floods, windstorms, wildfires, earthquakes and hail-ice storms) on the personal property insurance marketplace in Canada.

Following the consultation, CCIR will be in a better position to determine what work, if any, needs to be done to ensure acceptable levels of consumer protection and an innovative and competitive marketplace for personal property insurance in Canada.

The consultation period for this issues paper will be 90 days. The deadline to provide written submissions is **September 30, 2016**.

Both issues papers are available on CCIR's website (www.ccir-ccrra.org). CCIR encourages all interested parties to review and comment on the respective papers. Electronic submissions would be preferred via the CCIR Secretariat email: ccir-ccrra@fsco.gov.on.ca. Please note that CCIR intends to publicly release all submissions received pursuant to this consultation process by posting them on the CCIR website unless otherwise requested.

About the CCIR:

The Canadian Council of Insurance Regulators is a national association of insurance regulators that traces its roots back to 1914. The mandate of the CCIR is to support an efficient and effective insurance regulatory system in Canada to serve the public interest.

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TRAVEL HEALTH INSURANCE PRODUCTS
ISSUES PAPER

A document prepared by the
Canadian Council of Insurance Regulators (CCIR)
Travel Insurance Working Group

This document reflects the work of regulators who are members of CCIR and is intended to generate discussion. The views expressed should not be considered as legal opinions.

This document does not necessarily represent the official position or views of any provincial, territorial or federal government or agency.

JULY 2016

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EXECUTIVE SUMMARY

This Issues Paper (the "Paper") outlines the preliminary understanding of the Canadian Council of Insurance Regulators ("CCIR") in respect to the Canadian Travel Health Insurance marketplace.

At a time when the fair treatment of consumers is at the heart of international concerns, CCIR believes that it is essential to assess potential issues related to Travel Health Insurance ("THI") and consider options to enhance consumers' protection and confidence. CCIR feels that, for this particular product, there is a potential for misalignment between consumer expectations and industry practices based on identifiable knowledge and expectation gaps.

This Paper considers each of these gaps in a holistic manner, based on the entire lifecycle of the THI product. To that effect, the Paper reviews the design and market conduct practices of travel health insurers in Canada. Specifically it addresses potential issues with product design, marketing and sales, involvement of third party service providers, claims management, complaints, education and data collection.

Specific questions to stakeholders are included in the Paper.[1] However CCIR invites stakeholders to provide any relevant feedback that could assist the regulators to address issues and improve the fair treatment of consumers. Such consultation with industry and other stakeholders should yield results that should ultimately be beneficial for consumers and industry alike.

[1] A list of these questions is attached as Schedule 1 to this Paper.

1- CANADIAN COUNCIL OF INSURANCE REGULATORS

CCIR is an inter-jurisdictional association of provincial, territorial and federal insurance regulators. The provincial and territorial regulators are responsible for market conduct regulation and legislative compliance of insurers authorized in their province or territory. They may also have responsibility for the solvency of insurers incorporated in their jurisdictions.

One of the major goals of CCIR is to facilitate harmonization of insurance regulation across Canada to benefit both consumers and the insurance industry. Working towards a harmonized approach promotes efficiencies and cost savings while providing consistent protection to consumers across Canada.

It is recognized that individual jurisdictions may need to accommodate any local or regional issues in implementation.

2- INTRODUCTION

As provincial health insurance plans reimburse only a very small portion of medical expenses incurred outside of Canada[2], Canadians rely upon travel insurance to protect themselves from financial hardship when travelling outside the geographical boundary of coverage of other insurance they hold (e.g. provincial health insurance plans).

Canadian travelers get travel insurance because they wish to be covered for medical care received as a result of an accident or illness that occurs outside of their home province. Consumers who purchase travel insurance believe that their coverage will provide them with complete protection from hefty bills resulting from medical treatment. However, this is not always the case due to, for example, pre-existing conditions, length of travel, or ineligibility. This can lead to adverse financial consequences when, for example, consumers end up being unable to cover significant medical bills without the benefit of insurance or when their claims are denied as a result of a misunderstanding on their coverage. When publicised by the media, such events can be detrimental to consumer confidence in the role of travel insurance and the reputation of insurers and industry.

In response to growing concerns over public confidence in the market and the manner in which THI is manufactured and distributed, CCIR formed a working group on travel insurance at its fall 2014 meeting (the "Working Group").

2.1 Travel Insurance Working Group

The Working Group is composed of representatives from the CCIR and from the Canadian Insurance Services Regulatory Organizations ("CISRO"). The Working Group's mandate is to improve consumer's confidence in the THI market and to promote harmonization in regulatory approaches to travel insurance in Canada.

[2] Provincial government health plans generally cover only the medical care provided within the geographical area of the province. However, there is an interprovincial agreement that allows a resident of Canada to receive services in a hospital of another province upon presentation of the health insurance card without having to pay for them.

At the Fall 2014 CCIR meeting, the Working Group was tasked with identifying practices that are causing harm, or have the potential to cause harm to the public, and to develop recommendations to address them in order to prevent loss of consumer confidence. In achieving this mandate, the Working Group was also asked to consult with industry stakeholders where possible.

The work of the Working Group is in alignment with CCIR's strategic priorities of identifying common emerging issues (fact gathering), and engaging stakeholders and policy makers so that the right information is in the hands of those in charge of making policy decisions in a timely manner. It is also in alignment with CCIR's risk-based approach to regulation.

The Working Group undertook a thorough review of the Canadian THI market in order to identify and better understand the issues. The Working Group conducted a survey in 2015 and liaised with various industry stakeholders such as:

- The Canadian Life and Health Insurance Association;
- The Travel Health Insurance Association;
- The Canadian Association of Financial Institutions in Insurance;
- The General Insurance Ombudservice; and
- The Ombudservice for Life and Health Insurance.

In addition, the Working Group called for public submissions in February 2015 and received 27 submissions. Finally, the Working Group considered disclosure documents, policies and other material made available and obtained through the course of the regulatory activities of its members.

2.2 The Purpose of this Issues Paper

This Paper aims to set out the context and situation of the THI market as CCIR believes it currently exists. It reflects what the Working Group has learned from the 2015 survey and other findings based on the above-mentioned materials. It is intended to stimulate discussion, launch a process of consultation as well as to educate and build a common understanding of the topics and issues for both regulators and stakeholders.

CCIR seeks to engage stakeholders (from both the industry and the public), on the accuracy of its findings and to obtain their views on how best to achieve the fair treatment of customers in the THI market. More specifically, stakeholders are asked to provide their input on:

- Whether CCIR's understanding of the topic and issues as presented is accurate;
- Whether all significant issues have been identified; and
- Whether the proper questions have been asked to mitigate the issues and gaps identified in this Paper.

Some of the stakeholders identified above have already presented to the Working Group some initiatives they have undertaken or plan to undertake to enhance consumers

experience with THI. CCIR acknowledges the engagement of the industry and will continue to work with these stakeholders in light of the issues raised in this Paper.

Throughout this Paper, THI means any product containing health-related coverage complementary to provincial or territorial health insurance plans only. It excludes products sold to visitors, students living temporarily in Canada and expatriates. It also excludes insurance products sold to Canadians travelling within Canada and employer group insurance products where the insurer provided administrative services plans ("ASO") only.

2.3 Fair Treatment of Customers

Fair treatment of consumers is increasingly becoming the central focus of international bodies' standards and principles. Both international standards setters and governments are raising the bar in market conduct regulation by emphasizing the importance of treating consumers fairly. Over the past years, the insurance industry has begun to adapt its practices to these new or improved requirements, the most important being the Insurance Core Principles ("ICPs") 18[3] and 19[4] of the International Association of Insurance Supervisors ("IAIS").[5]

Although it is not the aim of this Paper to examine at length the compliance of the THI industry to the ICPs, it is important to summarize some of their key aspects in order for the Paper to achieve its purpose.

ICP 19, which relates to conduct of business, established the necessity for the "supervisor to set requirements for the conduct of the business of insurance to ensure that customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied".

The standards found under ICP 19 are aimed at helping to strengthen public trust and consumer confidence in the insurance sector. The IAIS does not prescribe a specific approach or expectation regarding the fair treatment of customers. It does, however, suggest that insurance supervisors and insurers should focus on achieving outcomes such as the following:

- Developing and marketing products in a way that pays due regard to the interests of customers;
- Providing customers with clear information before, during and after the point of sale;
- Reducing the risk of sales which are not appropriate to customers' needs;
- Ensuring that any advice given is of a high quality;

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[3] "*ICP 18 Intermediaries*
The supervisor sets and enforces requirements for the conduct of insurance intermediaries, to ensure that they conduct business in a professional and transparent manner." www.iaisweb.org

[4] "*ICP 19 Conduct of Business*
The supervisor sets requirements for the conduct of the business of insurance to ensure customers are treated fairly, both before a contract is entered into and through to the point at which all obligations under a contract have been satisfied" www.iaisweb.org

[5] "*IAIS is the international standard setting body responsible for developing principles, standards and other supporting material for the supervision of the insurance sector and assisting in their implementation*." http://www.iaisweb.org/page/about-the-iais. *ICPs provide a globally accepted framework for the supervision of the insurance sector.*

- Dealing with customer complaints and disputes in a fair manner;
- Protecting the privacy of information obtained from customers; and
- Managing the reasonable expectations of customers.

ICP 19 also states that the fair treatment of customers should form an integral part of an insurer's business culture and be promoted by its management structure and embedded in all of its key functions (strategy, decision making, internal controls, etc.).

More importantly, the IAIS expects that practices and outcomes should take into account the nature of the customer and the type of insurance sold.

3- THE TRAVEL HEALTH INSURANCE SURVEY

CCIR Members conducted a survey in 2015 to obtain information from regulated insurers about THI products sold in Canada. The survey was sent to 241 insurers and was designed to gather information on their 10 main travel insurance products for the 2014 calendar year.

The Working Group encountered challenges in analyzing the data from the survey. It appears that the data requested is not systematically collected and/or monitored by the industry. As a consequence, the Working Group noticed that some of the requested data was missing and that there were inconsistencies in some of the information provided. This prevented the Working Group from conducting the in-depth analysis it initially wanted to achieve. Still, significant parts of the survey were found to be reliable and this allowed the Working Group to make notable observations.

In total, 33 insurers and financial groups[6] responded that they offered THI products to Canadians in 2014. Most of them (64 percent) offered their products in all of the Canadian provinces and territories. The survey identifiedthat there were 614 individual and 170 group THI products on the Canadian market in 2014. It is important to note, however, that the survey was focused only on the 10 main products listed by each insurer and that the findings of the Working Group focused solely on 145 individual insurance and 101 group insurance THI products which generated about $839 million in gross written premiums (net of voids) in 2014.

The survey also indicated that more than 12 million individual policies and group insurance certificates were issued for these main products during that period and each policy could grant coverage to one or more persons (e.g., insured's partner or children).

The survey results also illustrated that these products were offered to Canadians through three main distribution channels. In no order, they were:

- Credit cards;
- Licensed agents; and
- Travel agents / agencies / other exempt sellers (jurisdictions without restricted certificates).

[6] See the list under Schedule 2.

The survey indicated that claims were made on about 2 percent of the total number of policies/certificates issued with approximately 7 percent of those claims denied and approximately 50 percent of the total premiums paid out in benefits. The survey did not provide reliable data on the number of policies voided. The denial rate was approximately the same for both, individual and group coverage, the leading reason for claim denial being that there was "no coverage"; however, the survey results did not provide sufficient details to allow the Working Group to identify specific situations or circumstances to explain denials based on this motive. The second reason for claim denial was "exclusions", either for pre-existing conditions or other exclusions.

The Working Group observed that there were twice as many group insurance certificates issued compared to individual insurance policies. However, keeping everything in proportion, there were almost twice as many claims submitted in individual insurance compared to group insurance. The survey results also suggest that complaints represent less than 0.5 percent of all claims submitted.

Based solely on these results and despite the lack of a complete in-depth analysis of the THI market, the Working Group could have concluded that there is no need for immediate regulatory action to address the issues found within the THI industry.

4- COMMON FEATURES AND PRACTICES IN TRAVEL HEALTH INSURANCE IN CANADA

THI provides protection for unexpected medical emergencies that may occur while travelling. Generally speaking, THI products are designed to cover Canadian residents who are insured under a Canadian Government or Provincial Health Insurance Plan ("CGHIP" or "PHIP") during the entire duration of their insured trip. Coverage granted applies as a supplement to CGHIP and PHIP. The trip must take place outside of the province or territory of the insured's residence, or outside of Canada.

Travel insurance policies are typically a bundle of accident and sickness and property and casualty insurance ("P&C").[7] The common benefits of THI products are emergency hospital and medical costs due to a sudden and unforeseen illness or accidental injury. A majority of these insurance products also cover losses that result from trip cancellation or interruption due to health-related reasons, and might include P&C benefits like loss or damage of personal property during the trip and delayed arrival of personal baggage while on the trip.[8]

There does not seem to be standard THI products. THI products extend from one protection (i.e. trip cancellation) through full comprehensive coverage, they can be offered separately or in bundles and they can provide coverage for one specific trip or multiple trips.

[7] "Property and casualty" insurance is insurance that protects property from damage or loss.
[8] See a detailed list of typical protections in Schedule 3.

5- ISSUES AND GAPS

5.1 Product Design

5.1.1 The Complexity of Travel Health Insurance Products

THI products can be complex for consumers to understand, depending on the nature of the product and the type and situation of the consumer involved. Considered separately, THI protections are not excessively complicated but when offered in bundles they become more complex since they include several types of coverage (medical or non-medical) which are usually subdivided (emergency medical care, hospitalization, ambulance cost etc.).

The Working Group has observed that insurers often combine different coverage in order to create "plans". A single product will often present several plans (basic, general, superior, etc.) to choose from. Also, these plans may be offered under a single-trip plan, a multiple-trip plan or both. In these cases, insurers present modular clauses in the policy or certificate so that it can be adapted to different plans. In addition, each of the coverage may have its own effective date, exclusions, pre-existing medical conditions, etc. Most insurance products present information about at least two insurance plans.

Different plans often target different categories of consumers, based on their age and trip duration. Eligibility conditions and protections included will change according to the consumer's age and trip duration.

The Working Group believes that the complexity of the design of some THI products can be an obstacle to the consumer's ability to fully understand all available options and relevant limitations.

5.1.2 Terminology and Definitions

Although consumers tend to see THI as a homogenous product, the THI market is very diverse and insurers offer a wide range of products to consumers. The Working Group noticed that key terms and conditions used in these products lack standardized definitions and terminology. The vocabulary and definitions seem to vary not only from one insurer to another but also from one product to another offered by the same insurer.

In the course of their supervision activities, the Working Group members noted that the same concepts were sometimes referred to with different expressions/words. They also noted that the same words were used to represent different key concepts. The Working Group members also observed that the meaning given to certain key words, such as "*emergency"*, "*sickness"* or "*treatment*" to name a few, do not always have the same scope and in some cases, the insurance terminology commonly accepted by the industry seems to be misused.

For example, the Working Group has seen the expression "*insured risk"* to describe the events that will generate the benefit under a risk covered by the insurance rather than describing the risk itself.

Navigating the vast array of available THI products and options can be confusing for the uninitiated. The lack of consistency in the use of terminology and the absence of

standardized definitions adds to the confusion. In fact, it makes it hard for consumers or anyone else to compare and understand products. The Working Group believes that this could also compromise the consumer's ability to understand the extent of the coverage of a particular product, thus to make informed decisions.

Questions at Issue – Design of a THI Product

1. What terms or expressions should be defined and standardized in order to allow a better understanding of THI products by consumers, and enable them to more readily compare products and make informed decisions?

2. What other initiatives related to product design could be put in place by the industry to help consumers better understand the extent of the coverage offered and the terms and exclusions, so they can make informed decisions?

3. What type of controls should be put in place at the insurer or other levels in order to ensure that consumers of THI products are treated fairly?

5.1.3 Underwriting of Travel Insurance Products

Underwriting is "the process of selecting risks and classifying them according to their degrees of insurability so that the appropriate rates may be assigned." [9]

Under a traditional underwriting process of a life and health insurance product, the applicant answers personal detailed medical questions in his or her application form and the insurer then decides whether it will accept or refuse to cover the risk. Acceptance by the insurer can be subject to specific conditions.

In contrast, THI products are often based on automatic acceptance. In fact, based on the replies to the survey, the Working Group observed that 95 percent of the applications for THI products that were sold in 2014 had been accepted automatically; the applicants may have answered general medical questions in the application form but did not undergo any additional underwriting process beyond that. In such situations, premiums are determined according to the value and duration of the trip and the consumer's age rather than his or her medical condition. The Working Group considers this to be an exceedingly high automatic acceptance rate and is surprised that so few applicants have to undergo medical examinations during the underwriting process.

5.1.3.1 Exclusion, Restriction and Limitation Clauses

The Working Group believes that the high automatic acceptance rate of applications may be due, at least in part, to the existence of exclusion, restriction and limitation clauses, including those pertaining to pre-existing medical conditions, which spare insurers from conducting further medical underwriting at the time of subscription.

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[9] GOUVERNEMENT DU CANADA, TRAVAUX PUBLICS ET SERVICES GOUVERNEMENTAUX CANADA, 2016, *TERMIUM Plus, la banque de données terminologiques et linguistiques du gouvernement du Canada,* un produit du Bureau de la traduction, [Electronic resource], online : <http://www.btb.termiumplus.gc.ca/tpv2alpha/alphara.html?lang=fra&i=1&srchtxt=ressource&index=alt&codom2nd_wet=1 > (Electronic visit : February 18, 2016).

Pre-existing medical conditions are health-related problems that have existed before a consumer applies for insurance. In general, insurers will exclude known pre-existing medical conditions from coverage or charge higher premiums to cover them.

Where exclusions, restriction and limitation clauses, including those related to pre-existing medical conditions, are used rather than a traditional underwriting process, the burden of determining the limits of coverage that apply to the insured lies with the applicant.

This burden is particularly heavy when exclusion for pre-existing medical conditions could be applicable. These exclusions can be particularly difficult for consumers to interpret and understand,[10] given that the health related conditions are often described in medical terms that are not accessible to all. The issues regarding the lack of standardized terms and definitions previously raised can also compound matters further.

The Working Group is concerned that consumers might not be in a position to understand the key conditions and exclusions that may affect their eligibility or suitability to a given product. Often, consumers do not expect that THI products will contain such clauses or simply don't fully understand the scope of such clauses, thus creating expectation and knowledge gaps. Price and speed of getting coverage then become overriding considerations for those consumers.

Speed is sometimes a crucial consideration for the consumer. When consumers make late travel decisions, they do not have time to undergo the whole underwriting process. Choosing a THI product with automatic acceptance allows them to get insurance in a timely-manner. Speed simplifies the consumer's ability to obtain the THI product while placing him or her in a position where he or she might not have the needed and expected coverage.

These underlying factors and the expectations which they create likely contribute to the perception, amongst consumers, that applications are reviewed post-claim[11]. This, in turn, can affect the reputation of the THI industry and the efforts deployed by its stakeholders to continuously improve products and practices.

While the efforts deployed by the THI industry to mitigate this perception is commendable, the Working Group is concerned that the type of information required to understand restrictions, limitations and exclusion clauses might not always be known or available to applicants. It might therefore not be fair to apply such clauses without proper informational or educational material. Even with proper informational and educational material, the Working Group wonders to what extent a consumer having no medical credentials can make an informed decision when purchasing a travel insurance product as the majority of them are currently designed.

[10] Furthermore, the Working Group has observed a new trend: pre-existing condition clauses that apply to people other than the insured. Pre-existing condition clauses may apply to the person hosting the insured during his or her trip. For instance, one insurer mentioned in its disclosure documents that no trip cancellation benefits will be paid if the trip is cancelled because of a medical problem sustained by the host, if this problem was not stable in the year before the trip. That is to say that the insured must be made aware of all medical problems of his or her host in the year that precedes his or her trip.

[11] See section 5.4 for more details.

Questions at Issue – Exclusion, Restriction and Limitation clauses

4. How could the industry improve consumers' awareness about and understanding of exclusion, restriction and limitation clauses, especially pre-existing medical conditions?

5. What changes could be made to the application process to ensure that consumers have sufficient knowledge to have a thorough understanding of exclusions for pre-existing medical conditions as well as to complete an application for THI, thus enhancing consumer confidence in the underwriting process?

5.1.3.2 Suitability

When opting for a product with automatic acceptance, the burden of determining whether a given insurance product is suitable lies with the applicant. This fact does not seem to be clear to some consumers and the acceptance of an application, even though it is automatic, may give a false sense of security among consumers or create unrealistic expectations.

THI products are offered for a very large pool of individuals whose age and medical condition may vary. Certain products with automatic acceptance might not be suitable for someone with a medical history and again, it seems therefore important that consumers be made aware:

- That the insurance product they are being offered does not involve an extended underwriting process on the part of the insurer; and

- That their particular health condition might not be covered and that it would be of benefit to them to turn to an insurance product with less exclusions and which involves going through an extended underwriting process.

Training is an important tool in bridging the gaps and issues found in this Paper. People offering these products, licensed or not, should be trained to recognize the situations mentioned above and act accordingly. At this time, the Working Group notes that exempt sellers do not have training in insurance (except for that provided by the insurer about the exempted product) nor any obligation to know the consumer's needs or to determine the suitability of the product they are offering.

To ensure the fair treatment of consumers, the Working Group believes that a pre-screening/flagging process might be relevant to identify customers who should first speak with a THI expert or undergo a more thorough underwriting process before acquiring a THI product.

Fair treatment of customers involves achieving outcomes such as developing and marketing products in a way that pays due regards to the interests of consumers. Insurers are expected to take into account the interests of different types of consumers when developing insurance products, and thus the Working Group feels that insurers should carry out a diligent review of their THI products in order to ensure that they are

adapted to the consumers for whose needs the product is likely to be suitable, while limiting access by those for whom the product is likely to be inappropriate.[12]

Question at Issue – Suitability

6. How can the industry ensure that consumers are offered THI products that are suitable for their needs?

5.1.3.3 Medical Questionnaires

Applicants must answer complex and technical medical question that are important in the insurer's appraisal of the risk to be underwritten. The absence of clear definitions and standardized terminology mentioned above further compounds the acuteness of the issue of medical questionnaires. One of the common complaints raised by consumers and by industry observers is that they are too complicated even for medical experts to fully understand.

Yet, these medical questions or questionnaires are particularly important for the application process and failure to properly complete them can lead to very serious consequences, such as denial of coverage or voidance.

Any error or omission to disclose a medical condition, whether related or not to a later claim, can lead to claim rejection and policy voidance, even when consumers answer medical questions in good faith and to the best of their knowledge and understanding. Fully understanding the significance and scope of such questionnaires as well as being able to understand the questions themselves is of the utmost importance to consumer protection and the overall client experience.

Furthermore, the review of the survey data has allowed the Working Group to realize that when there was a medical questionnaire to be filled, it was, in few cases, the applicant who was responsible for answering the medical questions on every traveller's behalf. In practice, this can speed up the application process, but since applicants may not be aware of the other travellers' pre-existing conditions, nor that other travellers might wish to add information pertaining to pre-existing conditions, the Working Group is concerned that this way of doing things might alter consumers' confidence in the THI industry.

Question at Issue –Medical Questionnaires

7. How can the use of medical questionnaires by insurers be improved in the context of the underwriting of travel insurance products, in order to ensure fair treatment of customers?

[12] ICP 19.

5.2 Product Marketing and Sales

5.2.1 Disclosure Obligations and Sales

The design of THI products can be extremely complex. Insurers offer a wide variety of protections that can be combined to create plans which may be offered for a single trip or multiple trips.

The Working Group emphasizes again that THI products may contain numerous exclusions and that the burden to understand their scope and significance is left mainly to the consumer. Under such circumstances, it is crucial for consumers to receive clear and comprehensive information on the THI product in a timely manner.

The Working Group expects the information to be provided in a way that is clear, fair and not misleading. The information disclosed should enable customers to understand the characteristics of the product they are buying and help them understand whether and why it meets their requirements. It should allow consumers to fully understand the extent and limits of the coverage they are purchasing.

The Working Group has found that the information provided is not always drafted in plain language and not sufficiently comprehensive, to the point where consumers do not seem to have a full understanding of the THI product. Indeed, the survey indicated that of all claims denied, 21.6 percent in individual insurance and 48.1 percent in group insurance were denied because the claims were “not covered”. Although, this did not represent a significant portion of the amounts claimed,[13] the Working Group considers this ratio to be high. In addition, 30 percent of the claims made with regards to individual THI products were denied because of exclusions (for pre-existing conditions as well as exclusions for other reasons).

This strengthens the Working Group's position that disclosure is an important issue and that coverage and exclusions should be better understood. Documents and timing of disclosure appear to be key issues.

5.2.1.1 THI Documents[14]

Besides having complex designs, THI products target a wide range of consumers of different ages, education and literacy. Therefore, these products would benefit from documentation that would meet the utmost standards of legibility.

The complexity of THI products partly lies in the variety of protections that may be offered in bundles or combined to create plans that may be offered under a single-trip plan, a multiple-trip plan or both. A single product will often present several plans (basic, general, superior, etc.) to choose from. Each plan may have its own characteristics (effective date exclusions, pre-existing medical conditions, etc.) and often target different categories of consumers, based on their age and trip duration (eligibility conditions and protections included will change according to the consumer’s age and trip duration).

[13] Approximately 10 percent of the amounts claimed.

[14] For the purpose of this paper “THI documents” mean any document pertaining to THI products. This includes namely insurance contracts, applications and disclosure documents.

Currently, all these combinations are typically disclosed in legal and technical language, generally within a single insurance contract and in one disclosure document. This practice results in lengthy and illegible documents, where the information is abundant and scattered. The Working Group believes that such complexity in the products can lead to consumers not being as informed as they should be about the product and potentially, in their view, not being treated fairly.

5.2.1.1.1 Length and Complexity

The burden of fully understanding the product, particularly the limits thereof, lies to a large degree with the consumer; hence the importance of keeping the information simple and easily accessible.

We found that THI documents tend to be lengthy and complex. They describe all options and plans available in a single document while often many of the plans/coverage and options disclosed do not apply to the consumer's situation or needs. Because there are so many elements to disclose, the documents get more complicated and voluminous.

Example

Peter and John, two 64 year old retirees, are offered an insurance product where they can choose between single-trip insurance and multiple-trip insurance and from 14 plans and 8 coverages. The options are all described in the same 85 page booklet.

Depending on the package they choose, the conditions change. They must be:

- 60 years old or more for plan *A Superior*;
- Less than 85 for plans *B single-trip* or *C annual-trip comprehensive coverage;*
- Less than 70 for *$150,000 Plan D;*
- Less than 60 for *Plan E medical care only;*
- Etc.

Exclusions also vary:

- For a trip worth less than $15,000, their health condition must have been stable for 3 months before the insurance takes effect;
- For a trip worth $15,000 or more, it must have been stable for 12 months;
- For all Superior and Comprehensive plans:
    - People less than 60 years old must refer to exclusions nº 6 pertaining to pre-existing conditions;
    - People 60 or more who chose plan D+: no pre-existing condition exclusions apply;
    - People 60 or more who chose plan D: refer to exclusions nº 6 pertaining to pre-existing conditions;
    - People 60 or more who chose plans B or C: refer to exclusions nº 7 pertaining to pre-existing conditions;
    - Etc.
- For all Comprehensive plans, there are no pre-existing condition exclusions;
- Etc.

The Working Group observed that ancillary features[15] sometimes added in THI products are also explained within the THI documents. Though, these features may be interesting, they are not part of the THI and contribute to making the THI documents even more cumbersome.

As well, some insurers cross-reference sections in their THI documents. Doing so does not allow consumers to see the true impact of certain clauses. As such, consumers may not realize or easily understand which exclusions apply to their situation or how the application of these exclusions might be modulated depending on the regime which applies to them. Considering the importance of these factors, the Working Group feels that all information pertaining to each plan should be easily found and should not bring confusion between plans.

Example

June is reading documents pertaining to travel insurance she wishes to buy. In the disclosure documents, there are 15 different plans available, which include more or less benefits depending on her age and prior medical condition. In the disclosure documents, she finds:

- The disclosure document has 85 pages;
- Four pre-existing condition exclusion bundles have to be linked to the insurance plan chosen; they are found on pages 57 to 60;
- These exclusion bundles refer to definitions that are on pages 7 and 8;
- Other exclusions are found on pages 49, 57 to 63, 65, 69, 71 and 73.

Often, there is so much information and details scattered throughout the numerous pages of the documents that it makes it rather complicated and laborious for consumers seeking to find and understand relevant information on the product and compare it with others. The Working Group observed that the documents are often too difficult for the average consumer to read and understand.

In disclosure documents, the emphasis should be on the important elements rather than on extra or irrelevant components which may cause consumers to be distracted from the fundamentals or to not fully read the documents. The Working Group stresses that disclosure documents are intended to ensure the consumer has a proper understanding of the coverage, conditions, limitations and exclusions of the product in order to make an informed purchased decision. Current practices do not appear to meet this objective and, as such, do not treat customers fairly.

The Working Group also noted that, some disclosure documents are literal copies of the insurance contract to which information is added. Consequently, these documents tend to be longer than corresponding insurance policies/certificates. The objective of disclosure documents is then hardly reached.

As an example, in Québec, under the distribution without a representative regime (equivalent to incidental selling in other provinces), the Autorité des marchés financiers

[15] For example, the remittance of a gift certificate for another trip if the insured missed at least 70% of his or her insured trip in case it was interrupted because a family member has died.

noted that in 2015, 65 percent of travel insurance disclosure documents (i.e. distribution guides) filed in Québec[16] were more than 30 pages long.

Number of pages per distribution guide	Number of distribution guides	
Between 10 and 19	15%	
Between 20 and 29	20%	
Between 30 and 39	24%	65%
Between 40 and 49	17%	
Between 50 and 99	22%	
100 and over	2%	

The Working Group firmly believes that the length and complexity of THI documents, especially disclosure documents, is a barrier to customer's involvement and understanding. It would be advisable to focus on the quality of disclosure rather than the quantity of disclosure; we must bear in mind that when these documents become too voluminous, customers may be less likely to read the information and even less likely to understand it.

Moreover the Working Group is inclined to believe that effectiveness of disclosure documents would be improved by the introduction of a standardised format for disclosure (such as a product information sheet), which could enable consumers' understanding, aid comparability across competing products and allow for a more informed choice.

5.2.1.1.2 Language

Besides being complex and lengthy, THI contracts are not, as a rule, written in plain language. Rather, they are drafted using legal language and are not easily accessible to the average reader. But the Working Group has seen that applications and disclosure documents also tend to be legalistic and hardly legible. Thus, one of the common complaints heard from consumers is how confusing THI documents are.

The information provided should be clear, fair and not misleading.[17] The Working Group believes that some effort is required to improve the readability of THI documents, especially applications and disclosure documents.

5.2.1.1.3 Quality Control

In the course of their regulatory activities CCIR members have noticed that THI documents contain at times inconsistent or conflicting information. Regulators have found diverging information such as amounts of benefits, duration, nature of coverage, etc. among the documents pertaining to the same THI products.

[16] Some of these guides are also used in jurisdictions other than Québec.
[17] ICP 19 (19.4).

Example

> Richard bought multiple-trip *Travel Health Insurance*. In the disclosure documents the maximum trip length covered is 60 days while the insurance policy states 48 days.

This makes it even harder, if not impossible, for consumers to understand products. This also leads CCIR members to be concerned with the quality controls implemented by insurers over document preparation.

Questions at Issue – Disclosure Documents

8. How could insurers ensure that the information shown in the disclosure documents is limited to that which is essential, and that the format of these documents promotes a quick understanding of the fundamental information?

9. How could the industry improve disclosure documents so that they can be more easily understood by consumers?

5.2.1.2 Timely Disclosure

When buying any insurance product, including THI products, customers should be properly informed. The information provided should enable them to make informed purchase decisions before entering into a contract.[18]

In the context of THI, since products are offered through various channels including in person, online and through exempt sellers, and products themselves are quite complex, the need to ensure appropriate disclosure before the product is sold is all the more important. To make an informed purchase decision, consumers should be able to readily find the main characteristics of a product and fully understand the extent and limits of the coverage to enable their purchase decision.

The Working Group has been made aware of situations where disclosure documents are provided after the insurance has been purchased. As well, it has found that in the case of certain THI products no details of the coverage, exclusions, restrictions and limitations are provided until after the purchase is made.

The Working Group finds that the timing for the provision of information is not always suitable or acceptable. Disclosure documents should be provided upon the expression of interest by the consumer but before the purchase since these documents are intended to provide consumers with the information that will help them make an informed decision. Whereas the information provided after the point of sale, namely the insurance contract, should help them confirm whether or not they have made the right decision.

Questions at Issue – Timely disclosure

10. How can the industry ensure that consumers are informed of the key elements of the THI coverage in a timely manner, before they make a purchase decision?

[18] ICP 19 (19.5).

5.2.2 Distribution Channels

THI is available through several distribution channels as individual or group products. Consumers can get THI through licensed insurance representatives, deposit-taking institutions, travel agents, employee benefits plans, directly from insurers and as a credit card benefit (embedded or not).

According to the survey results, in 2014, THI products were mainly offered through these distribution channels:

- Group insurance was offered through credit cards in 77 percent of cases;
- Individual insurance was offered by :
    - Licensed agents (40 percent); and
    - Travel agents / travel agencies / other exempt sellers (36 percent).

From the survey, the Working Group noted that, keeping everything in proportion, the number of claims submitted with regards to group insurance certificates was half the number of claims presented in individual insurance policies, while there were twice as many group insurance certificates issued compared to individual insurance policies.

This leads the Working Group to conclude that there could be a relationship between the distribution channel mostly used with group THI, that is, “credit card”, and the fact that fewer claims were presented.

The survey did not allow the Working Group to establish a relationship between the distribution channels and the number of policies voided.

5.2.2.1 Credit Card

From the survey replies, the Working Group noted that 41 THI products were offered through credit cards (embedded[19] or not), in 2014. All credit card holders were automatically accepted.

THI products sold with credit cards (embedded or not) target a broad range of consumers of all ages and medical conditions.

Despite the expectations, where the insurance product is embedded in a credit card, full coverage does not necessarily apply to all consumers. Indeed, the extent of the coverage may vary depending on the consumer’s age, medical condition, etc. Consumers do not have to fill in an application form and they do not benefit from disclosure from a licensed agent or exempt seller to inform them if they are not eligible to full coverage promoted in the THI product embedded in their credit card. Hence, the importance of appropriate and timely disclosure in the context of THI products embedded in a credit card.

[19] Embedded insurance products are insurance products included in another product. In the context *THI*, insurance products might be embedded in credit card programs.

The Working Group is concerned with product embedded in credit cards because they seem to offer a broad insurance coverage while placing on consumers the responsibility to understand the scope of the coverage for which they are eligible.

Example

At least one insurer offers credit cards that include free Travel Health Insurance for a short period:

Jeff and Mary are leaving on a 14 day trip. They know that if they pay their travel with the credit card they've had for 5 years, free travel insurance coverage is granted. They are glad that they will not have to shop around for travel insurance.

The important thing that they do not remember is that this free THI coverage is granted for 3-day trips only. If their travel lasts for a longer period of time, they must contact the insurer in order to extend their coverage. Also, they will need to cover the entire duration of their trip but will pay for 11 days only.

If they omit to get the additional coverage, they will not be covered for the whole of the 14 days.

The Working Group has noted an issue with regard to disclosure documents. After having activated their credit card account, consumers are provided with booklets that explain all the advantages of their credit card as, for example, the credit card program, the reward program, the THI product, other insurance products, rebates on vehicle rental, shows and hotels, etc. These booklets appear to be the only disclosure document provided for THI products embedded in credit card. The Working Group is concerned that consumers' attention is diverted by the abundance of information and that the information about THI is overshadowed by other products.

Question at Issue – Credit Cards

11. What should the industry do to ensure that all consumers get an appropriate and timely disclosure relating to THI embedded in credit cards?

5.2.2.2 Insurers' Responsibility

CCIR members have been made aware that unlicensed individuals who do not qualify for exemptions are distributing travel insurance. Ultimately it is the responsibility of insurers to ensure that any person who is acting as an insurance intermediary be appropriately licensed or qualified for an exemption. They also need to ensure that their distribution channels, including those which make use of exempt sellers, comply with retailing regulations in each jurisdiction they conduct business in.

Insurers must have effective controls and oversight of their distribution networks. As well, CCIR has long taken the view that insurers are ultimately responsible for ensuring that anyone selling their products have sufficient knowledge and expertise about the product to be able explain its features and exclusions, restrictions and limitations and/or identify where consumers should seek more expert information.

As well, CCIR members have noted in the course of their supervision activities that the insurance industry seems to have a broad interpretation of THI.

Some insurance products are marketed as THI products while they include non-emergency, routine and periodic care benefits,[20] The Working Group has also seen products designed for foreign students and individuals who are not insured or eligible for benefits under CGHIP or PHIP. Sometimes, these coverages are included as regimes inside traditional THI products.

Some CCIR members have noticed that these products/protections are sold through alternative distribution networks even though they do not qualify as travel insurance. The Working Group feels that these benefits should be offered by licensed agents as extended health insurance coverage rather than as THI products. For example, travel agents offer "travel insurance" to foreign seasonal workers. These insurance products cover, in particular, medical examination and eyesight test, pregnancy medical care and follow-ups, prescription medicine, vaccination, etc.

Questions at Issue – Insurers' Responsibility

12. How do insurers ensure that they have effective controls and oversight over their distribution channels and that proper distribution channels are used for the distribution of their travel insurance products, as well as for other coverages that do not qualify as travel insurance and which are embedded in these products?

5.3 Involvement of Third-party Service Providers/Program Administrators

5.3.1 Role of Third-Parties

Insurers commonly use third parties to facilitate the distribution and administration of THI. Third parties can act as the travel insurance program administer, providing almost all of the program functions for the insurer including product design, sales, distribution, underwriting, claims handling and customer service. Others provide specialized services such as medical cost containment services, 24/7 emergency call centre support services, or emergency evacuation/air ambulance services.

Outsourcing business functions to a third-party can provide the insurer with needed expertise, cost efficiencies and access to markets. However, when an insurer outsources a business function to a third-party, there must be adequate safeguards in place to ensure legislative requirements are being met and that there is no harm to consumers from the manner in which the third-party is discharging its function(s) on behalf of the insurer.

Insurers remain ultimately accountable for the product and for how the product is delivered and serviced. Insurers are expected to have adequate systems of controls and oversight over outsourced functions including:

- A clear strategy selecting, appointing and managing the third-party provider;

[20] Such as pregnancy care, vaccinations or annual check-up.

- Carrying out thorough due diligence of the third-party prior entering into the arrangement to provide services;
- Clear and well defined roles and responsibilities established for the third-party and including them in a written agreement which clearly defines the conditions, scope and limits of contracted services; and
- Proactive oversight of the third-party to ensure compliance with contract conditions and monitoring for instances of consumer harm.

CCIR members periodically receive complaints from the public that point to potential misconduct of third parties and suggest weak oversight or controls over these service providers by some insurers. Some of the common issues identified from complaints are:

- Lack of clarity of the identity of insurers;
- Lack of direct recourse to the insurer for information or to pursue complaints;
- Occasional use of unlicensed third-parties to adjust claims or sell products; and
- Controls over cost containment services.

5.3.2 Disclosure of Identity (White Labelling)

Consumers are expected to be able to identify the identity of the insurer underwriting their policy with relative ease. Some THI programs administered by third parties place more prominence on the identity of the program provider or the name of an association, (affiliation business), than the insurer. Websites and promotional material of these program providers give the appearance that the travel insurance is theirs and they are the party responsible for all decisions made under the policy. The text box below is a recent sample taken from a program provider.

Policy contracts and certificates often only identify the insurer in the definition page or near the end of the policy and only as the underwriter. One sampled policy had over 60 references to the program administrator and only six to the insurer. Another sampled policy had over 45 references to the program administrator and eight to the insurer, all of which occurred on or after page 29 of the policy.

The references to the program administrator typically give the appearance that the policy is issued by the administrator and that the administrator is fully responsible for all underwriting and claims decisions. For example the first referenced sampled policy had the following language:

- … payable shall be limited to $X million for all eligible insurance policies issued and administered by [program administrator], including this policy;
- The claimant shall provide [program administrator] with the opportunity to examine you when and so often as it reasonably requires while a claim is pending;
- If you fail to notify [program administrator] without reasonable cause, then [program administrator] will pay 80 percent of the claim payable.

The program administrator often uses a brand name so the policy also contains references to its legal name adding to the potential confusion for some consumers.

The Working Group is concerned that policies and promotional material provided through the use of program administrators can give a misleading representation as to who the consumer has the contract with and who is ultimately responsible for the decisions made under the contract.

Questions at Issue – Disclosure of Identity

13. What can be done to make sure that promotional material and policy or certificate documentation provided indirectly by the insurer through the use of third parties are not misleading or deceptive as to the identity and responsibilities of the insurer?

14. Are there functions that should not be outsourced to third-party administrators in order to make the roles and responsibilities clear?

15. How does delegating product development to third parties affect the insurer's role as manufacturer?

5.3.3 Lack of Recourse to Insurer

Some CCIR members have received complaints involving a THI claim where the complainant's are placed in a loop being passed off between a third-party administrators and the underwriting insurance company. In other cases, they are not aware they have recourse to the insurer to resolve a claim. The policy documentation and claims denial letters lead the complainant to believe that the ultimate decision resides with the third-party and not the insurer.

Questions at Issue - Lack of Recourse to Insure

16. What should be done to ensure that consumers are made aware of their right to contact the insurer regarding questions about the terms and conditions of the policy and claims disputes?

17. What are some of the best practices insurers could follow to ensure that there is appropriate oversight and controls over outsourced claims functions?

5.3.4 Oversight of Unlicensed Third-Parties

THI providers commonly use third-parties that are not licensed to conduct insurance business to provide ancillary services that are part of an insurance product and/or for exempt sales. When using third-parties, it is the insurer's responsibility to have adequate oversight and controls to ensure third-parties comply with legal requirements and codes of conduct.

Insurers are ultimately responsible to ensure third-parties are not conducting activity that is to be conducted by a licensed entity. Insurers need to be vigilant of functions being carried out by unlicensed third-parties that have a high likelihood for an unlicensed third-party to be acting in a role that requires licensing.

In addition, care needs to be taken when using third-parties to market/distribute travel insurance to end sellers. In some jurisdictions, the marketing of insurance products on a business-to-business basis requires the use of licensed agents; the licensing requirement is not just limited to retail sales.

5.4 Claims Management

Under ICP 19 insurers are expected to ensure the fair treatment of consumers through the full product life cycle including claims handling.

Insurers should have fair and transparent claims handling and claims dispute resolution procedures in place.

Good practices, in accordance with international standards,[21] would be to document those procedures in writing. In addition, consumers should be informed about claims handling and claims dispute resolution procedures and the formalities of claim submissions. Determinative factors in claim assessments should also be clearly explained.

In further accordance with good practices, a fair claims assessment requires appropriate competence of the claims staff (insurer and/or intermediary) and expects those that deal with disputed claims be experienced in claims handling and be appropriately qualified (in some jurisdictions handling a claim requires a licensed adjuster).

CCIR members also expect insurers to have effective controls in place over their processes, including, as mentioned above, outsourced functions, to ensure that consumers are not being unfairly treated or harmed.

Consumers raised the issue that they are being denied (or their policies are being voided) at claims time for material misrepresentation even though they made best and most honest efforts to try to complete the applications truthfully and to provide full disclosure about their medical condition. Moreover, consumers expressed the view that unknowingly misrepresenting a material fact should not necessarily give an insurance company grounds to systematically void a contract.

CCIR members believe insurers should improve their controls and oversight of claims to ensure that they are treating consumers fairly and are not denying claims or voiding policies where it is not appropriate. Furthermore, CCIR members understand insurers can be subject to fraudulent applications, however when a consumer completes an application in good faith and to the best of its knowledge and understanding, they expect the insurer to honour the contract. The Working Group feels that accepting claims unrelated to such mistakes would help maintain consumers' confidence in THI and they believe that fair treatment entails managing the reasonable expectations of consumers.

Consumers have expressed that they are uncomfortable with the common practice of an application being reviewed only at the time a claim is made. For instance, where a claim arises, the insurer might become aware of an inadequate answer in the application

[21] ICP19.

form[22] that would have rendered the claimant ineligible to the insurance product if the information provided had been in line with the medical information sought after by the insurer. Consumers might perceive this as "post-claim underwriting"[23] while in fact, it is "claims investigation". [24] We believe that better disclosure of the claims handling process would allow for better understanding and reassure consumers.

Example

Sebastian purchased *THI*. On his application, he answered "no" when asked if he had a prior medical condition. However, he had been to see the doctor 2 months prior to applying for insurance because he had felt pressure in his chest. After having undergone some tests, his doctor told him that it was probably stress.

As per the terms of the contract, Sebastian should have replied "yes" to the medical question but his interpretation was that since his doctor found nothing and no further investigation was necessary, he did not have to mention it.

During his trip, Sebastian had a bike accident. The insurer denied coverage, alleging that because of his prior medical condition he was not eligible to the insurance in the first place.

Had Sebastian replied "yes" to the general medical question, he would have had to fill a full medical questionnaire and the insurer would have been in a position to decide whether it wished to grant him coverage – and under what conditions – or decline his application.

The Working Group also found that some claimants are not aware of where to go to dispute a claim, especially claims handled by intermediaries and third party administrators. The Working Group recommends that industry consider immediately implementing better disclosure to consumers of the claims dispute processes. Adopting best practices across the industry for internal reviews of claims and ensuring that consumers are provided with a clear explanation of how to escalate a claim appeal, including how to access the appropriate Ombudservice might reassure consumers.

[22] Sometimes in their application forms consumers mistakenly give replies that do not trigger further medical questions on the part of the insurer.

[23] "Post-claim underwriting" consists of waiting until after a claim has been filed to assess, among other criteria, the insured's risk related to his or her medical condition even though the insured answered in a way that should have immediately prompted further validation in the underwriting process. When offered insurance products, consumers must satisfy various conditions which might be more or less elaborate depending on the product. Often, in THI, these criteria include age, citizenship, location of residence, general medical questions, etc. Where an insurer asks such questions, it should verify the validity of the replies before granting coverage. Choosing to validate them after a claim has been filed would be considered "post-claim underwriting".

[24] "Claims investigation" is a normal process by which an insurer obtains all the necessary information to evaluate a claim.

Example[25]

A husband and wife purchased travel insurance prior to an extended vacation in Florida. During their trip, the wife became seriously ill and died. While at the hospital, she was diagnosed with cirrhosis of liver relating to an addiction related issue and subsequently, it discovered that she had been diagnosed with such addiction many years prior to their trip to Florida. The insurer denied the husband's claim for his wife's medical expenses on the basis that her addiction was excluded under the policy.

The Court found that the exclusion clauses were to be construed narrowly, and that the wording in the insurer's contract was quite ambiguous. The wife had met the standard for "stability" in the months prior to travel, and did not engage in her addiction in the period during which the policy was in effect.

Moreover, the Court found that the *contra proferentem* rule applied. This well-established rule holds that where there is a clause in an insurance policy that is ambiguous, it should be interpreted in favour of the insured and against the insurer who seeks to rely on the clause to avoid liability. The decision also found that the language of the clause should be interpreted in an effort to give effect to the intention of the parties. In this case, it should be interpreted in favour of the insured and against the insurer who seeks to rely on the clause to avoid liability.

Questions at Issue – Claims Management

18. What initiatives could be put in place by insurers to ensure that best practices are implemented with regards to claims handling?

5.5 Complaints

The Working Group found that the majority of complaints were related to claims denials. However, the responses to the survey did not allow for further conclusions.

However, insurers are expected to have in place internal processes for handling consumer complaints and designated individuals responsible for those processes. Insurers are to disclose to consumers how those processes work and how to initiate contact. They are also expected to be members of independent ombudservices and where a dispute remains unresolved, provide the complainant with a final decision letter and information on how to contact the appropriate ombudservice or, where applicable, the CCIR member for that jurisdiction.

Question at Issue – Complaints

19. What initiatives could be put in place by insurers to ensure better claims dispute processes?

[25] *Bird Estate v. Canada Life Assurance Co*. 2001 CarswellOnt 4076 (Ont. S.C.J.).

5.6 Education

Consumers perceive that THI will fully cover for expenses related to a medical emergency occurring while travelling, as Government Health insurance plans would do if the medical emergency was to happen in their home province.

There is a strong need for appropriate disclosure for THI products, but the Working Group believes that there is also a need for a better understanding of the THI market and of the nature of THI products themselves.

Contrary to common belief, the THI market is vast and diversified and consumers should be made aware of this reality. In order to make an informed purchased decision, the Working Group believes that consumers would greatly benefit from increased general knowledge on THI. The following list gives a non-exhaustive illustration of what the Working Group believes to be the minimum knowledge and understanding that consumers should be provided with:

- There are different coverage options available, possibly not all suitable for them;
- There are many exceptions and limitations that can apply and they can vary from one product or even from one plan to another;
- What are pre-existing medical conditions, their role and their potential impacts;
- The importance of the application process and the consequences of misrepresentation, good faith or not; and
- The need to declare any change in their health conditions they may experience between the moment they filed their application and their departure.

CCIR members take the view that the industry has a crucial role in consumers' education. We acknowledge that current initiatives to better educate consumers (e.g. brochure and videos) have merit and we encourage the industry to continue improving them.

5.7 Data Collection

From the survey, the Working Group observed that, in 2014, some insurers did not monitor or could not provide breakdowns of data that regulators expected them to collect and use as part of their oversight and controls over THI products.

The Working Group believes that all insurers should collect specific metrics on, for example, claims and voided policies, and use that data to make adjustments to their product designs and sales processes to address the causes as part of the best practices they develop over THI.

Standardized key indicators should be implemented in order to allow for a better overview and help determine if there are issues as, for instance, reasons for claims denials, etc.

Question at Issue – Data Collection

20. What key indicators could be standardized and implemented to ensure proper monitoring of insurers' THI activities?

6- CONCLUSION

The CCIR welcomes the comments, suggestions and ideas of the industry and consumer associations on the issues and gaps identified in this report. Stakeholders are encouraged to identify any other issues that should be considered and how these could be addressed.

It is essential for the THI industry to adapt its practices to better reflect the concerns voiced by CCIR members in terms of market conduct and the current practices adherence to international standards. Although, some aspects of the 2015 survey do give credence to some longstanding industry positions on customer satisfaction and complaints, the Working Group was able to identify some key issues which clearly affect the fair treatment of customers as defined by current international standards.

CCIR now invites the stakeholders to provide any relevant feedback that could assist the regulators to address issues and improve the fair treatment of customers.

7- CONSULTATION DETAILS

An electronic copy of this document is available on CCIR's website at: www.ccir-ccrra.org/.

We look forward to receiving your submissions 30 September, 2016.

Electronic submissions are preferred and should be forwarded to: ccir-ccrra@fsco.gov.on.ca.

Written submissions should be forwarded to:

CCIR Secretariat
5160, Yonge Street, Box 85
Toronto, Ontario M2N 6L9

CCIR intends to make the submissions received publicly available. If you indicate that you do not want your submission or specific parts of your submission to be made public, we will treat the submission, or the designated parts, as confidential to the limited extent permitted by law.

SCHEDULE 1 – LIST OF QUESTIONS AT ISSUE

Design of a THI Product

1. What terms or expressions should be defined and standardized in order to allow a better understanding of THI products by consumers, and enable them to more readily compare products and make informed decisions?

2. What other initiatives related to product design could be put in place by the industry to help consumers better understand the extent of the coverage offered and the terms and exclusions so they can make informed decisions?

3. What type of controls should be put in place at the insurer or other levels in order to ensure that consumers of THI products are treated fairly?

Exclusion, Restriction and Limitation Clauses

4. How could the industry improve consumers' awareness about and understanding of exclusion, restriction and limitation clauses, especially pre-existing medical conditions?

5. What changes could be made to the application process to ensure that consumers have sufficient knowledge to have a thorough understanding of exclusions for pre-existing medical conditions as well as to complete an application for THI, thus enhancing consumer confidence in the underwriting process?

Suitability

6. How can the industry ensure that consumers are offered THI products that are suitable for their needs?

Medical Questionnaires

7. How can the use of medical questionnaires by insurers be improved in the context of the underwriting of travel insurance products, in order to ensure fair treatment of customers?

Disclosure Documents

8. How could insurers ensure that the information shown in the disclosure documents is limited to that which is essential, and that the format of these documents promotes a quick understanding of the fundamental information?

9. How could the industry improve disclosure documents so that they can be more easily understood by consumers?

Timely disclosure

10. How can the industry ensure that consumers are informed of the key elements of the THI coverage in a timely manner, before they make a purchase decision?

Credit Cards

11. What should the industry do to ensure that all consumers get an appropriate and timely disclosure relating to THI embedded in credit cards?

Insurers' Responsibility

12. How do insurers ensure that they have effective controls and oversight over their distribution channels and that proper distribution channels are used for the distribution of their travel insurance products, as well as for other coverages that do not qualify as travel insurance and which are embedded in these products?

Disclosure of Identity

13. What can be done to make sure that promotional material and policy or certificate documentation provided indirectly by the insurer through the use of third parties are not misleading or deceptive as to the identity and responsibilities of the insurer?

14. Are there functions that should not be outsourced to third-party administrators in order to make the roles and responsibilities clear?

15. How does delegating product development to third parties affect the insurer's role as manufacturer?

Lack of Recourse to Insure

16. What should be done to ensure that consumers are made aware of their right to contact the insurer regarding questions about the terms and conditions of the policy and claims disputes?

17. What are some of the best practices insurers could follow to ensure that there is appropriate oversight and controls over outsourced claims functions?

Claims Management

18. What initiatives could be put in place by insurers to ensure that best practices are implemented with regards to claims handling?

Complaints

19. What initiatives could be put in place by insurers to ensure better claims dispute processes?

Data Collection

20. What key indicators could be standardized and implemented to ensure proper monitoring of insurers' THI activities?

SCHEDULE 2 – INSURERS AND FINANCIAL GROUPS OFFERING TRAVEL HEALTH INSURANCE

The insurers and financial groups that confirmed that they offered Travel Health Insurance products in 2014 are:

- AIG Insurance Company of Canada
- American Bankers Insurance Company of Florida
- American Bankers Life Assurance Company of Florida
- Association d'hospitalisation Canassurance
- Berkley Insurance Company - Canadian Branch
- Blue Cross Life Insurance Company of Canada
- CAA Insurance Company (Ontario)
- Chubb Insurance Company of Canada
- Co-operator Life Insurance Company[26]
- Co-operators Life Insurance Company
- Desjardins Sécurité financière, compagnie d'assurance vie
- Empire Life
- Green Shield Canada
- Group Medical Services GMS Insurance Inc.
- Industrial Alliance Insurance & Financial Services Inc.
- Intact Insurance Company
- La Capitale assurances et gestion du patrimoine inc.
- La Survivance-Voyage, compagnie d'assurance
- Legacy General Insurance Company
- Lloyd's Underwriters
- Manitoba Blue Cross
- Manulife
- Medavie Inc.
- Northbridge Insurance Corporation
- Orion Travel Insurance Company
- RBC Insurance Company of Canada
- Reliable Life Insurance Company
- Royal & Sun Alliance Insurance Company of Canada
- SSQ, Société d'assurance-vie inc.
- Sun Life Assurance Company of Canada
- TD Life Insurance Company
- The Canada Life Assurance Company
- The Great-West Life Assurance Company
- Zurich Insurance Company Ltd Canadian Branch

[26] We considered Co-Operator Life Insurance Company and Co-Operators Life Insurance Company as one group since one of them replied in individual insurance and the other, in group insurance.

SCHEDULE 3 – BENEFITS COMMONLY INCLUDED IN TRAVEL HEALTH INSURANCE

The benefits commonly included in Travel Health Insurance products are:

- Emergency Medical Insurance, in excess of the CGHIP or PHIP:
  - Hospitalization + incidental expenses (telephone, television, etc.);
  - Emergency medical care and dental treatments;
  - Prescribed treatments or appliances (for example, prescription drugs, crutches, cane, etc.);
  - Other professionals (for example, chiropractor, physiotherapist, etc.);
  - Diagnostic services (laboratory tests, X-rays, etc.);
  - Accidental death or dismemberment:
    - Whatever the cause;
    - Accident while in a public transportation;
    - Aircraft accident.

- Transportation expenses, in excess of the CGHIP or PHIP:
  - Ambulance or taxi;
  - Return of dependent child / travelling companion to his/her province/territory of residence – includes an escort person when needed;
  - Repatriation of the insured and of the travelling companion in case of accident or sickness;
  - Transportation of a member of the insured's family or of a friend to the insured's bedside or to identify the insured's remains;
  - Repatriation of the travelling companion when the insured is repatriated to Canada for medical reasons;
  - Repatriation of the deceased person or cremation or burial at the place of death;
  - Return of the insured's vehicle or vehicle rental when unable to bring it back because of an illness or an injury;
  - Return of baggage;
  - Interruption of the travel for medical or other reasons (for example, death or hospitalization of a family member);
  - Return of the pet when the insured is repatriated for medical reasons:
    - Insured's dog or cat;
    - Insured's assistance-trained dog.

- Subsistence allowance:
  - For travel companion when the return date is postponed due to insured's illness or injury;
  - Of a member of the insured's family or of a friend to the insured's bedside or to identify the insured's body.

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Agenda Item 3(a)(ii)3
July 19/16 CAFII EOC Meeting

CAFII Travel Medical Insurance Experts Working Group
Accomplishments and Next Steps As At July 15, 2016

Accomplishments Completed

- Agreement on a work plan and commitment of resources by CAFII members to a working group of travel medical insurance experts
- Draft Travel Medical Insurance Code of Principles
- Quantitative Consumer Research presented to the following audiences:
  - CLHIA Travel Insurance Working Group
  - CCIR Executive
  - CAFII Board members
  - CAFII Reception attended by members, Associates, and regulator guests
  - CCIR representatives nationally
- Policy limitations and exclusions
  - Analysis of/agreement on limitations and exclusions required and those no longer required
  - Analysis of/recommendation on common language for limitations and exclusions
  - Provision of limitations and exclusions document to Joan Weir for CLHIA Committee on Reform #1 to build upon
- CLHIA Guideline G5: Important Notice Wording to be used on all policies
  - Redrafted important notice wording and provided it to Joan Weir for CLHIA Committee on Reform #1 to build upon
- Policy terms and definitions
  - Analysis of all terms and conditions across CAFII members
  - Recommendations for terms to keep, terms not needed, and terms not requiring common language
  - Draft of common language recommendations for final review by working group members

Next Steps

- Policy terms and definitions
  - Finalize common language recommendations for terms and definitions (late August 2016)
- Quantitative Consumer Research
  - Refresh consumer research and at same time consider increasing sample size, particularly of claimants and evaluate other potential enhancements (Fall 2016)
- Policy Layout
  - Analyze and prepare joint recommendations on policy layout (Fall 2016)
- Travel Medical Insurance Code of Principles
  - Agree on next steps

July 19/16 CAFII EOC Meeting
Agenda Item 3(a)(iii)

From: Martin Boyle [mailto:Martin.Boyle@fsco.gov.on.ca]
Sent: Tuesday, July 12, 2016 4:08 PM
To: 'Brendan Wycks'
Subject: CCIR Annual Statement on Market Conduct

Good afternoon Brendan,

The CCIR is seeking your input, as well as the input of your member companies, on the attached draft of a harmonized market conduct annual statement ("Annual Statement"). We ask that you share the attached document with your membership. We welcome feedback from your association as well as from you member insurers who may wish to respond directly.

The Annual Statement is designed to provide information on industry practices that will allow CCIR members to assess the fair treatment of consumers in Canada and the achievement of outcomes that have been identified in the Insurance Core Principles (ICP) of the International Association of Insurance Supervisors (IAIS). It will also assist in identifying industry trends and potential areas for review with the Canada's insurance marketplace. CCIR members will also utilize the information obtained through the Annual Statement in the development of cooperative supervisory plans. It is anticipated that CCIR members will begin collecting 2016 data in the first quarter of 2017.

Over the past year, CCIR members have worked closely with select industry representatives from both the life and health and the P&C insurance industries to develop a harmonized information return that will eliminate duplication and multiple requests for information by market conduct regulators. The Annual Statement is also intended to replace the requirements that currently exist for insurance companies to report their complaint data biannually through the National Complaint Reporting System.

For the purposes of this consultation, the Annual Statement has been provided as a Microsoft Word document. Microsoft Excel files will be used to collect the data once the Annual Statement has been implemented. It should also be noted that the CCIR is considering a phased-in approach to implementing the Annual Statement that would utilize a threshold based on market share of national premiums written. Those insurers below this threshold would not be asked to complete all sections of the Annual Statement at the outset (Governance and Complaint Reporting sections would still apply). The CCIR would appreciate any comments you might have in regards to determining this threshold.

The CCIR also has a French language version of the Annual Statement which is available upon request to ccir-ccrra@fsco.gov.on.ca

We ask that you provide any comments you may have regarding the proposed Annual Statement via email to ccir-ccrra@fsco.gov.on.ca by **August 26, 2016**.

Regards,

Martin Boyle
Policy Manager | Canadian Council of Insurance Regulators
Martin.Boyle@fsco.gov.on.ca | 416-590-7031 | www.ccir-ccrra.org
5160 Yonge Street, Toronto, ON, M2N 6L9

DRAFT ANNUAL STATEMENT ON MARKET CONDUCT

Life and Health Insurance Industry

July 12, 2016

1. General Instructions

1. Introduction	
a)	This form is to be completed for each licensed insurance entity. Each insurer within a group of companies is required to complete the form.
b)	MOU signatories have entered into agreements with the Autorité des marchés financiers (AMF) to collect on behalf of the provincial and territorial regulatory authorities where applicable.
c)	The information that is collected will be subject to and administered in accordance with the provisions of the MOU and the applicable law. This includes the privacy and confidentiality provisions included with the MOU and the applicable law.
d)	The information that is sought relates to the insurer's Canadian operations and/or Canadian consumers. Information regarding activities or developments abroad are limited to those that my impact Canadian operations and consumers.
e)	The data provided must cover the most recent fiscal year end.
f)	This form relates only to life and health insurance, including individual and group products. Reinsurance is excluded and commercial insurance are excluded for all sections except for the Complaint Reporting Sections.
g)	The information requested is required to establish trends and evaluate the means implemented by the industry regarding fair treatment of consumers.
2. Filing requirements	
a)	All amounts reported should be in thousands of dollars ($000s).
b)	Some fields will only accept a numeric response.
c)	You must complete this form respecting as much as possible, the choices available in the dropdown menus.
d)	You must provide a response to all questions. If the response options do not apply or relate to your company, please select "Other" and provide details in the appropriate space.
e)	At the end of each section, a general comments section has been provided for any additional comments you may wish to provide.
3. Definitions	
a)	Agent means a licensed life and/or accident and sickness insurance agent.
b)	Breaches (of privacy) reported in this form are those that have a significant impact on the customer and require disclosure under applicable privacy legislation.
c)	A complaint is the expression of at least one of the following elements that persists after being considered and examined at the operational level capable of making a decision on the matter:

	• a reproach against an organization; • the identification of a real or potential harm that a consumer has experienced or may experience; or • a request for a remedial action. Complaints are generally expressed in writing through correspondence, e-mail, fax or other form that allows a complaint to be kept on file. Where a consumer makes a complaint by phone or in person and the complaint is handled and examined by the person responsible for the examination of complaints and designated as such in the organization's policy, the complaint must be documented so that it can be kept on file. The initial expression of dissatisfaction by a consumer, whether in writing or otherwise, will not be considered a complaint where the issue is settled in the ordinary course of business. However, in the event the consumer remains dissatisfied and such dissatisfaction is referred to the person who is responsible for the examination of complaints and designated as such in the organization's policy, then it will be considered as a complaint. However, organizations must refrain from any undue delay in referring a matter to a higher level solely for the purpose of avoiding reporting requirements. Where a consumer remains dissatisfied after a reasonable attempt has been made to settle the issue, organizations without a multilevel complaint examination structure are then considered to have received a complaint.
d)	Consumer means all current and prospective customers of insurance products.
e)	Distribution channels refers to the following methods of distribution: • Independent Agent – A representative authorized to act in the life and health insurance sector who offers a range of life and health insurance product from several insurers and/or contracts with one or more Managing General Agencies or Associated General Agencies for access to insurers. • Direct and Exclusive Agent: A representative authorized to act in the life insurance sector who is bound by an exclusive contract with a single life and health insurer to act on behalf of a firm that is an insurer.
f)	Employee means any salaried employee working more than 25 hours per week, but does not include an employee paid primarily by commission.

g)	Fair treatment of consumers ("FTC") is a principle that focuses on consumer outcomes, in particular, having due regard for the interests of the consumer and treating the consumer fairly. It refers to the consumer-related conduct of insurers and how insurers treat consumers at each stage of the life cycle of a product. The lifecycle of the product begins with its design to after-sales services and from the moment obligations under the contract arise until the point at which all obligations under the contract have been fulfilled. The outcomes associated with FTC as described by the International Association of Insurance Supervisors include the following: • developing and marketing products in a way that pays due regard to the interests of customers; • providing customers with clear information before, during and after the point of sale; • reducing the risk of sales which are not appropriate to customers' needs; • ensuring that any advice given is of a high quality; • dealing with customer complaints and disputes in a fair manner; • protecting the privacy of information obtained from customers; and • managing the reasonable expectations of customers. Areas within an insurer and its operations that can influence and help ensure the FTC include: • Board and senior management responsibility; • Strategy and decision making; • Internal processes and mechanisms (controls); • Performance management; • Remuneration; and • Policies and procedures.
h)	Lapse refers to the termination of a policy for nonpayment of the premium. This occurs when the policy owner does not pay the premiums on time or the value of the policy (cash value) is insufficient for the payment requirements.
i)	Lawsuit means a court case involving a dispute between the insurer and the insured, based on an insurance product.
j)	Market conduct encompasses any product or service relationship between the insurance industry (insurers or intermediaries) and the public, specifically the risks to customers that arise if an insurer or intermediary fails to treat customers fairly and in accordance with Applicable Law, and includes the terms "conduct of business" and "commercial practices" as used in some jurisdictions.
k)	Material change refers to any change that may impact or affect the outcomes associated with FTC as described by the International Association of Insurance Supervisors and listed above.
l)	Product means all insurance protections marketed under the same name and sold as a whole, although some options are possible. For purposes of this disclosure, an endorsement is not considered an insurance product if it cannot be sold alone.
m)	Regulatory action means any action that results in an order, penalty, fine, or other sanction.

n)	Sales management means either an employee of an insurer, a managing general agent, or a third party administrator, responsible for oversight of the sales force.
o)	Sales force means those who offer the product to the consumer (for example agents, exempt sellers, restricted licensees and those who offer the product through Quebec's "without a representative" regime).
p)	Senior officer in charge of fair treatment of consumers means the person in charge of ensuring the development, implementation and enforcement of fair treatment of consumers-related operational policies and practices.
4. Detailed instructions	
General Information and Governance (2)	
a)	"Risks associated with the product" includes any potential risks associated with the product. This could include stated exclusions and deductibles.
b)	"Organizational or operational changes" includes mergers and acquisitions or other material changes within the insurer that may impact or affect the outcomes associated with FTC as described by the International Association of Insurance Supervisors and listed above.
Product changes (4) and (5)	
a)	List all the products you have sold during the last fiscal year. Products reported in this table include new coverages offered to consumers.
b)	In the business line column, please indicate the main guarantee only.
c)	Changes to be reported are limited to material changes initiated by the insurer or are the result of a decision made by the insurer. Excludes regulatory required changes.
d)	"Products" covered includes, but are not limited to, life insurance, annuities, short-term disability, long-term disability, critical illness, long-term care and travel insurance that are sold in the reporting period.
Distribution channels (8)	
a)	For each distribution channel, list your 25 largest distributors (determined by amount of direct written premium) within the channel.
b)	The information collected in this table is intended to be in regards to independent agents.
Sales and incentives management (9)	
a)	List the types of variable remuneration (e.g. cash prizes, training, bonuses).
b)	List only the incentives that are provided by the insurer. Do not report on incentives provided through other sources, such as those provided by MGAs.
c)	For "Lapses by distribution channel", identify the number of policies.

Claims (10)	
a)	“Accident and Sickness” is limited to short-term disability, long-term disability and travel insurance-related information.
b)	“Original amount claimed relating to denied claims during the period” does not apply to monthly benefits paid for short-term disability and long-term disability insurance.
Complaint Reporting (11)	
a)	“Unique Identifier” refers to the customer’s and/or complaint’s reference number or file number provided after the complaint has been reported into the system.
Protection of Personal Information (12)	
a)	“Number of breaches” refers to incidents and occurrences. It does not include the number of individuals impacted by the breach.

2. Governance

1. Identify the senior officer(s) in charge of ensuring the development, implementation and enforcement of policies and practices related to the fair treatment of customers at December 31 (This individual is often the CCO or CEO for smaller firms. It is *not* the Ombudsperson):	
a) Name of the senior officer(s):	
b) Title	
c) Address:	
d) Telephone number:	
e) Email:	
a) Name of the senior officer(s):	
b) Title	
c) Address:	
d) Telephone number:	
e) Email:	
a) Name of the senior officer(s):	
b) Title	
c) Address:	
d) Telephone number:	
e) Email:	
Provide an overview of the processes and responsibilities regarding the development, implementation and enforcement of policies and practices related to the fair treatment of customers within your organization:	

2. Total number of employees whose responsibilities are solely for facilitating and monitoring of risk management practices over market conduct risks (i.e.,	

second line of defence):	

3. Do you have a code or policy that specifically addresses the fair treatment of consumers/treating consumers fairly ?	Y/N
If yes, please answer the questions below:	
a) When was the last time you reviewed/evaluated the code or policy?	Month/Year
b) When is the last time you modified the code or policy?	Month/Year
c) Have you communicated this policy to all of your staff?	Y/N
If no, please complete question below:	
d) Do you intend to develop such a document in the next year?	Y/N

4. Is the fair treatment of consumers a priority at each stage of the product life cycle and in every area of your operations?	Y/N
If yes, please indicate which of the following practices you engage in to ensure the fair treatment of consumers:	
a) Develop strategies, objectives and initiatives to promote the fair treatment of consumers	☐
b) Embed the fair treatment of consumers in the organization's policies and code of ethics	☐
c) Develop mechanisms and procedures to identify and address any conflicts that could impact the fair treatment of consumers	☐
d) Development measures and reports to inform management of the organization's performance in the fair treatment of consumers	☐
If no, please explain why the fair treatment of consumers is not a priority of each stage of the product life cycle and in every area of your operation in the space below.	

5. Please provide an overview of the type and length of training employees receive on hiring and on an ongoing basis with respect to the fair treatment of consumers.

6. During the past year, have you been the subject of any regulatory action of significance by a regulator outside of Canada that relates to market conduct that could have a material impact on market conduct practices in Canada?	Y/N/NA
If yes, please provide details (which regulator, product concerned, outcome, etc.):	

7. Please indicate the number of licensees within your distribution channel that were the subject of a market conduct audit/review in the reporting period.	
a) Please identify the scope of the audit(s)/review(s):	
b) How often is the effectiveness of the audit process assessed?	-Annually -More frequently than annually -Less frequently than annually

8. Do you have processes/mechanisms in place to ensure that the information, as noted below, is properly given at the point of sale (before or at the time of purchase)?	Y/N
If yes, please indicate the information is disclosed to consumers before or at the time of purchase (check all that apply):	
a) Insurer name and contact information	☐
b) Product and its main features	☐
c) Risks associated with the product	☐
d) Right of termination or rescission (if applicable)	☐
e) Clear, plain language communication that is not misleading	☐
f) Formatting that is easy to read and understand	☐
g) Up-to-date information and provided in a timely manner	☐
h) Potential conflicts of interest	☐

9. Please identify from the list below the after sale information provided to the customer.	
a) Confirmation of any after-sales transactions	☐
b) Annual statements for IVICs and life products with variable elements	☐
c) Contract amendments	☐
d) Customer rights and obligations in connection to any material changes in the product that was sold or offered (if applicable)	☐
e) Changes in the environment that may impact the product (e.g., legislative changes)	☐
f) Organizational or operational changes that may impact the customer, product or related services	☐

10. Do you engage in advertising campaigns directed toward consumers?	Y/N
If yes, please indicate if you have processes/mechanisms in place to ensure/address the following in your advertising campaigns:	
a) Advertising satisfies all applicable legal and regulatory requirements	☐
b) Ensure the name of the insurer is clearly indicated	☐

c) Advertising is appropriate for the target consumer group	☐
d) Written advertisements are presented in a format that is easy to read and understand	☐
e) Advertising is truthful and authentic with respect to the use of statistics and testimonial	☐
f) Unclear, misleading or inaccurate advertisements are promptly modified or withdrawn	☐
g) Advertising is reviewed independently of the person who designed or prepared the advertisement prior to its dissemination	☐

11. Do you conduct consumer satisfaction surveys?	
If yes, please indicate how often	-Following a sale -Following a claim -Following a complaint -Other: -Annually -More frequently than annually -Less frequently than annually

General comments:

3. Policies

	Individual								
	Number of new policies issued	**Number of rescissions**	**Number of lapses**	**Number of cancelations**	**Number of insurer-initiated non-renewals of policies in the period**	**Number of cancellations with full refund of premium**	**Number of cancellations without full refund of premium**	**Number of cancellations for non-payment or non-sufficient funds**	**Number of applications from consumers declined by insurer**
Life									
Annuity									
A&S									

Group									
	Number of new policies issued	Number of rescissions	Number of lapses	Number of cancelations	Number of insurer-initiated non-renewals of policies in the period	Number of cancellations with full refund of premium	Number of cancellations without full refund of premium	Number of cancellations for non-payment or non-sufficient funds	Number of applications from plan sponsor declined by insurer
Life									
Annuity									
A&S									

General comments:

4. Products – Individual

1. In the past year, have you conducted a periodic review of your products?	Y/N

**All products sold within the reporting period are to be listed in the first column "Product name" below.*

Product name	**Currently available (as of Fiscal Year End)**	**Product category** (A&S insurance, Disability, Extended health, Life insurance, Mortgage, Travel, Other)	**Material changes in the offer or in the product**	**If yes, list the initial date of change**	**Type of change, if applicable** (Change to product features, Change to pricing, Change to product features & pricing, New product, Discontinued product)	**Comments or any additional information you wish to provide**	**If yes, did the change in product result in a change in the target market?**
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N

General comments:

5. Products – Group

1. In the past year, have you conducted a periodic review of your products?	Y/N

**All products sold within the reporting period are to be listed in the first column "Product name" below.*

Product name	**Currently available (as of Fiscal Year End)**	**Product category** (A&S insurance, Disability, Extended health, Life insurance, Mortgage, Travel, Other)	**Material changes in the offer or in the product**	**If yes, list the initial date of change**	**Type of change, if applicable** (Change to product features, Change to pricing, Change to product features & pricing, New product, Discontinued product)	**Comments or any additional information you wish to provide**	**If yes, did the change in product result in a change in the target market?**
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N

General comments:

6. Products – Individual and Group Variable Insurance Contracts

1. In the past year, have you conducted a periodic review of your products?	Y/N

**All products sold within the reporting period are to be listed in the first column "Product name" below.*

Individual							
Product name	**Currently available (as of Fiscal Year End)**	**Product category** (Annuities, Guaranteed investments, Mutual funds, Segregated funds, Scholarship plans)	**Material changes in the offer or in the product**	**Initial date of change**	**Type of change, if applicable** (Change to product features, Change to pricing, Change to product features & pricing, New product, Discontinued product)	**Comments or any additional information you wish to provide**	**Did the change in product result in a change in the target market?**
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N

**All products sold within the reporting period are to be listed in the first column "Product name" below.*

Group							
Product name	**Currently available (as of Fiscal Year End)**	**Product category** (Annuities, Guaranteed investments, Mutual funds, Segregated funds, Scholarship plans)	**Material changes in the offer or in the product**	**Initial date of change**	**Type of change, if applicable** (Change to product features, Change to pricing, Change to product features & pricing, New product, Discontinued product)	**Comments or any additional information you wish to provide**	**Did the change in product result in a change in the target market?**
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N
	Y/N		Y/N	date/province			Y/N

General comments:

7. Premiums and Commissions by Distribution Channel

1. Premium and claims by distribution channel consolidated ($000)

	Lines of Business	Direct Premiums Written				Commissions, including all types of variable remuneration			
		Independent Agent	Direct and Exclusive Agent	Other	Total	Independent Agent	Direct and Exclusive Agent	Other	Total
	Life								
1	Individual				0				0
2	Group				0				0
3	Subtotal - Life	0	0		0	0	0		0
	Annuity								
4	Individual				0				0
5	Group				0				0
6	Subtotal - Annuity	0	0		0	0	0		0
	Accident & Sickness								
7	Individual				0				0
8	Group				0				0
9	Subtotal - A&S	0	0		0	0	0		0
TOTAL		**0**	**0**		**0**	**0**	**0**		**0**

2. Do you market products via telesales or a call centre?		
If yes, please complete the table below:		
	# of Policies Sold	**Direct Premiums ($'000s)**
Insurer		
Affinity Arrangements		
Other Third Party Arrangements		

3. Do you market products through the Internet?	
If yes, please provide the following information for direct sales, excluding third party aggregators:	
a) Number of policies sold	(#)
b) Direct premiums	($'000s)

General comments:

8. List of Distribution Channels

The information collected in this table is considered competitive in nature

Individual											
1. Name of firm (list 25 main firms)	**Licensed**	**Percentage of total business** (drop down citing ranges (i.e., 0-20%, 21-40%, 41-60%...)	**Distribution channels**	**Exclusivity clause**	**Loans to firm ($000)**	**Percentage participating in firm's equity**	**Minimum volume clause**	**First refusal right over firm**	**Other types of advantage (resource loan, marketing, Etc.) If yes, list in #2 below.**	**Date of most recent compliance review**	**Additional information (optional)**
Firm 1	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 2	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 3	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 4	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 5	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 6	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 7	Y/N			Y/N			Y/N	Y/N	Y/N		

Firm 8	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 9	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 10…	Y/N			Y/N			Y/N	Y/N	Y/N		

Group											
1. Name of firm (list 25 main firms)	**Licensed**	**Percentage of total business (**drop down citing ranges (i.e., 0-20%, 21-40%, 41-60%...)	**Distribution channels**	**Exclusivity clause**	**Loans to firm ($000)**	**Percentage participating in firm's equity**	**Minimum volume clause**	**First refusal right over firm**	**Other types of advantage (resource loan, marketing, Etc.) If yes, list in #2 below.**	**Date of most recent compliance review**	**Additional information (optional)**
Firm 1	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 2	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 3	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 4	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 5	Y/N			Y/N			Y/N	Y/N	Y/N		

Firm 6	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 7	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 8	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 9	Y/N			Y/N			Y/N	Y/N	Y/N		
Firm 10…	Y/N			Y/N			Y/N	Y/N	Y/N		

2. Other type of advantage:

3. General Comments:

9. Sales and Incentives Management

1. THIS QUESTION IS RELATED TO DIRECT WRITERS ONLY: **Excluding personnel whose remuneration is fully variable, the variable proportion of the remuneration of staff:**	
a) List by product below, the range of commissions paid (% of first annual premium) within the first year of the policy being in force:	
Life	
Individual	(%)
Group	(%)
Annuity	
Individual	(%)
Group	(%)
Accident & Sickness	
Individual	(%)
Group	(%)
b) List by product below, the range of commissions paid (% of renewal premium) within the second year of the policy being in force:	
Life	
Individual	(%)
Group	(%)
Annuity	
Individual	(%)
Group	(%)
Accident & Sickness	
Individual	(%)
Group	(%)

2. List of compensation methods other than fixed commission and base salary (Please, check all that apply to you):		
Sales force	Sales management	Type of variable remuneration:
☐	☐	Cash prizes or other gifts
☐	☐	Money loan
☐	☐	Profit sharing
☐	☐	Bonus
☐	☐	Other, please specify in the space below:

3. Indicate whether sales force performance measures and incentives or commissions consider the following			
	Sales Force Performance Measures	Incentives or Commissions	
a) Lapses	☐	☐	
b) Number of complaints	☐	☐	
c) Premium volume	☐	☐	
d) Claims volume	☐	☐	
e) Consumer satisfaction	☐	☐	
f) Number of post-sale consumer touches	☐	☐	
g) Provide details of any other sales force performance measures and incentives or commissions you have that are based on the fair treatment of consumers:			

4. Other comments on variable remuneration:

5. Lapses by distribution channel									
Line of Business		**First Year**				**Second Year**			
		Direct & Exclusive Agent	Independent Agent, Broker, or MGA	Other, (include drop down)	Total	Direct & Exclusive Agent	Independent Agent, Broker, or MGA	Other, (include drop down)	Total
	Life								
	Individual								
	Group								
	Subtotal								
	Annuity								
	Individual								
	Group								
	Subtotal								
	Accident & Sickness								
	Individual								
	Group								
	Subtotal								
	TOTAL								

10. Claims

1. Complete the table						
	Life		**Annuity**		**Accident & Sickness**	
	Individual	Group	Individual	Group	Individual	Group
Number of claims open at the beginning of the period						
Number of new claims opened during the period						
Number of claims closed with payment during the period						
Amount paid in benefits during the period						
Number of claims denied in the period						
Number of claims open at the end of the period						
Average days to final payment						
Number of claims closed within 0-90 days from date of claim reported						
Number of claims closed within 91-180 days from date of claim reported						
Number of claims closed within 181-365 days from date of claim reported						
Number of claims closed over 365 days from date of claim reported						

2. Please indicate the 3 main reasons for denial of claims in the reporting period and the total number of denials for the three reasons selected.		
☐ Exclusions and limitations in the policy	(#)	
☐ Policy not in force	(#)	

☐ Delay in submitting claim	(#)	
☐ Not covered, except for exclusions and limitations in the policy	(#)	
☐ Failure to disclose or misrepresentation of a material fact	(#)	
☐ Other, please specify in the space below	(#)	

3. Other main reasons for claims denial:
4. General comments:

11. Complaint Reporting

1. Identify the senior officer(s) responsible for complaint handling at Fiscal Year end:	
a) Name of the senior officer(s):	
b) Title:	
c) Address:	
d) Telephone number:	
e) Email:	
a) Name of the senior officer(s):	
b) Title:	
c) Address:	
d) Telephone number:	
e) Email:	
a) Name of the senior officer(s):	
b) Title:	
c) Address:	
d) Telephone number:	
e) Email:	

2. Please indicate which of the following are present within your organization:		
a) Complaint handling policies and procedures guideline	☐	
b) Complaint handling unit or department	☐	
c) Reporting mechanism on a periodic basis that is sent to management and the board regarding aggregate complaints	☐	
d) Ongoing training program regarding complaint handling for staff whose activities include complaint handling	☐	

3. Please indicate in the space below the stage of your complaint process at which you declare the complaint to the regulator:

4. Does your report contain new complaints for the reporting period?	Y/N

5. Lawsuits arising from complaints:	
a) Number of lawsuits outstanding at beginning of the period:	
c) Number of new lawsuits:	
d) Number of closed lawsuit, by pre-court settlements:	
a) Number of closed lawsuits, by Court judgement:	
c) Number of class action lawsuits:	

Report number	Information concerning complaint					Voided	Identification of the product concerned by the complaint				Cause for complaint and outcome of the complaint			
	File	Complainant												
	Insurer file number	Unique identifier	Forward Station Area (FSA)	Opening date	Closing date	Check if a complaint has been declared in error	Product category *	If other, specify	Type of product *	Distribution channel	Complaint category *	Reproach against insurer*	Outcome *	Comments
1						☐								
2						☐								
3						☐								
4						☐								
5						☐								
6						☐								
7						☐								
8						☐								
9....						☐								

Proposed drop-down menus for above table

1. **Regulator having received the complaint, if applicable:**
    - Newfoundland & Labrador
    - Prince Edward Island
    - Nova Scotia
    - New Brunswick
    - Quebec
    - Ontario
    - Manitoba
    - Saskatchewan
    - Alberta
    - British Columbia
    - Northwest Territories
    - Yukon
    - Nunavut
    - Non-applicable

2. **Product category:**
    a. Life and health insurance:
    b. A&S insurance
    c. Disability insurance
    d. Extended health
    e. Life insurance
    f. Mortgage
    g. Travel
    h. Other
    i. Insurance/investments
    j. Annuities
    k. Guaranteed investments
    l. Mutual funds
    m. Segregated funds
    n. Scholarship plans
    o. Other

3. **Type of product (individual/group):**
    - Individual
    - Group

4. **Distribution mode of product:**
    - Employer's representative
    - Licenced representative

Other

5. **Cause Level 1:**
    - Underwriting
    - Administration
    - Marketing and sales
    - Product
    - Claims/Settlement

6. **Causes Level 2:**
    a. **Underwriting**
        - Alleged discrimination
        - Change in risk category
        - Credit scoring
        - Customer services (timeliness, knowledge, expertise)
        - File confidentiality of insured
        - Information collection and needs analysis
        - Other
        - Performance of mandate
        - Policy provisions
        - Premium
        - Refusal
        - Reporting to client

    b. **Administration**
        - Administrative procedures
        - Collection
        - Credit rating
        - Customer service (timeliness, knowledge, expertise)
        - Fees/commissions
        - Non-authorized transaction
        - Other
        - Personal information protection
        - Preauthorized Debit / Payment Plan
        - Statements
        - Transfers

    c. **Marketing and sales**
        - Advertising
        - Alleged misleading statement or misrepresentation
        - Delivery of policy
        - Discontinuation/Termination of service
        - Illustration of cost or return
        - Other
        - Replacement disclosure form

- Tied selling

d. Product

- Adequacy of product
- Availability / Accessibility
- Other
- Policy provisions
- Policy value
- Prospectus
- Rate of Return (ROR)

Renewal

e. Claims/Settlement

- Claim procedure
- Customer service (timeliness, knowledge, expertise)
- Delay in settlement
- Direct Compensation Agreement /Fault Determination Rules
- Other
- Performance of mandate
- Refusal of claim
- Reporting to client

Suspension of benefit

7. Outcome of the complaint:

- Agreement reached
- Agreements not reached

Withdrawn

12. Protection of Personal Information

1. Do you have policies and procedures in place regarding breaches in confidentiality and the protection of personal information?	Y/N
If yes, please indicate which of the following are addressed by your policies and procedures:	
a) timely notification to consumers of any breaches that could impact their interests or rights	
b) timely notification to the appropriate authorities of any breaches that could impact the consumer's interests or rights	
c) timely notification to the responsible and appropriate individuals within your organization	
Comments:	
2. Have you had any breaches in the protection of personal information in the past year?	Y/N
If yes, indicate the number of breaches	
3. Were the breaches reported to the proper authorities where required by law (e.g., Privacy Commissioner, regulatory authority)?	Y/N
If no, please provide details as to why the incident(s) was not reported to the appropriate authority	

July 2016

CAFII Consultations/Submissions Timetable 2016-17

Regulatory Issue	Deliverable	Deadline	Accountable
BC FICOM 10-Year Review of FIA (consultation paper released June 2, 2015)	• CAFII Response to Initial Consultation Paper • Meetings with Ministry of Finance officials • Public Report on input received on Initial Consultation Paper • Policy Paper on proposals for change • **CAFII Response to Policy Paper** • *Meeting with Ministry of Finance officials, if necessary* • Amendments to Act and drafting of Regulations	• Sep 15, 2015 • Nov 10, 2015 • Issued March 23, 2016 • Q1 or Q2 2017 • **Q2 or Q3 2017** • *Q2 or Q3 2017* • Q4 2017	• Joint Market Conduct/ Licensing Committee; ED to monitor
BC "Effecting" of CGI Issue	• FICOM Information Bulletin on CGI • Meeting with FICOM officials re Bulletin's directives • CAFII follow-up letter seeking clarification on key Bulletin issues • CAFII teleconference with FICOM officials re follow-up letter • **CAFII to provide further info re auto dealers**	• Issued Sep 14, 2015 • Nov 10, 2015 • March 15, 2016 • April 14, 2016 • **Sep 2016**	• EOC; ED to monitor
QC Ministry of Finance Review of Distribution Act	• CAFII Response to June 12/15 Consultation Report • Dialogue with Ministry re meeting re online distribution • Legislation to be tabled, via omnibus Bill, for industry consultation • **CAFII Response to draft legislation**	• Sep 30, 2015 • Completed March 2016 • Q4 2016 • ***Q4 2016 or Q1 2017***	• Joint Mkt Cndct/ Lcnsing Cttee; ED to monitor
CCIR Annual Statement on Market Conduct	• CAFII Response to Draft Annual Statement (released Oct 28/15) • Revised Draft released for 45 day consultation period • **CAFII Response to Draft 3**	• Dec 4, 2015 • July 12, 2016 • **August 26, 2016**	• Market Conduct Cttee; ED to monitor
CCIR Review of Travel Health Insurance	• CAFII/CLHIA joint update meeting with CCIR TIWG • Issues Paper released for 90 day consultation • *Meeting with CCIR TIWG re Issues Paper* • **CAFII Response to Issues Paper** • *Meeting with CCIR TIWG re Response to Issues Paper, if necessary* • CCIR releases Position Paper	• March 2016 • July 4, 2016 • *Aug 10, 2016* • **Sep 30, 2016** • *Oct/Nov 2016* • Q4 2016 or Q1 2017	• EOC; ED to monitor
SK Bill 177	• FCAA conducts Part I of consultation on Draft Regulations • FCAA releases Draft Regulations for Part II of industry consultation • **CAFII Response to Draft Regulations** • *Meeting with FCAA officials re CAFII submission*	• Q3 2016 • Q3 2016 • **Nov/Dec 2016** • *Nov/Dec 2016*	• Market Conduct Cttee; ED to monitor
FCAC "Compliance Framework"	• FCAC publishes consultation document • **CAFII submission**	• Summer/Fall 2016 • Fall 2016	• EOC; ED to monitor
"Modernizing the New Brunswick Insurance Licensing Framework"	• CAFII Response to Position Paper on aspects related to life agents • FCNB delivers final recommendations to Minister	• Jan 22, 2016 • ?	• Licensing Cttee; ED to monitor

Underline = new/updated item since previous publication; **Boldface = CAFII response pending**; *Italics = CAFII meeting with regulators/policy-makers pending*