Life and Health Insurance FAQ

General Questions

1. When will insurers requested by their provincial/territorial regulatory authority be notified of their requirement to file (i.e., Tier 3)?
Insurers requested to by their provincial/territorial regulatory authority to complete the Annual Statement will be notified on March 28 at the latest. That is the date insurers will receive instructions on how to fulfill their requirements. However, the provincial/territorial regulatory authority may contact them directly in advance of that.

2. When will the final Excel version that is to be completed and submitted be made available to insurers?
The Excel version of the Annual Statement will be made available on March 28. We have received a number of requests to make it available earlier to assist insurers in compiling the information. Efforts are being made to get the final Excel version to reporting insurers as soon as possible. It should be noted that the only Excel version that will be made available to insurers will be the final version (i.e., the version that insurers will be able to file). This is being done in order to prevent potential issues related to data transfer between Excel files and to ensure only the compliant versions are submitted.

3. Who should insurers contact with any questions they may have regarding the Annual Statement?
For technical questions regarding the database, file or interface through which the data will be submitted, insurers are asked to contact the Autorité des marchés financiers (AMF). Details and contact information will be included in the instructions that will be emailed to the insurers required to file.

For all other questions (i.e., non-technical in nature), insurers are asked to contact their provincial/territorial regulatory authority.

4. CCIR has stated: “Detailed information regarding completion and filing of the Annual Statement will be provided to those insurers that are required to complete the Annual Statement in 2017”. If a company does not receive a communication, then it is not expected to file a report, even though it may be filing complaints through the complaint system today?
If a company was required to file complaint data through the National Complaint Reporting System (CRS), they are now required to file that data through the Annual Statement (as well as complete the section on governance). This category of reporting requirements is our second of three tiers. More information on these tiers can be found on the CCIR website.

To answer the question implied by the example, email service issues and junk mail filters cannot spare an insurer from this requirement. If your company files information through the CRS but does not receive instructions from the CCIR by March 28, please contact your provincial or territorial regulatory authority.

5. How much advance notice will insurers be provided in terms of changes being made to the Annual Statement? What will the compliance expectations be for insurers following changes to the Annual Statement?

The CCIR intends to provide insurers with sufficient notice of changes being contemplated for the Annual Statement. We do not intend to include any substantive changes for the 2018 return, which will be used to file 2017 data. We expect to begin consultations this year regarding possible changes for 2019's return which will be used to file 2018 data.

In terms of compliance expectations, it really depends on the circumstances and new questions or changes to the questions being asked. For the first year, some fields are considered mandatory, and the CCIR has adopted a "best efforts" approach.

6. The *Introduction to the Annual Statement* states that "yes-no" questions are mandatory. Does this include the "yes-no" questions that are in the tables (i.e., Distributors)?
The "yes-no" questions on the tables are mandatory.

7. Do insurers completing only the Governance and Complaints sections (i.e., Tier 2 insurers) need to sign the attestation?
Yes. All insurers providing information through the Annual Statement need to complete and sign the attestation.

General Instructions

1. Does "complete denials of claims" mean a denial of all exposures? (4. Detailed Instructions: Claims (8))
Complete denial of claims in the definition refers to denials of all exposures.

2. What is meant by "product family" and what are the implications
The CCIR had intended on collecting information on each product sold by an insurer in the reporting period. During our consultations with industry, it was noted that as contracts, insurance policies differ slightly from one client to the next. As a result, the input we received from industry was that requesting information on each product sold would lead to insurers having to report every contract since each could be slightly different from the next.

"Product family" is intended to refer to the base product. This is more focused than product category (i.e., auto insurance, home insurance…), but not as specific as "unique contract". We understand that contracts may be revised or include an endorsement that is offered or accepted in one circumstance but not in another. If the products sold by the insurer can be grouped together based on their core similarities, we expect the insurer to report them together.

Governance

1. Do third-party sales include insurance broker distribution for an indirect insurer?
Yes, while not defined in the document, third-party refers to sales that are not direct.

2. Question 2 asks for the number of employees. Does this include contract employees?
Indicate the total number of employees within the insurer. It includes all categories and classifications of employees.

3. Question 2, section 4: “How many of these products were reviewed with a focus on fair treatment of consumers and suitability in the reporting period?” What would satisfy such a review?
Section 3f of the definitions subsection in the instructions provides a definition of fair treatment of consumers (FTC). This definition includes a list of seven outcomes associated with FTC. Reviews that focused on any or all of these seven outcomes would be appropriate for this question.

Policies & Products

1. Does “number of new policies” refer to policies or coverages?
New policies refers to policies, not coverages.

2. Does Accident and Sickness” include critical illness insurance?
Yes, A&S includes critical illness in this section.

3. What is meant by “non-renewal”?
When a policy that is in force is not renewed following the end of the policy term. Non-renewal can be initiated by the insurer or the client.

4. What is meant by “number of insurer-initiated cancellations for non-payment or non-sufficient funds”?
This refers to policies that have been cancelled by the insurer for the specific reasons provided (i.e., that payments were not made or that the payments were insufficient).

5. We do not track application acceptance/denial. How is this to be reported?
For any data that is not tracked by an insurer, we ask that you use the “comments” section to explain that. You are also expected to provide details on when this data will become available. This is part of our “best efforts” approach. We understand that not all of the required data is available for all insurers this year. Please provide the data that you can and provide an explanation as to when you will have the data if it currently isn’t available.

6. Do we include the information if a company or product is in run off? For example, if we stopped writing new business in June 2016 for a particular company/line of business, and we will have policies in force until the end of June 2017, do we include those policies?
Yes. The licensed entity is to report all the requested information. If the circumstances for the insurer are unique or unusual, we expect you to use the comments section to provide this context.

7. How do we show provincial differences if this is a drop down fillable PDF that we are completing? Or do we need to split out by province?
The table in question does not request province-specific data. The information is to be reported by entity, not by province or territory.

8. Should insurers report products that are closed for new sales?
Insurers must report all products sold and in force during the reporting period. If a product was not sold during the reporting period it is not to be reported. If a product was sold during the period, or has in force policies during the period it must be reported.

Premiums, commissions and claims

1. Commissions – does this include broker commissions + contingent profit + overrides?
It includes all variable forms of remuneration tied to sales activity.

2. What is the definition of an Independent Agent and Direct & Exclusive Agent?
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 agents or associated general agents 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.

3. What is the definition of a general agent and managing general agent?
General agent is the same as an MGA in that it is a third party. Broker includes general agent and managing general agent ("MGA").

4. For the Commissions section, is this net commission and does it include all forms of commission?
We refer to direct commission in respect of premiums written and it includes all forms of commission.

5. For the Claims Incurred section, is this Net Claims Incurred?
We refer to direct Claims, before recovery and without reinsurance.

Distributors

1. What information is to be reported in the column immediately after the one that contains numbers 1-25? Are we expected to report the broker name or some other identifier?
You do not report the broker name. In that space you are to report "Firm 1", "Firm 2"…

2. Who will the information on distributors be shared with? Is this information remaining strictly with the CCIR?
The information you provide will not be shared beyond the CCIR members who have signed the MOU.

3. What does "% participating in firm's equity" mean?
For this question, please identify your ownership interest in the firm.

4. Are career distribution networks considered a single entity that is owned by a parent company?
If "career distribution networks" refers to a distribution method that could be described as "captive agencies", then insurers are to report it as one "Direct or Exclusive agent".

5. We currently do not publicly disclose/specifically identify brokers who have loans with our company. Can we use an alternative identifier?

Insurers are required to provide the information being asked by the question. Alternative identifiers and other data sources are not acceptable. Many of the questions included in the Annual Statement will result in insurers providing data they had not reported in the past.

Sales and Incentives Management

1. What is meant by “direct sale”?
Direct sales are the sales that are done by direct agents. A direct or exclusive agent is bound by an exclusive contract with a single insurer to act on behalf of a firm that is an insurer.

2. What information is expected for “second year” under lapses since this is the first year of reporting?
If the policy lapses in the first 365 days of being in force, it is to be reported under “first year’. So, for this year, any policies that came into force in 2016 and lapsed in 2016 are to be inputted under “first year”. Policies that came into for in 2015 (i.e., the previous year) and lapsed in 2016 are to be reported under “second year”.

Claims

1. Could you specify the reasons for denials that are provided?
There are five reasons for denial provided, their definitions are as follows:

- **Exclusions and limitations:** the claim fall outside of the coverage as expressly identified in the exclusions or limitations included in the contract;
- **Delay in submitting the claim:** instances where the permitted time for consumers to file the claim has expired;
- **Not covered, except for exclusions or limitations in the policy:** the claim does not fall within the scope of the insurance contract (not that it is expressly excluded or limited);
- **Failure to disclosure or misrepresentation of material fact:** situations where critical information provided by the insured is either incorrect or has not been provided; and
- **Other:** refers to circumstances that do not correspond with the four categories provided.

2. Are health and dental or AD&D claims expected to be reported under “accident and sickness”?
Only those items listed in the instructions are to be reported.

3. Does “travel insurance-related information” mean travel insurance?
Yes, insurers are to report information related to travel insurance under A&S.

4. Does short or long term disability under A&S include waiver of premium claims under a life policy and claims paid under all products that pay benefits in the event of disability (credit insurance, mortgage protection, etc.)?
Yes. It should include all of the examples provided in the question.

5. Do insurers answer based on the policy or based on the type of claim? There could be multiple claims being made in different categories through one policy
Answers are to be based on the policy.

6. Under lawsuits, what does “new” mean?
“New lawsuits” refers to any lawsuits that were opened during the reporting period.

7. Under lawsuits, what does “closed” mean?
“Closed lawsuits” refers to any lawsuits that were closed during the reporting period.

8. Are payments for periodic and instalment payments that closed within the reporting period included in “amount paid in benefits during the period”?
Yes, it includes those payments.

Complaint Reporting

1. Are entities that are currently exempted from reporting complaints also exempted from reporting them through the Annual Statement?
The intention for the first year is to ensure the data currently being captured on complaints through the CRS is captured through the Annual Statement. Entities that do not have to file complaint data through the CRS do not fit under tier 2 (i.e., do not file complaints through the Annual Statement).

2. Are insurers required to file all complaint data for 2016 or only the data that has not yet been filed?
The data insurers filed through the CRS for the first half of the reporting period do not have to be filed again through the Annual Statement. Only unreported complaints for the period need to be filed.

3. Why does the Annual Statement ask insurers to identify the stage at which an insurer reports a complaint to the regulator if this has been established by the Financial Services Commission of Ontario (FSCO) and the AMF?
The Annual Statement is a national form that is not limited to insurers that had been filing through the CRS. It will be used across the country. In jurisdictions that had not been using the CRS, the responses to this question may differ from what has been established in by FSCO and the AMF.

4. What should insurers report for “distribution channel” if the complaint is based on a policy that had been sold prior to the insurer tracking information on distribution methods?
Insured are expected to list it as “Other” and provide the details as to why they cannot accurately account for the type of distribution channel the product was sold through.

5. Will data for complaints that are not closed be carried over in the Excel file for subsequent years?
Yes, this information will be included in the Excel files provided to insurers beginning in the second year.

6. How many options can/should be selected for “cause of complaint”? Complaints from insured may be in respect of more than item/concern with the policy (i.e., limitation endorsement and the amount paid by the insurer)
The section on complaints is intended to be consistent with the CRS. You are to identify the main cause for the complaint. You can use the comments section to identify other causes for the complaint.

7. There are some agencies/firms (e.g. in Quebec), which are not insurers, that file complaints data semi-annually through the CRS. Will these firms continue to file through the CRS semi-annually?
Yes. Only insurers will file complaints through the Annual Statement. The firms in Quebec will continue to file through the CRS.

8. Do the complaint reporting requirements include provinces that were not previously included in the CRS (e.g., British Columbia)?
All complaint data is to be reported through the Annual Statement. It is a national form.