Combined Insurance Company of America Complaint Examination and Dispute Resolution Policy ("Policy")

As part of its objectives toward the fair treatment of consumers and in order to foster sound commercial practices, Combined Insurance Company of America ("Combined Insurance" or "Company") is committed to providing high quality products and services to assist Canadians with their supplemental insurance protection needs. If consumers have any concerns or complaints about the Company's products, services or representatives, these concerns shall be handled fairly and efficiently, in accordance with the terms of this Policy.

Consumers shall be provided with a free and accessible means with which to communicate their complaint. Combined Insurance will make every effort to respond to complaints promptly, accurately and with the utmost courtesy. All complaints, whether written or oral, shall be handled in a timely, professional and secure manner, and in accordance with applicable laws, including those laws governing the protection of personal information.

Purpose of the policy

The purpose of this Policy is to provide consumers with a clear and fair procedure for dealing with their complaints. This Policy explains the process put in place by Combined Insurance to handle the receipt of consumer concerns or complaints, the delivery of the acknowledgement of receipt and notices to the complainant, the creation of the complaint file, the fair and thorough review of the complaint and the compilation of complaints for the purpose of preparing and filing reports with the appropriate provincial regulators, as required. In addition, this Policy outlines the right of the complainant to request the transfer of the complaint file to the Autorité des marchés financiers ("AMF") for Québec residents or the OmbudService for Life and Health Insurance ("OLHI") for all Canadian residents.

Definition of a Complaint

For the purposes of this Policy, a complaint must include one or more of the following three elements:

- A reproach against Combined Insurance;
- A description of the actual or potential harm that the complainant has sustained or may sustain; or
- A request for remedial action.

Combined Insurance has a multi-level complaint escalation process. Each level is further described below:

- Level 1 – Let us know; contact a Customer Service Representative at **1 888 234-4466**
- Level 2 – Talk to management or send the complaint in writing
- Level 3 – Contact Combined Insurance's Chief Complaint Officer
- Level 4 – Review by an external organization

Individual Responsible for Applying this Policy

The Chief Complaint Officer, Fabienne Azoulay, is an employee of Combined Insurance who is responsible for applying this Policy. This person ensures that Combined Insurance's staff who handle complaints are trained and provides them with the necessary information for compliance with this Policy. The Chief Complaint Officer reviews and responds to formal complaints and serves as an intermediary with the various regulatory bodies that govern Combined Insurance with respect to dispute resolution and the handling of complaints. This person is also responsible for transferring the complaint file to the AMF or OLHI, as applicable, at the complainant's request as well as for the semi-annual and annual reporting to the appropriate provincial regulators with regards to complaints.

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Dissatisfaction (Level 1)

If consumers have a concern, they should first contact a Customer Service Representative at **1 888 234-4466** between 8 a.m. and 7 p.m. Eastern time, Monday through Friday. Most situations can be resolved quickly and easily by speaking with a Customer Service Representative. Or, consumers may communicate with the Company in writing by mail at the address below:

Combined Insurance Company of America
P.O. Box 3720, MIP
Markham, Ontario L3R 0X5
Attention: Customer Service

Concerns can also be sent through Combined Insurance's website at www.combined.ca under "Contact Us" or by fax at 905 305-8600.

Complaints (Level 2)

If a concern or complaint cannot be quickly resolved by the Customer Service team, it will be forwarded to the department that handles and makes decisions about the subject matter outlined in the communication. The person handling the complaint will send the consumer a letter within five (5) business days to acknowledge receipt of the complaint. A written response will be sent once the complaint has been reviewed, generally within thirty (30) business days.

If this does not resolve the concern, there are additional steps that can be taken.

Formal Complaints - Chief Complaint Officer (Level 3)

When a concern or dispute cannot be resolved in the course of normal Company business (Levels 1 and 2), or if the consumer remains dissatisfied with the written response that has been provided, a formal complaint can be sent in writing to the Chief Complaint Officer at:

Combined Insurance Company of America
P.O. Box 3720, MIP
Markham, Ontario L3R 0X5
Attention: Chief Complaint Officer

Upon receipt of a formal complaint, the Chief Complaint Officer ensures that the concern or complaint has been handled and has gone through the escalation steps in the internal process described above, failing which the Chief Complaint Officer returns the request to the appropriate department so these steps can be followed.

If the complaint was properly escalated through the internal process, the Chief Complaint Officer will:

- Make sure the complaint process has been followed and that the complaint has been fairly considered;
- Send the consumer an acknowledgment of receipt and notice, within 5 business days. The correspondence will include a description of the complaint, specifying the real or potential harm, the reproach against the Company or the requested remedial action, the Chief Complaint Officer's name and contact information along with a copy of this Policy. In the case of an incomplete complaint, more information will be requested. If a response is not provided within a set deadline, the complaint will be deemed to have been abandoned;
- Review and analyze the complaint in a fair and impartial manner, requesting more information if required;
- Provide the consumer with a final written response (final position letter) within 30 business days of receiving all the information necessary for the examination, explaining the outcome along with the reasons behind the decision. If the examination of the complaint cannot be completed within 30 business days, the consumer will be informed of the status and progress of the examination and provided with an approximate response date;
- The response shall include a notification of the external recourses available to consumers if they remain dissatisfied and wish to pursue or transfer their complaint file. For Québec residents, this will include a reminder that transferring the file does not interrupt the prescriptive period for civil remedies.

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Complaint File, Register and Regulatory Reporting

A separate file is created for each complaint received. Subject to continued compliance with applicable privacy laws, each complaint file contains the complainant's written complaint and the defining element(s) of a complaint, as described above, all supporting documentation, information and notes, the acknowledgement of receipt and the outcome of the complaint examination process (the analysis and supporting documents), a copy of the complaint response and, if applicable, the Chief Complaint Officer's final position letter outlining the justification behind the decision. Such records are kept in accordance with applicable laws and the Company's record retention policy.

The information related to the complaint is entered in a complaint register and given a file number. Reports to provincial regulators are filed twice per year in Québec (with the AMF), detailing the number and type of complaints received. In addition, an annual report is filed with the Canadian Council of Insurance Regulators (CCIR).

Complaint Transfer (Level 4)

If consumers are dissatisfied with the outcome of the handling of their complaint by the Chief Complaint Officer or the complaint examination process, they can request that the complaint file be transferred to the appropriate regulatory body or consumer organization at any time.

For residents of Québec, the file may be transferred to the Autorité des marchés financiers (AMF) for their review (www.lautorite.qc.ca). The AMF may be reached by calling toll-free at 1-877-525-0337, via email at information@lautorite.qc.ca, or by mail:

Québec City Place de la Cité, tour Cominar 2640, boulevard Laurier, bureau 400 Québec (Québec) G1V 5C1 Telephone: 418-525-0337 Fax: 418-525-9512	**Montréal** 800, square Victoria, 4e étage C.P. 246, Place Victoria Montréal (Québec) H4Z 1G3 Telephone: 514-395-0337 Fax: 514-873-3090

All Canadian residents including those in Québec, may contact the OmbudService for Life & Health Insurance (OLHI) (www.olhi.ca). The OLHI is a national independent complaint resolution and information service for consumers of Canadian life and health insurance products and services. The OLHI deals with concerns about life and health insurance products and services that have not been resolved through the Company's dispute resolution system. The OLHI can be reached by calling:

Telephone numbers:	
Toll-free: 1 888-295-8112	**Québec:** 1 866-582-2088
Toronto: 416-777-9002	**Montréal:** 514-282-2088
Edmonton: 780-643-6165	
All correspondence should be sent to OLHI's Toronto office: OmbudService for Life & Health Insurance 20 Adelaide Street East, Suite 802, PO Box 29 Toronto ON M5C 2T6	

Policy Review

This Policy is effective as of July 2021. It is reviewed every two years or earlier to reflect changes in applicable legislation or guidance..

Last updated: July 2021