



Strengthening Our Impact

2026 Annual Report

April 1, 2025 to March 31, 2026



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Our Commitment to Canadians

Accessibility

Our free services are available in English and French to consumers of life and health insurance products, who can contact us online, by phone, fax, or mail.

Timeliness

We aim to respond to voicemails within 48 hours and webforms and emails within 72 hours.

Courtesy

Civility, professionalism, and respect define every interaction.

Clarity

We use plain language in all communications to help consumers navigate the complaints process and understand the applicable provisions of their insurance policies.

Accuracy

We are committed to providing accurate and reliable information.

Fairness & Impartiality

We are unbiased and impartial.

Consistency

We continuously follow a rigorous process, treating similar cases consistently, while recognizing the uniqueness of each case.

Knowledge

We are knowledgeable in the areas of insurance and dispute resolution and strive to learn from each case.

Privacy

All our communications and cases are 100% confidential. We follow rigorous standards and policies to protect privacy and safeguard personal information.

Independence & Objectivity

Our governance framework, including a majority of independent directors and external oversight by the Canadian Council of Insurance Regulators (CCIR), ensures that we are independent and separate from the government and the industry.

OLHI Services

OLHI: Supporting Consumers Every Day

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

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

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

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

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

Free

Our services are **free to consumers**.

Fast

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

Impartial

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

Independent

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

Visit olhi.ca to learn more



Dan Levert

Message from the Chair

During my first full year as Chair of OLHI's Board, we welcomed two new Directors, industry representative Mary Nemeth and independent director Charlene Butler. Mary, who served as a director of the Canadian Life and Health Insurance Association comes from Winnipeg, where she spent her career in the insurance industry. Charlene hails from Edmonton and brings with her extensive board experience in both the public and private sectors. Our new Directors have already demonstrated their attentiveness and diligence, and we look forward to working with Mary and Charlene to fulfill our mandate.

Following a tenure of 15 years, Dr. Dieter Kays has announced he will be stepping down as industry director in September. Since joining OLHI in 2010, Dieter has maintained an exceptional attendance record, and his dedication to this organization cannot be overstated. With broad industry and board experience, Dr. Kays played an integral role in OLHI's development and success. We wish to express our deep appreciation for Dieter's dedication and loyalty to this organization.

I am pleased to report that the recommendations stemming from the Fourth Independent Review, including the consumer satisfaction survey, will have been implemented by the end of the first quarter of 2027. I want to thank independent director Louise Shiller and her Standards Committee, as well as our management and staff for their extensive work in addressing the matters raised by the Independent Review.

We are grateful to industry director Frank Swedlove and our Executive Director and Ombudsman Stéphanie Robillard for their dedicated work assisting our industry's regulatory oversight body, the Canadian Council of Insurance Regulators (CCIR), in reviewing and updating the Insurance OmbudServices Cooperation and Oversight Framework. We look forward to working more closely with CCIR in the years to come.

Our records indicate that consumers of life and health insurance products are requesting our services more than ever. This increase in demand is being closely monitored and has led to a corresponding increase in staff resources. Our staff, ably led by Stéphanie and Senior Deputy Ombudsman Dorothee Beaupré Bernier, has responded admirably to the challenge. We thank them for their dedication and service.

Finally, a word of gratitude to my fellow directors for their insight and guidance, and to our participating companies for their continued confidence in OLHI.



*Stéphanie
Robillard*

Message from the Executive Director and Ombudsman

This year marked an important step in the continued evolution of our organization. Building on the progress made over the past year, we strengthened the foundation that supports our mission while continuing to respond to the increasing needs of consumers across Canada seeking independent, impartial and fair resolution of life and health insurance complaints.

Throughout the year, we further modernized our organization by enhancing our governance, refining internal policies and practices, and strengthening the tools and resources that support our work. A clear objective guided these efforts: ensuring that OLHI remains well-positioned to meet evolving expectations while continuing to deliver high-quality services to Canadians.

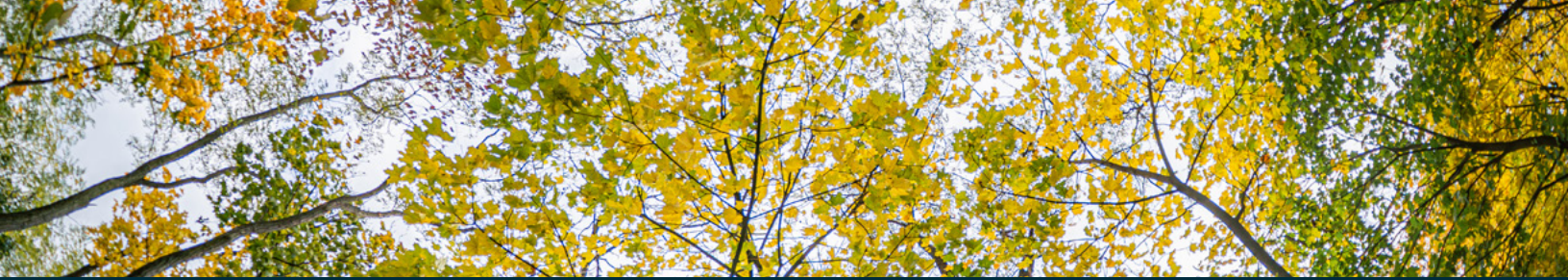
One of this year's most significant milestones was the collaborative work undertaken with our stakeholders, including the Canadian Life and Health Insurance Association (CLHIA), the General Insurance OmbudService (GIO), the Insurance Bureau of Canada (IBC), and with our oversight body, the Canadian Council of Insurance Regulators (CCIR), to modernize the Framework upon which we rely. Additionally, we launched our new website, designed to improve accessibility and usability. Together, these initiatives resulted in the implementation of key recommendations of the Fourth Independent Review, demonstrating our ongoing commitment to continuous improvement.

As demand for our services continued to grow, reaching the highest level in OLHI's history, our dedicated team remained focused on providing Canadian consumers with reliable information, guidance, assistance, and timely, impartial and fair dispute resolution. The growing number of inquiries and complaints reflects both the need for our services and the trust that consumers continue to place in OLHI. At the same time, we advanced strategic initiatives that will benefit our organization well into the future, including the final stages of implementing the recommendations arising from the Fourth Independent Review.

Looking ahead, we will continue to build on this momentum. Our priorities remain clearly defined: enhancing the consumer experience, working collaboratively with stakeholders to strengthen Canada's life and health insurance dispute resolution system, continually improving the effectiveness of our services, and ensuring the sustainability of our organization, all while fostering trust through transparency.

This year's achievements have not only reinforced our organization but have also positioned OLHI to better meet the evolving needs of Canadian consumers.

I am proud of what our team has accomplished and confident that this work will enable us to continue delivering independent, impartial and effective services to Canadian consumers and insurers, with integrity, fairness and accountability.



OLHI OUTREACH

During 2025-2026, OLHI maintained an active presence within the insurance industry by participating in key industry events.

These efforts reflect our commitment to fostering collaboration and strengthening relationships with all stakeholders, including consumers, regulators, insurers, and other dispute resolution professionals.

Compliance and Consumer Complaints Annual Conference (CLHIA)

OLHI staff members participated in CLHIA's annual conference in May 2026. Dorothee Beaupré Bernier, Senior Deputy Ombudsman, facilitated a workshop on the updated Insurance OmbudServices Cooperation and Oversight Framework, using a case study to demonstrate the practical application of the fairness principle. The conference is one of Canada's leading forums for professionals involved in compliance and complaint management in the life and health insurance sector.

International Network of Financial Services Ombudsman Schemes

In October 2025, Stéphanie Robillard, Executive Director and Ombudsman, attended the INFO Network conference hosted by the International Network of Financial Services Ombudsman Schemes. Participation in this global forum supports OLHI's commitment to continuous learning, international collaboration, and the exchange of leading practices in consumer dispute resolution.

Consumer Outreach

In April 2026, OLHI delivered an educational workshop to AlphaNet Canada, a non-profit patient advocacy

organization, whose members were interested in learning more about OLHI's services. The session provided an overview of OLHI's mandate, complaints review process, and role as an independent dispute resolution service. Through outreach initiatives such as this, OLHI continues to raise awareness of its services and engage directly with consumer communities.

Professional affiliations

In 2025 and 2026, OLHI joined two professional associations: the Association des responsables de la gestion des plaintes (ARGP) and the Forum of Canadian Ombudsman (FCO). The ARGP provides a forum for information sharing, collaboration, and the advancement of effective complaint management practices in the province of Québec. The FCO brings together ombuds and complaint resolution professionals from government, private industry, colleges, and universities across Canada. Through these memberships, OLHI strengthens its connections with complaint resolution professionals and remains engaged in ongoing discussions on fairness, accessibility, and best practices in complaint handling.



How we help
consumers



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

Inquiries

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

Consumer Assistance, Complaints, Policy Searches

OLHI responds to three types of inquiries:

- Consumer assistance—help with insurance questions and guidance.
- Complaints—formal disputes with insurance companies.
- Policy searches—facilitating life insurance policy searches.

OLHI can review a complaint if:

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

Complaints Manager Evaluations

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

Complaints Analyst Reviews

When a complaint is accepted for review, a Complaints Analyst conducts an independent and impartial review to determine if it has merit. The analyst speaks with both the insurer and the consumer to gather information. OLHI's complaints team works to resolve cases as quickly as possible. This may involve informal negotiation at the complaint analysis level.

OmbudService Officer (OSO) Investigations

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

Senior Adjudicative Officer (SAO) Investigations

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

Web Session

An interaction between a consumer and OLHI's English or French portals.

Inquiry

Direct contact with OLHI's staff.

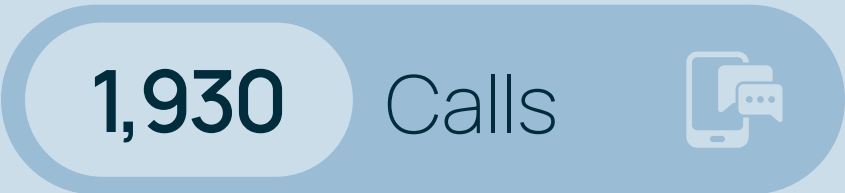
Complaint

OLHI received consumer complaint documents and authorization form.

Investigation

A complaint was escalated to OSO or SAO levels.

How Consumers Consulted Us



Total 

155,811

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

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

148,998

Web Sessions

6,813

Inquiries

1,018

Consumer
assistance

2,258

Complaints

3,537

Policy
Searches

486

Complaints
Manager Evaluations

379

Complaints
Analyst Reviews

13

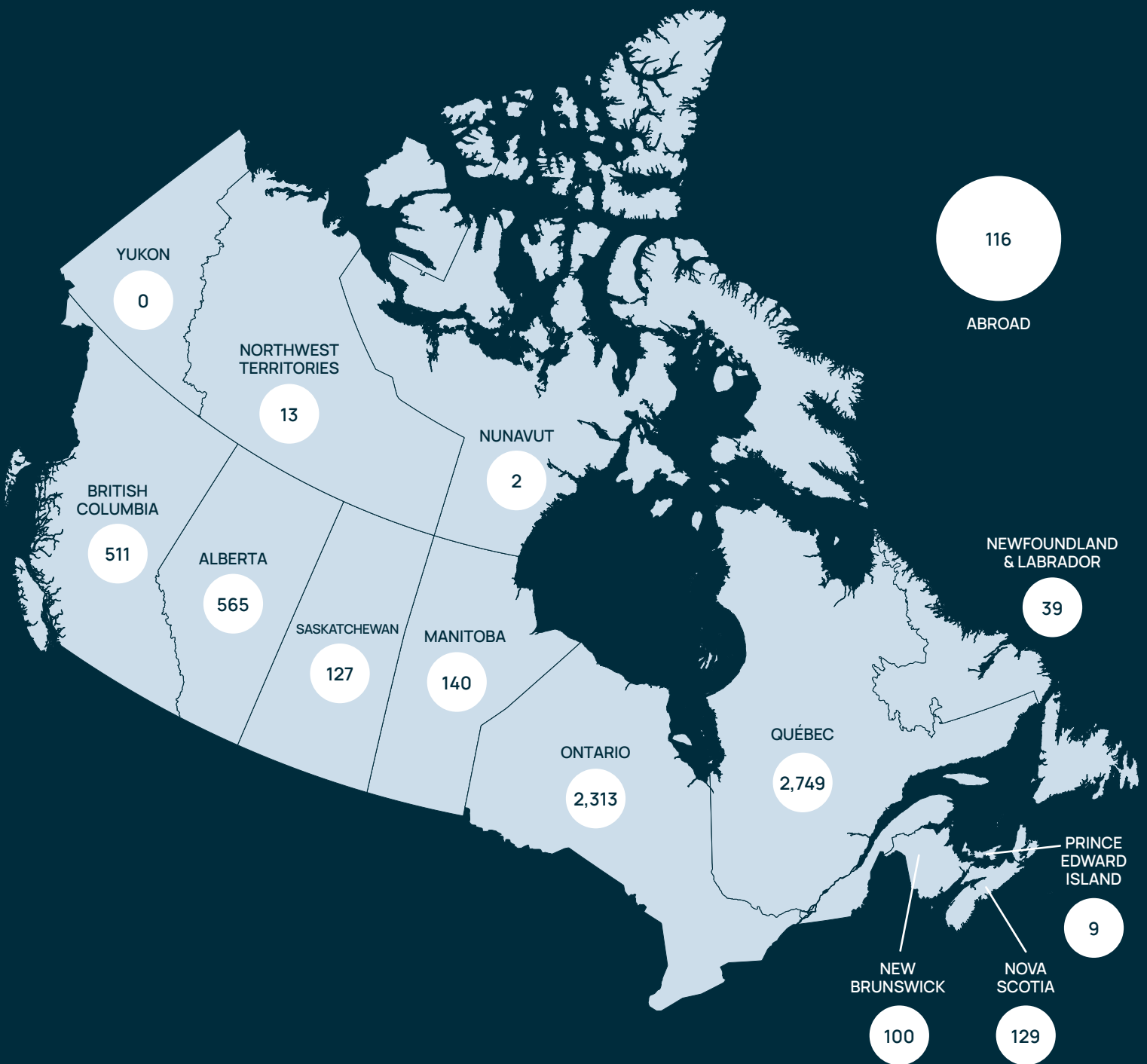
OmbudService
Officer Investigations

0

Senior Adjudicative
Officer Investigations



Consumer Engagement Overview

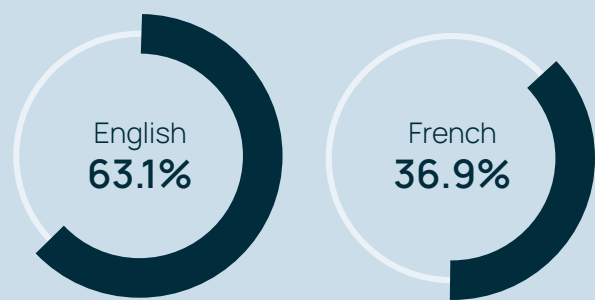


Inquiries by Provinces and Territories

Abroad	116
Alberta	565
British Columbia	511
Manitoba	140
New Brunswick	100
Newfoundland and Labrador	39
Northwest Territories	13
Nova Scotia	129
Nunavut	2
Ontario	2,313
Prince Edward Island	9
Québec	2,749
Saskatchewan	127
Yukon	0
Total	6,813

Inquiries by language

English	4,301
French	2,512

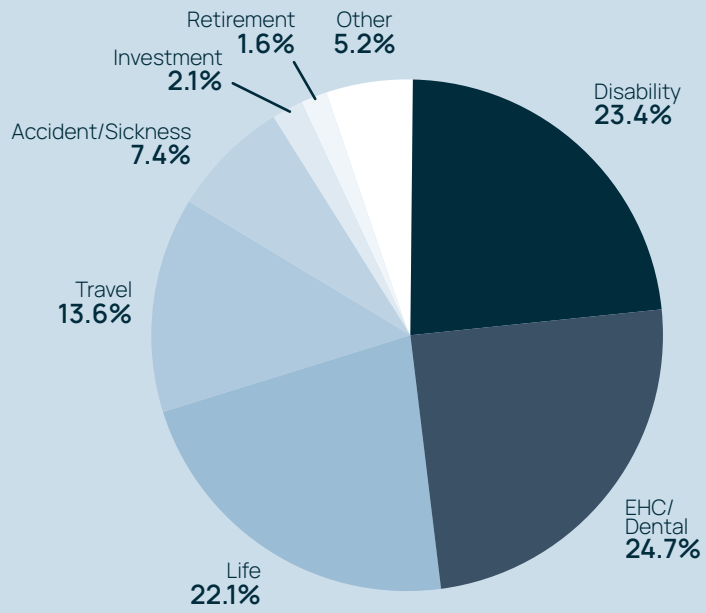




Complaint Trends and Breakdown

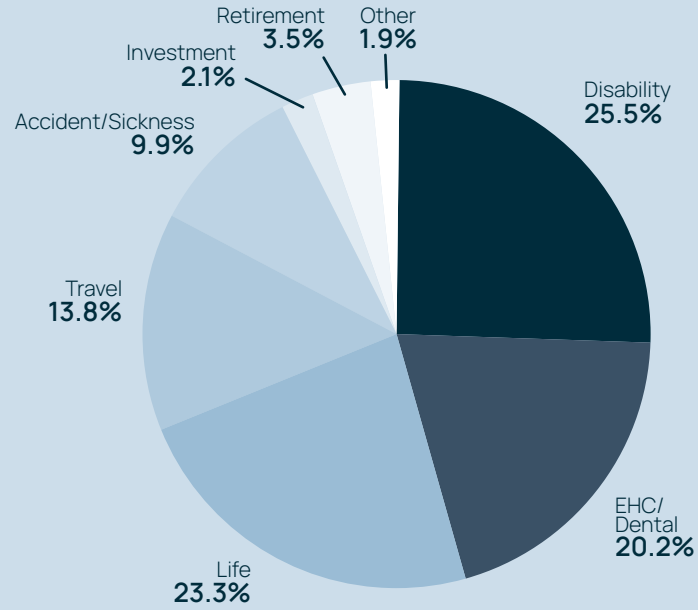
Complaint Inquiries by Product

Disability	528
EHC/Dental	557
Life	499
Travel	306
Accident/Sickness	168
Investment	47
Retirement	36
Other	117
Total	2,258



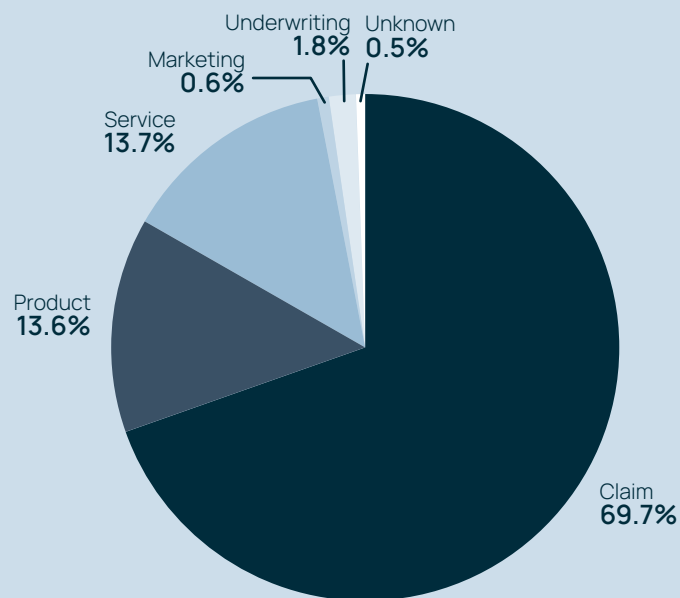
Complaints by Product

Disability	124
EHC/Dental	98
Life	113
Travel	67
Accident/Sickness	48
Investment	10
Retirement	17
Other	9
Total	486



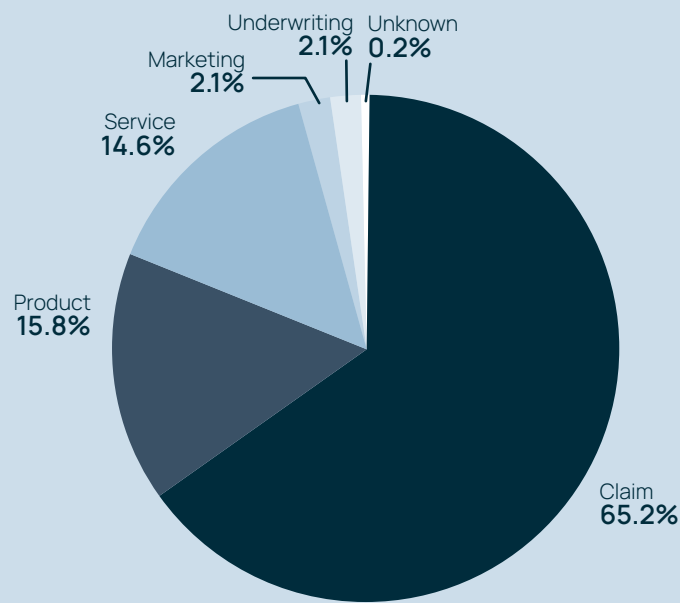
Complaint Inquiries by Company Function

Claim	1573
Product	308
Service	310
Marketing	14
Underwriting	41
Unknown	12
Total	2,258



Complaints by Company Function

Claim	317
Product	77
Service	71
Marketing	10
Underwriting	10
Unknown	1
Total	486





Case Studies



Case Studies

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

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

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

CASE 1

Clarifying a Complex Situation

A consumer was denied a critical illness claim because the illness had been diagnosed before coverage began

OLHI can clarify complex situations and help consumers reach successful outcomes.

While insured under a previous group policy, the consumer was diagnosed with low-grade follicular lymphoma and did not submit a claim due to the nature of the diagnosis. Their condition remained stable for a few years. After coverage transitioned to a different insurer, the disease progressed and eventually required chemotherapy. When the claim was submitted to the new insurer, it was denied on the grounds that the initial diagnosis had occurred before the coverage took effect.

The consumer's representative reached out to OLHI for assistance. OLHI assessed whether the claim met the eligibility criteria under the second insurer's policy and found that the insurer had acted in accordance with the terms of the policy and did not recommend further action. Although the consumer's representative was initially dissatisfied with this outcome, OLHI advised them to pursue the claim with the first insurer before OLHI could review the matter further.

The first insurer eventually agreed to pay the claim after the claims process was completed by the consumer. After the resolution, the consumer's representative thanked OLHI for its involvement and clarification regarding this situation.

This case shows how OLHI can clarify complex situations and guide consumers to a successful outcome, even when its analysis does not result in a recommendation to the insurer that was the subject of the complaint.

CASE 2

Identifying an Important Contractual Gap

When visa delays prevented the consumer's family from travelling to Canada, they were left with an expired travel medical policy and no refund.

OLHI's intervention led to the insurer revisiting its position and issuing a full refund.

The consumer purchased travel medical insurance for their parents, who were applying for a super visa to visit Canada. Due to delays in visa issuance, they were unable to travel during the policy period, and no coverage was used. The consumer asked for a full refund from the insurer and the request was denied because the insurer stated the policy was non-refundable.

The consumer reached out to OLHI for help. In its review, OLHI identified an important contractual gap: the policy defined the effective date as the insured's arrival in the destination country. Because the consumer's parents did not arrive in Canada during the coverage period due to the delay in the visa issuance, coverage never started under the terms of the policy.

OLHI brought this to the insurer's attention and raised concerns about the fairness of retaining the full premium when the insurer assumed no risk. After reconsidering the matter, the insurer agreed to refund the full premium of \$3,650 to the consumer. The consumer was grateful for OLHI's professionalism and care throughout the process. This case demonstrates how OLHI's comprehensive review of policy provisions can help consumers achieve fair outcomes when unexpected circumstances arise.

Providing Assurance Through a Comprehensive Review

A consumer contacted OLHI after feeling misled about how long they would be required to pay premiums.

OLHI gave the consumer confidence that they have pursued all avenues for recourse.

The consumer purchased a whole life policy and alleged that they were told premiums would only be payable for 10 years. After paying premiums for 10 years, they found out this was not the case and surrendered the policy. Feeling misled, they turned to OLHI for help. They alleged that the agent and insurer failed to provide adequate advice, misrepresented the policy terms, and sought compensation for financial losses.

OLHI verified the policy documentation and disclosures and found no administrative errors in how the policy was managed by the insurer. The signed documentation showed that premium obligations extended beyond 10 years, whereas the consumer relied partially on non-contractual materials that referenced a shorter payment period. OLHI explained to the consumer that, while it had reviewed the information provided, assessing independent advisor conduct and determining whether advice was appropriate fell outside the scope of OLHI's mandate. The consumer expressed appreciation for the thoroughness and clarity of OLHI's review, recognizing that OLHI was not the appropriate avenue to obtain the outcome they were seeking.

This case highlights how OLHI's clear, transparent, and comprehensive process helps consumers better understand their situation and feel confident that they have pursued all avenues for recourse.

CASE 4

Correcting the Impact of Misinformation

A consumer's monthly life insurance premium increased from \$67 to \$460 after incorrect information left them without enough time to secure another coverage option.

OLHI's review helped ensure the resolution fully reflected the financial impact of the misinformation.

The insurer's customer service representative initially advised the consumer that their life insurance policy could be renewed without medical underwriting. However, this information proved incorrect; the insurer required either medical underwriting or conversion to a more expensive permanent policy.

By the time the consumer was notified of this error, it was already close to the renewal date, and they had insufficient time to complete the underwriting process. To maintain coverage, the consumer's original \$67 per month of premium payment increased to \$460 per month.

While the insurer offered to reimburse the equivalent of two months of the original premium payment, the consumer felt the compensation did not adequately reflect the financial impact of the misinformation. OLHI reviewed the case and confirmed that the information initially provided by the insurer was incorrect and that the consumer was not notified of the underwriting requirement until shortly before the renewal date. As a result, the consumer did not have enough time to complete the underwriting process and had to maintain coverage under the renewed policy at a substantially higher premium to avoid a lapse in coverage. OLHI engaged the insurer to reassess the appropriateness of the compensation, resulting in a mutually agreed settlement between the consumer and the insurer.

This case shows how OLHI's extracontractual approach can help consumers reach a fair resolution.

CASE 5

Ensuring Every Piece of Evidence Counts

A consumer's claim for accidental death benefit was denied after the spouse passed away several weeks following a hip fracture.

This case shows how OLHI's comprehensive evaluation can lead to a fair resolution.

While at the hospital for medical testing, the insured fell from a stretcher, resulting in a fractured hip that required surgery. The surgery was completed and the insured was discharged from the hospital 10 days later. Eight days after discharge, unfortunately, the insured passed away at home.

Since the spouse was insured under a universal accident insurance policy, the consumer submitted the claim, but it was denied by the insurer on the basis that the available medical documentation did not show that the insured's death resulted from the accident as defined in the insurance policy. However, the spouse believed that the fall, resulting in a hip fracture, and subsequent medical complications, led to the death, and therefore turned to OLHI for help.

The main question was whether the medical evidence supported a connection between the accident and the death of the insured. Hospital records documented that the insured had significant pre-existing respiratory conditions, including chronic obstructive pulmonary disease and bronchiectasis. OLHI reviewed the medical opinions of the emergency physician, orthopedic surgeon, and family physician, focusing on the medical complications that developed following the insured's surgery and discharge from the hospital. After this thorough review, OLHI concluded that the treating physicians indicated the hip fracture led to reduced mobility and complications that exacerbated the insured's condition, leading to respiratory infection, sepsis, and ultimately, death.

The insurer's initial decision focused primarily on the hospital's records up to the insured's discharge and accorded limited weight to the treating physicians' opinions. OLHI shared its analysis with the insurer and requested reconsideration based on all available medical evidence. The insurer subsequently reassessed the claim, reversed its decision, and paid the \$20,000 policy benefit to the consumer, including both hospitalization and accidental death benefits.

This case shows the importance of considering all available medical evidence when assessing causation in accidental death claims and how OLHI's in-depth and careful evaluation can lead to a fair resolution.

CASE 6

Resolving a Complex Medical Dispute

A family faced nearly \$20,000 in medical expenses after their four-year-old child became seriously ill and was hospitalized during a trip abroad.

OLHI can help consumers navigate challenging disputes.

During a family trip to the United Kingdom, the consumer's four-year-old child fell sick and was hospitalized for 2 weeks after being diagnosed with Kawasaki disease, incurring close to \$20,000 in expenses. The insurer later denied the claim submitted by the consumer, stating that the Kawasaki disease was related to an unstable medical condition that existed within 30 days prior to departure. If the hospitalization abroad was related to a pre-departure unstable condition, the insurer had grounds to deny coverage because of the policy's exclusion applicable to unstable medical conditions.

However, the consumer disagreed and believed that the child's pre-travel symptoms were unrelated to the later diagnosis of Kawasaki disease. Feeling overwhelmed and stressed about the situation, they asked OLHI for help. In its review, OLHI found that the child had received medical attention within the 30 days before departure for a recurrent fever and respiratory symptoms that were diagnosed and treated as asthma.

To better assess the case, OLHI asked the consumer to obtain additional medical records from the hospitalization in the United Kingdom. The consumer found information supporting the position that the hospitalization was unrelated to the respiratory symptoms and asthma identified prior to departure. Based on a thorough review of all the medical evidence, the policy provisions, and the medical opinion obtained by the insurer, OLHI concluded that there was insufficient evidence to support the insurer's position that the hospitalization abroad was related to the unstable condition before departure.

OLHI brought these findings to the insurer and requested that it reconsider its application of the policy exclusion applicable to unstable medical conditions. After reviewing the information, the insurer agreed to reimburse the consumer approximately \$20,000 in medical expenses. The consumer expressed appreciation for how the case was handled, noting that OLHI played a pivotal role in resolving the matter.

This case demonstrates how OLHI's investigation can help ensure that policy exclusions are applied fairly and supported by evidence, particularly where the connection between an unstable condition and a later medical event is unclear.

Participating Companies



Acadia Life	BMO Life Assurance Company	CUMIS Life Insurance Company
Actra Fraternal Benefit Society	Canadian Insurance Company (Canada Life)	Desjardins Financial Security Life Assurance Company
Aetna Life Insurance Company	Canadian Premier Life Insurance Company (Securian)	Empire Life Insurance Company, The
Alan CA Inc.		
Alberta Blue Cross		
Allianz Care	Canassurance Insurance Company	Equitable Life Insurance Company of Canada, The
American Bankers Life Assurance Company of Florida (Assurant)	Chubb Life Insurance Company of Canada	Europ Assistance
		Foresters
American Health and Life Insurance Company (Triton Insurance)	CIBC Life Insurance Company Limited	Foresters Life
	CIGNA Life Insurance Company of Canada	Green Shield Canada
Assumption Mutual Life Insurance Company	Co-operators General Insurance Company	Green Shield Canada Insurance
Beneva		Group Medical Services (GMS Insurance Inc.)
Blue Cross Life	Co-operators Life Insurance Company	
Blumont Annuity Company	Old Republic Insurance Company of Canada	Humania Assurance Inc.

Industrial Alliance Insurance and Financial Services Inc.	National Bank Life Insurance Company	Sun Life Financial
Combined Insurance Company of America	New York Life Insurance Company	TD Life Insurance Company (TD Insurance)
First Canadian Insurance Corporation	Pacific Blue Cross	Teachers Life Insurance Society (Fraternal)
ivari	Pavonia Life Insurance Company of Michigan (now Revol One Financial)	Trans Global Insurance/Trans Global Life
Knights of Columbus	Primerica Life Insurance Company of Canada	TruStage Life of Canada
Life Insurance Company of North America	Quebec Blue Cross	UV Insurance
Lloyd's Canada Inc.	RBC Life Insurance Company	Wawanesa Life Insurance Company, The
Manitoba Blue Cross	Reliable Life Insurance Company	Zurich Canada
Manulife	Saskatchewan Blue Cross	
Medavie Blue Cross	Serenia Life	
Munich Reinsurance America, Inc.	Starr Insurance & Reinsurance Limited	



Our Board

Independent Directors



*Dan
Levert*



*Charlene
Butler*



*Leah
Myers*



Geoff Plant
OBC, KC



*Louise
Shiller*

Industry Directors



*Dr. Dieter
Kays*



*Mary
Nemeth*



*Frank
Swedlove*

A photograph of a forest with tall, moss-covered tree trunks and a ground covered in fallen yellow leaves. A fallen log lies on the ground in the foreground.

Financial Statements

Canadian Life and Health Insurance Ombudservice (operating as Ombudservice for Life & Health Insurance)

And Independent Auditor's Report thereon Year ended March 31, 2026

INDEPENDENT AUDITOR'S REPORT

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

Opinion

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

- the statement of financial position as of March 31, 2026
- the statement of operations for the year then ended
- the statement of changes in operating fund balance for the year then ended
- the statement of cash flows for the year then ended
- and notes to the financial statements, including a summary of significant accounting policies

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

In our opinion, the accompanying financial statements, present fairly, in all material respects, the financial position of the Entity as of March 31, 2026, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

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

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

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

KPMG LLP

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

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

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

We also:

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

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

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- Communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.



Chartered Professional Accountants

Licensed Public Accountants
Toronto, Canada
June 15, 2026

Statement of Financial Position

March 31, 2026, with comparative information for 2025

Assets	2026	2025
Current assets		
Cash and cash equivalents (note 2)	\$ 2,405,666	\$ 2,017,099
Prepaid expenses and deposits	70,975	33,219
Accounts receivable	2,016	32,658
	2,478,657	2,082,976
Capital assets (note 3)	727	—
	\$ 2,479,384	\$ 2,082,976
Liabilities and Fund Balance		
Current liabilities		
Accounts payable and accrued liabilities	\$ 291,569	\$ 222,271
Fund balance		
Operating fund		
Invested in capital assets	727	—
Unrestricted	2,187,088	1,860,705
	2,187,815	1,860,705
Commitments (note 5)		
	\$ 2,479,384	\$ 2,082,976

Full audited financial statements are available upon request.

Statement of Operations

Year ended March 31, 2026, with comparative information for 2025

Revenue	2026	2025
General assessment fees	\$ 2,645,320	\$ 2,592,760
Investment	26,944	54,819
	2,672,264	2,647,579
Expenses		
Staff and adjudicative services	1,493,058	1,370,864
Professional fees	194,792	186,590
Board of Directors' fees	214,592	180,077
Board meetings and travel	85,061	101,852
Management fees (note 4)	105,863	101,632
Information technology	49,644	50,552
Rent and occupancy	34,550	35,620
Staff meetings and travel	24,001	22,525
Communications	74,447	2,055
Telecommunications	16,707	17,062
Insurance	24,820	23,970
Supplies and services	12,128	9,667
Training and development	14,473	5,682
Amortization of capital assets	81	—
Translation	937	995
	2,345,154	2,109,143
Excess revenue over expenses	\$ 327,110	\$ 538,436

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Statement of Changes in Operating Fund Balance

Year ended March 31, 2026, with comparative information for 2025

	2026			2025		
	Invested in capital assets	Unrestricted operating fund	Total	Invested in capital assets	Unrestricted operating fund	Total
Net assets, beginning of year	—	\$ 1,860,705	\$ 1,860,705	—	\$ 1,322,269	\$ 1,322,269
Excess (deficiency) of revenue over expenses	(81)	327,191	327,110	—	538,436	538,436
Net change in investment in capital assets	808	(808)	—	—	—	—
Net assets, end of year	\$ 727	\$ 2,187,088	\$ 2,187,815	—	\$ 1,860,705	\$ 1,860,705

Full audited financial statements are available upon request.

Statement of Cash Flows

Year ended March 31, 2026, with comparative information for 2025

	2026	2025
Cash provided by (used in)		
Operating activities		
Excess of revenue over expenses	\$ 327,110	\$ 538,436
Amortization of capital assets which does not involve cash	81	—
Change in non-cash operating working capital		
Prepaid expenses and deposits	(37,756)	22,499
Accounts receivable	30,642	(32,408)
Accounts payable and accrued liabilities	69,298	(453,352)
	389,375	75,175
Investing activities		
Purchase of equipment	(808)	—
Increase in cash and cash equivalents	388,567	75,175
Cash and cash equivalents, beginning of year	2,017,099	1,941,924
Cash and cash equivalents, end of year	\$ 2,405,666	\$ 2,017,099

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