COMPLAINT MANAGEMENT POLICY

In an effort to continue providing its customers with top-quality services, Blue Cross follows a complaint management policy.

OBJECTIVE

The goal of this policy is to ensure that all consumer complaints about a product or service are processed fairly and diligently.

PROCESS AND STEPS FOR FILING A COMPLAINT

STEP 1: *Ask for an explanation*

As a first step, we suggest that you contact the Customer Service Department and **ask for an explanation** regarding the product or service you found unsatisfactory.

Customer Service Department

- Travel insurance: 1-800-873-2583
- Health insurance: 1-866-722-3444

STEP 2: *If you're not satisfied with the explanation, you can request a review*

In the event the explanation provided by the Customer Service Department is not satisfactory, you may request that the Customer Service agent refer your complaint to a supervisor of the business sector involved to request **a review of your file**.

STEP 3: *File a formal complaint*

If you are still dissatisfied with the decision made or with how your file was processed, you can **file a formal complaint** by writing the Dispute Resolution Officer or by filling out our complaint form. Send your complaint to the following address and be sure to write the word "complaint" in the header of your letter:

Yvan Fortin
Dispute Resolution Officer
Ontario Blue Cross / Canassurance
185 The West Mall, Suite 610
Etobicoke, Ontario M9C 5P1
Email: complaint@ont.bluecross.ca

Please note that a **formal complaint** is the expression of one of the following elements, which persists after being considered and examined at the operational level charged with making a decision:

- A reproach against the company
- Identification of real or potential harm that you have or could have sustained
- A request for remedial action

If you do not use our complaint form, it is important to provide your contact information and describe the reason for your complaint, the steps you have already taken, and the responses you have received. Please indicate your arguments and the solution you are seeking.

Upon receipt of a **formal complaint** from a customer, the Dispute Resolution Officer will issue an acknowledgement of receipt within five (5) days of receiving the complaint. The acknowledgement of receipt will include:

- A description of the complaint received
- The expected processing time for the complaint
- A notice indicating alternative dispute-resolution mechanisms available to you in the event you remain unsatisfied with how your complaint was processed or the result of the review
- The procedure for requesting that your file be forwarded to OmbudService for Life & Health Insurance

The Dispute Resolution Officer will ensure that the company's decision, including the reasons for it, is sent to you in writing.

STEP 4: *Transfer the complaint*

If after these steps you are still not satisfied with the process or response, you may ask our Dispute Resolution Officer to forward a copy of your file to:

- (Québec residents) Autorité des marchés financiers au Québec (www.lautorite.qc.ca/fr/traitement-plaintes.html)
- (rest of Canada) OmbudService for Life & Health Insurance (www.oapcanada.ca)

Please note that customers are entitled to exercise this right only after the deadline for receiving a final response has passed. Such action must be taken within a year of receiving the response.

CREATION AND MAINTENANCE OF A REGISTER

A complaints register was created for the purposes of applying the policy. Information on complaints that comply with the regulator's definition of a complaint is entered into the register and updated by the complaints officer.

REPORTS SUBMITTED TO REGULATOR

The complaints officer submits a report on the complaints filed during the pre-determined period to the Financial Service Commission of Ontario twice a year.

EFFECTIVE DATE

This policy was adopted in January 2006. It was reviewed in December 2016 and is subject to further review every three (3) years, or sooner as required.