Ontario Society of Occupational Therapists

October 7, 2020

Tim Bzowey
EVP, Auto/Insurance Products
Financial Services Regulatory Authority of Ontario(FSRAO)

Delivered by email

Dear Tim,

RE: Unfair and Deceptive Acts and Practices (UDAP)

Thank you for the opportunity to provide the feedback of members of the Ontario Society of Occupational Therapists (OSOT) regarding the UDAP provisions.

We believe that the overriding principle with respect to the UDAPs is to give insurers, health care practitioners and consumers clear guidance to ensure consumer protections against unscrupulous business practices, and to empower and protect consumers. We support FSRA's goal "to create clear service expectations…that will improve service delivery, accountability and process transparency." OSOT also supports the need for integrity, consistency, enhanced transparency and accountability with respect to insurer processes across those insurers who write auto insurance policies in Ontario.

OSOT supports FSRA's goal: 'to seek consistent application of Fair Treatment of Customers guidance with respect to examples of fair and unfair treatment in the conduct of auto insurance business.

I. EMPOWERING CONSUMERS and INSURER ACCOUNTABILITY

While the UDAP provisions have been in existence since 2003, it has been unclear as to how they are accessed; who accesses them; how often they are accessed; and the outcomes of a UDAP complaint. If the UDAPs are to be an effective means of insurer accountability, OSOT recommends the following:

1) **Clear communication to consumers and health care practitioners explaining the process for preparing an application to FSRA around a potential UDAP infringement.**

2) **Clarity around the process once a UDAP application has been made—what happens next?**

3) **Clarification of what the outcome is for the complainant (e.g. consumer, health care practitioner) if an insurer is found to have committed an unfair and deceptive act or practice.**

In the spirit of full transparency, OSOT recommends that FSRA include the names of insurers who have committed UDAPs on their website such that consumers are aware of insurer claims handling practices prior to selecting an insurer and purchasing insurance.

II. CLAIMS HANDLING

As noted during our discussion on September 30, 2020, I raised a concern around the claims handling portion of the *UDAP Rulemaking: Stage 1 Update*, which proposes the following:

Redraft to make the following a UDAP:

- *Conduct that does not meet the standard of examining and settling claims fairly and/or treating claimants fairly*
- *Indicators of fair treatment include:*
    - *maintaining written documentation on claims handling procedures;*
    - *informing claimants about the status of their claim, processes for claims settlement and where appropriate claims-determinative factors;*
    - *subject to legal requirements, following balanced and impartial dispute resolution procedures;*
    - *establishing and using internal mechanisms to review claims disputes; and*
    - *taking measures to ensure that services and service quality provided by a Preferred Provider Network is equal to or greater than what is commonplace in the industry*.

We understand that there is a move towards principle-based regulation versus a more prescriptive approach, however, FSRA also recognizes that there are situations which require a more prescriptive approach such as in the case of signing blank forms or improving timelines. OSOT does not believe that our more prescriptive UDAP language will in any way interfere with opportunities for insurance product innovation or flexibility, but instead will ensure that unprincipled adjudication practices do not interfere with the treatment of injured claimants

when expediency and expert care are required. The end goal is for the fair treatment of customers.

We all agree that adjusters must follow those rules and procedures as set out in the SABS, the Guidelines, etc. We all agree that information must be shared in a timely manner in order to promote timely access to treatment and recovery. Over the years, we have monitored unfair treatment of claimants and consumer harms. With this in mind, we would like FSRA to consider the following UDAP recommendations:

1) **An unfair and deceptive act and practice is committed when an adjuster's claims handling practice is in direct violation of a FSCO/FSRA bulletin.**

2) **An unfair and deceptive act and practice is committed when an adjuster's claims handling involves providing an opinion which is outside the scope of the adjuster's training, education and expertise.**

3) **An unfair and deceptive act and practice is committed when an adjuster's claims handling conflicts with bona fide billing (HCAI) codes resulting in arbitrary denials of necessary health care services.**

4) **An unfair and deceptive act and practice is committed when the insurer does not provide the results of an Insurer Examination to the claimant in a timely way, namely within 10 business days of receipt of the report; delays in delivery create unnecessary delays in services.**

Examples of each are listed below.

1. Direct violation of a FSCO/FSRA bulletin

a) OSOT has recently lodged a complaint to FSRA with respect to various insurers who deny the usual and customary fees of driving instructors working in MTO approved Driving Centres in spite of clear guidance found in the 2003 *Superintendent's Bulletin (A-17/03)* that directs insurers to do otherwise. Please refer to the attached letter to FSRA dated September 30, 2020.

b) There are insurers who are calculating the attendant care benefit by strictly adhering to the hourly rates as opposed to the monthly calculation as instructed to do by the 2018 *Superintendent's Bulletin (A-03/18).*

When we forward the appropriate Bulletins to offending insurers, our complaints are typically ignored and the behaviour continues unabated. This unfair practice results in injured persons who do not receive the care and protections they require, and the services they have contracted to receive and paid for through their insurer, as per the *Insurance Act* and the SABS.

2. An opinion which is outside the scope of the adjuster's training, education and expertise

In our experience we have found adjusters who outright deny or reduce services on a Treatment and Assessment Plan (OCF-18) that are necessary to safeguard the person's physical and emotional wellbeing *without* getting a professional opinion by a Regulated Health Professional, qualified to address the issue in dispute. These arbitrary denials place injured claimants at risk. This proposed UDAP underscores the very reason these provisions were first contemplated—to protect consumers.

***3.* Adjuster's claims handling conflicts with bona fide HCAI codes**

For many years now, we have heard repeated complaints from our members around arbitrary denials of specific items found on the OCF-18 that are required to ensure fulsome care of injured claimants. These services are required to ensure that occupational therapists meet the standards of practice as determined by the regulatory body (the College of Occupational Therapists of Ontario) and are described by HCAI as bona fide codes.

The codes allow for telephone contact with the client, family member and/or another member of the treatment team (brokerage, 7.SF.15), planning (7.SF.12), preparation (7.SF.13), consultation (7.SF.15) and documentation (7.SJ.30). Please refer to the attached letter to FSRA dated December 5, 2019.

4. Timeliness: Delays in delivering Insurer Examination reports:

When insurers arrange for their insured to undergo an Insurer Examination, this usually causes a great deal of anxiety for the claimant and, often, their family members. Once the examination is completed, the claimant, family members and treating practitioners must wait for the results to determine if treatment will continue and/or if the claimant will receive the goods required to resume an independent life. Consequently, delays in delivery of the report not only create unnecessary interruptions in the injured person's treatment but can result in emotional distress, in some cases serving to worsen the claimant's condition.

Further, we have heard complaints from our members that the complaint process at FSRA requires multiple steps and multiple follow-ups which create further delays in providing clients with their medical and rehabilitation needs. We would like to work with FSRA to address the complaints processes.

III. Preferred Provider Networks

With respect to the UDAP Stage 1 proposal around Preferred Provider Networks (PPNs), i.e., **"***Taking measures to ensure that services and service quality provided by a Preferred Provider Network is equal to or greater than what is commonplace in the industry"*. OSOT supports FSRA in its goal to enhance transparency, quality and comprehensibility of disclosures to consumers, and enhance consumer choice. In this vein, here are our observations and concerns with respect to PPNs:

In order to maintain/attain profit margins, PPNs are incented to hire personnel who are newly graduated and have little or no experience treating patients with complex and/or multiple injuries common to MVA; "service quality" may suffer as a result. We invite FSRA to undertake their own investigation to determine if this, indeed, is the case. There are many claimants with complex and/or multiple injuries that require experienced health care professionals much the same way FSRA has called on experienced personnel to perform their complex duties. This is just one subtlety that will be lost in the principle-based regulation captured above.

Language and culture are important variables in a good therapeutic patient/therapist relationship. Will the PPN have to take measures to ensure that "service quality" includes health care practitioners who meet the language and/or cultural demands of their clientele? In a world without PPNs, the claimant would be able to seek out a health care practitioner who speaks their language and/or understands their culture; this translates into "quality service" for these individuals. Who defines "service quality"? Is this a consumer decision? What if the PPN cannot meet the service quality expectations of the claimant? OSOT supports FSRA's promise to protect consumer choice.

Who measures whether the PPN meets the *"service quality"* that *"is equal to or greater than what is commonplace in the industry?"* Is this the responsibility of the insurer, the PPN, FSRA and/or health care experts? Who decides what the benchmark or "industry" is? Is a PPN's care for auto accident victims compared against Ontario WSIB patients or those outside our province or to the evidence-based science? Health "service quality" means different things in different jurisdictions—it is wide open to interpretation. This does not appear to meet FSRA's goal to create clear service expectations.

As per the reason for UDAPs—fair treatment and protection of consumers - FSRA must protect the rights of the consumer in terms of full transparency and choice of provider. Will the consumer obtain full disclosure around the terms and conditions between the insurer and the PPN provider *prior* to selecting a PPN policy optional benefit? Will there be informed consent

including choice of provider and the ability to change the provider outside of the PPN, if the PPN service does not resolve their complaints or if there is no therapeutic rapport established?

Finally, what if a PPN existed within 100 km. of the consumer's home at the time of purchase, but no longer exists when the service is required? What is the expectation for the consumer to receive his/her care? There must be clear guidelines and choices that err on the side of the consumer.

In closing, we see the importance of the UDAP provisions to ensure fair treatment of consumers and consumer protections. We are concerned that open-ended, ambiguous language within the UDAP provisions will only serve the "bad actors" in allowing them to continue in their unfair behaviours on the backdrop of an imbalance of power between claimant and insurer. Conversely, when the UDAP provides more specific, clear guidance, it will lead to a higher standard of claims handling, greater efficiency and effectiveness and, ultimately, fair and balanced adjudication.

We look forward to continuing this dialogue in our collective efforts to ensure the highest standard of care, compassion and safety for our patients; to raise the standards of claims adjudication; and ultimately to reduce the adversarial nature of insurance claims handling. Please feel free to contact the undersigned with any questions you might have.

Sincerely yours,

Karen Rucas, B.Sc.O.T, OT Reg. (Ont.)
OSOT Government Lead in the Auto Sector/ Chair of the OSOT Auto Sector Team
Cell: 416-918-0261
Home office: 647-343-2803
OSOT office: 416-322-3011

Enclosures (see below):
Letter to FSRA re: arbitrary denials in relation to HCAI codes, December 5, 2019
Letter to FSRA re: driving instructors, September 30, 2020
2003 Superintendent's Bulletin (A-17/03)
2018 Superintendent's Bulletin (A-03/18).

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Ontario Society of Occupational Therapists

December 5, 2019

Ann McKenzie
Senior Manager, Policy Interpretation
Financial Services Regulatory Authority
5160 Yonge Street, 16th Floor
Toronto, Ontario
M2N 6L9
Delivered by email: Ann.MacKenzie@fsrao.ca

Dear Ms. McKenzie,

RE: Insurer Denial of Preparation and Documentation Time on OCF-18s

Occupational therapists working under Ontario's *Statutory Accident Benefits Schedule (SABS*), are encountering a recurring problem with insurer denials of specific professional time allocations under specific HCAI codes which impacts their ability to deliver treatment to injured clients in a cost-effective and responsible manner.

Occupational therapists create Treatment and Assessment Plans (OCF-18s) and submit them to the insurer with a set of proposed treatment services and their associated costs which are identified after assessment to assist the client in his/her recovery from injury. Some of these clients are seriously injured but not catastrophically injured or seriously injured but not yet designated catastrophic and as a result do not have access to a case manager.

Occupational therapists are often asked to coordinate client services and sign-off on treatment plans for treating team members who are not qualified to sign the OCF-18 such as a social worker or rehab aide. In order to properly complete the treatment plan and to assume responsibility for its submission, the occupational therapist must be aware of what each team member is doing. This can require telephone or face-to-face consultations, reviewing documentation, etc. Further, it is often the role of the occupational therapist to plan, organize and attend team meetings, school meetings and/or meetings around returning to work and to provide minutes of these meetings to team members, doctors and legal counsel. These activities entail planning, preparation and specific documentation which is time not captured under 'direct one-to-one patient treatment sessions' per se. This notwithstanding, these are vital health professional services that promote progress in treatment.

All of these services have codes associated with them. For instance:

Brokerage or 7.SF.15 includes telephone advice, health advice, delegation of clinical support activities on the client's behalf, determination of service needs, case management, monitoring of third party administered therapy, client referral. May involve initiating or maintaining a collaborative process to assess, plan, implement, coordinate, monitor and/or evaluate the options and services required to meet a client's health care needs.

Facilitation or 6.DA.07 involves assisting a client to overcome any obstacle, related to a health condition, by aiding the client to develop effective study habits and classroom behaviours by supporting the educational facility, with training and counseling, to ensure the client a safe and productive educational environment.

Services such as planning (7.SF.12), preparation (7.SF.13), consultation (7.SF.15) and documentation (7.SJ.30) time are frequently denied by insurers who claim that these services are only provided by case managers. We disagree with this position.

A few examples that illustrate this point include:

1) An insurer who denies a team meeting with a child's school prior to their return to school would prevent teachers and the education team accessing/understanding necessary information about the child's specific education support needs, safety issues, and medical information that would support seamless integration of the child back into the classroom. Without this essential meeting, exchange of information, the ability to answer the school team's questions and to share specific strategies or techniques to manage the child at school, puts this child at risk for safety, re-injury and failure.

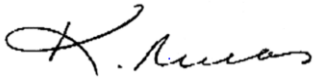
2) An insurer who denies an occupational therapist the opportunity to connect with a client's employer and/or to meet with them to provide education around the client's limitations when returning to work, scheduling modified hours and duties for return to work, discussing adaptations to the client`s workstation and safety issues, etc., clearly limits the success, safety and independence of the client.

We bring this to the attention of FSRA with a request to address our concern that insurer interpretation and application of billing codes can and does have a detrimental impact on treatment and a claimant's recovery progress. We assert that a variety of professionals who work collaboratively as evidence-informed interprofessional teams will spend time in collaboration or facilitating that collaboration. Where these services might be performed by a case manager when a claimant has been deemed catastrophic, we assert that these services can be critical for the seriously injured, non-catastrophic client as well. We urge your support of occupational therapists billing for such services when appropriate, and your communication of this position to insurers.

FSRA's intervention can prevent adversarial interactions and improve the consumer experience while promoting expeditious recovery of persons injured in motor vehicle accidents in Ontario.

Thank you for your attention to this request. Please know that we would be pleased to provide any further clarification of this issue and request if needed. Please contact me at the contact information below.

Sincerely,



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Ontario Society of Occupational Therapists

September 30, 2020

Ann McKenzie
Senior Manager, Policy Interpretation
Financial Services Regulatory Authority

delivered by email

Dear Ann,

Re: Fee paid to Driving Instructors at Ministry of Transportation Ontario approved Functional Assessment Centres

I hope this finds you doing well during these stressful times.

It has come to our attention by a group of OTs who operate MTO approved Functional Driving Assessment centres that they are experiencing denials by, in particular, Aviva and Intact with respect to the appropriate cost of a Driving Instructor. First, let me explain the driving assessment process.

1. The claimant is assessed by an occupational therapist initially to address cognitive, emotional and physical issues to ensure they are ready to embark upon an in-car assessment and/or driving rehab program. The OT also determines if they need adaptive equipment to drive the vehicle and then this equipment is installed into the specialized vehicle.

2. Next, the claimant gets into the car for the driving assessment. As required by MTO and the Highway Traffic Act, the OT and Driving Instructor must go out together during the assessment and during the driving rehab program. The vehicle must be appropriately insured, have the proper adaptive equipment and must be equipped with a driving instructor brake for safety. After this, sometimes, driver rehab training sessions are recommended to help the claimant get over their issues related to driving, i.e. adapt to new strategies or vehicle modifications or to adjust to being in the driver's or passenger's seat again.

3. OTs are not driving instructors but they must oversee and put forth the plan for the driving instructor to follow and only qualified driving instructors can be used. With respect to the Driving Instructor's rate, it must cover their professional time, the costs of the vehicle (which may have costly modifications) along with very expensive insurance since the risk in this area is very high.

4. The cost of a driving instructor with vehicle ranges from $144/hour to $165/hour; however, Aviva and Intact have only agreed to pay $58.19/hr at the "Unregulated Provider" rate as per the 2014 PSG and sometimes agree to pay the driving instructor at the OT rate of $99.75.

   Occupational therapists had identified this problem back in 2003 and, fortunately, then Superintendent, Bryan Davies prepared this clarification bulletin (attached) which states: *"As well, providers who provide services that are not health care services (e.g., social workers, driving instructors) do not fall under the "Unregulated Providers" category."* Unfortunately, these insurers are ignoring this Bulletin even when it is brought to their attention.

As a point of interest, the Association for Driver Rehab Specialists in 2018 had 180 members; in 2020, membership declined to 124. The experts in this area opine that the decline of 56 members over a two-year period are substantially all in the driving instructor category. OTs are not going to be able to provide suitable services to safeguard injured claimants to drive if driving instructors are leaving the field.

I understand that FSRA is examining legacy documents. Is it time to update this bulletin? Please provide the approved Functional Driving Assessment centres in Ontario and the Ontario Society of Occupational Therapists with some guidance. Thank you!

Stay safe, stay healthy!

Sincerely yours,

Karen Rucas, B.Sc.O.T, OT Reg. (Ont.)
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Superintendent's Bulletin no A-17/03
(retrieved October 6, 2020
https://www.fsco.gov.on.ca/en/auto/autobulletins/2003/Pages/a-17_03.aspx

Application of Professional Services Guideline; and New Superintendent's Guidelines on: Conflicts of Interest in the Designated Assessment Centre (DAC) Selection Process, and Reporting Obligations For DACs Assessing Treatment Plans; and Insurers' Delivery

With this Bulletin, the Financial Services Commission of Ontario is clarifying the *Professional Services Guideline* and issuing two new Superintendent's Guidelines.

1. Application of Professional Services Guideline

This Bulletin clarifies the application of Superintendent's Guideline No. 05/03, titled *Professional Services Guideline*, issued on September 18, 2003.

The *Professional Services Guideline*'s maximum hourly rates and maximum fees apply only to the expenses described in the Guideline for services rendered by health care providers listed in the Guideline. The Guideline reference to "Unregulated Providers" is meant to identify only health care providers who are not regulated under the *Regulated Health Professions* Act, 1991 (e.g., kinesiologists, and case managers who are not otherwise members of a profession regulated under the *Regulated Health Professions* Act, 1991).

As well, providers who provide services that are not health care services (e.g., social workers, driving instructors) do not fall under the "Unregulated Providers" category.

The *Professional Services Guideline* does not apply to treatment plans approved before September 18, 2003. Insurers are expected to pay for goods and services provided pursuant to treatment plans approved before September 18, 2003, at the rates set out in the treatment plans as approved, whether such goods and services are rendered before or after November 1, 2003.

Insurers are not prohibited from paying above any maximum fee or hourly rate set out in the *Professional Services Guideline*.

The *Professional Services Guideline* does not apply to fees charged by Designated Assessment Centres.

2. Superintendent's Guideline: *Conflicts of Interest in the Designated Assessment Centre (DAC) Selection Process, and Reporting Obligations for DACs Assessing Treatment Plans*

The Superintendent of Financial Services is issuing a Guideline to address possible conflict of interest situations arising in the new DAC selection process (Section 53 of the revised *Statutory Accident Benefits Schedule*).

The Guideline also deals with the reports to be delivered by DACs concerning treatment plans in circumstances where the DAC has determined that the insured person's impairment does not come within a *Pre-approved Framework Guideline.*

The Guideline (No. 08/03) is attached.

3. Superintendent's Guideline: *Insurers' Delivery of Documents to Insured Persons*

The Superintendent of Financial Services is issuing a Guideline to describe the circumstances in which a health care provider may act as an insured person's authorized representative for the limited purpose of receiving certain documents from an insurer if specific conditions have been met.

The Guideline (No. 09/03) is attached

Contact Information

Questions about this Bulletin should be directed to FSCO's Automobile Insurance Policy Unit by calling the DAC Hotline at 416-590-7137 or 1-800-668-0128, extension 7137, or by fax to (416) 590-7265. You may also write to FSCO at:

Automobile Insurance Policy Unit
Financial Services Commission of Ontario
5160 Yonge Street, Box 85
North York Ontario
M2N 6L9

Bryan P. Davies
Chief Executive Officer and Superintendent of Financial Services
October 30, 2003

Attachments (PDF):

- **Conflicts of Interest in the Designated Assessment Centre (DAC) Selection Process, and Reporting Obligations for DACs Assessing Treatment Plans - Superintendent's Guideline No. 08/03**
- **Insurers' Delivery of Documents to Insured Persons - Superintendent's Guideline No. 09/03**

Superintendent's Bulletin A-18/03
Retrieved October 6, 2020
https://www.fsco.gov.on.ca/en/auto/autobulletins/2003/Pages/a-18_03.aspx

Filing a complaint about a Paralegal (SABS Representative)

With this bulletin, the Financial Services Commission of Ontario (FSCO) is outlining the complaint process that should be followed in order to file a complaint about a paralegal (SABS representative), beginning November 1, 2003.

Complaint process

Effective November 1, 2003, the Office of the Insurance Ombudsman (OIO) at FSCO will accept and review written complaints about the activities and conduct of SABS representatives. These complaints could include such matters as the representative has not filed the required declaration with FSCO, does not have errors and omissions insurance, or is committing an unfair or deceptive act or practice. Such acts and practices are referenced later in this bulletin. Any person who wishes to file a complaint that the activities or conduct of someone acting as a SABS representative violates the *Insurance Act*, (the "Act") or regulations made under the Act, can do so by providing the following information to the OIO, at the address noted below.

Required information

The following information has to be provided to the OIO when making a complaint:

1. the name, mailing address and telephone number of the individual making the complaint;
2. the name and contact information of the SABS representative about whom the individual is complaining;
3. the specific activity or conduct about which the individual is complaining (e.g., committing an act or omission after November 1, 2003, that is inconsistent with the Code of Conduct issued by the Superintendent); and
4. any documents or other information that supports the complaint.

The complaint should be made in writing and sent to the OIO at the following address:

Financial Services Commission of Ontario
c/o Office of the Insurance Ombudsman
5160 Yonge Street,
4th Floor, Box 85

North York ON
M2N 6L9

Complaints may also be faxed to the OIO at 416-590-8480.

Please note that any information provided to the OIO may be disclosed to the SABS representative so that he or she has an opportunity to respond fully to the complaint.

Background

As announced in Bulletin A- 04/03 (Implementing Bill 198: New and Amending Regulations), and Bulletin A- 06/03 (Filing & Other Regulatory Requirements for Paralegals (SABS Representatives)) the provisions applicable to SABS representatives come into force on November 1, 2003. (See Regulation 664, amended by O. Reg 275/03.)

As a result of these changes, no one may act as an adviser, consultant or representative on behalf of a person concerning a claim for statutory accident benefits, as of November 1, 2003, unless the representative meets the requirements set out in the regulations. This includes, for example, a person who does any of the following activities concerning a claim for statutory accident benefits:

- advises another person about his or her rights under the
- Statutory Accident Benefits Schedule (SABS);
- completes or assists in completing application forms;
- discusses and negotiates with an insurer or adjuster;
- attends dispute resolution proceedings at FSCO, in Small Claims Court or private arbitration; or
- negotiates the settlement of SABS claims.

The regulations also require SABS representatives to file information required by the Superintendent with the Financial Services Commission of Ontario (FSCO); carry errors and omissions (e & o) liability insurance coverage of $1,000,000 in respect of any one occurrence; and refrain from acting for any individual who they know, or ought reasonably to know, has a catastrophic impairment as defined in the SABS.

The regulations also amend the definition of "unfair or deceptive acts or practices" to prohibit the following conduct by SABS representatives:

- charging fees under a contingency fee arrangement;
- paying or accepting referral fees;
- committing an act or omission inconsistent with a Code of Conduct issued by the Superintendent; and
- failing to disclose any conflict of interest to the claimant and the insurer (O. Reg. 7/00 amended by O. Reg. 278/03).

Lawyers acting in the usual course of the practice of law and insurer representatives are exempt from these requirements. Lawyers' employees are also exempt, provided they act only under the direct supervision of a lawyer who is retained, or whose law firm is retained, by the claimant.

Persons who provide representation without compensation (such as a friend or family member who assists a claimant in an informal and unpaid manner) are also exempt from these requirements. However, a person is considered to be providing representation for "compensation" if he or she receives, directly or indirectly, a financial benefit in connection with the claimant's representation. Individuals who are paid service providers who combine the provision of health care or other services with claimant representation, must comply with these requirements.

All SABS representatives must file a declaration form with FSCO before November 1, 2003. Anyone who becomes a SABS representative after November 1, 2003, will need to file before engaging in the activities of a SABS representative. In addition, SABS representatives must re-file on or before the renewal date of their e & o liability insurance policy and any time the filed information changes (e.g. change to personal or business information, change to e & o liability insurance, or ceasing to act as a SABS representative).

Additional information is available

Further information is available through the *Paralegals / SABS Representatives* page of FSCO's web site. If you have questions about the complaint process, filing & other requirements, new regulatory changes or the Code, please contact FSCO at 416-250-7250 or 1-800-668-0128, or by e-mail at **paralegalinfo@fsco.gov.on.ca**

Bryan P. Davies
Chief Executive Officer and
Superintendent of Financial Services
November 4, 2003