ANNUAL REPORT 2013

OMBUDSMAN
FOR LONG-TERM INSURANCE

Complaints received
10 028

Full cases finalised
4 496

Percentage of cases resolved wholly/partially in favour of complainants
33%

Percentage of cases finalised within six months
77%

KEY FIGURES

R2 450
Cost per standard case

R103.8m
Recovered for complainants (in lump sums)

R343 741
Compensation awarded

R16m
Total expenses for the year

TABLE OF
CONTENTS

FOREWORD BY THE CHAIRPERSON OF THE
OMBUDSMAN'S COUNCIL

"The Council acknowledges the importance of sound corporate governance and at all times strives to fully comply with the accepted best practice standards. The Council oversees the corporate governance of the office and ensures that the said standards are maintained."

Judge John Smalberger served on the Council since 2003; became its Vice-Chairperson on 13 April 2007 and was appointed as its Chairperson on 23 April 2010. He had indicated his intention to retire from the Council on 10 May 2013, but, fortunately for the Council, he was persuaded to postpone his retirement until the Council meeting which was held on 25 October 2013, when I was elected as Chairperson in his place. Judge Smalberger's insight and his quick grasp of the issues at stake were matched with a kind and tactfully persuasive manner. We are grateful for the important role that he played on the Council and will miss his valuable contribution thereto. The Council also met on 10 May 2013, when Judge Brian Galgut was still the Ombudsman. The incumbent Ombudsman, Judge Ron McLaren, attended this meeting by invitation. Judge Galgut's highly successful term of office expired on 31 May 2013 and he leaves with our sincere thanks and best wishes for the future. Judge McLaren was appointed as the Ombudsman for Long-term Insurance on 1 June 2013. The Council welcomes Judge McLaren and wishes him well in dealing with the challenges of his new post.

Section 10(1)(b) of the Financial Services Ombud Schemes Act, 37 of 2004, provides that one of the requirements for recognition of a voluntary ombudsman scheme is that "a body that is not controlled by participants in the scheme and to which the ombud is accountable must appoint the ombud and monitor the performance and independence of the ombud and monitor the continued compliance by the scheme with its constitution, the provisions of the scheme and this Act...".

The Council was established during 1999 and has, since that time, fulfilled the functions and met the requirements which became statutorily prescribed during 2005, when Act 37 of 2004 came into force. The office of the Ombudsman for Long-term Insurance is answerable to the Council and is independent of the long-term insurance industry.

At its two meetings which were held during 2013 the Council received a comprehensive overview of all the activities of the office from the Ombudsman. Having monitored the performance of the Ombudsman and the office, the Council was satisfied that, for the year concerned, they had fulfilled their mission; had complied with all their obligations and had steadfastly maintained the independence which is vital to their function.

The Council acknowledges the importance of sound corporate governance and at all times strives to fully comply with the accepted best practice standards. The Council oversees the corporate governance of the office and ensures that the said standards are maintained. At the Council meeting held on 25 October 2013, it was resolved that the Council's Audit Committee will in the future also function as its Risk Committee. At the 2013 Conference of the International Network of Ombudsman Schemes which was held in Taipei, one of the topics dealt with was "Governance in the broader context of Ombudsman Schemes". This demonstrates the international recognition of the importance of and the need for sound corporate governance in the office.

I thank the members of the Council for their support and valued contributions during the year.

Leona Theron

Judge Leona Theron was elected as Chairperson of the Council, having been a member thereof since 23 April 2012. Judge Theron was born and grew up in KwaZulu-Natal. She attended Natal University from 1984 to 1988 where she completed her BA and LLB degrees. In 1989 she was awarded a Fullbright Scholarship by the American Government to study in the United States of America. She obtained a Master of Laws degree from Georgetown University in Washington DC in 1990. While she was in the United States she worked for the International Labour Organisation in Washington DC and for a firm of attorneys in Los Angeles. She practised as an advocate at the Durban Bar from the end of 1990 and also lectured at the University of Natal. In 1995 she was appointed as a member of the Judge White Commission by the late President Mandela. Judge Theron was appointed as a judge of the High Court on 15 October 1999. She was the first black female judge to be appointed in KwaZulu-Natal and, at the age of 32, the then youngest judge in the country. In December 2010, Judge Theron was appointed as a judge of the Supreme Court of Appeal and she is currently the youngest member of that Bench. Judge Theron sits on a number of boards, has delivered papers at various conferences in South Africa and internationally and has, over the years, received numerous awards for her contribution to the development of justice in South Africa.

MISSION

The mission of the Ombudsman is to receive and consider complaints against subscribing members and to resolve such complaints through mediation, conciliation, recommendation or determination.

The Ombudsman shall seek to ensure that:

- he or she acts independently and objectively in resolving any complaint received and takes no instructions from anybody regarding the exercise of his or her authority;
- he or she follows informal, fair and cost-effective procedures;
- he or she keeps in balance the scale between complainants and subscribing members;
- he or she accords due weight to considerations of equity;
- he or she maintains confidentiality, in so far as it is feasible to do so and subject to Rules 3.8 and 7, in respect of every complaint received;
- he or she co-operates with the Council established in terms of the Financial Services Ombud Schemes Act, 2004, in promoting public awareness of the existence, function and functioning of the Ombudsman and the Ombudsman's office and in informing potential complainants of available dispute resolution forums;
- subscribing members act with fairness and with due regard to both the letter and the spirit of the contract between the parties and render an efficient service to those with whom they contract.

MEMBERS OF THE OMBUDSMAN'S COUNCIL AS AT 31 DECEMBER 2013

Judge Leona Theron (Chairperson)
Judge of the Supreme Court of Appeal

Mr Ken Baldwin
Retired senior partner of KPMG

Mr Moses Moeletsi
Independent consultant; formerly Chairperson of the Board of the Ombudsman for Short-term Insurance

Mr Desmond Smith
Chairperson of Reinsurance Group of America (South Africa); Chairperson of Sanlam; director of companies

Ms Mpho Thekiso
Head of the Debt Review Centre at FNB Shared Services, formerly Project Manager: Debt Counselling with the National Credit Regulator

Mr Jonathan Dixon (*ex officio*)
Deputy Executive Officer: Insurance, Financial Services Board, as such Deputy Registrar of Insurance

Judge Noel Hurt
Retired judge of the KwaZulu-Natal High Court

Ms Thandile Zulu
Regional Manager of the Black Sash

Ms Dorea Ozrovech (*ex officio*)
Principal Officer: Customer Relations, Sanlam Life; Chairperson of the Ombudsman's Committee

Judge Ron McLaren (*ex officio*)
Ombudsman

FOREWORD BY THE CHAIRPERSON OF THE OMBUDSMAN'S COMMITTEE

2013 was a year of many changes – a new Ombudsman, the publication of subscriber complaints information for the first time, active positioning for Treat Customers Fairly ("TCF"), a new referral process for complaints from the Ombudsman to subscribers, the retirement of the Chairperson of the Ombudsman's Council and the appointment of a new Chairperson for it.

During May 2013 Judge Brian Galgut retired. The subscribing insurers really want to thank him for his effort in supporting fair decision making and complaints resolution through alternative dispute resolution interventions. We wish him a pleasant retirement. We were also very pleased to welcome Judge Ron McLaren as the new Ombudsman and look forward to working with him for the years to come.

A first for the Ombudsman's office was the publication of subscriber complaints details during June 2013. The number of complaints received and finalised per subscriber, as well as the percentage of cases determined in favour of complainants and the subscriber were published. Details per complaints categories were also available per subscriber. The industry welcomed this, as it supports transparency and provides information on an equal basis, which prevents subscribers from using unaudited data for marketing purposes.

Subscribers spend many hours of planning and positioning for TCF implementation, which has a huge focus on complaints handling and reporting on complaints. The industry will be looking at the Ombudsman's guidance on the understanding of fairness and how to make sure that the different outcomes are effectively embedded in all industry processes, as indicated by complaints trends.

The Ombudsman started with a new referral process of complaints to subscribers during the last part of 2013. With this process any complaint not previously dealt with by the subscriber is first referred back to the subscriber to give it the opportunity to solve the dispute directly with the complainant. Any complaint not finalised in favour of the complainant is referred back to the Ombudsman. This process was welcomed by the industry.

The Ombudsman's Committee, as liaison body between subscribing members and the Ombudsman's office, welcomed a few new members during 2013 and experienced great opportunities for networking and sharing of trends and best practices. The number of fraudulent hospital claims remained high. The Ombudsman reported an increase in complaints on poor service and also indicated an increase in reminders sent to subscribers to request feedback. The industry will focus on processes to ensure proper complaints handling.

We want to thank Judge Smalberger, Chairperson of the Ombudsman's Council, who retired in October 2013, for his leadership and wisdom in the leading of the Council to give guidance to the Ombudsman's office and to oversee sound practices. We also wish him a pleasant retirement. We congratulate Judge Leona Theron on her appointment as Chairperson of the Ombudsman's Council and wish her a happy and successful term of office.

We want to thank the Ombudsman's office for their guidance and open relationship and, once again, confirm our commitment to support them and work with them to solve disputes in a fair and impartial manner.

Dorea Ozrovech

REPORT BY THE OMBUDSMAN

"The consensus of opinion in the office is that the complaints to it are getting increasingly complex and that complainants are becoming more demanding and persistent in pursuing their complaints."

THE OMBUDSMAN'S COUNCIL

As Judge Theron pointed out in her foreword, Judge Smalberger deferred his retirement as Chairperson of the Council to 25 October 2013. In the 2012 Annual Report, the Ombudsman paid a fitting tribute to Judge Smalberger. In the transitional period, which was created by the deferment of his retirement, I had the opportunity to work with Judge Smalberger and can, therefore, fully endorse his attributes which are so eloquently spelt out in that Annual Report.

I know that Judge Theron has the ability, experience and leadership qualities to ensure that her term of office as Chairperson will be successful and I look forward to working with her.

THE RETIREMENT OF JUDGE GALGUT

Having worked together for many years, I got to know Judge Galgut well. It was, therefore, no surprise when I heard the accolades for him on the occasion of the farewell function, which was held shortly before his term of office expired on 31 May 2013. For me, his most endearing qualities are his easy manner with people, his wry sense of humour and his modesty. Judge Galgut was very supportive of me, particularly when I visited the office for a week during May 2013, in order to familiarise myself with it. That must have been a very busy period for Judge Galgut, but he unstintingly gave me as much of his time as I required, patiently answered all my questions and offered sound advice regarding the office and the way in which it operates.

Judge Galgut left behind a well-run office which functioned smoothly with a dedicated, loyal and skilled staff. It is going to be difficult to emulate him, but I will do my utmost to maintain the high standards set by him.

OVERVIEW OF 2013

Comprehensive statistics for the year under review appear elsewhere in this Annual Report. By way of synopsis of those statistics, I draw attention to only the following: 10 028 complaints were received, which represents an increase of 4.5% over 2012; complaints in which the complainants were wholly or partially successful (in office and industry parlance, the "W/P percentage") was 33%, compared to 37.4% for 2012. It is my view that the lower W/P percentage may be the result of concurrent causes, namely the improved handling of complaints by some insurers; the impact of the office's new business model and an increase in complaints relating to hospital cash plans.

The consensus of opinion in the office is that the complaints to it are getting increasingly complex and that complainants are becoming more demanding and persistent in pursuing their complaints. It is well-recorded that these trends are experienced internationally in offices which are similar in function and structure to our office.

FedGroup Life Limited joined the scheme as a subscribing member in 2013, bringing the total number of members to 49.

PUBLICATION OF COMPLAINTS DATA

On pages 8 and 9 of the 2012 Annual Report it was said that the Financial Services Ombud Schemes ("FSOS") Council had strongly recommended to all the recognised financial ombudsman schemes that they should publish their complaints data and it was announced that this office intended to do so, for the first time, on 3 June 2013. In that publication it was pointed out that such disclosure of complaints data was in accordance with international and local trends; that the publication was done to promote transparency; that, in order to eliminate any potential manipulation of data, it is preferable for the office to disclose such data in a uniform manner and that the office does not interpret the data, but leaves that to others, such as insurers, industry bodies, reporters and consumer organisations. It was, furthermore, pointed out that, because there is no single generally accepted measure to accurately reflect market share in the long-term insurance industry, there was no reference thereto in the publication. In the published complaints data the only contextualising was, accordingly, the expression of the complaints against an individual insurer as a percentage of the total complaints received by the office. The publication of the complaints data by the office received attention in the financial press. It is fair to say that the press and the majority of long-term insurers welcomed the publication of the complaints data and that the positive approach of our subscribing members bodes well for the future. One concern which we have in this regard is that the publication of the complaints data may influence an insurer's decision to settle a complaint, as it would affect the W/P percentage and the publication of this figure seems of great concern to insurers.

NEW BUSINESS MODEL

The international practice in offices similar to our office is that a complaint against an insurer will only be accepted after the insurer has had an opportunity to resolve it. The office has, however, traditionally accepted complaints for investigation, despite the fact that the said practice had not been followed. Part of the rationale for such acceptance lies in the South African demographics. Many policyholders live in rural areas with non-existent or poor communication facilities. In its bid to render an accessible and effective service to such policyholders, the office did not want to place an additional hurdle for them in the complaints process and, therefore, did not require of them to first lodge a complaint with the insurer concerned.

The trend in the office over the last few years shows that a meaningful number of complaints to it were resolved by the insurer to the satisfaction of the complainant as soon as the complaint had been referred to the insurer. This trend was carefully monitored and discussed with interested parties and, with the direction of the Council, a decision was taken to adopt a new business model along the following lines in respect of complaints received by the office:

- A complaint in which there was some interaction between the complainant and the insurer about the complaint, will be taken up by the office as a "full case" and it will be handled until the finalisation thereof.
- A complaint in which there was no such interaction, will be referred to the insurer as a "transfer" for resolution by it, dealing directly with the complainant.
- If such a "transfer" is resolved to the satisfaction of the complainant, the office requires confirmation thereof from the complainant.
- If such a "transfer" is not so resolved, the complaint is returned to the office by the insurer for a "review".
- The office will discuss such a "review" with the complainant and, if required to do so, the complaint will be taken up as a "full case" by the office.

The new process started with a pilot project during June 2013 and initially involved only a few insurers, the number of which was increased over time. At the end of 2013 only 4 insurers were, for logistical reasons, not following the new business model.

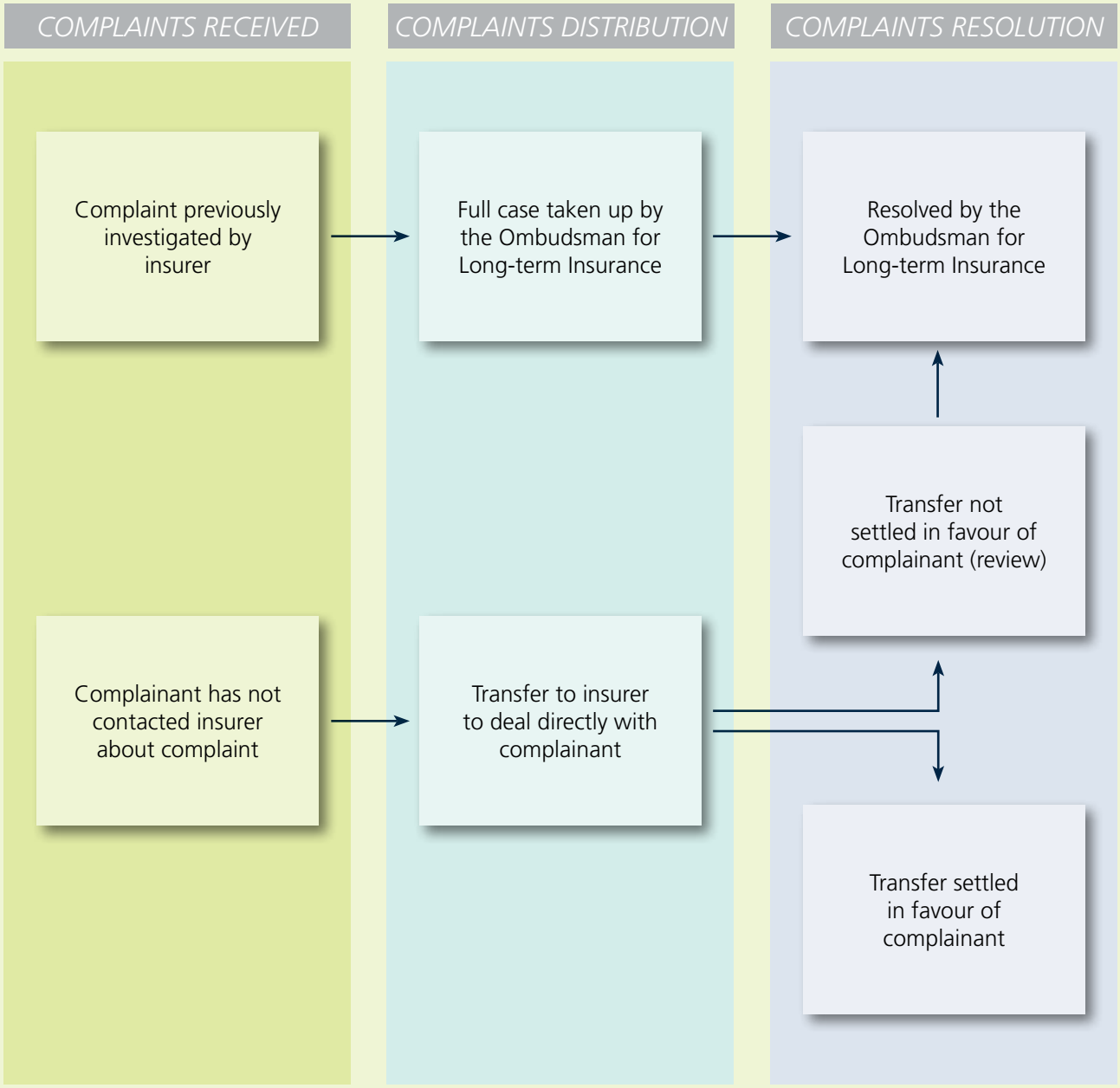
Approximately 75% of complaints received by the office are handled in accordance with the new business model. The implementation of the new business model required some system and operational changes, but has resulted in the following significant benefits:

- In the "transfers" which are resolved, the complaints are finalised very expeditiously.
- In any "review" which becomes a "full case", the complainant does not have to re-submit the complaint.
- The adjudicative resources of the office are put to more effective use to handle the complex and time-consuming complaints.

It is envisaged that the new business model, with possibly a few minor changes, will be applied to all insurers early in 2014.

The new business model impacts on the complaints data of the office principally in two ways: on the number of cases that are finalised and on the W/P percentage, as cases settled by insurers on transfer to them will not form part of our complaints data. The impact of the new business model on the complaints data will be even more pronounced in 2014 when the new business model has run for a full year.

NEW BUSINESS MODEL FLOW DIAGRAM



REMINDER SYSTEM

In terms of our procedures we grant insurers four weeks to respond to a complaint. If we do not receive a response, we send a reminder, granting a further week. If still no response is received, we send a second or "omnibus" reminder.

An area of concern for the office is the increase in second reminders which have to be sent to certain insurers. The Ombudsman's Committee shared our concern. Although most insurers comply with time limits, there are certain insurers that repeatedly fail to do so. Currently, such cases are marked as "incompetent" and the case is charged at double the standard rate. Once a case is marked as "incompetent" there is, however, no further penalty and, hence, less incentive for a defaulting insurer to adhere to the time limits during the rest of the complaint handling process.

The following measures will be introduced, with the full support of the Ombudsman's Committee, to act as a deterrent to try to reduce the number of reminders:

- A further additional charge can be levied, even if a case is already marked "incompetent" and charged double. In other words, an insurer could be charged up to three times the standard rate.
- Where an insurer has more than five omnibus/second reminders per year, the number of reminders will be published with the publication of other complaints data. This first publication will be in respect of 2014.

If an insurer does not respond even after a second reminder, our office makes a determination. A determination in respect of compensation for inconvenience in favour of the complainant will be made, even if a determination on the merits is not possible. Rule 3.2.5 specifically provides for such a situation.

REGULATION OF THE FINANCIAL SECTOR

On 11 December 2013 the National Treasury published a media statement, "Implementing the Twin Peaks Model of Financial Regulation" and invited public comment on the Financial Sector Regulation Bill, 2013. In the statement it was said: "The twin peaks regulatory framework will provide a comprehensive framework for regulating the financial sector. The implementation of twin peaks reform is a multi-year project, with a two-phase process envisaged … " The Bill relates to the first phase, which is to establish a new prudential authority within the Reserve Bank and a new market conduct authority to protect customers of financial services providers and to improve the way in which such providers conduct business. In addition to creating the two regulators and strengthening financial stability, the five other stated objectives of the Bill include the "strengthening of ombud schemes". In this regard the following is said:

"The ombud system is a powerful redress mechanism in the hands of consumers. The Bill, through consequential changes to the Financial Services Ombud Schemes (FSOS) Act, seeks to strengthen the ombud system and requiring all financial institutions to be members of an ombud scheme."

The proposed amendments to the FSOS Act and to the Long-term Insurance Act, 52 of 1998, are set out in Schedule 3 to the Bill.

AMENDMENTS OF RULES

On 10 May 2013 the Council resolved to amend Rules 3.1 and 3.8 of the Rules which regulate the procedure in the office. Following that resolution an application was successfully made to the FSOS Council for its approval of the amendments, which came into effect on 27 August 2013.

MEETINGS WITH INTERESTED PARTIES

During the year, my deputy, Ms Preiss, and I had meetings with representatives of the National Treasury, the Financial Services Board, the Association for Savings and Investment South Africa and the FSOS Council. All these constructive meetings were conducted in a cordial atmosphere and we presented to the parties with whom we met, the 2012 Annual Report, which was well-received, with accompanying compliments thereof. Meetings were held with individual insurers and the office participated in workshops with them and in industry wide workshops. Ms Preiss and I also met with representatives of the offices of the other financial ombudsman schemes.

TRIBUTE TO STAFF

It is my pleasure to attest to the good, hard work which is performed by the staff members. And to the cheerful way in which they go about it. In my "First Impressions"(on page 12 of this Annual Report) I mention the significant assistance and support which I received from the two other members of our management team, namely Jennifer Preiss and Ian Middup. Since recording those impressions, nothing has changed and I still constantly rely on and receive their advice and assistance, without which I will not be able to fulfil my task. There are two other matters to which I would like to refer. Firstly, I point out that this Annual Report is the result of an effort involving everybody in the office – if not directly, then at least indirectly. I received considerable comfort and re-assurance (not to mention an easing of my workload) from this joint effort, for which I am grateful. Secondly, I think it is only fitting that I should pay particular tribute to Jennifer by quoting the following from the letter written by Mr Melville, which appeared in the January 2014 newsletter of the International Network of Financial Ombudsman Schemes ("INFO"):

"First of all, I wish to thank Jennifer Preiss who, as the Network Chair since INFO 2012, has dedicated much passion and effort to enhance the INFO Network for the rest of us. I assume the role of Chair from her with the Network vibrant and growing. For this we owe her our sincere thanks. I am very pleased that she has agreed to remain as a member of the Network Committee through this coming year."

At the office, we are proud of Jennifer's achievements at INFO.

To all the staff members, I express my sincere gratitude for the role they play in making my time spent at the office the pleasant experience which it is.

Ron McLaren

THE NEW OMBUDSMAN'S
FIRST IMPRESSIONS

I was appointed Ombudsman for Long-term Insurance for an initial period of five years with effect from 1 June 2013. During August 2013, I wrote, and distributed amongst the staff members, a short piece about my first impressions of the office. Subsequently Jennifer explained to me that the Annual Reports of the office also serve as a historical record. For that reason, my piece is included below.

A few weeks ago Ian suggested that I should write something about my first impressions of the office. He made the point that, with the passage of time, one tends to forget what one's first impressions were. This holds true, regardless of whether one recalls a person, an object or organisation. My first impressions of our office encompass a large number of components and, by the very nature of things, these impressions are bound to fade or to become old hat. Before that happens, I decided to record those impressions which were gained in the period of about three months, following my appointment on 1 June 2013.

It is not my intention to give a running account of my experiences and to relate how I spent my first three months at the office. Suffice it to say that my first and overriding impression, which has been continuously confirmed, is that the office runs like a well-oiled machine which is coping with an enormous workload.

The office space is generous, although the third floor in the building is a bit like a warren and it is not easy to find our offices, more so until one knows to turn right when coming out of a particular lift and to turn left when using one of the other lifts. My office has a wonderful view of Table Mountain and I cannot believe that my first impressions of Table Mountain will ever fade or become dull. As I am writing this, the mountain is majestically beautiful on a bright sunny winter's day.

I was struck by the sheer volume of the work in progress, as evidenced by the huge number of files in the filing room. The space occupied by the support staff appears to be the "engine room" of the office. I always sense the vibrant energy being expended there to keep the engine running – and it runs smoothly. The dedicated effort of the staff to make things happen, is easy to observe at all times, from early morning until the evening. I am grateful for the commitment by every staff member towards the goal of making things happen in the office.

Part and parcel of my first impressions, is the learning process which I experienced. People call it a learning curve, but mine was more like a hairpin bend on a precipitous mountain pass. Most of the time I just managed to gather information and to perfunctorily acquaint myself with it, while hoping that the passage of time and repetition will somehow turn information into knowledge. At times the experience has been somewhat overwhelming – it was always daunting. When I performed my first acting appointment on the Bench, I was allocated a particularly bad high-profile murder case. In a misguided search for sympathy, I spoke to the Judge President who simply said: "There is nothing like the deep end". Well, I got into the deep end at the office and at times battled to keep my head above water. With the very able, kind and generous support and assistance of Jennifer and Ian, I managed to stay afloat and, advancing from a doggy paddle, I feel that I am beginning to learn the strokes.

I thoroughly enjoy the regular weekly adjudicators' meetings which we have. I find them challenging and stimulating. In my preparation for these meetings, I learnt a lot about the long-term insurance business and about the complex nature of some of the complaints submitted to the office.

I feel happy in my position and I am privileged to make a contribution to a dedicated team. In my view, the entire staff is under too much pressure of work. This is an impression which I want to reassess in due course. I believe that my perception is justified, but it may be clouded by my personal struggle to get on top of the work. If this impression stands the test of time, i.e. if it persists, this excessive workload problem will have to be suitably addressed. In the meantime – "*Vasbyt!*"

Ron McLaren

TRIBUTE TO
JUDGE STEYN

The late Judge Steyn passed away on 30 December 2013. He joined the office as a joint Ombudsman until the retirement of the late Judge Kotze in 1997, after which he remained the Ombudsman until 2003. Shortly after his death various tributes were paid to Judge Steyn in the press and in the social media. It is not intended to refer to those extensively – a quotation from only one such report encapsulates the essence of those attributes: "Jan Steyn was a passionate advocate for justice and equality in South Africa and served South Africa and several Southern African Development Community countries in the highest capacity in the fields of law and development."

In order to demonstrate the huge influence which Judge Steyn had on the way in which the office functions, it is fitting to quote from the 2009 Annual Report in which the following was said:

"Under Judge Steyn's influence the Rules were changed in 1997 to stipulate that, if resolution by conciliation or mediation could not be achieved, the office could make decisions and that subscribing members would be bound thereby. An internal appeal procedure was also introduced for the first time. The Rules were also changed to give the office the power to award compensation to a complainant who suffers inconvenience, distress or financial loss caused by an insurer's error, omission or maladministration. ... There were also structural changes. In 1999 the Ombudsman's Council was established, which is the independent body to which the Ombudsman became answerable, and which was put in place to monitor the proper functioning and independence of the Ombudsman and henceforth to appoint the Ombudsman and his Deputy."

As Judge Theron pointed out in her foreword, the establishment of the Council preceded the statutory requirement for such a body by some six years. In her foreword to the 2008 Annual Report the Chairperson of the Council, Ms Mokhobo, declared that the Council was "ahead of its time, its establishment in 1999 having foreseen the future need for such bodies in the interests of consumers". This is eloquent testimony of foresight on the part of Judge Steyn.

The staff members who worked with Judge Steyn during his tenure of office as Ombudsman have fond memories of him. They describe him as a "passionate, compassionate, principled and charming man of stature who came up for the underdog and who did not tolerate any form of discriminatory behaviour". They also say that "he was generous to a fault". The staff members benefited from that generosity. So did the office – Judge Steyn made a very handsome donation which was used to acquire a much-needed set of South African Law Reports and various other publications for the office. In recognition, the office library was named after and in honour of Judge Steyn on 31 May 2013. This fitting tribute to an outstanding person will ensure that his memory lives on in the office.

STATISTICS

COMPLAINTS RECEIVED

A total of 10 028 complaints were received by the office in 2013, an increase of 4.5% over 2012 and a new record for the office.

While it has always been difficult to forecast complaint volumes, especially when no major negative economic factor is involved, a few trends have been identified that could be responsible for the consistent increase in complaints received over the past few years.

- The significant increase in the number of policies sold by the industry is likely to result in an increase of complaints.
- Public awareness of Ombudsman offices in general has been growing.
- The increase in social media activities, which on the one hand may result in insurers resolving some complaints before they are addressed to the office, also makes a wider audience aware of the office's activities.

The composition of complaints received shows a marked difference from previous years, mainly as a result of a change during the year in the office's business model, described in detail on pages 8 and 9 of this Annual Report.

Mini Cases – the complaints which are within the jurisdiction of the office, but are simple enquiries which the insurers can more easily handle at source.

Out of Scope Complaints – the complaints which do not fall within the jurisdiction of the office remained consistent at about 33% of the total. All such complaints are assessed and recorded by the office and, where appropriate, forwarded promptly to the correct external dispute resolution office.

More Information – the office receives complaints in various forms and often more information regarding the policy, the insurer or the complainant is needed.

Full Cases – the complaints already seen by insurers and handled by the office from inception to finality, reduced by 444 cases.

Transfers – the new category of complaints initially unseen by insurers, but now referred to them in the first instance, totalled 1 045. A number of these will be settled directly in favour of the complainant, the balance being returned to the office as Reviews for further resolution. See the analysis below.

Transfers to Insurers – the complaints which are transferred to insurers who, by agreement with the office, have appointed internal arbitrators.

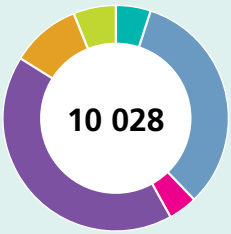
ANALYSIS OF TRANSFERS

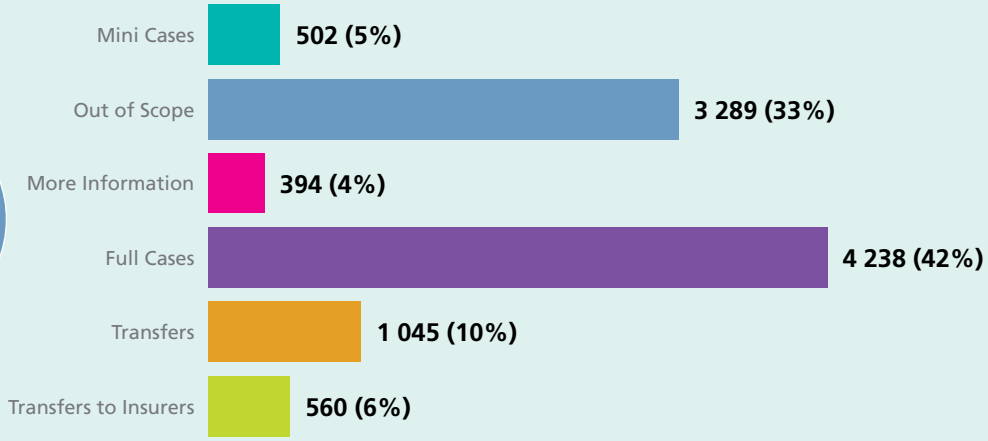
The table below expands the 1 045 Transfers processed in 2013 and gives an indication of their outcome. The length and scope of the pilot project make it difficult for any informed comment on them, but the number settled in favour of the complainants is encouraging.

ANALYSIS OF NEW BUSINESS MODEL TRANSFERS 2013

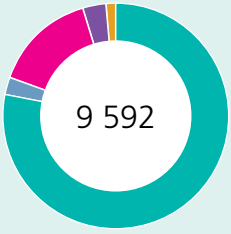
Settled in favour of complainants by insurers	242
Returned to the office for review	511
Awaiting response from insurers	292
	1 045

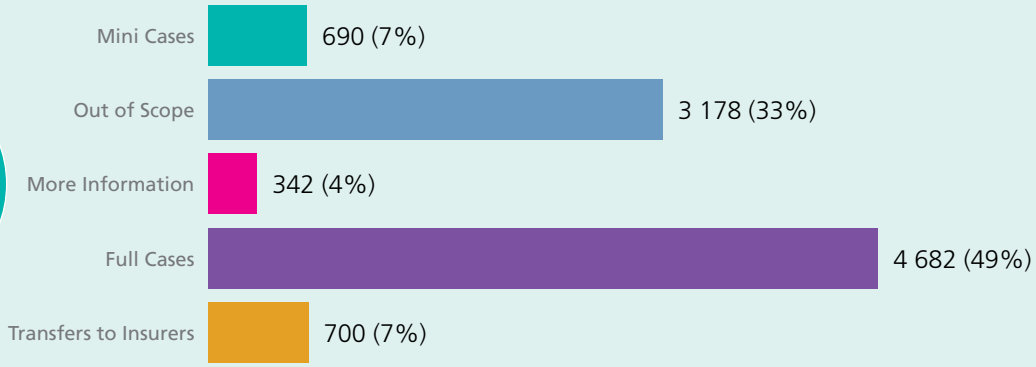
COMPLAINTS RECEIVED 2013





COMPLAINTS RECEIVED 2012





CASES FINALISED

Cases Finalised, which now incorporate Full Cases and those Transfers returned to the office as Reviews, numbered 4 496, a decline of almost 1% from 2012. During 2013 the trend of complainants being more persistent continued, as evidenced by the slight increase in our turnaround times and the increase in our persistency rating (5.8 to 6.1). As mentioned on page 8 of this Annual Report, the new business model impacted on the complaints data.

The reduction by 304 of Standard Cases finalised is largely explained by the 242 complaints which were settled in favour of the complainants on transfer to subscribing members, thus not requiring any further attention from the office. The percentage of Standard Cases finalised also reduced with the increase in other categories of cases but, at 72%, they still remain the bulk of cases finalised by the office.

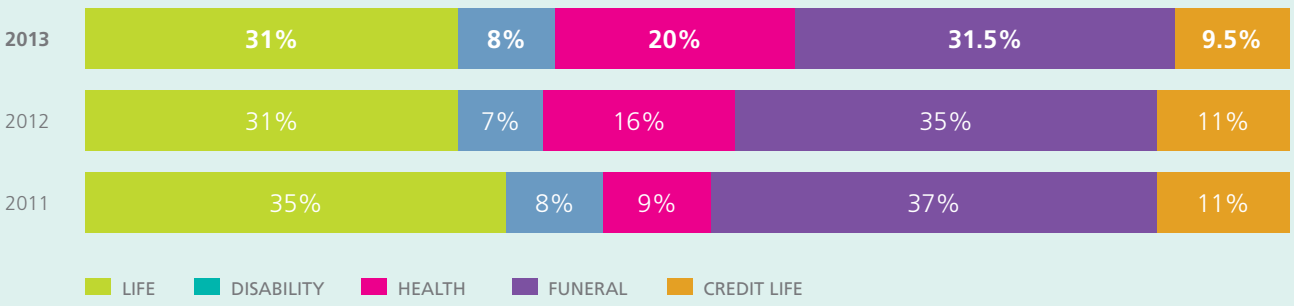
Complicated Cases and Complicated Plus Cases followed a similar pattern to 2012, with the latter increasing by 28%, which highlights the increasing number of technically difficult and challenging cases handled by the office. These cases tend to be extremely lengthy and complex and are often submitted by persistent complainants. The W/P percentage of 53 in these cases is well above the average.

Incompetent Cases almost doubled from 2012 to 284 cases – a major disappointment and concentrated largely in only a few subscribing members. A new process to address this problem will be instituted during 2014 – see page 10 of this Annual Report.

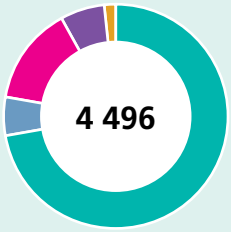
The number of Basic Cases (those involving mainly smaller insurers and which are settled promptly and with smaller benefits) more than doubled from 2012.

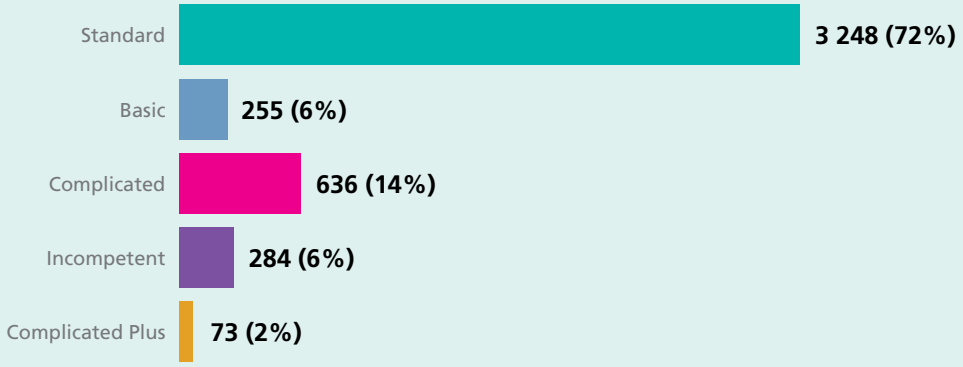
TYPES OF BENEFIT

The graph shows, over three years, the impact of the reducing complaints about funeral policies and the increasing health benefit claims, comprising mainly hospital cash plans.

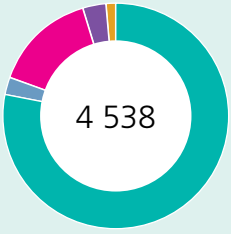


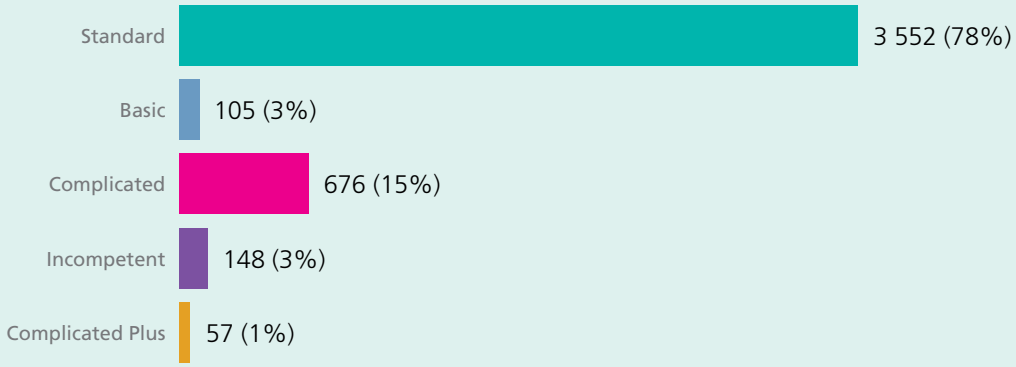
CASES FINALISED 2013





CASES FINALISED 2012





CASES **FINALISED** SUMMARY

	LIFE				DISABILITY			
NATURE OF COMPLAINT	**2012**	**W/P***	**2013**	**W/P***	**2012**	**W/P***	**2013**	**W/P***
Poor communications/documents or information not supplied/poor service	1 064	44%	1 049	45%	14	43%	22	18%
Claims declined (policy terms or conditions not recognised or met)	1 837	37%	1 383	33%	259	33%	238	36%
Claims declined (non-disclosure)	108	15%	114	16%	47	11%	71	8%
Dissatisfaction with policy performance and maturity values	149	15%	150	17%	1	0%	2	0%
Dissatisfaction with surrender or paid-up values	64	14%	62	17%	0	0%	0	0%
Misselling	29	31%	31	34%	0	0%	0	0%
Lapsing	120	30%	140	37%	1	100%	2	50%
Miscellaneous	102	25%	332	10%	6	50%	8	25%
TOTAL	**3 473**	**37%**	**3 261**	**32%**	**328**	**31%**	**343**	**28%**

** Resolved wholly or partially in favour of the complainant.*

The above statistical summary reflects the cases finalised by the office over a two year period. They form the basis of the individual subscribing member's published complaints data and assist the office and insurers in identifying trends and highlighting problem areas.

OVERVIEW

The new business model, although not yet fully implemented, impacts on the finalised statistics, to the extent that 242 complaints transferred to insurers were settled directly in favour of the complainants and do not form part of the above table.

Claims Declined Cases reduced in volume for the first time since 2009 and also reduced to less than 50% of the total Cases Finalised. This welcome trend is mainly the result of a decline in complaints about funeral policies for a large number of insurers.

Poor Service Cases, which in 2012 reversed its downward trend, again increased in 2013. The main contributor for poor service complaints is the increase in this category of Hospital Cash Plan Cases. However, the decrease in complaints about funeral policies is, unfortunately, not duplicated in the Poor Service Cases.

HEALTH				TOTALS				PERCENTAGE TO TOTAL	
2012	W/P*	2013	W/P*	2012	W/P*	2013	W/P*	2012	2013
141	59%	248	69%	1 219	46%	1 319	47%	27%	30%
568	40%	545	27%	2 664	37%	2 166	31%	59%	48%
16	25%	61	11%	171	15%	246	13%	4%	5%
0	0%	0	0%	150	15%	152	13%	3%	4%
1	0%	1	0%	65	14%	63	18%	1%	1%
2	0%	2	100%	31	29%	33	27%	1%	1%
5	40%	5	40%	126	31%	147	37%	3%	3%
4	50%	30	83%	112	26%	370	17%	2%	8%
737	**43%**	**892**	**39%**	**4 538**	**37%**	**4 496**	**33%**	**100%**	**100%**

RESOLVED WHOLLY OR PARTIALLY IN FAVOUR OF THE COMPLAINANT ("W/P")

The total W/P percentage dropped to 33 in 2013, a reduction of four percentage points. As mentioned on page 8 of this Annual Report, the new business model impacted on the complaints data. If the resolved Transfer Cases are taken into account in this total, as they would probably have resulted in the same outcome, the W/P percentage would be 36.4%.

While the W/P percentage is without doubt a useful measure, both in South Africa and internationally, Ombudsman offices are experiencing significant variations from year to year. The W/P percentage depends largely on the benefit and complaint mix at the time and should not be overly emphasised, without a full reference to and an understanding of the various factors which may have a bearing on it.

As well as the case volume reduction, the W/P percentage for Claims Declined reduced by six percentage points – a welcome trend, but off-set by the increase in the Poor Service W/P percentage.

MATTERS OF INTEREST

APPEALS

The only decision by an Appeal Tribunal (Judge Melunsky) was dated 15 July 2013 and in it the complainant's appeal was dismissed. The Judge expressed the view (in accordance with our Rule 6.8.4) that the appeal was substantially unsuccessful. In the decision the following was said with regard to the principles which apply to the interpretation of a policy:

"By referring to the aforegoing illustrations my concern is only to ascertain whether it is reasonably possible for the policy to bear the meaning contended for by the Appellant: this is purely a question of construction of the phrase in its context and according to its nature. Like any other contractual document, a policy of insurance must be considered as a whole and the words used should be interpreted reasonably and in conformity with the subject matter of the policy. Thus, the ordinary literal meaning of the words cannot be given effect to if, from the instrument as a whole, it is clear that a more limited construction was intended.

To sum up at this stage:

(a) The Appellant, in construing the phrase in issue, relies on the ordinary grammatical meaning of the words in the abstract, without taking into account the context in which the language is used. This is not the correct approach in the interpretation of the policy.

(b) The exercise of construction is one unitary exercise and the context should be considered and applied in the first instance.

(c) The interpretation relied on by the Ombudsman and by me gives the policy a sensible meaning and not one that leads to insensible or unbusinesslike results or undermines the apparent purpose of the policy."

EQUITY JURISDICTION

In terms of our Rule 1.1 the "mission of the Ombudsman is to receive and consider complaints against subscribing members and to resolve such complaints through mediation, conciliation, recommendation or determination".

The office acquired its equity jurisdiction in the mid-90s when our Rule 1.2.4 was adopted. Under the rubric "Mission", that Rule provides that the Ombudsman shall seek to ensure that he or she accords due weight to considerations of equity. Section 10(1)(e)(iv) of the FSOS Act stipulates the following requirement for recognition of an ombudsman scheme:

"the proposed procedures of the scheme must enable the ombud, where appropriate, to apply principles of equity in resolving a complaint."

It is thus clear that the pre-existing equity/fairness jurisdiction of the office acquired a statutory imprimatur in 2005, when the FSOS Act came into operation.

In addition, our Rule 1.2.7 enjoins the Ombudsman to "seek to ensure that subscribing members act with fairness and with due regard to both the letter and the spirit of the contract between the parties and render an efficient service to those with whom they contract".

Against this backdrop it is surprising that some insurers still appear to question the existence of our equity jurisdiction. We give one example. In a final determination which the office made against an insurer during 2013 in the exercise of its equity jurisdiction the following was said in the comprehensive reasons for that determination:

"(The insurer) has also questioned the fairness to it if it were required to consider a claim which it has declined in accordance with the express provisions of the policy. However, fairness must be exercised in relation to both parties, not just one of the parties. This necessarily entails weighing up the competing interests of the parties and determining how best to balance the equities.

In any event, if our office was precluded from exercising its equity jurisdiction on the basis that the insurer's repudiation of the claim was in accordance with the express provisions of the policy, we would be precluded from exercising equity in every case. This is because, as explained, the very purpose of our equity jurisdiction is to enable us to depart from the express terms of the contract when they result in an unjust hardship."

The insurer appealed against the final determination, but withdrew the appeal after the Appeal Tribunal had already been appointed. It is perhaps unfortunate that a good opportunity was lost for the office to obtain a comprehensive and, given the stature of that Appeal Tribunal, definitive decision on its equity jurisdiction. Maybe the opportunity will present itself again.

During the year a number of meetings were held with insurers and in presentations by our office its "equity jurisdiction approach to complaints" was comprehensively explained. It is our belief that those who attended these workshops benefited from them and we find it encouraging that all these workshops were conducted at the request of the insurers.

FUNERAL POLICIES

Funeral policies have unique problems, some of which have been mentioned in previous Annual Reports. The following problems continued to trouble consumers during the past year.

Funeral policies not owned by lives insured/ members

There have been media reports and the office has reported on the problems which are experienced where a funeral insurer designed a product in such a way that the policyholder is not the life insured/member of the group policy, but instead the policyholder is the funeral parlour, which markets the product. The insurer's design ensures that the life insured/premium payer is not in a contractual relationship with the insurer and cannot claim a benefit from the insurer. Our jurisdiction is thus ousted and we cannot assist the life insured/premium payer or any party claiming through him/her. The life insured, therefore, only has recourse against the funeral parlour.

Although the Financial Services Board engaged with the insurer concerned, there has as yet been no resolution to this problem. This arrangement becomes particularly problematic when the funeral parlour is one of the "rogue operators" in the market and does not pay premiums over to the insurer. This inevitably leads to a cancellation of the policy by the insurer and non-payment of any benefit to the life insured's family.

Unfortunately, there are some operators in the market that can only be described as dishonest. These are administrators or funeral parlours or intermediaries which do not play by the rules. They tend not to pay over premiums or not all the premiums collected from clients. When the insurer, which underwrites the particular group scheme, terminates the policy because of such conduct, the scheme is moved to another insurer. There are instances where schemes change insurers up to three or four times a year! This naturally causes problems and confusion for the members of the scheme and often leaves them without cover. The surprising aspect is the fact that insurers continue to underwrite these schemes. It would be so much more prudent if all insurers did some type of due diligence check before taking over group schemes.

EXCESSIVE CLAIMS ON HOSPITAL CASH PLANS

We reported in the 2011 Annual Report (page 22) and in the 2012 Annual Report (page 24) on the incidence of complaints about excessive claims under hospital cash plans. Unfortunately, we cannot report that there was any improvement in 2013. The office continues to receive complaints involving such claims, despite the fact that we uphold the insurers in almost all of the complaints. Some complainants have several hospital cash plan policies with the same insurer or with different insurers, and we then receive multiple complaints from the same complainant in respect of the different policies.

It is obvious that the "syndicates" operating in this field are either still functioning or that new operators have taken their place. It is also evident that the insurers concerned are still selling these policies, also to policyholders in KwaZulu-Natal, where this undesirable practice mostly occurs – insurers, it seems, cannot exclude this area.

The office continues to draw attention to this problem in the hope that it may lead to a concerted effort to curb the undesirable activities of and the excessive claims by complainants.

THE OMBUDSMAN
ENVIRONMENT

INFO

INFO is the International Network of Financial Services Ombudsman Schemes – a network which ombudsman schemes can join to share and exchange ideas and to assist each other.

The organisation continues to grow as the "ombudsman phenomenon" spreads around the world. An indication of this is the fact that INFO now has 56 members from 37 countries and there are also a number of countries considering the establishment of new ombudsman systems. What is particularly pleasing is that alternative/external dispute resolution in the form of ombudsman schemes is spreading to new geographical areas, particularly to countries with developing economies.

A number of Asian countries have started such schemes over the past few years (for instance, Taiwan, Malaysia and Hong Kong) and more are considering them.

In sub-Saharan Africa there is also renewed interest in establishing ombudsman schemes, particularly in the credit market.

Eastern Europe is another region where there is growth and interest in ombudsman schemes, with the Armenian Financial System Mediator being the trendsetter.

Although there are fundamental principles to which all ombudsman schemes should aspire, it is not a "one size fits all" approach. The system has to be adapted to suit the culture, the environment and the consumer profile of the particular country. For example, in one country an ombudsman scheme will work perfectly well if it is a voluntary scheme, while in another country such a system will fail and it would have to be a mandatory statutory scheme.

INFO 2013

The annual conference of INFO took place in Taipei, Taiwan in 2013, the first time the conference was hosted in Asia. This is a reflection of the increasing interest in ombudsman schemes in that region. The conference had a range of interesting and topical sessions.

As mentioned in the 2012 Annual Report, INFO has been debating the question whether it should set standards for its members. After studying worldwide standards relevant to ombudsman schemes, INFO has settled on seven fundamental principles to which members should aspire, namely:

- Independence, to secure impartiality
- Clarity of scope and powers
- Accessibility
- Effectiveness
- Fairness
- Transparency
- Accountability

At the 2013 Annual General Meeting of INFO its members agreed to proceed with an eight-part guide which introduces and addresses each of the above principles, including approaches that will assist schemes to meet them. This guide is in the process of being drafted.

CURRENT TRENDS

The office experiences the following trends in complaints resolution and, as we heard at the INFO 2013 conference, these trends are echoed in other schemes, both nationally and internationally:

- Complainants are more persistent and more demanding.
- As mentioned on page 7 of this Annual Report, ombudsman schemes (including our scheme) are experiencing the difficulty of dealing with persistent and demanding complainants. This impacts on productivity and turnaround times. This, and the fact that complaints are becoming more difficult, is an ongoing challenge for ombudsman schemes. See also page 6 of the 2012 Annual Report.
- Complainants want continuous feedback regarding their complaints and want a quick resolution of the complaint, even where the issues are complex and warrant in-depth investigations.

- Social media is increasingly being used to resolve complaints. As this trend grows, complainants use social media to voice their dissatisfaction – not only with financial institutions, but also with ombudsman schemes themselves. Social media is seen as an alternative to the more traditional forms of consumer recourse. Financial institutions tend to react swiftly to social media complaints because of the threat of negative publicity, which, in turn, encourages the use of this as a medium for complaint resolution. It is expected that this trend will continue to grow.
- Complainants want "fair" resolutions from financial institutions – not just a reliance on legal or contractual grounds.
- Ombudsman schemes used to be on the periphery of financial services, but they are no longer and they are now viewed as being integral to financial services. This has, in turn, led to closer scrutiny of the schemes and more court challenges for them in some jurisdictions.
- Complaints data from financial institutions and from ombudsman schemes is increasingly being regarded as important by regulators and policy makers. The publication by schemes of complaints data, in respect of financial institutions for the benefit of consumers and intermediaries and other stakeholders, is also becoming more common. So is the publication of determinations/decisions in which the financial institutions are named. The office recently adopted both these practices.
- Systemic issues/complaints with wider implications are reported to industry regulators as a matter of course in most jurisdictions, including ours, and this assists in the early detection of problems by them.
- Standard setting for complaints handling and benchmarking, both internationally and locally, to find best practices has and continues to be a focus.
- Costs and efficiency within ombudsman schemes are becoming ever more important considerations and financial institutions and regulators are increasingly concentrating on these aspects.

STAFF IN THE OMBUDSMAN'S OFFICE AS AT 31 DECEMBER 2013

Management team:
Judge Ron McLaren
Jennifer Preiss
Ian Middup

Adjudicators/assessors:
Eddie de Beer
Heinrich Engelbrecht
Sue Myrdal
Nceba Sihlali
Nuku van Coller
Cikizwa Nkuhlu
Lisa Shrosbree
Deon Whittaker
Cheryl Steyn
Diana Mills
Lorraine Allan
Kathy Heath
Ganine Bezuidenhoudt
Jameelah Leo
Edith Field
Rene Venter
Jenny Jenkins
Tasneem Ebrahim

Support staff:
Clyde Hewitson
Rosemary Galolo
Charmaine Bruce
Andrea Lennox
Marshalene Williams
Tamara Sonkqayi
Angelo Swartz
Sureena Gallie
Sithandwa Tolashe
Lisa Fincham
Yolanda Augustine
Colline Alexander
Tania Thomas
Phindiwe Fana
Puleka Ngalo
Nosiphiwo Sifingo
Virginia Smith
Colleen Louw

APPENDICES

APPENDIX 1: SUBSCRIBING MEMBERS AS AT 31 DECEMBER 2013

1 Life Direct Insurance Limited

Absa Life Limited
Allied Insurance Company Limited
UBS Insurance Company Limited

Absa Insurance and Financial Advisers (Pty) Limited

Acsis Limited

African Unity Insurance Limited

AIG Life South Africa Limited
Chartis Life

Allan Gray Life Limited

Alexander Forbes Life Limited

Assupol Life Limited

AVBOB Mutual Assurance Society

Bidvest Life Limited
Mclife

Centriq Life Insurance Company Limited

Channel Life Limited
PSG Anchor Life

Clientèle Life Assurance Company Limited

Discovery Life Limited

FedGroup Life Limited

Frank Life Limited

Guardrisk Life Limited
Platinum Life

Hollard Life Assurance Company Limited
Crusader Life
Fedsure Credit Life
Investec

Investec Assurance Limited

Investment Solutions Limited

JDG Micro Life Limited

Liberty Group Limited
Manufacturers Life
Prudential
Sun Life of Canada
Capital Alliance Life Limited
AA Life
ACA Insurers Limited
Amalgamated General Assurance
Fedsure Life
IGI Life
Norwich Life
Saambou Credit Life
Standard General – pre-1999
Traduna
Rentmeester Assurance Limited
Rondalia

Liberty Active Limited

Lombard Life Limited
Pinnafrica Life Limited

MS Life Assurance Company Limited

Metropolitan Life International Limited
Commercial Union
Homes Trust Life

Metropolitan Odyssey Limited
Protea Life

Momentum Group Limited
African Eagle Life
Allianz Life
Anglo American Life
FNB Life
First Rand
Guarantee Life
Legal and General
Lifegro
Magnum Life
Rand Life
Sage Life
(National Mutual of Australasia)
(Ned Equity)
(Netherlands of 1845)
Shield Life
Southern Life
Yorkshire

Nedbank Limited

Nedgroup Life Assurance Company Limited
NBS Life
BOE Life Limited

Nestlife Assurance Corporation Limited

New Era Life Insurance Company Limited

Old Mutual Life Assurance Company (South Africa) Limited
Colonial Mutual

Outsurance Life Insurance Company Limited

Professional Provident Society Insurance Company Limited

Prosperity Insurance Company Limited

PSG Futurewealth Limited
M Cubed Capital Limited
Time Life

Real People Assurance Company Limited

Regent Life Assurance Company Limited

Relyant Life Assurance Company Limited

RMB Structured Life Limited

Safrican Insurance Company Limited

Sanlam Life Insurance Limited

Sanlam Sky Solutions (African Life Assurance Company Limited)
Permanent Life
Sentry Assurance

SA Home Loans Life Assurance Company Limited

Union Life Limited

Vodacom Life Assurance Company Limited

Workers Life Assurance Company Limited
Sekunjalo Investments Limited

APPENDIX 2: MEMBERS OF THE OMBUDSMAN'S COMMITTEE AS AT 31 DECEMBER 2013

Dorea Ozrovech (Chairperson)
Sanlam Life Insurance Limited

Chantal Meyer
Sanlam Sky Solutions
African Life Assurance Company Limited

Gail Walters
Hollard Life Assurance Company Limited

Anna Rosenberg
Association for Savings and Investment South Africa

Glenn Hickling
Discovery Life Limited

Russel Krawitz
Clientèle Life Assurance Company Limited

Brian Gibbon
Momentum Group Limited

Pieter Spreeuwenberg
Old Mutual Life Assurance Company (SA) Limited

Keith van Lingen
Assupol Life Limited

Mariza Schlushe
Metropolitan Life International Limited

Mellony Ramalho
Liberty Group Limited

Audrey Rustin
Nedgroup Life Assurance Company Limited

Kurt Terblanche
1 Life Direct Insurance Limited

Joe Peters
Workers Life Assurance Company Limited

APPENDIX 3: RULES

1 Mission

1.1 The mission of the Ombudsman is to receive and consider complaints against subscribing members and to resolve such complaints through mediation, conciliation, recommendation or determination.

1.2 The Ombudsman shall seek to ensure that:

1.2.1 he or she acts independently and objectively in resolving any complaint received and takes no instructions from anybody regarding the exercise of his or her authority;

1.2.2 he or she follows informal, fair and cost-effective procedures;

1.2.3 he or she keeps in balance the scale between complainants and subscribing members;

1.2.4 he or she accords due weight to considerations of equity;

1.2.5 he or she maintains confidentiality, in so far as it is feasible to do so and subject to Rules 3.8 and 7 below, in respect of every complaint received;

1.2.6 he or she co-operates with the Council established in terms of the Financial Services Ombud Schemes Act, 2004, in promoting public awareness of the existence, function and functioning of the Ombudsman and the Ombudsman's office and in informing potential complainants of available dispute resolution forums;

1.2.7 subscribing members act with fairness and with due regard to both the letter and the spirit of the contract between the parties and render an efficient service to those with whom they contract.

2 Jurisdiction

2.1 Subject to Rule 2.2, the Ombudsman shall receive and consider every complaint by a policyholder, a successor in title or a beneficiary, or by a life insured or premium payer, against a subscribing member concerning or arising from the marketing, conclusion, interpretation, administration, implementation or termination of any long-term insurance contract marketed or effected within the Republic of South Africa.

2.2 The Ombudsman shall not consider a complaint:

2.2.1 if such complaint is, or if it has been, the subject of legal proceedings instituted and not withdrawn, or if legal proceedings are contemplated to be instituted by the complainant against the subscribing member, during such time as the complaint remains under advisement by the Ombudsman; or

2.2.2 if it has previously been determined by the Ombudsman, unless new evidence likely to affect the outcome of a previous determination has thereafter become available; or

2.2.3 if three years or more have elapsed from the date on which the complainant became aware or should reasonably have become aware that he or she had cause to complain to the Ombudsman, unless the failure so to complain within the said period was due to circumstances for which, in the opinion of the Ombudsman, the complainant could not be blamed.

3 Procedure

3.1 The Ombudsman shall require, or in suitable circumstances cause, all complaints to be reduced to written or electronic form, shall elicit such further information or expert advice as is regarded as necessary and shall seek to resolve every such complaint through mediation, conciliation, recommendation, failing which, by determination.

3.2 The determination aforesaid may be to:

3.2.1 decline to consider the complaint;

3.2.2 uphold the complaint, either wholly or in part;

3.2.3 dismiss the complaint;

3.2.4 make a ruling of a procedural or evidentiary nature;

3.2.5 award compensation, irrespective of a determination made in terms of Rule 3.2.2 or 3.2.3, for material inconvenience or distress or for financial loss suffered by a complainant as a result of error, omission or maladministration (including manifestly unacceptable or incompetent service) on the part of the subscribing member; provided that the amount of such compensation shall not exceed the sum of R30 000 or such other sum as the Long-term Insurance Ombudsman's Council ("the Council") may from time to time determine;

3.2.6 order a subscribing member, in addition to any other recommendation or determination made, to pay interest to a complainant on the pertinent sum at a rate and from a date that is considered to be fair and equitable in the circumstances;

3.2.7 order a subscribing member to take, or refrain from taking, any such action in regard to the disposal of a specific complaint as the Ombudsman may deem necessary;

3.2.8 issue a declaratory order.

3.3 The Ombudsman may decline to consider or may dismiss a complaint, without first referring it to the subscribing member concerned, if it appears to him or her, on the information furnished by the complainant, that:

3.3.1 the complaint has no reasonable prospect of success; or

3.3.2 the complaint is being pursued in a dishonest, frivolous, vexatious or abusive manner; or

3.3.3 the complaint can more appropriately be dealt with by a court of law; or

3.3.4 the complaint is predominantly about investment performance or the legitimate exercise by a subscribing member of its commercial judgment; or

3.3.5 the complainant has not suffered, and is not likely to suffer, material inconvenience or distress or financial loss either within the meaning of Rule 3.2.5. or at all.

3.4 If a complainant or a subscribing member fails or refuses to furnish information requested by the Ombudsman within the period fixed for that purpose, the Ombudsman shall be free to make a determination on the information as may then be available to him or her.

3.5 A determination made by the Ombudsman shall be binding on the subscribing member concerned.

3.6 A determination made by the Ombudsman shall not preclude the complainant from thereafter instituting legal proceedings against a subscribing member in respect of any such complaint.

3.7 All exchanges between, on the one hand, the office of the Ombudsman and a complainant and, on the other, the office and a subscribing member in relation to a complaint and all the documentation generated in regard thereto, shall by agreement be regarded as privileged and shall as such be immune from disclosure in evidence, save by an order of court or the consent of the parties concerned.

3.8 In any case in which a determination as provided for in Rule 3.2.2 is made against a subscribing member, or in which in an appeal by a complainant a ruling is made by the Appeal Tribunal holding that the appeal is substantially successful as envisaged in Rule 6.8.3, the Ombudsman shall publish such determination or ruling, including a summary of the facts concerned, the reasons for the determination and the identity of the subscribing member; provided that the Ombudsman shall not publish as aforesaid in any case in which there is reason to believe that such publication will expose the identity of the complainant, the policyholder, a successor in title or beneficiary, a life insured or a premium payer; provided further that there will be no publication of a determination by the Ombudsman against a subscribing member if on appeal the subscribing member is substantially successful as envisaged in Rule 6.9.1.

4 Prescription

The receipt of a complaint by the Ombudsman suspends any applicable contractual time barring terms or the running of prescription in terms of the Prescription Act (Act 68 of 1969), for the period from such receipt until the complaint has been withdrawn by the complainant concerned, been determined by the Ombudsman or any appeal in terms of these Rules has been disposed of.

5 Determination of disputes of fact

5.1 The Ombudsman shall resolve material disputes of fact on a balance of probabilities and with due regard to the incidence of the onus.

5.2 If the Ombudsman is of the opinion that a material and conclusive dispute of fact cannot be resolved on a balance of probabilities and with due regard to the incidence of the onus, the parties concerned shall be advised that a determination in favour of the one or the other party cannot be made.

5.3 Notwithstanding Rule 5.2, if the Ombudsman and all the parties concerned are in agreement that a complaint or a material and conclusive dispute of fact can best be determined by the hearing of evidence, it may be so determined.

5.4 A hearing as aforesaid may be conducted by the Ombudsman or any other person or persons appointed for that purpose by the Ombudsman.

5.5 At such a hearing all issues of a procedural or evidentiary nature shall be determined by the Ombudsman or other person or persons so appointed.

6 Appeals

6.1 A complainant who or a subscribing member which feels aggrieved by any determination by the Ombudsman may apply to the Ombudsman for leave to appeal against it to a designated Appeal Tribunal.

6.2 Such an application shall be made within a period of one calendar month from the date on which the determination that is challenged has been made.

6.3 Such leave to appeal shall be granted:

6.3.1 if the determination is against a subscribing member and involves an amount in excess of R250 000 or such other sum as the Council may from time to time determine; or

6.3.2 if the Ombudsman is of the opinion that the determination as such or the particular issue in dispute is of considerable public or industry interest; or

6.3.3 if the Ombudsman is of the opinion that the aggrieved complainant or subscribing member has a reasonable prospect of success in an appeal before a designated Appeal Tribunal.

6.4 The member or members of the Appeal Tribunal shall be appointed by the Ombudsman with the consent of all the parties concerned or, failing such consent, with the approval of the Chairman of the Council or, if he or she is unavailable, two members of the Council not connected with the Industry.

6.5 The Ombudsman shall prepare the record for consideration by the Appeal Tribunal.

6.6 All issues of a procedural or evidentiary nature shall be determined by the Appeal Tribunal itself.

6.7 The decision of the Appeal Tribunal shall be final and binding:

6.7.1 if the complainant is the appellant, on all the parties concerned;

6.7.2 if the subscribing member is the appellant, on it.

6.8 When the complainant is the appellant:

6.8.1 he or she may be required to deposit such amount as the Ombudsman may consider appropriate into the trust account of an attorney designated by the Ombudsman;

6.8.2 such amount shall be held in trust pending the outcome of the appeal;

6.8.3 if the appeal is, in the view of the Appeal Tribunal substantially successful, such amount shall be refunded to the complainant;

6.8.4 if the appeal is, in the view of the Appeal Tribunal substantially unsuccessful, such amount shall be applied by the Ombudsman to defray, either wholly or in part, the costs incurred by the Ombudsman in connection with the appeal proceedings and to refund any surplus to the complainant.

6.9 When the subscribing member is the appellant:

6.9.1 if the appeal is, in the view of the Appeal Tribunal substantially successful, the Ombudsman shall defray the costs incurred by him in connection with the appeal proceedings;

6.9.2 if the appeal is, in the view of the Appeal Tribunal substantially unsuccessful, the subscribing member shall defray the costs incurred by the Ombudsman in connection with the appeal proceedings.

7 Enforcement

7.1 If a subscribing member should fail or refuse to comply with a determination made by the Ombudsman:

7.1.1 it shall be given notice by the Ombudsman that it is to comply with such determination within a period of four weeks or such further period as the Ombudsman may determine;

7.1.2 on the failure or refusal by the subscribing member to comply with such notice, the Ombudsman shall report such failure or refusal to the Chairman of the Long-Term Insurance Ombudsman's Committee ("the Committee").

7.2 The Ombudsman may thereupon:

7.2.1 determine what, if any, further opportunity should be afforded to the subscribing member concerned to make representations as to why the measures described below should not be implemented;

7.2.2 publish, in whatever manner the Ombudsman considers to be appropriate, the fact of such failure or refusal;

7.2.3 suspend or terminate, with the consent of the Chairmen of both the Council and the Committee, the membership of the subscribing member concerned; and, in that event,

7.2.4 publish in whatever manner the Ombudsman considers to be appropriate, the fact of such suspension or termination of such membership.

8 Report

The Ombudsman shall report publicly on or before 31 May of each year on his or her activities during the previous calendar year.

USEFUL INFORMATION ABOUT OTHER OFFICES

The Ombudsman for Short-term Insurance
PO Box 32334, Braamfontein 2017
Sharecall: 0860 726 890
Telephone: 011 726 8900
Fax: 011 726 5501
E-mail: info@osti.co.za

Ombudsman for Banking Services
PO Box 87056, Houghton 2041
Sharecall: 0860 800 900
Telephone: 011 712 1800
Fax: 011 483 3212
E-mail: info@obssa.co.za

The Credit Ombud
PO Box 805, Pinegowrie 2123
Call Centre: 0861 662 837
Fax: 086 683 4644
E-mail: ombud@creditombud.org.za

The Financial Advisory and Intermediary Services Ombud
PO Box 74571, Lynnwoodridge 0040
Sharecall: 0860 324 766
Telephone: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

The Pension Funds Adjudicator
PO Box 580, Menlyn 0063
Telephone: 012 346 1738
Fax: 086 693 7472
E-mail: enquiries@pfa.org.za

The Financial Services Board
PO Box 35655, Menlo Park 0102
Toll-free: 0800 110 443 or 0800 202 087
Telephone: 012 428 8000
Fax: 012 346 6941
E-mail: info@fsb.co.za

The Council for Medical Schemes
Private Bag X34, Hatfield 0028
Telephone: 012 431 0500
Fax: 012 430 7644
E-mail: support@medicalschemes.com

Public Protector
Private Bag X677, Pretoria 0001
Telephone: 012 366 7000
Fax: 012 632 3473/0865 753 292
E-mail: Elainei@pprotect.org

The Statutory Ombudsman
PO Box 74571, Lynnwoodridge 0040
Sharecall: 0860 324 766
Telephone: 012 470 9080
Fax: 012 348 3447
E-mail: info@faisombud.co.za

The National Credit Regulator
PO Box 2209, Halfway House, Midrand 1685
Call Centre: 0860 627 627
Telephone: 011 554 2600
Fax: 011 554 2871
E-mail: info@ncr.org.za or complaints@ncr.org.za

National Consumer Commission
Private Bag X84, Pretoria 0001
Call Centre: 0860 003 600
Telephone: 012 940 4500
Fax: 086 151 5229
E-mail: complaints@thencc.org.za

ASISA: Cape Town office
PO Box 23525, Claremont 7735
Telephone: 021 673 1620
Fax: 021 673 1630
E-mail: info@asisa.org.za

ASISA: Johannesburg office
PO Box 787465, Sandton 2146
Telephone: 011 369 0460

OMBUDSMAN'S **CENTRAL HELPLINE**

Sharecall 0860OMBUDS/0860662837

3rd Floor
Sunclare Building
21 Dreyer Street
Claremont 7700
Private Bag X45
Claremont 7735

Telephone: 021 657 5000
Sharecall: 0860 103 236
Fax: 021 674 0951
E-mail: info@ombud.co.za
www.ombud.co.za

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