Annual REPORT 2012

OMBUDSMAN
FOR LONG-TERM INSURANCE

Complaints received	Full cases finalised	Percentage of cases resolved wholly/partially in favour of complainants	Percentage of cases finalised within six months
9 592	**4 538**	**37.4%**	**80%**

KEY **FIGURES**

R2 300	**R94.3m**	**R413 428**	**R14.2m**
Cost per standard case	Recovered for complainants (in lump sums)	Compensation granted	Total expenses for the year

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FOREWORD BY THE CHAIRPERSON OF THE OMBUDSMAN'S COUNCIL

"The Council was again satisfied with the independence and performance of the Ombudsman and his office during 2012, and that they duly fulfilled their mission under the office's Rules."

The Ombudsman

Judge Galgut's term of office as Ombudsman for Long-term Insurance expires on 31 May 2013, and Judge R P McLaren has been appointed to fill the post for the next five years commencing on 1 June. Judge Galgut's tenure as Ombudsman has been a highly successful one. Under his wise and responsible guidance the office has flourished and enhanced its enviable reputation for excellence, fairness and independence. He and the members of his able staff deserve our appreciation and congratulations. Judge Galgut leaves with our sincere thanks and best wishes for the future.

My retirement

With some hesitation, and considerable regret, I have decided, after a period of 10 years on the Council, that the time has come for me to retire and that at the next meeting on 10 May 2013 I will resign my membership of the Council. The time I have spent on the Council has been an interesting and enriching one which has seen a number of important developments. Amongst the highlights of that period are that the number of complaints received by the office rose from 7 613 in 2003 to 9 592 in 2012; that the Council amended the Rules in 2009 to compel the Ombudsman to publish final determinations made against subscribers, at the same time disclosing the identity of the insurer concerned; and that the Council decided in 2012 that the office must publish statistics on the number of complaints against each subscriber and the percentage thereof resolved wholly or partially in favour of the complainant (W/P), the first of which will be published shortly dealing with 2012 (see page 8).

On a personal level I would like to thank the members of Council for the harmonious relationship I have enjoyed with them, particularly over the period that I have been the Chairperson. The Council is a multi-talented body. I am grateful to its members for having given unstintingly of their time and expertise, and for their loyal support

and valuable contributions. May the same spirit continue to prevail in future.

Changes

There were changes to the composition of the Council during 2012. The Vice-Chairperson of the Council, Judge Selby Baqwa, left. He had been a member of the Council since 2002, having formerly been the Public Protector and thereafter the head of Enterprise Governance and Compliance, Nedbank Group. He became the Vice-Chairperson in 2010, but due to work commitments he resigned from the Council upon his appointment in 2012 as a Judge of the High Court. His experience in alternative dispute resolution and his objective appreciation of consumer needs were of great value to the Council, and his presence will be missed.

Upon Judge Baqwa's resignation Judge L Theron, who is a judge of the Supreme Court of Appeal and who has been a Council member since 2009, was appointed as the Council's Vice-Chairperson.

Judge N V Hurt, a retired judge of the High Court in KwaZulu-Natal and Ms Thandile Zulu, Regional Manager of the Black Sash, have been appointed to the Council with effect from 10 May 2013.

Independence

When the Council was established in 1999 it was for the very purpose of ensuring that the appointment of the Ombudsman and the independence and functioning of his/her office are free of any suggested interference by subscribing members. Its establishment therefore preceded by some years the coming into operation in 2006 of the Financial Services Ombud Schemes Act, No. 37 of 2004. In particular it anticipated the requirement of section 10(1)(b)(i) of the Act, which stipulates that for a voluntary scheme to be recognised, a "body" that is not controlled by its participating members, and to which the ombudsman concerned is to be answerable, must appoint the ombudsman and monitor his/her performance and independence. In the case of the Ombudsman for Long-term Insurance that body is, of course, the Council.

During 2012 questions were asked about the independence of the body in respect of one of the other voluntary ombudsman schemes, and it would therefore be as well were I to emphasise the following in regard to our Council:

(1) In terms of paragraph 2.3 of the Council's Constitution members of the Council, apart from the *ex officio* members, "*are appointed in their personal capacity, having due regard to the knowledge and skills required by the office of the Ombudsman, and the need to represent the broad public interest and promote public confidence*". The Council has been at pains to ensure compliance with the Constitution in that regard.

(2) With that requirement in mind the Council has always sought to include persons in its composition who, although not necessarily consumer advocates, are generally perceived as having the interests of consumers at heart, as well as persons who understand the industry or who have the necessary experience to understand the competent running of an office such as ours, including administrative, accounting, actuarial, legal and all-round business skills.

New Ombudsman

As mentioned above, Judge McLaren has been appointed to the office of Ombudsman as from 1 June 2013. He matriculated in 1960 at the Central High School, Beaufort West and attended the South African Police College during 1961. He commenced his legal studies at the University of the Orange Free State in 1962 and obtained a BA degree there in 1964 and an LLB degree in 1966. He won the Bar Prize for the best final year

student and was awarded the Moritz Bobbert Medal for Exceptional Achievement in his LLB studies. He practised as an attorney in Pietermaritzburg from 1968 until 1978, and then joined the Pietermaritzburg Bar where he practised as an advocate for 12 years, being accorded senior status in 1984. In 1990 he was appointed to the bench in the KwaZulu-Natal Division of the High Court. After serving as a judge in that division for over 20 years he retired in 2011, after which he served spells in 2012 as an acting judge in the Supreme Court of Appeal in Bloemfontein and in the KwaZulu-Natal Division of the High Court.

The Council welcomes Judge McLaren and wishes him well in dealing with the challenges of his new post.

General

During 2012 the Council, as is its function, duly monitored the independence and performance of the Ombudsman. In doing so it received reports by the Ombudsman and others in his office covering the scheme's operations. Having received and considered the said reports the Council duly fulfilled its obligations under section 10(1)(b) of the Act, and I confirm, for the purposes of that section, that it was again satisfied with the independence and performance of the Ombudsman and his office during 2012, and that they duly fulfilled their mission under the office's Rules.

Of the many matters dealt with in 2012 I may mention that the Council commenced an ongoing consideration of the office's business and funding models, and corporate governance as it applies to the Council's role, but these have not yet been completed and will be reported on in due course.

John Smalberger

MEMBERS OF THE OMBUDSMAN'S COUNCIL

as at 31 December 2012

Judge John Smalberger (Chairperson)
Formerly Judge of the Supreme Court of Appeal; formerly Chairperson of the Electoral Court.

Mr Ken Baldwin
Retired senior partner KPMG, currently engaged in various areas of Corporate Governance.

Mr Moses Moeletsi
CEO, National Regulator for Compulsory Specification; formerly Chairperson of the Board of the Ombudsman for Short-term Insurance.

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

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

Judge Leona Theron
Judge of the Supreme Court of Appeal.

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

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

Judge Brian Galgut *(ex officio)*
Ombudsman.

FOREWORD BY THE CHAIRPERSON OF THE **OMBUDSMAN'S COMMITTEE**

Another year passed almost with a blink of the eye, due probably to all the activities in the Long-term Insurance Industry which also affected the Ombudsman's office. During 2012 both the industry and the Ombudsman's office were involved in providing input on changes in legislation and proposed legislation, like the Treating Customers Fairly (TCF) initiative of the Financial Services Board and different reform papers.

The TCF implementation is planned for 2014, one of its focuses being on complaints handling and reporting on complaints. The Ombudsman's Committee was therefore involved in the proposal to the Ombudsman's Council on reporting by the Ombudsman's office of complaints data. The industry will also be looking to the Ombudsman for guidance on the understanding of fairness and how to make sure that the different TCF outcomes are effectively embedded in all industry processes.

The Ombudsman's Committee is pleased to report that 2012 was a productive year for it. As the liaison body between subscribing members and the Ombudsman's office, the Committee successfully explored the opportunities for networking. The subscriber briefing held by the Ombudsman at the time of the release of his 2011 Annual Report was found useful and was welcomed by subscribers. Committee members shared common trends and received feedback about the operations of the Ombudsman's office and how to support the Ombudsman in dealing with complaints in the most effective way. Input from the Ombudsman could also be fed into industry processes.

The Committee noted that the industry was flooded with fraudulent Hospital Claims giving rise to many complaints, which impacted on the Ombudsman's office. Industry players are trying their utmost to combat this kind of activity effectively. The Committee noted that most complaints handled by the Ombudsman were in the Claims Declined category, and that a substantial number of these were finalised wholly or partially in favour of complainants. There were also still a large number of complaints about poor service. Both of these categories need the industry's attention and hopefully will be attended to via the implementation of TCF.

The Committee would like to thank Judge Galgut for his guidance and leadership of the office over the past number of years and wishes him all the best for a well-deserved retirement. As industry we look forward to working with his successor. We once again confirm our ongoing commitment to support him and the office. We continue to regard the Ombudsman's office as a very important partner for guidance in fair treatment of complainants and sound decision-making in a balanced and impartial manner.

The Committee would also like to thank the Ombudsman's office for its open relationship with the industry and continued effort with informative workshops, visits to insurers and the publication of newsletters and clarifying articles that provide views and guidance on difficult technical scenarios.

It gives me great pleasure to thank Judge Galgut and his team on behalf of subscribing members of the industry for a job well done during 2012. Our best wishes for 2013.

Dorea Ozrovech

FOREWORD BY THE **OMBUDSMAN**

"As time went on subscribing members began to accept that the office in fact seeks no less than to see that justice is done, something that they themselves presumably aim to do."

The Ombudsman's Council

Judge J S Smalberger

It is with regret that my office received the news that the Chairperson of the Ombudsman's Council, Judge John Smalberger, has decided to retire from the Council, which means its next meeting on 10 May 2013 will be his last. Having served on the bench for 27 years until his retirement in 2002, the last 17 of which in the Supreme Court of Appeal, he became a member of the Council in 2003, and was its Vice-Chairperson from 2007 until April 2010 when he became the Chairperson. The Council and the office owe him a debt of gratitude. He has always been willing to give up his time for the Council and the office, and he became known for his mannerly, tactful, calm, practical, sensible and friendly but firm approach to problems of all kinds. He leaves with the blessing of both the Council and my office, but his presence will be sorely missed.

Comment on 2012 generally

Our mission is of course to receive complaints against subscribing long-term insurers and to resolve them through mediation, conciliation, recommendation or determination, doing so independently and objectively and cost free to the complainant, and by following informal, fair and cost-effective procedures. A significant obligation in these regards, as required by both our Rules 1.2.4 and 1.2.7 and section 10(1)(e)(iv) of the Financial Services Ombud Schemes (FSOS) Act of 2004 is to apply considerations of equity.

Throughout the year, as always, the office strove to fulfil these obligations, as the contents of this Annual Report,

which will hopefully be of interest to those concerned, will show.

The year was not remarkable, but remarkability is not of course the measure of the performance of an ombudsman's office. Worthy of mention, however, is that we received 9 592 complaints during the year, the highest ever and 4% higher than in 2011; that of these 4 682 became full cases, more than the 4 295 of 2011; and that we finalised 4 538 cases, 7% more than the 4 254 in 2011. The noteworthy feature about these figures is that they were achieved despite the fact that consumers are continuing to become more insistent and persistent, and that the cases are becoming ever more complex.

The W/P figure, which reflects the percentage of cases which were resolved wholly or partially in favour of complainants, reduced to 37.4% in 2012, and although it is always difficult to identify the reason for either upward or downward changes in this percentage each year, it is clear that the main driver in 2012 was the four percentage points drop in the predominantly Claims Declined category. It may be that insurers are dealing more effectively with claims.

Regulation of the Financial Sector

In 2011 a document headed *"A Safer Financial Sector to Serve South Africa Better"* was issued by the Minister of Finance in which it was proposed that a so-called Twin Peaks model of financial regulation be adopted in South Africa, one whereby the prudential and market conduct regulation would be separated, the former to be the function of the South African Reserve Bank and the latter of the Financial Services Board (FSB). The Twin Peaks model has since been approved, and on 1 February 2013 the Minister of Finance issued for public comment a further document, this one headed *"Implementing a Twin Peaks model of financial regulation in South Africa"*. Of the many matters dealt with therein, one relevant to ombudsman offices is a short section called the *"Enhanced effectiveness of the ombud system"*, which states in particular that a review of the current so-called ombud system, which includes all six of the financial ombudsman schemes, is under way –

"... to develop recommendations to improve its efficiency and effectiveness while building on the work and expertise of existing bodies".

The options under consideration for the financial ombudsman system structure are therein stated to include –

"1. Continuing the current system of independent offices, but with stronger oversight by the FSOS Council.

2. Establishing a merged entity with a single representative governing body under the leadership of an executive officer, while retaining separate ombuds for each sector. In this model the sectoral ombuds will be tasked with dispute resolution and issuing determinations, while governance and operational matters would be centrally co-ordinated."

The office submitted its comments, saying that while we have no difficulty in principle with option 1, for the benefit of all concerned the matter ought first to be debated in-depth with all of the ombudsmen concerned before any changes are introduced.

Final determinations against insurers

It is by now well known that the office's process, if attempts at settlement fail, is initially to issue a provisional determination setting out our preliminary view and asking the parties whether they have any further facts or contentions to submit before the matter is reconsidered for the purpose of making a final determination. While many such provisional determinations are made against subscribing members, if they have no new evidence or submissions they virtually always accept the office's provisional determination despite the fact that in many cases they do not agree with it.

During the year final determinations were made against insurers in three cases. In two the insurer, the same in both, succeeded on appeal (dealt with on page 19).

In the third (reported on our website at www.ombud.co.za) the deceased had been a life insured under a policy underwritten by Safrican Insurance Company Limited, in which no beneficiary was nominated. The policy provided that *"if (there is) no nominated beneficiary ... and no clear proof of marriage can be provided by the spouse, Safrican shall pay the benefits to (the life insured's) relative ..."*. On the death of the life insured the deceased's ex-spouse claimed the benefit from Safrican, stating that she was the deceased's *"wife"* but at the same time enclosing a copy of their divorce order, whereupon the death benefit of R26 000 was paid to her. A complaint was lodged with the office on behalf of the deceased's mother, a pensioner who had borne the funeral costs. Safrican maintained that it had paid the life insured's ex-wife in good faith. In the office's provisional determination it was held, however, that because in terms of the policy the benefit was not payable to an ex-wife, but was said to be payable to a relative where there was neither a spouse nor a beneficiary, and because an ex-spouse could not be considered as a relative, the benefit was not payable to the ex-wife and should in any event be made to the complainant. Safrican disputed the provisional determination, adding certain further arguments, but in due course the final determination was made that Safrican must pay the benefit to the complainant.

Treating customers fairly

The Treating Customers Fairly (TCF) initiative has reached a stage where legislation is expected to be introduced in 2014. In the meanwhile, however, the FSB and the FSOS Council have proposed to the voluntary ombudsmen that, in advance of the legislation, they start to give effect to the TCF outcomes when applying principles of equity. We agreed with the proposal.

Publication of data

On 6 June 2012 the FSOS Council sent all recognised financial ombudsman schemes a letter in which they strongly recommended that they publish *inter alia* complaints data in respect of settlement orders.

The request was not entirely unexpected. It is a growing trend internationally for ombudsman schemes to publish subscribing insurers' complaints data in order to promote transparency. TCF documentation also mentions that complaints data is a necessary disclosure.

As early as 2011 a sub-committee of the Ombudsman's Committee had already been looking at the format in which complaints data could be published. Another reason for this step is that certain insurers use complaints data as a marketing tool and it had become evident that insurers

do so to their advantage without giving the complete picture. It is therefore preferable, to eliminate any potential manipulation of data by individual insurers, that our office should disclose the data in a uniform manner.

Our office settles complaints by way of mediation, conciliation and recommendation. We do not issue settlement orders, the term used by the FSOS Council. We cannot therefore refer to settlement orders in the proposed format for publication. What we propose to do is publish the number of complaints we receive for each subscriber, the number of complaints we consider and finalise and whether the complaint was resolved in favour of the complainant or the insurer.

It was decided that in the publication of the data there would be no reference to *"market share"* of the individual insurers. This means that the data will be published without giving that type of context. This decision came about because of the difficulty of providing context in the life insurance industry where complaints are concerned. It was in fact not at all clear what the fairest and most accurate way to give context would be. If for example it were to be in relation to the number of policyholders, it could be unfair to insurers operating mainly by means of group schemes where there would be one policyholder with a multitude of members and even more lives assured. It would also not be easy to obtain the relevant information in respect of all subscribing members. After due consideration, it was decided to follow the UK Ombudsman's example and not to give context.

We propose to publish the data on our website www.ombud.co.za on an annual basis, the first publication to be on 1 June 2013, in respect of 2012.

INFO 2012

The annual conference of the International Network of Financial Ombudsmen (INFO) was held in Copenhagen in September 2012.

Jennifer Preiss

At the conference Jennifer Preiss, our Deputy Ombudsman, was elected Chairperson of INFO. INFO being an international body of standing, and having a membership of 53 ombudsmen from 35 countries, this was a signal honour for Jennifer. It also redounds to the benefit of the office, and we are extremely proud of her.

Business conducted at the Conference

The emphasis of the conference was on communication. Of particular interest for our scheme was a session in which speakers explored the difficulties of communication in developing countries and suggested some solutions. One speaker emphasised the importance of maintaining appropriate forms of communication with all stakeholders in order to maintain a scheme's status as a trusted resource. This includes communication not only with complainants, but also with consumer bodies, subscribers, the regulator, policymakers and of course the media. Ombudsman schemes all over the world are facing challenges, and when during such times they face changing and complex situations, an action plan for effective communication is important.

A speaker from the Financial Education and Consumer Protection Unit of the Organisation of Economic Co-operation and Development updated delegates on the progress of the G20 High Level Principles on Financial Consumer Protection and encouraged co-operation between that unit and INFO.

There was a debate on the question whether INFO should set standards for members. Although INFO does not currently set standards it encourages best practice for ombudsmen, and two INFO committee members drafted a document for the World Bank setting out the fundamentals for financial ombudsmen (see www.networkfso.org). During 2013 INFO will continue to focus on two fundamental principles – independence and impartiality. The debate regarding standard setting will no doubt continue at the next INFO conference, which takes place in Taipei in September 2013.

Reflections

My six-year term as Ombudsman for Long-term Insurance expires on 31 May 2013, so this Annual Report is my last. Before taking office I had spent 50 years as a law student, an advocate and on the bench, and as such I was steeped in the confrontational element of the adversarial system. The less formal and hands-on process of alternative dispute resolution, which is in essence the function required of an ombudsman, therefore made for a change in approach.

The essential difference is of course that in our office resolutions by settlement are sought through the office's mediation, conciliation and recommendation process before resort is had to making determinations, which was a new experience for me.

When I started in 2007 the impression I gained was that insurers were sometimes confrontational and on rare occasions not entirely mannerly, as if the office was in some sense an opponent and as such inimical to their interests. I perceived as time went on, however, that they began to accept that the office in fact seeks no less than to see that justice is done, something that they themselves presumably aim to do. That they disagree with us on occasion is inevitable, but when they do it is essential that they should express such disagreement, with their reasons of course, because this will always contribute to ensuring the correct resolution. Where there is disagreement, however, a co-operative relationship remains in the interests, not only of complainants, but also of the insurers themselves.

Complainants sometimes expect the office to *"fight"* their cases for them, thereby to side with them, which is of course not our function – we represent neither the complainant nor the insurer but seek to ensure just resolutions. Consumerism has arrived to stay, and with it have come ever more difficult and persistent complainants who do not take no for an answer even when their complaints are without merit, a trend experienced by other ombudsman schemes both in South Africa and internationally.

All in all my experience in the office has been interesting and pleasurable, dealing as we do with so many different kinds of complaints and problems and meeting with so many different and interesting people. It is therefore with sadness that I will be leaving.

I should say finally that I have enjoyed the work itself, made possible because of the steadfast support I have received from the staff and the resultant smooth and successful functioning of the office's operations. The adversarial system of justice through the courts is formal and time-consuming and is generally inaccessible to most consumers because the cost of legal proceedings would put our courts beyond their reach, and courts have no

Case duration	2012 %	2011 %
0 – 30 days	**10**	11
31 – 60 days	**20**	19
61 – 90 days	**19**	17
91 – 180 days	**31**	31
181 – 365 days	**16**	17
Over 365 days	**4**	5

The finalisation period has maintained a steady pattern over the past three or four years, at between 78% and 80% of cases finalised within six months.

power furthermore to apply equity where an application of the law leads to an unfair result. It has therefore been a rewarding experience to work in an office that accommodates consumers who would otherwise have no recourse, and that has the power, indeed the obligation, to take considerations of equity into account. It is for these very reasons that ombudsman schemes are on the increase in many countries, and I value the opportunity to have been part of one.

Tribute to staff

The proper functioning of the office depends almost entirely on the staff and it is due to them that it has functioned smoothly throughout my six years in the post. Each year I have therefore paid tribute to the staff for their contribution, and in doing so I have perhaps not put it strongly enough. I can say unreservedly that the office has at all times been blessed with able members of staff. The support staff, without whom the office would not be able to function properly, deserve to be commended. My adjudicating and assessing staff have considerable knowledge and experience in law and/or industry products and practice, and deserve the highest praise. So too does the Operations and Finance Manager, Ian Middup, whose tight rein on the office's functioning has contributed considerably to its success.

I owe a special word of thanks, however, to Jennifer Preiss, my Deputy. She has been with the office for 13 years, having first qualified in law and having thereafter had 13 years' experience in the long-term insurance industry. Adding to this her innate ability and sense of fairness it comes as no surprise that she has been made the Chairperson of INFO. She has borne a substantial load of the office work and the whole office has relied on her for advice and assistance. I am grateful to her for her unstinting help and support.

Brian Galgut

STATISTICS

Complaints received

The office received a record number of complaints in 2012, in total 9 592, which was a 4% increase over 2011. The increase, not being entirely unexpected, was budgeted for. Complaints were received fairly regularly throughout the year, on average approximately 39 per working day.

The composition of the complaints, however, showed a number of significant changes.

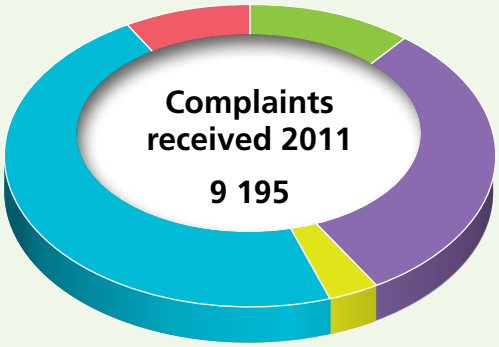
Full cases – Complaints in these cases are those the office handles from inception to finality. They increased by 9%, straining the resources of the adjudicating staff.

Out of scope complaints – Increased by 13%. These are complaints which are either intended for other ombudsman offices, are unconnected with life insurance, or for some other reason are not within the jurisdiction of this office. While no funds are recovered for this activity the office ensures that where required they are forwarded to the correct office or regulatory body electronically within a few days of being received.

Mini cases – These complaints are those that relate to simple enquiries that the insurer can readily handle at source, and they reduced by 31%.

Transfers to insurers – These complaints are transferred to insurers who, by agreement with the office, have appointed an internal arbitrator (but the complainants can come back to the office if not satisfied).

Mini cases	**690**
Out of scope	**3 178**
More information	**342**
Full cases	**4 682**
Transfers to insurer	**700**



Mini cases	**1 011**
Out of scope	**2 805**
More information	**318**
Full cases	**4 295**
Transfers to insurer	**766**

Cases finalised

Cases finalised, which encompass only full cases, totalled 4 538 in 2012, an increase of 7% over the previous year.

In any given year the office strives to finalise a similar number of full cases to those it receives. In this way work in progress would show little increase and turnaround times (see page 11) would be held constant. During 2012 the office fell slightly short of this target, as there were 144 more full cases received than were finalised. The main reason for this was the extended absence of one senior adjudicator on sick leave.

Complicated and Complicated + cases increased to 733, or 16% of the total cases finalised. These cases are predominantly of a complex legal or financial nature. Coupled with this is the growing trend in consumerism both nationally and internationally, where complainants are more persistent than previously, which tends to lengthen the finalisation period.

Standard cases, the office's benchmark category, also increased by 4%. Faster turnaround times in this area enabled the office to marginally improve its overall turnaround time in 2012 (up to 80% of cases finalised within six months of receipt compared to last year's 78%).

Incompetent cases are those where responses by insurers are late or inadequate. Unfortunately these increased to 148 cases, breaking the positive trend in this category over the last few years.

Standard	**3 552**
Basic	**105**
Complicated	**676**
Incompetent	**148**
Complicated +	**57**

Standard	**3 406**
Basic	**56**
Complicated	**635**
Incompetent	**108**
Complicated +	**49**

CASES **FINALISED** SUMMARY

	LIFE				DISABILITY			
NATURE OF COMPLAINT	**2011**	**W/P***	**2012**	**W/P***	**2011**	**W/P***	**2012**	**W/P***
Poor communications/documents or information not supplied/poor service	924	46%	1 064	44%	10	50%	14	43%
Claims declined (policy terms or conditions not recognised or met)	1 856	41%	1 837	37%	268	34%	259	33%
Claims declined (non-disclosure)	102	25%	108	15%	59	14%	47	11%
Dissatisfaction with policy performance and maturity values	166	18%	149	15%	0	0%	1	0%
Dissatisfaction with surrender or paid-up values	93	18%	64	14%	0	0%	0	0%
Mis-selling	65	38%	29	31%	0	0%	0	0%
Lapsing	183	45%	120	30%	3	0%	1	100%
Miscellaneous	143	20%	102	25%	7	14%	6	50%
TOTAL	**3 532**	**40%**	**3 473**	**37%**	**347**	**30%**	**328**	**31%**

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

The above table summarises key aspects of cases that were finalised during 2012, in comparison to the same data for 2011:

- What the complaints were about (the nature of complaint).
- The percentage of cases finalised for each nature of complaint category.
- The insurance benefit the complaint related to ie Life, Health or Disability.
- Whether the complaint was resolved wholly or partially in favour of the complainant (the W/P).

Nature of complaint

Claims Declined (policy terms not met) increased during the year to 59% of the total cases finalised. Ten years ago, in 2003, this category made up only 26% of the total.

Poor Communication and Poor Service cases, which had been showing a decreasing trend, increased during the year both as a percentage and by volume.

The changing nature of cases handled by the office is reflected in the fact that 90% of cases were contained in the above two categories and the Claims Declined (non-disclosure) category. As recently as 2009 they totalled 74% while in 2003 it was 58%.

HEALTH				TOTALS				PERCENTAGE TO TOTAL	
2011	W/P*	2012	W/P*	2011	W/P*	2012	W/P*	2011	2012
17	47%	141	59%	951	46%	1 219	46%	22%	27%
336	43%	568	40%	2 460	41%	2 664	37%	58%	59%
14	21%	16	25%	175	21%	171	15%	4%	4%
0	0%	0	0%	166	18%	150	15%	4%	3%
0	0%	1	0%	93	18%	65	14%	2%	1%
1	0%	2	0%	66	41%	31	29%	2%	1%
4	0%	5	40%	190	44%	126	31%	4%	3%
3	0%	4	50%	153	20%	112	26%	4%	2%
375	**41%**	**737**	**43%**	**4 254**	**40%**	**4 538**	**37.40%**	**100%**	**100%**

W/P

The overall W/P reduced to 37.4%, a reduction from 2011 of three percentage points and the lowest since 2003.

The reduction was driven by the fall of four percentage points in the predominant Claims Declined category, while holding steady for Poor Communications, with all the minor categories reducing except for Miscellaneous.

Mirroring this reduced W/P, eight out of ten subscribers against whom there were complaints in excess of 250 per year showed a reduction in W/P compared to 2011.

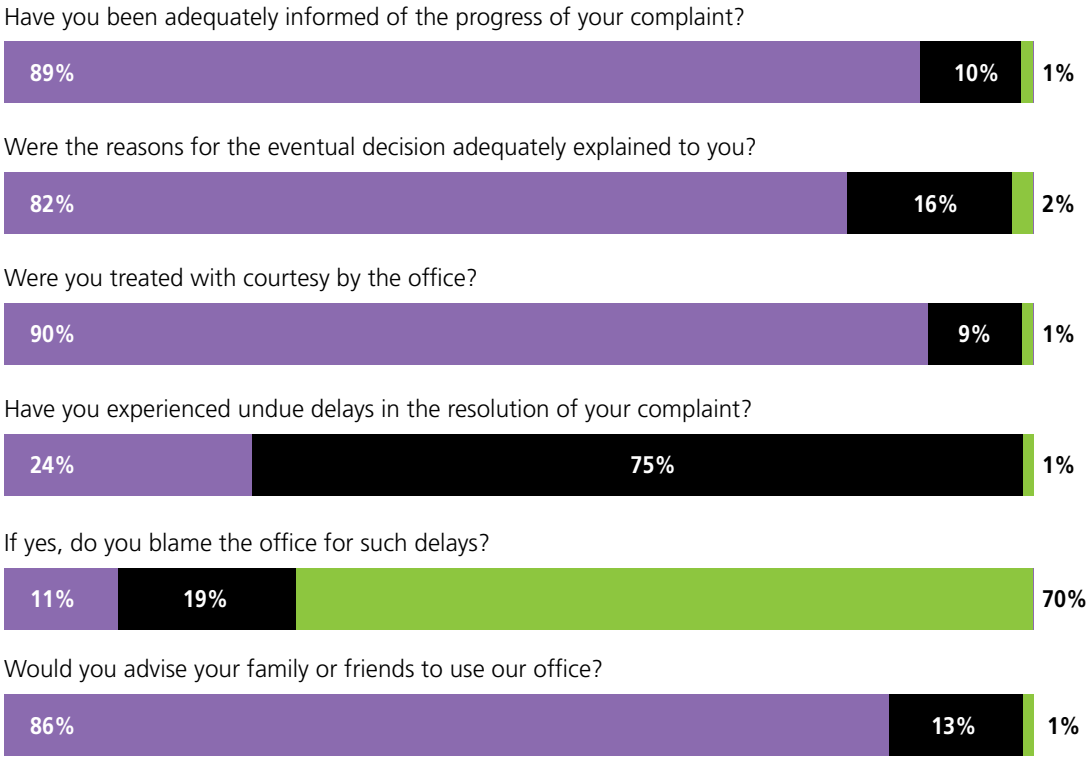
Types of benefit

	2012 %	2011 %
Life	**31**	35
Disability	**7**	8
Health	**16***	9
Funeral	**35**	37
Credit Life	**11**	11

** This increase reflects the impact of the hospital cash plan complaints (see page 22).*

COMPLAINANT SURVEY

Complainants' response to survey

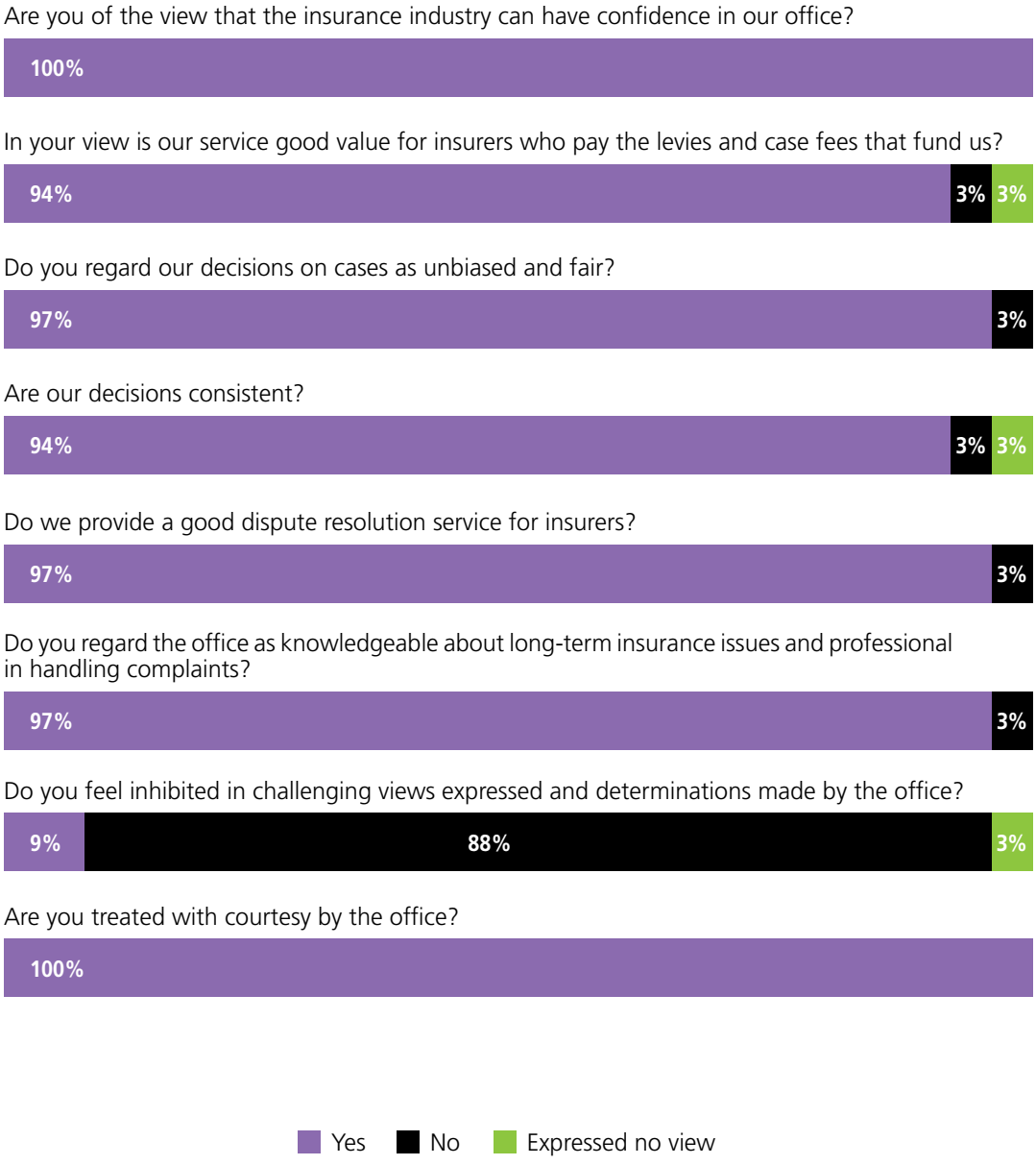


It is encouraging that 86% of complainants would advise family and friends to use the office, the more so because 44% of complainants who responded did not have their cases resolved in their favour.

It has become more difficult over the years to get complainants to respond to the survey. Given the proliferation of customer surveys it is not altogether surprising that only 20.47% of surveys are returned.

INSURER SURVEY

Insurers' response to survey



MATTERS OF **INTEREST**

Appeals

In 2012 the Ombudsman received 20 applications for leave to appeal, two of which were by an insurer and the balance by complainants.

By complainants

Of the 18 cases in which leave was sought by complainants, it was granted in four. In one the insurer paid the claim upon the granting of leave; in the second the insurer made an offer of settlement after leave was granted, which was accepted by the complainant; in the third the appeal is still pending; and in the fourth case the appeal was dismissed and the office's determination upheld.

The last-mentioned case, which was dealt with in the 2011 Annual Report (at page 19) before leave to appeal had been granted, is of interest because it involved an unusual aspect of insurable interest. (See block alongside for the relevant facts.)

The Appeal Tribunal, Mr Justice L S Melunsky, dismissed the appeal, in so doing indicating –

- that in life insurance there are no limited categories as to what will constitute an insurable interest and that each case must be decided on its own particular facts;
- that the standard is not static, but is influenced by the generally accepted notions of society and that the concept of insurable interest can be broadened provided there is no objection by way of public policy to the insuring of such an extended interest;

"The case was unusual because, while it is usually the insurer that takes the point that there had not been an insurable interest and does so at claim stage, in this case it was the policyholder who took the point, and she did so four years after she had taken out the policy.

The applicant for the policy, a woman in her fifties, sought cover on the life of a man in his sixties. In making the application she described him as her "boyfriend" and added that they were "dating". The insurer accepted the application and a policy was issued. Some four years later the complainant surrendered the policy, in doing so contending that there had never been an insurable interest and claiming repayment of the premiums. The circumstances described by her were that she and the life insured had not been engaged, had not intended to become married and had never lived together, and that she had never been supported by him. Because the office feels ... that an insurable interest may exist in such a relationship, it was vital to know what the full extent of their bond, their companionship and the emotional support had been. On such information as was provided in these regards the office was not satisfied, however, that the full extent of these features had been disclosed by the complainant, and because the onus was on her we were unable to hold that it had been proved by her on a balance of probabilities that there had not been an insurable interest. Her claim for repayment of the premiums could therefore not be upheld."

- that in the particular circumstances of the case the onus was on the appellant to establish that no insurable interest had been present at the inception of the policy;
- that the rule of interpretation provides that where a contract is capable of more than one meaning, it should be construed to save a contract from legal ineffectiveness;
- that he agreed with the statement in **Life Insurance in South Africa** by Nienaber & Reinecke (at 1.27) that –

  "*In the case of doubt a court or tribunal will invariably lean in favour of finding rather than rejecting the existence of an insurable interest.*"; and
- that the office had correctly concluded that a number of relevant factual questions had not been answered by or on behalf of the appellant and that it was therefore not possible to hold that there had not been an insurable interest.

The ruling by the Tribunal, which is on the office's website (www.ombud.co.za) makes for interesting reading.

By insurers

In the other two cases it was the same insurer that applied for leave to appeal. Although there were two separate complainants and therefore two separate cases, the appeals were dealt with together because both arose from a single policy issued to the same life insured, and the complaint lodged by the complainants, each being a beneficiary under the policy, raised exactly the same issue, alleged non-disclosure by the life insured. The Appeal Tribunal, again Mr Justice L S Melunsky, delivered a joint ruling on 11 February 2013 in which, based on evidence that had not been placed before the office but was only made available to the Appeal Tribunal for the first time, both appeals were upheld.

In denying liability for payment of the benefits the insurer had relied on non-disclosure of alleged bipolar mood disorder and a couple of consultations the life insured had had with a clinical psychologist. The office had held that it was not proved that the policyholder had ever been diagnosed with bipolar mood disorder, and that the policyholder's consultations with the psychologist, which had been for alleged depression resulting from marital problems and which at application stage the policyholder alleged had cleared up a couple of years earlier, did not support a finding that there had been non-disclosure.

Despite the fact that the Appeal Tribunal upheld the insurer's appeal, it agreed with all of the office's findings and the reasons therefor. In particular:

- It confirmed, despite the insurer's contentions to the contrary, that the authors were quite correct in saying, in the above-said work **Life Insurance in South Africa** (at 23.22) and in **MacGillivray on Insurance Law** (10th edition at 442), that an insurer is required to make its own additional enquiries if such information as is disclosed raises alarm bells or needs further elucidation, and that an insurer cannot therefore take advantage of a failure to follow it up, so that "*if they shut their eyes to the light, it is their own fault*".
- It found that there had indeed been insufficient proof that the policyholder had suffered from bipolar mood disorder.
- It found that sufficient information had been disclosed by the policyholder, because of the types of medication prescribed, to put the insurer on the alert, and that its failure to follow the matter up constituted negligence by the insurer.

The appeal was nevertheless upheld because of the new evidence that was placed before the Appeal Tribunal, which as stated above had not been submitted to the office. Such evidence was a further report by the psychologist from which two further facts appeared for the first time. The first was that, far from the policyholder's depression having cleared up as the life insured had stated in the application, the policyholder had consulted the psychologist for psychotherapy on no less than 26 occasions in the two years immediately before the application for the policy was made; and the second was that the policyholder later told a psychiatrist, only one month before the application, that the depression had become worse. In the result the Appeal Tribunal found that the policyholder's non-disclosure in these regards had been intentional, and it held that, despite the fact that the insurer had been negligent, it could not be held liable in the light of the non-disclosure having been fraudulent.

Review application

In 2011 the Ombudsman was taken to court for the first time in the office's existence when a complainant, Mrs M de Lange, launched a review application against two decisions by the Ombudsman and, because the matter had in the meanwhile gone on appeal, also against the Appeal Tribunal. The application was, however, ultimately dismissed with costs in 2012.

The review was dealt with in the office's Newsletter published in Issue Number 21 (August 2012), which is available on its website.













STAFF

Management team
Judge Brian Galgut
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

Support staff
Clyde Hewitson
Rosemary Galolo
Charmaine Bruce
Andrea Lennox
Marshalene Williams
Tamara Sonkqayi
Angelo Swartz
Sithandwa Tolashe
Yolanda Augustine
Tania Thomas
Phindiwe Fana
Puleka Ngalo
Nosiphiwe Sifingo
Colleen Louw
Colline Alexander
Annamarie Sinclair

Excessive claims on hospital cash plans in KwaZulu-Natal

In the 2011 Annual Report (at page 24) the office commented on the complaints it received on hospital cash back policies from complainants in KwaZulu-Natal. Because it is a systemic problem, the office also reported the matter to the relevant authorities. This trend has however continued, the difference being that claim conditions are now more diverse and the number of medical practitioners involved has grown. What has remained the same, however, is that most of the complainants belong to one medical scheme, the same hospital group is involved and the *modus operandi* has not changed.

What happens is that the claimant submits a claim for hospitalisation for a period of five to ten days for a condition which requires a short or no period of hospitalisation. The medical scheme covers some or all of the costs and in terms of his policy the claimant then claims from the insurer the fixed daily sum, usually between R500 and R1 500. The insurers tend to pay for part of the period and advise the claimant that to have the rest paid would depend on substantiation for the rest of the period from a medical practitioner.

In the cases that come to the office it is very seldom possible, however, for the claimant to provide persuasive evidence of the need for hospitalisation for the full period. In most of its determinations the office has therefore upheld the insurer's decision. However, the office has to deal with each case on its merits so it nevertheless has to investigate each complaint.

It would seem from the extent of the problem that these claims are part of an organised "scam". Although insurers have advised the office that they are investigating the problem, at this stage it has not had any effect and the problem is not diminishing but has carried on into 2013.

The impact of these excessive claims will no doubt lead to an increase in premiums for this type of policy. There are also other consequences:

- The payment by insurers of more in claims than they would have assumed when the policy was designed, as some of the claim payments are not justified.
- Insurers are also incurring costs for the investigation of these claims and for the case fees that are charged by the office when the claimant complains to it.
- The negative effect on medical schemes that pay out on these excessive claims.
- The impact of the extended periods of unwarranted sick leave on productivity.
- The general negative effect on society of this type of dishonest behaviour by claimants and medical practitioners.

It is important that steps be taken by the relevant parties to curtail this trend as soon as possible.

Example case

The following example demonstrates the type of case where excessive claims have been submitted leading to the suspicion that the complainant was not acting *bona fide*.

- January 2010 – hospitalised for 5 days (chest pain)
- April 2010 – hospitalised for 11 days (Pelvic Inflammatory Disease* (PID))
- July 2010 – hospitalised for 10 days (PID)
- December 2010 – hospitalised for 7 days (PID)
- March 2011 – hospitalised for 7 days (PID)
- April 2011 – hospitalised for 5 days (lower abdominal pain)
- June 2011 – hospitalised for 7 days (lower respiratory inflammation)
- September 2011 – hospitalised for 6 days (influenza)
- December 2011 – hospitalised for 6 days (PID)
- February 2012 – hospitalised for 7 days (influenza)

* *Medical opinions the office received from independent medical practitioners state that it is unusual to be hospitalised for PID, as it is mostly treated on an outpatient basis.*

Cancellation of policies

In 2012 the office received complaints for the first time about insurers cancelling hospital cash plan policies. Those insurers had issued them as whole life policies in which they had nevertheless reserved for themselves the right to cancel by way of, for example, the following clause –

> "*We may cancel the policy by sending you one calendar month's notice in writing to your last known address.*"

The insurers concerned are not cancelling all policies in the portfolio but only selected ones based on certain criteria (differing from one insurer to another). For example one insurer cancelled policies where the claimant had more than four claims in the preceding year.

Although it is understandable that insurers would want to limit their exposure to high risk lives, this approach obviously holds dangers for policyholders. As policyholders age they would be more likely to claim, not because they are doing so fraudulently or excessively, but because being older they are more likely to suffer from medical conditions necessitating hospitalisation.

It would be unfair and against a fundamental principle of long-term insurance if, after issuing whole life policies, an insurer could freely select which policies it wished to cancel. The clause itself does not appear to be in conflict with the law, but even though the policyholders agreed to the clause in the policy the insurer should not unfairly apply its discretion to cancel. As the office sees it the clause implies that the insurer has to exercise its discretion in a reasonable manner.

The office engaged with the insurers concerned and pointed out that there would have to be good reason to cancel any particular such policy. If, for instance, it was clear that the policyholder had claimed excessively and had therefore not acted in good faith, there would be good cause to cancel the policy, but in cases where there were legitimate reasons for many claims an insurer would not be justified in doing so.

Equity

Section 10(1)(e)(iv) of the Financial Services Ombud Schemes (FSOS) Act of 2004, which was put into operation in 2006, stipulates that a voluntary financial ombudsman Scheme will not be recognised unless it has an equity jurisdiction. In 1997 the office had already acquired an equity jurisdiction, thereby being required by Rule 1.2.4 to "*accord due weight to considerations of equity*", and by Rule 1.2.7 to "*ensure that subscribing members act with fairness and with due regard to both the letter and the spirit of the contract*".

It has often enough been said, because it is incapable of being satisfactorily defined, that equity is an elusive concept. In the Eleventh Sultan Azlan Shah Lecture delivered in Kuala Lumpur in October 1996 by Lord Steyn, a Judge in Britain's House of Lords, he expounded on the need to introduce an equitable approach to contracts and their interpretation in the United Kingdom, and said that this should be done by giving effect to what he called the reasonable expectations of honest men. While he did not offer this as a definition, it certainly is a more than useful yardstick for the application of equity. Equity is after all nothing other than what the reasonable man in the street – in other words public opinion – would consider to be fair.

Because the voluntary ombudsman schemes are required by the FSOS Act to apply considerations of equity, the equity jurisdiction of the schemes is here to stay – in fact in due time our courts might well be accorded that very power. The application of equity, what is more, will of course take on a yet greater perspective with the coming into operation of the Treating Customers Fairly (TCF) drive.

Common misconceptions about the office's equity jurisdiction:

1. That the office can only exercise its equity jurisdiction within the law, and that it is bound by the terms of the policy.

   Many insurers hold the view that no solution can ever be equitable if it conflicts with a term of the policy contract, and in any event that it cannot find application for as long as the insurer has not breached the policy contract. This approach is of course incorrect because equity would thereby be rendered irrelevant. The fact is that it is where an application of the law itself, which obviously includes the terms of the policy contract, would lead to an unfair result that considerations of equity become relevant.

   Where for example a time-barring provision in a policy would lead to an unfair outcome, the office will advise the insurer to consider the claim in certain circumstances. (See the procedural note on the office's website.) Another example arises in non-disclosure cases, where the office applies the so-called Didcott principle even though it is not in accordance with the law. That means that the office may expect an insurer to reconstruct a policy when non-disclosure has been discovered, unless it would not have granted a policy at all had it known the relevant facts or unless the non-disclosure was fraudulent.

2. That the office's decisions set a precedent.

   This is not so. Each case is decided on its own facts, as fairness can only be established **on the particular circumstances** of the case concerned. No two cases are likely ever to have the same facts. There can accordingly be no precedent.

3. That prejudice to the insurer or other policyholders precludes the office from exercising its equity jurisdiction.

   It is not correct that the office is precluded from doing so. It takes such prejudice into account and weighs it against the prejudice suffered by the complainant, and then considers whether an equity decision is justified.

4. That the office's equity jurisdiction can only apply to a practice or provision that is against public policy.

   This argument usually emanates from the legal department of an insurer. It is premised on a misconception that the office's equity jurisdiction is confined to legal considerations. Its equity jurisdiction is not constrained by this principle (see 1 above). Obviously, if a public policy consideration is present the office would take that into account, but it is not confined to such circumstances.

5. That applying the "*contra proferentem*" rule equates to the application of equity.

   The *contra proferentem* rule is a principle of our law and to apply it is therefore a legal solution, not one in terms of the office's equity jurisdiction. It does not require the exercise of its equity jurisdiction to apply this rule.

6. That treating every policyholder exactly the same means that the insurer is acting fairly.

   This is not always so. Equity has to take account of the individual circumstances of the particular policyholder. An insurer for example advises policyholders of a change to its procedure in respect of sending loan statements, whereby instead of posting them to policyholders it will e-mail them, and policyholders who do not have e-mail access have to go to their local branch to collect the loan statement in terms of this new procedure. All policyholders are being treated the same, but it cannot be regarded as fair to policyholders without e-mail access.

7. That the office can only apply its equity jurisdiction where the insurer has done something wrong in dealing with the policyholder, or, conversely, that where the policyholder has erred the office cannot apply its equity jurisdiction.

   Equity may very well be considered in circumstances where the insurer has made a mistake but these are not the only circumstances where equity applies. Even where the insurer has not made a mistake the office could apply equity. In the case of late submission of a claim, for example, the insurer has not erred but the office will consider equity and in suitable circumstances determine that the insurer should assess the claim.

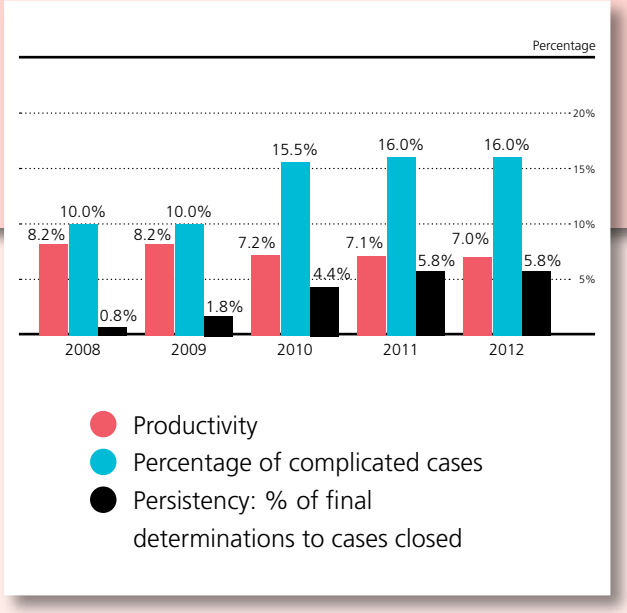
Productivity

It was clear from the interaction at INFO that most schemes are experiencing increasingly complex complaints and more persistent complainants, which impact on the productivity and cost effectiveness of schemes. The office has always measured productivity by the number of cases closed per adjudicator/assessor per week. Persistency is measured by the number of complainants that reject the office's provisional determinations and revert to it, but where the office issues final determinations against them. This is expressed as a percentage of finalised cases.

The accompanying graph demonstrates how the twin effects of complexity and persistency impacted on the office's productivity.

At the same time there is an increasing demand for instant access and response, and if these demands are not met the complainants' satisfaction levels suffer.

Schemes are also becoming more concerned about quality control and maintaining consistency of decisions. These are good for ensuring the standard of determinations, but it cannot be achieved without affecting the cost of the process and the time taken.



In order to keep productivity at acceptable levels and costs down the office uses the following tools:

- fast tracking some complaints;
- segmenting complaints; and
- encouraging insurers, by differentiating case fees, to settle complaints more quickly. A basic case fee was, for example, introduced for certain complaints which are settled on first response from insurers. At the other end of the spectrum the Complicated + fee was introduced to try and spread costs more fairly for complaints that take up a lot of the office's time and attention.

The office is also re-evaluating its business model.

MONEY RECOVERED

The table below shows the monetary value of complaints resolved W/P where the benefits were payable in lump sums. The total amount of such lump sum recoveries for 2012 was R94.3 million.

In 78% of the cases found in favour of the complainant the benefits were less than R25 000. These recoveries would have benefited the smaller policyholder, mainly holders of funeral and credit life policies. The money recovered for these categories amounted, however, to approximately 9% of the total.

Conversely the three highest categories (over R500 000 recovered) comprised less than 3% of the total cases, but approximately 56% of the money recovered.

Monetary values in rands (for benefits payable in lump sums)

	< 5 000	5 001 – 15 000	15 001 – 25 000
Number of cases	550	483	134
Total value recovered	R1 394 206	R4 539 201	R2 548 912

	25 001 – 50 000	50 001 – 100 000	100 001 – 500 000
Number of cases	103	81	101
Total value recovered	R3 715 979	R5 814 446	R23 014 491

	500 001 – 1 000 000	1 000 001 – 2 500 000	2 500 001 – 5 000 000
Number of cases	24	18	2
Total value recovered	R17 197 763	R29 210 305	R6 873 205

Total number of cases: **1 496** | Total value recovered: **R94 308 508**

APPENDICES

APPENDIX 1: **Subscribing members as at 31 December 2012**

1 Life Direct Insurance Limited

Absa Life Limited
Allied Insurance Co. Ltd
UBS Insurance Co. Ltd

Absa Insurance and Financial Advisers (Pty) Ltd

Acsis Ltd

African Unity

AIG Life SA
Chartis Life

Allan Gray Life Ltd

Alexander Forbes Life Ltd

Assupol Life

AVBOB Mutual Assurance Society

Bidvest Life Ltd
Mclife

Centriq Life Insurance Company Ltd*

Channel Life Ltd
PSG Anchor Life

Clientèle Life Assurance Co. Ltd

Discovery Life Ltd

Frank.Net

Guardrisk Life Ltd
Platinum Life

Hollard Life Assurance Co. Ltd
Covision Ltd
Crusader Life
Fedsure Credit Life
Investec

Investec Assurance Ltd

Investment Solutions Ltd

JDG Microlife Ltd

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

Liberty Active Ltd
Charter Life

Lombard Insurance Group
Pinnafrica Life Ltd

MS Life Assurance Co. Ltd

Metropolitan Life Limited
Commercial Union
Homes Trust Life

Metropolitan Odyssey Ltd
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

Nedgroup Life Assurance Ltd
NBS Life
BOE Life Ltd

Nestlife Assurance Corp. Ltd

New Era Life Insurance Co. Ltd

Old Mutual Life Assurance Co. (SA) Ltd
Colonial Mutual

Outsurance Life Insurance Co. Ltd

Professional Provident Society Ins Co. Ltd

Prosperity Insurance Co. Ltd

PSG Futurewealth Ltd
M Cubed Capital Limited
Time Life

Real People Assurance Company Ltd

Regent Life Assurance Co. Ltd

Relyant Life Assurance Co. Ltd

RMB Structured Life Ltd

Safrican Insurance Co. Ltd

Sanlam Life Insurance Ltd

Sanlam Sky (African Life Assurance Co. Ltd)
Permanent Life
Sentry Assurance

SA Home Loans Life Ltd

Union Life Ltd

Vodacom Life Assurance Company Ltd*

Workers Life
Sekunjalo Investments Ltd

* During 2012 two subscribers, Centriq Life Insurance Company Limited and Vodacom Life Assurance Company Limited, joined the scheme; and KGA Life left.

APPENDIX 2: **Members of the Ombudsman's Committee as at 31 December 2012**

Dorea Ozrovech (Chairperson)
Sanlam Life Insurance Limited

Chantal Meyer
Sanlam Sky Life Assurance Company Limited

Gail Walters
Hollard Life Assurance Company Limited

Anna Rosenberg
ASISA

Glenn Hickling
Discovery Life Limited

Russel Krawitz
Clientèle Life Assurance Company Limited

Brian Gibbon
Momentum Group Limited

Andrew Raichlin
Old Mutual Insurance Company (SA) Limited

Keith van Lingen
Assupol Life Insurance Company Limited

Mariza Schlushe
Metropolitan Life Limited

Hazel Lerman
Liberty Group

Audrey Rustin
Nedgroup Life Assurance Ltd

Kurt Terblanche
1 Life Direct

APPENDIX 3: **Rules**

These Rules, effective from 1 January 1998 and last amended with effect from 9 July 2009, regulate the relationship between the Ombudsman for Long-term Insurance (the Ombudsman) and each member of the Long-term Insurance Industry (the Industry) who subscribes to the Ombudsman's scheme, as well as between the Ombudsman and each complainant who lodges a complaint with the Ombudsman's office.

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; and

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 has 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 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; and

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, the Ombudsman shall publish such determination, 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 any case in which there is reason to believe that such publication will expose the identity of the complainant.

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; or

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; and

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; and

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; and

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

The Banking Ombudsman
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 Ombud for Financial Service Providers
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
Tel: 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

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

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

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 (N.C.R.)
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

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

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