EXECUTIVE **SUMMARY**

Annual **REPORT** 2012

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

OMBUDSMAN
FOR LONG-TERM INSURANCE

Ombudsman: Brian Galgut

New Ombudsman

Judge Galgut's term of office expires on 31 May 2013, and to succeed him Judge R P McLaren has been appointed for five years as from 1 June. In 1990 Judge McLaren was appointed to the bench in the KwaZulu-Natal Division of the High Court. He served as a judge in that division for over 20 years before retiring in 2011, after which he served a spell in 2012 as an acting judge in the Supreme Court of Appeal in Bloemfontein.

General

In 2012 the office received 9 592 complaints, the highest ever and 4% more than in 2011. Of these 4 682 became full cases, more than the 4 295 of 2011, and 4 538 cases were finalised, 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.

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%.

In response to one of the questions in the office's annual complainant survey 86% of complainants said they would advise family and friends to use the office, a heartening statistic because 44% of them had not had their cases resolved in their favour.

Statistical summary of full cases finalised (pages 14 and 15)

	TOTALS				PERCENTAGE TO TOTAL	
NATURE OF COMPLAINT	**2011**	**W/P***	**2012**	**W/P***	**2011**	**2012**
Poor communications/documents or information not supplied/poor service	951	46%	1 219	46%	22%	27%
Claims declined (policy terms or conditions not recognised or met)	2 460	41%	2 664	37%	58%	59%
Claims declined (non-disclosure)	175	21%	171	15%	4%	4%
Dissatisfaction with policy performance and maturity values	166	18%	150	15%	4%	3%
Dissatisfaction with surrender or paid-up values	93	18%	65	14%	2%	1%
Mis-selling	66	41%	31	29%	2%	1%
Lapsing	190	44%	126	31%	4%	3%
Miscellaneous	153	20%	112	26%	4%	2%
TOTAL	**4 254**	**40%**	**4 538**	**37.40%**	**100%**	**100%**

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

Publication of data

On 6 June 2012 the Financial Services Ombud Schemes (FSOS) Council strongly recommended to all recognised financial ombudsman schemes that they publish *inter alia* complaints data in respect of settlement orders.

The request in regard to complaints data generally was not entirely unexpected. It is a growing trend internationally for ombudsman schemes to publish subscribing insurers' complaints data in order to promote transparency. The documentation issued by the Financial Services Board in its Treating Customers Fairly drive 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 the office should disclose the data in a uniform manner.

The office settles complaints by way of mediation, conciliation and recommendation. It does not however issue settlement orders, the term used by the FSOS Council. The office cannot therefore refer to settlement orders in the proposed format for publication. What the office proposes to do is publish the number of complaints received for each subscriber, the number of complaints considered and finalised and whether the complaint was resolved in favour of the complainant or the insurer.

The office proposes to publish the above data on its website www.ombud.co.za on an annual basis, the first publication to be on 1 June 2013, in respect of 2012.

Equity

Section 10(1)(e)(iv) of the 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 its 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*".

Equity is really nothing other than what the reasonable man in the street – in other words public opinion – would consider to be fair. In the industry there are common misconceptions, however, about the office's equity jurisdiction, the more significant ones being -

- That the office can only exercise its equity jurisdiction within the law, and that it is bound by the terms of the policy.
- That the office can only apply its equity jurisdiction where the insurer has breached the policy contract or done something wrong in dealing with the policyholder, or, conversely, that where the policyholder has erred the office cannot apply its equity jurisdiction.

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.

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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.

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, and there are of course other consequences.

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.

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.

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, 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.

Brian Galgut