WE ARE HERE TO HELP →

THE INSURANCE & SAVINGS OMBUDSMAN IS AN INDEPENDENT SERVICE FOR RESOLVING INSURANCE AND SAVINGS DISPUTES, WHICH IS FREE TO CONSUMERS.

INSURANCE & SAVINGS OMBUDSMAN I·S·O

EFFECTIVENESS

"Whichever way the Ombudsman decided, I felt I had been dealt with on an individual basis rather than [the insurer's] all in one basket attitude."

"...it is of real comfort to know that there is an independent and fair process that is available to look at situations such as that I found myself in."

"The service was fantastic...the issues involved [were] clarified quickly...after all of my discussions with the ISO I felt empowered...the information I received was so good, easy to understand and delivered in a way I could digest it all. At all times I felt respected."

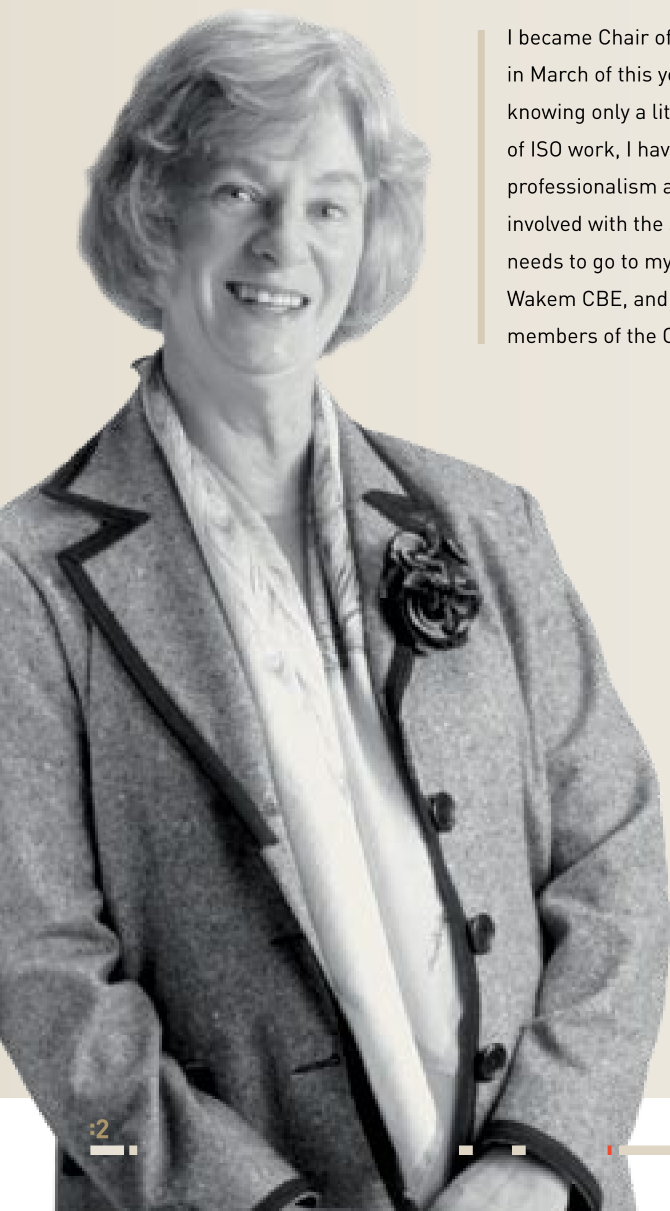
"It is great to have the ISO Scheme – I was going to go to court but have found ISO is definitely a better option and probably a lot more thorough."

2005 CONTENTS

02 Comments from the Chair
04 Insurance & Savings Ombudsman's Report
11 How we got our message into the community
12 Complaints Summary
13 Jurisdiction
14 How do people rate us?
16 Case Studies
27 Financial Statements
32 Auditors' Report
33 Scheme Participants

COMMENTS FROM THE CHAIR

"THE YEAR HAS BEEN A BUSY ONE. THE NUMBER OF COMPLAINTS AND CONSUMER CONTACTS ARE COMPARABLE TO LAST YEAR, INDICATING THAT THE SCHEME CONTINUES TO FILL A STRONG NEED FOR INFORMATION AND ADVICE, AS WELL AS DISPUTE RESOLUTION."



I became Chair of the ISO Commission in March of this year. As a new Chair, knowing only a little of the scope and scale of ISO work, I have been impressed at the professionalism and dedication of all those involved with the Scheme. Much credit needs to go to my predecessor, Beverley Wakem CBE, and to the past and present members of the Commission.

Beverley guided the Commission through the review of the Scheme in 2003 and the progressive implementation of the review recommendations. She and the Commission members established good working relationships with the industry and provided sound advice, guidance and support to the ISO. The members of the Commission: David Smith of IAG who, in his capacity as a Commission Member and also as Chair of the ISO Board, has worked hard to promote the Scheme within the industry and to smooth the way for changes arising from the review; Jo Hutchinson of Sovereign; and our consumer representatives Deborah Rundle and Raewyn Nielsen; together bring a wealth of knowledge and experience to their roles and all have contributed to making my first months as Chair positive and rewarding.

The year has been a busy one. The number of complaints and consumer contacts are comparable to last year, indicating that the Scheme continues to fill a strong need for information and advice, as well as dispute resolution. The education and information function of the Scheme has been especially busy, with a large number of presentations to industry and consumer groups, submissions to reviews and Task Forces, the redesign of the website to include languages other than English and to include case studies and the launch of the new brochure. All these initiatives have been part of the Commission's drive to make the Scheme more widely known, easily accessible and effective.

Also in 2004, the Scheme held its first conference, with the themes of fraud and non-disclosure. This was very well attended and received very positive feedback. Based on its success, it is likely that a conference will become a regular event every 2 years.

The Commission has continued to progress the implementation of the Review Committee's recommendations and many have now been implemented. Notable achievements in this regard were the recent lifting of the Scheme's jurisdiction for complaints from $100,000 to $150,000 and the inclusion in its jurisdiction of small business complaints from the beginning of the coming financial year.

The formula by which the Scheme's levy is apportioned remains an issue. A formula which takes into account the totality of the work done by the ISO, rather than only the number of complaints handled, is urgently needed. In addition, the process of amending the Terms of Reference and of implementing Rule changes needs to be streamlined and simplified, to ensure that the Scheme's documentation is always up-to-date, relevant and accurate. These 2 points will be a focus for the Commission in the coming year.

It is my good fortune to take over as Chair as the Scheme finishes its first decade of operation. This is an important milestone for any organisation. That the ISO Scheme has reached it in such good shape and in good standing with the industry and consumer groups owes much to the work of the ISO, Karen Stevens, and her staff. Their professionalism and dedication is greatly appreciated by the Commission.

We look forward to our second decade with pride in our achievements to date and with confidence in future achievements.

Alison Timms

Alison Timms Chairperson, Insurance & Savings Ombudsman Commission

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

NOW WE ARE TEN

WITH A DECADE OF EXPERIENCE, THE ISO SCHEME HAS A PROVEN TRACK RECORD, RESOLVING OVER 3,000 INSURANCE AND SAVINGS COMPLAINTS IN THAT TIME.

There have been 3 Chairs of the ISO Commission: the first, Dr Mervyn Probine, followed by Beverley Wakem CBE and, currently, Alison Timms. There have been 2 Ombudsmen: Terry Weir was my predecessor and I have held the position since May 1998. We have had a number of different industry and consumer Members of the ISO Commission and an ever changing industry Board, with our current Chairman, David Smith of IAG New Zealand Limited.

LOOKING BACK

In a speech to the Insurance Institute's Conference in June 1994, the then Minister of Consumer Affairs (The Hon. Katherine O'Regan) made the following comment:

> *"Lively competition requires that markets provide full and accurate information to consumers and other participants. It demands efficiency. It is commanded by principles of fairness and equity."*

Against this background, the ISO Scheme was set up at the beginning of 1995. In order to be able to use the name "Ombudsman", the ISO Scheme had to satisfy the criteria laid down by the Chief Parliamentary Ombudsman. One of the requirements was that the *"charter establishing the particular* 'Ombudsman' *scheme should be subject to periodic public review to assess its effectiveness and credibility".*

It is appropriate, given that we are celebrating a decade as an industry-based consumer dispute resolution scheme, that my focus this year should be on the ISO Scheme's effectiveness.

INDEPENDENT REVIEW

In 1997, the first independent Review Committee was appointed in accordance with the ISO's Rules. This was followed in the same year by a review of the ISO Scheme by the Retirement Commissioner.

In February 2003, the Retirement Commissioner released his report covering the results of the ongoing monitoring of the Banking Ombudsman and ISO Schemes, since 1997. In his report, the Retirement Commissioner, Colin Blair, said:

> *"The two private sector Ombudsman schemes continue to offer an effective disputes resolution scheme for those disputes that fall within their terms of reference".*

In March 2003, the second independent Review Committee released its report. The Review Committee was *"confident that the* [ISO Scheme] *provides consumers and insurers with an effective and affordable external complaints resolution service."* In its assessment of the ISO Scheme, the Review Committee used the Australian Securities and Investment Commission's scheme approval criteria, which includes the principle of effectiveness.

The principle requires that *"the scheme is effective by having appropriate and comprehensive terms of reference and periodic independent reviews of its performance".* The purpose of this is to promote customer confidence in the scheme and ensure that the scheme fulfils its role.

In its 2003 report, the Review Committee used the principle to make recommendations to improve the ISO's effectiveness. In the 2004/2005 year, we have made progress implementing recommendations which change the Terms of Reference ("TOR"), making them more appropriate to the changing needs of consumers. We have done so, in the following areas:

TERMS OF REFERENCE

- **Limit of $150,000**

Over the last financial year, the ISO Board has agreed to amend the TOR, increasing the monetary limit to enable the ISO to consider complaints of up to $150,000. The increase in jurisdictional limit to $150,000 reflects the general increase in the value of insured items. In the 2003 review of the ISO Scheme, the Review Committee believed that *"Average property values have increased since the last* [ISO Scheme] *review* [in 1997], *as have wages and sums insured. This suggests the maximum claim values are inadequate compensation for potential loss."* The increase also provides consistency with the Banking Ombudsman, who has jurisdiction to consider complaints about insurance provided by banks of up to $150,000.

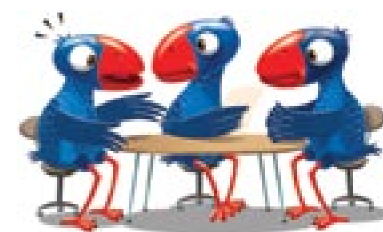
- **Small business**

Since its inception, the ISO has been unable to investigate any complaints of a commercial nature, unlike the Banking Ombudsman. In one complaint outside jurisdiction, the owner of a small business said, *"in the real world, just to get a legal opinion will cost $10,000 and then the drama to take it to court means small business always loses. A more economical way to get justice is required for small business ...".*

In the 1997 Review of the ISO Scheme, the Review Committee *"did not accept the argument that small businesses are sufficiently sophisticated to assess and deal with commercial risk. Instead, it felt that small businesses are more akin to domestic clients ... to enhance the consumer's perception of the industries' consumer orientation, small businesses should be included under the Scheme".* This view was reiterated by the second Review Committee's recommendations in 2003.

While small businesses have not been able to make complaints to the ISO Scheme, they will be able to do so in the coming financial year. By bringing small businesses under the ISO's jurisdiction, they are acknowledged as being in the same situation as individuals, with access to the ISO Scheme, a more cost-effective option than legal proceedings. In 2004, 22% (71,820) of the total businesses in New Zealand had 5 or fewer employees (Statistics New Zealand).

HIGHLIGHTS



The WEBSITE was redesigned and relaunched in September 2004. Changes were made in accordance with the Review Committee's recommendations: information about the ISO Scheme is now included in Maori, Hindi and Chinese; the website is now updated on a monthly basis; the 2002, 2003 and 2004 case studies are now included; when the website was redesigned, a comprehensive search engine was developed to find specific information in the case studies; in future, all case studies will be published on the website to make them more accessible to the public.

We are delighted to have recorded over 23,500 sessions on the website since October 2004 – almost twice the number recorded last year.

Our first CONFERENCE was held in Auckland in September 2004, with its focus on fraud and non-disclosure. About 120 participants from industry and interested groups attended and, from the very positive feedback, we intend to hold regular conferences every second year.

The BROCHURE has been independently reviewed and obtained the *"WRITE MARK"* standard for plain English.

I gave 29 PRESENTATIONS and staff were involved in 10 presentations, a total number of 39 presentations for the year. This is to create a greater level of understanding within the industry and community at large about the ISO Scheme and the service it provides. I dealt with at least 9 media enquiries, including telephone interviews for various publications and was interviewed on radio. The ISO Office published 2 *"Assessment"* newsletters, the first in September 2004 and the second in May 2005.

JOINT INFORMATION DAYS were held in conjunction with the Banking Ombudsman, Liz Brown, and the Electricity and Gas Complaints Commissioner, Judi Jones, in Tauranga, Hamilton, Nelson, Blenheim and Christchurch. This was part of an outreach programme in the community, targeting particularly Community Law Centres, Citizens Advice Bureaux and Budget Advisers.

SUBMISSIONS were prepared in response to the Law Commission's review of life insurance and for the Task Force on Financial Intermediaries.

The ISO Scheme's participation in the Australian and New Zealand Ombudsman Association ("ANZOA") is aimed at forming stronger links with other New Zealand and Australian industry-based Ombudsman Schemes. In that context, I have been acting as secretary for ANZOA and a member of its Executive Committee in the last year.

We received 167 new COMPLAINTS for investigation and closed 178 investigated complaints. The majority of complaints were resolved by agreement with both parties to the dispute at Assessment stage, with only 4 requiring Recommendations (or final decisions) to be made by me. As at 30 June 2005, there were 21 open files with none being open for more than 100 days (14 new complaints were received in June 2005). For the complaints closed in June 2005, the average number of days from the complaint date to the close date was 77 days.

We have reviewed all standard DOCUMENTS to ensure they comply with current best practice in the use of plain English. Complainants receive a plain English summary on the first page of every written Assessment of their complaint. A revised questionnaire, based on the Labett Report used by the Review Committee, has been introduced and is in current use. It is sent out automatically to all Complainants as soon as a resolution of their complaint has been reached. We want to demonstrate our commitment to listening to consumers by asking for feedback from everyone who complains to us.

The FINANCIAL STATEMENTS show that the ISO Scheme is in a sound financial position, with a budget deficit for the coming year of about $85,000 and significant reserves. While there has been increased spending to comply with the Review Committee's recommendations (particularly, in respect of the website), we have been able to hold the levies at $900,000 this year.

LEADERSHIP

My thanks to both our outgoing Chairperson, Beverley Wakem CBE and our incoming Chairperson, Alison Timms. Beverley provided us with 5 years of excellent leadership, from April 2000. Since March 2005, Alison has taken over the Chair's role and shares our commitment to providing an effective disputes resolution service.

Special thanks go to my staff, who are faced with different challenges on a daily basis and handle them to the best of their ability with the care and attention they deserve.

LOOKING FORWARD

There are still other areas in which the ISO Scheme can improve its effectiveness and adopt the Review Committee's recommendations. Changes to the governance of the ISO Scheme and the relationship between the ISO Board and ISO Commission have been recommended. The recommended changes could have a very positive effect on the day-to-day operation of the ISO Scheme.

A more effective funding formula for collecting levies on Participants has been targeted by the ISO Commission and it has resolved to work with the ISO Board to achieve that change, during this financial year.

In respect of the complaints handling, work will continue on developing ways of improving our service and having a more visible profile in the community. We are particularly looking forward to dealing with complaints made by small businesses, knowing that we can offer consumers a cost-free alternative to the courts for complaints now covered by the ISO Scheme.

Karen Stevens Insurance & Savings Ombudsman BA LLB MCIArb AAMINZ FNZIM ASB LTCL

HOW WE GOT OUR MESSAGE INTO THE COMMUNITY

IN 2004/2005

SPEECHES AND PRESENTATIONS: We spoke at 39 seminars and conferences.

CONFERENCE: We held our first ISO Conference in Auckland in September 2004.

SEMINARS FOR CONSUMER ADVISERS: We co-hosted, with the Banking Ombudsman and Electricity and Gas Complaints Commissioner, 5 seminars for consumer advisers, including Citizens Advice Bureaux, Community Law Centres and Budget Advisers.

MEDIA ENQUIRIES: We handled 9 requests for information from newspapers, journals and TV and gave 1 radio interview.

WEBSITE SESSIONS: Over 23,500 people visited www.iombudsman.org.nz (from October 2004).

TELEPHONE ENQUIRIES: We dealt with over 1,900 telephone enquiries from consumers.

0800 NUMBER: We received over 3,600 inward calls on our freephone number 0800 888 202, which provides information in a step down service and a message facility.

SUBMISSIONS: We made submissions in response to the Law Commission's review of life insurance and to the Task Force on Financial Intermediaries.

"It really is a non-biased, independent organisation. Thank you for being who you are."

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

COMPLAINTS SUMMARY

There were 167 complaints received for investigation and 178 complaints resolved in the 2004/2005 financial year, as set out in the tables below.
There were 37 disputes resolved, as a result of conciliation, before investigation.

STATUS	2004/05	2003/04
Complaints carried over from previous year and completed	32	100
Complaints received for investigation	167	172
Complaints under investigation	199	272
Complaints completed during the year	178	240
Complaints for investigation but incomplete at year end	21	32

RECEIVED BY SECTOR	2004/05		2003/04	
Fire and General	97	58%	106	62%
Health	26	16%	12	7%
Life and Savings	44	26%	54	31%
TOTAL	167		172	

OUTCOMES	2004/05		2003/04	
Complaints upheld	36	20%	30	12%
Complaints partly upheld	6	3%	12	5%
Complaints settled	17	10%	17	7%
Complaints withdrawn	–		4	2%
Complaints not upheld	119	67%	177	74%
TOTAL	178		240	

A COMPLAINT has gone through a company's internal complaints procedure and has been referred to the ISO Office, after "deadlock" has been reached and jurisdiction established.

A complaint is UPHELD, when the ISO finds the company has not treated the consumer's complaint fairly, reasonably and in accordance with the policy terms. The resolution is totally in favour of the consumer.

A complaint is PARTLY UPHELD, if the resolution is partly in favour of the consumer.

A complaint is SETTLED, when the parties agree to a favourable outcome for the consumer after a full investigation, without a formal decision being made by the ISO.

A complaint is WITHDRAWN, if the consumer decides not to pursue his/her complaint with the ISO, usually because the claim is paid.

A complaint is NOT UPHELD, when the ISO finds that the company has treated the consumer's complaint fairly, reasonably and in accordance with the policy terms. However, sometimes the company has made/will make an ex-gratia payment, acceptable to the consumer.

IN THE YEAR ENDED 30 JUNE 2005, APPROXIMATELY **$660,000** WAS PAID BY THE COMPANIES TO CONSUMERS WHO HAD THEIR COMPLAINTS CONSIDERED BY THE ISO. (NOT INCLUDING WEEKLY DISABILITY BENEFIT PAYMENTS UNDER INCOME PROTECTION, SUPERANNUATION OR LIFE POLICIES).

IN ADDITION, THERE WERE 9 COMPLAINTS FOR WHICH A DECISION WAS MADE IN FAVOUR OF THE CONSUMER, BUT THE AMOUNT TO BE PAID HAD NOT BEEN FINALISED WHEN THE ISO FILE WAS CLOSED.

JURISDICTION

In the 2004/2005 financial year, we received written enquiries about 99 disputes outside jurisdiction, which required consideration and a written response. We also received more than 300 telephone enquiries about disputes outside the ISO's jurisdiction, of which 83% related to third party claims (18%), companies which did not belong to the ISO Scheme (25%) and commercial/underwriting decisions made by the Participant (40%).

DISPUTES RECEIVED IN WRITING OUTSIDE ISO'S JURISDICTION	
Commercial/underwriting decision	30%
Not defined service	22%
Brokers/company not Participant	21%
Outside ISO's monetary limits	6%
3rd party	6%
No remedy available	5%
Investment performance	4%
Outside time limits	4%
Referred elsewhere	2%

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

HOW DO PEOPLE RATE US?

"I BELIEVE ISO ARE CONTRIBUTING GREATLY TOWARDS A JUST AND EQUITABLE SOLUTION TO BOTH INSURANCE COMPANIES AND INDIVIDUAL INSURED PERSONS COMPLAINTS."

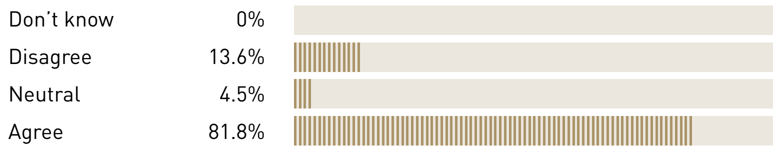
WHAT DO THE CONSUMERS WHO COMPLAIN TO THE ISO THINK ABOUT OUR EFFECTIVENESS?

In July 2004, we reviewed the questionnaire sent to consumers when their complaints have been considered by the ISO. A number of changes were made to the questionnaire, in order to improve the on-going monitoring of the ISO Scheme's process and to evaluate our performance.

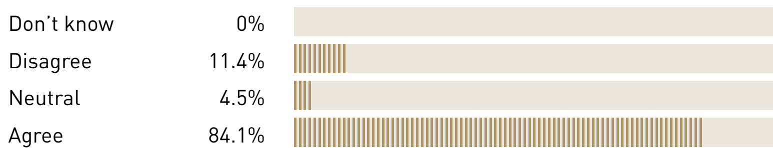
The questionnaire provides the ISO with important feedback about the consumers' perceived effectiveness of the ISO Scheme's process and the amount and quality of information provided by the Participants.

Of the 178 questionnaires sent out, 44 were completed and returned. Generally, most consumers felt the Case Managers investigated all the issues and explained the reasons for the decisions. It is of concern, however, that less than 50% of consumers believed companies gave them enough information about their own internal complaints procedures, or the ISO's process.

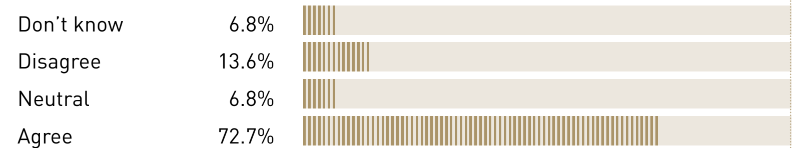
THE ISO KEPT YOU WELL INFORMED ABOUT PROGRESS ON YOUR COMPLAINT



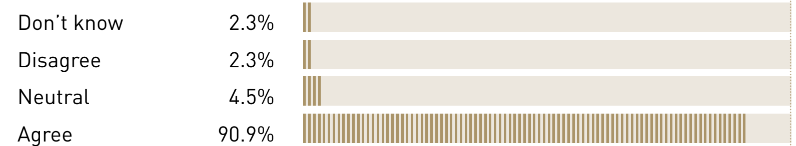
THE REASONS FOR THE DECISION MADE ABOUT YOUR COMPLAINT WERE EXPLAINED CLEARLY



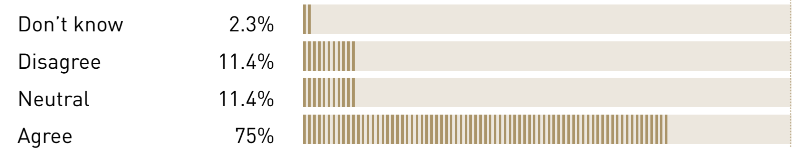
THE ISO'S INVESTIGATION OF YOUR COMPLAINT COVERED ALL OF THE ISSUES



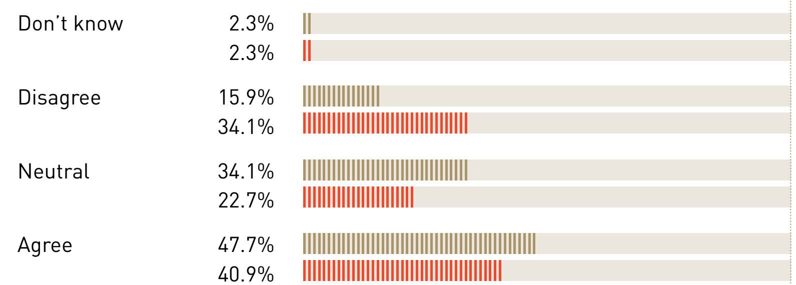
THE ISO'S SERVICE IS EASY TO USE



THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME



INFORMATION PROVIDED BY PARTICIPANTS



You received enough information from the Participant about the ISO Scheme.

You received enough information from the Participant about its own internal complaints procedure.

CASE STUDIES

BEING EFFECTIVE CAN ALSO BE SEEN FROM THE POINT OF VIEW OF OUR STAKEHOLDERS – PARTICIPATING COMPANIES AND CONSUMERS. HOW EFFECTIVE ARE WE IN RESOLVING COMPLAINTS?

If we are receiving more positive feedback from our consumer questionnaires, then we are being more effective. Do we provide acceptable resolutions for most complaints? If an increase in settled complaints and very few Recommendations indicate a greater acceptance of our initial Assessment of complaints, then we are effective. Have we been effective in providing on going education for the industry in complaints handling? If a decrease in the number of investigated complaints indicates a better level of handling complaints within the industry, then we are effective.

In the case studies, C = Complainant/consumer and P = Participant/company.

1 EXCLUSION

Background

On 15 June 2003, C insured his motorcycle with P. On 2 January 2004, the motorcycle was extensively damaged when C was participating in a rider training day at a racing track. C made a claim to P, but P declined the claim because it considered the purpose, for which the motorcycle was being used when the accident occurred, was excluded by the policy ("the exclusion"). The exclusion stated that cover would not apply while the motorcycle was being used for "[e]*ither practising for or taking part in any race, time trial, rally, sprint or drag race or similar motor sport event demonstration, or test."*

C made representations to P that the rider training day did not come within any of the uses excluded by the policy. He indicated that the rider training day, run by a motorcycle touring club ("the MTC"), consisted of 15 minute sessions of groups of riders with a lead rider at a pre-determined speed and did not involve any starting flags, time keeping, point scoring, speed trials or testing. C asked P to be more specific about which part of the exclusion it was relying upon to decline the claim. P advised C it considered the rider training day was a motor sport event demonstration, or test. P maintained its decision to decline the claim.

Assessment

The Case Manager noted that, if an insurer wishes to rely on an exclusion in the policy, the onus is on it to establish the application of the exclusion.

The Case Manager made enquiries with the MTC and other groups running similar rider training events and established that such events are generally a safe environment for motorcycle riders to enhance their riding skills. The Case Manager considered the information provided by P for both this complaint and another one arising from the same rider training day.

The Case Manager concluded the rider training day could not be considered a race, a time trial, a rally, a sprint or drag race. Nor did he believe the rider training day could be considered *"a motor sport event demonstration, or test."* To be excluded by the policy, any such motor sport event, demonstration, or test is required by the wording to be *"similar"* to a race, time trial, rally, sprint or drag race. The words *"motor sport event demonstration, or test"* must be read in conjunction with the preceding words and interpreted in accordance with the legal principle of ejusdem generis.

The Case Manager also considered relevant case law and, in particular, *Rogers v HIH Casualty and General Insurance (NZ) Ltd* [2000] NZCA 269. This case concerned a claim for a Ferrari, damaged when it was travelling at about 200km/h during an organised event at the Pukekohe racetrack. That event was described by the promoters as *"the Ferrari Test Day"*.

The policy exception used by the insurer to decline Mr Rogers' claim was the same wording used by P. In *Rogers*, the High Court concluded that the Ferrari Test Day was best described as a *"test"* and found in favour of the insurer. However, on appeal, the Court of Appeal overturned the High Court's decision and said the exclusion did not apply. Mr Rogers was entitled to cover. In the Court of Appeal, McGechan J held as follows:

> *"[14] What the insurer needed to do was to word the exclusion so as to shut out activity which while not sporting competition, and not reckless, posed heightened risk. The insurer did not go so far and cannot strain this policy wording to do so".*

The Case Manager concluded that P was not entitled to rely upon the policy exclusion to decline C's claim.

Result *Complaint upheld*

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

2 UNTRUE INFORMATION IN SUPPORT OF A CLAIM

Background

In February 1987, C arranged insurance for his Ferrari with P, under a standard vehicle policy.

On 20 July 2002, while C was taking a *"passenger"* ("Y") for a ride in the vehicle, organised by Y's partner ("X"), it was involved an accident. C made a claim to P for the damage to the vehicle. P appointed an investigator to make enquiries into the circumstances of the claim.

In September 2002, P advised C that it had declined the claim and cancelled all the policies C held with P. P believed that, at the time of the accident, C was charging money for taking Y for a ride in the vehicle. Therefore, the *"vehicle was being used for a purpose which* [fell] *outside the description of* [use] *allowed by the* [policy]" and C had provided untrue information in support of the claim. P made a formal complaint against C to the police, who charged C with using a document for pecuniary advantage. However, C maintained that he did not provide P with any false information; rather, he gave *"the truth as* [he] *saw it."*

In June 2004, because the incorrect date was entered on the information, the police withdrew the charge against C. In July 2004, C argued that, because the police had withdrawn the charge, he had a valid claim. C requested that P apologise for its conduct and pay the claim.

Assessment

In order to decline the claim on the basis of untrue information, P had to show that any incorrect information provided by C in support of the claim was deliberately, or knowingly, incorrect. The standard of proof required was on the balance of probabilities.

In C's statement to the investigator, he indicated he had not *"had any commercial passengers"* in the vehicle. C also said he *"didn't say* [he] *was going to charge* [$200]" and, because he was enjoying Y's company, C *"decided not to"* charge X for the ride, just prior to the accident occurring.

However, in X's statement to the investigator, she stated that C had discussed the minimum charge of $200 with her and, as a result of this discussion, she gave C a cheque for $200, just prior to Y's departure.

In situations where there is contradictory evidence, the ISO's ability to investigate is limited. Unlike a court of law, the ISO is unable to assess matters of credibility and, therefore, cannot resolve conflicts of evidence. Because of this limitation, the Case Manager had to rely on the documentation provided to make an assessment of the matter.

The evidence showed that C had advertised in the Yellow Pages (2002 edition) under **"[t]*our* [s]*ervices &* [s]*ightseeing*"**; the vehicle's licensing details noted its **"[u]*sage*"** was "[t]*axi,* [c]*ommercial* [p]*assenger*"; and the investigator located a cheque butt in X's cheque book, reading "*anniversary $200.* [C]". Therefore, the Case Manager believed it was more probable than not that C deliberately provided P with untrue information *"regarding payment for* [his] *passenger's ride"*.

Having regard to the circumstances, the Case Manager believed the evidence indicated C discussed the fact he required a fee of $200 with X prior to 20 July 2002 and X gave him a cheque for $200, prior to his departure with Y.

Accordingly, the Case Manager believed P had proved that, on the balance of probabilities, the information provided by C *"regarding payment for* [his] *passenger's ride"* was deliberately, or knowingly, incorrect.

Because the Case Manager found that C provided untrue information in support of the claim, it was unnecessary for her to consider the *"description of* [use]*"* issue.

Result *Complaint not upheld*

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

3 NON-DISCLOSURE

Background

On 3 November 2003, C completed an application for health insurance with P. Completing the personal statement for his children, C stated as follows:

> *"2) When did each child visit a doctor and what was the reason?*
>
> *Details : Two children, one visit each over the last year for colds. No other problems."*

P issued the policy with a commencement date of 1 December 2003.

In January 2004, C's son was referred to an Otorhinolaryngologist who removed his tonsils. As part of its claims review process, P requested a copy of C's son's medical records, which showed a consultation on 19 November 2003 when C's doctor noted as follows:

> *"19-Nov-2003 Fever pulling at ears.*
> *Snores.*
> *...*
> *Throat large tonsils."*

The medical records also showed a series of consultations for otitis media over 2 years and an audiology test in July 2002.

P declined to pay the claim, because in terms of the policy, it was *"entitled to reduce its liability under the contract in respect of a claim"*, to the extent that it was prejudiced by the claim. P also imposed an endorsement on the policy from inception, in respect of expenses for the treatment of C's son's tonsils and ears.

C complained he had fully disclosed his son's health at the time he completed the application, including agreeing that P could access the family's medical records. C quoted from a letter provided by his doctor in support of his argument.

Assessment

At law, C's duty of disclosure continued to apply after the application was completed and until the policy was issued. As the policy was issued with a commencement date of 1 December 2003, C had a duty to disclose the consultation on 19 November 2003 to P. The duty of disclosure was stated in the application C had signed.

C had not disclosed the consultation on 19 November 2003. The Case Manager obtained an independent underwriting opinion that the consultation was material. In terms of the policy, to the extent that it was prejudiced by C's claim, P was *"entitled to reduce its liability under the contract in respect of a claim"*.

In his complaint, C stated he had agreed to P being able to *"access family medical records."* The Case Manager advised C that insurers do not, as a matter of course, check the medical history of every applicant. Insurers only ask for an applicant's medical history from his/her doctor when, as a result of information disclosed in the application, the insurer needs more information to form an opinion about what terms it will offer the applicant.

In his letter to P, in support of his argument, C quoted his doctor who had stated that, *"*[i]*n December 2003 I would not have considered him needing his tonsils removed."*

The Case Manager advised C that information was *"material"* if it would have influenced the mind of a prudent insurer in deciding on what terms it would accept an applicant for insurance. This is a totally different question to the question of what treatment his doctor considered necessary for his son's health. While C's doctor might not have thought his son's tonsils needed to be removed on 19 November 2003, the underwriter considered that there was a known risk he would need further treatment for them in the future.

P's policy wording did not allow it to impose an endorsement on the policy from inception. Further, the Case Manager considered that the endorsement was redundant, as C's son's tonsils had been removed. P agreed the endorsement could not be imposed on the policy from inception and agreed it was unnecessary.

Result *Complaint partly upheld*

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

4 PARTIAL DISABLEMENT

Background

In August 2002, C, a taxi driver, arranged disability cover with P under a health policy.

In April 2003, C claimed under the policy for 12 days' partial disability in late March, because of left thigh pain.

In June 2003, P had C examined by an independent Occupational Physician. The Occupational Physician believed C would only have been partially disabled by his condition for the first day of his disablement. On the basis of the Occupational Physician's report, P paid the partial disability benefit for one day.

C made a complaint to the ISO that he had been partially disabled for 12 days and wanted P to pay the claim.

Assessment

The policy defined partially disabled as *"*[t]*he inability to perform one or more but not all of the substantial duties of your … occupation"*. In order to be *"partially disabled"* in terms of the policy, the insured had to be unable *"to perform one or more … of the substantial duties of* [his] *… occupation"*.

The Case Manager considered the medical evidence to establish the extent to which C's partial disability met the requirements of the policy definition. However, neither C's doctor, in the claim form, nor the Occupational Physician, in his report to P, stated which *"substantial duties"* C was unable to perform as a result of the pain in his left thigh.

To establish the substantial duties of C's occupation, the Case Manager referred to the *"Tasks and Duties"* and the *"Skills"* required to be a taxi driver, in the New Zealand Government's *"Kiwi Careers"* website.

Considering the skills required for a taxi driver, that they must be: responsible, safe drivers, be able to remember routes and streets, have good communication skills, have basic car maintenance and maths skills, the Case Manager concluded the substantial duties of a taxi driver were as follows:

- to collect passengers and drive them to where they want to go;
- to collect fares and give change;
- to keep records of rides and fares;
- to be responsible for passenger safety; and
- to conform to local authority by-laws on taxi stands.

In his report to P, the Occupational Physician stated that, according to C, C was *"able to continue driving* [his] *taxi, albeit on reduced hours"*. In a telephone conversation with C, the Case Manager confirmed C had continued driving the taxi throughout the time he was partially disabled. Because C drove an automatic car, he was able to drive safely using only his right leg, despite the pain in his left thigh. The only difficulty C recalled experiencing was getting in and out of the car.

Throughout the period of partial disability, C was able to and did drive the taxi, doing fewer trips and working reduced hours. C experienced some discomfort, but was able to drive safely, collect fares, keep records and conform to local authority by-laws. The Case Manager considered C performed all the substantial duties of a taxi driver during the period he was partially disabled. Because C was able to perform *"the substantial duties of* [his]*… occupation"*, C was not *"partially disabled"* as defined in the policy and P was entitled to rely on the policy definition to decline to pay the claim.

Result *Complaint not upheld*

2005 ANNUAL REPORT INSURANCE & SAVINGS OMBUDSMAN

5 MISLEADING INFORMATION

Background

In August 2000, C met with an adviser. C said that, during the discussions, he and his wife stressed they were conservative investors and were seeking an investment which was a *"tortoise"*, rather than a *"hare"*. As a result of the discussions, C invested $55,000 and agreed to make monthly contributions of $100 to a personal superannuation plan offered by P.

After one year, C received an annual statement showing that all contributions had been invested in international equities and the value of the investment had reduced by approximately 13%. C contacted the adviser to express his concern about the fund in which the money had been invested, but was encouraged to continue the plan.

In March 2003, after discovering his concerns could be pursued through other channels, C made a complaint to P.

In June 2004, with the matter remaining unresolved, C submitted a complaint to the ISO. C raised a number of issues, with the main one being that the *"investment was not prudently placed"*.

In July 2004, P contacted the ISO and advised it wanted to review its position, because it had received additional information about the adviser. This resulted in P offering C a "without prejudice" payment of slightly more than $50,000. C did not accept this amount and advised he was prepared to settle the matter, if he was paid $60,000. P did not agree to this and the matter was referred back to the ISO.

Assessment

There was a considerable amount of conflicting information about what had been discussed between C and the adviser, before the plan was established. Examples included the following:

- C understood the investment would be in a diversified fund, whereas the adviser stated the investment was to form *"the higher risk portion of a diversified portfolio"*.
- The adviser said C knew the money was to be invested in international equities. C said he would not have proceeded, if he had known the money was to be invested in international equities.
- C had no recollection of being provided an Investment Statement, whereas the adviser was adamant C was given one and had the opportunity to study it before signing the application.

Because of the informal nature of the ISO's investigations, the Case Manager was unable to resolve these conflicting views.

The adviser said the investment decision was based on C's overall portfolio. However, in recommending the international equities fund, the adviser relied on undated handwritten notes prepared by someone else. The adviser did not appear to have attempted to update, or verify, the information. There was no evidence to show the adviser had completed a needs analysis/risk profile for C. Had he done so, it would have established a $50,000 investment, which was mentioned in the handwritten notes, did not exist.

In recommending an amount invested in fixed interest and/or cash should be invested in international equities, the adviser significantly increased the risk component of C's investments.

C and the adviser appeared to agree that, when it was signed, the application had not been fully completed. (Details of required investment fund/s had not been included.) However, in signing the application, C stated that all information which had to be completed, was completed, before the application was signed and acknowledged an Investment Statement had been received and read.

C met the adviser on 2 consecutive days to discuss and arrange the plan. There was some doubt whether the application was signed at the first, or second, meeting. The date on the application suggested it was signed at the first meeting. If this was correct, the adviser could not, as he suggested, have given C an Investment Statement and the opportunity to study it before the application was signed. On the other hand, if the application was signed at the second meeting, there was no reason why the adviser could not have ensured all the required information was included before it was signed.

5 CONTINUED...

C did not appear to have had a clear understanding of the fund in which his contributions were to be invested. The only document C received from P showing this information, was a membership certificate showing the international equities fund had been selected. However, because no free-look period was offered, C would not have been automatically entitled to a refund, if the matter had been queried when the membership certificate was received.

In arriving at the amount of $60,000, which C said he would accept in settlement of his complaint, C had referred to the returns provided by a variety of different funds. In considering this information, the Case Manager believed it became a matter of speculation to decide what alternative fund may have been appropriate for and/or selected by C.

The Case Manager believed the adviser had not acted with *"diligence, care and skill"* as required by his agreement with P and, as a result, C should receive more than the current value of the plan. However, the Case Manager also believed that C had to bear some responsibility for not ensuring he understood which investment fund was being used before the application was signed and for not making sure an Investment Statement was received. The Case Manager concluded that an appropriate solution would be for C to receive a refund of the contributions paid, totalling $58,133, without interest.

P queried the decision. The ISO concluded P had not provided new information on which to overturn the decision reached in the Assessment. The position was discussed with P and a letter provided addressing the points raised by P.

Result *Complaint partly upheld*

FINANCIAL STATEMENTS

INSURANCE & SAVINGS OMBUDSMAN COMMISSION

FOR THE YEAR ENDED 30 JUNE 2005

27 Directory
28 Statement of Financial Performance
28 Statement of Movements in Equity
29 Statement of Financial Position
30 Notes to the Financial Statements
32 Auditors' Report

DIRECTORY

FOR THE YEAR ENDED 30 JUNE 2005

NATURE OF BUSINESS

To appoint an Insurance & Savings Ombudsman with power (on behalf of the Insurance & Savings Ombudsman Commission):

(I) to consider, subject to the Terms of Reference, complaints in connection with the provision within New Zealand of any of the Services by any Participant; and

(II) to resolve such complaints whether by agreement, by making Assessments, Recommendations or Awards, or by such other means as shall seem expedient.

BUSINESS LOCATION

7th Floor, BDO House, 99-105 Customhouse Quay, Wellington

BANKERS The National Bank of New Zealand Ltd Wellington

ACCOUNTANTS Horwath Strategy (Wellington) Limited Wellington

AUDITORS PricewaterhouseCoopers Wellington

STATEMENT OF FINANCIAL PERFORMANCE: For the year ended 30 June 2005

	Note	2005	2004
Income			
Levies		970,391	968,293
Casebook Sales		3,087	6,636
Brochure Sales		1,778	0
Surplus from ISO Conference		8,126	0
Interest Received		57,142	41,777
Total Income		**1,040,524**	1,016,706
Less: Expenditure			
Administration Costs		132,464	128,104
Audit Fees		5,288	4,013
Commissioners' Fees & Expenses		34,000	35,035
Depreciation – Office Equipment		25,048	18,710
Depreciation – Furniture & Fittings		1,746	1,746
Professionals & Consultancy		42,457	36,458
Occupancy		12,147	7,618
Promotion		17,101	12,677
Rent	3	75,180	70,150
Salaries		593,161	554,696
Scheme Review Fees & Expenses		0	2,652
Staff Costs		29,670	5,828
Total Operating Expenditure		**968,262**	877,687
Net Surplus Before Tax		**$72,262**	$139,019
Tax Expense		12,289	7,472
Net Surplus After Tax		**$59,973**	$131,547

This statement should be read in conjunction with the Notes To The Financial Statements.

STATEMENT OF MOVEMENTS IN EQUITY: For the year ended 30 June 2005

	Note	2005	2004
Balance at Beginning of Year		462,516	330,969
Net Surplus After Tax		59,973	131,547
Balance at End of Year	6	**$522,489**	$462,516

This statement should be read in conjunction with the Notes To The Financial Statements.

STATEMENT OF FINANCIAL POSITION: As at 30 June 2005

	Note	2005	2004
Equity			
Accumulated Funds Account		522,489	462,516
Total Equity		**$522,489**	$462,516
Represented By:			
Current Assets			
Accrued Income		3,628	1,830
Prepayments		8,803	8,748
Cash & Bank		222,933	185,506
National Bank of N.Z. Term Deposits		304,078	280,000
Income Tax Refund		0	585
G.S.T. Refund		7,473	6,048
Total Current Assets		**546,915**	482,717
Fixed Assets	2	**48,966**	33,807
Total Assets		**595,881**	516,524
Current Liabilities			
Accounts Payable		71,895	54,008
Income Tax Payable		1,497	0
Total Current Liabilities		**73,392**	54,008
Total Liabilities		**73,392**	54,008
Net Assets		**$522,489**	$462,516

The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on 9 August 2005.

Chairperson: Alan Timms Date: 9.08.05

Ombudsman: K. Stevens. Date: 9.08.05

This statement should be read in conjunction with the Notes To The Financial Statements.

NOTES TO THE FINANCIAL STATEMENTS: For the year ended 30 June 2005

NOTE 1 – STATEMENT OF ACCOUNTING POLICIES

ENTITY REPORTING & STATUTORY BASIS

The Financial Statements presented here are for the Insurance & Savings Ombudsman Commission.

The Financial Statements are prepared in accordance with Generally Accepted Accounting Practice (GAAP) as defined in the Financial Reporting Act 1993.

DIFFERENTIAL REPORTING

The Insurance & Savings Ombudsman Commission is a qualifying entity within the Institute of Chartered Accountants of New Zealand differential reporting framework. The Insurance & Savings Ombudsman Commission is not publicly accountable and qualifies under the size criteria and has taken advantage of all differential reporting concessions available to it.

GENERAL ACCOUNTING POLICIES

The measurement base adopted is that of historical cost. Reliance is placed on the fact that the business is a going concern.

Accrual accounting is used to match expenses and revenues.

PARTICULAR ACCOUNTING POLICIES

Accounts Receivable:

Accounts Receivable are valued at expected realisable value.

Fixed Assets:

Initial Recording

The cost of Fixed Assets is the value of the consideration given to acquire the assets and the value of other directly attributed costs which have been incurred in bringing the assets to the location and condition necessary for their intended service.

Depreciation

All fixed assets are depreciated using the straight line method of depreciation to write assets off over their expected useful lives. The rates are as follows:

Office Equipment	10-40%
Furniture & Fittings	6-24%

Investment Income:

Interest income is accounted for as it is earned.

Levy Income:

Levies comprise amounts received and receivable from Participants in the Insurance & Savings Ombudsman Scheme, and are recognised on an accrual basis.

Goods & Services Tax:

The statement of financial performance has been prepared so that all components are stated exclusive of GST. All items in the statement of financial position are stated net of GST, with the exception of receivables and payables, which include GST.

Employee Entitlements:

Employee entitlements to salaries, wages and annual leave are recognised when they accrue to employees.

Taxation:

The taxes payable method of accounting for taxation has been followed. Provision has been made for taxation after taking full advantage of all deductions and concessions permitted. No provision has been made for deferred tax due to there being no timing differences.

Reclassifications:

Certain reclassifications of prior year balances have been made to conform with current year classifications.

CHANGES IN ACCOUNTING POLICIES

All policies have been applied on bases consistent with those used in the previous year.

NOTE 2 – FIXED ASSETS

	Cost Price	Accum.Depn.	Net Value
Plant & Equipment – 2005			
Office Equipment	160,620	117,296	43,324
Furniture & Fittings	77,322	71,680	5,642
	$237,942	**$188,976**	**$48,966**
Plant & Equipment – 2004			
Office Equipment	118,668	92,249	26,419
Furniture & Fittings	77,322	69,934	7,388
	$195,990	**$162,183**	**$33,807**

NOTE 3 – OPERATING LEASE COMMITMENTS

Analysis	2005	2004
Current	75,180	75,180
Non-Current	48,610	123,790
	$123,790	$198,970

Obligations payable after balance date on non-cancellable operating leases are as detailed above.

Upon expiry the operating lease gives the Insurance & Savings Ombudsman Commission the right to renew the lease subject to a redetermination of the lease rental by the lessor.

NOTE 4 – CONTINGENT LIABILITIES & COMMITMENTS

There were no known contingent liabilities or commitments for capital expenditure as at balance date (2004 Nil).

NOTE 5 – RELATED PARTY TRANSACTIONS

There were no transactions involving related parties during the year, other than those already disclosed elsewhere in these Financial Statements (2004 Nil).

NOTE 6 – ACCUMULATED FUNDS

Included in Accumulated Funds is $20,000. This will be used for the ISO Scheme Review which will be undertaken in 2008.

AUDITORS' REPORT: To the Participants in the Insurance & Savings Ombudsman Scheme

We have audited the financial statements on pages 27 to 29. The financial statements provide information about the past financial performance of the Insurance & Savings Ombudsman Scheme (the "ISO Scheme") for the year ended 30 June 2005 and its financial position as at that date. This information is stated in accordance with the accounting policies set out on pages 30 to 31.

INSURANCE & SAVINGS OMBUDSMAN COMMISSION'S RESPONSIBILITIES

The members of the Insurance & Savings Ombudsman Commission (the "ISO Commission") are responsible for the preparation and presentation of the financial statements which present fairly the financial position of the ISO Scheme as at 30 June 2005 and its financial performance for the year ended on that date.

AUDITORS' RESPONSIBILITIES

We are responsible for expressing an independent opinion on the financial statements presented by the ISO Commission and reporting our opinion to you.

BASIS OF OPINION

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

(a) the significant estimates and judgements made by the ISO Commission in the preparation of the financial statements; and

(b) whether the accounting policies are appropriate to the circumstances of the ISO Scheme, consistently applied and adequately disclosed.

We conducted our audit in accordance with generally accepted auditing standards in New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

We have no relationship with or interests in the ISO Scheme other than in our capacity as auditors.

UNQUALIFIED OPINION

We have obtained all the information and explanations we have required. In our opinion the financial statements:

(a) comply with generally accepted accounting practice in New Zealand; and

(b) present fairly the financial position of the ISO Scheme as at 30 June 2005 and its financial performance for the year ended on that date.

Our audit was completed on 10 August 2005 and our unqualified opinion is expressed as at that date.

Chartered Accountants, Wellington

SCHEME PARTICIPANTS: as at 30 June 2005

AA Insurance Limited
- SIS (Superannuation Insurance Service)

ACE Insurance Limited
- Vodafone phoneInsure

Allianz New Zealand Limited
- Protecta

American Home Assurance Company (NZ Branch)

American International Assurance Co (Bermuda) Limited

AMI Insurance Limited

AMP Services (NZ) Limited

Asteron Life Limited
- Asteron Retirement Investment Ltd

Asteron Trust Services Limited

BT Funds Management (NZ) Limited

China Insurance (NZ) Company Limited

CIGNA Life Insurance New Zealand Limited

Combined Insurance Company of New Zealand

EIG-Ansvar Limited

Equitable Life Insurance Company Limited

Farmers' Mutual Insurance Association
- Farmers' Mutual Insurance Limited

Farmers' Mutual Life Limited

Fidelity Life Assurance Company Limited

Hallmark Life Insurance Company Limited t/a GE Money Insurance Services

Health Service Welfare Society Limited

I.O.O.F of New Zealand – Friendly Society

IAG New Zealand Limited
- Clipper Club Underwriting Agency
- NZI
- State
- Mike Henry Travel
- National Auto Club Underwriters Agency (NZ) Limited
- Swann Insurance (Australia) Pty Limited

ING (New Zealand) Limited

ING Insurance (NZ) Limited

ING Life (NZ) Limited

Lumley General Insurance (N.Z.) Limited
- Australis Underwriting Agency
- Lumley Services (N.Z.) Limited

Manchester Unity Friendly Society

Medical Insurance Society New Zealand Limited

Medical Life Assurance Society Limited

MFL Mutual Fund

Mitsui Sumitomo Insurance Company Limited

National Mutual Assets Management (New Zealand) Limited t/a AXA NZ

Orange Insurance Limited

Pacific Life Limited

PSIS Life Limited

Public Trust

SAI Life Limited

SIL Mutual Fund

Southern Cross Benefits Limited (Travel)

Southern Cross Medical Care Society

Southsure Assurance Limited

Sovereign Assurance Company Limited
- Sovereign Superannuation Funds Limited
- The Colonial Mutual Life Assurance Society

The National Mutual Life Association of Australasia Limited (The) t/a as AXA NZ

TOWER Health & Life Limited

TOWER Insurance Limited

TOWER Managed Funds Limited

Union Medical Benefits Society Limited t/a UNIMED

Vero Insurance New Zealand Limited
- AMP General Insurance
- Autosure
- Comprehensive Travel
- Mariner Underwriters Limited
- Vero Marine Insurance Limited

•Denotes subsidiary or associated company or business division

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