Annual **REPORT**

2010

Resolving

your insurance and savings problems

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INSURANCE & SAVINGS OMBUDSMAN I·S·O

THE PRIMARY OBJECTIVES OF THE INSURANCE & SAVINGS OMBUDSMAN SCHEME ARE...

TO PROVIDE A FAIR, IMPARTIAL AND INDEPENDENT DISPUTE RESOLUTION SERVICE WHICH IS ACCESSIBLE AND FREELY AVAILABLE TO THE GENERAL PUBLIC, WHILE ITS OPERATIONAL AIMS ARE ECONOMY, EFFICIENCY AND EFFECTIVENESS.

RIESLAW

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Chairperson's

COMMENTS

The Commission has been engaged this year upon a series of reviews designed to increase the efficiency and effectiveness of the ISO scheme and of the support infrastructure.

The 5 year Scheme Review was undertaken by a team chaired by Stuart Macaskill, including industry and consumer representatives. There were 37 recommendations made by the review committee. The Commission has carefully considered these and where practicable many of them have already been actioned. Other recommendations, which need amendments to the Terms of Reference or Rules, await a joint meeting of the ISO Board and the Commission to consider and resolve action on these.

It was pleasing for the Commission that the Review Committee concluded that, overall...

"...the Scheme continues to operate in accordance with the benchmark standards for industry ombudsman schemes (accessibility, independence, fairness, accountability, efficiency and effectiveness). Its key strengths are the efficient administration of the overall Scheme and the provision of an affordable and professional complaints resolution service for consumers."

The Commission records its thanks to Stuart and his team for their comprehensive analysis of the Scheme and the clarity of the recommendations made.

Alongside the formal review, the Commission has undertaken a review of its internal support structure and processes and its IT requirements. This has resulted in changes which will assist the processing of complaints and facilitate more effective case management. The Commission records its thanks to staff for their participation in that review and the many practical suggestions that were made for improvements.

Brian Howard-Clarke resigned from the Commission during the year upon transfer to Australia. We appreciate the contribution he made to the Scheme from its inception and the wise counsel he offered. Carol Abernethy also resigned during the year and the Commission records its thanks to Carol for her contribution. Paul Fyfe of ING and John Balmforth of AMI joined the Commission as industry representatives.

After 5 years of service as Commission Secretary and Administration Manager, Craig Thorn has retired. The Commission records its thanks to Craig for his work and support of the Scheme during this period.

Finally, I should like to thank my fellow Commission members for their support and Karen and her staff for the exemplary way in which they have discharged their duties during a period of change and increasing pressure of work.

Beverley A Wakem CBE
Chairperson
Insurance & Savings Ombudsman Commission

Insurance & Savings

OMBUDSMAN'S REPORT

NUMBERS

This year there was a 19% increase in the number of complaints received by the ISO Office. We received nearly 300 complaints for consideration, the highest number since 1999. There was no specific reason for the increase, which covered fire and general, life and disability insurance.

We also had a review of the ISO Scheme and a subsequent Office review, to ensure the continued quality of our service and, wherever possible, its improvement.

The additional cost of these reviews has increased Participants' levies accordingly for this year but, because of the increase in complaints, the actual cost of each complaint has only risen marginally from last year to approximately $2,550 per complaint.

Karen Stevens
Insurance & Savings Ombudsman

TIMELINESS

Our aim is to resolve all of the complaints in a timely way. However, because of their number and greater complexity, many complaints have taken longer this year to resolve than our 90 day target.

Following the model used successfully overseas in consumer dispute resolution schemes, we are now trying to talk through issues more with consumers and Participants.

If we can resolve a complaint satisfactorily by negotiation or conciliation, without a full and often lengthy investigation, we should be able to provide a more timely service.

After 5 years as ISO, I believe Participants will also support a more informal conciliation process in appropriate cases, in the knowledge that we will still have regard to the law and good industry practice. A less formal process does not mean we will be making arbitrary decisions, or changing our decision-making process.

REVIEW OF ISO SCHEME AND OUTCOME

The Review Committee released its report in March 2003. By way of response, the ISO Commission agreed to make changes, where any changes were considered appropriate.

> "The Review Committee is confident that the Insurance and Savings Ombudsman Scheme ...provides consumers and insurers with an effective and affordable external complaints resolution service."

The Review Committee obtained a general public survey of 500 representative New Zealanders of the awareness and likely use of the ISO. The conclusions reached in the survey, were that about a third were aware the ISO Office is available to them, if they have a dispute with their insurance company.

Most of those people were over 40 years old. They were most likely to have been made aware through the media, mainly print and TV, particularly *Consumer Magazine* and *Fair Go*. The 2 main *"perceived"* alternatives to using the ISO Scheme, are *Fair Go* and a lawyer. About a third said they did not know what they would do if they had a dispute. This indicates a need to increase the public profile of the ISO Scheme, to ensure more consumers are aware of the free service provided.

The Review Committee made a number of recommendations to increase the ISO Scheme's accessibility to a wider range of consumers. At the moment, the ISO Rules only require Participants to publicise the ISO Scheme. However, the Review Committee recommended that the ISO and the ISO Commission should be required to promote the ISO Scheme. While we already promote the ISO Scheme through the media, our in-house publications, speeches and presentations to the industry and community groups, the ISO Commission supported these recommendations. We intend to focus on increasing the promotion of our service and consumers' awareness of the ISO Scheme over the coming year.

The Review Committee also surveyed 116 Complainants who were chosen at random, rather than being selected as a representative group. There were 43 respondents – only 3 had their complaints wholly upheld and 7 partly upheld. The survey indicated that this would naturally bias the sample towards some dissatisfaction. Interestingly, however, the survey concluded that satisfaction was evident in the following areas:

- Service – with the ISO being approachable and friendly;
- Motivation – acknowledgment of hard work; and
- Processes – respondents were generally happy with forms and the process used to make a complaint.

There was some dissatisfaction shown by respondents, arising from frustration at feeling they were not able to effectively put forward their case and from unmet expectations. Complainants believed the ISO would

be willing and able to act in their interests, on the grounds of what they perceived to be "*fair*" or "*moral*".

In order to maintain independence and impartiality, our decisions are made in accordance with the policy and with the law. Many Complainants feel the ISO should make decisions based on "*fairness*", or what is "*morally*" right. However, the ISO can only consider whether the insurer has any liability to pay a claim under the policy.

Perceptions of "*fairness*" in a disputed claim can be quite different. In many cases, it is extremely difficult to persuade Complainants that a decision (as distinct from the process) is fair or reasonable. The ISO is not a consumer advocate and our decisions cannot always give Complainants what they want. If there is no valid claim payable under the policy, the ISO has no power to impose any additional penalties or award compensation.

We acknowledge that some Complainants may feel the ISO is biased towards the industry but, making our decisions in accordance with the policy and the law, ensures our continuing independence and the impartiality of our decision-making process. However, I do acknowledge these perceptions are important and it indicates the need to develop a greater level of communication with Complainants. I intend to focus on this area in the coming year.

I was pleased to see that the majority of the 43 respondents rated their overall impression of the ISO Office as good or excellent, given that only 3 got a decision entirely in their favour.

From comments made by respondents in the survey about what they believed the ISO should be able to do, together with submissions made, the Review Committee made a number of recommendations. The recommendations were about improving effectiveness and accountability, by changing the composition of the ISO Board and amending the Terms of Reference ("TOR"). In terms of what it would mean for consumers, this was primarily in respect of increasing the monetary limits currently available, including small businesses and providing the ISO with the ability to award up to $4,000 as compensation to a Complainant for inconvenience. These recommendations would require the support of the ISO Board to change the TOR.

Overall, there was an emphasis in the Review Committee's recommendations on better communication with consumers and the part the ISO Scheme should play in helping consumers feel satisfied that their views have been heard and their complaints understood. In addition to publishing brochures, an annual Casebook of complaints and the "*Assessment*" publication, the Review Committee recommended that more information should be included on the website for consumers, in languages other than English. This will require further development of the ISO database and website over the coming year.

SUPPORT

I would like to thank Beverley Wakem CBE for her support and guidance over the last year, together with the continued input from the other ISO Commission members. I would also like to thank my staff, who have worked diligently to resolve a much greater case load than in recent years.

GOALS

In my last Annual Report, I stressed the need for increased transparency, within the parameters of my jurisdiction. The Review of the ISO Scheme and the subsequent Office review have provided us with new ideas to extend and improve our existing service.

It is of real importance that consumers know they can make a complaint to us and understand that we provide an independent and impartial service, which is free to them. It is for us to ensure that the service offered is of the highest possible quality, providing a fair and speedy resolution of complaints.

Karen Stevens
Insurance & Savings Ombudsman

Complaints

SUMMARY

There were 290 complaints received for consideration and 253 complaints resolved in the 2002/2003 financial year, as set out in the tables below. There were 108 outside jurisdiction, in some of which a partial consideration of the issues was required to decide whether the ISO had jurisdiction.

There were also 1497 consumer telephone enquiries in the same period. Since August 2002, because of a request made by the Review Committee, we have been identifying the telephone enquiries by specific categories. It is interesting to note that there are consistently high numbers of enquiries relating to the issue of non-disclosure and there are more enquiries every month about vehicle insurance than any other type of cover.

STATUS	2002/03	2001/02
Complaints carried over from previous year	72	70
Previous year's complaints completed	72	70
Complaints received for investigation	290	236
Complaints under investigation	362	306
Complaints completed during the year	253	234
Complaints for investigation but incomplete at year end	109	72

RECEIVED by SECTOR	2002/03		2001/02	
Fire and General	206	71%	154	65%
Health	7	2%	8	4%
Life and Savings	77	27%	74	31%
Total	**290**		**236**	

OUTCOMES	2002/03		2001/02	
Complaints upheld	42	17%	38	16%
Complaints partly upheld	19	8%	9	4%
Complaints withdrawn	6	2%	5	2%
Complaints not upheld	186	73%	182	78%
Total	**253**		**234**	

A complaint means that a consumer's complaint has gone through a Participant's internal complaints procedure and has been referred to the ISO Office, after "*deadlock*" has been reached and jurisdiction established.

Many of the complaints withdrawn or not upheld could also be described as settled, on the basis that the Complainants accepted the ISO's decision and, in some cases, ex-gratia payments were made by Participants.

ISO's

COMPLAINT PROCEDURE

This will help you understand our process.
"C" is for Complainant, or the consumer; and
"P" is for Participant, which is the insurance or savings organisation.

1. Deadlock
reached by C and P in P's internal complaints process

2. Submissions
made to ISO by C and P (written and oral by telephone)

3. Investigation
of complaint by Case Manager, including independent enquiries

4. Assessment
written by Case Manager in consultation with ISO

5. Request for Recommendation
can be made by C or P if there is relevant new information or proper grounds for such a request

6. Recommendation
made by ISO after review of all information and further submissions

7. Award
made by ISO, if complaint **upheld**, accepted by C, but not accepted by P within 1 month of Recommendation

Conciliation and/or negotiation, if appropriate, to reach a fair and reasonable outcome acceptable to C and P; and file closed

if complaint **upheld**, P pays C's claim and/or satisfies substance of complaint; and file closed; or P can request Recommendation

if complaint **not upheld**, C can request Recommendation or go to another forum; and file closed

if complaint **upheld** and Recommendation accepted by C and P, P pays C's claim and/or satisfies substance of complaint; and file closed

if complaint **not upheld** and Recommendation not accepted by C, C can take the complaint to another forum; and file closed

FAIR AND REASONABLE

means different things to different people. The courts have considered *reasonable* in the context of disability complaints; the ISO considers what is *fair and reasonable* in the decision-making process; Complainants often understand *fair and reasonable* to be payment of their claims; insurers realise that, sometimes, the policy might not provide any cover, but an ex-gratia payment is fair in all the circumstances. These case studies show how differently people can understand the concept of *fair and reasonable*.

FIRE & GENERAL

1 BREACH OF POLICY CONDITION – DRIVER'S LICENCE, INSURANCE LAW REFORM ACT 1977

Background

C arranged insurance cover for his vehicle with P. C's teenage son, who held a restricted driver's licence, was named as a driver of the vehicle.

C's son was involved in a fatal vehicle accident, while driving the vehicle. At the time of the accident, C's son was in breach of the terms of his restricted driver's licence, because he was carrying passengers without a suitably qualified person after 10.00pm.

P declined the claim, because the policy did not provide cover when the driver of the vehicle did not adhere to the terms and conditions of his/her driver's licence.

C challenged P's decision, because the evidence indicated that there had been serious defects in the road conditions where the accident occurred. C also argued that the vehicle had been converted, because he and his wife had not given permission for their son to use it outside the terms of his driver's licence.

Assessment

At the time of the accident, C's son had passengers in the vehicle. The conditions of C's son's restricted driver's licence stipulated that, if he was carrying passengers in the vehicle, he must be accompanied by a suitably qualified person as described in the Land Transport (Driver Licensing) Rule 1999.

The policy excluded cover when any person who was not complying with the conditions of his/her licence, was driving the vehicle at the time of the accident. This type of condition is included in policies, because the specified circumstances (driving in breach of licence conditions) would be likely to increase the insurance risk.

In some cases, where an insurance contract contains an exclusion excluding liability in defined circumstances (and the reason for the condition is that the circumstances would be likely to increase the risk), the insured can argue that the exclusion should not apply. This is dealt with by the second part of section 11 of the Insurance Law Reform Act 1977. The insured has to prove, on the balance of probabilities that,

even although the excluded circumstances did occur, they did not cause or contribute to the accident.

The scene investigation indicated that C's son steered the vehicle too far to the left hand side of the road, causing the front left wheel to break the road's seal. C's son then took evasive action by overcorrecting the vehicle, causing the vehicle to swerve. This made the vehicle heel over significantly which ultimately caused the vehicle to roll 5 times. At the time of the accident, C's son was driving at approximately 80 kmph in a 100 kmph speed zone.

A Senior Constable of the New Zealand Police Serious Crash Unit identified 3 possible causes of the accident; the vehicle, the road conditions and C's son's inexperience.

An inquest was held into the death of C's son. The Coroner relied on the Senior Constable's observations about the causes of the accident, because he was an experienced crash analyst.

The Coroner's enquiries established that "*a similar vehicle to the one involved in this crash begins to roll at a speed of only 47kph when oversteered or when a fast correction to the other 'lock' is made when the driver becomes concerned by the vehicle's heel*". Given that four wheel drive vehicles handle differently to passenger cars and the vehicle's propensity to roll, it was possible that, had a passenger vehicle been involved in the accident, the extent of damage to the vehicle and the driver's loss of control would not have been so significant.

The Coroner also found that, in the days leading up to the accident, roadworks had been carried out on the rural road. This involved the resurfacing of the road, so that the painted road markings needed to be reapplied when the roadworks were completed. However, on the day prior to the accident, the temporary warning signs were removed from the area before the road markings had been reapplied.

Furthermore, a number of edge marker posts were missing in the vicinity of the accident site. The Coroner found the missing marker posts, road markings and the removal of the warning signs, were significant factors in the cause of the accident. Without these driving aids, C's son did not have the usual visual aids available to a motorist to help with the safe tracking of rural roads.

There was no dispute that C's son was a relatively inexperienced driver and that this was a contributory factor to the accident. However, it was not C's son's inexperience that was the breach of his licence. Rather, it was the lack of a suitably qualified person in the vehicle. The Senior Constable could not say whether the accident was caused or contributed to by the lack of a suitably qualified person in the vehicle. This was important, because it meant that a suitably qualified person might not have been able to prevent the accident, given the Coroner's findings.

The Case Manager believed that the evidence supported a finding that C's son would not have left the road surface had the road markings and roadside marker posts been present on the road. Also, the vehicle's dynamics played a crucial role in the chain of events which followed C's son's initial overcorrection. The Case Manager did not believe there was any evidence on which it could be determined that a suitably qualified person in the vehicle could have prevented the accident.

Therefore, in accordance with section 11 of the Insurance Law Reform Act 1977, C proved, on the balance of probabilities, that the accident was not caused or contributed to by C's son's breach of his restricted driver's licence.

Having upheld C's complaint, the Case Manager did not need to give any consideration to C's argument that the vehicle was converted.

Result Complaint upheld

FIRE & GENERAL

2 NON-DISCLOSURE – CONVICTIONS

Background

In August 2002, C made a claim to P for his vehicle which had been stolen and found burnt out. P obtained details of C's traffic conviction history which consisted of 6 convictions and 2 periods of driver's licence suspension. C had disclosed 2 convictions when completing the insurance proposal in June 1999, but these did not seem to relate to the correct details of the convictions. P avoided the policy from its commencement.

When C and his partner received the verbal notification of P's intention not to accept the claim, C's partner decided to check if P would insure someone with similar convictions to C. C's partner, using a fictitious name of "*Miss Smith*", arranged cover with P and disclosed traffic convictions she believed were similar to C's convictions. P agreed to provide cover for "*Miss Smith*".

C argued that, there was no intentional non-disclosure, P's acceptance of cover for "*Miss Smith*" confirmed P would have provided cover and the convictions were irrelevant to the cause of the loss. However, P advised C that, if it had been provided with full details of the convictions in June 1999, cover would not have been provided.

Assessment

The Case Manager did not consider that P's acceptance of cover for "*Miss Smith*" was relevant, because a complete record of the convictions had not been provided and the convictions were much more recent when the proposal was completed in June 1999.

C thought the convictions were not relevant to the cause of the loss and the Case Manager believed C was trying to rely on the provisions of section 11 of the Insurance Law Reform Act 1977. However, section 11 was not relevant to the complaint, because P was not seeking to decline the claim on the basis of a policy exclusion.

The Case Manager concluded that C had failed to disclose all of his traffic convictions and P was correct in deciding the convictions were material. The Case Manager provided details of the convictions to 2 other insurers who both confirmed the information would provide P with grounds for avoiding the policy.

Result Complaint not upheld

FIRE & GENERAL

3 INTERPRETATION – SPECIFIC POLICY PROVISIONS, SCOPE OF COVER

Background

In June 2002, C obtained travel insurance for his trip to Australia, subject to the terms and conditions of a bank's travel policy, underwritten by P. C's parents also arranged to travel to Australia to holiday with C, but did not arrange travel insurance.

In August 2002, C's mother became critically ill and required emergency surgery at the Gold Coast Hospital. C postponed his return to New Zealand so he could take care of both his parents until his mother was fit to return to New Zealand. C incurred significant additional expenses as a result of his extended stay in Australia.

In September 2002, C made a claim to P for the additional expenses. In October 2002, P declined the claim on the basis that the policy did not provide cover for his additional expenses, because his mother was not covered under the policy. C advised P he disagreed with its declinature of the claim. In November 2002, P advised C that following its review of the claim, its decision remained unchanged. C argued that the claim was covered under the policy.

Assessment

The Case Manager found that C's mother was not covered under the policy and, therefore, any costs which related directly to C's mother's hospitalisation were not covered. However, C argued that the policy provided cover for the additional costs he incurred during his stay in Australia.

The Case Manager believed the issue to be resolved was whether C's mother's illness was an "*...Unforeseeable circumstance ... outside* [C's] *control*". When C's mother became ill, he made the decision to extend his stay in Australia to look after his parents. Given the circumstances, the Case Manager believed C might have felt he had no other option than to stay with his parents, but that C's decision to stay on in Australia was well within his control. However, in interpreting the policy, the Case Manager believed it was necessary to consider whether the "*Unforeseeable circumstance*", which led to C deciding to extending his stay, was outside his control.

The "*Unforeseeable circumstance*" was C's mother's illness, which was sudden and unexpected and, quite clearly, outside C's control.

While P might not have intended the policy to provide any cover in the circumstances of the claim, the Case Manager did not believe that the wording of the policy conveyed that intention. Therefore, because C decided to stay in Australia when his mother unexpectedly took ill and because her illness was outside his control, the Case Manager believed C was entitled to cover under the policy.

Having determined the claim was covered, the Case Manager had to determine whether the additional expenses C incurred were "*reasonably and necessarily incurred*". The Case Manager did not believe that food costs could be claimed, because C would have incurred grocery bills in the normal course of events. The Case Manager believed C's accommodation costs should be covered, but was unable to determine what would constitute a reasonable period in that regard. The Case Manager was of the opinion that P should make a realistic settlement offer to C in respect of the quantum for the expenses he incurred and claimed.

Result Complaint upheld

LIFE & DISABILITY

4 DEATH CLAIM, NON-DISCLOSURE – LIFE INSURANCE

Background

In April 2000, C and his wife completed an application for life insurance cover on his wife's life. This was to be included on a policy on C's life.

In June 2000, P sent an endorsement stating the cover on C's wife's life would start in July 2000.

In June 2002, C's wife died. P avoided the cover, because it had not been advised of changes since the proposal was completed and before the cover was accepted. P was asked to review its position and, after doing so, advised C that it was maintaining its previous decision.

However, because it did not consider that C or his wife had acted in a manner which could be considered to be "*deliberately misleading or fraudulent*", it offered an ex-gratia payment of 25% of the sum insured. In offering this amount, P advised that it was happy for C to pursue any legal remedy available to him and encouraged him to contact the ISO.

C believed that there was no gain or dishonesty on his or his wife's part, because they were only changing companies and were not increasing the cover on his wife's life. He believed his actions were fair and reasonable and that P had a "*legal and moral duty*" to pay the cover arranged on his wife's life.

Assessment

The proposal declaration which was signed by both C and his wife, required them to advise P if there were any changes in the information provided, before the policy was issued. C stated he and his wife did not read the small print and were not given a copy of the proposal. In discussing this with the adviser, the Case Manager was informed the adviser's normal practice was to summarise the declaration's contents, including the need to advise of any changes in health, rather than reading it out to clients. It was not known if this occurred in this instance, but it was noted C and his wife had signed the same declaration in proposals completed in May 1999 and December 1999.

Based on the information included in the proposal completed in April 2000, P wrote to Medical Practice A, requesting that a questionnaire be completed. When the completed questionnaire was received, P decided

it could accept the cover with a loading. However, from the available information, it appeared the doctor who completed the questionnaire was not aware C's wife had consulted doctor M at Medical Practice B on the day after the proposal was completed and had had 2 further consultations with doctor M before the report was completed. Similarly, P was not aware of the ongoing consultations. (During the investigation, C advised the Case Manager that his wife decided to obtain a second opinion from Medical Practice B, because she found she was seeing a different doctor each time she visited Medical Practice A.)

Dr M's records showed that, in mid-May 2000, C was aware his wife had a tumour, but the histology results were not known. At a 9.30am appointment with doctor M, 3 days later, C's wife was advised she had lung cancer. The same day, P prepared an acceptance terms advice addressed to the adviser.

The adviser stated that he had informed C and his wife as soon as he received the "*offer of terms*". However, it was not known exactly when this occurred, because the adviser no longer had the acceptance terms advice he originally received. There was no indication that the acceptance terms advice was faxed from P to the adviser and P believed it was posted to the adviser. Consequently, it would not have been received until after C's wife had received the diagnosis of lung cancer from doctor M. However, even if the acceptance terms advice had been sent by fax, it seemed unlikely the adviser would have informed C and his wife of P's decision, before C's wife's 9.30am appointment with doctor M. This matter was made a little more confusing because there was a note on P's file, dated 11 days later, which suggested that, at this date, the adviser had not received the acceptance terms advice.

What was known was that, in early June 2000, the adviser wrote to C and his wife, advising that C's wife had been accepted with a lower loading than had applied with the previous insurer. Included with this letter was a letter for C and his wife to sign cancelling the other insurer's policy. This was duly signed and the cover with the other insurer cancelled.

Although it was not known precisely when the adviser informed C and his wife of P's acceptance terms, the Case Manager concluded that C's wife would have been aware she had lung cancer before the adviser received the acceptance terms advice. In accordance with her continuing

duty of disclosure, C's wife was required to advise P about any changes in her health before the endorsement was issued in June 2000.

After completing the proposal and before P prepared the acceptance terms advice, C consulted doctor M 3 times, had a chest X-ray and a bronchoscopy. C's wife had a common law duty to provide P with this information. When P was considering the claim, its underwriter indicated the risk would not have been accepted if the results of the chest X-ray had been known. This view was supported by comments the Case Manager received from another underwriter. When the other underwriter was given details of the diagnosis of the biopsies taken during the bronchoscopy, it advised it would have deferred the offer of cover for 3 years.

On this basis, the Case Manager concluded the information C's wife failed to provide would have been material to a prudent underwriter and provided P with the right to avoid the cover on C's wife from its commencement date. It was acknowledged that C and his wife were only transferring cover from another insurer to P and there was no *"gain or dishonesty"* on their part. However, the current law does not distinguish between innocent and blameworthy non-disclosure and the ISO cannot make a decision which ignores the insurer's right to avoid the policy and decline to consider the claim.

It is important to note in this case that, even although it had no legal obligation to do so, P had paid C 25% of the sum insured on an ex-gratia basis.

Result Complaint not upheld

LIFE & DISABILITY

5 AGENT/REPRESENTATIVE, INTERPRETATION – SPECIFIC POLICY PROVISIONS, MISLEADING INFORMATION

Background

In 2000, C arranged a policy with P. This was to replace an existing policy held with another insurer. There was a family history of prostate cancer and C's brother had recently been paid a benefit for this condition under a policy he held with P. C informed the adviser he wanted the same cover as his brother.

In 2001, C was diagnosed with prostate cancer and made a claim to P. P subsequently declined the claim, because C's condition did not come within the definition of cancer, as set out in the policy issued to him.

Subsequent investigation showed that P had altered the definition of cancer between 1997, when C's brother's policy was issued and April 2000, when C's policy was issued. The benefit the adviser included on C's policy had the same name as the benefit he included on C's brother's policy. The adviser stated he had not been informed by P of the change in the benefit's definition of cancer.

C believed that, because P had paid a benefit to his brother on the same diagnosis of prostate cancer, he should also be covered by the policy.

Assessment

After considering the diagnosis of C's condition and applying the policy wording, P was entitled to rely on the definition of cancer, in order to decline the claim. However, with reference to paragraph 5.7 of the ISO's TOR, the Case Manager concluded it would not be fair or reasonable for P to rely on the benefit wording in C's policy to decline the claim, based on the following reasons:

- When the application for C's policy was completed, P's on-line adviser information showed different wording for the benefit in question to the wording being included in policies issued at the time. Under the Fair Trading Act 1986, P either misrepresented the product to advisers, who could not be expected to check the actual policy wording against what was available on-line, or was likely to mislead advisers about the type of products available to consumers.

- When the application was completed, the benefit wording in P's on-line adviser information showed the same definition of cancer as in C's brother's policy. Consequently, if the adviser had checked the definition in C's brother's policy to the on-line information, it would have confirmed the adviser's understanding the same cover had been provided.
- On the basis that a primary requirement in selling the policy to C was that the adviser believed he had sold the same benefit as he had sold to C's brother, P should have been able to prove it had informed the adviser of the change in the definition of cancer. It was unable to do so.
- During its consideration of the claim, P informed the adviser he had a duty to be aware of the specifics of products he was selling. The Case Manager felt this was reasonable, if P was able to show it had informed the adviser of the changes. But if advisers were not being informed of changes in benefits and/or definitions, it was felt this was an unrealistic expectation. (Advisers could not be expected to check the wording each time they sold a benefit to make sure it had not altered since they had last sold the particular benefit.)
- The adviser stated he had discussed the position regarding prostate cancer with P's underwriters, before submitting the application. While it was not known precisely what was discussed, this would have provided an opportunity for the adviser to be informed of the change in the benefit wording, which appeared to have occurred in September 1999.
- The other insurer's policy included a similar benefit. If C had been advised the wording in P's policy was different to the wording in his brother's policy, the Case Manager believed consideration would have been given to the wording in the other insurer's policy. This could have resulted in the original insurer's cover being continued or, alternatively, it would have given C the opportunity to find another product which may have met his needs. By receiving misleading information, C was denied the opportunity to consider the alternatives and had suffered to his detriment.

P accepted these views and agreed to meet C's claim.

Result Complaint upheld

LIFE & DISABILITY

6 TOTAL PERMANENT DISABLEMENT – REASONABLE DECISION, TOTAL PERMANENT DISABLEMENT – WHETHER TOTALLY DISABLED

Background

From 1994, C held income protection insurance with P. In August 1998, C's doctor noted that C was suffering from a stress related illness, with alcohol consumption as a result. In December 1998, C made a claim to P, because he was suffering from a stress related illness and had become completely unable to continue to work in his high level managerial position from 31 July 1998.

P considered C's medical evidence and requested a report from a psychologist. In May 1999, when P received the psychologist's report, it advised C that it did not believe he met the requirements in order to be entitled to a Total Disablement ("TD") benefit under the policy.

At the time of making a complaint to this Office, C was so incapacitated that his wife (who had power of attorney) and solicitor acted on his behalf. C was "*living rough … and drinking heavily and … unemployed*".

Assessment

As with any claim under an insurance policy, the initial onus lies on the claimant to establish that he/she has a valid claim under the policy.

The approach of the ISO to complaints concerning a claim for a total disability benefit is similar to that taken by the courts. In particular, in investigating the complaint, the Case Manager considered whether, in view of all the information, P's decision to decline the claim was reasonable and made in good faith.

Edwards v The Hunter Valley Co-op Dairy Co Ltd (1992) 7 ANZ Insurance Cases ¶61–113 establishes that, if P's decision was reasonable based on the information before it at the time, it cannot be replaced with a decision of the court or, in this case, a decision of the ISO.

Under the policy, in order to be considered to have a TD, C must have had a "*complete and continuous inability due to illness or injury to carry out* [his] *usual occupation.*" The policy also provided that an insured could not be considered to have a TD, unless he/she remained "*under the regular care and attention of a legally qualified medical practitioner in relation to that illness or injury*", or if he/she performed "*any remunerative work.*"

On the basis of the information provided by C, the Case Manager believed that he met the burden of proof to establish that, prima facie, he was entitled to make a claim under the policy. Therefore, in order to decline the claim, P had to establish that C's claim did not come within the terms of the policy. On the basis of the information obtained by it, P did not believe that C provided sufficient evidence to establish he had a TD.

Regardless of the reason that C left his job, the Case Manager noted there was no requirement in the policy for an insured to have ceased work solely due to illness or injury, in order to be eligible for the TD benefit.

C's doctor advised that he believed C had a complete and continuous inability to carry out his usual occupation. The Case Manager believed this was sufficient medical evidence to show that C met the requirements of the TD definition.

The psychologist stated that C met the requirements for a generalised anxiety disorder. The psychologist also noted that C was intending to study for up to 40 hours per week. However, under the policy, the Case Manager believed it was not relevant if C had a capacity to perform any other work, or study. The only relevant consideration was whether C had a complete and continuous inability, due to illness, to carry out his usual occupation.

The courts have held that "*usual occupation*" means the occupation of the insured at the time of the injury, which may or may not be the same as at the time of taking out the policy. A consideration of the insured's "*usual occupation*" must be of the specific duties of the insured's job to give full effect to the meaning of "*usual occupation*".

The Case Manager believed the psychologist had established that C was suffering from an illness, because she diagnosed him with a "*Generalised Anxiety Disorder*". The psychologist also stated that C needed to learn ways of managing his stress and increasing his ability to relax. The psychologist believed that, when C had done so, he would be able to return to the workforce.

The Case Manager believed this established that C was unable to perform his usual occupation, because the psychologist did not believe C was able to perform to his previous level of work, until he had intervention to learn ways of managing his stress.

Accordingly, the Case Manager did not believe P's decision to decline the claim, on the basis that C did not meet the policy definition of TD, was reasonable, because none of the evidence provided established that C was able to carry out his usual occupation in accordance with the policy.

A significant period of time had elapsed since the claim was made, caused in part by P's consideration of the claim, delays in C's responses and the consideration of the complaint by this Office. The Case Manager also noted that, since June 2001, C did not appear to have been under the care and attention of a legally qualified medical practitioner and, because of his "*living rough*" since 2001, it was extremely difficult to obtain any recent medical information.

The approach generally taken by the ISO to disability complaints is that, if it is found an insurer's decision to decline a claim was unreasonable and the insured is found to meet the policy definition of total permanent disability, then the insurer is liable to pay a disability benefit for the entire period of the complaint.

From information provided by C's solicitor, it appeared unlikely that a medical practitioner would find C capable of carrying out his usual occupation at the time the complaint was being considered by this Office. C was severely incapacitated and required urgent rehabilitation.

Therefore, the ISO believed that the most appropriate way to resolve the complaint on a fair and reasonable basis, was to suggest a settlement between P and C. P accepted that a settlement was appropriate in the circumstances and accepted C's claim to pay full monthly benefits from December 1998 until December 2002, with an update on his health to be obtained.

Result Complaint upheld

SUPERANNUATION

7 ABILITY TO WITHDRAW, CHARGES/FEES, NATURE OF BENEFITS

Background

In 1997, C commenced a personal superannuation plan.

In November 2002, C asked P to surrender his plan for an amount quoted by P in September 2002. In making this request, C raised a number of matters. This included the assertions that:

- he had been told by the adviser he could withdraw after 2 years;
- the adviser informed him that commission would be paid over the first 2 years;
- P had never sent him documentation for the Plan;
- he had been misled about the performance of the investment funds; and
- all the reports provided by P had falsely implied that a greater rate of return would be achieved than had occurred in practice.

P declined the withdrawal request, because it did not believe there were grounds to release the benefits. The Plan's trust deed required benefits to be locked-in to age 50, with withdrawal before then being confined to a limited number of specified circumstances including; death, permanent emigration from New Zealand, total and permanent disablement, severe financial hardship and if the Trustee allowed the member to transfer to another registered scheme.

C believed he had been badly misled and was seeking a refund of the plan value.

Assessment

There was a considerable amount of conflicting information about what was discussed between C and the adviser. In this situation, the ISO relies on the available documentation. This is because the ISO's investigations are of an informal nature, as opposed to a court where conflicts of evidence can be examined under oath and credibility can be determined.

The proposal completed by C included details of the charging structure for the Plan. This made it clear that charges were not confined to the first 2 years. The Case Manager noted these charges provided a source of funds from which commission could be paid, but the actual commission entitlement would be governed by a separate document between the

adviser and P. The proposal also included an application, signed by C, in which he agreed to be bound by the Plan's trust deed provisions.

On the day after the proposal was completed, the adviser sent C a letter stating he would receive the Plan documentation shortly and that she would contact him again to run through the documentation. An illustration was included with this letter. A copy of the illustration was not available, but a specimen (provided by P from the same time) showed the impact of the charging structure detailed in the proposal and made reference to the limited circumstances in which withdrawals could be made before age 50.

The adviser informed the Case Manager that it was her practice to run through the client's documentation, rather than using specimen documents. If the client had not received the documentation, she would delay the follow-up appointment until the documentation had been received. C said he could recall the adviser coming back and "*running through bits and pieces*", but was adamant he had not received the Plan documentation. On the other hand, P had no record of it being returned as unclaimed and C's address had not altered since the proposal was completed.

Examination of the Plan documentation showed that it provided full details of the charging structure and clearly described the limited circumstances in which benefits could be withdrawn before age 50. The adviser was fully aware of the withdrawal constraints and that P would send documentation direct to C. Consequently, the adviser would not derive any benefit by stating that benefits could be withdrawn after 2 years, because this would only result in cancellation of the Plan under the free-look offer, when the documentation was received by a client.

The Plan documentation included projected illustrative values, which were based on rates prescribed in accordance with the Life Office Association's Code of Business Practices for Life Insurance Companies. Accompanying notes made it clear the investment performance of the funds was not guaranteed. The Case Manager did not believe these could be considered to be misleading. On each anniversary date of the Plan, P sent C updated information about the Plan, including new illustrative values. After considering a variety of factors and, in particular, the limited circumstances in which withdrawals could be made before age 50, the Case Manager did not believe these illustrative values could be considered to be misleading.

Result Complaint not upheld

Insurance & Savings Ombudsman Commission

FINANCIAL STATEMENTS

for the year ended 30 June 2003

STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2003

	Note	This Year	Last Year
Income			
Levies		797,933	735,021
Interest Received		41,488	36,778
Sundry Income		89	–
TOTAL INCOME		**839,510**	**771,799**
Less: Expenditure			
Administration Costs		79,336	76,374
Audit Fees		4,125	4,005
Commissioners' Fees & Expenses		37,928	33,131
Depreciation - Office Equipment		17,219	20,269
Depreciation - Furniture & Fittings		1,746	1,760
Specialist Reports		2,163	249
Legal Fees		–	2,460
Consultancy Fees		19,880	–
Office Review		32,388	–
Office Costs		51,171	52,430
General Staff Expenses		4,205	1,469
Rent	3	67,330	67,330
Scheme Review Fees & Expenses		54,403	–
Salaries		560,482	533,178
TOTAL OPERATING EXPENDITURE		932,376	792,655
Net Surplus/(Deficit) Before Tax		($92,866)	($20,856)
Tax Expense		7,393	6,521
Net Surplus/(Deficit) After Tax		$(100,259)	$(27,377)

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 2003

	Note	This Year	Last Year
Balance at Beginning of Year		431,228	458,605
Net Surplus/(Deficit) After Tax		(100,259)	(27,377)
BALANCE AT END OF YEAR		$330,969	$431,228

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

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2003

	Note	This Year	Last Year
Equity			
Accumulated Funds Account		330,969	431,228
TOTAL EQUITY		$330,969	$431,228
Represented By :			
Current Assets			
Accrued Income		1,368	835
Prepayments		6,646	5,430
Cash & Bank		34,622	37,891
National Bank of N.Z. Term Deposits		300,000	382,658
Income Tax Refund		454	470
G.S.T. Refund		5,855	5,189
TOTAL CURRENT ASSETS		348,945	432,473
Fixed Assets	2	29,096	32,501
Total Assets		378,041	464,974
CURRENT Liabilities			
Accounts Payable		47,072	33,746
TOTAL CURRENT LIABILITIES		47,072	33,746
Total Liabilities		47,072	33,746
Net Assets		$330,969	$431,228

The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on **13 August 2003**

Chairperson: _____ Date: **13.8.03**

Ombudsman: _____ Date: **13.8.03**

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 2003

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 are at 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.

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.

Income Tax:

The income tax expense recognised for the year is determined using tax rules.

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.

CHANGES IN ACCOUNTING POLICIES

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

NOTE 2 – FIXED ASSETS

Plant & Equipment – This Year	Cost Price	Accum.Depn.	Net Value
Office Equipment	157,837	137,875	19,962
Furniture & Fittings	77,322	68,188	9,134
	$235,159	$206,063	$29,096

Plant & Equipment – Last Year	Cost Price	Accum.Depn.	Net Value
Office Equipment	142,277	120,656	21,621
Furniture & Fittings	77,322	66,442	10,880
	$219,599	$187,098	$32,501

NOTE 3 – OPERATING LEASES

Analysis	This Year	Last Year
Current	44,887	67,330
Non-Current	–	44,887
	$44,887	112,217

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 (2002 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 (2002 Nil).

DIRECTORY

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 Wellington Limited, Wellington

Auditors PricewaterhouseCoopers, Wellington

AUDITORS' REPORT

to the Participants in the
Insurance & Savings Ombudsman Scheme

We have audited the financial statements on pages 28 to 31. 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 2003 and its financial position as at that date. This information is stated in accordance with the accounting policies set out on pages 29 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 2003 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 2003 and its financial performance for the year ended on that date.

Our audit was completed on 13 August 2003 and our unqualified opinion is expressed as at that date.

PricewaterhouseCoopers

Chartered Accountants
Wellington

SCHEME PARTICIPANTS

ACE Insurance Limited

Allianz New Zealand Limited

American Home Assurance Company New Zealand Branch

American International Assurance Company (Bermuda) Limited

AMI Insurance Limited

AMP Life Limited

BT Funds Management (NZ) Limited

China Insurance (NZ) Company Limited

CIGNA Life Insurance New Zealand Limited

Club Life Limited

EIG-Ansvar Insurance (New Zealand) Limited

EIG-Ansvar Life Limited

Equitable Life Insurance Company Limited

Farmers' Mutual Insurance Association (Health Insurance)

Farmers' Mutual Insurance Limited (Fire & General Insurance)

Farmers' Mutual Life Limited

Fidelity Life Insurance Company Limited

Hallmark Life Insurance Company Limited t/a GE Insurance Services

Health Service Welfare Society Limited

IAG New Zealand Limited
- State Insurance
- Circle

ING (New Zealand) Limited

IOOF of New Zealand – Friendly Society

Lumley General Insurance (NZ) Limited
- Lumley Services (NZ) 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 New Zealand

The National Mutual Life Association of Australasia Limited t/a AXA New Zealand

New Zealand Insurance Limited
- National Auto Club
- Swann Insurance

Pacific Life Limited

Public Trust

PSIS Limited (Healthcare)

QBE Insurance (International) Limited

Royal & Sun Alliance Insurance (New Zealand) Limited
- AA-GIO Insurance Limited
- AMP General Insurance
- SIS
- Sun CIS
- Sun Direct
- International Marine Insurance Agency (NZ) Ltd

Royal & Sun Alliance Life and Disability (New Zealand) Limited
- Royal & Sun Alliance Retirement Investment (New Zealand)

Royal & Sun Alliance Trust Services Limited

Save and Invest Limited

SIL Mutual Fund

Southern Cross Medical Care Society
- Aetna Health (N.Z.) Limited
- Southern Cross Benefits Limited

Southsure Assurance Limited

Sovereign Assurance Company Limited
- Sovereign Superannuation Funds Ltd
- Sovereign Life Limited
- The Colonial Mutual Life Assurance Society Ltd
- Metropolitan Life Assurance Company of New Zealand Ltd

TOWER Insurance Limited
- Financial Telephone Services

TOWER Health & Life Insurance Limited

TOWER Managed Funds Limited

Union Medical Benefits Society Limited t/a UNIMED

• Denotes subsidiary or associated company or business division.

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