

ISO2004ANNUALREPORT



THE ISO IS AN INDEPENDENT
RESOLVING
& SAVINGS
WHICH



NT SERVICE FOR INSURANCE DISPUTES, IS FREE TO CONSUMERS.

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The ISO Commission continued steady progress this year in implementing recommendations from the 2003 ISO Scheme Review. Simplification of the ISO Scheme's documentation generally, including a new brochure, has greatly aided accessibility for consumers.



MESSAGE FROM CHAIR

There are other recommendations which will require changes to the Rules and Terms of Reference and we are working in a very constructive way with the new ISO Board on this project.

In that regard, we welcome the appointment of David Smith, Managing Director of IAG New Zealand Limited, as Chairman of the ISO Board and as a Member of this Commission. A regular schedule of joint meetings is being established and more clarity developed around the roles and responsibilities of each body. This will greatly assist communication between the 2 bodies and the establishment of good processes to govern the relationship in the future. A closer working relationship will strengthen support for the ISO Commission's work and is a very welcome development.

We also welcome Jo Hutchinson of Sovereign Limited to membership of the ISO Commission. Jo and David replace Paul Fyfe of ING (NZ) Limited and John Balmforth of AMI Insurance Limited on the ISO Commission. We record our thanks to both Paul and John for their contribution to the ISO Commission and, in particular, acknowledge John's additional contribution as Chairman of the ISO Board until 2003. The other members of the ISO Commission are Deborah Rundle and Raewyn Nielsen who represent consumer interests and bring a wealth of experience to bear on our discussions.

An important innovation this year was a meeting in New Zealand of Financial Sector Ombudsmen in July 2003. This was jointly hosted with the Banking Ombudsman and was attended by delegates from the UK, South Africa, Canada and Australia. It was both illuminating as to international practice in this field and helpful in terms of benchmarking our scheme against other similar schemes.

THE PERSON

A challenge for the future is the sustainability of the current form of funding for the ISO Scheme. The ISO Scheme is funded by an annual levy on each Participant, paid to the ISO Commission based on the budget for the financial year.

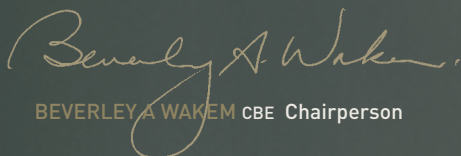
The Rules provide that 75% of the total levy is based on the total number of complaints in the preceding financial year, with the remaining 25% based on a combination of a set fee and an amount based on the gross premium/number of contracts written for each Participant.

This usually means that the biggest companies with the most business pay a larger proportion of the levy. However, it is often the smaller companies, with only one or 2 complaints, which will be more concerned with any increase in the cost per complaint.

The way in which the ISO Scheme is funded will need careful consideration by both the ISO Commission and the ISO Board to ensure fairness and equity for Participants as well as the continuation of a free service to consumers.

Thanks are due to the ISO, Karen Stevens, and her staff who continue to maintain high professional standards in their work combined with a degree of innovation and imagination in developing new and better ways of serving our stakeholders.

And, finally, my thanks to ISO Commission Members for their support throughout the year.


BEVERLEY A WAKEM CBE Chairperson

INSURANCE & SAVINGS OMBUDSMA

This year, I started to wonder whether consumers had stopped making complaints to companies about their insurance and savings. After the severe flooding in the Manawatu and Wellington regions in February, I expected more than a single complaint to eventuate out of well over

10,000

claims – but there was only one.

All in all, we only received 172 complaints for investigation for the year.

N'S REPORT



In last year's Annual Report,

we recorded a 19% increase in the number of complaints received by the ISO Office, nearly 300 complaints in total. While there was no apparent reason for the increase, there is equally no apparent reason for the marked decrease of 41% in the number of new complaints received this year. However, we had 272 complaints for investigation and closed 240 files, leaving 32 files as work in progress – which compares favourably with the last few years.

Last year, I indicated that we would be using a more informal conciliation process in appropriate cases, in order to decrease the time taken to resolve complaints. We have done so, with good results, both at the initial stage and when complaints have been accepted for investigation. However, it must be remembered that, if we are able to resolve complaints at the initial stage, they are not classified as formal complaints and are not included in the levy on Participants for our funding.

The way in which we are approaching complaints management now means that there may be questions raised in respect of funding, where fewer complaints will attract a higher individual cost to the Participants against which the complaints are made. Will this have the effect of a further decrease in complaints? It is for the ISO Board to consider how the ISO Scheme is funded to accommodate all of the work in which the ISO Office is now involved, in addition to resolving formal complaints. I note particularly the number of enquiries received about disputes outside the ISO's jurisdiction: 92 of which were in writing and 345 by telephone.

REVIEW OF ISO SCHEME AND OUTCOME

In the last Annual Report, I referred to the release of the Review Committee's report in March 2003. The ISO Commission supported many of the Review Committee's recommendations and it was my task to ensure that, where possible and without Rule changes, those changes were made by the ISO Office.

In its recommendations, the Review Committee focused on benchmarks for monitoring quality assurance within the ISO Scheme, one of which was accessibility.

ACCESSIBILITY

The Review Committee defined accessibility as *"the scheme makes itself readily available to customers by promoting knowledge of its existence, being easy to use and having no cost barriers"*.

It was easy for the ISO Scheme to comply with that part of the definition referring to “no cost barriers”, because the ISO Scheme is free for consumers. It is more challenging to ensure that, in every respect, the ISO Scheme “*makes itself readily available to customers by promoting knowledge of its existence [and] being easy to use*”. The Review Committee made a number of recommendations in this regard which have been helpful and we have tried to implement them over the last year.

These initiatives include:

1. Brochure

We have introduced a new brochure for the first time in 3 years. Taking into consideration the need for clear and simple language, we developed a new concept for the brochure which is designed to provide important information about making a complaint, contact details and a brief explanation about what we do. I am very pleased with the result and I am also delighted that American International Assurance Company (Bermuda) Limited (“AIA”) has decided to send ISO brochures out to customers with all its new policies. This is a milestone in the creation of a greater public awareness of the ISO Scheme and I encourage all of our Participants to follow AIA’s initiative by providing our brochure to consumers at the earliest opportunity.

2. Our documents

We have changed the introduction in the written Assessment of a complaint, which is sent to each Complainant at the end of a full investigation. Our aim in doing so, was to provide a better explanation of what we can and cannot do. We have included a summary on the front page of the Assessment to tell the Complainant, at a glance, the outcome of our investigation.

We have also changed many of the precedents we use, so that consumers are getting a plain English explanation of the law or insurance principles involved in the complaint.

3. Website

For the first time since 2000, we have undertaken a major revision of the website. Appreciating that there is now a much greater use of the internet for information and communication, the ISO website must provide user friendly information and direct links to the ISO Office and other service providers. To rethink the website, we have had to go through a virtual rebranding exercise, looking at every aspect of how we present ourselves to both consumers and Participants. While not an easy task, it was timely and very necessary.

Next year, with an improved website facility and efficient search engine, I hope the website will include the Casebooks published to date, together with the most up-to-date Casebook. This is part of a longer-term plan to improve the website and access to information about complaints considered by the ISO.

We will also include some information in Maori and other languages on the website, to provide an improved source of information to consumers for whom English may be a second language.

4. Publicity

We have made contact with numerous ethnic publications, asking them to include information about the ISO Scheme. This has been met with a mixed reaction, with some of the publications requiring information of specific relevance to the ethnic group represented. This, of course, is not easy – particularly when all of our case studies are published with identifying details removed to preserve confidentiality.

5. Test Case procedure

The ISO Commission asked Neil Campbell to provide an opinion about how to improve the Test Case procedure (“TCP”) set out in the ISO’s Terms of Reference. Mr Campbell made a number of recommendations to improve the TCP, without compromising the objectives of the ISO Scheme.

Mr Campbell recognised the importance of preserving the ISO Scheme’s accessibility as a free, independent and impartial disputes resolution scheme. At the same time, it was also important to allow a Participant to use the TCP to remove important or novel matters of law to the High Court.

Mr Campbell included a recommendation that a Participant invoking the TCP should commence proceedings in the High Court for a declaration it was entitled to decline the claim, avoid the policy, or terminate the policy. He also included a recommendation that the consumer’s reasonable costs would be met by the Participant.

The ISO Commission agreed to accept Mr Campbell’s recommendations and submit them to the ISO Board, with the Commission’s endorsement.

6. Communication

We are always looking for better ways to communicate with consumers, Participants and other interested parties. Over the last year this has included:

- contributing a chapter to the book *“Insurance Law”* edited by Duncan Webb and David Rowe;
- acting as secretary to the Australian and New Zealand Ombudsman Association (“ANZOA”), formed in May 2003. ANZOA acts as a network for consultation and discussion about areas of interest, concern or common experience by Australian and New Zealand Ombudsman schemes;
- co-hosting, with the Banking Ombudsman, an international Financial Sector Ombudsman Conference in July 2003;
- attending a Financial Ombudsman Service Conference in London in March 2004, to meet and exchange views with more than 100 Ombudsmen from 30 countries;
- attending regular meetings with the Banking Ombudsman and the Electricity Complaints Commissioner, to discuss and improve complaints handling in the 3 New Zealand industry based dispute resolution schemes;
- publishing our fifth Casebook and 3 *“Assessments”* with news, views and recent case studies;

- giving presentations at 24 conferences and seminars; and
- dealing with over 1,800 consumer telephone enquiries, including 345 related to enquiries about disputes outside our jurisdiction.

7. Opportunities

We are continuing to look for other opportunities to publicise the ISO Scheme and urge Participants to provide their customers with information about our service as soon as possible. Some Participants do not give their customers information about the ISO Scheme until a complaint arises or, in some cases, after the complaint has been through the internal disputes process.

However, we suggest that customers are given a copy of our brochure at least as soon as concerns are raised about any product or service provided by the Participant. As a matter of best practice, we recommend that our brochure is provided at the earliest opportunity.

SUPPORT

The ISO Scheme has had another busy and exciting year, under the guidance of the ISO Commission. I would like to thank the ISO Commission and, in particular, the Chairperson of the Commission, Beverley Wakem CBE. The support and independent contribution of the ISO Commission are of great value to the ISO Scheme as a complaints handling organisation.

I would also like to thank my 6 full-time and 3 part-time staff. They continue to be resourceful and innovative, trying to find ways to accommodate the many diverse issues arising in the course of a year. I would particularly like to mention Iain Opray and Lionel Hinton, the team leaders, whose experience is invaluable.

GOALS

I believe we have made significant improvements this year, making it easier for consumers to understand and use the ISO's complaints process. In the coming year, I would like to focus on other ways of promoting the ISO Scheme in the community. This is to ensure that any decrease in complaints is not due to a lack of public awareness about the service provided by the ISO Scheme. I would also like to focus on the ISO's educative role in the industry, to encourage better claims handling which can prevent claims turning into complaints.

We need the industry's support to improve publicity and gain greater consumer awareness about the ISO Scheme. Then we could be more certain that any further decrease in complaints was entirely due to an improvement in companies' internal complaints procedures.



KAREN STEVENS Insurance & Savings Ombudsman



COMPLAINTS SUMMARY

There were 172 complaints received for consideration and 240 complaints resolved in the 2003/2004 financial year, as set out in the tables below.

There were 15 disputes resolved as a result of conciliation before investigation and 1 complaint outside jurisdiction resolved by a formal mediation.

STATUS	2003/2004		2002/2003	
Complaints carried over from previous year and completed	100		63	
Complaints received for investigation	172		290	
Complaints under investigation	272		353	
Complaints completed during the year	240		253	
Complaints for investigation but incomplete at year end	32		100	

RECEIVED BY SECTOR	2003/2004		2002/2003	
Fire and General	106	62%	206	71%
Health	12	7%	7	2%
Life and Savings	54	31%	77	27%
Total	172		290	

OUTCOMES	2003/2004		2002/2003	
Complaints upheld	30	12%	42	17%
Complaints partly upheld	12	5%	19	8%
Complaints settled	17	7%		
Complaints withdrawn	4	2%	6	2%
Complaints not upheld	177	74%	186	73%
Total	240		253	

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 2004,
APPROXIMATELY **\$560,000** 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).

HOW WE GOT OUR MESSAGE INTO THE COMMUNITY IN 2003/2004:

Speeches and presentations: We spoke at 20 seminars and conferences.

Conferences: We co-hosted, with the Banking Ombudsman, an international Financial Sector Ombudsman conference in Wellington.

Seminars for consumer advisers: We co-hosted, with the Banking Ombudsman and Electricity Complaints Commissioner, 4 seminars for consumer advisers, such as citizens advice bureaux and community law centres.

0800 number: We received over 4,400 inward calls on our freephone number 0800 888 202, which provides information in a step down service and a message facility.

Website hits: Over 12,000 people visited www.iombudsman.org.nz (from November 2003).

Telephone enquiries: We dealt with over 1,800 telephone enquiries from consumers.

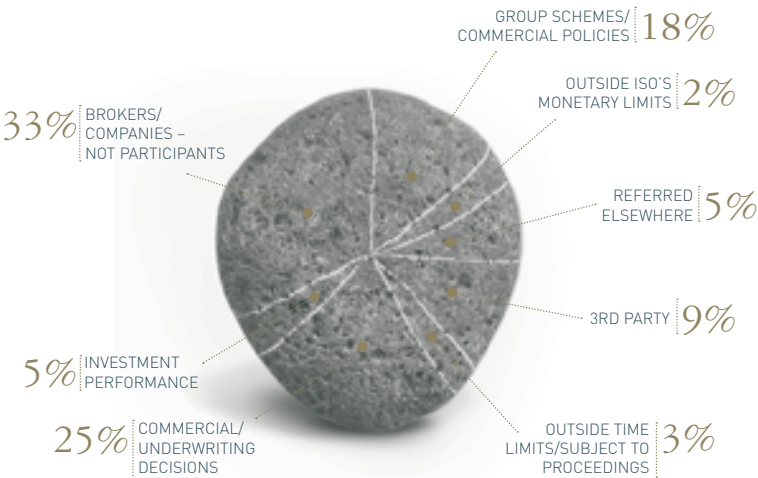
Media enquiries: We handled 11 enquiries from newspapers, journals and TV and gave 2 radio interviews.

Submissions: We made submissions to the Periodic Review Group on retirement savings and to the Law Commission on the regulation of life insurance and life insurance products in New Zealand, particularly in relation to complaints handling.

JURISDICTION

In the 2003/2004 financial year, we received written enquiries about 92 disputes outside jurisdiction, which required consideration and a written response. There were an additional 345 telephone enquiries about disputes outside the ISO's jurisdiction, almost half of which related to third party claims and companies which do not belong to the ISO Scheme.

Disputes received in writing outside ISO's jurisdiction



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

We send out a questionnaire to nearly every consumer who has had a complaint investigated and resolved by the ISO Office. Of about 240 questionnaires sent out this year, 74 were completed and sent back to us. Generally, most consumers appear to believe the ISO Scheme is easy to use and they understand the decisions. It is of concern that over half of the consumers who responded said they did not receive enough information from the companies about their internal complaints handling procedures.

Did you think the ISO's investigation of your complaint was thorough?

Completely/Mostly	72%	<div></div>
Adequate	15%	<div></div>
Some of it/Not at all	9%	<div></div>
No response	4%	<div></div>

How was the Case Manager's communication with you?

Very good/Helpful	77%	<div></div>
Adequate/Could have been better	15%	<div></div>
Unhelpful/Difficult	3%	<div></div>
No response	5%	<div></div>

Did you understand the decision and the reasons for it?

All/Most of it	87%	<div></div>
Some of it	8%	<div></div>
None of it	1%	<div></div>
No response	4%	<div></div>

Was it easy to use the ISO Scheme?

Very Easy/Easy	81%	<div></div>
Adequate/Could have been better	14%	<div></div>
Difficult	4%	<div></div>
No response	1%	<div></div>

How much information did you receive from your insurance or savings company about its internal complaints procedure?

More than enough/Enough	47%	<div></div>
Not enough/None	53%	<div></div>

How much information did you receive from your insurance or savings company about the ISO Scheme?

More than enough/Enough	69%	<div></div>
Not enough/None	28%	<div></div>
No response	3%	<div></div>

POLICY INTERPRETATION

Many complaints relate to the interpretation of policies. Sometimes, it is simply a matter of reading the policy to be able to understand it, without any further assistance being required. In other cases, the words used in the policy can cause difficulty. How do you define a “room”? What does “in transit” mean? When are your children “normally residing” with you to get the benefit of your contents cover? When is someone “totally disabled”? What is “paraplegia”?

We may be able to answer some of these questions quite easily by looking at the policy. But if the policy does not clearly define the words, we may have to make a decision based on any relevant law and what is fair and reasonable in all the circumstances.

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

case study::fire & general

1.

Interpretation –
specific words/expressions,
scope of cover – “room”



Background

In September 1997, C arranged insurance for her contents. In May 2003, C spilt a glass of wine on the formal lounge carpet. C attempted to spot clean the wine stain and an existing carpet stain in the family lounge. Both cleaning attempts were unsuccessful and severely damaged the carpet. C made a claim to P for the damage.

P accepted the claim and advised C that it would replace the carpet in the formal lounge and family lounge.

C did not accept P’s settlement offer. C believed that the formal lounge, family lounge and hall were in effect one room, because she left the double doors open to create an open plan effect. Consequently, C also wanted the hall carpet replaced.

P did not accept C’s argument that the hall, formal lounge and family lounge were one room. P believed it was only required to replace the carpet in the formal lounge and family lounge, because the policy stipulated that it was only liable for replacing carpet in the room(s) in which damage occurred.

There was no dispute that there was a valid claim under the policy for damage to the carpet. What was in dispute was the extent of P's liability. The policy wording stated that, in the event of a claim, P would pay to replace the carpet in the room(s) in which the damage occurred.

C argued that the hall, formal lounge and family lounge could be defined as one room. This was because doorways provided access into the 3 different areas and the dictionary definition of “room” did not refer to the word “door”

15
page

The Case Manager was provided with photographs and a floor plan of the various areas in dispute. Except for the doorways leading into each room, walls provided significant divisions between the hall, formal lounge and family lounge. The Case Manager believed it was clear that the formal lounge was separate from the hall, as was the family lounge from the formal lounge, regardless of whether C chose to leave the double doors open to create an open plan effect. Therefore, the Case Manager was unable to accept C's argument that the hall, family lounge and formal lounge were, in effect, one room.

Result Complaint not upheld

2.

case study::fire & general

Exclusion – Contents,
Scope of cover – “in transit”



Background

In 2000, C arranged insurance for his contents with P. In June 2003, because C was relocating from Wellington to Auckland, he moved out of his house and put some of his contents into his vehicle. The next day, items of C’s contents were stolen from his vehicle while it was parked in a car parking building. C made a claim to P for the loss.

P declined the claim because the contents were “in transit” and, therefore, the loss was not covered by the policy.

C argued that the policy provided cover for the contents “anywhere in New Zealand”. C believed the items had been temporarily removed from the situation and were not “in transit” when they were stolen. In addition, C said some of the items were in his vehicle for reasons other than because he was relocating and he was not driving directly to Auckland, but staying with family on the way.

Assessment

While the policy provided cover for contents “anywhere in New Zealand”, this was subject to the policy exclusions, one of which excluded loss to contents “in transit from one permanent **situation** to another”.

The Case Manager believed that, when C moved out of his house and put the items of contents into his vehicle, the items were “in transit from one permanent **situation** to another”. The items would have remained “in transit”, until C reached another permanent situation and P agreed to provide cover for the contents at the new situation.

While some of the items may have been in C’s vehicle for other reasons and he was not driving directly to Auckland, the items were in C’s vehicle because he was taking them with him to Auckland. Therefore, the items were “in transit”.

Because C had said he put the items in his vehicle and moved out of the house, with the intention of driving to Auckland to relocate 2 days later, the Case Manager did not believe the items had been temporarily removed from the situation. Rather, because C had no intention of returning the items to the house, when he put them in his vehicle, they had been permanently removed from the house.

Accordingly, the Case Manager believed P was entitled to decline the claim on the basis of the policy exclusion.

Result Complaint not upheld

3.

case study::fire & general

Scope of Cover –
“normally residing”



Background

In February 2003, C arranged house and contents insurance with P.

In July 2003, C’s son decided to move into C’s house. During the journey to C’s house, C’s son parked his vehicle and went to visit a friend. When he returned to the vehicle, he found it had been broken into and his personal belongings stolen (“the theft”).

C made a claim to P for the theft. P declined the claim on the basis that C’s son’s personal belongings were not covered by the policy, because he was not living with her at the time of the theft.

C disputed P’s decision arguing that her son was in the process of moving to her house when the theft occurred and he had lived with her for several weeks about 9 months earlier.

Assessment

It is established law that, in the event of a claim, the insured must prove that he/she suffered a loss which falls within the scope of cover provided by the policy.

According to the policy wording, P agreed to provide cover for “...contents you own [and]...contents owned by [your children] while they are living at the house...”. The policy defined the words “you” and “your” as “...[you]...and your children normally residing at the [house]”.

Therefore, C had to prove that her son’s personal belongings were covered by the policy, because he was living at her house when the theft occurred and he normally resided at the house.

On the day of the theft, C’s son was in the process of moving to C’s house. However, he did not arrive at the house until 2 days after the theft, where he stayed for a relatively short period of time. While C’s son had lived at the house for several weeks in July/August 2002, there was no evidence to suggest that C’s son “normally” resided at the house.

Having regard to all the circumstances, the Case Manager did not believe C had proved that her son’s personal belongings were covered by the policy, because C’s son was not living with her at the time of the theft, nor did he normally reside with her. Therefore, P was entitled to decline the claim.

Result Complaint not upheld

4.

case study: life & disability

Interpretation –
Specific words/expressions,
Total Permanent Disablement –
Elements of definition,
Whether totally disabled



Background

In 1993, C made a claim under her income protection insurance policy for the Total Disablement benefit (“the TD benefit”). P accepted the claim and began benefit payments under the policy.

In May 2002, P ceased benefit payments on the basis that C was no longer totally disabled (“TD”) and stated it was clear C was *“now able to return to work in [her] previous occupation”*. C argued she was unable to return to full-time work in her previous position.

Assessment

The policy offered TD and Partial disability (“PD”) benefits. The TD Benefit defined TD as *“the total inability due to illness... to perform Your normal or usual occupation from which You have derived income”*.

P argued C was no longer TD because she:

- no longer suffered from a Mood Disorder or had a Major Depressive Disorder;
- *“no longer had a significant psychiatric impairment that prevents her from working in a light sedentary occupation”*. C was cognitively capable of performing the types of duties she was carrying out before making the claim.
- An occupational assessment of C showed that there was no objective reason why C could not return to her former work and that C was *“medically fit for full time work in light work”*.

In order to qualify for the TD benefit, C had to fulfil the following elements:

1. *“the total inability”* due to the disability
2. to perform her *“normal or usual occupation from which [she] derived income.”*

P argued that C was capable of *“working in a light sedentary occupation”*. However, the policy stated that C must be unable to perform her *“usual occupation”*. Unfortunately, the policy did not define the phrase. However, the courts have addressed this issue in *Duncan v Prudential Assurance Co Ltd* (1999) 10 ANZ Insurance Cases ¶¶61-433. Franklyn J in *Duncan* stated that *“usual occupation”* was that of the insured at the time of the injury.

In the case of *Alessiv National Mutual Life Association of Australasia Ltd* (1982) 2 ANZ Insurance Cases ¶¶60-481, the court considered whether the claimant met the policy requirement that he was unable to follow his own occupation and any other occupation for which he was reasonably suited. The court considered his *“own occupation”* in a narrow sense as a roofing carpenter. The Case Manager believed it was clear that the court in *Alessiv* considered the claimant’s occupation to be more specialised than merely part

	of the carpentry industry. The wider role of a carpenter only became relevant when considering what other type of occupation for which the claimant may have been reasonably suited.
	MacGillivray and Parkington note that Total Disability clauses “ <i>must receive a reasonable construction in relation to their object. If the insurance is limited to accidents wholly disabling the insured from following his usual business or occupation, full effect must be given to the word ‘usual’.</i> ” (MacGillivray & Parkington on Insurance Law (8th ed) Sweet & Maxwell, London, 1988, at paragraph 1806).
	There was no provision within the policy for P to end the TD benefit on the basis that C could work in an alternative occupation. Additionally, there was no requirement that C must also be unable to work in another occupation, for which she was reasonably suited. The policy only made reference to C’s “ <i>usual occupation</i> ”.
	In accordance with <i>Alessi</i> and in order to give full effect to the word “ <i>usual</i> ”, the Case Manager believed that, while C may have been able to work in a variety of clerical and administrative roles, her “ <i>usual occupation</i> ” could not be considered to be wider than her previous occupation as an administration and finance manager.
	The Case Manager did not accept P’s argument that C was clearly both physically and intellectually able to cope with returning to her “ <i>normal or usual occupation</i> .” P’s specialist occupational physician (“P’s specialist”) was asked to consider C’s ability to work “ <i>in a light sedentary occupation like office management...</i> ”, rather than in her “ <i>usual occupation</i> ” of an administration and finance manager.
	In accordance with <i>Butcher v Port</i> (1985) 3 ANZ Insurance Cases ¶¶60-638, any opinion relied upon by an insurer must be formed with reference to sufficient information to enable the specialist to form the relevant opinion. In this case, the Case Manager was not satisfied that the medical opinion from P’s specialist, which was relied upon by P, was in response to the correct questions, based on the policy wording.
	The Case Manager believed P relied upon the suggestion that C was able to work in “ <i>a light sedentary occupation like office management...</i> ” as one of the bases on which to decline the claim. While P argued that C was now capable of full-time work, it had not considered whether, due to the disability, C had “ <i>the total inability</i> ” to perform her “ <i>normal or usual occupation</i> ”.
	As in <i>Edwards v The Hunter Valley Co-op Dairy Co Ltd & Anor</i> (1992) 7 ANZ Insurance Cases ¶¶61-113, the Case Manager believed P had not fully considered the required elements of the policy definition for TD. In the policy, there was a specific requirement to consider whether C had “ <i>the total inability</i> ” due to the disability to perform her “ <i>normal or usual occupation from which [she] derived income</i> ”.

The issue is not whether C was able to return to full-time work but, in order to meet the requirements of the policy definition of TD, C must have the “*total inability*” to perform her “*usual occupation*”. This did not mean C must be able to do her “*usual occupation*” on a full-time basis, but that C was **totally unable** to perform **all** the duties of her “*usual occupation*”.

As the medical evidence provided to the ISO did not address the correct questions, as part of the investigation, the Case Manager asked P's specialist and another occupational specialist ("the independent specialist"), to provide some additional information.

The Case Manager asked P's specialist and the independent specialist ("the specialists") whether or not they believed C had a total inability to perform her usual occupation as an administration and finance manager, with reference to a job description provided by her former employer. The Case Manager asked the specialists to comment on C's ability to do the duties specified in the job description and/or her ability to perform these functions in a reduced capacity.

The specialists confirmed that C was able to return to her previous occupation, even if only in a part-time capacity.

The Case Manager believed that, because C was able to carry out the duties of her usual occupation, even though initially in a reduced capacity, C had not established that she had a **total inability** to perform her usual occupation, in accordance with the policy definition of TD. While C may continue to be unable to work full time, this did not mean that she met the definition of TD.

C also raised the issue of her entitlement to a PD benefit. However, C was not currently working. The definition for the PD benefit required C to “*return to employment*”. The Case Manager advised C that, should she return to work, any claim for PD would have to be referred to P for consideration and, therefore, the Case Manager did not address this issue in the Assessment.

P agreed to pay the TD benefit from the date of the first declinature in May 2002 to the date of the ISO's decision in December 2003. This was on the basis that P's decision to close the claim in May 2002 was on incorrect grounds. It was not until a reasonable decision was made in the Assessment in December 2003, using new medical evidence, that the TD benefit payments could be properly terminated by P, on the basis C no longer met the TD definition.

Result Complaint partly upheld

5.

case study::life & disability

Interpretation –
Specific policy provisions,
Scope of cover – “paraplegia”



Background

In January 1997, C arranged life insurance with P, which included a critical illness benefit. In March 1997, the critical illness benefit was established as a separate policy from the life insurance and a new policy was issued to C (“the critical illness policy”).

In October 2002, C made a claim to P under the critical illness policy, as he was suffering from Spinal Muscular Atrophy (“SMA”).

P declined the claim, on the basis that C’s SMA did not meet any of the critical illness definitions under the policy.

C argued that his SMA met either the “diplegia”, “hemiplegia”, “paraplegia” or “quadriplegia” definitions under the policy.

Assessment

Both the original life insurance policy and the critical illness policy stated that C was only entitled to a critical illness benefit, if he suffered from one of the defined conditions. In March 1997, P provided C with a copy of the critical illness policy. The Case Manager believed that the onus was on C to read the terms and conditions of the critical illness policy and, if he was dissatisfied with the cover provided for critical illnesses, he was able to cancel it.

Therefore, the Case Manager believed it was necessary to determine whether C’s SMA could be considered “diplegia”, “hemiplegia”, “paraplegia” or “quadriplegia” under the definitions in the critical illness policy.

– Diplegia

The critical illness policy defined “diplegia” as “the total loss of function of both sides of the body due to injury or disease...”.

Unfortunately, “function” and “total” were not defined in the critical illness policy. Therefore, the Case Manager adopted a similar approach to that used by the courts and considered the natural and ordinary meaning of the words.

The Concise Oxford Dictionary (8th edition) (“the dictionary”) defines “function” and “total”, as follows:

“function...1...b a mode of action or activity by which a thing fulfils its purpose...

total...1 complete, comprising the whole...”.

On this basis, the Case Manager believed that, in order for C to be entitled to the “*diplegia*” benefit, he must have suffered a permanent, complete loss of action or activity in both sides of his body due to his SMA.

Based on the information provided to the ISO, it appeared that C was still able to walk and use all of his limbs, although this was limited due to his SMA. Therefore, the Case Manager did not believe that C had a “*total loss of function of both sides of the body*” due to his SMA.

– **Hemiplegia**

The critical illness policy defined “*hemiplegia*” as “*the total loss of function of one side of the body due to injury or disease...*”.

Based on the information provided to the ISO, the Case Manager did not believe that C had a complete loss of movement or function in one side of his body.

– **Paraplegia**

The critical illness policy defined “*paraplegia*” as “*the total loss of function of the lower limbs due to spinal cord injury or disease...*”.

C was experiencing significant weakness in his legs and his knees which meant that he was having difficulty with activities such as kneeling and jumping. The lack of strength in C’s legs was also severely limiting his mobility and was going to get worse. However, the Case Manager did not believe that this information supported a finding that C had a “*total loss of function of the lower limbs*” due to his SMA. This is because the information provided to the ISO showed that C was still able to walk and move his legs.

– **Quadriplegia**

The critical illness policy defined “*quadriplegia*” as “*the total loss of function of both upper and lower limbs due to spinal cord injury or disease...*”.

Because the Case Manager did not believe C had a “*total loss of function of the lower limbs*” to be entitled to the “*paraplegia*” benefit, the Case Manager did not believe C met the definition of “*quadriplegia*” under the critical illness policy.

Therefore, the Case Manager believed that P correctly and reasonably applied the terms and conditions of the policy to the claim, in finding that C’s SMA did not meet any of the critical illness policy definitions of “*diplegia*”, “*hemiplegia*”, “*paraplegia*” or “*quadriplegia*”.

The Case Manager concluded that the complaint could not be upheld. However, it was noted C’s SMA was caused by a missing gene and that his condition would progressively deteriorate. As a result, the Case Manager asked P if it would consider making an ex-gratia payment. P subsequently agreed to offer a one-off ex-gratia payment of 20% of the sum insured under the critical illness policy. The complaint was settled on this basis.

Result Complaint settled

FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2004

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DIRECTORY

FOR THE YEAR ENDED 30 JUNE 2004

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

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2004

	NOTE	2004	2003
INCOME			
Levies		968,293	797,933
Interest Received		41,777	41,488
Sundry Income		-	89
TOTAL INCOME		1,010,070	839,510
LESS : EXPENDITURE			
Administration Costs		121,468	100,690
Audit Fees		4,013	4,125
Commissioners' Fees & Expenses		35,035	37,928
Depreciation - Office Equipment		18,710	17,219
Depreciation - Furniture & Fittings		1,746	1,746
Professionals & Consultancy		36,458	37,157
Occupancy		7,618	7,620
Promotion		12,677	7,083
Rent	3	70,150	67,330
Salaries		554,696	560,482
Scheme Review Fees & Expenses		2,652	54,403
Staff Costs		5,828	36,593
TOTAL OPERATING EXPENDITURE		871,051	932,376
NET SURPLUS/(DEFICIT) BEFORE TAX		\$139,019	(\$92,866)
Tax Expense		7,472	7,393
NET SURPLUS/(DEFICIT) AFTER TAX		\$131,547	(\$100,259)

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 2004

	NOTE	2004	2003
Balance at Beginning of Year		330,969	431,228
Net Surplus/(Deficit) After Tax		131,547	(100,259)
BALANCE AT END OF YEAR		\$462,516	\$330,969

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

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2004

	NOTE	2004	2003
EQUITY			
Accumulated Funds Account		462,516	330,969
TOTAL EQUITY		\$462,516	\$330,969
Represented By :			
CURRENT ASSETS			
Accrued Income		1,830	1,368
Prepayments		8,748	6,646
Cash & Bank		185,506	34,622
National Bank of N.Z. Term Deposits		280,000	300,000
Income Tax Refund		585	454
G.S.T. Refund		6,048	5,855
TOTAL CURRENT ASSETS		482,717	348,945
FIXED ASSETS	2	33,807	29,096
TOTAL ASSETS		516,524	378,041
CURRENT LIABILITIES			
Accounts Payable		54,008	47,072
TOTAL CURRENT LIABILITIES		54,008	47,072
TOTAL LIABILITIES		54,008	47,072
NET ASSETS		\$462,516	\$330,969
The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on 17 August 2004.			
Chairperson :		Date : 17.08.04	
Ombudsman:		Date : 17.08.04	

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

NOTES TO THE FINANCIAL STATEMENTS

AS AT 30 JUNE 2004

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.

NOTES TO THE FINANCIAL STATEMENTS

AS AT 30 JUNE 2004

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 - 2004			
Office Equipment	118,668	92,249	26,419
Furniture & Fittings	77,322	69,934	7,388
	\$195,990	\$162,183	\$33,807
Plant & Equipment - 2003			
Office Equipment	157,837	137,875	19,962
Furniture & Fittings	77,322	68,188	9,134
	\$235,159	\$206,063	\$29,096

NOTE 3 - OPERATING LEASE COMMITMENTS

Analysis	2004	2003
Current	75,180	44,887
Non-Current	119,035	-
	\$194,215	\$44,887

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 (2003 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 (2003 Nil).

AUDITORS' REPORT TO THE PARTICIPANTS IN THE INSURANCE & SAVINGS OMBUDSMAN SCHEME

We have audited the financial statements on pages 23 to 27. 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 2004 and its financial position as at that date. This information is stated in accordance with the accounting policies set out on pages 26 to 27.

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 2004 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 2004 and its financial performance for the year ended on that date.

Our audit was completed on 17 August 2004 and our unqualified opinion is expressed as at that date.

The logo for PricewaterhouseCoopers, featuring the company name in a stylized, cursive script.

Chartered Accountants, Wellington

INSURANCE & SAVINGS OMBUDSMAN

SCHEME PARTICIPANTS

AA Insurance Limited • Superannuation Insurance Services	Manchester Unity Friendly Society
ACE Insurance Limited	Medical Insurance Society New Zealand Limited
Allianz New Zealand Limited	Medical Life Assurance Society Limited
American Home Assurance Company (New Zealand Branch)	MFL Mutual Fund
American International Assurance Company (Bermuda) Limited	Mitsui Sumitomo Insurance Company Limited
AMI Insurance Limited	National Mutual Assets Management (New Zealand) Limited t/a AXA New Zealand
AMP Life Limited	The National Mutual Life Association of Australasia Limited t/a AXA New Zealand
Asteron Life Limited • Asteron Retirement Investment Limited	Pacific Life Limited
Asteron Trust Services Limited	PSIS Limited (Health Care)
BT Funds Management (NZ) Limited	Public Trust
China Insurance (NZ) Company Limited	SAI Life Limited
CIGNA Life Insurance New Zealand Limited	SIL Mutual Fund
EIG-Ansvar Limited	Southern Cross Benefits Limited (Travel)
Equitable Life Insurance Company Limited	Southern Cross Medical Care Society
Farmers' Mutual Insurance Association • Farmers' Mutual Insurance Limited	Southsure Assurance Limited
Farmers' Mutual Life Limited	Sovereign Assurance Company Limited • Sovereign Superannuation Funds Limited • The Colonial Mutual Life Assurance Society Limited
Fidelity Life Assurance Company Limited	TOWER Health & Life Limited
Hallmark Life Insurance Company Ltd t/a GE Insurance Services	TOWER Insurance Limited
Health Service Welfare Society Limited	TOWER Managed Funds Limited
I.O.O.F of New Zealand – Friendly Society	Union Medical Benefits Society Limited t/a UNIMED
IAG New Zealand Limited • National Auto Club Underwriters Agency (NZ) Limited • Swann Insurance (Australia) Pty Limited	Vero Insurance New Zealand Limited • AMP General Insurance • Mariner Underwriters Limited • Vero Marine Insurance Limited
ING (New Zealand) Limited	• Denotes subsidiary or associated company or business division
ING Life (NZ) Limited	
Lumley General Insurance (N.Z.) Limited • Lumley Services (NZ) Limited	



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