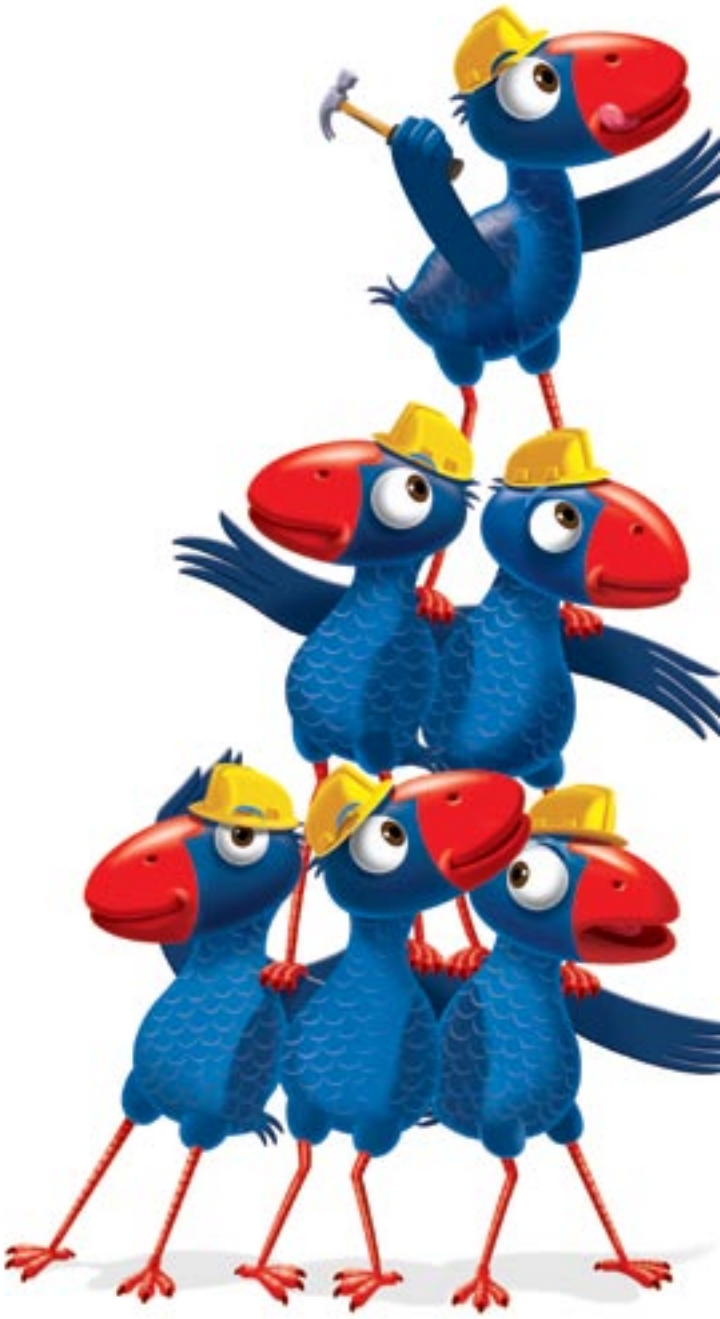
BEST PRACTICE GROWS CONSUMER CONFIDENCE

THE INSURANCE & SAVINGS OMBUDSMAN

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



"The Case Manager was extremely helpful, considerate and explained things in terms easily understood. Impressed with her skills and ability to handle a difficult case."

"The Case Manager was able to successfully mediate a settlement between the insurance company and myself without having to carry out a full investigation of my case."

The Assessment of my client's claim was complete and thorough. The Case Manager left no stone unturned!!"

Building on best practice principles

- Increased Customer Awareness ☑
- Greater Consumer Confidence ☑
- Accessibility ☑
- Fairness ☑
- Efficiency ☑
- Independence ☑
- Accountability ☑
- Effectiveness ☑
- Visibility ☑
- Transparency ☑
- Responsiveness ☑
- Objectivity ☑
- Confidentiality ☑
- Customer Focused ☑
- Continual improvement ☑
- Commitment ☑
- Responsibility + Authority ☑
- Investigation of complaints ☑
- Response to complaints ☑
- Communicating the response ☑
- Satisfaction ☑
- Effective + Efficient complaints handling ☑
- Enhanced Customer Satisfaction ☑
- Customer Focused Environment ☑
- Recognising Expectations of Complainants ☑
- Easy-to-use complaints process ☑
- Accessible Information ☑
- Flexibility ☑

2006 CONTENTS

COMMENTS FROM THE

THE ANNUAL REPORT GIVES ME THE OPPORTUNITY TO FORMALLY THANK MY COLLEAGUES ON THE ISO COMMISSION FOR THEIR CONTRIBUTION TO THE GOVERNANCE OF THE ISO SCHEME AND THE ISO AND HER STAFF, FOR THEIR PROFESSIONALISM AND COMMITMENT TO THE OPERATION OF THE ISO SCHEME.

I am fortunate in having extremely able and knowledgeable colleagues on the ISO Commission and, despite changes of personnel, the ISO Commission has continued to function effectively in providing governance oversight to the ISO Scheme.

During the 2005/2006 financial year, our 2 industry representatives, David Smith and Jo Hutchinson, resigned from the ISO Commission as a result of changes in their professional lives. Both were strong champions of the ISO Scheme. While a permanent replacement for David has still to be finalised, representatives of the Insurance Council have made themselves available to attend meetings and have provided ongoing advice and support which has been very valuable. Jo Hutchinson's position has been very ably filled by Dr Ian McPherson, who has also taken up the role of Chairman of the ISO Board.

The crossover of representation on the ISO Commission and the ISO Board enables good communication between the 2 bodies and a collegial approach to discussing and resolving issues in respect of the ISO Scheme.

An example of this collegiality was the agreement of all parties to adopt a new funding formula which will come into effect for the 2006/2007 financial year. The new formula provides for 60% of the levy on Participants to be calculated on the basis of gross

CHAIR

written premium and contracts written and 40% on the basis of the previous year's investigated complaints. This formula results in a more equitable levy spread among Participants and better reflects the totality of the work of the ISO Office.

The ISO continues to carry out a heavy schedule of speaking engagements, interviews and presentations. She participated in the International Financial Ombudsmen Conference in Toronto in September 2005 and has continued to be involved in ANZOA – the Australian and New Zealand Ombudsman Association. These activities reflect important aspects of the ISO Scheme; to increase awareness of and education about the ISO Scheme, to ensure the highest standards in its operation, and to foster sound working relationships among the parties.

As we continue into our second decade, there are further changes and challenges upon the horizon. We will farewell our 2 consumer representatives during the year, and welcome 2 new ones. Arising from the Financial Intermediaries Task Force, consideration is being given to a disputes resolution framework for financial intermediaries. The ISO and the ISO Commission expect to be involved in these discussions and we await the release by the Ministry of Economic Development of the discussion paper. Our next review is due in early 2008 and planning for this will start this year.

Looking back over the year, it has been a year of consolidation and continuation of operational activity as well as progress on major issues. The ISO Office continues to be well managed and is well regarded by Participants and consumers alike. The ISO Commission looks forward to a busy and productive year in 2006/2007.

Alison Timms Chairperson, Insurance & Savings Ombudsman Commission

INSURANCE & SAVINGS OMBUDSMAN'S

THE ISO SCHEME WAS ESTABLISHED TO HANDLE COMPLAINTS FROM CONSUMERS AGAINST INSURANCE AND SAVINGS COMPANIES AND, IN THE LAST YEAR, WE RECEIVED 1,810 COMPLAINT ENQUIRIES AND 191 COMPLAINTS FOR INVESTIGATION.

While our primary focus is on resolving complaints, we are also focused on improving complaints handling in the industry. We do this by publishing all of our investigated complaints as case studies on our website; speaking to industry groups at conferences and seminars; responding to media enquiries; and working with industry where process problems have developed, to ensure changes are made. We also work with consumer groups and government, to publicise the process as widely as possible.

There is no recognised standard for complaints handling in New Zealand – not because there is no need for one, simply because one does not currently exist. We look for guidance to the Australian Standard: *"Customer Satisfaction – Guidelines for complaints handling in organizations (ISO 10002:2004, MOD)"*, the newest version of the standard which was released in May 2006.

This International Standard is designed to improve customer satisfaction, by assisting organisations to design and implement an efficient and effective complaints handling process. Ultimately, the goal is to improve consumer confidence in the particular industry.

REPORT

According to the introduction of the International Standard, *"the handling of complaints through a process as described in this International Standard can enhance customer satisfaction. Encouraging customer feedback, including complaints if customers are not satisfied, can offer opportunities to maintain or enhance customer loyalty and approval, and improve domestic and international competitiveness.*

Implementation of the process described in this International Standard can:

- *provide a complainant with access to an open and responsive complaints-handling process,*
- *enhance the ability of the organization to resolve complaints in a consistent, systematic and responsive manner, to the satisfaction of the complainant and the organization,*
- *enhance the ability of an organization to identify trends and eliminate causes of complaints, and improve the organization's operations,*
- *help an organization create a customer-focused approach to resolving complaints, and encourage personnel to improve their skills in working with customers, and*
- *provide a basis for continual review and analysis of the complaints-handling process, the resolution of complaints, and process improvements made*

Organizations may wish to use the complaints-handling process in conjunction with customer satisfaction codes of conduct and external dispute resolution processes."

It has been 5 years since we considered the obligation of ISO Scheme Participants to publish details of the ISO Scheme to their customers and referred to Best Practice Standards imposed by statute in the UK (2001 Annual Report).

I BELIEVE IT IS TIMELY FOR ME TO REFER TO BEST PRACTICE AGAIN, BECAUSE OF THE CURRENT WORK BEING DONE BY THE MINISTRY OF ECONOMIC DEVELOPMENT AND THE MINISTRY OF CONSUMER AFFAIRS. LEGISLATION IS EXPECTED TO PROVIDE FOR CONSUMER DISPUTES RESOLUTION.

The empirical evidence collected by the ISO Scheme through complaint questionnaires indicates that, this year, only 30% of those Complainants who responded thought they had received enough information from the Participant about its own internal complaints process and about 45% thought they had received enough information about the ISO Scheme.

In order to build consumer confidence in an industry, the industry (and organisations within that industry) must deal with complaints through a process which is accessible and easy-to-use. The needs and expectations of Complainants must be recognised and addressed. Feedback is to be encouraged. Senior management should be involved and committed to the process, ensuring accountability and improvement. Having a complaints handling process and not telling consumers about it, does not inspire confidence in the process.

Some Participants have well established complaints handling processes and tell customers about them in a standard brochure. They have also nominated specific individuals within the organisation, who have the responsibility of ensuring complaints are handled in accordance with the established process and information is properly and regularly communicated to the customer throughout the process.

With some other organisations, the process, such as it is, is a little less structured, a bit less customer focused and, altogether, more haphazard in approach.

For the first time this year, we surveyed Participants to get their feedback about the ISO Scheme, in the same way as we canvass Complainants. On the positive side, of the Participants which responded, 95% believed that information about the ISO Scheme was easy to access and that it was a better alternative than going to court.

However, in response to questions about publicity, the majority of Participants said they inform a customer about their own internal complaints process when the customer makes a complaint, or if the customer asks about it. About the same number of Participants said they only tell customers about the ISO Scheme when they have reached *"deadlock"*, at the end of their own process, or if a customer asks if there is any external process they can use.

Using the International Standard as a guide, it is clear that the visibility and accessibility of a complaints handling process is essential; customers should know about it and how to use it, otherwise it is not going to achieve the purpose of enhancing consumer confidence in the organisation, or the industry. To use an old adage *"if you've got it ... flaunt it!"*.

The complaints process should represent and promote the ideals and aspirations of the organisation.

The insurance and savings industry's continued support for the ISO Scheme indicates that the industry acknowledges the value of an external dispute resolution scheme, for its customers. We do know the ISO Scheme could be used more often by Participants and, with the funding formula change introduced to determine levies for the coming year, we hope that will be the case.

I would like to thank my staff and, in particular Lionel Hinton and Iain Opray, without whom many more complaints about insurance and savings would remain *"deadlocked"*.

I would also like to thank the ISO Commission – the Members' contribution and support is much appreciated.

Finally, I look forward to working with the insurance and savings industry in the year to come because, by providing better complaints processes, consumer confidence in the industry will continue to grow.

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

WHAT COMPLAINTS CAN WE HELP WITH?

COMPLAINTS ABOUT...

- ✓ house, contents, vehicle, travel and health insurance
- ✓ income protection, mortgage protection, critical illness cover, life insurance and superannuation
- ✓ claims up to $150,000, or $1,000 per week unless the insurer agrees to a higher amount
- ✓ the cover provided by your policy
- ✓ claims made by, or on behalf of, the policy holder
- ✓ the amount payable under a claim
- ✓ small business claims

BUT NOT COMPLAINTS ABOUT...

- ✗ awards of compensation or damages
- ✗ commercial insurance, except small business claims
- ✗ third party or uninsured losses
- ✗ premiums, charges, excesses, returns, underwriting decisions
- ✗ financial advisors and brokers

HOW WE GOT OUR MESSAGE INTO THE COMMUNITY

IN 2005/2006

SPEECHES AND PRESENTATIONS: We spoke at 29 seminars and conferences.

SEMINARS FOR CONSUMER ADVISERS: We co-hosted, with the Banking Ombudsman and the Electricity and Gas Complaints Commissioner, 3 seminars for consumer advisers, including Citizens Advice Bureaux, Community Law Centres and Budget Advisers.

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

WEBSITE SESSIONS: Over 46,000 people visited www.iombudsman.org.nz

COMPLAINT ENQUIRIES: We dealt with 1,473 telephone and 337 written complaint enquiries from consumers.

MEDIA ENQUIRIES: We handled 12 requests for information from newspapers, journals and TV and gave 3 radio interviews and 1 TV interview.

SUBMISSIONS: We made submissions in response to the Ministry of Economic Development on the Securities Legislation Bill Regulations, the Ministry of Consumer Affairs on Industry-led Regulation, the review of the Banking Ombudsman Scheme and the Finance and Expenditure Committee review of the KiwiSaver Bill.

GOVERNMENT ADVISORY GROUPS: We were involved in the Insurance Advisory Group for the Ministry of Economic Development's Review of Financial Products and Providers.

"The way the Case Manager handled my case and communicated to me was exemplary in all respects."

COMPLAINTS SUMMARY

There were 1,810 complaint enquiries (337 in writing), 191 complaints received for investigation and 173 complaints resolved in the 2005/2006 financial year, as set out in the tables below. There were 38 complaints resolved, as a result of conciliation, before investigation.

STATUS	2005/06	2004/05
Complaints carried over from previous year and completed	21	32
Complaints received for investigation	191	167
Complaints under investigation	212	199
Complaints completed during the year	173	178
Complaints for investigation but incomplete at year end	39	21

RECEIVED BY SECTOR	2005/06		2004/05	
Fire and General	109	57%	97	58%
Health	24	13%	26	16%
Life and Savings	58	30%	44	26%
TOTAL	**191**		**167**	

OUTCOMES	2005/06		2004/05	
Complaints upheld	25	15%	36	20%
Complaints partly upheld	5	3%	6	3%
Complaints settled	12	6%	17	10%
Complaints withdrawn	–		–	
Complaints not upheld	131	76%	119	67%
TOTAL	**173**		**178**	

A COMPLAINT ENQUIRY can be made by telephone or in writing and can relate to any aspect of an insurance or savings complaint, before it has been through the company's internal complaints procedure.

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 2006, APPROXIMATELY $491,000 WAS PAID BY THE COMPANIES TO CONSUMERS WHO HAD THEIR COMPLAINTS CONSIDERED BY THE ISO (NOT INCLUDING WEEKLY DISABILITY BENEFIT PAYMENTS UNDER INCOME PROTECTION, SUPERANNUATION OR LIFE POLICIES). IN ADDITION, THERE WERE 7 COMPLAINTS FOR WHICH A DECISION WAS MADE IN FAVOUR OF THE CONSUMER, BUT THE AMOUNT TO BE PAID HAD NOT BEEN FINALISED WHEN THE ISO FILE WAS CLOSED.

TIMELINESS

For the 173 investigated complaints closed in the year ending 30 June 2006, the average time taken to close them was 68 days.

CONTINUED...

JURISDICTION

In the 2005/2006 financial year, we received written enquiries about 88 disputes outside jurisdiction, which required consideration and a written response. We also received more than 300 telephone enquiries about disputes outside the ISO's jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO'S JURISDICTION

Commercial/underwriting decision	28%
Brokers/company not Participant	26%
Not defined service	19%
3rd party	18%
No remedy available	4%
Investment performance	2%
Outside time limits	1%
Subject other/previous proceedings	1%
Outside ISO's monetary limits	1%

TERMS OF REFERENCE AND RULES

Rule 10

There has been a change to the funding formula and how the levies will be calculated from 1 July 2006. The ISO Board agreed to levy Participants on a share of 40%, based on a number of complaints in the previous year; and a share of 60%, based on the size of the Participant's business.

Rule 22

Based on a recommendation made by the Review Committee in its 2003 report, the ISO Commission can now appoint such person/s as it thinks fit to independently review the ISO Scheme. The next review will be in 2008.

Paragraph 3, Terms of Reference

From 1 January 2006, the ISO has been able to consider a complaint about a claim relating to disability insurance, which provides for weekly payments of up to $1,000 (or more, if the Participant agrees).

HOW DO PEOPLE RATE US?

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

Questionnaires are sent to consumers when their complaints have been investigated by the ISO. They provide the ISO with important feedback about the consumers' perceived effectiveness of the ISO Scheme's process and the amount and quality of information provided by the Participants. We continue to monitor the ISO Scheme's process and to evaluate our performance.

Of the 173 questionnaires sent out, 49 were completed and returned. About half of those consumers who returned the questionnaires, did not have their complaints upheld. Despite this, most consumers felt the Case Managers investigated all the issues and clearly explained the reasons for the decisions. It is very encouraging that about 90% of the consumers who responded believed the ISO Scheme was easy to use.

THE ISO KEPT YOU WELL INFORMED ABOUT PROGRESS ON YOUR COMPLAINT

Don't know/Disagree	8.2%
Neutral	12.2%
Agree	79.6%

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

Don't know/Disagree	2%
Neutral	10.2%
Agree	87.8%

THE ISO'S SERVICE IS EASY TO USE

Don't know/Disagree	0%
Neutral	10.2%
Agree	89.8%

CONTINUED...

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

Don't know/Disagree	18.4%
Neutral	10.2%
Agree	71.4%

THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME

Don't know/Disagree	14.3%
Neutral	14.3%
Agree	71.4%

INFORMATION PROVIDED BY PARTICIPANTS

Don't know	4.1%	
	8.2%	
Disagree	32.6%	
	42.8%	
Neutral	18.4%	
	18.4%	
Agree	44.9%	
	30.6%	

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

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

"I would like to thank you for all your hard work. I didn't realise there was such a thing as an Ombudsman to deal with this. You were very positive which gave me hope that I was on the right track. Just to know there is someone to go to for help."

CASE STUDIES

IN THE CASE STUDIES, C = COMPLAINANT/CONSUMER AND P = PARTICIPANT/COMPANY.

1 NON-DISCLOSURE - MODIFICATIONS, CRIMINAL CONVICTIONS

Background

In March 2005, C and his wife completed a proposal for vehicle insurance with P by telephone. In April 2005, C's work colleague, ("B"), took the vehicle for a drive without C's permission and had an accident. C made a claim to P for the vehicle.

P avoided the policy and declined to consider the claim, on the basis that C had not fully disclosed the significant modifications to the vehicle and B's conviction for sexual violation.

Assessment

Disclosure of modifications

P believed C and his wife breached their duty of disclosure, because they did not disclose the full extent of the modifications. The modifications to the vehicle included the following:

- 6 point roll cage
- $600 lead filter
- 5 speed race preparation box including clutch
- Konis
- Rebuilt Bathurst differential
- New exhaust, tuned custom extractors

At common law, the duty of disclosure is satisfied if the insured discloses sufficient information to put the insurer on enquiry, provided that what is conveyed fairly indicates to the insurer there is more information to be obtained, if it chooses to ask for it.

Because P relied, in part, on the non-disclosure of the modifications to avoid the policy, the Case Manager had to consider whether P was put on notice to make further enquiries about the modifications, before deciding whether to offer terms.

When C arranged the policy, he disclosed the following material information:

1. *"... a small upgrade and stuff like that to the engine* ***and everything else****"* (Case Manager's emphasis);
2. $30,000 had been spent on a vehicle worth $15,000;
3. it was a collectable car;
4. it had $4,000 Simmons wheels; and
5. it would be registered.

The Case Manager believed C and his wife had provided sufficient information to put P on notice that the vehicle had been extensively modified and P should have made further enquiries.

To determine whether the information provided was sufficient to put P on notice to make further enquiries, the Case Manager presented this fact situation (with identifying details omitted) to 2 prudent underwriters and asked how this information would have affected the insurer's decision to insure.

Both underwriters said they would have requested further information about the extent of the modifications.

Having regard to the underwriters' opinions and the experience of this Office, the Case Manager believed C and his wife provided P with sufficient information to put it on enquiry about the modifications. Because P did not make further enquiries about the extent of the modifications, the Case Manager did not believe P was entitled to rely on the non-disclosure of the modifications to avoid the policy.

Materiality of B's criminal conviction

Because B was entitled to reposition the vehicle within the car lot, P believed B should have been listed as a regular driver and, therefore, his criminal conviction for sexual violation should also have been disclosed.

Even if C and his wife were required to disclose B as a regular driver and his criminal conviction, P could only avoid the policy if the information was material. A fact is material if it would influence the mind of a prudent insurer in deciding whether or not to accept a proposal for insurance and, if so, on what terms. Whether a particular fact is material depends upon the circumstances of the case and is a question of fact. The onus of proof of materiality is on the insurer.

The Case Manager sought the opinions of 2 prudent underwriters to obtain their views on the materiality of B's criminal conviction.

Both underwriters commented that B's criminal conviction was of a low risk when underwriting the policy. They said that, even if B had to drive the vehicle on the road to reposition the vehicle, it would not affect their decisions to insure.

Having regard to the underwriters' opinions and the experience of this Office, the Case Manager did not believe that, in the circumstances, B's criminal conviction was material to the risk. On this basis, the Case Manager did not believe P was entitled to avoid the policy.

Result *Complaint upheld*

2 REASONABLE CARE

Background

On 28 September 2005, C and her 25-year-old daughter, S, arranged travel insurance with P, for return travel to the USA to attend a wedding. Cover, in their joint names, was provided for the period 8 - 24 October 2005.

On 24 October 2005, during a short stopover at Sydney Airport, C forgot to pick up her handbag ("the bag") after resting on a seat outside the bathrooms and, when she and S returned a few moments later, the bag was gone. C and S made enquiries with lost property and with the airport security and then reported the loss to the police. The bag contained a wallet and cash, plus a number of items of S's jewellery.

C made a claim to P for the bag and its contents. P wrote to C and advised the claim was declined, because there was no cover under the policy. The letter did not provide specific reasons for declining the claim, but referred to the following policy exclusions:

> *"We will not pay for any claims arising directly or indirectly from:*
>
> *(a) The loss, theft or damage of personal effects, money or documents:*
>
> *1. due to Your failure to take due care and precautions to safeguard Your property;* ["the duty of care exclusion"] *or...*
>
> *(b) Personal effects, money or documents merely mislaid or forgotten, including left in hotel or other accommodation rooms"* ["the merely negligent exclusion"].

C made representations to P that she had taken *"due care and precautions"* and forgetting the bag for a matter of seconds, could have happened to anyone. P again wrote to C confirming the original decision and commented that *"leaving your handbag on a seat in a public place does not demonstrate reasonable care."* C would still not accept P's decision and asked for a further review of the claim. P's senior manager wrote to C, confirming the original decision and also commented that C had *"not demonstrated reasonable care"*. He referred to the police report, which recorded that the loss that occurred between 7.15 and 7.25am. He believed this conflicted with C's comment about the loss occurring in a *"matter of seconds"*.

Assessment

After discussing the complaint with C, the Case Manager established that C and S had just arrived in Sydney off a flight from Los Angeles. They placed their luggage in lockers, S went to the bathroom and C waited for her on a seat outside, before they went to have breakfast. They had only moved about

7-8 metres away from the seat, when S exclaimed *"Mum, where's your bag?"*. C and S rushed back to the seat, but found the bag had gone. They walked up and down hoping to see something, checked with lost property and airport security and then went to the police.

Because they could not remember the precise time they had left the seat, C and S told the police it could have been between 7.15 and 7.25 am. This did not mean they were away from the seat for 10 minutes before discovering the loss.

The Case Manager concluded C had been careless and negligent, but not grossly careless, grossly negligent or reckless, which was what P had to prove at law, before it was entitled to decline the claim on the basis that C had failed to exercise reasonable care.

The Case Manager then considered the application of the merely negligent exclusion, which was only referred to in P's first letter to C. The ISO would have been very concerned if P had continued to rely on the merely negligent exclusion, for the following reasons:

- legally, unusual or onerous clauses in a policy must be specifically drawn to the attention of the policyholder, or they will have no effect;
- the merely negligent exclusion appeared to conflict with the intention of the policy, which stated, as follows:

  "Important - Please Read!...
  The spirit and intent of this policy is to cover you for unexpected events ... ".
- while P encouraged its policyholders to read the policy, it was unlikely a policyholder would appreciate the onerous nature of the merely negligent exclusion; and
- insurers are entitled to apply restrictive clauses to their policies. However, we believe Neazor J's comments in *MMI Insurance (NZ) Limited v PD Davies Limited* (7 May 1998) unreported, High Court, Napier Registry, AP 1/98, 5, are very pertinent:

  " ... that such a clause has to be construed in a way that is not repugnant to the commercial objectives of the policy which include protection of the insured, inter alia, against [his / her] *own negligence".*

Notwithstanding these comments, even if C's attention had been specifically drawn to the merely negligent exclusion, the Case Manager did not believe it would apply to the claim. He believed the words "merely mislaid or forgotten" imply a vagueness or uncertainty about a loss, or a loss occurring over a longer timeframe, which would not apply to the facts in this case.

Result *Complaint upheld*

3 TOTAL DISABLEMENT

Background

In February 2000, C took life, disability income and waiver of premium cover with P.

On 15 July 2005, C's husband advised P his wife had injured her knee while riding a bicycle in 2002, she had stopped work because of chronic pain two months earlier and had claimed on ACC.

In September 2005, C claimed the disability income benefit as she had stopped work because of an acute ACL rupture of her left knee.

After considering the claim and, in particular, a report from an occupational physician who had reviewed C for ACC, P declined the claim on the grounds that C had *"a work capacity"* and so did not meet the policy's Total Disability ("TD") criteria.

C complained to the ISO that both her orthopaedic surgeon and ACC believed she was unfit for work until she had further treatment and rehabilitation and she was totally disabled in terms of the policy.

Assessment

P relied on the occupational physician's report and, in particular, his comment that C had *"work capacity"*, in order to decline the claim.

In accordance with *Edwards v The Hunter Valley Co-Op Dairy Co Ltd & Anor* (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 was *"so seriously incapacitated by ... injury that* [she was] *unable to follow the occupation or carry on the business which* [she was] *involved in before the* disablement date *for more than 10 hours per week".*

C's occupation, in which she was involved before her disablement, was as a cardio-thoracic registrar, the tasks of which were considered by the occupational physician. The occupational physician stated that theatre work comprised 60% of C's duties, ward rounds 20% and administration 20%. The major part of C's work time was spent on her feet. The occupational physician stated C would *"not manage roles ... in acute on-call work ... assisting in the theatre ... or lifting significant load as part of her work tasks".* The occupational physician stated, in effect, that C could not manage more than 20 - 40% of the work duties of a cardio-thoracic registrar.

The occupational physician also reported that C had *"work capacity"*. He stated C could work in out-patient clinics and perform administrative tasks. However, as in the *Edwards* case, a claim may be wrongly refused on that basis, because of the insurer's failure to properly consider the specific terms of the policy.

In *Mercantile Mutual v Selikas* [2000] NSWCA 331, Mr Selikas was an electrical contractor who, in addition to physical and manual duties as an electrician, carried out the administrative and managerial duties of his business. He suffered an injury, which rendered him unable to carry out his physical and manual duties. However, it did not impact on Mr Selikas's ability to continue carrying out his administrative and managerial duties. The Court held that the requisite inability, for the purposes of the relevant TD definition, was an inability to engage in the usual occupation at any sensible or realistic level, even if there was an ability to perform some of the normal duties of that occupation.

While P's Medical Adviser relied on the occupational physician's report to form the opinion that C was *"fit for some of the duties of her job"*, the legal test in *Selikas* is based on a consideration of the insured's ability to perform all the duties of his/her usual occupation at a reduced level. The work C could no longer do formed between 60 - 80% of her usual workload as a cardio-thoracic registrar.

Had P considered the correct question of whether C was able to *"follow the occupation or carry on the business"* of a cardio-thoracic registrar, it would not have had a sufficient basis on which to decline the claim.

In accordance with *Edwards*, because P was obliged, under the policy, to form its opinion about the impact of C's illness on her ability to work as a cardio-thoracic registrar and failed to do so, the Case Manager was able to determine whether C's illness meant she was unable to perform the duties of her usual occupation.

Having regard to all the information provided, the Case Manager did not believe C was able to *"follow the occupation or carry on the business"* of a cardio-thoracic registrar at a sensible or realistic level. Therefore, the Case Manager believed C was *"so seriously incapacitated by illness or injury that* [she was] *unable to follow the occupation or carry on the business which* [she was] *involved in before the* disablement date *for more than 10 hours per week"*.

On the basis of the occupational physician's report, C was TD in terms of the policy and P was obliged to consider the claim.

Result *Complaint upheld*

4 PRE-EXISTING CONDITION

Background

In January 2005, C visited an O & G Consultant, for *"problems with irregular periods"* and *"deep dyspareunia"*. The Consultant suspected C was suffering from endometriosis and suggested she undergo a laparoscopy.

The following day, C applied for health insurance with P. P accepted C's application and cover commenced immediately.

In March 2005, C underwent a laparoscopy and an endometriotic lesion was removed. C made a claim to P for the hospital and disability benefits under the policy.

P declined the claim, on the basis that symptoms of her condition were evident prior to the policy's commencement.

C argued that, because the Consultant had said the endometriosis was not *"a pre-existing condition"*, P was required to meet the claim.

Assessment

In accordance with the terms of the policy, P was not liable to pay for any loss, which was the result of a *"Pre-existing Sickness"*. *"Pre-existing Sickness"* was defined as:

- An illness or disease for which C received medical advice or treatment within 24 months prior to the policy commencement date ("the first limb of the definition"); or
- symptoms of an illness or disease, which were evident within 24 months prior to the policy commencement date, that would have caused an ordinarily prudent person to seek medical advice or treatment ("the second limb of the definition").

On the claim form, the Consultant said C had been suffering from "[p]*ain abdomen / Dyspareunia ... Endometriosis"* and the symptoms had first appeared about 6 months prior to the claim.

The medical information indicated C suffered from symptoms of endometriosis prior to the policy's commencement. Because she visited the Consultant for these symptoms, the Case Manager believed they *"would have caused an ordinarily prudent person to seek medical advice and treatment"*. Therefore, in accordance with the second limb of the definition, the endometriosis was a *"Pre-existing Sickness"* and, because loss arising from a *"Pre-existing Sickness"* was excluded, P was not liable to meet the claim.

C argued that the endometriosis was not a *"Pre-existing Sickness"* because, in a letter to P, the Consultant said as follows:

> *"... The finding of endometriosis was fairly coincidental based on* [C's] *symptoms of dyspareunia and hence it cannot be deemed as a pre-existing condition in my view.* [C] *was not aware of it."*

Whether or not a particular illness or disease is a *"Pre-existing Sickness"* (and, therefore, excluded) had to be determined by reference to the policy definition of *"Pre-existing Sickness"*.

In accordance with the policy, for P to decline the claim, it was not necessary for C to know she suffered from endometriosis prior to the policy commencement date. In addition, merely because the Consultant said, *"in* [his] *view"*, the endometriosis was not a *"pre-existing condition"*, did not prove the endometriosis was not a *"Pre-existing Sickness"* as defined in the policy.

Result *Complaint not upheld*

5 ILLUSTRATIONS, SURRENDER VALUE

Background

In 1990, C arranged whole of life policies for his 3 children.

In 2004, C enquired about the surrender values of 2 of the policies and found the values were approximately 56% of the illustrative surrender values provided in 1990, after 15 years.

In August 2005, the 2 policies were surrendered for amounts offered by P. However, C was not satisfied with the explanations offered by P about why the surrender values were so much lower than the illustrative values provided in 1990 and referred the matter to the ISO.

Assessment

C advised the Case Manager that his original intention had been to pass the policies to his children when they started earning an income. However, because of their financial circumstances, C decided it would be more beneficial to give his children the surrender values. C also said the policies were not effected with a view to surrendering them after a certain period of time.

C believed the illustrations provided in 1990 should have given *"a reasonably accurate indication"* of what the surrender value would be. The Case Manager considered this comment in the context of whether the 1990 illustrations were realistic or misleading and, in deciding the 1990 illustrations were not misleading, took various factors, including the following, into account:

- It is a general principle of the Contractual Remedies Act 1979 and the Fair Trading Act 1986, that statements about the future can only be considered misleading if, at the time they are made, there is no sound basis upon which they are made. The documentation showed there was a sound basis for the 1990 illustrations.
- A code of business practices for life insurance companies was introduced in January 1990 ("the Code"). For illustrations, the Code specified a number of conditions which had to be satisfied. The 1990 illustrations, provided by P to C, met these conditions.
- Notes accompanying the 1990 illustrations stated what bonus rates had been assumed in calculating the various figures and that the current

surrender value bases had been used. They also made it clear that future bonus rates and surrender values were not guaranteed.

- At the time, it was industry practice to use the most recently declared bonus rates, when calculating any figures which required an assumption about future bonuses. In this instance, P used the 1988 bonus rates rather than the 1989 bonus rates, which were lower than the 1988 bonus rates. The Case Manager understood that, about the time the 1990 illustrations were prepared, P introduced a new system for calculating illustrative values and there could have been a delay in updating the bonus rates. However, because the use of the lower bonus rates would only have reduced the 1990 illustrative surrender values, after 15 years, by about $300 to $350, it was evident that, if the 1989 bonus rates had been used when preparing the 1990 illustrations, the actual values in 2004/2005 would still have been significantly less than the 1990 illustrations.

C had suggested that, if surrender values were not guaranteed and could be varied by P, they should not have been included in the table of benefit illustrations. However, the Code required illustrative surrender values to be provided after 3, 5 and 10 years. Consequently, P was obliged to provide this information. In practice, P went further by providing a wider range of illustrative surrender values.

C also believed P should have informed policy owners that, because bonus rates were reducing, the surrender values offered would also be reduced. In considering this, the Case Manager noted that a comparison of the information in the annual bonus notices to the original illustrations would have shown the value of the policies was not growing as quickly as shown in the illustrations. For example, for one of the policies, the 1990 illustration showed the claim value after 15 years as $60,760. Whereas, the 2005 annual statement provided by P, which coincided with the end of 15 years, showed the claim value as $40,760.80. In addition, the notes in the 1990 illustrations indicated that bonuses could be cashed for an amount which was less than their face value. This information, together with the reduced rate at which bonuses were being added to the policies and other information provided with the bonus notices, would have indicated the policies' values were not growing in the line with the 1990 illustrations.

5 CONTINUED...

The policy documents did not provide any undertaking about how the surrender value would be calculated, or what it would be at any particular point in time. Consequently, in offering surrender values which were less than the values shown in the 1990 illustrations, P was not breaching any policy conditions. Similarly, the policy documents did not provide any undertaking about the rate at which bonuses would be declared.

Enquiries made by the Case Manager showed that P had not altered the surrender value bases since the policies were effected. Consequently, the difference between the surrender values received and the equivalent figures in the 1990 illustrations resulted from the reduction in the portion of the surrender value which arose from the cash value of the bonuses. In turn, this resulted from the declared reversionary bonus rates being less than the rates assumed in the 1990 illustrations.

The ISO's Terms of Reference precluded the Case Manager from considering and/or commenting on the rate at which bonuses had been declared.

Result *Complaint not upheld*

FINANCIAL STATEMENTS

INSURANCE & SAVINGS OMBUDSMAN COMMISSION

FOR THE YEAR ENDED 30 JUNE 2006

DIRECTORY

FOR THE YEAR ENDED 30 JUNE 2006

NATURE OF BUSINESS

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

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

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

BUSINESS LOCATION

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

BANKERS	The National Bank of New Zealand Ltd Wellington
ACCOUNTANTS	Horwath Strategy (Wellington) Limited Wellington
AUDITORS	Martin Jarvie PKF Wellington

STATEMENT OF FINANCIAL PERFORMANCE: For the year ended 30 June 2006

	Note	2006	2005
Income			
Levies		899,500	970,391
Casebook Sales		1,783	3,087
Brochure Sales		1,911	1,778
Surplus from ISO Conference		0	8,126
Interest Received		61,120	57,142
Depreciation Adjustment on Disposal of Fixed Assets		100	0
Total Income		**964,414**	1,040,524
Less: Expenditure			
Administration Costs		134,284	132,464
Audit Fees		4,225	5,288
Commissioners' Fees & Expenses		34,000	34,000
Depreciation - Office Equipment		27,398	25,048
Depreciation - Furniture & Fittings		1,351	1,746
Professionals & Consultancy		32,358	42,457
Occupancy		11,040	12,147
Promotion		15,156	17,101
Rent	3	75,180	75,180
Salaries		634,463	593,161
Scheme Review Fees & Expenses		2,625	0
Staff Costs		7,856	29,670
Total Operating Expenditure		**979,936**	968,262
Net Surplus (Deficit) Before Tax		**($15,522)**	$72,262
Tax Expense		13,536	12,289
Net Surplus (Deficit) After Tax		**($29,058)**	$59,973

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 2006

	Note	2006	2005
Balance at Beginning of Year		522,489	462,516
Net Surplus (Deficit) After Tax		(29,058)	59,973
Balance at End of Year	6	**$493,431**	$522,489

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

STATEMENT OF FINANCIAL POSITION: As at 30 June 2006

	Note	2006	2005
Equity			
Accumulated Funds Account		493,431	522,489
Total Equity		**$493,431**	$522,489
Represented By :			
Current Assets			
Accrued Income		0	3,628
Accounts Receivable		10,320	0
Prepayments		13,175	8,803
Cash & Bank		515,791	222,933
National Bank of N.Z. Term Deposits		0	304,078
G.S.T. Refund		3,206	7,473
Total Current Assets		**542,493**	546,915
Fixed Assets	2	**34,291**	48,966
Total Assets		**576,783**	595,881
Current Liabilities			
Income Received In Advance		13,111	0
Accounts Payable		69,330	71,895
Income Tax Payable		911	1,497
Total Current Liabilities		**83,352**	73,392
Total Liabilities		**83,352**	73,392
Net Assets		**$493,431**	$522,489

The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on 7 August 2006.

Chairperson: Date: 7.08.06

Ombudsman: Date: 7.08.06

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 2006

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	10-48%
Furniture & Fittings	6-24%

Investment Income:

Interest income is accounted for as it is earned.

Levy Income:

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

Goods & Services Tax:

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

Employee Entitlements:

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

Taxation:

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

CHANGES IN ACCOUNTING POLICIES

All polices 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 - 2006			
Office Equipment	172,764	142,764	30,000
Furniture & Fittings	77,322	73,031	4,291
	$250,086	**215,795**	**$34,291**
Plant & Equipment - 2005			
Office Equipment	160,620	117,296	43,324
Furniture & Fittings	77,322	71,680	5,642
	$237,942	**188,976**	**48,966**

NOTE 3 – OPERATING LEASE COMMITMENTS

Analysis	2006	2005
Current	48,610	75,180
Non-Current	0	48,610
	$48,610	$123,790

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 (2005 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 (2005 Nil).

NOTE 6 – ACCUMULATED FUNDS

Included in Accumulated Funds is $40,000 which is for the ISO Scheme Review which will be undertaken in 2008. (2005: $20,000).

AUDIT 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 performance of the Insurance & Savings Ombudsman Scheme (the "ISO Scheme") and its financial position as at 30 June 2006. This information is stated in accordance with the accounting policies set on pages 30 & 31.

INSURANCE & SAVINGS OMBUDSMAN COMMISSION'S RESPONSIBILITIES

The members of the Insurance & Savings Ombudsman Commission (the "ISO Commission") are responsible for the preparation of Financial Statements, which gives a true and fair view of the financial position of the ISO Scheme as at 30 June 2006 and of the results of operations for the year ended on that date.

AUDITOR'S RESPONSIBILITIES

It is our responsibility to express an independent opinion on the Financial Statements presented by the ISO Commission and report 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:

- The significant estimates and judgements made by the ISO Commission in the preparation of the Financial Statements; and
- Whether the accounting policies are appropriate to the ISO Scheme's circumstances, 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 in order 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 the information in the Financial Statements.

Other than in our capacity as Auditors, we have no relationship with or interest in the ISO Scheme.

UNQUALIFIED OPINION

We have obtained all the information and explanations we have required.

In our opinion:

- Proper accounting records have been kept by the ISO Commission as far as appears from our examination of those records; and
- The Financial Statements on pages 28 to 31:
  - comply with generally accepted accounting practice; and
  - give a true and fair view of the financial position of the ISO Scheme as at 30 June 2006 and the results of its operations for the year ended on that date.

Our audit was completed on 7 August 2006 and our unqualified opinion is expressed as at that date.

Martin Jarvie PKF
Chartered Accountants, Wellington

SCHEME PARTICIPANTS: as at 30 June 2006

AA Insurance Limited
- SIS Insurance

ACE Insurance Limited
- Vodafone phoneInsure

Allianz New Zealand Limited
- Protecta

American Home Assurance Company (NZ Branch)

American International Assurance Co (Bermuda) Limited

AMI Insurance Limited

AMP Services (NZ) Limited

ASB Group Investments Limited

Associated Marine Insurance Agents Pty Limited

Asteron Life Limited
- Asteron Retirement Investment Ltd

Asteron Trust Services Limited

China Insurance (NZ) Company Limited

CIGNA Life Insurance New Zealand Limited

Combined Insurance Company of New Zealand

EIG-Ansvar Limited

Equitable Life Insurance Company Limited

Farmers' Mutual Insurance Association
- Farmers' Mutual Insurance Limited

Farmers' Mutual Life Limited

Fidelity Life Assurance Company Limited

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

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

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

ING (NZ) Limited

ING Insurance (NZ) Limited

ING Insurance Services (NZ) Limited

ING Life (NZ) Limited

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

Manchester Unity Friendly Society

Medical Insurance Society New Zealand Limited

Medical Life Assurance Society Limited

MFL Mutual Fund

Mitsui Sumitomo Insurance Company Limited

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

Orange Insurance Limited

Pacific Life Limited

PSIS Life Limited

Public Trust

SAI Life Limited

Sentinel Assurance Company Limited

SIL Mutual Fund

Southern Cross Benefits Limited (Travel)

Southern Cross Medical Care Society
- Activa Health Limited

Southsure Assurance Limited

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

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

TOWER Health & Life Limited

TOWER Insurance Limited

TOWER Managed Funds Limited

Union Medical Benefits Society Limited t/a UNIMED

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

•Denotes subsidiary or associated company or business division

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