

# UNDERSTANDING EACH OTHER

THE INSURANCE & SAVINGS OMBUDSMAN

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



## ...IS ALL ABOUT COMMUNICATION |

“THE OUTCOME OF  
OUR COMPLAINT  
WAS AT ALL TIMES  
EXPLAINED TO  
US AND ANY  
QUERIES WERE  
ANSWERED WITH  
VERY EASY TO  
UNDERSTAND  
ANSWERS.  
THANK YOU.” |





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# COMMENTS FROM THE CHAIR

## A NUMBER OF SIGNIFICANT ISSUES HAVE ENGAGED THE COMMISSION DURING THE YEAR.

Foremost among these has been the 5-yearly Independent Review of the Scheme which is required by our Rules. The last Review was in 2003 and so much of 2007/2008 was taken up with developing Terms of Reference for the Review, selecting the Reviewer and providing input and information for the Report. The Navigator Company was selected to conduct the Review. It is a Melbourne based company with extensive experience and knowledge of industry dispute resolution schemes and involvement in a number of scheme reviews.

The Review addressed 2 Benchmarks, in particular – Efficiency and Fairness – but also addressed a number of other matters of current and future interest.

The Report was received at the end of June. Copies have been made available to all those who made submissions and stakeholder groups, in accordance with the requirements of the Rules. The Report is also on the ISO website.

The Commission takes pride in the overall finding of the Review that “... *in the ISO [Scheme] we found a very effective small to mid-size [External Dispute Resolution] scheme, with an excellent reputation amongst the overwhelming majority of its stakeholders. We were impressed with the simplicity and efficiency of the operation, with the depth of knowledge of the industry displayed by staff and with the quality of service provided to consumers. ... The Commission should be well pleased with the ISO [Scheme]’s operational performance ...*”.

Over the coming months, the Commission will be considering the recommendations in detail and working with the ISO and the ISO Board on implementation issues.

A second major matter for the Commission has been consideration of the possible changes to the regulatory environment for the financial sector, the implications of those changes for dispute resolution schemes in general and the ISO Scheme in particular. A working party of industry representatives has been established to work through issues and possible options and advise the Commission accordingly.

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Over the coming year, we will continue this work as the shape and timing of changes become clearer.

These matters have been in addition to our business as usual activities of ensuring sound governance of the ISO Scheme and monitoring its performance. The volume of complaints and enquiries handled has been about the same as last year, leading to a busy workload for staff.

During the year, we have had further changes in membership of the Commission. Rieny Marck of Lumley General Insurance (N.Z.) Ltd left the Commission in March. We farewelled him with regret; he had made a most useful contribution to our work. He was replaced by Nick Hawkins of IAG New Zealand Ltd and, most recently, by Martin Stokes of the Medical Life Assurance Society Ltd. Dr Ian McPherson of Southern Cross Healthcare continues to be an industry representative and Chairman of the ISO Board. Sam Huggard and Claire Dale remain on the Commission as consumer representatives.

As Chair of the Commission, I would like to thank Karen Stevens and her staff for the professionalism and expertise they bring to their work. All Commission Members are delighted at the positive recognition given in the Review Report. I also wish to thank my Commission colleagues for their work during the year and for the support given to me as Chair.

The 2008/2009 year promises to be another busy and interesting year as we look to implement the Review recommendations and position the ISO Scheme for industry changes.

**Alison Timms** Chair, Insurance & Savings Ombudsman Commission

# INSURANCE & SAVINGS OMBUDSMAN'S

## IT HAS BEEN A REWARDING YEAR, WITH A NUMBER OF MILESTONES ACHIEVED BY THE ISO SCHEME.

In our primary area of business, the number of complaints we received and investigated was virtually the same as last year. We have continued our educative role, in the community and with industry, both speaking and publishing information about our complaints handling. We have also contributed to work being done by the government and other organisations.

### PUBLIC AWARENESS SURVEY

In September 2007, we commissioned UMR Research to carry out a survey of consumers to establish the level of public awareness about the ISO Scheme. The results indicated that more needs to be done, so that consumers know where to go to make a complaint about their insurance or savings. The bottom line is that we need more help from our Participants to let their customers know about our free disputes resolution service. Good complaints handling is essential to instil consumer confidence in the insurance and savings industry. Part of that is about having an independent external disputes resolution process to refer customers to when they reach "deadlock". Customers of the insurance and savings industry have the ISO Scheme and we want them to be told about it, so they get the benefit of the industry's participation.

### REVIEW OF FINANCIAL PRODUCTS AND PROVIDERS

Over the last few years, we have been involved with the Ministry of Economic Development's Review of Financial Products and Providers ("RFPP"), taking part in the insurance advisory group and regularly responding to discussion documents. The outcome, thus far, are 2 Bills: the Financial Advisers Bill 2007 and the Financial Service Providers (Registration and Disputes Resolution) Bill 2007. Both Bills, when enacted, could change the face of consumer dispute resolution for the financial sector and, more particularly, the insurance and savings industry in New Zealand.

# REPORT



Currently, there is no disputes resolution scheme for consumers who wish to make complaints about financial advisers in New Zealand. Nor is there any statutory requirement for financial service providers to belong to a dispute resolution scheme. The banking and insurance and savings industries have the only industry Ombudsman Schemes, set up in 1992 and 1995, respectively. Both the Banking Ombudsman and the ISO Schemes are highly regarded in their respective industries and provide a valuable service to consumers with complaints.

The proposed legislation will change the existing dispute resolution framework, requiring expanded services to match a greater number of regulated financial services.

We made written submissions in respect of both Bills and have a great deal of interest in the outcome of the proposed Disputes Resolution legislation. Areas of concern for us include whether financial advisers are covered; whether consumers could be charged for what is now offered by the Banking Ombudsman and the ISO Schemes as a free service; and whether an appeal to the District Court is an appropriate process to review a decision of an external dispute resolution scheme.

There are significant ramifications for the insurance and savings industry with mandatory membership of a dispute resolution process. It is for the industry to take a proactive approach to determine what model of Ombudsman Scheme it requires for the future – both to instil confidence in consumers and to ensure statutory compliance.

## INDEPENDENT REVIEW

Future proofing was targeted in the ISO Commission's public Review of the ISO Scheme, carried out extremely professionally by Phil Khoury and Debra Russell of The Navigator Company. We appreciated the opportunity to be involved, knowing that a rigorous process had been undertaken to interview a wide cross-section of stakeholders (including recent Complainants) and review complaints files.

One of the 2 aspects of the operation reviewed was the efficiency of the ISO Scheme. This is an area on which we have worked very hard since the 2003 Review. The Reviewers said that *"by comparison with many of the [External Dispute Resolution] schemes that we have reviewed, the ISO complaints process is remarkably straightforward and speedy. ... We were impressed to see that the ISO has managed to achieve this efficiency whilst fulfilling ... its natural justice obligations – generally striking an appropriate balance between timeliness and thorough process"*.

It was also very pleasing to know that the Reviewers were impressed by our level of communication with Complainants and that their interviews with Complainants *"revealed a high level of satisfaction with this aspect of the complaints process – easily the best that [they] have seen"*.

The other aspect of the operation reviewed was the fairness of the ISO Scheme. The Reviewers commented that they were satisfied the ISO Scheme meets the Benchmark of fairness and made some very helpful recommendations to *"fine tune its processes and its settings in the interests of enhancing the fairness of outcomes"*. On the Reviewers' recommendation, there is scope for us to document our procedures better, to ensure consistency of approach.

**“THE STAFF AT ISO WERE  
HELPFUL AT ALL TIMES.  
I ALSO THINK INSURANCE  
COMPANIES SHOULD  
ACTUALLY EXPLAIN TO  
YOU WHAT YOU ARE  
INSURED FOR AND WHAT  
YOU ARE NOT.”**



The Reviewers also recommended that we specifically refer, in our written Assessments, to paragraph 5.7 of the Terms of Reference ("TOR"), which requires that, "[i]n making any decision in the Resolution process, the ISO shall do so by reference to what is, in his/her opinion, fair and reasonable in all the circumstances". The ISO shall also have regard to the law, rules of natural justice, insurance practice and codes. It was acknowledged by the Reviewers that we are taking into account all of the criteria for decision-making and *"the outcomes of the complaints [they] saw were overwhelmingly fair"*.

The Reviewers noted, with concern, that some of the stakeholders interviewed had suggested the ISO *"should stay away from notions of fair and reasonable or good industry practice"*. However, that is not about to happen, because we would be acting in breach of the TOR by doing so. We have always had regard to the law and general principles of good industry practice, where they were relevant and applicable, in order to reach a decision which is fair and reasonable in all the circumstances.

Our jurisdiction, in that regard, is very similar to the Financial Ombudsman Service ("FOS") in the United Kingdom and the Court of Appeal has just ruled that FOS does not have to follow the law. Rather, FOS must take account of the law when determining what is fair and reasonable in all the circumstances, in accordance with its statutory framework. We shall continue to make decisions that are fair and reasonable in all the circumstances in accordance with the TOR but, by way of fine tuning, we will be more explicit about doing so.

## THANKS

Without the help and support of the ISO Commission and, in particular, Alison Timms as Chair, I would be unable to operate effectively as the ISO. In the same way, without the hard work and commitment of excellent staff, led by Lionel Hinton and Iain Opray, we could not have achieved such a good operational result in the Review. It is most rewarding to see how far we have come in the 10 years since my appointment as ISO in May 1998.

## THE FUTURE

We face a number of challenges in the coming year, not the least of those being statutory changes for the financial sector. The ISO Scheme and the industry will need to continue to work together to achieve consumer confidence and a more integrated approach to dispute resolution across the financial sector.



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

# COMPLAINTS SUMMARY

There were 1,680 complaint enquiries (564 in writing), 202 complaints received for investigation and 191 complaints resolved in the 2007/2008 financial year, as set out in the tables below. There were 53 complaints resolved, as a result of involvement of the ISO Office before a formal investigation was undertaken.

| STATUS   | 2007/08 |     | 2006/07 |     |
|--|---------|-----|---------|-----|
| Complaints carried over from previous year and completed | 31      |     | 39      |     |
| Complaints received for investigation                    | 202     |     | 201     |     |
| Complaints under investigation                           | 233     |     | 240     |     |
| Complaints completed during the year                     | 191     |     | 209     |     |
| Complaints for investigation but incomplete at year end  | 42      |     | 31      |     |
|  |         |     |         |     |
| RECEIVED BY SECTOR                                       | 2007/08 |     | 2006/07 |     |
| Fire and General   | 121     | 60% | 110     | 55% |
| Health   | 48      | 24% | 39      | 19% |
| Life and Savings   | 33      | 16% | 52      | 26% |
| TOTAL  | 202     |     | 201     |     |
|  |         |     |         |     |
| OUTCOMES   | 2007/08 |     | 2006/07 |     |
| Complaints upheld  | 35      | 18% | 28      | 13% |
| Complaints partly upheld                                 | 11      | 6%  | 3       | 1%  |
| Complaints settled                                       | 37      | 19% | 37      | 18% |
| Complaints not upheld                                    | 108     | 57% | 141     | 68% |
| TOTAL  | 191     |     | 209     |     |

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 **PARTLY UPHELD** or **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 partly or totally in favour of the consumer.

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

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.



COMPLAINTS SUMMARY CONTINUED...

JURISDICTION

In the 2007/2008 financial year, we received written enquiries about 142 disputes outside jurisdiction, which required consideration and a written response. We also received 279 telephone enquiries about disputes outside the ISO's jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO'S JURISDICTION

|                                  |     |             |
|----------------------------------|-----|-------------|
| Brokers/company not Participant  | 30% | <div></div> |
| Not defined service              | 20% | <div></div> |
| 3rd party                        | 20% | <div></div> |
| Commercial/underwriting decision | 17% | <div></div> |
| No remedy available              | 4%  | <div></div> |
| Outside ISO's monetary limits    | 3%  | <div></div> |
| Subject/previous proceedings     | 2%  | <div></div> |
| Investment performance           | 2%  | <div></div> |
| Outside time limits              | 1%  | <div></div> |
| Another forum more appropriate   | 1%  | <div></div> |

IN THE YEAR ENDED 30 JUNE 2008, \$413,912 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 TOTAL, THERE WERE 19 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

The average time to close the 191 complaints investigated in the year ended 30 June 2008, was 88 days from receiving the company's file and accepting the complaint.

# HOW WE GOT OUR MESSAGE INTO THE COMMUNITY

## IN 2007/2008:

**SPEECHES AND PRESENTATIONS:** We spoke at a total of 17 seminars and conferences.

**CONSUMER OUTREACH:** We co-hosted, with the Banking Ombudsman and Electricity and Gas Complaints Commissioner, 6 sessions around New Zealand for consumer advisers, including Citizens Advice Bureaux, Community Law Centres, Budget Advisers and other community groups.

**0800 NUMBER:** We received 3,215 inward calls on our freephone number 0800 888 202, which provides information in a step down service and a message facility, with a direct operator link for those who want to speak to us.

**WEBSITE SESSIONS:** There were about 55,200 website sessions on our website: [www.iombudsman.org.nz](http://www.iombudsman.org.nz)

**COMPLAINT ENQUIRIES:** We dealt with 1,114 telephone and 564 written complaint enquiries from consumers.

**MEDIA ENQUIRIES:** We handled 12 requests for information from the media.

**SUBMISSIONS:** We made 2 submissions to Parliamentary Select Committees, on the Financial Service Providers (Registration and Dispute Resolution) Bill 190-1 and the Financial Advisers Bill 192-1.

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

“WIN OR LOSE I AM VERY GRATEFUL FOR YOUR EFFORTS. THANK YOU SO MUCH, WE ARE LOOKING FORWARD TO [THE INSURER] MEETING THEIR COMMITMENT TO US.”

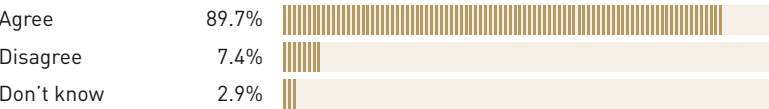
# HOW DO PEOPLE RATE US?



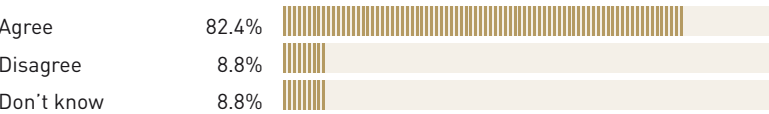
We send questionnaires to all consumers who have had their complaints investigated by the ISO for feedback. We use the information to monitor our process and evaluate our performance.

This year, we sent out 191 questionnaires and 68 were returned to us. Of the 68 returned, half of those complaints were not upheld and, despite that, the responses were generally very positive.

## THE ISO KEPT YOU WELL INFORMED ABOUT PROGRESS ON YOUR COMPLAINT



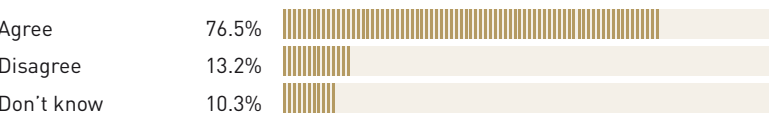
## THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME



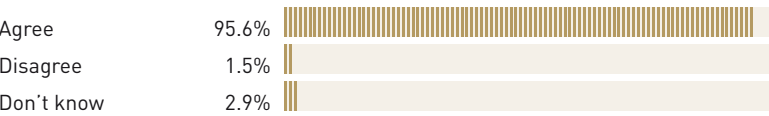
## THE REASONS FOR THE DECISION MADE ABOUT YOUR COMPLAINT WERE EXPLAINED CLEARLY



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



## THE ISO'S SERVICE IS EASY TO USE



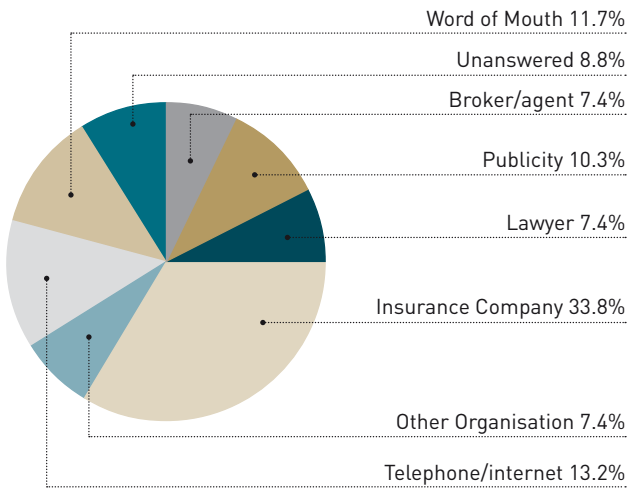


HOW DO PEOPLE RATE US CONTINUED...

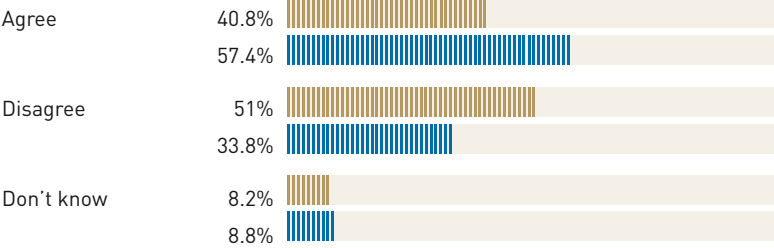
THE CASE MANAGER WAS HELPFUL AND EASY TO SPEAK TO ON THE TELEPHONE





HOW DID YOU FIND OUT ABOUT THE ISO?



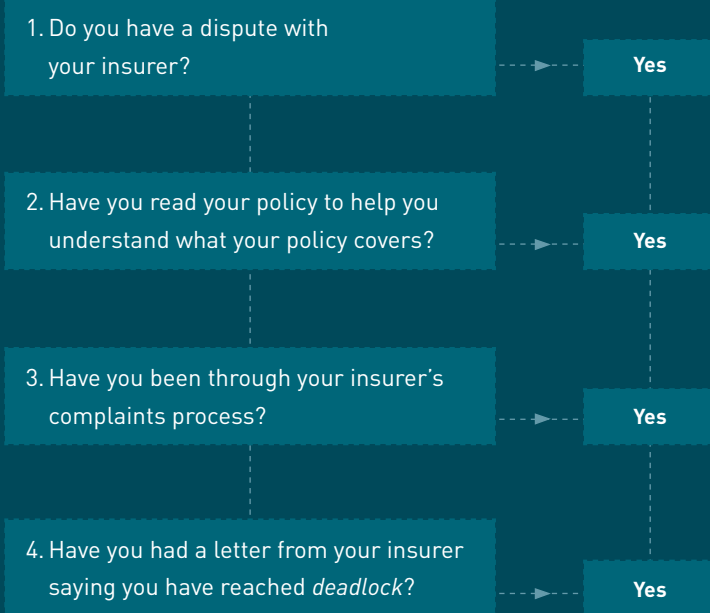
INFORMATION PROVIDED BY PARTICIPANTS



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

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

# COMPLAINTS CHECKLIST



If consumers can answer **Yes** to all of these questions we can help.

# CASE STUDIES



|    |  |
|----|--|
| 14 | 1: Breach of policy condition – Fair and reasonable, Interpretation – Ambiguities                                  |
| 16 | 2: Damage – House, Change in provisions, Policy excess, Scope of cover   |
| 18 | 3: Scope of cover, Unattended  |
| 20 | 4: Non-disclosure – Convictions, Adviser/Agent/Representative, Whether 'on notice', Fair and reasonable            |
| 22 | 5: Non-disclosure – Life insurance, Non-disclosure – Pre-existing conditions                                       |
| 24 | 6: Avoidance ab initio, Pre-existing condition, proposal questions, Reinstatement of policy, Suitability of policy |

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

# 1

## BREACH OF POLICY CONDITION – FAIR AND REASONABLE, INTERPRETATION – AMBIGUITIES

### Background

In November 2006, C purchased a Subaru Impreza WRX ("the vehicle") from a car dealer. The sales manager arranged insurance with P and an alarm/immobiliser was to be installed the next day. When the alarm was being installed, the vehicle's engine stopped working and, consequently, the alarm could not be installed. The vehicle was taken to a mechanic for repairs.

Between November 2006 to January 2007, the vehicle remained with the mechanic. The engine was removed to be rebuilt and an alarm could not be installed in the vehicle. At the end of January, the mechanic finished the repairs and contacted C to collect the vehicle. C immediately arranged for an alarm to be installed the next afternoon, on 1 February 2007.

On the morning of 1 February 2007, C parked the vehicle in his work car park. The vehicle was stolen and C made a claim to P for the loss. After investigating the loss, P declined C's claim, because he did not have an alarm installed in the vehicle, as required by the terms of the policy.

### Assessment

The policy schedule stated that "[i]t is warranted that the Insured Vehicle is to be fitted with a NZ Security Association 5 star certified alarm/immobiliser system which is operative when the Insured Vehicle is not in use". However, there was no timeframe for this to take place.

P said it intended that insurance would not be approved for the vehicle unless an alarm was fitted, because of the high risk of theft. P's intention was not clearly stated in the schedule, which provided that the "insured vehicle is to be fitted" with an alarm. The use of a passive tense can indicate a future action and did not specify a timeframe within which the action "is to be" done.





Moreover, the Case Manager found P's actions contradictory. In stating it would not have insured the vehicle without an alarm, P approved the insurance without an alarm and issued the "Certificate of Currency".

In accordance with accepted legal interpretation, if no timeframe is stated, a "reasonable" timeframe will be implied. The Case Manager believed a fair interpretation was to view the policy as providing cover for the vehicle, without an alarm, on the strict proviso that C would have one installed as soon as reasonably possible.

From the sequence of events, the Case Manager believed C tried to get an alarm installed as soon as he could. It was his intention to have it installed immediately after the insurance was approved. However, due to circumstances beyond C's control, the vehicle was unable to be fitted with an alarm until February 2007.

The Case Manager concluded that C had done all he could have done to get the alarm installed as soon as possible and, in doing so, he complied with the terms and conditions of the policy. If P had intended for the vehicle not to be insured until an alarm was fitted, it should have said so on the schedule. Because it failed to do so, the Case Manager believed the vehicle was insured for theft when it was stolen.

**Result** *Complaint upheld*

**“VERY SATISFACTORY OUTCOME  
FROM MY POINT OF VIEW. WOULD  
NOT HESITATE TO RECOMMEND  
SERVICE TO ANYBODY ELSE IN  
MY SITUATION.”**

## 2

DAMAGE – HOUSE, CHANGE IN PROVISIONS,  
POLICY EXCESS, SCOPE OF COVER

## Background

C's house was insured with P. In February 2005, C decided to spend a year travelling around New Zealand. C advised P the house would be tenanted during his absence and some contents would be stored in a locked shed on his property. P advised C it would not cover the contents in storage. C said P told him that an additional excess of \$200 would apply while the house was tenanted, but made no mention of other changes to the cover, or the options available to C. C appointed a real estate firm as property manager during his absence and a tenancy agreement was entered into on 1 March 2005.

In early January 2006, the property manager advised C that the tenants had stopped paying rent and he had been unable to inspect the inside of the house since December 2005. However, external inspection showed an accumulation of rubbish and a general untidiness. A notice to vacate the house was issued to the tenants on 13 March 2006, with a moving date of 18 March 2006.

C returned to the house on 20 March 2006 and discovered damage to walls, a vanity unit, multiple stains and burn marks on different areas of the carpet ("the damage") and accidental damage to the shed. P's assessor estimated the total cost of repairing the damage at \$3,600 and \$5,500 in respect of the shed.

P accepted the claim for the shed, less the applicable excess of \$300. However, it did not accept the claim for the damage because, as the house was tenanted, the policy did not provide cover for "*Landlord's Fixture and Fittings*" or "*Accidental Damage*".

## Assessment

C advised P the house was to be tenanted and requested the cover be changed from "*owner occupied*" to "*tenanted*". P endorsed C's policy, noting the alterations he requested and issued a new certificate of insurance, confirming the changes and the terms and conditions which would apply. As a result of the changes, the policy did not include cover against accidental damage and did not cover landlord's fixtures and fittings.



C said that, when he arranged the revised cover, P made no mention of a change from accidental damage cover to defined events. He said he was also unaware of the need to arrange additional cover for landlord's fixtures and fittings. However, C believed the damage should be regarded as malicious damage caused by the tenants, which was covered by the policy.

After careful consideration of all the evidence and after discussing matters with C, the Case Manager did not believe P adequately advised C about the implications of the changes to the policy cover while the house was tenanted. The Case Manager believed the changes were significant and C should have been given a full explanation, notwithstanding that he had been provided with a new certificate of insurance.

The Case Manager discussed his concerns with P in respect of each item claimed. The claim for damage to the vanity was accepted, subject to the policy excess of \$300. P was also prepared to consider the part of the claim which related to the walls and carpet. However, there was no way of determining whether most of the damage occurred at the same time, or as a result of a number of events.

The Case Manager did not believe P could apply a separate excess to each mark on the walls and carpet, simply on the possibility they were made at different times. From the Case Manager's experience, this was not a fair and reasonable approach to this sort of situation. Therefore, the Case Manager suggested that, where damage was extensive and likely to have occurred over a period of time, an excess be applied to each room affected.

As there were 4 rooms affected, the Case Manager suggested that 4 excesses (\$1,200) be deducted from this part of the claim. The Case Manager did not attempt to quantify the amount required to settle, because no decision had been made about the method of settlement, particularly for the carpet.

The Case Manager subsequently discussed P's settlement of the claim with C, who was very happy with the outcome.

**Result** *Complaint settled*

## 3

## SCOPE OF COVER, UNATTENDED

## Background

In April 2007, C arranged travel insurance through his bank with P. In June 2007, when C was the “overseas player” for a UK Cricket Club, he attended a barbeque at the Cricket Club. This was a function to which only the Cricket Club’s playing members and their families were invited. On arrival at the Cricket Club, after playing an “away” game, C asked his team captain whether he could leave his bags in the captain’s vehicle. The captain instructed him to leave his bags outside the main function room in the corridor, with the other playing members’ bags.

During the barbeque, one of C’s bags was stolen. When C came back to New Zealand, he made a claim to P for the loss. In August 2007, after investigating the claim, P declined the claim, on the basis that C “left [his] bag unattended in a room which was accessible to the general public and was not locked”.

The policy excluded cover in such circumstances.

## Assessment

P based the declinature of the claim on the exclusion, which states the insured is not covered for “loss... or claims for... theft... of ... **personal baggage left unattended in a public place or left in any unlocked ... room**”. P had the onus of proving the exclusion applied and, in particular, that C had left his bag “unattended in a public place”.

## 1. “unattended in a public place”

The Case Manager found that the phrase “unattended in a public place” was not defined in the policy and, therefore, the usual legal rules of interpretation applied. The question of whether the bag was “left unattended” was not relevant, if a finding was made that the Cricket Club was not a “public place” at the time of the function. The ordinary meaning of the word “public” is set out in the *Shorter Oxford English Dictionary* (5th edition), as follows:

**“public ... 3 a** Open or available to, used or shared by, all members of a community; not restricted to private use.”

In order for the Cricket Club to be a “public place” on the evening of the function, it was required to be “not restricted to private use”. P said “[t]here were a number of people walking in and out through the evening”. However, this was not evidence of the function allowing unrestricted access to the general public.

In the Case Manager’s discussion with C, it was explained that the Cricket Club’s barbeque was a function, to which only playing members and their



families were invited. In applying the definition of “public” to the Cricket Club’s function, the Case Manager believed the function was limited to the playing members and their families and, therefore, “restricted to [their] private use” at the time of the function.

The Case Manager also made contact with a long time playing member and member of the Cricket Club Committee, who confirmed that the Club was not open to the general public and stated as follows:

*“The fact that it must have been one of the members of the Club only made matters worse. It is inconceivable that a member of the general public could have entered the building and taken the bag without being noticed.”*

Accordingly, on the basis of all the information, the Case Manager believed the Cricket Club and its function could not be regarded as a “public place”, as intended by the policy. The Case Manager did not believe the first part of the exclusion had any application to the circumstances of the claim.

## 2. “unlocked ... room”

P also declined the claim, because it believed the bag was left in an “unlocked room” and, therefore, P had the onus of proving the circumstances fell within the second part of the exclusion.

The Case Manager did not believe it was possible for the corridor to be locked, as it provided access to the function room and, therefore, part of the function area as a whole. For the corridors to be locked and secured, the whole Cricket Club would also have to have been locked, which would be impractical, considering the function was still going on and the members were still inside. Accordingly, the Case Manager did not believe that the second part of the exclusion could apply to the circumstances of the claim.

On an application of paragraph 5.7 of the ISO’s Terms of Reference, the Case Manager did not believe it was fair or reasonable for P to rely on the exclusion. This is because C was acting under the instructions of the captain to leave his bag in the corridor. C did not have any reason for not trusting and acting on those instructions. It should also be noted that C originally asked to leave his bag in the captain’s locked vehicle.

In all the circumstances, the Case Manager did not believe P correctly and reasonably applied the terms and conditions of the policy to the claim.

## **Result** *Complaint upheld*

## 4

NON-DISCLOSURE – CONVICTIONS, ADVISER/  
AGENT/REPRESENTATIVE, WHETHER ‘ON  
NOTICE’, FAIR AND REASONABLE

## Background

In January 2006, C purchased a motorbike from a motorbike shop. C and his father arranged insurance for the motorbike, through the shop, with P.

In January 2007, C made a claim to P, because the motorbike had been stolen. On the claim form, C ticked “yes”, in response to a question asking whether the motorbike’s rider had been, in the previous 5 years, “*disqualified from driving or had their licence endorsed cancelled or suspended*”.

After obtaining C’s traffic conviction history, P wrote to C’s father and said, because C had not disclosed his traffic convictions when the insurance was arranged, it had “*cancelled [the policy] ... [from the beginning]*” and it was unable to accept the claim.

## Assessment

C argued that, when he arranged the insurance, he was “[so] *happy that [he] had just recently obtained [his] licen[c]e back after being without it for 2 years that [he] said to [the shop assistant], ‘I’ve just got my licen[c]e back’*”. C said his father told the shop assistant this was the reason they went to the shop to buy the motorbike, which C’s father had previously traded-in to the shop.

C maintained that the fact he had been disqualified from driving increased the policy’s premium and this was the reason the policy was put under his father’s name.

Under section 10(a) of the Insurance Law Reform Act 1977, a representative of the insurer, who acts within his authority in negotiating a contract of insurance, shall be deemed to have notice of all matters material to the contract of insurance known to the representative.

The Case Manager believed the shop assistant was P’s agent in the negotiation of the policy and P was deemed to have notice of all matters known to the shop assistant in its negotiation. The duty of disclosure is satisfied if the insured disclosed sufficient information to reasonably put the insurer (or its agent) 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.



File notes on P's file indicated the policy was put in C's father's name, as *"the premium would have been too great for [C] if [the] insurance [was] put in [C's] name."* The Case Manager asked P to clarify why the premium would have been more expensive if the policy had been in C's name and how the shop assistant would have calculated the premium payable.

However, P did not provide any evidence from the shop assistant on this point and nor did it provide any information about how the shop assistant would have calculated the premium. The Case Manager noted, in his correspondence to P, the shop assistant had not refuted C's contention that he said he had been disqualified from driving.

The Case Manager believed the fact C had been disqualified from driving was a factor which made the premium too expensive and resulted in the policy being put in C's father's name. She also believed C disclosed sufficient information to put the shop assistant (and, therefore, P) on enquiry that he had further traffic convictions. It was unacceptable that the shop assistant put the policy in C's father's name, knowing C was to be the primary rider and that C's father had no insurable interest in the motorbike.

For all these reasons, in accordance with paragraph 5.7 of the ISO's Terms of Reference, it was not fair or reasonable for P to avoid the policy and decline to consider the claim.

P asked the Case Manager whether it would be appropriate to settle the complaint by paying the claim, less the difference between the premium C paid and the premium C would have been charged, if the policy had been put under his name. The Case Manager believed this was a reasonable outcome and C agreed to settlement on this basis.

**Result** *Complaint upheld*

## 5

NON-DISCLOSURE – LIFE INSURANCE,  
NON-DISCLOSURE – PRE-EXISTING CONDITIONS

## Background

During March 2001, C arranged life insurance with P. The cover commenced on 20 June 2001. On 21 June 2006, C completed an application to increase the sum insured.

On 30 August 2006, P advised C that it was avoiding the policy from its commencement date and declining the application for additional cover, on the basis of non-disclosure of chronic renal failure (“the decision”).

C was unhappy with the decision, as she believed she had answered the questions on the application honestly and to the best of her knowledge. She asked P to refund all the premiums paid from the start of the policy.

## Assessment

When C completed the application and prior to the policy being issued, she had a duty to disclose to P any information which a prudent insurer would consider material.

P avoided the policy and kept the premiums paid, on the basis that C did not disclose a history of kidney problems. It was entitled to do so under the policy, if C failed to disclose information and that information was material.

- **Non-disclosure**

When C completed the application, she was asked a number of questions relating to her past and current health. She answered “no” to all of the questions and did not provide any additional information. C then signed and dated the application and, by doing so, declared the information provided was “true and complete to the best of [her] knowledge”.

During its investigations for the application for additional cover, P obtained C’s medical records. These showed that C did not disclose a history of urinary tract infections, appointments with a renal physician, medication prescribed for kidney function and a number of referrals for a renal biopsy and ultrasound. Therefore, it was necessary to determine whether this information was material information, which should have been disclosed to P on the application.

- **Materiality**

P was entitled to avoid the policy, if C failed to disclose material information when she arranged the policy. 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.

In order to determine whether the information C did not disclose was material, the Case Manager considered whether it would have influenced the mind of a prudent insurer in fixing the premium or determining whether the risk would have been taken or continued on the same terms. When considering this, the Case Manager presented C's medical history (with identifying details omitted) to 2 independent underwriters and asked how this would have affected their decisions to insure her.

Both underwriters responded and advised that, based on C's medical history, they would have postponed a decision until a renal biopsy had been carried out. One underwriter also advised that, if cover had been offered, it would not have been on the same terms.

P confirmed that, had it been aware of C's kidney problems, it would also have requested further information from her doctor and postponed cover until the test results were available. P only entered into the contract on the terms it did, because of C's non-disclosure of material information.

Having regard to the experience of this Office and the independent underwriters' opinions, the non-disclosure was material. If C had disclosed her full medical history to P, it would have requested further information, which would have led to it imposing an additional premium, or not offering cover.

On this basis, P was entitled to avoid the policy and decline to refund the premiums under the policy.

However, the ISO asked P to refund the premiums, on the basis that C's non-disclosure was not fraudulent. In most policies, forfeiture of premiums is only available when there is evidence of fraud. However, P's policy allowed forfeiture, even if there was no fraud. This is contrary to the common law position and, given that the only remedy for non-disclosure at common law is avoidance, the ISO did not believe P's practice reflected good insurance practice.

P refused to refund the premiums and because it was relying on its rights under the policy, the ISO could not require P to make a refund.

**Result** *Complaint not upheld*

## 6

## AVOIDANCE AB INITIO, PRE-EXISTING CONDITION, PROPOSAL QUESTIONS, REINSTATEMENT OF POLICY, SUITABILITY OF POLICY

### Background

In 2006, C arranged mortgage protection insurance with P.

In June 2007, C made a claim to P, as he was unable to work due to a prolapsed disc. P requested further medical information.

P declined the claim and avoided the policy, because when C completed the application, he had been diagnosed with and was receiving treatment for diabetes, sleep apnoea and a back injury. P believed C had incorrectly accepted and signed the customer declaration/authority when completing the application for insurance, because he had failed to disclose material information.

### Assessment

The customer declaration asked an insured to confirm that he/she was *"in good health"* and *"unaware of any illness, disease or physical defect, which could result in a claim against the Policy"*. The declaration stated *"pre-existing conditions or defects [we]re not covered by the Policy"*.

The Case Manager was concerned with the following:

- any declaration of *"good health"* would be a consumer's subjective opinion;
- the declaration implied there was no requirement to declare pre-existing conditions, because they were not covered and could never be claimed for;
- given C's medical history, the policy would never be suitable for his needs; and
- P had not established whether the claimed condition was related to a pre-existing condition.

The Case Manager discussed her concerns with P, who agreed there were issues and, upon confirmation that the claimed condition was not pre-existing, agreed to re-instate the policy and settle the claim.

**Result** *Complaint settled*

# FINANCIAL STATEMENTS

INSURANCE & SAVINGS OMBUDSMAN COMMISSION  
FOR THE YEAR ENDED 30 JUNE 2008

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# DIRECTORY

## FOR THE YEAR ENDED 30 JUNE 2008

### 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

|                    |   |
|--------------------|---|
| <b>BANKERS</b>     | The National Bank of New Zealand Wellington |
| <b>ACCOUNTANTS</b> | BDO Spicers (Wellington) Limited Wellington |
| <b>AUDITORS</b>    | Martin Jarvie PKF Wellington                |

**STATEMENT OF FINANCIAL PERFORMANCE:** For the year ended 30 June 2008

|  | Note | 2008             | 2007             |
|--|------|------------------|------------------|
| <b>Income</b>  |      |                  |                  |
| Levies   |      | 991,689          | 890,000          |
| Casebook Sales   |      | 156              | 1,156            |
| Conference   |      | –                | 42,253           |
| Workshop/Training Day  |      | 311              | 5,476            |
| Interest Received  |      | 66,443           | 62,477           |
| Sundry Income  |      | 498              | –                |
| <b>Total Income</b>  |      | <b>1,059,097</b> | <b>1,001,362</b> |
| <b>Less : Expenditure</b>  |      |                  |                  |
| Administration Costs   |      | 140,873          | 128,807          |
| Audit Fees   |      | 4,800            | 4,183            |
| Commissioners' Fees & Expenses   |      | 34,000           | 32,250           |
| Conference   |      | –                | 29,536           |
| Depreciation – Office Equipment  |      | 29,194           | 18,227           |
| Depreciation – Furniture & Fittings  |      | 390              | 722              |
| Professionals & Consultancy  |      | 45,891           | 32,095           |
| Occupancy  |      | 11,363           | 12,746           |
| Promotion  |      | 14,634           | 5,725            |
| Rent   | 3    | 97,683           | 83,174           |
| Salaries   |      | 665,984          | 665,870          |
| Scheme Review Fees & Expenses  |      | 60,812           | –                |
| Staff Costs  |      | 8,732            | 22,383           |
| Workshop/Training Day  |      | –                | 2,494            |
| <b>Total Operating Expenditure</b>   |      | <b>1,114,356</b> | <b>1,038,212</b> |
| <b>Net Surplus (Deficit) Before Tax</b>  |      | <b>(55,259)</b>  | <b>(36,850)</b>  |
| Tax Expense  | 4    | –                | 13,961           |
| <b>Net Surplus (Deficit) After Tax</b>   |      | <b>(55,259)</b>  | <b>(50,811)</b>  |
| 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 2008

|  | Note | 2008           | 2007           |
|--|------|----------------|----------------|
| Balance at Beginning of Year   |      | 442,620        | 493,431        |
| Net Surplus (Deficit) After Tax  |      | (55,259)       | (50,811)       |
| <b>Balance at End of Year</b>  | 7    | <b>387,361</b> | <b>442,620</b> |
| This statement should be read in conjunction with the Notes To The Financial Statements. |      |                |                |

**STATEMENT OF FINANCIAL POSITION:** As at 30 June 2008

|                                     | Note | 2008           | 2007    |
|-------------------------------------|------|----------------|---------|
| <b>Equity</b>                       |      |                |         |
| Accumulated Funds Account           | 7    | 387,361        | 442,620 |
| <b>Total Equity</b>                 |      | <b>387,361</b> | 442,620 |
| <b>Represented By:</b>              |      |                |         |
| <b>Current Assets</b>               |      |                |         |
| Accrued Income                      |      | 3,205          | 3,027   |
| Accounts Receivable                 |      | 1,590          | 1,165   |
| Prepayments                         |      | 16,810         | 19,379  |
| Cash & Bank                         |      | 121,794        | 115,212 |
| National Bank of N.Z. Term Deposits |      | 250,000        | 350,000 |
| Income Tax Refund                   |      | 14,734         | –       |
| G.S.T. Refund                       |      | 8,852          | 16,982  |
| <b>Total Current Assets</b>         |      | <b>416,985</b> | 505,765 |
| <b>Fixed Assets</b>                 | 2    | <b>73,707</b>  | 59,616  |
| <b>Total Assets</b>                 |      | <b>490,692</b> | 565,381 |
| <b>Current Liabilities</b>          |      |                |         |
| Income Received in Advance          |      | 444            | –       |
| Accounts Payable                    |      | 102,887        | 120,392 |
| Income Tax Payable                  |      | –              | 2,369   |
| <b>Total Current Liabilities</b>    |      | <b>103,331</b> | 122,761 |
| <b>Total Liabilities</b>            |      | <b>103,331</b> | 122,761 |
| <b>Net Assets</b>                   |      | <b>387,361</b> | 442,620 |

The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on 12 August 2008.

Chairperson:  Date: 12.08.08

Ombudsman:  Date: 12 .08.08

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 2008

### 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:** Property, Plant and Equipment are recorded at cost less accumulated depreciation.

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:

|                      |        |
|----------------------|--------|
| Computer Equipment   | 25%    |
| 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 policies have been applied on bases consistent with those used in the previous year.

**NOTE 2 – FIXED ASSETS**

|                                     | Cost Price       | Accum. Depn.     | Net Value       |
|-------------------------------------|------------------|------------------|-----------------|
| <b>Plant &amp; Equipment – 2008</b> |                  |                  |                 |
| Office Equipment                    | 192,881          | 122,353          | 70,528          |
| Furniture & Fittings                | 77,322           | 74,143           | 3,179           |
|                                     | <b>\$270,203</b> | <b>196,496</b>   | <b>\$73,707</b> |
| <b>Plant &amp; Equipment – 2007</b> |                  |                  |                 |
| Office Equipment                    | 210,212          | 154,165          | 56,047          |
| Furniture & Fittings                | 77,322           | 73,753           | 3,569           |
|                                     | <b>\$287,534</b> | <b>\$227,918</b> | <b>\$59,616</b> |

**NOTE 3 – OPERATING LEASE COMMITMENTS**

| Analysis    | 2008           | 2007           |
|-------------|----------------|----------------|
| Current     | 97,683         | 97,683         |
| Non-Current | 56,984         | 154,664        |
|             | <b>154,667</b> | <b>252,347</b> |

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 – TAXABLE INCOME RECONCILIATION**

| Income Adjustments                             | 2008            | 2007          |
|--|-----------------|---------------|
| Book Profit/(Loss) Before Tax                  | (55,259)        | (36,851)      |
| Adjustment for Non-Taxable Income and Expenses | 1,451           | 94,703        |
| <b>Taxable Profit/(Loss)</b>                   | <b>(53,808)</b> | <b>57,852</b> |
| <b>Tax Provision</b>                           |                 |               |
| Tax @ Marginal Rates                           |                 | 13,961        |
| <b>Total Tax Provision</b>                     | <b>–</b>        | <b>13,961</b> |

In the 2007 year, tax was calculated on investment earnings less costs relating to that income. Only investment earnings were treated as taxable. Income and expenditure within the circle of membership were treated as non-taxable. During the 2008 year it was discovered that the Commission is not a club, society or association, and is an unincorporated body of persons which pays income tax at individual marginal rates.

**NOTE 5 – CONTINGENT LIABILITIES & COMMITMENTS**

As at balance date, the Insurance & Savings Ombudsman Commission had no capital commitments (2007 \$15,440).

As at balance date, the Insurance & Savings Ombudsman had no contingent liabilities (2007 Nil).

NOTE 6 – RELATED PARTY TRANSACTIONS

There were no transactions involving related parties during the year, other than those already disclosed elsewhere in these Financial Statements (2007 Nil).

NOTE 7 – ACCUMULATED FUNDS

There was an ISO Scheme Review during 2008 which cost a total of \$60,812. Included in Accumulated Funds is \$20,000 which is for the ISO Scheme Review which will be undertaken in 2011. (2007: \$60,000).

|                                | 2008           | 2007    |
|--------------------------------|----------------|---------|
| <b>Total Accumulated Funds</b> | <b>387,361</b> | 442,620 |
| <b>Allocated as follows:</b>   |                |         |
| Reserves                       | 367,361        | 382,620 |
| Scheme Review Provision        | 20,000         | 60,000  |

NOTE 8 – ADOPTION OF INTERNATIONAL FINANCIAL REPORTING STANDARDS

In December 2002 New Zealand Government announced that New Zealand International Financial Reporting Standards ("NZ IFRS") will apply to all New Zealand reporting entities for the periods commencing on or after 1 January 2007. In September 2007, the Accounting Standards Review Board announced that small to medium-size businesses which satisfy certain criteria, would not be required to apply the NZ IFRS until further notice.

The Insurance & Savings Ombudsman Commission satisfies these criteria.

All the financial information in these financial statements has been prepared in accordance with current New Zealand Generally Accepted Accounting Practice, (NZ GAAP).



**AUDIT REPORT:** To the Participants in the Insurance & Savings Ombudsman Commission

Martin Jarvie PKF  
Chartered Accountants



We have audited the financial report on pages 26 to 30. The financial report provides information about the past financial performance of the Insurance & Savings Ombudsman Commission ("ISO Commission") and its financial position as at 30 June 2008. This information is stated in accordance with the accounting policies set out on page 28.

**INSURANCE & SAVINGS OMBUDSMAN COMMISSION'S RESPONSIBILITIES**

The ISO Commission is responsible for the preparation of a financial report which gives a true and fair view of the financial position of the ISO Commission as at 30 June 2008 and the results of operations for the year ended on that date.

**AUDITOR'S RESPONSIBILITIES**

It is our responsibility to express to you an independent opinion on the financial report presented by the ISO Commission.

**BASIS OF OPINION**

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

- the significant estimates and judgements made by the ISO Commission in the preparation of the financial report; and
- whether the accounting policies are appropriate to the ISO Commission's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with New Zealand Auditing Standards. 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 obtain reasonable assurance that the financial report is 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 report.

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

**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 report on pages 26 to 30:
  - complies with generally accepted accounting practice in New Zealand;
  - gives a true and fair view of the financial position of the ISO Commission as at 30 June 2008 and the results of its operations for the year ended on that date.

Our audit was completed on 12 August 2008 and our unqualified opinion is expressed as at that date.

Martin Jarvie PKF  
Wellington

## **MATTERS RELATING TO THE ELECTRONIC PRESENTATION OF THE AUDITED FINANCIAL REPORT**

This audit report relates to the financial report of the Insurance & Savings Ombudsman Commission for the year ended 30 June 2008 included on the ISO Commission's website. The ISO Commission is responsible for the maintenance and integrity of the website. We have not been engaged to report on the integrity of the ISO Commission's website. We accept no responsibility for any changes that may have occurred to the financial report since it was initially presented on the website.

The audit report refers only to the financial report named above. It does not provide an opinion on any other information which may have been hyperlinked to/ from this financial report. If readers of this report are concerned with the inherent risks arising from the electronic data communication they should refer to the published hard copy of the audited financial report and related audit report dated 12 August 2008 to confirm the information included in the audited financial report presented on this website.

Legislation in New Zealand governing the preparation and dissemination of financial reports may differ from legislation in other jurisdictions.

# 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



**SCHEME PARTICIPANTS:** as at 30 June 2008**AA Insurance Limited**

- SIS Insurance

**ACE Insurance Limited**

- Vodafone phoneInsure

**Allianz New Zealand Limited**

- Club Marine
- Protecta
- 1Cover

**American Home Assurance Company  
(NZ Branch) t/a AIG New Zealand****American International Assurance  
Co (Bermuda) Limited t/a AIG Life****AMI Insurance Limited**

- CLIC Car Insurance Limited

**AMP Services (NZ) Limited****Ansvar Insurance Limited****ASB Group Investments Limited****Associated Marine Insurance Agents  
Pty Limited****Asteron Life Limited**

- Asteron Retirement Investment Limited
- Asteron Trust Services Limited

**China Insurance (New Zealand)  
Company Limited****CIGNA Life Insurance New Zealand Limited****Combined Insurance Company of  
New Zealand****Dorchester Life Limited****Equitable Life Insurance Company Limited****Farmers' Mutual Group****Fidelity Life Assurance Company Limited**

- Farmers' Mutual Life

**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 (NZ) Limited

**ING (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
- Star Underwriting Agents Limited

**Manchester Unity Friendly Society****Medical Insurance Society New Zealand  
Limited****Medical Life Assurance Society Limited****MFL Mutual Fund****Mitsui Sumitomo Insurance Company  
Limited****Pacific Life Limited****PSIS Life Limited****Public Trust****Sentinel Assurance Company Limited****SIL Mutual Fund****Simply Insurance New Zealand Limited  
t/a GE Money Insurance Services****Southern Cross Benefits Limited (Travel)****Southern Cross Medical Care Society**  
• Activa Health Limited**Southsure Assurance Limited****Sovereign Assurance Company Limited**

- Sovereign Superannuation Funds Limited
- Colonial Mutual Life Assurance Society

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

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

**TOWER Health & Life Limited****TOWER Insurance Limited****TOWER Investments Limited****Union Medical Benefits Society Limited  
t/a UNIMED****Vero Insurance New Zealand Limited**

- AMP General Insurance
- Comprehensive Travel Insurance Limited
- Mariner Underwriters Limited
- Vero Marine Insurance Limited
- Vero Warranty (Autosure, Crown)

**Zurich Australian Insurance Limited  
t/a Zurich New Zealand**

- Denotes subsidiary or associated company or business division

**“ISO COVERED ALL  
ISSUES AND KEPT ME  
WELL INFORMED  
THROUGHOUT THE  
INVESTIGATION  
PROCESS. I BELIEVE  
THE COMPLAINT WAS  
RESOLVED IN A  
REASONABLE TIME.  
I’M VERY HAPPY WITH  
THE WAY ISO HANDLED  
MY CASE.”**



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7th Floor, BDO House, 99-105 Customhouse Quay, Wellington 6011

PO Box 10-845, Wellington 6143, New Zealand

Phone 04 499 7612 Fax 04 499 7614 Freephone 0800 888 202

Website [www.iombudsman.org.nz](http://www.iombudsman.org.nz) Email [info@iombudsman.org.nz](mailto:info@iombudsman.org.nz)