

ENCOURAGING CONFIDENCE IN FINANCIAL SERVICES

THE INSURANCE & SAVINGS OMBUDSMAN

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



**“THE CASE MANAGE
PROFESSIONAL, IN
ABOUT THE PROCE
GENUINE INTEREST
MY COMPLAINT.”**



**“THE INVESTIGATION WAS
THOROUGH AND FAIR –
THE ATTENTION TO DETAIL
MUCH APPRECIATED.
THE CASE MANAGER
OBVIOUSLY GIVES 100% TO
HER WORK. WELL DONE!”**

R WAS EXTREMELY FORMATIVE, CLEAR DURE AND TOOK AND CARE ABOUT

“MY THANKS TO MY CASE
MANAGER WHO AT ALL TIMES
TREATED ME WITH RESPECT
AND KEPT ME INFORMED OF
THE PROCESS.”

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COMMENTS FROM THE CHAIR

THE YEAR UNDER REVIEW HAS BEEN A BUSY ONE FOR THE INSURANCE & SAVINGS OMBUDSMAN (“ISO”) COMMISSION.

Consideration and implementation of the Recommendations of the Independent Review occupied much of our time, and it is pleasing to note that the majority of the Recommendations have now been actioned. A number of the Recommendations related to operational matters and these have been actioned by the ISO and her staff. Those for the Commission’s consideration included an increase in the jurisdictional limit for a lump sum – from \$150,000 to \$200,000; compensation for a Complainant’s incidental expenses; and the ability for the ISO to consider part of a claim if it is under the jurisdictional limit. These all required the ISO Board’s agreement to make the necessary changes to the Rules. They were considered by the Board, agreed to at its meeting in December 2008 and came into effect from April 2009.

The other matter occupying much of the Commission’s time has been considering how best to position the ISO Scheme in the new regulatory environment, arising from the requirements of the Financial Service Providers (Registration and Dispute Resolution) Act 2008 (“the Act”). This continues to be a work in progress for 2009/2010.

The Commission has agreed to become an incorporated society. This is desirable for tax, legal and liability considerations, but is also consistent with the suggested requirements for an approved dispute resolution scheme under the Act, because of the requirement for a high level of perception of independence from industry interests. It is expected that the Commission will be progressing this in conjunction with the ISO Board, together with any changes to the Rules and/or Terms of Reference required under the Act, for the ISO Scheme to become an approved dispute resolution scheme.

Other Review Recommendations, not yet actioned will be considered as part of a suite of measures to bring the ISO Scheme into line with the guidelines for approval under the Act issued by the Ministry of Consumer Affairs. This means that there will continue



to be a heavy workload, covering important matters for the ISO Scheme, during the 2009/2010 year.

In May 2009, the Commission hosted a lunch for our Minister, the Hon Heather Roy. All Commission Members appreciated the opportunity to exchange views and comment on consumer rights and consumer protection and, in particular, the changing regulatory environment for financial service providers and the positive effect that will have on consumer redress.

The membership of the Commission has remained relatively unchanged during the year, which has helped in its deliberations. We welcomed the appointment of Martin Stokes, CEO of Medical Assurance Society to the Commission in July 2008.

The business as usual aspect of the ISO Scheme's work has been carried out with the customary efficiency and professionalism we respect and have come to expect of the ISO and her staff. Once again, I thank Karen and her team for the excellence of their service. They are rightly held in high regard by both industry and consumer interests, as well as by the international external dispute resolution community. I have enjoyed working with them and with being associated with such a highly regarded dispute resolution scheme.

Looking forward, my term as Chair of the Commission finishes in September 2009 and I wish the incoming Chair, Paula Rebstock CNZM every success in progressing all of the matters required in the new regulatory environment.

Alison Timms Chair, Insurance & Savings Ombudsman Commission

INSURANCE & SAVINGS OMBUDSMAN'S REPORT

GOOD COMPLAINTS HANDLING IS BASED ON AN ABILITY TO COMMUNICATE WELL.

While a 20% increase in the number of complaints for investigation has had its undoubted challenges, 95% of consumers who had a complaint investigated by the ISO and provided us with feedback, agreed that the ISO's service was easy to use.

Nearly all of those consumers agreed that they were kept well informed and the reasons for the decision were explained clearly. At the same time, we were able to maintain reasonable timeframes for all of our complaint investigations.

There has been a focus on good communication this year, following on from our conference in September 2008. Good complaints handling is based on an ability to communicate well; to listen, understand, explain, set realistic expectations and, above all, to ensure a Complainant feels he or she has been heard. It is essential that the ISO Scheme produces decisions which are fair and seen to be fair by both Complainants and Participants. We have continued our outreach work with the Banking Ombudsman and the Electricity & Gas Complaints Commissioner to increase our accessibility, by educating and informing those individuals and groups who work in the community about our respective schemes.

Equally, we have maintained a visible profile with the industry, meeting with Participants and providing them with complaints handling training from our knowledge and experience of industry complaints. These presentations are supported by online access to all of the ISO case studies from 2000-2008, with an enhanced search engine. In order to ensure the ISO Scheme's accountability, all of our publications are available on the website, including: case studies, annual reports, the "Assessment" newsletter and 13 consumer information sheets.



I have also been invited to speak at numerous conferences and seminars, notably for the Australian and New Zealand Institute of Insurance and Finance, as the main insurance qualifications organisation in New Zealand. Highlights include the invitations to speak about the ISO Scheme to the International Network of Financial Ombudsmen conferences in New York in 2008 and Dublin in 2009, to an international forum of ombudsmen working in the financial sector. It is always surprising that, despite differences in size, scope and language, there are many similarities among independent external dispute resolution ("EDR") schemes in both complaints trends and the approach taken to them.

With a deepening financial crisis in June 2009, EDR schemes in the financial sector around the world have been faced with dramatic increases in the number of complaints made by consumers. For many, hiring staff to provide an adequate service may, or may not, be feasible. Sometimes, an adjustment to the usual process may be more appropriate for particular types of complaints in order to ensure they are efficiently and effectively resolved.

Given the current global trends in the financial sector, it was extremely timely when new legislation was enacted at the end of 2008, with the purpose of encouraging consumer confidence in the New Zealand market. The Financial Service Providers (Registration and Dispute Resolution) Act 2008 ("the Act"), requires all EDR schemes to be approved by the Minister of Consumer Affairs and sets out the requirements to be met. All financial service providers must belong to an approved EDR scheme in order to become registered and to be able to carry on business. Currently, the only EDR schemes in the financial sector are the ISO Scheme and the Banking Ombudsman Scheme.

The ISO Commission and Board are considering the best long term options for the ISO Scheme, having particular regard to the interests of Participants and consumers. There are many financial service providers who do not belong to an EDR scheme, including about 3,500 financial advisers. The most important issue for consideration, of course, is what is the best outcome for consumers as customers of financial service providers.

The customers of insurance and savings organisations have had a very good EDR service in the ISO Scheme, providing them with a free and independent complaints resolution service for 14 years. Consumers with complaints about financial advisers, finance companies and other financial service providers have not been as fortunate. In many instances, it has been the most vulnerable people in our community who have had no means of redress. This is a very important consideration when looking to the future.

The disputes resolution environment in the New Zealand financial sector will look very different by the end of 2010. The ISO Scheme may, or may not, remain the same, but whatever decisions are made, the parameters set out in the Act are clear: the ISO Scheme has had, and will continue to have, an important role in encouraging confidence in financial services in New Zealand.

ACKNOWLEDGEMENTS

Thanks first to my staff, in particular, Lionel Hinton and Iain Opray, for understanding how important a good complaints process is for the customers of the insurance and savings industry in New Zealand.

An important thank you, with an acknowledgement of her contribution and commitment to the ISO Scheme over the last 4 years, to Alison Timms as the outgoing Chair of the Commission. Thanks also to the Members of the Commission for their ongoing support.



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



COMPLAINTS SUMMARY



There were 1,974 complaint enquiries (681 in writing), 242 complaints received for investigation and 220 complaints resolved in the 2008/2009 financial year, as set out in the tables below. There were 47 complaints resolved, as a result of involvement of the ISO Office before a formal investigation was undertaken.

STATUS	2008/09		2007/08	
Complaints carried over from previous year and completed	42		31	
Complaints received for investigation	242		202	
Complaints under investigation	284		233	
Complaints completed during the year	220		191	
Complaints for investigation but incomplete at year end	64		42	
RECEIVED BY SECTOR	2008/09		2007/08	
Fire and General	142	59%	121	60%
Health	39	16%	48	24%
Life and Savings	61	25%	33	16%
TOTAL	242		202	
OUTCOMES	2008/09		2007/08	
Complaints upheld	33	15%	35	18%
Complaints partly upheld	10	5%	11	6%
Complaints settled	23	10%	37	19%
Complaints withdrawn	2	1%	–	–
Complaints not upheld	152	69%	108	57%
TOTAL	220		191	

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.

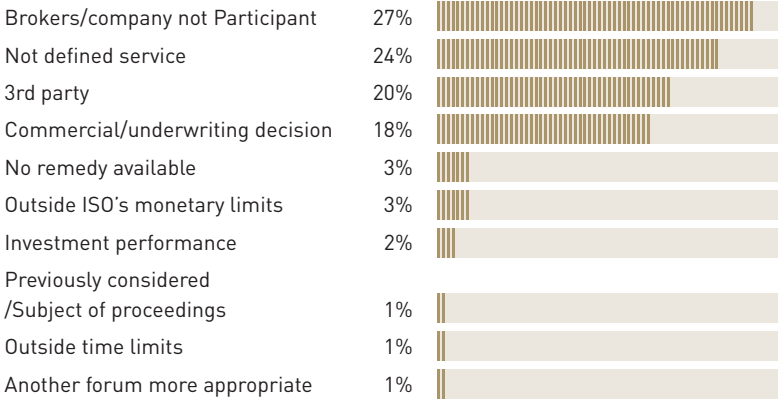
A complaint is **NOT UPHELD**, when the ISO finds that the company has treated the consumer’s complaint fairly, reasonably and in accordance with the policy terms. However, sometimes the company has made/will make an ex-gratia payment, acceptable to the consumer.

In the year ended 30 June 2009, more than \$745,000 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 total, there were 8 complaints for which a decision was made in favour of the consumer, but the amount to be paid had not been finalised when the ISO file was closed.

JURISDICTION

In the 2008/2009 financial year, we received written enquiries about 98 disputes outside jurisdiction, which required consideration and a written response. We also received 206 telephone enquiries about disputes outside the ISO’s jurisdiction.

DISPUTES RECEIVED OUTSIDE ISO’S JURISDICTION



TIMELINESS

The average time to close the 220 complaints investigated in the year ended 30 June 2009, was 87 days from receiving the company’s file and accepting the complaint.

HOW WE GOT OUR MESSAGE INTO THE COMMUNITY

IN 2008/2009:

SPEECHES AND PRESENTATIONS: We spoke at a total of 13 seminars and conferences. In addition, we held the ISO Conference on "Communication" in September 2008.

CONSUMER OUTREACH: We co-hosted, with the Banking Ombudsman and Electricity and Gas Complaints Commissioner, 5 sessions around New Zealand for consumer advisers, including Citizens Advice Bureaux, Community Law Centres, Budget Advisers and other community groups.

0800 NUMBER: We received 3,194 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 62,000 website sessions on our website: www.iombudsman.org.nz

COMPLAINT ENQUIRIES: We dealt with 1,292 telephone and 681 written complaint enquiries from consumers.

MEDIA ENQUIRIES: We handled 9 requests for information from the media.

SUBMISSIONS:

1. Oral Submissions to the Parliamentary Select Committee on the Financial Advisers Bill and the Financial Service Providers (Registration and Dispute Resolution) Bill.
2. Submission to the Finance & Expenditure Committee on the Financial Advisers Bill.
3. Submission to the Reserve Bank on the Insurance (Prudential Supervision) Bill.

ADVISORY GROUPS: We were involved in the complaints handling advisory group for the Ministry of Consumer Affairs in its preparation of discussion documents for the Financial Service Providers (Registration and Dispute Resolution) Act 2008.

We also chaired a forum for the Privacy Commission.

HOW DO PEOPLE RATE US?



THE ISO KEPT YOU WELL INFORMED ABOUT PROGRESS ON YOUR COMPLAINT

Agree	93.2%	<div><div></div></div>
Disagree	6.8%	<div><div></div></div>
Don't know	0.0%	<div><div></div></div>

THE ISO RESOLVED YOUR COMPLAINT WITHIN A REASONABLE TIME

Agree	76.3%	<div><div></div></div>
Disagree	15.3%	<div><div></div></div>
Don't know	8.4%	<div><div></div></div>

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

Agree	92.5%	<div><div></div></div>
Disagree	5.8%	<div><div></div></div>
Don't know	1.7%	<div><div></div></div>

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

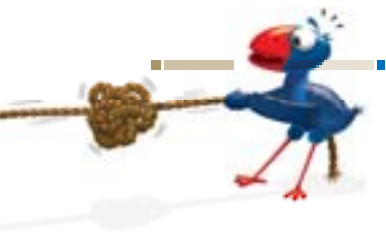
Agree	78.0%	<div><div></div></div>
Disagree	11.8%	<div><div></div></div>
Don't know	10.2%	<div><div></div></div>

THE ISO'S SERVICE IS EASY TO USE

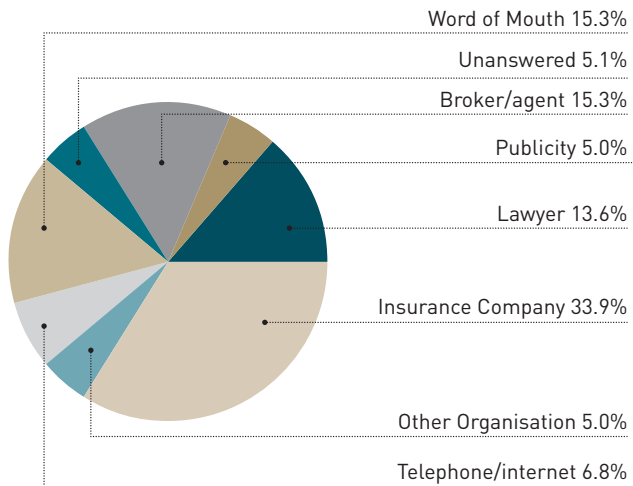
Agree	94.9%	<div><div></div></div>
Disagree	5.1%	<div><div></div></div>
Don't know	0.0%	<div><div></div></div>

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

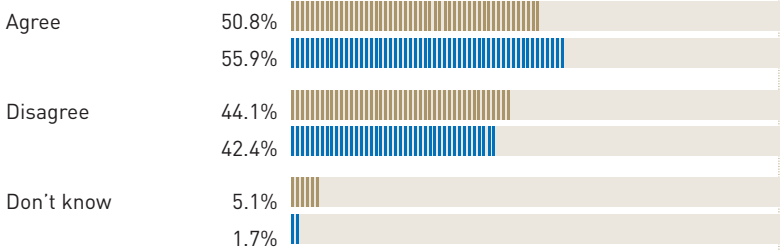
Agree	96.6%	<div><div></div></div>
Disagree	1.7%	<div><div></div></div>
Don't know	1.7%	<div><div></div></div>



HOW DID YOU FIND OUT ABOUT THE ISO?



INFORMATION PROVIDED BY PARTICIPANTS



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

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

“CASE MANAGER MADE A GREAT SUPPORT FOR ME, ESPECIALLY HIS CONSIDERATION TO ME AS A NON-NATIVE ENGLISH SPEAKER.”

COMPLAINTS CHECKLIST

1. Do you have a dispute with your insurer?	Yes
2. Have you read your policy to help you understand what your policy covers?	Yes
3. Have you been through your insurer's complaints process?	Yes
4. Have you had a letter from your insurer saying you have reached "deadlock"?	Yes

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

CASE STUDIES

13	1: Fire & General: False Statement
15	2: Fire & General: Gradual Damage
16	3: Fire & General: Small Business, Reasonable Care, Scope of Cover, Services Issues
18	4: Fire & General: Cancellation of Travel, Completion of Proposal/ Application, Fair and Reasonable, Interpretation – Specific Words/ Expressions, Knowledge, Materiality, Redundancy
19	5: Fire & General: Adviser/Agent/Representative, Cancellation of travel, Exclusion – Travel, Fair and reasonable, Pre-existing condition, Provision of information
21	6: Health: Exclusion – Health, Interpretation – Medical Evidence, Pre-existing Condition, Scope of Cover
22	7: Health/Life: Avoidance Ab Initio, Non-disclosure – Life Insurance, Non-disclosure – Pre-existing Conditions, Prudent Underwriter, Representation by Broker
24	8: Savings: Charges/Fees, Investment Statement, Withdrawal – Values



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

1

FIRE & GENERAL

FALSE STATEMENT

Background

C's house, contents, farm tools and outbuildings were insured under a bank policy, underwritten by P.

On 8 January 2008, C telephoned P 3 times to increase the sums insured for the contents and the farm assets under the policy. On the same day, because of heavy rain in the area, C's house was flooded with river water, causing extensive damage to the house, contents and farm assets. C made claims to P for the damage.

An investigator appointed by P interviewed C and his partner ("D") about the circumstances of the loss. P subsequently declined the claims and cancelled the policy, because it believed the house was already flooded when C increased the sums insured. Therefore, C had made false statements about when the flooding occurred, in support of the claims.

C and D disputed the declinature, stating that they had not made any false statements about the timing of the flood.

Assessment

It is established law that an insurer is entitled to decline a claim in support of which a false statement has been made, if the policy contains an exclusion or condition to that effect. In order to establish that a false statement has been made, an insurer must establish 3 requirements:

1. the insured made a false statement, knowing it to be false;
2. the false statement was deliberate; and
3. the false statement was significant to the claim and could not be dismissed as *de minimis*.

- **False statement**

In the interview, C and D denied that there was any water around the house when C telephoned P to increase the sums insured. C maintained this assertion in an email to the investigator.

P's system recorded the time of C's third telephone call to P (to increase the sums insured of the contents and the farm assets), as 4.24pm.

However, an aerial photograph provided by the regional council, showed that there was already substantial flooding to C's property at 4.23pm on 8 January 2008.

Therefore, on the balance of probabilities, the Case Manager believed the aerial photograph indicated that it was more likely than not, C's property was flooded when he made the third telephone call to P. Consequently, the Case

Manager believed C and D provided untrue information about the timing of the flood waters entering C's property.

- **Deliberateness**

Given that the aerial photograph showed the property was flooded at 4:23pm on 8 January 2008, the Case Manager believed that, on the balance of probabilities, C knew and deliberately misrepresented the time at which the property had flooded. Therefore, the Case Manager believed that the misrepresentation was deliberate.

- **Significance of the false statement**

The impact and falsity of C's and D's representations were directly relevant to the amount of P's liability for the contents and farm assets claims. The evidence indicated C was increasing the sums insured when he knew the property was flooded and this potentially invalidated the increase of the sums insured. P said, had it known that the property was flooded at the time, it would not have agreed to the increase.

Therefore, C misrepresented the time at which the property had flooded, to validate the increase. The increase was approximately \$50,000 greater than the original sums insured. Consequently, the misrepresentation would have misled P to indemnify C for \$50,000 to which he was not entitled. On this basis, the Case Manager did not believe that the misrepresentation was so insubstantial for the legal principle of *de minimis* to apply to the circumstances of the claims.

- **Did C's breach of the false statement condition entitle P to decline the house claim?**

P believed the house claim had been "tainted" by the false statement in regard to the contents and farm assets claims, entitling it to also decline the house claim.

In *Gibbs v New Zealand Insurance Co Limited* (6 December 1983), unreported, High Court, Auckland Registry, A173/80, Chilwell J stated that fraud in one claim taints multiple claims arising out of the same event, including those situations where the insured submitted false evidence in support of an otherwise genuine claim.

Therefore, because C made a false statement in respect of the contents and the farm assets claims, the house claim was also affected and the Case Manager did not believe P was liable to indemnify C for the house claim.

Result *Complaint not upheld*

2

FIRE & GENERAL

GRADUAL DAMAGE



Background

C's house was insured under a contents policy with P. In 2005, C noticed paint discolouration between the bath and an adjoining wall in the bathroom. C converted the bath into a shower over a bath alcove. The walls bordering the bath were not wet walls and were not designed to have water splashing onto them. To safeguard against any further damage, C pinned and taped a plastic shower curtain over one of the walls.

In 2007, C made a claim to P for damage to the walls in the bathroom. He reported rot, mould and holes through to the wooden framework of the walls. P declined the claim, on the basis the damage was gradual in nature and it fell outside the gradual damage benefit provided in the policy.

Assessment

In his report, the loss adjuster determined the damage was gradual in nature and, by C's own admission, the damage had begun to manifest at least 2 years before the claim was made. The Case Manager did not believe it was hidden, in the sense of C not being able to discover it, nor did it become hidden by virtue of C concealing the damage from view by attaching a plastic shower curtain to the walls.

The loss adjuster found no evidence of a leak from an internal water pipe or system, which may have caused the damage. He concluded the damage was clearly gradual in nature and the result of a continual wet problem and lack of adequate maintenance. The Case Manager believed the damage was outside the scope of the gradual damage benefit and P was entitled to decline the claim.

Result *Complaint not upheld*

**“THE ISO HAS BEEN HELPFUL,
TRANSPARENT AND VERY
‘USER FRIENDLY’.”**

3

FIRE & GENERAL

SMALL BUSINESS, REASONABLE CARE,
SCOPE OF COVER, SERVICE ISSUES

Background

In November 2006, C arranged insurance with P for stock and materials used in conjunction with C's business of selling cleaning equipment on a door-to-door basis.

In August 2007, C made a claim to P for some items of stock stolen from C's vehicle, which had been parked outside a prospective buyer's house. The driver of C's vehicle had temporarily left the vehicle to help with delivering items to a house and, on his return, he discovered the vehicle had been stolen. The vehicle was later recovered without the stock.

P declined the claim, because the policy excluded cover for theft "*from an unlocked unattended vehicle*" and because the employee had not taken reasonable care to safeguard the property. C made representations to P that she had never received a copy of the policy and was, therefore, unaware cover was not provided for such a loss. Following a review of the claim, P maintained the decision to decline the claim.

Assessment

The Case Manager's investigation established that the driver had stayed in C's vehicle while his colleague removed items, knowing he was not to leave the vehicle unattended. However, when the colleague called for help, as he was about to drop some items, the driver rushed to assist. Both employees carried the items to the house and the driver returned promptly to the vehicle, only to find that, in the 3-4 minutes he had been away, an opportunist had taken the vehicle. In view of the circumstances in which the vehicle had been left unintentionally unlocked and unattended, the Case Manager did not believe P could rely upon a breach of duty of care to decline the claim.

The Case Manager noted that the unlocked vehicle exclusion was clear and, unlike the reasonable care condition, did not allow for any exceptions. To rely upon the exclusion, P simply had to prove the theft occurred from an "*unlocked unattended vehicle*" and C's driver confirmed that had been the case.

The Case Manager also noted C had made 3 attempts prior to the loss occurring to obtain a copy of the policy and the possible confusion over the use of a post office box and a street address. The Case Manager concluded P's level of service relating to C's enquiries was unsatisfactory. Although the



ISO does not have jurisdiction over how P chooses to conduct its business, the Case Manager made representations to P about this aspect, but P insisted it had provided the policy documentation on more than one occasion and stated that “*we are comfortable that we have discharged our obligations to the insured in this regard*”.

The Case Manager concluded that, even if C had received the policy, given the circumstances of the loss, C’s employee would probably not have acted differently and the loss would still have occurred.

Result *Complaint not upheld*

“I WAS GIVEN CLEAR EXPECTATIONS AND SOME REALLY GOOD ADVICE. A DIFFICULT SITUATION AND FACED WITH LOSING EVERYTHING FOUND ISO COULD SALVAGE SOMETHING FROM ALL THE YEARS OF CONTRIBUTION TO LIFE INSURANCE. WE ARE FOREVER GRATEFUL.”

4

FIRE & GENERAL

CANCELLATION OF TRAVEL, COMPLETION OF PROPOSAL/APPLICATION, FAIR AND REASONABLE, INTERPRETATION – SPECIFIC WORDS/EXPRESSIONS, KNOWLEDGE, MATERIALITY, REDUNDANCY

Background

In August 2008, C arranged and paid for flights to Europe. C intended to depart in early December 2008 and return January 2009. On 13 October 2008, C's employer ("D") met with C and other staff to discuss redundancies which were to occur. On or about 17 October 2008, C arranged travel insurance with his travel agent. The cover was underwritten by P. On 20 October 2008, C was notified he was to be made redundant, effective 24 October 2008.

In November 2008, C completed a claim form and made a claim to P for the non-refundable portion of the airfare. In support of the claim, C attached a letter from D. There was initially some confusion over the date on which C was informed of the redundancy. P sought clarification of the date, to which D apologised for the "*misunderstanding*" and stated he "*didn't think it mattered*". He said he would get back to P with "the whole process and dates". D confirmed that redundancies were discussed at the meeting on 13 October 2008, but who would be made redundant was not communicated until 20 October 2008. P wrote to C, declining the claim.

Assessment

P said that, because C knew "*redundancy was a possibility*", the subsequent cancellation of his trip was not an "*unforeseen*" event. The Case Manager did not accept P's interpretation of the level of knowledge required by the policy, which was on the balance of probabilities. This would require C to have known that it was more probable than not he would be made redundant. This level of awareness is implied by the insuring clause which refers to awareness of any "*circumstance likely to give rise to a claim*" (Case Manager's emphasis).

The Case Manager telephoned D and discussed what he told his staff at the meeting on 13 October 2008. D said he told the staff, including C, that "*he needed to lay-off four*" of the 9 apprentices. However, he said he did not discuss which of the 16 staff were to be made redundant.

No indication was given of which 4 apprentices were likely to be made redundant and certainly no indication was given to C that it was more likely than not to be him. C only knew there was a possibility of staff redundancies. Therefore, the Case Manager believed C's redundancy was "*unforeseen*" at the time the policy was arranged and the claim should be paid.

Result *Complaint upheld*

5

FIRE & GENERAL

ADVISER/AGENT/REPRESENTATIVE,
CANCELLATION OF TRAVEL, EXCLUSION –
TRAVEL, FAIR AND REASONABLE, PRE-EXISTING
CONDITION, PROVISION OF INFORMATION

Background

C arranged travel insurance with P, through her travel agent, for a trip to Europe. While C was in Europe, her mother died. C curtailed her journey and returned home. C made a claim to P for the “[c]urtailment of [her] journey due to [the] sudden illness (and subsequent death) of [her] mother”.

P declined the claim, “as [C’s] mother’s condition was pre-existing at the time the policy was issued and the pre-existing condition cover was not applied and paid for”.

Assessment

The policy included a benefit for “**Curtailed**” of travel, if C could not “complete [her] journey due to an unforeseeable circumstance beyond [her] control”. However the policy excluded claims caused by “any pre-existing condition suffered by [C] or by a close relative or any complications directly attributable to those conditions, except when [P] ... agreed in writing to provide cover and [C] ... paid the pre-existing condition surcharge”.

The policy stated that, in order for a condition to be considered a “**Pre-existing condition**” in terms of the policy, it must have been “any physical defect, infirmity, existing or recurring illness, injury or disability which [C] [was] aware of for which [C’s mother] ha[d] received medical examination, consultation, treatment, investigation and/or medication in the 6 months prior to the date [the] policy [wa]s issued”.

The medical information indicated C’s mother was first diagnosed with Idiopathic Pulmonary Fibrosis in 1995. However, there was no clear indication in the correspondence received by the ISO that C was aware of the condition when she arranged the policy. Although P maintained the condition was a “**Pre-existing condition**”, P did not take any steps to confirm whether C was aware of the condition when the policy was issued. Consequently, the Case Manager did not believe it was fair or reasonable for P to assume C was aware her mother was suffering from the condition when the policy was issued.

C’s mother’s doctor advised that C’s mother “did not use any medication for her chest” and “only consulted [her] about her lung condition in May 02 July 04 July 06”. As such, there was no evidence that C’s mother received “medical examination, consultation, treatment, investigation and/or medication” for the condition in the 6 months prior to the date the policy was issued.

In accordance with paragraph 5.7 of the Terms of Reference, the ISO makes decisions having regard to what is fair and reasonable in all the circumstances. Although the condition was diagnosed in 1995, the Case



Manager did not believe that P had proved that it was a “*Pre-existing condition*” in terms of the policy definition.

The Case Manager believed that there were several issues of concern in respect of the policy exclusion relating to pre-existing conditions of close relatives (“the exclusion”), as follows:

1. There was no indication in the policy brochure that pre-existing conditions suffered by anyone other than the insured were excluded under the terms and conditions of the policy.
2. The travel agent who sold C the policy confirmed that, until C’s claim was declined, she was unaware of the policy exclusion relating to pre-existing conditions suffered by relatives of an insured. This was a training issue for which P was responsible.

These issues raised the concern that C was not made aware of the exclusion. Therefore, even if C had been aware of the condition, she was not given any opportunity to apply for cover. As such, even if P was able to show that the condition was a “*Pre-existing condition*” in terms of the policy, it was the Case Manager’s opinion that, in accordance with paragraph 5.7 of the Terms of Reference, it would be unreasonable to apply the exclusion in all the circumstances.

Result *Complaint upheld*

“HAVE REALLY APPRECIATED THE SERVICES OF ISO EVEN ALTHOUGH THE ORIGINAL COMPLAINT HAS NOT BEEN UPHELD THEY HAVE ALSO BEEN HELPFUL IN ATTENDING TO OTHER MATTERS WHICH APPEAR TO BE HEADING TOWARDS A POSITIVE OUTCOME.”

HEALTH

6

EXCLUSION – HEALTH, INTERPRETATION –
MEDICAL EVIDENCE, PRE-EXISTING CONDITION,
SCOPE OF COVER

Background

In February 2008, C arranged health insurance with P. In March 2008, C contacted P to request prior approval for a CT scan of her sinuses. C advised that the CT scan was required due to “a sinus blockage” caused by a deviated septum and rhinitis. P declined C’s request for prior approval, advising that her conditions were pre-existing and, therefore, excluded under the policy.

C was unhappy with the decision, because she was not diagnosed with a deviated septum or rhinitis until after the policy started, so she did not believe that they should be considered to be pre-existing conditions.

Assessment

The policy was the basis of C’s relationship with P. The policy stated there was no cover for any “**Pre-existing condition**”. The policy defined “**Pre-existing condition[s]**” as “*any health condition which relate[d] to a sign, symptom or event occurring or existing ... before the **policy start date**; and ... where [C] was aware ... or ought reasonably to have been aware, of the health condition, sign, symptom or event*” (Case Manager’s emphasis).

In terms of the policy, there was no reimbursement for any healthcare services for any condition, which was related to any symptom C was aware of, before the policy commenced. The issue was not whether C considered her conditions were pre-existing, but whether the conditions were “**Pre-existing condition[s]**”, in terms of the policy definition.

The medical information provided indicated that C had suffered from a blocked nose and severe nasal congestion for approximately 4 years before her cover on the policy commenced and she had seen specialists regarding these symptoms. However, she was not diagnosed with a deviated septum or rhinitis until March 2008.

From the Case Manager’s research, she understood that a blocked or congested nose is often a symptom of both a deviated septum and rhinitis, although it can also be caused by other conditions. However, in this case, it appeared that C’s blocked or congested nose was, more likely than not, a “*symptom*” of a deviated septum and rhinitis, the conditions she was diagnosed with in March 2008.

Because a blocked or congested nose was a “*symptom*” C was aware of before the policy start date, her deviated septum and rhinitis were considered “**Pre-existing condition[s]**” in terms of the policy wording. Because they were “**Pre-existing condition[s]**”, P was not liable to pay a benefit for any treatment related to C’s deviated septum or rhinitis.

Result *Complaint not upheld*

7

HEALTH/LIFE

AVOIDANCE AB INITIO, NON-DISCLOSURE – LIFE INSURANCE, NON-DISCLOSURE – PRE-EXISTING CONDITIONS, PRUDENT UNDERWRITER, REPRESENTATION BY BROKER

Background

In August 2007, with the help of his broker, C arranged critical illness cover with P.

In April 2008, C made a claim to P for the critical illness cover, because he had been diagnosed with prostate cancer. P avoided the policy and declined to consider the claim, as it believed C had failed to disclose material information when he arranged the policy.

C was unhappy with the decision; he believed he had disclosed the necessary information to the adviser and the adviser had told him P would obtain a copy of his medical records before accepting the policy.

Assessment

P was entitled to decline to consider the claim and avoid the policy, if C failed to disclose material information.

- **Non-disclosure**

When C completed the application, he was asked a number of questions relating to his past, present and future health. C answered “Yes” to having had medical examinations or tests in the last 5 years and declared that he had suffered from a “*broken wrist*”, an “*ear infection & tin[n]it[u]s*”. C signed and dated the application and, by doing so, declared the information provided was “*true and complete to the best of [his] knowledge*”.

During its investigations for the claim, P obtained C’s medical records. Based on the medical information provided, C did not disclose that he was being monitored for gradually increasing PSA levels. Therefore, it was necessary to determine whether this information was material information, which should have been disclosed to P.

- **Materiality**

P could avoid the policy, if C failed to disclose material information when he 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 had to consider 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 him.

Both of the underwriters responded and advised that, based on C's medical history, they would have deferred cover until further investigation of the elevated PSA levels had been carried out. As such, the cover would not have been provided on the same terms as those offered. Having regard to the experience of this Office and the independent underwriters' opinions, the Case Manager believed that the non-disclosure was material.

P also had to prove the non-disclosure of the information induced it to enter the contract on the terms provided. If C had disclosed his full medical history to P, P said it would have "[d]eferred cover pending full investigation of the progressively rising PSA". On this basis, having regard to the information in the underwriting review, the Case Manager was satisfied the non-disclosure caused P to enter the contract on the terms provided.

- **Medical records**

C believed that the adviser told him P would obtain a copy of his medical records prior to approval of the application. However, insurers do not, as a matter of course, check the medical history of every applicant for insurance. Insurers only ask for an applicant's medical history when, as a result of information disclosed on the application, the insurer needs more information to form an opinion about what terms it will offer the applicant. If the applicant states on the application that he/she has not had any medical treatment, medication, or tests, the insurer accepts the statements as true and does not ask for the applicant's medical history, or make further enquiries with the applicant's doctor.

- **Adviser's conduct**

C stated he discussed his "*annual check ups*" with the adviser and she decided that it did not need to be noted on the application. However, the adviser had retired and her adviser group was unable to find records of any such discussion in its files.

On the evidence available, P was entitled to assume the application contained correct information regarding C's health at the time. C failed to disclose material information and, therefore, P was entitled to take the action that it did.

Result *Complaint not upheld*



8

SAVINGS

CHARGES/FEES, INVESTMENT STATEMENT,
WITHDRAWAL – VALUES

Background

In August 2000, C invested the proceeds of 2 maturing policies in an international shares fund (“the investment fund”), which was available under a personal superannuation plan offered by P. In September 2007, C contacted P, expressing concern at the reduction in the value of the investment. In October 2007, P responded to C’s concerns.

In February 2008, C wrote to P highlighting a further reduction in the value of the investment, requesting the immediate payment of the bulk of his investment and reimbursement for the loss resulting from the decision to follow the adviser’s advice.

In May 2008, after pursuing the matter with P and through the ISO, C’s request was actioned and he received payment for the units which had been cashed. C subsequently requested an additional payment from P. P declined to make the payment and stated it had found no evidence that the adviser misled C or provided poor advice. It concluded the reduction in the value of C’s investment arose from market movements which could not have been predicted by P or the adviser.

In submitting the complaint to the ISO, C felt he had been inveigled into investing the money by the adviser. C suggested there was something wrong with the administration of the investment fund, highlighting the fees shown for the investment fund in the 2007 annual report for the personal superannuation plan. C sought payment of the difference between the amount he received from P and the amount which would have been available if the money had been invested, on a compound interest basis, in a term deposit at an interest rate of 5%.

Assessment

The Case Manager could not be certain about what was discussed when the investment was arranged. Consequently, it was necessary to rely on the available documentation.

In correspondence with P, C said he had not received an Investment Statement for the personal superannuation plan from the adviser. However, the application declaration which C signed confirmed he had received, read and understood the Investment Statement. C subsequently told the Case Manager the investment was arranged in one visit and that, if he had been given a copy



of the Investment Statement, he would not have read it and would have relied on what the adviser said.

The Case Manager believed the layout of the Investment Statement was such that, even if the whole document was not read, a cursory examination of it would have provided key details. From a consideration of the information provided in the Investment Statement, the Case Manager concluded it made it clear that investing in the personal superannuation plan would not provide a capital guarantee and that no particular rate of return was promised. It also showed that, while shares had the potential for the highest returns, they also had the potential for the highest risk and volatility of the specified asset classes.

At 6 monthly intervals, P sent C a half yearly statement with details of his investment, together with an investment report. The investment reports included information about the various investment funds which were available. For the investment fund, this information showed that it was suitable for long term investments and had the potential for high risk and high returns.

The ISO's Terms of Reference precluded the ISO from considering P's funds management performance or the returns offered. However, from information provided by P, the Case Manager noted the return for the investment fund was very close to the return for the index to which the investment fund was aligned.

The Case Manager noted the price at which C's units were cashed in May 2008 was higher than the price which would have applied, if they had been cashed when C's request was initially received by P in February 2008. Consequently, in terms of the unit price applying to cash units, C had not been disadvantaged by the delay.

Although the ISO's Terms of Reference precluded the Case Manager from commenting on the level of charges made, calculations made by the Case Manager, when considered in conjunction with information in the Investment Statement, indicated that the amount of the fees charged for the investment fund appeared reasonable.

After considering the available information, the Case Manager concluded there was no basis on which P could be required to make an additional payment to C.

Result *Complaint not upheld*

FINANCIAL STATEMENTS

INSURANCE & SAVINGS OMBUDSMAN COMMISSION
FOR THE YEAR ENDED 30 JUNE 2009

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DIRECTORY

FOR THE YEAR ENDED 30 JUNE 2009

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, 99-105 Customhouse Quay, Wellington

BANKERS	The National Bank of New Zealand Ltd, Wellington
ACCOUNTANTS	BDO Spicers (Wellington) Limited, Wellington
AUDITORS	Grant Thornton, Wellington

STATEMENT OF FINANCIAL PERFORMANCE: For the year ended 30 June 2009

	Note	2009	2008
Income			
Levies		1,110,000	991,689
Casebook Sales		1,187	156
Conference		36,668	–
Workshop/Training Day		–	311
Interest Received		54,447	66,443
Sundry Income		450	498
Profit on Sale of Fixed Assets		173	–
Total Income		1,202,925	1,059,097
Less : Expenditure			
Administration Costs		152,035	140,873
Audit Fees		5,535	4,800
Commissioners' Fees & Expenses		34,000	34,000
Conference		25,513	–
Depreciation – Office Equipment		29,890	29,194
Depreciation – Furniture & Fittings		237	390
Professionals & Consultancy		47,196	45,891
Occupancy		11,912	11,363
Promotion		13,700	14,634
Rent	3	97,683	97,683
Salaries		724,590	665,984
Scheme Review Fees & Expenses		–	60,812
Staff Costs		9,873	8,732
Workshop/Training Day		–	–
Total Operating Expenditure		1,152,164	1,114,356
Net Surplus (Deficit) Before Tax		50,761	(55,259)
Tax Expense	4	6,614	–
Net Surplus (Deficit) After Tax		44,147	(55,259)

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

STATEMENT OF MOVEMENTS IN EQUITY: For the year ended 30 June 2009

	Note	2009	2008
Balance at Beginning of Year		387,361	442,620
Net Surplus (Deficit) After Tax		44,147	(55,259)
Balance at End of Year	7	431,508	387,361

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

STATEMENT OF FINANCIAL POSITION: As at 30 June 2009

	Note	2009	2008
Equity			
Accumulated Funds Account	7	431,508	387,361
Total Equity		431,508	387,361
Represented By:			
Current Assets			
Accrued Income		678	3,205
Accounts Receivable		–	1,590
Prepayments		8,041	16,810
Cash & Bank		183,345	121,794
National Bank of N.Z. Term Deposits		250,000	250,000
Income Tax Refund		4,479	14,734
G.S.T. Refund		7,475	8,852
Total Current Assets		454,018	416,985
Fixed Assets	2	60,959	73,707
Total Assets		514,977	490,692
Current Liabilities			
Income Received in Advance		–	444
Accounts Payable		83,469	102,887
Total Current Liabilities		83,469	103,331
Total Liabilities		83,469	103,331
Net Assets		431,508	387,361

The Insurance & Savings Ombudsman Commission authorised these financial statements for issue on

Chairperson:  Date: 12.08.09

Ombudsman:  Date: 12.08.09

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 2009

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 New Zealand Institute of Chartered Accountants 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

Property, Plant & Equipment are included at cost less aggregated depreciation. Depreciation is provided up to the maximum rates allowed by the Inland Revenue Department. Fixed assets are depreciated using the straight-line method at the following rates:

Office Equipment	18.6–48%
Furniture & Fittings	6.5–9.6%

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
Plant & Equipment – 2009			
Office Equipment	123,125	65,108	58,017
Furniture & Fittings	7,679	4,737	2,942
	\$130,804	69,845	\$60,959
Plant & Equipment – 2008			
Office Equipment	192,881	122,353	70,528
Furniture & Fittings	77,322	74,143	3,179
	\$270,203	196,496	\$73,707

NOTE 3 – OPERATING LEASE COMMITMENTS

Analysis	2009	2008
Current	56,984	97,683
Non-Current	–	56,984
	56,984	154,667

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

The existing operating lease expires during the year ended 30 June 2010. No automatic right of renewal exists. Consideration of future (lease space) requirements could dictate that an alternative tenancy may be required.

NOTE 4 – TAXABLE INCOME RECONCILIATION

Income Adjustments	2009	2008
Book Profit/(Loss) Before Tax	50,761	(55,259)
Adjustment for Non-Taxable Income and Expenses	573	1,451
Losses Utilised	(15,649)	–
Taxable Profit/(Loss)	35,685	(53,808)
Tax @ Marginal Rates	6,614	–
Opening Balance	(14,734)	–
Tax payments made	–	(1,817)
RWT Paid	(11,093)	(12,917)
Refund Received	14,734	–
Tax Payable/(Refundable) as at 30 June 2009	(4,479)	(14,734)

Following the decision to treat the organisation as a society a tax provision has been included in the Financial Statements.

NOTE 5 – CONTINGENT LIABILITIES & COMMITMENTS

As at balance date the Insurance & Savings Ombudsman Commission had no capital commitments (2008: \$Nil).

As at balance date, the Insurance & Savings Ombudsman had the following contingent liability: An ISO Scheme Review will be undertaken during the 2011 year. The total cost of the review is estimated to be \$60,000. As part of prudent financial management, the Insurance & Savings Ombudsman Commission has designated \$40,000 of its accumulated funds for the ISO Scheme review (2008: \$20,000).

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 (2008: \$Nil).

NOTE 7 – ACCUMULATED FUNDS

	2009	2008
Total Accumulated Funds	431,508	387,361

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 MEMBERS OF THE INSURANCE & SAVINGS OMBUDSMAN COMMISSION

We have audited the financial report on pages 27 to 31. The financial report provides information about the past financial performance of the Insurance & Savings Ombudsman Commission and its financial position as at 30 June 2009. This information is stated in accordance with the accounting policies set out on pages 29 to 31.

THE MEMBERS OF THE INSURANCE & SAVINGS OMBUDSMAN COMMISSION RESPONSIBILITIES

The members of the Insurance & Savings Ombudsman Commission are responsible for the preparation of a financial report which fairly reflects the financial position of the Insurance & Savings Ombudsman Commission as at 30 June 2009 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 Commission and to report to you.

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 Insurance & Savings Ombudsman Commission in the preparation of the financial report; and
- whether the accounting policies are appropriate to the Insurance & Savings Ombudsman Commission 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 auditors, we have no relationship with, or interests in, the Insurance & Savings Ombudsman Commission.

UNQUALIFIED OPINION

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

In our opinion the financial report on pages 27 to 31 fairly reflects the financial position of the Insurance & Savings Ombudsman Commission as at 30 June 2009 and the results of its operations for the year ended on that date.

Our audit was completed on 12 August 2009 and our unqualified opinion is expressed as at that date.

Grant Thornton
Wellington
12 August 2009

SCHEME PARTICIPANTS: as at 30 June 2009

AA Insurance Limited	ING Insurance Services (NZ) Limited
• SIS Insurance	ING Life (NZ) Limited
ACE Insurance Limited	Lumley General Insurance (N.Z.) Limited
Allianz New Zealand Limited	• Australis Underwriting Agency
• Club Marine	• Lumley Business Solutions
• Protecta	Manchester Unity Friendly Society
• Motor & General	Medical Insurance Society Limited
• Mondial (1Cover, World Nomads)	Medical Life Assurance Society Limited
• Elders IPMNZ	MFL Mutual Fund
American Home Assurance Company (NZ Branch) t/a AIG New Zealand	Mitsui Sumitomo Insurance Company Limited
American International Assurance Co (Bermuda) Limited t/a AIG Life	Pacific Life Limited
AMI Insurance Limited	PSIS Life Limited
• CLIC Car Insurance Limited	Public Trust
AMP Services (NZ) Limited	Sentinel Assurance Company Limited
Ansvar Insurance Limited	SIL Mutual Fund
Associated Marine Insurance Agents Pty Limited	Simply Insurance New Zealand Limited t/a GE Money Insurance Services
Asteron Life Limited	Southern Cross Benefits Limited (Travel)
• Asteron Retirement Investment Limited	Southern Cross Medical Care Society
• Asteron Trust Services Limited	Southsure Assurance Limited
China Insurance (New Zealand) Company Limited	Sovereign Assurance Company Limited
CIGNA Life Insurance New Zealand Limited	• Sovereign Superannuation Funds Limited
Combined Insurance Company of New Zealand	• Colonial Mutual Life Assurance Society
Dorchester Life Limited	The National Mutual Life Association of Australasia Limited t/a as AXA New Zealand
Equitable Life Insurance Company Limited	TOWER Health & Life Limited
Farmers' Mutual Group	TOWER Insurance Limited
Fidelity Life Assurance Company Limited	TOWER Investments Limited
• Farmers' Mutual Life	Union Medical Benefits Society Limited t/a UNIMED
Hallmark Life Insurance Company Limited t/a GE Money Insurance Services	Vero Insurance New Zealand Limited
Health Service Welfare Society Limited t/a Accuro Health Insurance	• AMP General Insurance
I.O.O.F of New Zealand – Friendly Society	• Comprehensive Travel Insurance Limited
IAG New Zealand Limited	• Mariner Marine Insurance
• DriveRight	• Vero Marine Insurance
• Lantern Insurance	• Vero Warranty (Autosure, Crown)
• Mike Henry Travel	Zurich Australian Insurance Limited t/a Zurich New Zealand
• NAC Insurance	
• NZI	
• NZI Marine	
• State	
• Swann Insurance	
ING (NZ) Limited	

• Denotes subsidiary or associated company or business division

**“I FELT I WAS REALLY
LISTENED TO/OR
MY WRITTEN
EXPLANATIONS TAKEN
SERIOUSLY AND
IMPRESSED WITH THE
DETAILED LETTER
CITING REASONS FOR
THE ISO DECISION.”**



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